Coroners Court of
New South Wales

Inquest into the deaths at Westfield Bondi Junction on 13 April 2024

Volume Three

Findings of Magistrate Teresa O'Sullivan
New South Wales State Coroner

5 February 2026

State Coroner of New South Wales

Inquest into the deaths at Westfield Bondi Junction on 13 April 2024

Findings and Recommendations

5 February 2026

Published 5 February 2026 by the Coroners Court of New South Wales

1A Main Avenue, Lidcombe NSW 2141

Phone: (02) 8584 7777 Fax: (02) 8584 7788

Email: lidcombe.coroners@justice.nsw.gov.au

The photograph on the report's cover was taken by Brendan Esposito of ABC News.

It is reproduced here with the kind permission of ABC News.

Volume Three

Part 8 The response of the NSWPF to the events of 13 April 2024

The response of the NSWPF to the events of 13 April 2024

8.1 To address the evidence arising in relation to consideration of Issues 11 and 12 with respect to the response of the NSWPF, this Part will be divided into the following sections:

Section A	Introduction and expert evidence regarding NSWPF response
Section B	The NSWPF response to AAO incidents
Section C	The NSWPF response on 13 April 2024
Section D	NSWPF Command and Control
Section E	NSWPF first aid response
Section F	NSWPF response to reports of a second offender
Section G	Changes within the NSWPF since the events of 13 April 2024

A. Introduction and expert evidence regarding response of NSWPF

Introduction

8.2 Section I of Part 6 above considered the incredibly brave and swift actions of Insp Amy Scott in entering WBJ and confronting Mr Cauchi, ultimately fatally shooting him. Following this, the NSWPF response pivoted to managing the confronting scene within WBJ and tending to victims.

8.3 This Part will consider the broader response of the NSWPF in relation to the events of 13 April 2024. Central to considering the response of the NSWPF are the underlying policies and procedures in relation to how police respond to an AAO incident. The Court was greatly assisted by statements contained in the brief of evidence from numerous NSWPF officers, especially those who attended WBJ on 13 April 2024.

8.4 As will be discussed further below, Insp Scott, upon arriving at WBJ on the afternoon of 13 April 2024, determined that the circumstances before her amounted to an AAO incident. This resulted in her decision to immediately enter WBJ to locate Mr Cauchi.

8.5 At the outset, the Court acknowledges that whilst the Inquest sought to identify any potential shortcomings or areas for improvement in the NSWPF response, the aim of this was to learn from the extraordinary events of that day. There had been no AAO incident involving a similar knife attack in New South Wales, or indeed in Australia at the time of Mr Cauchi's attack – the events that unfolded at WBJ on 13 April 2024 were unprecedented.

8.6 At Inquest, oral evidence was provided by the following NSWPF witnesses (in addition to Insp Scott):

(a) Chief Inspector Christopher Whalley (**CI Whalley**), who assumed the role of NSWPF Forward Commander at WBJ on 13 April 2024;

(b) Senior Sergeant William Watt (**S/Sgt Watt**), the current coordinator of the NSWPF Operational Safety Training & Governance (**OSTG**), with part of his role involving the delivery and development of the training provided to NSWPF officers. S/Sgt Watt gave evidence regarding the overall response of NSWPF officers on 13 April 2024 in the context of applicable NSWPF policies and procedures; and

(c) Assistant Commissioner Peter McKenna APM (**AC McKenna**), who is the Commander of the Central Metropolitan Region. AC McKenna provided an executive statement in relation to the NSWPF response to the events of 13 April 2024. AC McKenna did not attend WBJ on the day.

Expert evidence

8.7 The Court was greatly assisted by receiving independent expert evidence from several witnesses that touched on aspects of the NSWPF response, including:

(a) Scott Wilson, who has 31 years' of policing experience in the UK, including senior roles for the Metropolitan Police at New Scotland Yard and the National Counter Terrorism Headquarters;

(b) Dr Stefan Mazur, an emergency medicine physician with over 20 years' medical experience, including as a Consultant Emergency Physician, a Prehospital and Retrieval Physician, and as a Chief Medical Officer. Dr Mazur, as part of his engagement, provided an expert opinion on the survivability of the injuries suffered by the deceased victims as well as the adequacy and appropriateness of the treatment provided, including by NSWPF officers; and

(c) Dr Phillip Cowburn, an emergency medicine physician from the UK with extensive experience as a Consultant Trauma Team Leader, who provided evidence concerning a number of topics, some of which pertained to the NSWPF response to the incident, including the operation of the Ten Second Triage Tool (**TST**), joint agency working through the JESIP methodology and also on the survivability of victims.

8.8 Abridged curriculum vitae for the court appointed experts are at **Appendix 9.**

8.9 Both Dr Mazur and Dr Cowburn provided individual detailed reports to assist the Court and gave evidence in conclave (concurrently) at Inquest on 23 May 2025, with Dr Thomas Evens, NSW Ambulance Acting Executive Director of Medical Services Fand Research. The evidence arising from this conclave was of great assistance to the Court and is considered further below.

Issues considered in relation to the NSWPF response

8.10 By reference to the issues list, the issues pertaining the NSWPF response to the events of 13 April 2024 were Issue 11 and Issue 12, which are outlined in full at **Appendix 5.**

B. The NSWPF approach to AAO incidents

8.11 To understand and consider the NSWPF response to the events of 13 April 2024, it is necessary to understand the framework that underpins how members of the NSWPF respond to an AAO incident.

The NSWPF organisational approach to AAO incidents

8.12 Within the NSWPF, two commands have relevant involvement in the response to an AAO incident. First, the OSTG, who are responsible for the physical training of operational police to enable them to respond to an AAO incident, including the application of tactical options and, secondly, the NSWPF TPU which provides terrorism threat information and protective security advice to government, police and owner operators of critical infrastructure, including crowded places, as outlined in Part 5.

8.13 As discussed further below, the NSWPF operational approach to AAO incidents evolved following the participation of OSTG staff in a trip to the US in 2015 to draw on international learnings about the response of emergency services to "active shooter" events.

8.14 This visit led to the development of an NSWPF AAO Training Package. Insp Amy Scott, who responded to WBJ on 13 April 2024, had undertaken this training.

8.15 S/Sgt Watt, the current Coordinator of OSTG, provided evidence concerning the evolution of the NSWPF AAO Training Package. This included his involvement in its development and the ongoing work of the OSTG to keep abreast of international developments regarding responses to AAO incidents.

8.16 In oral evidence, S/Sgt Watt explained that the Advanced Law Enforcement Rapid Response Training (**ALERRT**) program, which was developed as a cooperative arrangement between law enforcement in Texas and the University of Texas in response to active shooter situations, informed the NSWPF approach to AAO events.

8.17 The ALERRT program was selected by the NSWPF given its endorsement by the US Federal Bureau of Investigation (**FBI**) and subsequent use by other high-profile policing jurisdictions.

8.18 The three essential operational goals of AAO training based on the ALERRT program are as follows:

(a) Stop the killing;

(b) Stop the dying; and

(c) Rapidly evacuate the injured.

8.19 S/Sgt Watt explained that "stop the killing" refers to the primary purpose of police to stop the actions of an AAO actively engaged in killing or injuring bystanders, given police are the only first responders with the equipment, training and authority to confront the offender and stop them with lethal force if required.

8.20 "Stop the dying" refers to the provision of immediate trauma focused lifesaving first aid to injured people in areas S/Sgt Watt termed as a "warm zone" or "unsecured area", noting again that police are the first responders in an AAO environment.

8.21 The final goal of "rapidly evacuating the injured" to a suitable medical facility contemplates that injuries sustained by victims in an AAO incident are likely to require a higher level of care (for example, surgical intervention).

Evolution of the NSWPF AAO Training Package

8.22 During the Inquest, evidence was received regarding the evolution of the NSWPF AAO Training Package following the decision of the NSWPF that it would adopt the three essential operational goals of AAO training based on the ALERRT program.

8.23 In April 2015, OSTG arranged for several ALERRT qualified instructors to travel to Australia to deliver AAO training to a group of NSWPF Operational Safety Instructors (**OSIs**), who then developed the NSWPF AAO program in conjunction with the Commissioner's Executive Team. In conjunction with the AAO program, the NSWPF Active Armed Offender Response Guidelines (**NSWPF AAO Guidelines**) were also developed, with the current version published in August 2017, scheduled for review in February 2026.

8.24 The initial rollout of the AAO training (which commenced in October 2015) involved a four-day mandatory package for all police during the period from 2015 to 2018, followed by a second rollout with a two-day package during 2018 to 2020. A further mandatory training program was conducted from 2020 to 2021, focusing on tactical emergency casualty care and reinforcing content taught in earlier training.

8.25 Between 2021 and 2024, there was no mandatory AAO training for operational police who had already completed the earlier AAO package; however, AAO training was still delivered at the NSWPF Academy for new recruits.

8.26 The 2025 AAO training package commenced in July 2025 and is currently two and a half hours in length. It includes some scenario-based training. S/Sgt Watt explained that it is intended that the updated AAO training program:

> *... will focus on concepts rather than explicit tactics for officer movement inside and outside buildings when responding to an AAO. There will also be a focus on the need for*

> *rapid establishment of command and control to facilitate quick evacuation of the injured to a higher level of medical care.*[1754]

The NSWPF AAO Guidelines

8.27 The NSWPF AAO Guidelines, define an AAO as:

> *An armed offender who is actively engaged in killing or attempting to kill people and who a member of the police force reasonably suspects will continue to do so while having access to additional potential victims.*[1755]

8.28 The NSWPF AAO Guidelines outline guiding principles as to the development and maintenance of the NSWPF training packages and operational procedures for the first response to an AAO incident.

8.29 These guidelines recognise that in any police response to an AAO incident there "*... will generally be a need for a significant departure from the traditional strategy of contain and negotiate and its well established and understood use.*"[1756]

8.30 "Contain and Negotiate" is an element of the Tactical Options Model (see above in Part 6) and involves the following:

> *The principal strategy of the NSWPF in response to a high risk incident with the intention of containing the subject and incident to a single location, limiting the access to resources and potential victims, while allowing time for additional resources and communication techniques to be employed. The primary goal is to achieve a peaceful resolution of the incident.*[1757]

8.31 The NSWPF AAO Guidelines note:

> *The time critical nature of an active armed offender incident will generally require first response police to act quickly and decisively to prevent further loss of life and injury without recourse to higher authority.*[1758]

8.32 Whilst Contain and Negotiate remains the principal operating strategy for the resolution of high risk incidents, the NSWPF AAO Guidelines recognise that a key feature of an AAO incident is "*... the dependence of the offender on freedom of movement and ready access to victims in order to achieve their objective.*"[1759]

8.33 The NSWPF AAO Guidelines state that the number of casualties in an AAO incident is likely to be reduced by the following factors:

(a) Rapidity of response by appropriately equipped and trained police officers;

[1754] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [47].
[1755] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.33.
[1756] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.125.
[1757] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [11](h).
[1758] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.36.
[1759] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.37.

(b) The length of time an offender has freedom of movement during an incident; and

(c) Any activity undertaken that has the effect of restricting the offender's movements.[1760]

8.34 Once a first responder has identified that an incident involves an AAO, under the guidelines:

> *… they are authorised … to move beyond the principle of containment and negotiation and deploy for the purpose of:*
>
> *1. Locating the offender(s)*
>
> *2. Restricting any access the offender(s) may have to further victims, and*
>
> 3. *Implementing an appropriate resolution option*.[1761]

8.35 The Tactical Options Model, depicted in Part 6 above, also includes "Active Armed Offender Tactics". The AAO element of the Tactical Operations Model is described as follows:

> *Active Armed Offender: An active armed offender is an individual or group of individuals whose primary intent is to kill or injure as many persons as possible. In order to effectively deal with such individuals and minimise the injuries or deaths to members of the public, police must employ tactics that are different to those suitable for most police work. The core principles of those tactics are to rapidly locate the offender, restrict their access to any further potential victims and implement the appropriate resolution strategy. The reality is that in most circumstances this will result in a violent confrontation with a subject armed with a lethal weapon of some description.*[1762]

8.36 Police are trained that any delay in entry to locate the offender is likely to result in increased casualties. Recent AAO training conducted by NSWPF also:

> *… significantly increased emphasis on the necessity of the rapid establishment of a command structure from the bottom up, meaning starting with whoever was first on scene and building from there (regardless of, for example, individual officers being from different Police Area Commands). This is because in order to minimise the number of fatalities amongst the injured, rapid establishment of command is required to facilitate handover of casualties to medical care as soon as possible.*[1763]

8.37 The three essential operational goals of the training received by NSWPF officers responding to an AAO incident (consistent with the principles in ALERRT as outlined above) are:

(a) Stop the killing;

[1760] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.37.
[1761] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.37.
[1762] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [11](j).
[1763] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [25].

(b) Stop the dying; and

(c) Rapidly evacuate the injured.

Treatment of victims under NSWPF AAO Guidelines

8.38 Consistent with the three essential operational goals of the NSWPF AAO Guidelines, once police have fulfilled the primary purpose of stopping the actions of an AAO, they should pivot to the provision of immediate trauma care. S/Sgt Watt explained that this involves:

> *... the immediate administration of trauma focused lifesaving first aid in what is best termed a "warm zone" or "unsecured area". This is a police function because typically the injection of [NSWA] personnel is not possible given the fluid and uncertain situation in the early stages of an AAO response. It is crucial because given the nature of injuries typically suffered by victims in AAO incidents, there is insufficient time to wait for medical professionals - victims will die from their injuries before the site can be made secure enough to allow the entry of [NSWA] personnel.*[1764]

8.39 Police are provided training that focuses on triage in the early stages of an AAO incident at a time when they are "*...likely to be confronted with a significant number of people with life threatening injuries and will have both limited numbers of police and limited equipment available to treat them.*"[1765]

8.40 For this reason, police are trained not to commence CPR in mass casualty incidents until all casualties have been assessed. This is to enable victims with life-threatening but treatable injuries, for example, significant bleeding, to receive more rapid assessment and treatment.[1766]

8.41 The triage process employed by NSWPF consists of two categories: first, "Treatment priority"; and secondly, "Evacuation priority".[1767]

8.42 Injured victims will be categorised as either "immediate" or "delayed" under each of these categories.[1768]

8.43 As part of the NSWPF 2020/2021 Mandatory Training Direction, AAO training delivered to operational police included a review of Tactical Emergency Casualty Care (**TECC**).[1769] TECC is described as trauma-focused first aid applied in high-threat, high-risk environments and includes physical skills relating to the use of tourniquets and packing

[1764] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [48].
[1765] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [55].
[1766] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [55].
[1767] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [55].
[1768] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [55]; Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at p.72.
[1769] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [28].

wounds, along with a triage exercise involving the triage of patients with varying levels of injuries.[1770]

8.44 Police are also taught to use chest seals designed to address penetrating injuries that have a degree of lung involvement.[1771]

8.45 Police have been trained to assess a casualty by:

> *... conducting a sweep of the injured person, searching for and controlling major bleeding, check their airway viability, monitor for a tension pneumothorax and manage potential hypothermia if medical evacuation is delayed.*[1772]

8.46 To provide TECC in the field, first response officers are issued with one first aid equipment bag (known as a "go bag") per officer in a police vehicle.[1773] The "go bag" contains two separate pre-packaged trauma kits which collectively contain "*two SOFTT-W tourniquets, two OLEAS bandages, two trauma shears and two Hyfin chest seals, as well as resuscitation face shields, nitrile gloves and casualty cards.*"[1774]

8.47 The OLEAS bandages are specifically designed to be used as both a conventional trauma pad, as well as to pack penetrating wounds in junctional areas. They were selected by the NSWPF as providing "*...a capability to rapidly control major bleeding while being simple to use and easy to carry.*"[1775]

8.48 The practical application of the NSWPF AAO Guidelines to the circumstances of the events at WBJ on 13 April 2024 is considered further below.

[1770] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [28].
[1771] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [54].
[1772] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [54].
[1773] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [48] [b].
[1774] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [48] [b].
[1775] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [48] [b].

C. The NSWPF response on 13 April 2024

8.49 Noting the availability of extensive evidence including CCTV footage, radio transmissions and electronic records, as well as comprehensive witness statements, a detailed factual chronology of events pertaining to the NSWPF response on 13 April 2024 emerged during the coronial investigation.

8.50 The Court was greatly assisted by the input of the parties involved in the Inquest who contributed to the process of distilling the timeline of the NSWPF response on 13 April 2024, resulting in overall agreement regarding the chronology of events. This was supplemented with written submissions from parties, including submissions on behalf of the Commissioner of the NSWPF, which are incorporated into these findings.

8.51 The following is a summary of the facts presented to the Court concerning the NSWPF response on 13 April 2024

Initial response

8.52 Between 3:34pm and 3:35pm on 13 April 2024, numerous Triple 0 calls were directed to NSWPF. NSWPF Radio Operations Group, State Coordination Command received multiple reports of a man (Mr Cauchi) stabbing people with a knife at WBJ. The Triple 0 calls were allocated designations in the NSWPF CAD system, referred to in Part 6.

8.53 At 3:35:17pm, CAD 264181-13042024 was made the main CAD job for information in relation to the WBJ incident, with any subsequent reports or calls merged to that CAD job. Noting the location of WBJ, the job was broadcast on the radio channel covering Eastern Suburbs PAC.

8.54 Several police vehicles, including Insp Scott, immediately acknowledged the radio broadcast and responded urgently to WBJ. Insp Scott was the first NSWPF officer to arrive around 3:36pm.

8.55 As outlined above in Part 6, Insp Scott, having received information from civilian bystanders regarding Mr Cauchi's actions within WBJ, formed the view that the situation involved an AAO, and she had to go into WBJ to "*try and find the threat*" without waiting for her colleagues to arrive.

8.56 Although Insp Scott had requested via police radio for other police cars to meet her on Oxford Street, she ultimately entered WBJ alone via Level 4, notifying police radio that she was doing so at 3:37:15pm.

8.57 At 3:38pm, a further car crew, Eastern Suburbs 35 (**ES 35**) arrived and entered WBJ at Level 3 Zone A from Oxford Street and moved up through Level 4, Zone A, encountering a number of victims but continuing on to find the offender. By this stage, as outlined in Part 6, Insp Scott was in foot pursuit of Mr Cauchi along Level 5 and had notified police radio of her location as she pursued him.

8.58 It was moments later, at 3:38:33pm, that Insp Scott shot Mr Cauchi. At 3:38:44pm, an officer from ES 35 notified police radio "*shots fired*" whilst moving through Level 4, Zone B. At 3:39:40pm, Insp Scott broadcast the following on police radio:

> *YEAH RADIO - SHOTS FIRED - I HAVE 1 MALE DOWN - I NEED AMBOS - HE IS ABOUT 50 YEARS OLD - RADIO I AM OUTSIDE PRICELINE*.[1776]

Establishment of Command and Control

8.59 As part of Insp Scott's role as a duty officer on 13 April 2024, she was responsible for the management of staff and police resources during her shift, including taking command and control of any major incident that required a response. This was the position by virtue of Insp Scott being the most senior police officer on scene at the time.

8.60 A short time later, two further NSWPF officers arrived and took over the CPR of Mr Cauchi, enabling Insp Scott to make phone calls to her Commander and the Crime Manager and make plans to lock down and clear the centre and eventually establish a command post.

8.61 At around 3:40pm, the evacuation alarm began sounding inside WBJ.

8.62 At 3:41pm, Sgt 1[1777] (using callsign Eastern Suburbs 13 (**ES13**)) broadcast on police radio a request for responding police to remain at the exits to WBJ and for further paramedics to attend the centre. By this stage, several NSWPF officers were tending to victims on Levels 3 and 4 inside WBJ.

8.63 Insp Scott gave the following evidence regarding her initial discussions with Sgt 1, including in relation to appreciating her own involvement in a Level 1 critical incident:

> *Q. You were saying earlier that there were other civilians in the area who were speaking with you about the possibility of a second offender, or whether this was the offender. Is that right?*
>
> *A. Yeah. So I inquired with civilians in that, in that manner as well, because, like I said, it was something in the back of my mind based off the information and intelligence that was coming through the radio broadcast originally that there might have been a second offender, or third. But I was quite comfortable once I'd started talking to these civilians and the security guard that there was only one offender, although we still had to get down into that CCTV room and ensure that was the case.*
>
> *Q. Did you pass on the information to anybody that you thought there was only one offender?*
>
> *A. Yeah.*

[1776] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 2.
[1777] Sgt 1 is a pseudonym and this officer's name is subject to a Non-Publication Order dated 28 May 2025.

> *Q. Who to?*
>
> *A. My sergeant.*
>
> *Q. Who was that?*
>
> *A. Sgt 1.*
>
> *Q. Did you give any directions in relation to the CCTV room?*
>
> *A. Yeah. So I asked her to facilitate getting someone in there and, and looking after that, because I was very mindful that I was the involved officer in a level 1 critical incident, so - and what comes with that. So whilst I am the most senior officer, my sergeant, technically, should be in command and control at that point, but it was a unique situation.*[1778]

8.64 At 3:47:22pm, a Telstra Integrated Messaging System (**TIMS**) message was sent by State Coordinator Chief Inspector Jason Harrison (**CI Harrison**) to NSWPF Executive Members and a message applied to CAD that "*... police believe only 1 x offender who was shot.*"

8.65 At 3:49pm, Sgt 1 reiterated the need for police to position themselves at every exit to WBJ to ensure the centre was "locked down", stating:

> *WE NEED POLICE AT EVERY EXIT - THE POLICE THAT ARE COMING FROM OTHER COMMANDS - WE JUST NEED TO ENSURE IT IS LOCKED DOWN - IF I CAN HAVE POLICE AT THE ENTRANCE OF BRONTE RD LOCKING THAT DOWN AND POLICE AT THE ENTRANCE ON ROCHFORD.*[1779]

8.66 Insp Scott remained in effective command until she was relieved by another senior officer, CI Christopher Whalley, who had arrived on scene around 3:54pm.

Evidence of CI Christopher Whalley

8.67 CI Whalley is attached to Eastern Beaches PAC. On 13 April 2024, he was rostered on as a duty officer at Maroubra Police Station. CI Whalley ultimately assumed the role of police Forward Commander on scene.

8.68 CI Whalley attested as a police officer in 1989. During his career, CI Whalley had undertaken Forward Commander training, including the Incident Commander's Course in 2015. He gave evidence that although he had previously performed the role of police Forward Commander, it had not been to the "*level of scope*" of the incident on 13 April 2024.

8.69 Not long after the incident at WBJ, in June 2024, CI Whalley completed a "special high risk" Forward Commander's Course. This course, a Specialist Commander Course, was offered for the first time in February 2024.

[1778] Transcript, D2 (Scott): T93.26-94.2 (29 April 2025).
[1779] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 6.

8.70 Around 3:45pm that afternoon, CI Whalley heard the broadcast by ES10 (Insp Amy Scott) that there had been a shooting involving police at WBJ. CI Whalley then responded urgently, arriving on scene around 3:53pm.

8.71 At 3:53pm, CI Whalley broadcast on police radio:

> *MARK ME ON I AM WITH EB40 I HAVE LEFT 2 OFFICERS WITH EB40 WITH SECURITY AT THE ENTRANCE TO WESTFIELDS ON BRONTE ROAD OUTSIDE MCDONALDS.*[1780]

8.72 At 3:54pm, Cst Singh (CLM722), who was on Level 5 near Mr Cauchi's location, broadcast the following on police radio:

> *I AM CONFIDENT THAT THIS IS THE ONLY POI - IF THERE IS ANY CONFUSION CAN WE ORGANISE PORS TO DO A SWEEP OF THE SHOPPING CENTRE AND WE CAN WE GET SOMEONE TO LOOK AT THE FOOTAGE - NOT SURE IF WE HAVE ALREADY DONE THAT - BUT LOOK AT THE FOOTAGE TO ENSURE THERE IS ONLY 1 POI BUT FROM WHAT WE HAVE GOT I AM CONFIDENT IT IS HIM.* [1781]

8.73 CI Whalley entered WBJ, along with two other police officers, and made his way through the Centre to Level 5. Having walked through Level 4 on his way to Level 5, CI Whalley was aware that there were both deceased and injured civilians inside the Centre.

8.74 Around 3:55pm, a broadcast was made on the PORS radio channel (a separate radio channel on which only PORS were operating) that there was an offender "*outstanding*" with a "*black shirt, yellow striping*," with the report appearing to have arisen from a photograph shown to PORS Tactical Commanders by an unknown officer.[1782]

8.75 CI Whalley arrived outside Eckersley's on Level 5, spoke with Insp Scott and saw Mr Cauchi lying motionless nearby. CI Whalley identified that Insp Scott, having shot Mr Cauchi, was an involved officer in a critical incident. He then took command of the scene.

8.76 CI Whalley gave evidence that there was a "*very brief*" verbal handover between himself and Insp Scott. Insp Scott recalled the following from this conversation:

> *It was very brief. It was the fact that I believed there was just one offender and that was him. There were multiple victims that [Sgt 1] was facilitating below, and that we had begun the process of trying to get somebody into the CCTV room to review the footage.*[1783]

8.77 After being relieved, Insp Scott left WBJ and was driven to Waverley Police Station by an uninvolved police sergeant in accordance with the critical incident guidelines; she was also subject to mandatory drug and alcohol testing (which was negative).

[1780] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 7.
[1781] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 7.
[1782] Exhibit 1, Vol 10, Tab 585B, PORS Radio Transmission Transcript at p. 1; Exhibit 1, Vol 5, Tab 372, Statement of Inspector Scott Robertson at [13]-[15]; Exhibit 1, Vol 7, Tab 473, Statement of Detective Inspector Richard Strawbridge at [10].
[1783] Transcript, D2 (Scott):T105.34-47(29 April 2025).

8.78 At 3:59pm, a broadcast was made on NSWPF radio by an officer from CLM797:

> *IVE JUST BEEN SHOWN BY SOMEONE A SECOND POSSIBLE POI ARMED WITH A KNIFE - PORS IS AWARE AND THEY ARE GOING TO DO A SWEEP OF THE BUILDING.*[1784]

8.79 At 4:01pm, CI Whalley made a broadcast on police radio:

> *JUST FOR YOUR LOG RADIO – I HAVE SPOKEN TO EASTERN SUBURBS 10 [Insp Amy Scott] – I AM IN COMMAND OF THIS SITUATION AT THE MOMENT – I BELIEVE [Sgt 1] ARE COORDINATING A LOCKDOWN OF THE WESTFIELDS.*[1785]

8.80 CI Whalley understood that this broadcast was part of his role in taking over command.

8.81 Regarding the "lockdown of the Centre", CI Whalley stated in oral evidence:

> *I understood that to be that there was a perimeter being established…around [WBJ], focusing on the entry and exit points [and] that those people who were in public spaces and who were able to evacuate the centre were doing that. And that people who… were sheltering in place in various shops within the centre were remaining there in those locations.*[1786]

Establishment of a Forward Command Post

8.82 CI Whalley understood the significance of the Forward Command Post to be:

> *… the place in my view where the person who is in command needs to be located. That's where significant people from specialist agencies who are involved in the response would have a presence to allow communication between the various agencies or functions, and for decisions to be made…*[1787]

8.83 At 4:03pm, Sgt 1 broadcast on police radio that the alarms that had been sounding inside WBJ were off and a Command Post had been established "*AT THE BRONTE RD ENTRANCE THE LOADING DOCK AREA – OPPOSITE SEPHORA*."[1788] CI Whalley acknowledged the broadcast. He did not have any input into the selection of the initial location of the Forward Command Post.

8.84 At 4:05pm, CI Whalley called Superintendent Paul Dunstan, the Central Metropolitan Region Commander and was advised that Assistant Commissioner Anthony Cooke (**AC Cooke**) had declared the incident a "Level 1 Critical Incident". CI Whalley then provided a verbal briefing.

[1784] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 9.
[1785] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript: 264181-13042024 (Informant: Rachel Auteri) at p. 9; Exhibit 1, Tab 730, Statement of Chief Inspector Christopher Whalley at [20]; Transcript, D2 (Whalley): T130.5-43; T156.7-12 (29 April 2025).
[1786] Transcript, D2 (Whalley): T130.36-40 (29 April 2025).
[1787] Transcript, D2 (Whalley): T131.31-34 (29 April 2025).
[1788] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 10.

Coordination of a CCTV review

8.85 At 4:07pm, CI Whalley spoke with Chief Inspector Jason Reimer (**CI Reimer**) of Police Transport Command and A/Insp Nathan Evans of Kings Cross PAC as to "*next steps*", including the need to review CCTV to confirm the number of offenders involved. As noted, there were NSWPF radio broadcasts around 4:00pm raising the potential of multiple offenders.

8.86 Specifically, CI Whalley instructed CI Reimer to:

> *... attend the security office to view the CCTV that was available within the centre, backtracking from the Eckersley's store to identify the route that was taken. Ultimately what time the individual entered the centre, and importantly whether they were with anyone else.*[1789]

8.87 In his oral evidence, CI Whalley agreed that this was an urgent task.

8.88 Around this time, at 4:07pm, Sgt 2 attended the WBJ CCTV Control Room and spoke with Bradley Goldberg before leaving the room.

8.89 Regarding this attendance at the CCTV Control Room, Sgt 2 stated he had been approached by Inspector Richard Strawbridge (**Insp Strawbridge**) of PORS, who asked him to attend the Control Room "*to ascertain if there were any outstanding offenders.*"[1790] In relation to the information received, Sgt 2 stated:

> *... I was not provided any information [whilst in the CCTV Control Room]. I recall entering the [CCTV Control Room] with the place being busy understandably. I was there for a short time with a CCTV operator attempting to show me the incidents of the actual scene however the operators were waiting for a [manager] or senior controller to attend and go through footage. I was looking at all screens however there [were] so many. I was never provided any information about a second offender at any time. Around this time, I was aware [TOU] had a person on the roof of [WBJ] stopped from information that was supplied by police radio.*[1791]

8.90 Sgt 2 states that after attending the CCTV Control Room, he "*had no information to provide...[and] was NOT in the control room long enough to conduct any further assessments.*"[1792] Shortly thereafter, Sgt 2 states that he was requested to return to another location in WBJ to assist with the allocation and direction of NSWPF staff.

8.91 At 4:08pm, POL1, a police helicopter in the vicinity of WBJ broadcast on police radio that there was a person matching the description of the potential second offender on the WBJ carpark rooftop:

> *YEAH IVE GOT A MALE ON WHAT LOOKS LIKE A ROOFTOP CARKPARK - WEARING A BLACK SHIRT WITH YELLOW PIPING ON IT AND THEN CARRYING A BACKPACK - MALE*

[1789] Transcript, D2 (Whalley): T132.10-13 (29 April 2025).
[1790] Exhibit 1, Vol 6, Tab 447A, Supplementary Statement of Sgt 2 at p.2.
[1791] Exhibit 1, Vol 6, Tab 447A, Supplementary Statement of Sgt 2 at p.3.
[1792] Exhibit 1, Vol 6, Tab 447A, Supplementary Statement of Sgt 2 at p.3.

> *HAS LONG BLONDE [STRIPED] HAIR - I WILL GIVE YOU THE LOCATION - JUST CONFIRM THE DESCRIPTION.*[1793]

8.92 At 4:10pm, CI Harrison sent a further TIMS to NSWPF Executive Members and applied the following message to CAD:

> *Report of possible 2nd POI [person of interest] outstanding – Police have viewed an image of a male (not the male shot) armed with a knife wearing black top with yellow stripes – TOU deployed.*[1794]

8.93 At 4:15pm, CI Whalley received a phone call from the Senior Critical Incident Investigator (**SCII**), DCI Andrew Marks, and briefed him on the actions that had been taken at the scene.

8.94 At 4:17pm, a PORS officer broadcast on the PORS radio channel that the person of interest identified on the rooftop was in custody.

8.95 At 4:19pm, POL1 broadcast on the main channel that a second POI had been apprehended on the rooftop of the Eastgate shopping centre and CLM722 (then with PORS) requested their location.

8.96 At 4:19pm, CI Whalley requested that A/Insp Evans coordinate the security of the crime scene on Level 5 of WBJ, outside Priceline.

8.97 Shortly after this, CI Whalley made his way through the Centre via Level 4 and Level 3, to the police Forward Command Post located in the WBJ loading dock.

8.98 At 4:20pm, PORS8 broadcast on the PORS radio channel that there was "*still confusion*" regarding a second POI, but PORS were continuing searches.

8.99 At 4:22pm, CI Reimer attended the CCTV Control Room on Basement Level 4, WBJ to review the CCTV.

8.100 At 4.27pm, CI Reimer broadcast the following on police radio, from the CCTV Control Room:

> *JUST FOR EB10 THERE APPEARS TO BE THE ONE OFFENDER SO CONFIRMING THERE IS JUST THE 1 OFFENDER AND 9 VICTIMS – I AM IN THE SECURITY OFFICE.*[1795]

8.101 At 4:31pm, CI Reimer left the CCTV Control Room on Level P4 of WBJ and made his way to find CI Whalley to update him.

[1793] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant Rachael Auteri) at p. 12
[1794] Exhibit 1, Vol 8, Tab 519A, Summary Timeline of CAD 264176 at p. 25; Exhibit 1, Vol 8, Tab 519, Statement of Chief Inspector Jason Harrison at p. 2.
[1795] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript: 264181-13042024 (Informant: Rachel Auteri) at p. 18.

Attendance at the Forward Command Post

8.102 Around 4:33pm, CI Whalley arrived at the Forward Command Post that was established in the WBJ loading dock.[1796] On arrival, he spoke with an Inspector from the Tactical Operations Unit (**TOU**) regarding "*the coordination of the search of WBJ*."[1797]

8.103 In oral evidence, CI Whalley gave evidence that the purpose of the involvement of TOU in the search was:

> *Because of the type of incident that had occurred, the [TOU] I understand were dispatched as a matter of course…given the incident that happened. The coordination of the search of the centre by them, the purpose of that was because of the type of incident that had… occurred.*[1798]

8.104 CI Whalley gave evidence that he did not recall hearing the earlier broadcast of CI Reimer at 4:27pm, outlined above; however stated that "…*shortly after [he] had a face to face conversation with [CI Reimer] who told [him] the same information*."[1799]

8.105 This conversation occurred at 4:36pm when CI Reimer spoke to CI Whalley following his review of the CCTV footage. CI Reimer confirmed that only one offender was involved in the incident.

8.106 CI Whalley did not recall any conversation with NSWA officers or their attendance at the command post in the loading dock (noting "*there was a lot going on at that time*").[1800]

8.107 Additionally, CI Whalley did not recall any particular broadcast from NSWPF callsign 'ODN 20' asking to get an Ambulance Inspector to the Police Forward Commander, agreeing that he would not hear all the information on VKG (the police radio), given the amount of traffic.

Relocation of the Forward Command Post

8.108 At some point, a decision was made that the police Forward Command Post was not situated in an appropriate location and should be moved.

8.109 CI Whalley explained the need for the relocation as follows:

> *When I've walked into the initial command post it was, it's a loading dock. It's open to the laneway. There was no security available, which is critical… It was open to observance from members of the public, from the media… and there weren't, there was no access to chairs, tables, phones and other telecommunications and other things that are important to the running of a command post.*[1801]

[1796] Exhibit 1, Vol 14, Tab 730, Statement of Chief Inspector Christopher Whalley at p. 4; Transcript, D2 (Whalley): T132.47-T133.5 (29 April 2025).
[1797] Exhibit 1, Vol 14, Tab 730, Statement of Chief Inspector Christopher Whalley at [29].
[1798] Transcript, D2 (Whalley): T133.4-20 (29 April 2025).
[1799] Transcript, D2 (Whalley): T134.18-23 (29 April 2025).
[1800] Transcript, D2 (Whalley): T134.25-34 (29 April 2025).
[1801] Transcript, D2 (Whalley): T135.21-27 (29 April 2025).

8.110 CI Whalley also noted difficulties with telephone reception at the Forward Command Post. He formed the view that the location was "*not an appropriate place for us to conduct…or to host this sort of function.*" [1802] CI Whalley requested a change of venue for the Forward Command Post.

8.111 Rahim Zaidi, the Risk and Security Supervisor at WBJ, was on shift on 13 April 2024 as Assistant Duty Manager.

8.112 Around 4:29pm, Mr Zaidi received a phone call from a staff member on Level 4 with a "*Chief Inspector of police*" (CI Whalley) who wished to speak with him.

8.113 Around 4:36pm Mr Zaidi attended Level 4 and a discussion occurred regarding another location for the Command Post. Level 6 of Zone A within WBJ was determined as a suitable venue.

8.114 A note regarding the steps prior to the relocation of the Forward Command Post was made in the Forward Command Log by his scribe, Sergeant Chad Holland (**Sgt Holland**), on behalf of CI Whalley:[1803]

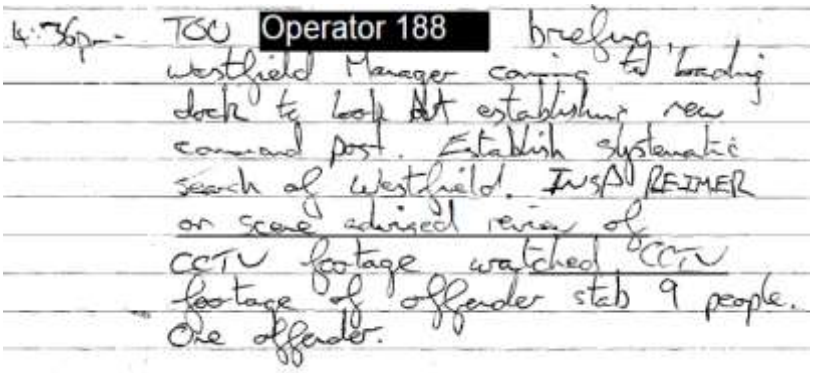
4:36pm - TCU Operator 188 briefing
Westfield Manager coming to loading
dock to look at establishing new
command post. Establish systematic
search of Westfield. Insp REIMER
on scene advised review of
CCTV footage watched CCTV
footage of offender stab 9 people.
One offender.

Figure 24: Extract from Forward Command Log of CI Whalley

Establishment of a New Command Post

8.115 At around 4:50pm, CI Whalley arrived in the Westfield Suite on Level 6 of WBJ, where the new Forward Command Post was then established.

8.116 At 4:55pm, Sgt 1 broadcast that the location of the command post was moving "*due to reception issues in the original loading area*."[1804]

[1802] Transcript, D2 (Whalley): T135.32-34 (29 April 2025).
[1803] Exhibit 1, Vol 12, Tab 731, Forward Command Log of Chief Inspector Christopher Whalley at p. 2. See also, Exhibit 1, Vol 7, Tab 482, Statement of Sergeant Chad Holland at p. 5.
[1804] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant: Rachel Auteri) at p. 26.

8.117 A note within the Forward Command Log was made as follows:[1805]

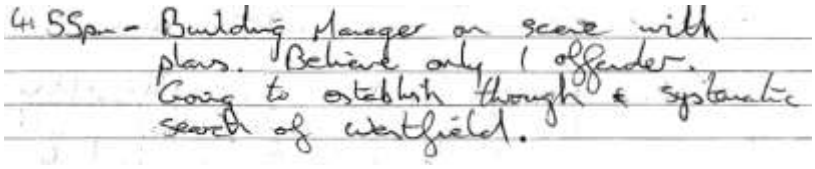

Figure 25: Extract from Forward Command Log of CI Whalley

8.118 At 5:00pm, Sgt 1 broadcast that the command post had moved and was now located in "*the Westfield Business Wing on Level 6*".[1806]

8.119 At 5:14pm, a further note was made in the Forward Command Log:[1807]

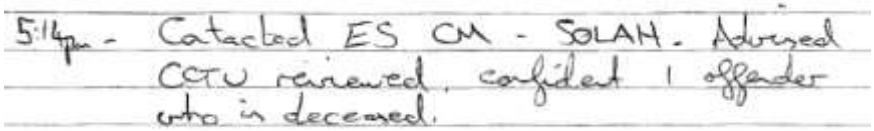

Figure 26: Extract from Forward Command Log of CI Whalley

8.120 Detective Inspector Adam Solah (**DI Solah**) had by this stage been liaising with detectives on the scene to provide confirmation to the police executive that there was only one offender involved in the incident.[1808]

Contact with NSWA staff at the new Forward Command Post

8.121 When questioned as to the first time he engaged with a senior NSWA officer following his arrival at the new Forward Command Post around 4:50pm, CI Whalley could not recall the exact time, or who that person was, but stated "*I don't believe it would have been any longer than ten minutes in.*"[1809]

8.122 CI Whalley gave evidence that whilst he could recall three senior Ambulance Officers being present at the Command Post when he was Forward Commander, including NSWA Ambulance Officer 1,[1810] he could not recall the intricacies of the discussions nor having engaged with the Ambulance Commander, Assistant Commissioner Brent Armitage (**AC Armitage**).[1811]

8.123 CI Whalley stated that he did not have nor was he asked to have, any discussions with NSWA officers in the Command Post about a second offender prior to the 5:30pm Inter-

[1805] Exhibit 1, Vol 12, Tab 731, Forward Command Log of Chief Inspector Christopher Whalley at p. 4. See also, Exhibit 1, Vol 7, Tab 482, Statement of Sergeant Chad Holland at p. 7.
[1806] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript 264181-13042024 (Informant: Rachel Auteri) at p. 27.
[1807] Exhibit 1, Vol 12, Tab 731, Forward Command Log of Chief Inspector Christopher Whalley at p. 3. See also, Exhibit 1, Vol 7, Tab 482, Statement of Sergeant Chad Holland at p. 6.
[1808] Exhibit 1, Vol 13, Tab 695A, Supplementary Statement of Detective Inspector Adam Solah at [29].
[1809] Transcript, D2 (Whalley): T136.14-23 (29 April 2025).
[1810] Ambulance Officer 1 is a pseudonym pursuant to non-publication order dated 28 May 2025.
[1811] Transcript, D2 (Whalley): T136.25-47 (29 April 2025).

agency Briefing (noting that by that time, NSWPF had confirmed by review of the CCTV that there was one).[1812]

8.124 CI Whalley agreed that there was a lot of information exchanged in the Command Post and that the information he required and received from Ambulance Officers on an updated basis concerned the people who had been injured.[1813]

8.125 The impact of the designation of WBJ as a "Hot Zone" is considered further in Part 9, together with the NSWA AAO Work Instruction. Regarding the role of police in relation to this Work Instruction, CI Whalley gave the following evidence (emphasis added):

> *Q. Yes. Do you see there the portion that reads as follows, "Police will divide the incident into three zones, hot zone, warm zone, cold zone", do you see that?*
>
> *A. I do.*
>
> *Q. Is that reference to police undertaking that role, that is dividing a scene into particular zones, consistent with your experience?*
>
> *A. I... don't have any independent recollection of those terms being used. I... understand what those words refer to, so the descriptions, <u>but I'm not certain that hot zone, warm zone, and cold zone are terms that are used by New South Wales Police in this type of incident.</u>* [1814]

8.126 CI Whalley agreed that in terms of first responders dealing with an incident like that on 13 April 2024, common terminology amongst the agencies was certainly useful "*in removing any potential confusion.*"[1815]

Interagency Briefing

8.127 As noted above, at 5:30pm, an Interagency Briefing was held in the new Forward Command Post on Level 6 of WBJ. It involved NSWPF (including representatives from the counter-terrorism unit), NSWA, Scentre, and representatives from the Australian Federal Police (**AFP**).

8.128 CI Whalley explained that the briefing was an opportunity to:

> *... provide a summary of what we knew at that time to give specialist and support agencies an opportunity to provide any relevant information that they had and to determine what the priorities would be moving forward, so what is next.*[1816]

8.129 Prior to and in preparation for the Interagency Briefing, CI Whalley:

(a) Tasked Sgt 1 to liaise with NSWA to confirm the number of deceased, the number of people injured and where they had been transported to;

[1812] Transcript, D2 (Whalley): T137.30-40 (29 April 2025).
[1813] Transcript, D2 (Whalley): T136.49-T137.12 (29 April 2025).
[1814] Transcript, D2 (Whalley): T161.50-T162.10 (29 April 2025).
[1815] Transcript, D2 (Whalley): T161.40-T162.15 (29 April 2025).
[1816] Transcript, D2 (Whalley): T138.23-27 (29 April 2025).

(b) Contacted the Police Media Unit and was advised that a holding statement had been approved by AC Cooke;

(c) Coordinated the obtaining of witness statements and welfare considerations such as the attendance of the police chaplain; and

(d) Provided a verbal briefing to DI Solah (the Crime Manager at Eastern Suburbs PAC) at 5:14pm, as outlined above.

8.130 As to the view of Scott Wilson that the holding of an Interagency briefing at 5:30pm was in effect, too late, CI Whalley referred to the "*scope and magnitude*" of the incident; the initial challenges, including establishing a suitable command post and the size and scope of the perimeter and "*careful negotiation of the various scenes within the Westfield centre*", which included putting in place an "*escort process*" to ensure various agencies could negotiate the perimeter.

8.131 CI Whalley also noted that there were "*a number of command level actions*" undertaken prior to 5.30pm, and a "*necessary delay*" to ensure that relevant agencies were present and briefed. This aspect of the process of NSWPF establishing Command and Control, as in the timing of this Interagency briefing, is considered later in Part 10.

8.132 CI Whalley confirmed that the number of offenders involved (that is, one only) was canvassed during this first Interagency Briefing. He did not recall any questions in relation to the issue.[1817]

8.133 Among reference to other matters, the Forward Command Log included the following:[1818]

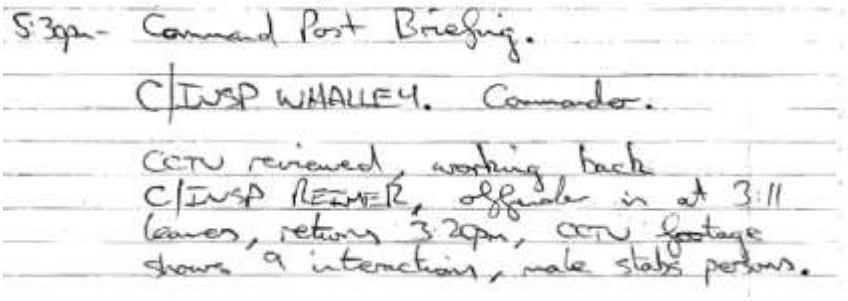
5:30pm- Command Post Briefing.
C/INSP WHALLEY. Commander.
CCTV reviewed, working back
C/INSP REMMER, offender in at 3:11
leaves, returns 3:20pm, CCTV footage
shows 9 interactions, male stabs persons.

Figure 27: Extract from Forward Command Log of CI Whalley

8.134 At around 6:08pm, the TOU were stood down and PORS took over to undertake a "*clear and search*" of the Centre.[1819]

[1817] Exhibit 1, Vol 14, Tab 730, Statement of Chief Inspector Whalley at p. 7; Exhibit 1, Vol 10, PORS Radio Transmission Transcript; Exhibit 1, Vol 42, Tab 1597, Statement of Rahim Zaidi at [67]-[70]; Transcript, D2 (Whalley): T140.22-35 (29 April 2025).
[1818] Exhibit 1, Vol 12, Tab 731, Forward Command Log of Chief Inspector Christopher Whalley at p. 4; Exhibit 1, Vol 7, Tab 482, Statement of Sergeant Chad Holland at p. 7.
[1819] Exhibit 1, Vol 14, Tab 730, Statement of Chief Inspector Whalley at p. 7; Exhibit 1, Vol 10, Tab 585B, PORS Radio Transmission Transcript; Exhibit 1, Vol 42, Tab 1597, Statement of Rahim Zaidi at [67]-[70]; Transcript, D2 (Whalley): T140.22-35 (29 April 2025).

8.135 At 6:15pm, a second Interagency Briefing occurred for about 15 minutes. At this time, further information was provided by Ambulance Officer 1 as to the status and disposition of patients. Information was also provided by Scentre regarding security matters. A further briefing was scheduled for 7:00pm.

8.136 At around 7.10pm, CI Whalley gave a command briefing. At around 7.25pm, he then handed over the role of Forward Commander to Inspector Joshua Madden (**Insp Madden**) from Eastern Suburbs PAC.

D. NSWPF Command and Control

8.137 As outlined above, a central issue that emerged at Inquest was the establishment of Command and Control by NSWPF in response to the events of 13 April 2024, and relatedly, the concept of interagency operability, considered further in Part 10.

8.138 To assist the Court in understanding the organisational response to an event such as that which occurred on 13 April 2024 at WBJ, evidence was provided regarding the approach of NSWPF to major incidents.

8.139 Under the NSW State Emergency Management Plan (**EMPLAN**), NSWPF are considered the "Combat Agency" for any act of terrorism. Noting this, NSWPF are the lead agency in managing an incident such as that which occurred on 13 April 2024 at WBJ.

The ANZPAA ICCS Plus

8.140 The NSWPF has adopted the Australian New Zealand Policing Advisory Agency ICCS Plus Policy: A Common Approach to Incident Management (**ANZPAA ICCS Plus**) to guide their response to major incidents, including high-risk situations.

8.141 The ANZPAA is an advisory agency, established in 2007 through agreement of the police commissioners across Australia and New Zealand and the then Australasian Police Ministers' Council. The current members are the police commissioners from each jurisdiction in Australia and New Zealand, and the Chief Police Officer from the ACT.

8.142 The ANZPAA ICCS Plus was "*designed by police for police*" and is "*intended to foster interoperability between jurisdictions and facilitate inter-agency cooperation when responding to different types of incidents, regardless of size, scale or complexity*".[1820]

8.143 The ANZPAA ICCS Plus incorporates the functions of the ANZCTC Incident Command and Control Structure and consists of the key principles of safety, flexibility, leadership, communication, management by objectives, functional management and span of control.[1821]

[1820] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p.45.
[1821] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [25].

Command and Control under the ANZPAA ICCS Plus

8.144 The ANZPAA ICCS Plus provides definitions of the following terms "... *[as] understood by each jurisdiction as they relate to their internal processes, policies, procedures and legislation*":[1822]

Command	The authority exercised by a Police Commander to direct, organise and co-ordinate available resources to achieve the Commander's Intent.
Command and Control	The structure which is assembled when an incident exceeds the span of control of an individual. Its establishment is based on the circumstances surrounding the incident.
Command and Control Structure	A Command and Control Structure within ICCS Plus consists of two levels of command – the Police Commander (Strategic) and Police Forward Commander (Operational). Both levels of command consider the ten functions within ICCS Plus.
Control	The overall responsibility for managing the response to an incident.

Figure 28: ANZPAA ICCS Plus definitions

8.145 The ANZPAA ICCS Plus identifies:

> ... *ten core functions to ensure consistency of incident management practice within, and across, police jurisdictions in Australia. It is designed to support the successful planning, response and resolution of incidents, including emergency response.*[1823]

8.146 The ten core functions are stated as follows:[1824]

Figure 29: ANZPAA ICCS Plus Core Functions

[1822] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 46.
[1823] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 48.
[1824] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 51.

8.147 The ANZPAA ICCS Plus is based on two key Command Leadership Levels: Strategic and Operational, which can be undertaken individually or collectively.[1825]

8.148 At the strategic level, the Police Commander is responsible for the effective overall strategic command of the incident, maintenance of support to forward commanders and identification and resourcing of policing capabilities in the context of maintaining a State-wide capability. [1826]

8.149 At the operational level, the police Forward Commander has command of police resources at an incident.[1827]

8.150 The NSWPF has adopted and incorporated the ANZPAA ICCS Plus into its own policy document entitled "Incident Command and Control Plus" (**NSWPF ICCS Plus**), which was published in March 2020. The definitions regarding Command and Control in the NSWPF ICCS Plus are identical to those in the ANZPAA ICCS Plus.

8.151 The NSWPF ICCS Plus notes that "*[a]ll Terrorism, Active Armed Offender and other High Risk Situation events will adopt the ICCS Plus framework in accordance with the NSW Police Force Police Command Guidelines…*".[1828]

8.152 Under the NSWPF ICCS Plus, for each incident there should be only one Control Agency at any one time, with a Control Agency defined as the agency that exercises control of an incident in accordance with the relevant State or Territory legislation.[1829]

8.153 The NSWPF ICCS Plus acknowledges that incidents may require more than one agency, and where there is a multi-agency incident, this may involve both a Control Agency and Support Agency.[1830]

8.154 The NSWPF ICCS Plus provides the following details regarding the roles of the Control Agency and Support Agency in a multi-agency incident:[1831]

[1825] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 50.
[1826] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 74.
[1827] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 74.
[1828] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at p. 76.
[1829] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at pp. 45, 73.
[1830] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at pp. 45, 76.
[1831] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at pp. 45, 76.

Control Agency

The Control Agency provides direction regarding the response activities, management of resources and delegates tasks (as required). There may be a need to delegate responsibility for one or more functions as the complexity of an incident increases. Where functions are delegated, the establishment of a clear command and control structure is essential.

Where police are the Control Agency, the Police Commander will nominate a primary point of engagement, often a Liaison Officer, to coordinate communication between agencies.

Support Agency

Support Agencies generally operate as independent units responsible for the command of their own personnel and resources. Each agency is responsible for establishing and maintaining their respective command and control structures. Where police are the Support Agency, the Police Commander is the primary point of engagement between agencies unless otherwise nominated.

During incidents, agencies collectively work together at the Strategic and Operational levels through their respective agency or nominated Liaison Officers. The focus of their activities is aligned to the mission objectives as determined by the Control Agency.

Figure 30: NSWPF ICCS Plus Control Agency and Support Agency role description

Witness evidence regarding NSWPF Command and Control

8.155 CI Whalley gave extensive evidence regarding his role as Police Forward Commander, and relatedly, the establishment of command and control on 13 April 2024, which is detailed as part of the chronology of the NSWPF response outlined above.

8.156 AC McKenna, Commander of the Central Metropolitan Region, provided an executive statement concerning the NSWPF response to the events of 13 April 2024, including as to command and control.

8.157 AC McKenna assessed CI Whalley's actions on 13 April 2024 as "… *consistent with ANZPAA ICCS Plus in all key respects.*"[1832]

8.158 AC McKenna noted that upon arriving on scene, CI Whalley:

> *Immediately proceeded to the location of engagement with the offender to confirm the situation and check on the welfare of Inspector Scott. This was an essential step in starting to gain the necessary situational awareness. Knowing he was the most senior officer on scene, Chief Inspector Whalley took charge and established himself as Forward Commander, including communicating this on police radio at 16:01. As set out in ANZPAA ICCS Plus, establishment of command, control and coordination by a*

[1832] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [26].

Forward Commander is critical where an incident, as here, exceeds a manageable span of control. [1833]

8.159 AC McKenna was questioned as to the command, control and coordination function under the ICCS Plus Guidelines concerning nomination of a "liaison officer":

Q. ... Police as control agency, the blue box, is the reference there to "Where police are the control agency, the commander nominates a primary point of engagement, often a liaison officer, to coordinate communication between agencies". Do you know who that person was as nominated by the police commander, namely Chief Inspector Whalley?

A. As I sit here I don't, but I will say ICCS Plus is flexible, adaptable. Sometimes we don't do that, sometimes you might have three positions that you say is your IMT, Incident Management Team. So just because there's not someone designated doesn't mean that was required.

Q. So you think there's some flexibility about whether that occurs?

A. There 100% is flexibility in that model.

Q. Not in relation to the model, in relation to that particular provision about whether or not a liaison officer is appointed as a means of communicating as between agencies?

A. So yeah. If I, if I go to an IMT or ICCS Plus model where there might be other agencies who are either collocated but not in the same room, you might have a liaison officer over there so you can talk direct to them or get information from them direct to you about the policing side of the matter. Sometimes even with an ICCS model, you don't have collocation of agencies because of just the nature of the job. So you might embed a police officer with them so that you are getting that conduit back and forth. But when you're in the same location you normally wouldn't have a liaison officer.

Q. You don't know whether or not that occurred?

A. Nothing I've read tells me that occurred. [1834]

8.160 The absence of an appointed liaison officer, or a related conduit to assist in communication between the NSWPF and NSWA is considered at Part 10 in the context of the joint agency interoperability in relation to the response on 13 April 2024.

Expert assessment of the NSWPF Command and Control

8.161 In his expert report and in oral evidence, Scott Wilson reviewed and assessed the organisational command structure of the NSWPF on 13 April 2024.

8.162 As outlined above, Mr Wilson has 31 years of policing experience in the United Kingdom and has conducted many senior roles for the Metropolitan Police at New Scotland Yard

[1833] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [26].
[1834] Transcript, D19 (P McKenna): T1748.10- 37 (27 May 2025).

and National Counter Terrorism Headquarters whilst a Detective Chief Superintendent between 2014 and 2018. Mr Wilson has experience in leading the policing response to high-risk threats and was the Bronze Commander for the Olympic and Paralympic Games in London in 2012.[1835]

8.163 Following his retirement from the Metropolitan Police in 2018, Mr Wilson was a Policing and Counter Terrorism Subject Matter Expert in both the *Manchester Area Inquiry* and the *Royal Commission into the terrorist attacks in Christchurch*, New Zealand in 2019.[1836]

8.164 As I have indicated in Part 7, the Court was fortunate to have Mr Wilson provide evidence in relation to this matter and he is eminently qualified to do so.

Gold/Silver/Bronze (GSB) approach to incident command

8.165 Mr Wilson's review of the command and control structure of the NSWPF on 13 April 2024 was conducted through the prism of the Gold/Silver/Bronze (**GSB**) hierarchy used in the UK - which is not the applicable model in NSW.

8.166 The GSB structure is used in the UK police service as:

> *A framework delivering a strategic, tactical and operational response to an incident or operation…[allowing] processes to be established that facilitate the flow of information and ensures that decisions are communicated effectively and documented as part of an audit trail.*[1837]

8.167 The GSB model consists of three tiers:

(a) Gold (Strategic) command;

(b) Silver (Tactical) command; and

(c) Bronze (Operational) command.[1838]

8.168 The generic response structure (on which the police GSB model is based), is considered in the context of interagency interoperability in Part 10.

8.169 In general terms, Mr Wilson opined that viewed objectively, the command and control aspect was dealt with by NSWPF "*reasonably well*."[1839] He noted that the NSWPF command roles were quickly established with CI Whalley declaring himself the Forward

[1835] Exhibit 1, Expert Volume. Tab 20, Expert Report of Scott Wilson, Appendix A at p. 91.
[1836] Exhibit 1, Expert Volume. Tab 20, Expert Report of Scott Wilson, Appendix A at p. 92.
[1837] College of Policing, Command Structures available at https://www.college.police.uk/app/operations/command-and-control/command-structures (dated 23 October 2013).
[1838] College of Policing, Definitions and Procedures available at https://www.college.police.uk/app/operations/command-and-control/definitions-and-procedures (dated 23 October 2013).
[1839] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [2.8].

Commander (or "Tactical Commander"), and Sgt 1 taking on the role of Operational Commander (or "Bronze command") and setting up a Forward Command Post.

8.170 Mr Wilson expressed the view that:

> *All the necessary management roles, including investigation, were put in place and an early command centre was established. However it took two hours for the first multi-agency tactical command meeting to take place with Senior Ambulance and Scentre Staff.*[1840]

8.171 This aspect and the broader issue of interagency communication is considered further in Part 10.

Submissions regarding the NSWPF Command and Control and response

8.172 Counsel Assisting submitted that in terms of the Court's assessment of the NSWPF response, in particular regarding the establishment of Command and Control, there was ultimately limited (if any) controversy as to the factual matters regarding the nature and timing of the NSWPF response to the events of 13 April 202 as articulated in Issue 11 and as outlined above.

8.173 Counsel Assisting submitted that the evidence established that the first call to NSWPF was received at approximately 3:34pm, with a distressed civilian shopper calling Triple 0 and reporting that "*[s]omeone has just stabbed someone …*". This was the first time NSWPF were informed of the incident taking place.

8.174 Counsel Assisting submitted, having received the first Triple 0 call at 3:34pm, the NSWPF CAD job had correctly been broadcast as a "double beeper" (otherwise referred to as a Priority 2 job and correctly indicating the urgency). This broadcast was at 3:35pm: that is, within a minute of the call being received. Insp Scott was then on scene two minutes later – by 3:37pm; and by 3:38:40pm, Insp Scott had fatally shot Mr Cauchi.

8.175 Counsel Assisting submitted that on any view, this was a commendably rapid response by NSWPF and, as Mr Wilson put it, time is of the essence in AAO incidents. The speed of the response by Insp Scott saved many lives.

8.176 Ultimately, Counsel Assisting submitted that the Court would accept Mr Wilson's opinion on the issue of the NSWPF response:[1841]

> *Reviewed overall the response from New South Wales Police to the Active Armed Offender at Westfield Bondi Junction was excellent. Large numbers of response officers were assigned through the control room and a number of them arrived on scene within the first 10 minutes from the first call being received by police. As all of New South Wales police officers are routinely armed, any of these officers would have been trained and equipped to deal with this incident. We know from the CCTV that Inspector Amy Scott quickly identified and shot the offender, therefore neutralising the threat.*

[1840] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [8.4.9].
[1841] Written Submissions of Counsel Assisting at [1964].

> *This occurred at 15.38.38, this was three minutes after accepting the assignment and just over a minute after entering Westfield Bondi Junction. This should be viewed as an exemplary response in order to save life.*[1842]

8.177 Regarding the evidence given by Mr Wilson, as outlined above, that "*viewed objectively*", the command and control at WBJ was "*dealt with reasonably well*" by NSWPF. Noting that "*[a]ll necessary management roles, including investigation, were put in place and an early command centre was established*", Counsel Assisting submitted that the Court make the following findings:

(a) Following her direct involvement in the shooting of Mr Cauchi, Insp Amy Scott appropriately assumed command and control (in the unique situation of being the most senior officer but also an involved officer), handing over command to Sgt 1 at the first available opportunity;

(b) Shortly after, CI Whalley attended the scene (promptly) and decisively assumed command and control; and

(c) CI Whalley's actions were multifarious, and included (amongst other matters), obtaining a debriefing from Insp Scott; liaising with senior police to update them; arranging for CI Reimer to conduct a review of the CCTV footage in the CCTV Control Room to confirm the number of offenders; arranging A/Insp Evans to coordinate the crime scene; attending the Forward Command Post and liaising with TOU; determining (appropriately) to relocate to a more suitable venue; and leading the 5:30pm and 6:15pm multi-agency briefings.

8.178 In relation to the establishment of command and control, Counsel for the Commissioner of NSWPF submitted that the significance, difficulty and sheer number of tasks undertaken by CI Whalley during the course of his role as Police Forward Commander warranted emphasis beyond the summary of actions by Counsel Assisting, as outlined below.

CI Christopher Whalley

8.179 Counsel Assisting submitted that the actions of CI Whalley in the critical hours after the incident (until he was relieved at around 7.25pm) were appropriate and in accordance with NSWPF policy and procedure. Counsel Assisting submitted that from his evidence, it was also apparent that CI Whalley was highly attuned to welfare concerns regarding Insp Scott, and the other junior police who attended the traumatic scene at WBJ. This was demonstrated by his reflection on what went well on 13 April 2024, and that is that there was a "*commitment shown by all emergency services who were present on that day*." CI Whalley went on to state the following:

> *... when I finished, as an example of what young police do and what we ask them to do as managers, I walked back through the centre, because that was the only way I knew*

[1842] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [2.7].

> *to get out of there. That's the way I'd been let in, so I followed the breadcrumbs back out, and I stopped and spoke to some of the 25 odd young people from Maroubra who attended that scene. And stopped next to a - some police that were guarding one of the scenes within the [C]entre and asked why they were standing where they were, which was quite close to one of the people who'd been affected. And their response was, "Because I don't want to leave them alone" ... These are the things that stay with you...*[1843]

8.180 Counsel for the Commissioner of NSWPF submitted that in addition to the critical role played by Insp Amy Scott, CI Whalley was the other police officer whose conduct on the 13 April 2024 warranted specific recognition.

8.181 Submissions on behalf of the Commissioner of NSWPF describe CI Whalley as a "*commissioned, highly experienced, senior police officer*" within the Eastern Beaches PAC. CI Whalley arrived at WBJ within 20 minutes of the first call to Triple 0 reporting Mr Cauchi's attacks, approximately 16 minutes after Insp Scott shot Mr Cauchi.

8.182 It is submitted by Counsel for the Commissioner of NSWPF that CI Whalley proceeded to Level 5 and immediately assumed the role of Police Forward Commander, holding this "*pivotal role*" for three and a half hours. It was noted that of the senior emergency personnel attending WBJ, CI Whalley was one of the first officers to arrive and one of the last to leave.

8.183 It was further submitted that CI Whalley faced one of the most harrowing situations that an officer could ever encounter over the course of a policing career and that the Court would accept that the evidence clearly establishes that in his command at the scene, he responded ably, with immense courage, composure and focus.[1844]

CI Whalley's training and actions on 13 April 2024

8.184 Regarding the submissions of Counsel Assisting with respect to CI Whalley's training, Counsel for the Commissioner of NSWPF submitted that his training, together with his significant depth of experience drawn from over 35 years of active policing undeniably contributed to his leadership of the NSWPF response on 13 April 2024.

8.185 It is submitted that it is unsurprising that CI Whalley's previous experience had not been to the "*level of scope*" of the incident that occurred on 13 April 2024, having regard to the rarity of such events in NSW, and Australia generally. Nevertheless, it was submitted that his experience served him well.

8.186 Counsel for the Commissioner of NSWPF submitted that CI Whalley's completion of the Specialist Commander Course in June 2024, was in keeping with his training schedule, noting that it was offered for the first time in February 2024. It is submitted that, despite

[1843] Transcript, D2 (Whalley): T141.26-42 (29 April 2025).
[1844] Written submissions on behalf of the Commissioner of NSWPF at [11]-[14].

not having yet had the opportunity to complete that training at the time of the incident at WBJ on 13 April 2024, CI Whalley's actions were consistent with this training.

8.187 It was submitted on behalf of the Commissioner of the NSWPF that CI Whalley held ultimate command over more than 92 NSWPF officers who responded to the incident at WBJ on 13 April 2024 by 4:02pm.[1845] WBJ was not within CI Whalley's usual area of duties, as it was located within the neighbouring Eastern Suburbs PAC, and the vast majority of responding police officers were unknown to him. The incident was the first of its kind in NSW, and the first time NSWPF's detailed AAO training was put into practice.[1846]

8.188 Notwithstanding this, it is submitted on behalf of the Commissioner that CI Whalley's assumption of control was swift and seamless and he immediately recognised that Insp Scott could have no ongoing involvement and it was necessary for him to assume command. As emphasised by the evidence of AC McKenna, CI Whalley was required to undertake numerous tasks in a large, complex, chaotic scene, all imperative to the timely resolution of the incident.

8.189 In particular, during the one-hour period between his arrival on Level 5 (just after 4pm), and his attendance at the new command post (around 5pm), the submissions on behalf of the Commissioner of NSWPF outlined the following actions undertaken by CI Whalley, among other things:

(a) Confirm the location and status of each victim and each injured person, and that they had received appropriate medical assistance;

(b) Instruct the planning and execution of a search and clearance of the entire shopping centre;

(c) Liaise with:

i. D/Insp Adam Solah in relation to a criminal investigation;

ii. DCI Andrew Marks in relation to a Critical Incident Investigation;

iii. A/Insp Nathan Evans in relation to crime scene management and security; and

iv. Superintendent Paul Dunstan (Central Metropolitan Region Operations Manager).

(d) Ensure a thorough, timely review of relevant CCTV was conducted to confirm the number of offenders involved;

[1845] Transcript, Closing Submissions D2: T1992.5-7 (28 November 2025).
[1846] Written submissions on behalf of the Commissioner of NSWPF at [18].

(e) Direct the moving of the Command Post to a more suitable location for the ongoing operation;

(f) Arrange for appropriate identification of Joel Cauchi and consideration of his motives (to address a key concern as to potential terrorism);

(g) Liaise with other responding agencies; and

(h) Brief the NSWPF Executive with timely, accurate and pertinent information.

8.190 It was submitted on behalf of the Commissioner of the NSWPF that having regard to their submissions in relation to the actions of CI Whalley, he is also deserving of specific recognition for his courageous, calm and decisive leadership on 13 April 2024.

8.191 In the Commissioner's submission, CI Whalley impressed as an honest and forthright, if understated, witness. CI Whalley's own description of the incident was that it constituted "*...a scene over a large area. The scope and magnitude of that incident was quite vast. There were, I guess some, some challenges or pivots that needed to be implemented along the way...*" and that it was "*an incident I'll not forget.*"[1847]

8.192 It was submitted that the Court would be left with the strong impression from CI Whalley's evidence that he perceives that on 13 April 2024, he was merely doing his job, consistent with his training. It is submitted, however, that the true import and impact of that job, and the care and skill with which it was undertaken by CI Whalley, is evident from his emotional evidence about the young police officers he spoke to at the conclusion of his shift as referred to above.

8.193 Ultimately, it is submitted that the pressure on CI Whalley on 13 April 2024 was enormous, with emergency responders, shoppers, security staff, families and friends of the victims and injured, the NSWPF executive and government departments, the media and indeed observers all over the world, looking to him for direction, leadership and answers. It is the Commissioner's submission, that, in the circumstances this warrants specific recognition.

The "missed opportunity" in relation to the CCTV review

8.194 Counsel Assisting submitted that the only shortcoming to emerge in regard to the NSWPF command and control structure was the issue of the appointment of a liaison officer who was tasked with communicating with other relevant agencies (in particular, NSWA) and that it was not apparent that any consideration was given to this, or that it occurred. This aspect dovetails into the issue of multi-agency communication and is considered in that context below in Part 10.

[1847] Written submissions on behalf of the Commissioner of NSWPF at [20]; Transcript, D2 (Whalley): T139.6-9; T141.22-23 (29 April 2025).

8.195 Otherwise, Counsel Assisting submitted that whilst not a criticism of CI Whalley or NSWPF, it was observed that there was a "missed opportunity" to review the CCTV footage in the CCTV Control Room prior to CI Reimer doing so and confirming that there was one offender at 4:27pm. Counsel Assisting indicates that there is no suggestion that this relevantly impacted events.

8.196 Counsel for the Commissioner of NSWPF submits that Sgt 2's attendance at the CCTV Control Room cannot be appropriately characterised as a "missed opportunity."

8.197 Counsel for the Commissioner submits that first, the evidence establishes that CI Whalley took command of the incident at 4:01pm and noting this, it is unrealistic to expect that by 4:07pm, CI Whalley would be aware of the movements and location of all police officers on site, and in particular that Sgt 2 had attended the CCTV Control Room, such that he could liaise with or instruct Sgt 2 in relation to the CCTV review.

8.198 It is submitted that in any event, Sgt 2's evidence was that at the time of his attendance:

(a) He was not provided with any information while in the CCTV Control Room;

(b) It was a very busy room and he was present for less than a minute; and

(c) While a security officer attempted to show him aspects of the incident, the operators were waiting for a manager or senior controller to attend and go through the footage.

8.199 It is submitted on behalf of the Commissioner that it is speculative to conclude that in these circumstances (and bearing in mind the significance of the task and the number of reports of possible other offenders) Sgt 2 could have conclusively reviewed the CCTV and determined that there was only one offender and there was in reality no "*missed opportunity*".

8.200 It is submitted that the evidence confirms that upon assuming command, CI Whalley immediately understood the importance of the review of the CCTV footage:[1848]

> *I asked Chief Inspector Reimer to attend the security office to view the CCTV that was available within the centre, backtracking from the Eckersley's store to identify the route that was taken. Ultimately what time the individual entered the centre, and importantly whether they were with anybody else.* [1849]

8.201 Counsel for the Commissioner submits that CI Whalley gave unchallenged evidence as to the need for a sufficiently senior and trusted officer to conduct the review of the CCTV, and this was why he selected CI Reimer to undertake this task, so he could have sufficient confidence in the conclusions drawn:

[1848] Transcript, D2 (Whalley): T132.10-13 (29 April 2025).
[1849] Transcript, D2 (Whalley): T132.10-13 (29 April 2025).

Q. Can I go back to just one other aspect of you speaking with Chief Inspector Reimer about going to the security room to review the CCTV?

A. Yes.

Q. Can I ask you to assume, if you assume that by 4pm, so just about you're taking command—

A. Yes.

Q. --officers from Scentre Security staff had reviewed CCTV and were confident that there was only one offender. First, were you given that information at the time?

A. By Scentre Security?

Q. By Scentre Security?

A. I don't recall having been given any information like that, no.

Q. If you had been given information to that effect, that Scentre Security staff had reviewed the CCTV and they were confident that there was only one offender, would you have nevertheless tasked Chief Inspector Reimer to do a review?

A. Yes.

Q. Why?

A. Because, because there's some specific questions that, that I would need answered, because I would expect that I would be required to provide a certain level of detail, so that's why I was fortunate to have Chief Inspector Reimer there who's an experienced officer at the same level as myself, to be able to go and review, distil the important points out of that, out of what he was able to view, and to report that information back. So, it was a way that I was fortunate to be able to get the right information as soon as possible, and I was then confident in being able to report up to Assistant Commissioner Cook and others.

Q. You've pre-empted my next question. Was a component of this being you in command feeling that you could be confident in the information that you were being provided because it had been undertaken by a person you knew to be an experienced police officer?

A. Yes, and who I had reason to understand had the same level of, or the same level of training as myself, or perhaps more. [1850]

8.202 It is submitted that whilst CI Whalley was not asked about Sgt 2's attendance at the CCTV Control Room, his evidence makes clear he was not prepared to rely on a review of the CCTV by Scentre Security staff, and sought someone who had a significant degree

[1850] Transcript, D2 (Whalley): T159.39-50; T160.1-27 (29 April 2025).

of training – at least to the level of a Chief Inspector – to conduct the review, reinforcing his excellent judgment.[1851]

8.203 The Commissioner submits that the evidence of AC McKenna also considered that the approach taken by CI Whalley was appropriate:

> *I've got no real criticism of the way it was done, because you did want an appropriate officer at that level to review that. Because reviewing it is not just watching it. Reviewing it is looking for things that you know could be really significant, and you need the appropriate person to do that. Again, in hindsight, if this was a perfect world, would someone have done that earlier? It's possible.*
>
> ...
>
> *Q. We're not talking about utopia. I'm talking reflections with the benefit of hindsight.*
>
> *A. Well, I - you know, I can say that I've got no criticism of how and when it was done. Could it have been done earlier? Yes.* [1852]

8.204 It is submitted on behalf of the Commissioner of NSWPF that ultimately the task of the CCTV review was done well and it was done quickly, noting that S/Sgt Watt opined that 30 minutes to confirm there was only one offender involved was swift, particularly when compared to AAO incidents internationally, and given the size of WBJ and the number of persons in and around the building at the time of the incident. [1853] The timeliness of the resolution of the number of offenders by the NSWPF is considered further in Section F.

Findings

8.205 I note that there was limited controversy as to the factual matters regarding the nature and timing of the NSWPF response to the events of 13 April 2024.

8.206 Noting the evidence received at Inquest on this issue, the expert opinion of Mr Wilson, and the submissions of the parties, I find that:

(a) The NSWPF's response to the scene was commendably rapid. As the Inquest heard, in AAO incidents, time is of the essence. Insp Scott arrived at WBJ within two minutes of the "double beeper" indicating the priority of the job. As outlined with respect to Part 6, this swift response undoubtedly saved lives. In addition, CI Whalley swiftly attended and took command, appropriately, from Insp Scott within 20 minutes of the first call to 000 reporting Mr Cauchi's attacks and approximately 15 minutes after Insp Scott fatally wounded Mr Cauchi. The timeliness of the NSWPF's response was exemplary.

[1851] Written submissions on behalf of the Commissioner of NSWPF at [52].

[1852] Transcript, D19 (Assistant Commissioner McKenna) T1724.35-T1725.11 (27 May 2025).
[1853] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [67].

(b) The command and control aspect of the NSWPF response was dealt with "*reasonably well*". The NSWPF command roles were quickly established as too was the Forward Command Post. Further, all necessary management roles, including investigation, were put in place and an early command centre was established.

(c) Whilst the command and control aspect of the NSWPF response was established, as Mr Wilson opined, it took two hours for the first multi-agency tactical command meeting to take place, with Senior Ambulance and Scentre Staff, at 5:30pm. First, I accept that the 5.30pm meeting was the first multi-agency tactical command meeting. Secondly, I find that it took too long for an inter-agency meeting to take place. This Inquest received extensive evidence as to the importance of interoperability and inter-agency communication, and the benefits of co-location of command centres to support shared situational awareness. Put simply, interoperable working can contribute to a more effective and efficient response by all emergency services and should be prioritised whenever possible. This is explored extensively in Part 10 of these Findings.

(d) There was a missed opportunity with regards to the review of the CCTV footage in the CCTV Control Room. CI Whalley took command of the scene at 4:01pm. CI Reimer attended the CCTV Control Room to review the CCTV footage at 4:22pm, with the outcome of that review at 4:27pm. The scene was chaotic and there were many decisions that CI Whalley was required to make in the initial stages of the NSWPF response. Notwithstanding this, I am of the view that 20 minutes is too long for the CCTV review task to be completed, this is especially so in circumstances where another NSWPF officer was in the CCTV Control Room prior to this time, and where confirmation of the number of offenders and risks at the scene was critical information to the provision of aid to those in need within the Centre (which is demonstrated further in the 'hot zone' issue addressed below). Relatedly, it is noted that a 'liaison officer' was not appointed to facilitate communication between the other relevant agencies. This was a shortcoming. The CCTV review should have happened earlier. However, I also find that this missed opportunity did not have an impact on patient outcomes.

(e) With respect to CI Whalley, I find that, notwithstanding my finding with respect to the timing of the CCTV review, his actions in the hours after the incident were appropriate and in accordance with NSWPF policy and procedure.

8.207 CI Whalley deserves specific recognition for his courageous, calm and decisive leadership in his response to the events of 13 April 2024. CI Whalley's contribution to the events of the day were significant, and I commend the professionalism with which he carried out his role. I also recognise the humanity and kindness that came through in the moving comments he made about the officers he observed to be remaining with victims so they would not be left unattended.

E. NSWPF first aid response

8.208 As outlined above, a further issue that emerged at Inquest, noting the essential operational goals of the NSWPF AAO Guidelines, was the adequacy and appropriateness of the first aid treatment provided to victims on 13 April 2024 by members of the NSWPF.

8.209 As part of the NSWPF AAO Guidelines, once the primary objective of stopping the actions of an AAO offender has been undertaken, police are trained to provide immediate trauma care to victims.

8.210 As part of the response by NSWPF on 13 April 2024, many police attended the scene. By 3:40pm, a short time after Mr Cauchi was shot, several police officers were on Level 4 providing aid to victims. This continued until further NSWA personnel were on scene to take over treatment.

Treatment of victims on 13 April 2024

8.211 Promptly after Insp Scott stopped the threat posed by Mr Cauchi, many NSWPF officers began rendering aid to those victims nearest to them.

8.212 Noting the trauma-informed approach of this Inquest, the specific details of the first aid rendered by those officers to the victims will not be set out in detail. It is, however, relevant to note that the first aid rendered by NSWPF included conducting CPR and applying direct pressure to the victims' wounds. All bar one victim was provided aid by an NSWPF officer within 10 minutes of their injuries being inflicted, with handover to NSWA occurring shortly thereafter.

8.213 As noted above, in addition to the six victims that died from their injuries, there were a further ten victims inside WBJ who had sustained penetrating trauma injuries of varying severity who also required the assistance of emergency responders.

Witness evidence regarding NSWPF first aid response

8.214 S/Sgt Watt explained that once Insp Scott had stopped the threat posed by Mr Cauchi:

> *... the decision by most police to switch to providing first aid to the victims nearest to them was entirely appropriate. It has been identified by overseas experiences that the victims in AAO incidents typically suffer penetrating trauma to the torso and head – these injuries are life threatening and difficult for police to deal with. My opinion is that the involved police did the best they were able to in the circumstances that confronted them.*[1854]

[1854] Exhibit 1, Vol 14, Tab 764, Statement of Senior Sergeant William Watt at [69].

8.215 S/Sgt Watt noted that consistent with AAO training, officers who did not have sufficient first aid equipment available to them improvised by using other items, such as clothing and cloths, available from nearby stores within WBJ.

Expert review of NSWPF first aid response

Best practice for out of hospital management of penetrating trauma

8.216 Dr Stefan Mazur outlined that when considering out of hospital management for penetrating trauma, "*the anatomical location of the injury is important and dictates management principles.*"[1855]

8.217 Whilst there is variation to the applicable principles dependent on the location of the penetrating injury (for example, whether to an extremity or another part of the body such as the chest or abdomen), in circumstances where there is an apparent significant injury, and/or where that injury is accompanied by ongoing blood loss, management principles relate to using a stepwise process to stop the bleeding. This process is subject to other considerations based upon the location of the injury (for example, a pneumothorax, non-medically known as a "*collapsed lung*", is an injury that can arise from a penetrating trauma to the chest).[1856]

8.218 The management of the bleeding, initially, involves "*firm direct pressure. Ideally with sterile gauze or combine dressings if available but if not any clean material or even just (ideally gloved) fingers, palm or fist will suffice initially*."[1857] Once pressure is applied, it is necessary to maintain pressure and to not continue to review the wound to see if it is bleeding "*unless it is obvious that it hasn't [stopped].*"[1858]

8.219 In relation to the victims on 13 April 2024 who died as a result of their injuries, Dr Mazur noted the application of C-ABC Principles in traumatic cardiac arrest due to penetrating trauma (**C-ABC Principles**).

8.220 When considering the care and treatment provided at WBJ on 13 April 2024, including by NSWPF officers, Dr Mazur adopted the C-ABC Principles as the applicable framework.

[1855] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [10].
[1856] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur. See for example, [11]-[13]; [19], [48], [54]. See also [26]-[43] regarding the management of pneumothorax and haemothorax.
[1857] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [13].
[1858] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [13].

8.221 The C-ABC Principles are:[1859]

1. C – Catastrophic haemorrhage.
   Stop/control obvious sources of catastrophic bleeding where possible.

2. A – Airway
   Ensure airway is open and patent. Where available, oxygen/ventilation should be provided.

3. B – Breathing
   If penetrating trauma is to the chest or epigastric area – decompress the chest initially. Reassess and consider resuscitative thoracotomy if the skill set is available and clinical circumstances appropriate.

4. C- Circulation
   Obtain IV or IO access. Give fluid volume – ideally blood, ideally warmed. Crystalloid if blood not available, again ideally warmed but administration should not be delayed if this isn't rapidly achievable.

5. If all the above have been considered and actioned a period of chest compressions may be warranted. There is no benefit in this going any longer than 10-15 minutes if the above actions have occurred and there has been no return of spontaneous circulation.

Figure 31: C-ABC Principles

8.222 Dr Mazur noted that "*the role and value of chest compressions…CPR in cardiac arrest due to trauma has undergone a significant evolution in recent times.*"[1860] He explained that the rationale for CPR is that by providing chest compressions, a degree of forward blood flow is provided to "*prolong the time that a person's brain and other vital organs can survive without the heart providing the pump*."[1861]

8.223 However, in terms of CPR in trauma situations, Dr Mazur stated the following in his report (emphasis added):

> *The problem is that in trauma, including penetrating trauma, the cause of cardiac arrest is most likely due to loss of circulating blood volume, or obstruction of cardiac output due to tension pneumothorax or cardiac tamponade, as described previously. Chest compressions in isolation will provide almost no benefit in these circumstances and may conceivably make the situation worse.*
>
> *In hypovolaemic cardiac arrest, chest compressions will be ineffective as there is no blood volume to be pumped around, the heart is empty. Current medical evidence suggests that by the time a patient arrests due to blood volume loss a successful recovery is very difficult to achieve. Death is particularly likely if a monitored cardiac rhythm shows asystole (a flat line). In some situations where the patient may be in a low flow state (undetectable cardiac output) and not in full cardiac arrest, simultaneously*

[1859] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [65].
[1860] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [57].
[1861] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [58].

> *controlling the source of blood loss and rapidly providing blood volume replacement may result in patient survival.*[1862]

8.224 In oral evidence on 23 May 2025 during the expert emergency conclave, which is considered further below, Dr Mazur expanded on his evidence regarding the utility of CPR in circumstances where a victim has sustained penetrating trauma wounds (emphasis added):

> *This is a, this is a fraught issue can I say... there's no simple black and white answer to this. And I would like to re-emphasise that the actions I saw and read about from the [NSWPF] were tremendous. What I will say is that CPR – and... really when we're talking about CPR we're talking about chest compressions; they're often used interchangeably although they're not strictly the same thing.*
>
> *There can be issues around that and traumatic cardiac arrest. And by that... generally when we're talking about traumatic cardiac arrest, patients have gone into arrest... for a number of possible... reasons. There's a problem with oxygenation. There's a problem with blood volume, or... there's a problem with obstruction to cardiac output for some reason, so a tension pneumothorax or a tamponade. <u>None of those problems will be well-addressed by chest compressions. They're unlikely to fix those issues.</u>*
>
> *So... <u>whilst CPR was admirable and was in the [NSWPF] training, [CPR] was unlikely in the vast majority of the situations to improve patient outcome...</u> . And that's primarily because the compression of a heart that's pushing against an obstruction or is under-filled won't fix the problem. So... it's nuanced, because in some situations of arrest, it's not due to trauma, and... then most definitely CPR should and must be undertaken... it's that level of nuance that will be difficult in the training... and I have no... doubts that... can be... difficult. I guess in the case of penetrating trauma... there are a number of things that should be addressed in priority, and then maybe a consideration be given to CPR after that.*
>
> *<u>And interestingly enough, those things are addressed... in the Ten Second Triage</u>**.** So we want to open an airway, make sure an airway is clear. We want to stop obvious haemorrhage if we can, and in order to do that we need to identify where haemorrhage is coming from, and we talk about those at-risk areas that are often missed, particularly in the junctional areas. And then if we've addressed the airway and we've addressed points of obvious haemorrhage, then it's maybe at that point we might want to consider chest compressions from a police service point of view. That will be different for an ambulance or health service.*[1863]

8.225 Dr Mazur's reference to the "Ten Second Triage" (**TST**) and the triage process undertaken on 13 April 2024 are considered further in Part 10.

NSWPF first aid treatment of the deceased victims

8.226 In preparing his report, Dr Mazur was asked to opine in relation to the first aid treatment provided by NSWPF officers. He had access to material contained within the coronial

[1862] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [59]-[60].
[1863] Transcript, D17 (Mazur): T1556.16-T1557.3 (23 May 2025).

brief, including CCTV and relevant BWV concerning the treatment of Ashlee Good and Faraz Tahir.[1864]

8.227 Dr Mazur opined that the first aid rendered to the victims by NSWPF officers was appropriate. In doing so, he identified the difficulty of applying pressure to, and controlling bleeding from, certain penetrating trauma wounds. In addition, Dr Mazur highlighted the importance of not assuming that a victim has only one wound. Rather, those administering aid should check the patient's body to ensure that pressure is applied to all wounds that might have been inflicted. This may involve physically moving or rotating the patient.

8.228 Further, Dr Mazur's review of the first aid treatment of the deceased victims identified that the officers acted in accordance with their training and the applicable NSWPF policies, for example by performing chest compressions (the utility of which is explored below), by creating space around victims to better provide care, and by utilising clothes and other objects to assist with bleeding control in circumstances where they did not otherwise have the equipment to do so.

Additional considerations in the provision of first aid by NSWPF officers

8.229 An additional consideration raised by Dr Mazur relevant to the first aid provided to victims of penetrating trauma was the importance of examining victims for the presence of stab injuries.

8.230 For NSWPF officers who are frequently first on scene, as with the response to the incident at WBJ, Dr Mazur stated:

> *When assessing victims of penetrating trauma, it is important to never assume there is only one stab injury. It is important additional wounds are actively looked for and managed. This will often require a degree of patient movement (rolling, arms up, etc). Other areas of stabbing injury often missed with the potential for poor outcomes include the groin, the armpits and the back.* [1865]

8.231 Dr Mazur also considered the utility of tourniquets, noting that NSWPF first response officers are provided with first aid equipment bags, also known as "go bags", that contain this in addition to other items.

8.232 Dr Mazur noted that tourniquets are considered a mechanism for stopping bleeding in cases of penetrating trauma to an extremity (for example, a leg or arm); in this case, a tourniquet can be readily placed at the point of an injury.[1866] The tourniquet is placed above the point of injury, but ideally as close to the injury as possible, "*to try and preserve as much viable tissue as possible*"[1867] and stem the bleeding from the injury.

[1864] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at p.3.
[1865] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [128].
[1866] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [14]-[17].
[1867] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [15].

8.233 However, for penetrating trauma injuries to junctional areas (between extremities and the torso), tourniquets are "*ineffective as these areas are too proximal or high up the limb such that it is physically impossible to place the tourniquet above the area of injury*."[1868] This is similarly the case with penetrating trauma to the abdomen, and although Dr Mazur states there is a commercially available "*abdominal tourniquet device*" its efficacy is yet to be established, and its use has a number of limitations.[1869]

8.234 The injuries sustained by the victims on 13 April 2024 were primarily to either the truncal/torso area or junctional areas; there was accordingly no utility in the use of tourniquets by NSWPF officers on that date.

Expert emergency conclave evidence regarding NSWPF first aid

8.235 In addition to the evidence outlined above regarding the utility of CPR in the context of the NSWPF provision of first aid to victims on 13 April 2024, Dr Evens (NSWA) stated during the emergency conclave (emphasis added):

> *I agree with Dr Mazur about… the exemplary actions of the police officers within their current scope of practice and work. With regard to CPR and whether CPR causes harm, I'd highlight again that within the doctrine for the treatment of traumatic cardiac arrest, CPR is de-emphasised but not removed. And that is because it is not possible to be certain of the diagnosis, only what is probable in the diagnosis, and therefore I think although CPR in the context of hypovolemia may cause theoretical damage to the heart, at the point that you have begun CPR in that circumstance there is no probability of survival, so you have not materially caused any harm.*[1870]

8.236 As to the difficulty for NSWPF officers making such a clinical judgement (that is, whether or not to start CPR in the case of penetrating trauma), Dr Evens opined (emphasis added):

> *It should… not be expected.*
>
> *There is a question though about CPR in a major incident, and that really relates to the availability of resources and whether continuing CPR prevents that person from moving on and undertaking other potentially lifesaving activities, and that could be a police officer or anybody else, and that is as Dr Mazur says addressed in the [Ten Second Triage Tool].*
>
> *Penetrating trauma is rare in New South Wales, although I think many of my colleagues would suggest that there is an increasing rate, albeit much lower than we experienced in the UK. And I do think again really within the discussion about Ten Second Triage, but also… if I reference my experience working with the Metropolitan Police in London and the training they receive with regard to the management of penetrating trauma… there are opportunities to provide further training and experience for police officers with*

[1868] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [19].
[1869] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [52].
[1870] Transcript, D17 (Evens): T1557.29-42 (23 May 2025).

> *regard to this condition given that there may well be an increase in prevalence in New South Wales.*[1871]

8.237 During conclave, Dr Mazur gave further evidence regarding the steps to be taken by police, including the need for police officers to assess a victim for potential sources of bleeding, even if that required moving the patient or rolling them (emphasis added):

> *Yes, so... again... I saw some really excellent demonstrations of that, and that particularly relates to the police care of Mr Tahir, who - we talk about creating space. So if you're trying to work or take care for an individual in a cramped environment, you can't do it successfully. So one of, one of the key principles that we operate to is "create space". So move the patient to an area whereby you get at, at best 360 degree access to the patient if you can, and that may mean - that will mean moving them.*
>
> *The other thing is that you need to expose them, and that will be, I... suspect something new or newish to police, if they were to undertake this and that. So you can see the areas where people are most significantly at risk of a catastrophic haemorrhage or... dangerous haemorrhage and they are armpits, groins, back, buttocks, which are areas that are hidden. So you need to roll a patient, and you need to expose those areas to see are there other injuries apart from the obvious that I'm missing that I need to put direct compression on.*[1872]

8.238 For his part, Dr Cowburn gave oral evidence that (emphasis added):

> *Again, I very much concur with the views of my colleagues, and... I have a role in both national and regional teaching and clinical governance of police first aid skills, and I think these need to be balanced against the time spent in training, the equipment, and the prevalence of these incidents. However, if a Ten Second Triage or a similar model is adopted which addresses those life threatening severe haemorrhage [injuries] and a willingness to expose to look for wounds in those junctional areas and other areas where bleeding internally may be going on, that will pay significant dividends.*[1873]

8.239 As noted above, the Ten Second Triage Tool was an important aspect to emerge from the Inquest and is considered in further detail in Part 10.

Submissions regarding the NSWPF first aid response

8.240 Regarding the assessment of the adequacy of the response of NSWPF to the events of 13 April 2024, Counsel Assisting submitted at the outset that the events of 13 April 2024 were unprecedented in NSW and that the Court would accept the dedication, commitment and professionalism of officers of the NSWPF attending a terrifying and confronting scene that day.

8.241 Counsel Assisting submitted that the NSWPF response was essentially in accordance with the applicable policies, procedures and training. It noted that with respect to a

[1871] Transcript, D17 (Evens): T1557.44-T1558.19 (23 May 2025).
[1872] Transcript, D17 (Mazur): T1557.9-25 (23 May 2025).
[1873] Transcript, D17 (Cowburn): T1557.44-T1558.19 (23 May 2025).

mass casualty incident, NSWPF does not have a specific policy, such as AMPLAN (that is applicable to NSWA and discussed further in Part 9).

8.242 Counsel Assisting submitted that the Court would commend the efforts of these first responders who did their best to save lives in the immediate aftermath of the incident. Many police (often of quite junior rank) were faced with devastating injuries and sought to provide first aid, notwithstanding the difficulties of doing so, given the challenging nature of the injuries they confronted.

8.243 Counsel Assisting submitted that in general terms, the expert conclave referred to the efforts of the attending police administering first aid as "*exemplary*", and submitted that the Court would accept the evidence of Dr Stefan Mazur, who relevantly stated:

> *It is important... to consider that for the majority of the [NSWA] and [NSWPF] personnel involved in this incident, it is likely this was the first incident of this nature they would have attended. And there is a is a good possibility that over the course of their careers this may be a once in a career event.*
>
> *On that basis it is important to acknowledge the skill, competence and expertise of all the emergency services personnel who attended, and supported those who attended, this incident and who undertook their tasks professionally in the most trying of circumstances*.[1874]

8.244 Relevant to the NSWPF first aid response was evidence given by S/Sgt Watt regarding a review of first aid equipment issued to NSWPF officers. This is considered further in Section G below.

8.245 Counsel for the Commissioner of NSWPF did not make any submissions regarding this aspect of the NSWPF response, that being the first aid provided by NSWPF officers to those affected by the events of 13 April 2024.

Findings

8.246 With respect to the adequacy and appropriateness of the NSWPF's first aid response, I accept the evidence of the experts, and I find:

(a) The NSWPF officers who performed first aid on the victims at WBJ should be commended for their bravery and skill. These officers responded promptly and did their very best to assist those in need in what were traumatic and terrible circumstances.

(b) The first aid administered by the NSWPF was appropriate. Further, the officers administering aid generally did so in accordance with their training and the relevant NSWPF policies.

[1874] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [289]-[290].

(c) The evidence revealed some areas for learning which ought to be considered in the context of assessing the adequacy of the first aid that was rendered. It should be noted that the following:

i. The Utility of CPR in penetrating trauma injuries – expert evidence was received that detailed the limited utility of CPR or chest compression (acknowledging they are technically different actions) in providing aid for victims with these types of injuries. It is unlikely, in the vast majority of situations, that the CPR performed at WBJ would have improved patient outcomes. This is not intended as a criticism of those who performed chest compressions on victims at the scene. Performing CPR is taught to first responders, and they acted in accordance with that training in this regard. This evidence is noted as a means of raising awareness as to how it can or should be relied upon when rendering aid to those suffering penetrating injuries. For the sake of completeness, it is noted that CPR has been de-emphasised but not removed. This gives rise to consideration of the Ten Second Triage Tool (**TST**) as an alternative triage tool which directs the steps emergency responders, including police officers, should take when faced with these injuries. The TST is addressed further in Part 10.

ii. Multiple Injuries – Dr Mazur stressed the importance of never assuming a single stab wound, and that it is necessary to assess every patient to confirm the number of wounds that they might have. This may require those performing first aid to move or rotate a person. If injuries are missed, attempts to control the bleeding in that area may not occur, and this could lead to poor outcomes for the victims of those injuries.

iii. 360-degree patient access – Evidence was received which emphasised moving patients into free spaces, or to an area that provides 360-degree access, whenever possible. When this is able to occur, those attending will have more access points from which to administer aid and better oversight of the patient overall.

(d) Whilst noting the above areas for learning, the first aid administered by NSWPF officers was adequate. It is acknowledged that it is difficult for NSWPF officers, who are generally not medically trained but for first aid, to make clinical decisions in situations such as those they faced at WBJ on 13 April 2024. This again forms a basis for consideration and implementation of the TST as a triage tool to direct any emergency responder on how to provide aid.

F. NSWPF response to reports of a second offender

8.247 An issue that emerged during the Inquest was the potential for there to have been more than one offender involved in the incident at WBJ on the afternoon of 13 April 2024.

8.248 As apparent from the detailed chronology of events in Section C, officers of the NSWPF were receiving further information following the commencement of Mr Cauchi's attack that suggested that more than one offender may be involved.

Potential for multiple offenders under NSWPF AAO Policy

8.249 During AAO training, NSWPF officers are taught to consider the possibility of multiple offenders, although research suggests that it is rare for there to be more than one offender in an AAO incident.[1875]

8.250 S/Sgt Watt explained that the operational goals in AAO training, as outlined in Section B, are considered flexible:

> *... That is, an officer's first priority is to stop the killing. Once they have achieved that, they transition to stopping the dying, but if actionable intelligence suggests there is more killing occurring (or about to occur), they should transition back to again stopping the killing.* [1876]

8.251 Further, reports of secondary offenders are considered common in AAO incidents, with "*... the primary cause due to variations in descriptions provided by members of the public, coupled with delays in getting through to emergency call takers.*"[1877]

Witness evidence regarding NSWPF response to reports of a second offender

8.252 In his supplementary statement dated 23 April 2025, S/Sgt Watt considered the response of the NSWPF to the reports of a potential second offender on 13 April 2024, including the time taken to resolve this issue.

8.253 To review this aspect of the NSWPF response, S/Sgt Watt analysed several sources of information including police BWV, CCTV footage and relevant statements from the coronial brief.

8.254 S/Sgt Watt stated that:

> *The first clear report of a second offender appears to occur at [3:59pm] when CLM 797 indicates via police radio that he has been shown a photograph of someone with a knife, with a description that is different from that of the known offender. Prior to that time,*

[1875] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [59].
[1876] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [59].
[1877] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [68].

> *both Inspector Scott and CLM 722 (Senior Constable Fricki) clearly indicated that there was only a single offender and he was accounted for.*[1878]

8.255 This broadcast is referred to above in the chronology outlined in Section C.

8.256 Arising from this report at 3:59pm, and a later report at 4:08pm from POLAIR1, that there was an individual who matched this description, several police resources moved to the roof of WBJ and detained this person. The police resources involved included TOU personnel, a PORS team, an officer known by callsign SC36, and some further CLM call signs. [1879] S/Sgt Watt noted that "*had this individual actually been a second offender, this was an arrest of an armed offender, not an intervention in an ongoing AAO incident.*"[1880]

8.257 Regarding the second offender issue, S/Sgt Watt opined that:

> *From my review of the BWV and CCTV footage, I note the second offender report (by CLM 797 at [3:58pm]) was not broadcast until after NSWPF officers had handed off primary care/assessment of all deceased victims except Pikria Darchia to [NSWA] staff. [NSWA] were already in the building and remained treating the injured, including Pikria Darchia from [3:59pm]. As is clear from the statements of [Insp Brett Simpson] and [AC Brent Armitage], [NSWA] remained inside the centre treating patients at this time (until withdrawn at approximately 4:30pm).*
>
> *This indicates the report of a second offender and response made no difference to the outcomes for the deceased…Further, and importantly in my view, just because the 'second offender' turned out not to be involved, does not mean police were wrong to investigate: self-evidently, ignoring reports of a further armed offender could be catastrophic.*[1881]

8.258 S/Sgt Watt noted that the radio broadcast of CI Reimer at 4:27pm, outlined in Section C "*appears to conclude any concerns about a possible second offender from the perspective of NSWPF, although of course the PORS teams continued to clear the centre shop by shop.*"[1882]

8.259 Further to this, S/Sgt Watt opined that (emphasis added):

> *In total therefore, it took less than 30 minutes for NSWPF to resolve the primary reports of a possible second offender. Given the size of Westfield Bondi Junction, the number of persons in and around the building at the time of the incident, the varying descriptions provided by members of the public and volume of traffic on the radio, in my view this was a very timely response.*[1883]

[1878] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [62].
[1879] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [62].
[1880] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [63].
[1881] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [64]-[65].
[1882] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [66].
[1883] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [67].

8.260 As outlined above, NSWPF officers are taught to consider the possibility of multiple offenders in an AAO incident, although it is rare for there to be more than one offender and reports of secondary offenders are common in AAO incidents.

8.261 In his second statement, S/Sgt Watt referred to two examples of AAO incidents in the US (these being at the Washington Navy Yard in 2013, and Fort Lauderdale, California, in 2017) where resolution of the second offender issue took more time than was taken by NSWPF on 13 April 2024 (upwards of an hour in both cases). S/Sgt Watt stated that this demonstrated that "*the time taken by NSWPF at [WBJ] to resolve the reports of other offenders was relatively swift.*"[1884]

8.262 Relevantly, S/Sgt Watt also noted that notwithstanding his opinion regarding the response of NSWPF on 13 April 2024:

> *... the experience at Westfield Bondi Junction will serve as a useful case study in future AAO training to emphasise to officers first, the rarity of there being a second or multiple offenders, and secondly, in the unlikely event there is a second offender who has separated from the first, given their goal of killing as many people as possible, other offenders will typically make their presence known very quickly.*[1885]

Review of CCTV footage

8.263 An aspect of the NSWPF response to reports of a second offender were the steps taken to review CCTV footage within WBJ to confirm whether there was only one offender involved in the incident.

8.264 As noted in Section C above, Sgt 2 was present in the CCTV Control Room at 4:07pm. Ultimately, it was established 20 minutes later at 4:27pm by CI Reimer that Mr Cauchi was the sole offender, following his attendance at the CCTV Control Room.

8.265 AC McKenna gave the following evidence regarding the earlier opportunity (at 4:07pm) to access the CCTV Control Room to conduct a review of footage regarding a potential second offender (emphasis added):

> *Q. Is that a matter that could be the subject of emphasis in terms of the case study about the response, that is, that it's a critical step to take to access the control room?*
>
> *A. Well, it's something we always know that that will be something that has to be done. But it comes back to the whole command and control element when you get jobs like this. So, you've got police on the ground doing what police do, and that is dealing with the threat, saving lives, working in collaboration with the ambulance officers, making sure people are safe.*
>
> *It's when you get that command and control come in, like we did with [CI Whalley], who then is really thinking about that, that modelling of, all right, we need to find*

[1884] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [68].
[1885] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [70].

out who this person is, we need to find out if they're alone, we need to look at crime scene preservation, we need to identify witnesses, we need to do all the things that he was doing. That's why that comes into play. Again, if you're saying benefit of hindsight and almost a utopian style of dealing with this—

Q. We're not talking about utopia. I'm talking reflections with the benefit of hindsight.

A. Well, I - you know, I can say that I've got no criticism of how and when it was done. Could it have been done earlier? Yes.

Q. The officer who was in attendance at [4:07pm] was a sergeant. That's a senior officer?

A. Yeah, also depending again on the instructions, on their experience and everything else, yes.[1886]

Submissions regarding the NSWPF response to reports of a second offender

8.266 Counsel Assisting submitted that interagency communication as between NSWPF and NSWA regarding a potential second offender emerged as a key issue in the Inquest. This is considered in Part 10 below.

8.267 Otherwise, Counsel Assisting submitted that the opinion of S/Sgt Watt may be accepted by the Court, namely that noting the size of WBJ, the number of shoppers inside the building and the varying descriptions received by NSWPF, the resolution of the reports by NSWPF regarding a potential second offender within 30 minutes was timely.

8.268 The exception to this was the "missed opportunity" for police to establish the number of offenders at 4:07pm by Sgt 2 making inquiries about, and reviews of, the CCTV footage in the CCTV Control Room. That is, the opportunity to have this information significantly earlier than the determination at around 4:27pm.

8.269 Counsel Assisting submitted that even had the CCTV review occurred at this time, given the communication issues with NSWA and having regard to the facts, the delay did not impact upon the outcome in any respect. I have considered the "missed opportunity" in Section B.

Findings regarding the NSWPF response to reports of a second offender

8.270 With respect to the adequacy and appropriateness of the NSWPF response to the reports of a second offender at WBJ, I accept the submissions of Counsel Assisting and the opinion articulated by S/Sgt Watt.

[1886] Transcript, D19 (P McKenna): T1724.42-T1725.16 (27 May 2025).

8.271 Noting the size of the Centre, the number of individuals in and around the scene at the time, the varying descriptions of the potential second offender provided by members of the public, and the volume of traffic on the radio, I find that the NSWPF's response to these reports was in fact timely.

8.272 I concur with the view of S/Sgt Watt that the fact that there was not a second offender does not mean that the police should not have investigated those reports. The NSWPF responded appropriately to the reports in seeking to verify or confirm them. Clearly, the inverse response – failing to investigate reports of a second offender where there is in fact a second offender – could have dire and catastrophic outcomes.

8.273 Notwithstanding the timeliness of the NSWPF response to the reports of a second offender, and as noted above in Part 8, Section D, I find that there was a missed opportunity with regard to the review of the CCTV footage in the CCTV Control Room. The fact that an officer was located inside the CCTV Control Room at 4:07pm indicates that there was the potential for police to undertake their investigations into the reports of a possible second offender much earlier than they otherwise did. Whilst I accept that the missed opportunity did not have an impact on outcomes, it is nonetheless imperative that the actions of the day be considered with the intention of learning from them. As S/Sgt Watt articulated, the experience at WBJ will serve as a case study in future AAO training.

8.274 It is noted that the NSWPF response to reports of a second offender leads to and highlights the topic of inter-agency communication and shared situational awareness. The failure to share critical information about the status of those reports and the resulting 'hot zone' issue are addressed below in Parts 9 and 10.

G. Changes within the NSWPF since 13 April 2024

NSWPF review of response to the events of 13 April 2024

8.275 In his statement, AC McKenna outlined a review undertaken of the NSWPF response to the events at WBJ on 13 April 2024 in the form of the formal debrief at the Art Gallery of NSW on 4 June 2024 (**the NSWPF Debrief**).[1887]

8.276 Amongst the issues emerging from the NSWPF Debrief, the feedback and opportunities for improvement identified included the following:[1888]

(a) As noted above, the alarms at WBJ were "*overwhelmingly loud and hampered the radio communications of officers*";

(b) There "*were extensive and in some cases unnecessary, broadcasts over the NSWPF radio network*";

(c) Some officers encountered missing or expired components in first aid bags; and

(d) The CAD system "*experienced lagging due to a large influx of CAD incidents received in a short period of time and a large number of police accessing the system at the same time.*"

NSWPF 2025 Mandatory Training Package

8.277 S/Sgt Watt explained that the upcoming NSWPF 2025 mandatory training package would commence in July 2025 and would be mandatory for all operational police with an equivalent course to run at the NSWPF Academy.[1889]

8.278 Additionally, S/Sgt Watt noted that whilst the review of the training package had commenced prior to the incident on 13 April 2024, any learnings and improvements identified from the incident would be incorporated into the updated AAO training package, including:[1890]

(a) A focus on the establishment of command and control in AAO incidents by officers of a variety of ranks;

(b) The nature and quantity of first aid equipment issued to general duties police officers, with "go bags" to include a greater number of tourniquets, additional wound packing material and trauma dressings; and

[1887] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [12].
[1888] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [36].
[1889] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [47].
[1890] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [48].

(c) Consideration of the storage of first aid equipment and how it is carried in both police vehicles and by officers.

8.279 Further, S/Sgt Watt also agreed that any further learnings from the Inquest could be incorporated in the upcoming mandatory training package.[1891] Other changes and improvements to that package included:[1892]

(a) The need to thoroughly search a victim for all potential wounds, including in junctional areas;

(b) The need to remove victim's clothing to conduct a thorough search for wounds, if required; and

(c) Some consideration of tactical emergency casualty care to enable participants to practice some of the techniques regarding haemorrhage control.

8.280 S/Sgt Watt is a member of the ANZPAA and noted that a periodic review of the AAO guidelines had just been undertaken and referred to the Commissioner for endorsement.[1893] S/Sgt Watt confirmed that he would be able to pass on any learnings from the Inquest to the ANZPAA.[1894]

Submissions regarding changes since the events of 13 April 2024

NSWPF Debrief

8.281 Counsel Assisting submitted that it was highly creditable that on 4 June 2024, prior to the Inquest, NSWPF conducted a comprehensive 4 hour debrief of the police response. It was noted by Counsel Assisting that the NSWPF Debrief was facilitated by a retired senior police officer, and involved NSWPF executives, as well as officers directly involved in the response, including Insp Scott, CI Whalley and DCI Marks. NSWA representatives (such as AC Armitage) also attended. The purpose of the NSWPF Debrief was to gather information and intelligence to determine "*what was done well and identify opportunities for enhancement in practices for future operations*".[1895]

8.282 Counsel Assisting submitted that the NSWPF Debrief was appropriately conducted with an awareness that the events on 13 April 2024 were the subject of both an active coronial and critical incident investigation. For example, by June 2024, essential investigative processes had been completed, such as obtaining key statements, and attendees were

[1891] Transcript, D18 (Watt): T1624.3-8 (26 May 2025).
[1892] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [48](e); Transcript, D18 (Watt): T1623.33-T1624.1-8 (26 May 2025).
[1893] Transcript, D18 (Watt): T1624.10-20 (26 May 2025).
[1894] Transcript, D18 (Watt): T1624.22-24 (26 May 2025).
[1895] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [14].

provided the opportunity to give feedback if desired (including anonymously), identifying the key issues as outlined above.[1896]

NSWPF first aid equipment

8.283 As outlined above, Counsel Assisting noted that S/Sgt Watt gave evidence of potential first aid equipment improvements and learnings to be incorporated into the 2025 AAO training package. This included a review of the nature and quantity of first aid equipment issued to general duties police officers, with "go bags" potentially containing a greater number of tourniquets, additional wound packing material and trauma dressings. Consideration was also being given to the storage of first aid equipment, and how it was to be carried in police vehicles and by officers in the field.

8.284 Counsel Assisting submitted that it is appropriate and creditable, that the NSWPF has undertaken such a review and has front of mind the adequacy of the first aid equipment issued to officers, given certain feedback received from the police first responders and given the evidence of S/Sgt Watt. Counsel Assisting therefore submitted that there is no scope for recommendations on this issue.

NSWPF officer communication

8.285 Counsel Assisting submitted that the Court would note the following matters as increasing the challenging nature of the scene that confronted the police first responders:

(a) The very large scale and layout of WBJ (which includes multiple levels), which can be difficult to navigate for the uninitiated;

(b) The "*overwhelmingly loud alarms*" that hampered communications;[1897] and

(c) The extensive, and in some cases, unnecessary broadcasts over police radio. In this regard, AC McKenna explained:

> *Yeah well the fact of the matter is, again, this is the first time we've had a job of this significance, of this type. Our training is for the police to call on and call off at jobs. One of the lessons we've learnt from that is we will be telling police to utilise the mobile CAD system which is in their vehicles to let us know they're there, to let radio know they're there ...*[1898]

8.286 It was submitted that AC McKenna also noted that the introduction of new technology – such as mobile CAD and BluLink (an application which allows police to immediately transmit their location via GPS) will be of assistance in the future. He gave evidence regarding: [1899]

[1896] Exhibit 1, Vol 45, Tab 1602B, Statement of Assistant Commissioner Peter McKenna APM at [12]-[17].
[1897] Transcript, D19 (P McKenna): T1718.48-T1719.5 (27 May 2025).
[1898] Transcript, D19 (P McKenna): T1719.12-16 (27 May 2025).
[1899] Transcript, D19 (P McKenna): T1719.23-37 (27 May 2025).

(a) The "*antiquated*" nature of the CAD system, which can become overwhelmed (and "*lagged*" in responding to the incident on 13 April 2024, given the volume of information). AC McKenna noted that the NSWPF is moving towards a new "*state of the art*" system, at the time hoped to be implemented by 2026, which would alleviate such issues;[1900] and

(b) Concerns were raised about potential communication difficulties WBJ at the initial command post in the loading dock. This was promptly investigated by NSWPF, and the issues were attributed as likely arising from the volume of traffic.[1901]

8.287 Counsel Assisting submitted that these issues were investigated and addressed by the NSWPF to the extent possible, demonstrating commendable proactivity and obviates the need for consideration of any recommendations connected to these matters.

8.288 Counsel for the Commissioner of NSWPF did not make any submissions regarding this aspect of the NSWPF response, that being the changes made since the events of 13 April 2024, as outlined above.

Findings

8.289 The evidence and submissions received at Inquest demonstrate that NSWPF have taken active steps to consider what can be learnt from the horrific events of 13 April 2024, and the ways in which the processes, policies, and equipment utilised by the NSWPF can be improved. Whilst the events of the day were extremely challenging, it is important to consider areas for improvement.

8.290 I accept the submissions of Counsel Assisting regarding changes made by the NSWPF since the events of 13 April 2024.

8.291 I commend the NSWPF for their proactivity, especially with respect to the consideration of further training on issues such as the establishment of command and control at AAO events, the administering of first aid including the need to search victims for potential wounds, and the nature and content of the "go bags" that officers are equipped with and use to provide aid to those in need.

8.292 I find that the NSWPF debrief process conducted on 4 June 2024 was comprehensive and conscientiously framed with the intention of considering opportunities for future enhancements.

8.293 As noted above, it is the submission of Counsel Assisting that the proactivity exhibited by the NSWPF in the implementation of changes following the events of 13 April 2024, obviates the need for any recommendations arising out of the matters considered in this Part. Noting the steps taken by the NSWPF as outlined above, I accept that submission

[1900] Transcript, D19 (P McKenna): T1720.15-24 (27 May 2025).
[1901] Transcript, D19 (P McKenna): T1721.43-50 (27 May 2025).

and do not propose to make any recommendations arising out of the matters considered in Part 8.

Part 9 The response of NSWA to the events of 13 April 2024

The response of the NSWA to the events of 13 April 2024

9.1 To address the evidence arising in relation to consideration of Issues 13 and 14 with respect to the response of NSWA, this Part will be separated into the following sections:

Section A	Introduction
Section B	The NSWA response to AAO incidents
Section C	Chronology of events
Section D	Triage and treatment
Section E	Command and control
Section F	NSWA Special Operations Team
Section G	Zoning for an AAO incident
Section H	NSWA changes since the events of 13 April 2024

A. Introduction

9.2 This Part will consider the response of NSWA in relation to the events of 13 April 2024, including the evidence regarding the extensive NSWA resources that were deployed to WBJ that day.

9.3 In considering the NSWA response, the Court was greatly assisted by statements contained in the brief of evidence from numerous NSWA staff, in particular paramedics who attended the scene to provide treatment to patrons of WBJ. What is clear from these statements is that those who responded to the incident went above and beyond in executing their roles, demonstrating great courage, skill and professionalism when faced with confronting and traumatic events.

9.4 At Inquest, oral evidence was provided by the following NSWA witnesses:

(a) Inspector Brett Simpson (**Insp Simpson**), who assumed the role of NSWA Forward Commander on scene at WBJ on 13 April 2024;

(b) Assistant Commissioner Brent Armitage (**AC Armitage**), who assumed the role of NSWA Commander at WBJ on 13 April 2024;

(c) **SOT1**,[1902] a Special Operations Team Paramedic, who attended the scene at WBJ on 13 April 2024;

(d) Critical Care Paramedic (**CCP**) Christopher Wilkinson (**CCP Wilkinson**), who was also present at the scene on 13 April 2024 and was involved in the treatment of Faraz Tahir;

(e) Doctor Thomas Evens (**Dr Evens**), Acting Executive Director of Medical Services and Research at NSWA, who as part of his role performed clinical reviews of the majority of the deceased and injured victims on 13 April 2024; and,

(f) Deputy Commissioner Wayne McKenna (**DC McKenna**), who gave evidence as an Executive Witness regarding the response of NSWA on 13 April 2024. DC McKenna did not attend WBJ that day.

9.5 In addition, independent expert evidence was provided by two experienced emergency clinicians regarding the NSWA response, including the treatment of the victims that did not survive their injuries:

(a) Dr Stefan Mazur (**Dr Mazur**), who provided an expert opinion on the survivability of the injuries suffered by the deceased victims as well as the adequacy and appropriateness of the treatment provided; and

[1902] SOT1 is a pseudonym pursuant to non-publication order dated 4 May 2025.

(b) Dr Philip Cowburn (**Dr Cowburn**), who provided evidence concerning a number of topics, including the operation of the Ten Second Triage Tool (**TST**), joint agency working through the JESIP methodology and also on the survivability of victims.

9.6 Abridged curriculum vitae for both Dr Mazur and Dr Cowburn are outlined in **Appendix 9.**

9.7 Both Dr Mazur and Dr Cowburn provided individual detailed reports to assist the Court and gave evidence in conclave (simultaneously) at Inquest on 23 May 2025, with Dr Evens of NSWA. The evidence arising from this conclave was of great assistance to the Court and is considered further below.

9.8 By reference to the Issues List, this Part concerns the evidence, findings and recommendations arising out of Issue 13 and Issue 14, which are outlined in full at **Appendix 5.**

9.9 It is noted that Issues 13(c) and 14(b) - concerning the nature and effectiveness of communications as between NSWA, the NSWPF and with Scentre - emerged as a central issue to the Inquest. Submissions were received from Counsel Assisting to the effect that interagency working and communication is the primary area of improvement as between NSWPF and NSWA and has led to the identification of certain recommendations as both necessary and desirable. This is dealt with in Part 10.

B. The NSWA response to AAO incidents

9.10 NSWA has various Operating Procedures, Work Instructions and Protocols which "operationalise" the NSW Ambulance Major Incident Response Plan (**NSW AMPLAN**), a document that guides the NSWA approach to the management of Major Incidents or emergencies.

9.11 Central to the NSWA response to the events of 13 April 2024 was a NSWA Work Instruction guiding the approach to AAO incidents.

NSWA AAO Work Instruction

9.12 NSWA Work Instruction WI2023-095, (issued on 14 December 2023) is entitled "Clinical Operations – Response to Active Armed Offender (AAO) and Public Disorder Incidents" (**AAO Work Instruction**). The AAO Work Instruction outlines the policy framework for the response of NSWA to an AAO. Compliance with the AAO Work Instruction is mandatory.

9.13 The AAO Work Instruction definition of an AAO replicates the definition provided by ANZCTC, as referred to above in Part 5.

9.14 Pursuant to the AAO Work Instruction, the primary objective of the NSWA is the safety of its staff, patients, other agency personnel and bystanders. In addition, it notes the NSWPF priorities are stop the killing, stop the dying, and rapid casualty evacuation consistent with the evidence outlined in Part 8. It provides that police will bypass injured patients to resolve the situation and minimise further casualties. Guidance for staff to 'Escape. Hide. Tell.' (as canvassed above) if they feel unsafe, is also provided in this policy.

9.15 The AAO Work Instruction sets out aspects of NSWA's response to AAO incidents, namely "Control Centre", "Approaching the Incident", and "Scene Management".

9.16 Part 3.1 of the Work Instruction concerns the actions to be undertaken by the NSWA Control Centre. In summary, it states that the Control Centre should try to obtain as much information as possible regarding the threat from the NSWPF via the Inter-CAD Electronic Messaging System (**ICEMS**) and verbal contact being made with NSWPF. In addition, it provides that a Forward Commander should be deployed to the scene immediately, that available SOT paramedics must be deployed immediately, and that the Control Centre must undertake the relevant notification and escalation procedures.

9.17 Part 3.2 guides the approach to an AAO scene and reminds paramedics to be vigilant, to be mindful of the people affected by the incident, and to look out for suspicious behaviour, people or secondary devices and to report any of the same to police.

9.18 Part 3.3 relates to 'Scene Management' as follows:

> **3.3 Scene management**
>
> Police will divide the incident into three zones:
>
> - **Hot Zone** (Active Threat)– a dynamic area where there is an active threat of harm.
> - **Warm Zone** (Indirect Threat) – a dynamic area of potential threat however the threat is not considered direct or immediate.
> - **Cold Zone** (No threat) – an area where no threat is present. It is considered safe. It is where the staging area, forward command post and patient treatment area can be set up.

Figure 32: AAO Work Instruction Part 3.3

9.19 The AAO Work Instruction then outlines the position regarding the operation of NSWA paramedics in each of the three zones. Of note, no NSWA clinician is to intentionally enter a Hot Zone. If any personnel find themselves in a Hot Zone, they are to immediately find cover and withdraw as soon as possible. Moreover, only Special Operations paramedics (**SOTs**) in appropriate ballistics personal protective equipment (**BPPE**) may enter a Warm Zone. The SOTs may enter a Warm Zone accompanied by armed specialist police in order to remove patients.

9.20 The AAO Work Instruction also notes:

> *Active armed offenders may still be on the scene at an incident so there could be a significant delay in accessing patients while police work to contain the offenders. NSW Ambulance staff must follow the directions of police regardless of whether patients are visible and paramedic crews believe they can access them safely. These circumstances may be very confronting to paramedics and Forward Commanders need to be cognisant of the need to support their staff but remain steadfast in following police instructions.* [1903]

9.21 Further, the AAO Work Instruction states that *"initial responding paramedics must liaise with police regarding access to other patients as soon as possible once the threat is* resolved.*"*[1904] It also directs that if the incident has not been resolved by police when the first responding paramedics arrive, they are to maintain continual liaison with the Police Commander to ensure paramedic access to all patients at the earliest opportunity.

Knowledge and awareness of the AAO Work Instruction by NSWA staff

9.22 The Inquest received evidence regarding the debrief process undertaken by NSWA following the incident at WBJ. This process, conducted through the NSWA Emergency Management Unit (**EMU**) identified observations, insights and lessons from the incident. This process is relatively new for NSWA and commenced in 2023 to examine the response of NSW to a Major Incident through a lessons management framework.

[1903] Exhibit 1, Vol 36, Tab 1214, Clinical Operations – Response to Active Armed Offender at p. 4.
[1904] Exhibit 1, Vol 36, Tab 1214, Clinical Operations – Response to Active Armed Offender at p. 4.

9.23 One insight that arose from the application of this process to the events at WBJ on 13 April 2024 was that there was a "*lack of awareness*" about the AAO Work Instruction. Specifically, when asked whether they had read the document, 25% of participants involved in the "Command" debrief process responded "Yes"; the remaining 75% stated "No". Further, in oral evidence, Insp Simpson indicated he was not aware of the AAO Work Instruction at the time of the incident (although he had since become aware).

9.24 This lack of awareness was acknowledged by DC McKenna (NSWA). DC McKenna gave written and oral evidence that in response, since April 2024, and to improve awareness of the document, NSWA have added a session on the AAO Work Instruction as part of the two-day face-to-face Mandatory Clinical Professional Development (**MCPD**) training that all new paramedics must complete.

The updated AAO Work Instruction

9.25 Following the Inquest, a further supplementary statement of DC McKenna dated 17 November 2025 was received. DC McKenna confirmed that NSWA reviewed and published an updated AAO Work Instruction (WI2025-057) (the **Updated AAO Work Instruction**). The Updated AAO Work Instruction was published on 11 July 2025.

9.26 The changes made in the Updated AAO Work Instruction were informed by consultation with and feedback from the NSWPF, along with insights captured through the NSWA lessons management process (noted above and below), and the evidence at the Inquest hearing.

9.27 The key aspects of the amendments in the Updated AAO Work Instruction include:

(a) Amendments to the "Background", including the formulation of what an AAO incident is (section 1).

(b) Amendments to the response by the Control Centre to an AAO event (section 3.1), including that a designated Ambulance Commander, available SOT paramedics, and a designated Ambulance Tactical Advisor must all be deployed to the incident immediately.

(c) Amendments to scene management (section 3.3). Unlike the AAO Work Instruction in place at the time of the incident at WBJ, the Updated AAO Work Instruction now dictates that, based on information from police or other source(s), the Ambulance Commander may divide the scene into three zones. The terminology of "hot", "warm", and "cold" remains the same due to the commonality of phrasing with other agencies besides NSWPF. With respect to the division of zones, the Updated AAO Work Instruction also includes the following directions:

Any information that leads to the division of zones should be documented by the Ambulance Commander in their operational logbook.

> *The Ambulance Commander and the Ambulance Tactical Advisor must endeavour to co-locate with the Police commander at the Police Forward Command Post to ensure joint situational awareness and optimal embedded interoperability.*
>
> *In the absence of a division into clear zones due to inadequate information, or tactical expertise, a dynamic risk assessment should be performed, and paramedics should stage or retreat to an area of safety until deemed safe to proceed.*
>
> *Throughout the incident, if established, the division of zones should be constantly reassessed based on the most current information. Any establishment or changes in zones should be communicated by the Ambulance Commander via radio together with any change in instructions on how staff are to proceed.*[1905]

9.28 The Updated AAO Work Instruction was circulated via an all-staff email on 11 August 2025.

Policy concerning NSWA response to a 'Major Incident'

9.29 Pursuant to the *Health Services Act 1997* (NSW) (the ***Health Services Act***) and the NSW State Emergency Management Framework, NSWA is responsible for the provision of ambulance services at a mass casualty event.

9.30 Under the NSW AMPLAN, a mass casualty event or incident falls within the definition of a Major Incident. A Major Incident is one where the location, number, severity or type of live casualties requires extraordinary resources. As Forward Commander, Insp Simpson's first priority was to assess the scene and determine whether it met the criteria for a Major Incident and/or a mass casualty incident. As is noted below, at 3:48:59pm, Insp Simpson declared a Major Incident. This was around three minutes and 28 seconds after Insp Simpson had entered WBJ. At 3:49:50pm, Insp Simpson declared a mass casualty incident, which alerted the NSW Control Centre that there were multiple patients involved. This declaration is considered a crucial step under the NSW AMPLAN framework.

9.31 For the purposes of the NSW AMPLAN, any incident that can be defined as a significant, major, catastrophic, multi, or mass casualty incident ought to be considered. Insp Simpson gave oral evidence that a Major Incident declaration activates incident management procedures, including additional NSWA resources and notification and escalation of the incident to the relevant command chain.

9.32 The policy makes clear that all employees of NSWA are required to follow the directions contained within NSW AMPLAN.

[1905] Exhibit 1, Vol 54, Tab 1698, Further supplementary statement of Wayne McKenna at pp. 6, 12-13.

NSWA command and control under NSW AMPLAN

9.33 Policy and procedure concerning NSWA command and control dictates who is responsible for each aspect of the response, when that response is to take place, and expectations concerning communication both internally within NSWA and with other emergency service providers. Evidence was tendered at the Inquest concerning the relevant "command and control" policy as it forms the basis for consideration of the adequacy and appropriateness of the NSWA response.

9.34 The NSW AMPLAN defines "command" and "control" in these terms:[1906]

Command

The authority to take command. Command is established in legislation or by agreement with an agency/organisation. Command relates only to agencies/organisations, and operates vertically within an agency/organisation.

Control

The overall direction of the activities, agencies or individuals concerned. Control operates horizontally across all agencies/organisations, functions and individuals. Situations are controlled.
[Source: *State Emergency and Rescue Management Act* 1989 *(NSW)* (as amended)].

Figure 33: NSW AMPLAN definitions

9.35 Under NSW AMPLAN, "command and control" is specific to role rather than rank, meaning that paramedics of a more senior rank to those appointed to incident management roles should not automatically assume command or control solely based on rank.

9.36 Part 5.1 of the NSW AMPLAN outlines the four levels of incident management as: Tactical, Operational, Strategic, and Political. Additionally, the NSW AMPLAN also include "Action Cards" which effectively provide a snapshot summary of the roles and responsibilities of various operational roles at the scene of an incident. Some of these Actions Cards are considered below.

9.37 The first NSWA resource on scene is required to immediately establish communication with the NSWA Control Centre and provide a brief "windscreen report" on what can be seen from their vehicle. Subsequent responsibilities include scene reconnaissance and a more detailed "situational report" (**SITREP**) using the METHANE methodology within 10 minutes of arrival, amongst other tasks.

[1906] Exhibit 1, Vol 36, Tab 1214A, NSWA Major Incident Response Plan at p. 34.

9.38 The METHANE method is outlined in the following diagram:[1907]

M	Message (I am declaring a major incident - standby for SITREP)
E	Exact location
T	Type of Incident
H	Hazards (present and potential)
A	Access to the area
N	Number of casualties (actual or estimated) and main categories
E	Emergency services (present or required)

Figure 34: METHANE method

9.39 The Action Card 02 for the first NSWA resource on scene also provides the following details regarding the role of "First on Scene":[1908]

The most experienced paramedic or Station Officer will immediately establish a Forward Command Post and **assume command** to undertake the role of *Forward Commander* until relieved by an appointed Forward Commander.

- ☐ Perform initial triage sieve using the current approved NSW Ambulance Adult/Paediatric Triage Sieve algorithm.
- ☐ The Forward commander will allocate tasks to further crews as they arrive and establish CCS(s); vehicle staging area; loading point; and access and egress route(s).
- ☐ Quarantine a suitable area to establish the Casualty Clearing Station that will adequately accommodate all patients. (See Hint)
- ☐ Provide regular SITREPs and updates via radio to the Control Centre.

HINT

Casualty Clearing Station size = No. of patients x $3.5m^2$

∴ An average football field has capacity for approximately 1500 supine patients

Figure 35: NSWA Action Card 02

9.40 Additional key roles contained in NSW AMPLAN and relevant to the incident at WBJ include the following:

(a) *Forward Commander*: is responsible for the efficient management of on-scene resources and the timely resolution of an incident. In the initial phases of an incident, a Forward Commander manages a number of roles while waiting for arrival of sufficient personnel to appoint to designated roles. Action Card 04 describes the specific role required by the Forward Commander, which also relevantly includes:

[1907] Exhibit 1, Vol 36, Tab 1214A, NSWA Major Incident Response Plan at p.42.
[1908] Exhibit 1, Vol 36, Tab 1214A, NSWA Major Incident Response Plan at p.42.

i. Assuming command of all NSWA personnel at the site or geographical sector;

ii. Reviewing the incident and reporting to the Ambulance Commander the nature and location of the incident, any hazards, the best approach route, the ambulance staging area, an assessment of casualty numbers/severity of injuries, and an assessment of the NSWA resources required;

iii. Establishing and maintaining close liaison with other emergency services commanders;

iv. Appointing the following positions (as required): Incident Site Supervisor(s), Treatment (Casualty Clearing Station[1909]) Supervisor, Loading Point Supervisor, Staging Area Supervisor, and Scribe;

v. Assuming overall responsibility for the establishment of primary triage sieve, Casualty Clearing Station(s), loading point(s) and staging area;

vi. Ensuring co-operation with the Medical Commander regarding priorities for clinical treatment and evacuation of casualties; and

vii. Ensuring that land-based SOTs have been requested to attend to provide tactical advice and specialist access skills as required.

It is noted that the first NSW Ambulance resource on scene at WBJ on 13 April 2024 – Insp Simpson – was also the Forward Commander.

(b) *Incident Site Supervisor*: responsible for the management of initial triage and movement of casualties, and ongoing assessment of resource requirements. This role is appointed by the Forward Commander and is the most clinically qualified and operationally experienced on scene.

(c) *Treatment Officer*: responsible for the early clinical management of patients in the Casualty Clearing Station area, including ensuring that all patients have undergone an initial Triage Sieve, and that there are sufficient paramedic resources available for the treatment and movement of patients to the Loading Point. Also provides information to the Forward Commander concerning patient numbers, clinical profiles and transport priorities.

(d) *Staging Area Supervisor*: responsible for the marshalling, security and access of all NSWA vehicles on scene.

[1909] A Casualty Clearing Station (CCS) is a treatment area where patient management activities can be focused. For large or complex scenes, multiple CCS may be required. The NSW AMPLAN dictates that the Forward Commander should immediately identify a suitable area to set up the CCS in a location of relative safety. The NSW AMPLAN also provides guidance as to the appropriate size of the CCS and the principles to consider when identifying the location of the CCS. See: Exhibit 1, Vol 36, Tab 1214A, NSWA Major Incident Response Plan at pp. 21-22.

(e) *Loading Point Supervisor*: responsible for management, loading and movement, and documenting destinations of all casualties.

(f) *Ambulance Commander*: responsible for managing the overall incident and retains accountability for all NSWA activities regarding the incident, in consultation and cooperation with the Duty Control Centre Officer, the Senior Control Centre Officer, and the appointed Forward Commander. The Ambulance Commander is typically situated away from the incident site, often in an Emergency Operations Centre (**EOC**). The role of the Ambulance Commander at the operational level is to manage the overall incident by determining priorities and objectives; allocating resources; obtaining additional resources as required; taking appropriate risk reduction measures; and considering the health, safety and welfare requirements for all paramedics, medical staff, and allied personnel at the incident. Additionally, NSW AMPLAN Action Card 09 provides that the Ambulance Commander will:

i. Obtain a situation report from the Forward Commander;

ii. Establish an incident management structure and ensure the Incident Management Teams (**IMT**) positions are appointed if required, these include Operations, Logistics and Planning (as a minimum);

iii. Establish and maintain close liaison with the State Operations Controller and the Forward Commander;

iv. Regularly review the incident and report to the State Operations Controller/Deputy State Operations Controller information including, but not limited to, the progress of the incident response, number of casualties and respective triage categories, any hazards, and an assessment of NSWA resources required; and

v. Direct personnel to muster at a designated location for debrief.

(g) *Medical Commander*: appointed to supervise clinical aspects of secondary triage, treatment, transport priority, and transport destination from the scene.

9.41 The evidence heard at the Inquest indicated some variation in the use of the above titles, both generally and at WBJ on 13 April 2024. This is considered below.

Policy concerning treatment and triage

9.42 The response of the NSWA paramedics dealing with the Major Incident they were confronted with on 13 April 2024 was guided by the triage principles outlined in Section 7.4 and Appendix 8 of NSW AMPLAN, together with "NSWA Protocol A11 Multiple Patient Situations" (**Multiple Patient Protocol**).

9.43 Section 7.4 of NSW AMPLAN outlines the triage process to be applied to a Major Incident. It states:

> *The aim of triage is to do the greatest good for the greatest number, which often requires a reversal of clinical intervention priorities which can be challenging. It seeks to prioritise patients by clinical severity and optimise outcomes whenever the number of patients exceeds the available resources on scene.* [1910]

9.44 There are two stages to the triage process – "Triage Sieve" and "Triage Sort".

9.45 Triage Sieve is the initial process that is performed in the field, prior to moving the patients. It is designed to be rapidly undertaken whenever the number of patients exceeds the available resources on scene. The Triage Sort occurs in the Casualty Clearing station.

9.46 At present, triage is undertaken using the SMART Triage Packs, which include colour-coded triage tags used as a means of identifying the priority of the patients. The triage tags are carried in a Smart Triage Kit, which is contained in all NSWA vehicles.

9.47 The Triage Tags (Smart Triage Tags) enable triage to be undertaken to identify patients under the following categories:

Colour	Priority	Description
RED	Priority 1 (Immediate)	Casualties who require immediate lifesaving procedures/transport.
YELLOW	Priority 2 (Urgent)	Casualties who require definitive treatment within four to six hours.
GREEN	Priority 3 (Delayed)	Less serious casualties who do not require treatment within the above times.
BLACK	Deceased	Victims and/or body parts are labelled and left undisturbed, in situ for Disaster Victim Identification (DVI) and forensic investigation.

Figure 36: Triage Tag categories

9.48 The NSWA Multiple Patient Protocol, which sets out the procedure for attending to multiple patient situations, states that the key to efficient management of multiple patient situations is the initial application of the Triage Sieve, and secondary application of the Triage Sort.

9.49 The NSWA Major Incident Response Plan emphasises that triage is a continuous process that is to be repeated frequently.

9.50 Various other protocols govern the procedure to be followed for the treatment of certain injuries and management of certain scenarios, and most relevantly to the events of 13 April 2024. These include:

[1910] Exhibit 1, Vol 36, Tab 1214A, NSWA Major Incident Response Plan at p. 22.

(a) NSWA Protocol A8: Urgent Transport;

(b) NSWA Protocol T1: Pre-Hospital Management of Major Trauma;

(c) NSWA Protocol T6: Chest Injuries;

(d) NSWA Protocol T8: Penetrating Trauma;

(e) NSWA Protocol T10: Traumatic Hypovolemia;

(f) NSWA Protocol T17: Deteriorating Trauma Patient;

(g) NSWA Protocol T20: Traumatic Cardiac Arrest; and

(h) NSWA Protocol T22: Abdominal Trauma.

9.51 All treatment and triage of patients at any incident is underpinned by the overarching principles of care. In parallel with the AMPLAN's focus on prioritising safety at the scene of a Major Incident, the first principle is to "*do no harm – keep your patient safe*". In all circumstances, responding paramedics are to assess the risk versus benefits of any treatment or procedure.

Submissions

9.52 Counsel Assisting submitted that there was compliance with the abovementioned applicable NSWA policies and procedures on 13 April 2024, but for the following:

(a) There was a significant lack of awareness within NSWA regarding the AAO Work Instruction (in the order of 75% of those who responded to the incident at WBJ). Evidence from NSWA institutional witness DC McKenna indicated that remedial action had already been undertaken by NSWA, with a session on the AAO Work Instruction being added as part of the two-day face-to-face MCPD training for all new paramedics added from April 2024.

(b) Insp Simpson entered the Hot Zone, contrary to the requirements of the AAO Work Instruction. The "Hot Zone issue" is more substantively canvassed below.

9.53 With respect to the adequacy of the relevant policies and procedures, Counsel Assisting submitted that there is clear scope for revision and amendment of both the NSW AMPLAN and the AAO Work Instruction (primarily as to zoning), which they assert forms the basis of a recommendation concerning consideration of and/or amendments to those policies.

Findings

9.54 I accept the submissions of Counsel Assisting with respect to the compliance and adequacy of the applicable policies and procedures relevant to an AAO and/or mass casualty incident, including as they were applied by NSWA on 13 April 2024.

9.55 With respect to compliance with the relevant policies and procedures, I find:

(a) There was a lack of awareness within NSWA regarding the AAO Work Instruction. This lack of awareness was acknowledged by NSWA, and by institutional witness, DC McKenna. Steps have been taken by NSWA to improve awareness of the policy, including by way of additional training.

(b) Insp Simpson technically breached the AAO Work Instruction by entering a Hot Zone. However, in circumstances where he was faced with an unprecedented environment and with knowledge of seriously injured patients located inside the Centre, I find no criticism of his entry into the Centre or the resulting contravention of the AAO Work Instruction. I also note that Insp Simpson himself conceded that the policy was breached by him. I note also that the Inquest received evidence from emergency medicine experts which mirrored the sentiment that the action ought not be criticised in the circumstances.

9.56 With respect to the adequacy of the relevant policies and procedures, I find that as at 13 April 2024, there was scope for revision and amendment of both the NSW AMPLAN and the AAO Work Instruction. As set out below, the evidence received indicated issues with the practical application of those policies and execution of the directions and guidance contained therein. Further findings concerning the basis for consideration of the revision and amendment of the NSW AMPLAN are set out below in Section E. I note that consideration of, and amendment to, the AAO Work Instruction has already occurred.

Recommendations

9.57 Proposed recommendations arose out of consideration of compliance with, and adequacy of, the NSWA policies and procedures relevant to an AAO and/or mass casualty incident. The basis for these proposed recommendations is also formed by evidence that is canvassed below. Accordingly, the proposed recommendation considered and made in relation to the NSW AMPLAN is set out at Section E of these findings. Similarly, the proposed recommendation concerning review of the AAO Work Instruction is set out in Section F.

C. Chronology of events

9.58 As noted, the Court was greatly assisted by the preparation of chronologies, including in relation to the response of NSWA to the events of 13 April 2024. In addition, written and oral evidence was given during the Inquest, which added further insight into the events of the day. The following is a summary of the facts presented to the Court concerning the response of NSWA.

Initial response of NSWA and resource allocation

9.59 At 3:34:25pm on the afternoon of Saturday 13 April 2024, the first Triple 0 call was received by NSWA regarding the events that were unfolding at WBJ. A job was created by NSWA dispatch for paramedics to attend in response to a "1B stabbing". Priority 1 cases are those determined as the highest priority and require an immediate ambulance response with lights and sirens. By 3:36pm, the first NSWA units were assigned to respond to WBJ.

9.60 Insp Simpson, with callsign INSP64, was the first NSWA resource to arrive at WBJ and assumed the role of NSWA Forward Commander on scene.

9.61 Insp Simpson commenced his employment with NSWA in April 2009 and became an Intensive Care Paramedic (**ICP**) in 2018. In July 2013, he participated in the NSWA Forward Commanders' Course, completing the final module of training in October 2014. This course included e-Learning modules on the NSW AMPLAN.

9.62 In addition to completing the NSWA Forward Commanders' Course, Insp Simpson had previously spent time with more senior NSWA Inspectors to obtain practical training regarding fulfilling the role of NSWA Forward Commander as part of the NSWA Station Manager Familiarisation Program and Station Manager Course. Of note, in February 2025, Insp Simpson was appointed the Station Manager of Paddington Ambulance Station.

9.63 At around 3:36pm, Insp Simpson was driving on Cleveland Street, Moore Park, when he received a job via Ambulance dispatch to attend WBJ in relation to a "1B stabbing". When the job was first received, there was minimal information, however, further information continually came through. Insp Simpson responded to WBJ under lights and sirens. Whilst en route, he received further information via the NSWA dispatch system, including that there were multiple patients with central stab wounds, and reports of "shots fired".

9.64 At 3:37:37pm, a broadcast was made on NSWA radio stating "*Insp 64 [Insp Simpson] … is your Forward Commander*".[1911] With the intention of keeping the responding NSWA crews in a safe and coordinated location, Insp Simpson replied, advising all crews of a

[1911] Exhibit 1, Vol 11, Tab 601B, Supplementary Statement of Inspector Brett Simpson at [12]-[14]; Exhibit 1, Electronic Material, Item 6B, File B.

staging point at the bus stop on Oxford Street, and that they were not to enter without police or until he himself arrived on scene. Insp Simpson repeated this broadcast at 3:42:04pm.

9.65 At around 3:40pm, two SOT paramedics were directed to respond to WBJ. SOT paramedics are responsible for specialised ambulance operations across the state and bring paramedic-level care to patients in any kind of hostile environment. SOTs operate on a day-to-day basis from rapid response vehicles spread across the state. These two officers attended from Point Clare, around 80km from WBJ. It took them approximately 40 minutes to travel to WBJ. Matters relating to the deployment of SOTs are considered further below in Section F.

9.66 At 3:42pm, aeromedical crews consisting of a Critical Care Paramedic (**CCP**), three medical doctors and two additional paramedics (**Aeromedical Crews**) were dispatched from Bankstown Aeromedical Base via road vehicle. In addition, at 3:43pm, a CareFlight crew, including two medical doctors and one CCP, were tasked by Rapid Launch Trauma Coordinators to attend WBJ.

Arrival of Insp Simpson and the first NSWA crews

9.67 Insp Simpson arrived at WBJ at 3:42:40pm, within six minutes of acknowledging the job. Around the time of Insp Simpson's arrival, three other NSWA crews arrived at WBJ: Unit 445 at 3:42:29pm, Unit 444 at 3:43:08pm, and Unit 442 at 3:43:42pm. Each of these crews contained two NSWA paramedics.

9.68 Upon arrival, Insp Simpson directed the crews to prepare their stretchers and equipment in anticipation of entering WBJ. He then spoke with a NSWPF Sergeant who informed him that an offender had been contained, but that he was unsure whether there were further offenders.

9.69 Insp Simpson acknowledged there was a slim chance, based on the information available to him, that there was a second offender. Whilst understanding it was a Hot Zone, he nonetheless decided to enter WBJ. Consideration of the terminology regarding scene zoning, including the significance of WBJ being considered a Hot Zone by Insp Simpson at this time, was canvassed at the Inquest. A summary of that evidence and my findings in relation to the same are addressed below in Section G. Insp Simpson was also advised by either police or security that the majority of casualties were on Level 4 of WBJ.

NSWA enter WBJ

9.70 At 3:44:27pm, Insp Simpson broadcast an "initial report" over NSWA radio, indicating that Units 442, 444 and 445 were with him and that they would be entering WBJ. At 3:45:31pm, Insp Simpson and the three identified units entered WBJ via Level 3 from Oxford Street, using the entry next to the Lego Store, arriving on Level 4 of WBJ at

3:48:10pm. They entered the Centre 12 minutes and 36 seconds after the first victim was stabbed.

9.71 Upon arriving on Level 4, Insp Simpson observed a number of patients with fatal injuries, with some already being assessed by paramedics from Unit 442. Due to the loud evacuation alarm (which had begun sounding at 3:40:38pm), Insp Simpson could not hear his radio. As a result, Insp Simpson paired up with a male NSWPF Sergeant for the first 10 to 15 minutes as he moved through the Centre. Insp Simpson gave evidence to the effect that this NSWPF Sergeant acted as a conduit to obtain reliable information around potential patient locations. And further, that due to the significant police presence on scene, the police radio network and the NSWPF officers themselves were best placed to provide Insp Simpson with that intelligence.

9.72 At 3:48:59pm, Insp Simpson made a Major Incident declaration over the NSWA radio. Following the making of this declaration, at 3:49:50pm, Insp Simpson made a further broadcast providing a situational report, indicating the incident was a mass casualty incident involving upwards of six patients who had been stabbed and shot, including one baby and six adults. In this broadcast, Insp Simpson requested that resources continue to be directed to the Centre, including senior staff.

9.73 Insp Simpson made a further radio broadcast at 3:58:07pm. In this broadcast, he indicated that he was unable to give a precise number of casualties as they were spread across all levels of the Centre, and that Ambulance Officer 1[1912] was at the staging area receiving patients.

9.74 In addition to Insp Simpson and Units 442, 444 and 445, many additional NSWA resources were subsequently deployed for the initial response to the incident at WBJ. A total of 14 crews, consisting of 28 NSWA officers and Insp Simpson, arrived in the period between 3:48pm to 4pm.

9.75 At approximately 3:53pm, a Major Incident Channel (**MIC**) was established. This radio channel was set up exclusively for communications concerning the incident at WBJ. Around the time it was established, there was a general broadcast instructing all NSWA resources responding to WBJ to turn to the MIC. This direction was repeated at 3:53:37pm and 3:55:58pm.

9.76 At 3:56:42pm, a SOT paramedic arrived at WBJ. This SOT was equipped with chest seals (an item not included in a standard paramedic kit), which he subsequently applied to several patients exiting WBJ.

9.77 At 3:59pm, the CareFlight team (consisting of two doctors and a CCP) arrived on scene. Between 4:01pm and 4:03pm, the Aeromedical Crews also arrived at WBJ.

[1912] Ambulance Officer 1 is a pseudonym pursuant to non-publication order dated 28 May 2025.

9.78 In the 45 minutes after Insp Simpson arrived on scene, a number of additional senior NSWA personnel arrived at WBJ.

9.79 At 4:25:40pm, Inspector Andrew Bibby (**Insp Bibby**) made a radio broadcast identifying the roles of senior NSWA personnel. For ease of reference, the following table (**Table 2**) sets out the arrival time of key NSWA personnel and the initial role they assumed in the immediate command and control structure, once on scene.

Table 2: Arrival time of key personnel

NAME	ARRIVAL AT WBJ	INITIAL ROLE
Insp Simpson (**Insp 64**)	3:42:40pm	First on scene, Forward Commander
Assistant Commissioner Brent Armitage (OPS 50) (**AC Armitage**)	Approx. 4:25pm	Ambulance Commander
Acting Superintendent Karl Cronan (OPS 65) (**A/Supt Cronan**)	4:27:47pm	Initially assumed the role of Deputy Ambulance Commander. As the role was not needed, this role was relinquished by him.
Ambulance Officer 1 (**Insp 63**)	Approx 3:50pm	Site Supervisor
Insp Bibby (**Insp 67**)	4:07:58pm	Casualty Clearing Officer
Insp Halcyon Mitchell (Insp 42) (**Insp Mitchell**)	4:11:05pm	Marshalling Officer
Insp Benjamin Saywell (Insp 47) (**Insp Saywell**)	4:11:02pm	Loading Point Officer

9.80 The NSWA response to the incident ultimately included five aeromedical teams (one by air, and four by land, dispatched by the Aeromedical Control Centre), five SOT paramedics, 56 paramedics, 86 Control Centre Staff (from all four Control Centres), 38 Aeromedical Staff and seven Operational Managers.

Hot Zone declaration and reports of a possible second offender

9.81 At around 3:58pm, NSWPF officers received intelligence suggesting that there may be a second potential offender at WBJ, with information pertaining to this broadcast on NSWPF radio. The communication of that information emerged as a notable issue at Inquest and was the basis for a proposed recommendation. The evidence received and submissions heard in respect of this issue are set out below.

9.82 A short chronology of the events regarding WBJ being declared a Hot Zone – with the effect that NSWA personnel could not operate there – is as follows:

(a) At 3:45:31pm, Insp Simpson, together with Units 442, 444 and 445 entered WBJ.

(b) At 3:58pm, a police officer (CLM 797) stated on police radio that he had been shown a photograph of someone with a knife, with a description different from that of the known offender.

(c) At 4:00:28pm, S/Cst Fricki, *in situ* with Mr Cauchi on Level 5 of WBJ, whilst listening to his police radio, stated out loud "*possible second offender*".[1913] NSWA Paramedic Marshall was also on Level 5 of WBJ at this time.

(d) At 4:01:46pm, Insp Simpson made a radio broadcast relaying information concerning a possible second offender and directing all crews to remain "*in situ with their patients*" until police clearance and further notice by him. In oral evidence, Insp Simpson explained that he made the decision that the NSWA crews were to remain in place because he did not want to broadcast a message that might be overheard and cause panic amongst the civilians located in the Centre. Nor did he want to risk moving civilians or paramedics into potentially unsafe locations.

(e) At 4:01:55pm, Paramedic Marshall broadcast from Level 5 indicating he was with someone they believed to be the offender, and that they were receiving reports of a second offender. Insp Simpson did not hear this broadcast.

(f) At 4:02:38pm, NSWA broadcast a message for all cars responding to WBJ to hold their positions and to not enter WBJ.

(g) At 4:06:16pm, Ambulance Officer 1 made a radio broadcast indicating police had provided information that there were two persons of interest with firearms, they did not know where they were or whether they were a threat to NSWA, and that they were awaiting police confirmation so they could exit the Centre. Insp Simpson also did not hear this broadcast.

[1913] Body-worn Video of Senior Constable Robert Fricki at 16:00:28 (sensitive not served).

(h) At 4:07pm, SOT 1 received a call from the Tactical Operations Unit (**TOU**) Co-ordinator and was informed of a possible second offender and that SOTs were required.

(i) At 4:18:08pm, NSWA radio raised Insp Simpson to confirm that he was the Forward Commander and requested his location. In response, Insp Simpson stated via radio that he was located inside WBJ on Level 4 with police officers trying to establish whether there were any further casualties and that he believed the last casualties were being taken to the staging point.

(j) At approximately 4:26pm, AC Armitage took control of the scene as Ambulance Commander.

(k) At 4:27pm, AC Armitage spoke with a male police officer (a Sergeant) outside the Apple Store on Oxford Street. Evidence indicated that the police officer gave information to AC Armitage and others regarding the potential for a second offender located around the area of the cinemas on Level 6 of WBJ. Whilst the accounts of this interaction vary slightly, the police officer confirmed that the scene was still "hot" or that he considered it an "active crime scene".

(l) At 4:27pm, the NSWPF confirmed there was one offender only, based on the review by CI Reimer of CCTV footage in the WBJ Security Control Room. This was confirmed via NSWPF radio. This information was not immediately shared with NSWA personnel. In oral evidence, AC Armitage agreed that this was crucial information, and that if it were known to him, the area would not have been declared a Hot Zone. However, he noted that Insp Simpson and the paramedics probably would have been withdrawn at this stage because there were no patients located in WBJ at the time.

(m) At 4:28:42pm, a direction of WBJ being a Hot Zone was made by AC Armitage. The direction was conveyed via NSWA radio by Insp Bibby. This broadcast also directed NSWA crews to exit WBJ and return to the Casualty Clearing Station. NSWA made a further broadcast to all cars, repeating the direction, at 4:30:59pm.

(n) At 4.33.28pm, Insp Simpson exited WBJ via Oxford Street.

(o) At 4:34:36pm, Ambulance Officer 1 made a radio broadcast from the NSWPF Forward Command Post stating that there was a possibility of a second "POI" but that it hadn't been confirmed.

(p) At 4:50:19pm, Insp Simpson made a broadcast stating he was no longer the Forward Commander of the scene and had been released.

(q) Around 5:30pm (or some point prior), Ambulance Officer 1 was present at the NSWPF Forward Command Post, together with AC Armitage.

9.83 In oral evidence, AC Armitage explained that within minutes of attending the NSWPF Command Post at some point between 5:03pm and 5:15pm, he spoke with the Police Forward Commander, CI Whalley. At this time, AC Armitage said that he believed he had asked about a potential second offender and was told, to the best of their knowledge, there was not a second offender. This information was not passed on to other NSWA resources via radio or otherwise.

9.84 However, AC Armitage gave evidence that he provided three separate briefings to paramedics on scene, including after his attendance at the NSWPF Forward Command Post. It is unclear from the evidence before the Court whether these briefings included information about a possible second offender. It is noted that the prospect of an ongoing threat remained a possibility for certain NSWA staff. For example, there were recorded phone calls involving NSWA staff at 5:48pm and 6:16:33pm that referred to an active shooter at WBJ.

9.85 In light of this factual summary, the Inquest considered issues with, and the importance of, interagency communication for agencies in attendance at Major Incidents. This issue is addressed below and in Part 10. It should nonetheless be noted that the declaration ultimately had no impact on the outcome for any victims.

9.86 As to the handover and phasing down of the incident, it is noted that at around 6:00pm, A/Supt Cronan was appointed as Ambulance Commander in place of AC Armitage. From this time, senior NSWA personnel progressively relinquished their call signs and left the scene. At around 10:02pm, Ambulance Officer 1 was appointed as Site Supervisor and the sole remaining Inspector on scene. And at 10:53:14pm, a broadcast advised that the MIC was closing down.

Special Operations Team (SOT) paramedics tasking

9.87 A key summary of the involvement of the SOT paramedics follows below.

9.88 At 3:46pm, SOT 1 became aware of the incident at WBJ after contacting the NSWA Operations Centre concerning another matter.

9.89 At 3:52pm, SOT Ryan Simmons, located at Caringbah Ambulance Station, received a call to attend the incident at WBJ; he arrived at WBJ at 4:40:20pm.

9.90 At 3:56:42pm, SOT Daniel McKell arrived at WBJ. SOT McKell attended the triage/Casualty Clearing Station and assisted by applying chest seals to several patients as they exited the Centre.

9.91 It is noted that on the day, SOT McKell (who is also an ICP) was on shift with another ICP team when he received a call requesting an Intensive Care Ambulance to attend the scene. The nature of his tasking is not entirely clear. However, it appears from the evidence that this SOT Paramedic may not have been tasked as a SOT resource, but as an ICP.

9.92 At approximately 4:00pm, two SOT Paramedics were tasked to the incident after receiving a call from Sydney Control to respond, urgent duties, towards WBJ. This call was received approximately five and a half minutes after the first Triple 0 call to NSWA.

9.93 Two of the SOT Paramedics (SOT 2[1914] and SOT Jesse Tait) tasked with the incident had to travel from Point Clare, around 80km from WBJ. It took approximately 40 minutes for them to travel to the Centre, ultimately arriving at WBJ at 4:39:04pm.

9.94 Around 4:07pm, SOT 1 received a call from the TOU Co-ordinator and was informed of a possible second offender at WBJ, and that SOTs were required on scene. SOT 1 confirmed that two would be dispatched and that the required BPPE would be sourced.

9.95 At 4:10pm, a further SOT Paramedic, SOT David Lloyd, was tasked to collect ballistics vests and helmets (necessary equipment for SOT paramedics to enter any Warm Zone to undertake their role) from a central repository and proceeded with them to the scene. SOT Lloyd was tasked to collect the vests approximately 37 minutes after the first victim was stabbed.

9.96 At or around 4:44pm, whilst awaiting the arrival of their BPPE, enquiries were made as to whether the attending SOTs could enter the scene using NSWPF ballistics gear. This involved various calls to SOTs, SOT 1, and the Duty Superintendent.

9.97 At 4:55pm, SOT Lloyd arrived at WBJ with the BPPE. Due to the distance that had to be travelled, it took SOT Lloyd approximately 40 minutes to collect the ballistics gear and proceed to WBJ.

9.98 At 4:56pm, SOT 1 contacted their Superintendent, and advised that due to the SOT response (involving five SOT paramedics on scene), a Tactical Advisor was required on site. SOT 1 then attended WBJ to fulfil that role. He arrived at 6:02:03pm and attended the staging area, meeting with the NSWPF TOU Supervisor.

9.99 At around 5:41pm, SOT 1 directed two SOT paramedics to remain with the NSWPF TOU (who were on standby at the time) and for two paramedics to accompany and assist the NSWPF Public Order and Riot Squad (**PORS**) to clear the Centre.

9.100 At 8:46pm, SOT 1 informed A/Supt Cronan that the building clearance was complete and that SOT resources would be departing the scene.

Submissions

9.101 Counsel Assisting submitted that there was ultimately limited (if any) controversy as to the factual matters in relation to the response of NSWA to WBJ on 13 April 2024.

9.102 Counsel for NSWA submitted that Part 8 of Counsel Assisting's submissions – that being the chapter concerning NSWA's response to the events on 13 April 2024 – presented a

[1914] SOT 2 is a pseudonym pursuant to non-publication order dated 4 May 2025.

fair summation of the evidence, including evidence drawn from statements provided by NSWA personnel, the evidence given during the hearing by some of those personnel, the contemporaneous records of NSWA, and were consistent with the collaboratively drafted and agreed chronology concerning the same. NSWA did indicate some minor corrections to the facts set out by Counsel Assisting. These suggestions have been considered, and included in these findings, as relevant.

9.103 With respect to the timing and response of NSWA, Counsel Assisting highlighted the importance of acknowledging the unprecedented nature of the events that occurred at WBJ on 13 April 2024. Further, that given the rarity of these events, it is extraordinarily important to learn as much as possible from them and it is through this prism that the response of emergency services, and in particular NSWA and the NSWPF, ought to be considered.

9.104 Counsel Assisting also iterated that it is important to acknowledge the skill, competence and expertise of all emergency services personnel who attended and supported those who were exposed to this incident. It was submitted that the competence and courage of these individuals ought not be open to criticism or question.

9.105 Noting the above chronology, Counsel Assisting asserted that the NSWA responded well to the rapidly unfolding events on 13 April 2024, and that the comprehensive and prompt response by NSWA was instrumental in saving a number of lives.

9.106 In oral submissions, Counsel for NSWA highlighted four key facts concerning the response of paramedics and the agency on the day:

(a) First, that there were only 12 minutes between the first call to emergency services and the arrival at the scene of three ambulance crews, including one Senior Ambulance Inspector.

(b) Secondly, that within six minutes of arriving, the first patient was extricated from the scene, and that happened to be the child whose life was saved.

(c) Thirdly, that within 12 minutes of the initial arrival, 14 ambulance crews had arrived at the scene. This was more crews than there were patients to treat.

(d) Fourthly, all survivors at the scene were taken out of the Centre by 4:16pm, which was within 28 minutes of the first ambulance arrival.

9.107 With respect to the question of whether there were impediments to the response by NSWA, Counsel Assisting submitted that:

(a) The large layout of WBJ, with stabbings occurring on multiple levels and across two towers, and the fact that victims were variably located inside different stores (some behind closed shutters and some in common areas), significantly

increased the difficulty of obtaining a 'rapid' assessment of the scene for the purposes of triage.

(b) The volume of the evacuation alarm impeded communications. Counsel Assisting contended that this was made clear by the oral evidence of Insp Simpson, who described it as a "*significant physical and mental [impediment] to basically every activity that was undertaken inside*"[1915] the Centre; and the opinions of Dr Mazur and Dr Cowburn who acknowledged and echoed the negative impact of the alarm and the exacerbating effect it would have had on the cognitive load of the emergency responders.

(c) There was a delay in transitioning all responding resources to the MIC. Evidence emerged that during the incident some NSWA crews inside WBJ continued to transmit radio broadcasts on the normal operating channel for the East dispatch jurisdiction (the East Channel) for a period of time. Counsel Assisting highlighted the intention of NSWA to introduce a training module directed at reinforcing paramedic awareness of moving to a dedicated radio for a Major Incident and proffered that the Court would accept the view of NSWA that no further changes are required of their existing practices or policies concerning radio communications.

Findings

9.108 Having regard to the evidence received and set out above, I find that the response of NSWA to the events of 13 April 2024 was comprehensive and timely. I accept the submissions of Counsel Assisting and echo the necessary acknowledgement of the skill and competence of the NSWA personnel involved in the response to the rapidly unfolding scene at WBJ.

9.109 Notwithstanding the extraordinary nature of the incident, the response of the agency and the attending personnel was impressive. This is clearly demonstrated, as articulated by Counsel Assisting, by the following short summary:

(a) NSWA Control Centres received 26 incident-related calls within five minutes and had over 100 interactions with callers and other agencies;

(b) The first NSWA crews were assigned to the incident at 3:36:53pm – that is, three minutes and 57 seconds after the first person was stabbed.

(c) The first NSWA crew and Inspector (Insp Simpson) arrived on scene within six minutes of the first Triple 0 call, (just over nine minutes after the first person was stabbed);

(d) A Major Incident was declared within 15 minutes;

[1915] Transcript, D9 (Simpson): T676.37-39 (9 May 2025).

(e) By 3:45pm, there were 17 crews and five Prehospital and Retrieval Medicine teams tasked to this incident; and

(f) Over the first hour of the incident, a total of 47 ambulance resources were assigned, which included 21 primary care crews.

9.110 I find that the extensive and timely response of NSWA is particularly notable in circumstances where there were impediments to that response, including the scale of the Centre and spread of victims throughout it, and the prohibitively loud evacuation alarm.

9.111 It is commendable that whilst the response was comprehensive and timely, NSWA have nevertheless taken steps to closely analyse and consider areas of improvement for any potential future incidents. These steps are set out further below in Section H.

D. Triage and treatment

Emergency medicine experts

9.112 Evaluation of the triage and treatment of the victims was informed by expert reports and evidence from three eminent emergency medicine physicians: Dr Stefan Mazur, Dr Philip Cowburn and Dr Thomas Evens.

9.113 As stated above Dr Mazur and Dr Cowburn provided independent expert reports.

9.114 Dr Thomas Evens (**Dr Evens**) is currently the Acting Executive Director of Medical Services and Research at NSWA. As part of his role, in the period 19 April 2024 to 12 May 2024, Dr Evens performed clinical reviews of the majority of the deceased and injured victims involved in the incident at WBJ. The purpose of these reviews was to consider the care provided to patients and to determine whether there were any learnings to come out of the treatment provided.

9.115 Additionally, Dr Evens holds the position of Staff Specialist in Pre-Hospital and Retrieval Medicine based at Bankstown Rescue Helicopter Base (with NSWA's Aeromedical Team), he is also a Staff Specialist in Emergency Medicine at Northern Beaches Hospital. Prior to holding these positions in Sydney, Dr Evens was the Assistant Medical Director for the London Ambulance Service (from 2014 to 2019), and a Consultant with London Air Ambulance (from 2016 to 2019).

9.116 Dr Evens' first-hand experience at Major Incidents included his role as the Medical-Advisor on scene at the 2017 Westminster Bridge Terror Attack in London and as the Hospital Emergency Department Resuscitation Commander at the 2017 Grenfell Tower Fire Incident in London.

9.117 The Court was fortunate to receive Dr Evens' contribution. As noted in Part 8, Dr Evens gave evidence in conclave (concurrently) at Inquest on 23 May 2025, with Dr Cowburn and Dr Mazur, which was of great assistance to the Court and referred to further below in this Part.

First aid performed by NSWA

9.118 As noted above, there was extensive evidence available concerning the treatment of all victims at WBJ on 13 April 2024 which was provided to Dr Mazur and Dr Cowburn to assist in their consideration of the injuries and treatment administered to the deceased.

9.119 The opinions of the experts were explored further in a pre-conclave meeting held on 16 May 2025 between the three emergency medicine experts, and their positions were also articulated in oral evidence during the conclave on 23 May 2025.

9.120 In addition to those who sustained fatal injuries, there were a number of other patients who were triaged and treated by NSWA personnel, some of whom were also conveyed to hospital for further treatment.

9.121 The seven surviving victims who remained inside the Centre were attended to by NSWA personnel within 30 minutes of their respective attacks. The remaining three surviving victims exited WBJ immediately following the attack and later received treatment.

9.122 Noting the trauma informed approach of this Inquest, the details of the treatment provided by NSWA personnel to each of the victims, and the expert evidence referring to that treatment, will not be further detailed in these findings.

9.123 As noted above in Part 8, the experts drew out a number of points concerning the first aid administered by those in attendance at the Centre. In doing so, they emphasised:

(a) That performing CPR or chest compressions on victims suffering penetrating injuries is generally of little utility and that, whilst admirably performed, it is unlikely the CPR performed at WBJ would have improved patient outcomes.

(b) That it is imperative for those attending to a victim to conduct a thorough assessment of the patient to confirm their number of injuries. Emergency responders should not assume that there is a single stab wound. Checking for multiple stab wounds may require moving the victim or rotating them to check their back and sides.

(c) If possible, victims should be moved into free space or an area where there is 360-degree access to the patient to facilitate the administering of first aid.

9.124 These points are noted for the purposes of learning from the incident and reflecting throughout the Inquest process.

9.125 Notwithstanding these areas for clinical learning, the treatment given for the large scale and complex scene that presented was regarded, on the evidence, as adequate and appropriate.

Expert evidence concerning survivability of the injuries

9.126 As victims of a stabbing, the deceased suffered penetrating trauma wounds. There are "best practice" principles for out of hospital treatment of a patient who has sustained penetrating trauma wounds (including a stabbing injury). These principles were agreed between the experts to be consistent with the prevailing opinion in Australian and UK practice and are outlined in detail in Part 8.

9.127 In conclave, Dr Evens, Dr Mazur and Dr Cowburn were unanimous in their view that, with the exception of Mr Faraz Tahir, the injuries sustained by the deceased were unsurvivable. The expert evidence concerning the treatment of Faraz is considered below.

9.128 In the process of scrutinising the treatment and triage of the deceased, the experts were cognisant of the learnings that could be drawn out of the actions of NSWA personnel on 13 April 2024.

9.129 Notwithstanding consideration of the alternative and/or additional treatments, procedures and/or triage processes considered by the experts, the global position reached by the emergency physicians was that none of those additional or alternative approaches would have altered the outcome for those patients who died as a result of their injuries.

Expert evidence concerning the treatment of Faraz Tahir

9.130 It is noted that Dr Mazur's expert report appeared to suggest a potential window of survivability for Faraz, classifying his injuries as "*probably unsurvivable*".

9.131 During their pre-conclave meeting held on 16 May 2025, the emergency medicine physicians considered a range of questions arising from the evidence. Dr Mazur and Dr Cowburn agreed with the following formulation proposed by Dr Evens regarding Mr Faraz's prospects of survival:

> *… the chance of "survivable" is at the very low extreme of "probable". The uncomfortability regarding "probably unsurvivable" is a bit nebulous as it lacks clear definition.*
>
> *… the injuries sustained by Mr Tahir mean that he was 'extremely unlikely to survive even with immediate access to the highest level of pre-hospital critical care, working in a well structured trauma system with rapid access to theatre or surgical intervention.* [1916]

9.132 Therefore, the emergency medicine experts agreed that, on the balance of probabilities, the injuries suffered by all the deceased were sadly, unsurvivable.

Triage performed by NSWA

9.133 The Inquest closely considered the triage process conducted by attending NSWA personnel at WBJ.

9.134 The NSW AMPLAN directs the triage process. After raising the alarm about the incident, establishing an interim command post, conducting an "*eyes-only*" reconnaissance of the scene, and providing a METHANE report, attending paramedics are directed to "*field triage, apply appropriate triage sieve and implement lifesaving treatment only (airway and haemorrhage control) and tag patients*."[1917] As noted above, a METHANE report is a mnemonic used by NSWA personnel to convey important information about the incident and scene.

[1916] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 1-2.
[1917] Exhibit 1, Vol 36, Tab 1191, NSW Ambulance Protocol A11 Multiple Patient Situations at p. 1.

9.135 Further, the Principles of Care direct that time on scene must be kept to a minimum, with only time-critical and/or meaningful interventions performed on-scene, with additional treatment provided en route. Consideration is to be given to a "load and go" approach.

9.136 Insp Simpson gave evidence that, as Forward Commander, his second priority (after his first priority of assessing the scene and determining whether it met the criteria for a Major Incident and/or a mass casualty incident) was to triage patients. Whilst he did receive information and updates on patients from police whilst on Level 4 of WBJ, Insp Simpson accepted that during the initial period of attendance he did not undertake a rapid sweep of Level 4 of WBJ, nor did he conduct this rapid sweep at any later stage whilst inside the Centre. He also gave evidence that he did not direct anyone else to undertake a sweep or conduct a triage of the number of patients. As was accepted by Insp Simpson, this is something that should have been done.

9.137 Insp Simpson gave evidence that whilst situated inside the Centre he performed the role of "carouseling" patients, which he described as directing paramedics as to which hospital each patient should be sent to. This role falls to the Forward Commander (under AMPLAN), until further resources arrive. Further, he performed the role of declaring the victims as deceased. Noting the commitment of the paramedics to their patients on that day and noted reluctance to move on, Insp Simpson gave evidence that he took on this role so that he could take the burden off treating crews and allow them to regain some of their "bandwidth". This also assisted by conserving some of the crews' supplies and helping them to move on and treat other patients.

Expert evidence concerning the NSWA triage process

9.138 In his expert report, Dr Mazur explained the common mass casualty triage approach. Importantly, once a scene is declared a Major Incident, patient assessment should become an initial triage sieve: meaning that the only treatment provided should be to open a patient's airway if they are not breathing, and to apply or direct external haemorrhage control. Following this triage, patients should be labelled according to their requirements.

9.139 As to the triage conducted at WBJ, Dr Mazur stated that there appears to have been some variation in the process followed by NSWA paramedics in attendance. He noted that whilst some appear to have carried triage tags, it is unclear if all crews did. He explained that when patients aren't tagged, later arriving teams will attempt to treat patients already beyond treatment. This has the potential to further delay identification and initial treatment for those patients who are awaiting initial triage. Dr Mazur opined that once the Major Incident had been declared, communication around the requirement for the tags and their use on scene would have streamlined the triage process.

9.140 Moreover, he opined that there does not appear to have been specific triage role allocations, resulting in paramedics doing a combination of triage *and* treating. Dr Mazur

acknowledged that while this approach is psychologically understandable, problems arise when initial teams continue to treat beyond the initial triage sieve. When this occurs more significantly injured patients not initially identified will have their interventions and treatment further delayed.

9.141 There was a duplication of attendances on a number of the victims at WBJ. Dr Mazur suggests that this may have been avoided through the use of triage tags and/or an alternative triage tool such as the Ten Second Triage Tool (**TST**).

9.142 Extensive evidence was heard – in particular, from Dr Cowburn – regarding the TST – an alternative to the existing NSWA triage process, which operates in the UK (amongst other places). In summary, the TST provides for a quicker initial triage process, and allows non-clinical first responders (such as police) to obtain a rapid understanding of the triage status of patients and convey that information to paramedics once they arrive on scene. In addition, it includes a "silver" triage category, which denotes that a patient is "not breathing", which alleviates paramedics from the traumatic task of declaring a patient deceased.

9.143 The use and impact of the TST and its potential application in NSW are considered in detail in Part 10 of these findings.

9.144 The conclave experts also considered the lack of a rapid sweep assessment at WBJ. In his report, Dr Mazur identified that the layout of WBJ, the fact that the scene was spread over 3 levels with multiple access points, and the frequent encountering of casualties combined with the overwhelming urge to at least informally assess (if not treat) each of them, would have made a "rapid eyes only" sweep extremely difficult.

9.145 In conclave during the hearing, Dr Mazur and Dr Evens agreed that there should have been a rapid sweep, and that what flowed from that was a lack of situational awareness of casualties. Notwithstanding this view, they too noted that it would have been extremely difficult given the noise, location and levels at WBJ. Dr Evens opined that in some major incidents, it is not possible for an individual to sweep through the scene and that instead, what a system needs to do is bring to a person who is allocating the resources the information they need in order to perform that role. He also offered the view, agreeing with Dr Mazur, that it is entirely plausible that if Insp Simpson was asked to walk through the entirety of WBJ, he would not have been effective in any of the other tasks he needed to attend to.

9.146 Dr Cowburn similarly offered the view that it is very difficult and "practically impossible" for a single individual to gain situational awareness of such a dynamic and spread-out environment with multiple patients.

9.147 Dr Cowburn also noted that the scale of the incident should not be underestimated: it was a significant Major Incident both in terms of the number of victims, but also the distribution of those casualties. The "casualty trail" was extensive, covering several hundred meters. This was a significant area for emergency services to assess.

9.148 All the emergency medicine experts agreed that the lack of rapid sweep assessment that led to a delay in the triage of some patients did not ultimately impact on clinical outcomes.

Other issues relating to NSWA triage and treatment

Triage and treatment of Victim 7

9.149 Victim 7 was stabbed by Mr Cauchi at 3:33:29pm. Victim 7 then exited WBJ and attended the Bronte Street Medical Centre, arriving there between 3:35pm and 3:40pm. Thereafter, the available evidence indicates that there was a delayed attendance by NSWA paramedics upon Victim 7.

9.150 At 4:05pm, NSWA crew 954 and the CareFlight crew (consisting of two doctors and a CCP) were approached by a doctor from the Bronte Street Medical Centre seeking assistance for Victim 7. The NSWA crews attended the medical centre. Upon arrival, Victim 7 was in a state of peri-arrest. Victim 7 was ultimately conveyed to hospital 4:18:50pm and survived his injuries.

9.151 Four calls had been made for assistance for Victim 7, including at 3:37:11pm, 3:45:30pm, 3:54:55pm, and 4:04:53pm.

9.152 AC Armitage considered that the call takers who received the calls concerning Victim 7, and the Control Centre supervisor, were compliant with the relevant policies directing their taking and follow up of those calls.

9.153 Notwithstanding this, AC Armitage accepted the response to Victim 7 (approximately 26 minutes) was longer than ought to have been the case in ordinary circumstances, noting also that the complexity of the overall situation and multitude of calls reporting the same type of injuries, within the same vicinity, contributed to the extended response.

Use of Tranexamic Acid (TXA)

9.154 The Inquest also heard evidence concerning the use of Tranexamic acid (**TXA**).

9.155 TXA can be used in the context of a major trauma as it causes the blood to clot and prevent bleeding where a patient has sustained a severed vein or artery. It has the potential to improve outcomes in trauma and/or bladed weapon attacks.

9.156 As at April 2024, the only NSWA unit to carry TXA was the Aeromedical Team.

9.157 It is noted that the evidence, particularly expressed in the statement of Dr Evens, did not suggest that the administration of TXA would have had any material impact on patient outcomes.

9.158 Further, in conclave, emergency physicians Dr Evens, Dr Mazur and Dr Cowburn agreed that whilst TXA has a role in aspects of trauma management in general, in scenarios

such as the incident at WBJ, it should not be prioritised over rapid extrication and control of bleeding and should only be administered where it does not cause delay.

9.159 In his statement of 28 May 2025, DC McKenna (NSWA) noted that the decision to distribute TXA to all NSWA paramedics has been the subject of internal review at NSWA for some time; and that the NSWA Clinical Practice Committee has endorsed its introduction to paramedic practice supported by appropriate training. DC McKenna stated that he had been advised that the introduction of TXA was scheduled for late 2025.

9.160 In a further statement of 17 November 2025, DC McKenna (NSWA) gave evidence that the NSWA Clinical Practice Committee is currently considering the introduction of TXA to all paramedics, subject to a determination by the NSWA peak clinical practice governance arrangements. DC McKenna noted that he previously indicated that the introduction of TXA was scheduled for later in 2025. He clarified that training packages and Clinical Practice Guidelines have been developed, and a procurement plan is being drafted, with the aim of implementation in early 2026.

Submissions regarding triage and treatment

9.161 Noting the evidence set out above, Counsel Assisting submitted that whilst there may have been some areas for clinical learning arising from a review of the treatment in some instances, the Court would accept that the treatment given for the large scale and complex scene that presented was adequate and appropriate.

9.162 Further, it was submitted that none of the injuries of the victims who died were ultimately survivable.

9.163 Drawing on the expert medical evidence given by Dr Mazur, Dr Cowburn and Dr Evens, it was similarly submitted on behalf of Glad that given the nature and severity of the victim's injuries, the outcome was tragically inevitable. Further, they submitted that even if the security officers or other personnel had contacted emergency services earlier, the evidence demonstrated that there would have regrettably been no practical difference to the outcome, as the injuries to the deceased victims were not survivable.

9.164 In their submissions, the Tahir family stated that they understood police, ambulance, specialist doctors, and even civilians who helped, did the very best they could. Further, they expressed their understanding that everything which could have been done for Faraz, and the other deceased and the other victims, was done.

9.165 Counsel Assisting also made submissions with respect to the adequacy and appropriateness of equipment available to NSWA. In doing so, regard was had to the opinions expressed by emergency medicine experts Dr Cowburn, Dr Mazur and Dr Evens. These experts agreed that there was no significant utility in chest seal equipment being available to all paramedics (noting that they are currently only available to SOT paramedics).

9.166 Submissions were also received in relation to the role and utility of TXA in trauma management. Noting the agreed position of the emergency medicine experts, and drawing on the evidence of Insp Simpson, Counsel Assisting submitted that given its potential utility, there is no clear basis why TXA would not be more broadly available for all general paramedic crews and thereby proposed a recommendation that distribution of TXA be considered.

9.167 In their written submissions, Counsel for the Commissioner of NSWA expressed their support for the recommendation that TXA be made available to all NSWA vehicles. Their evidence setting out steps taken towards implementation reflects this support.

9.168 Counsel Assisting identified that there was room for improvement in the first aid and treatment response of NSWA. The absence of triage tags being brought by the initial attending crews which led to a number of victims being re-triaged unnecessarily; the absence of a rapid sweep assessment which led to a lack of situational awareness of casualties at the scene; and the reluctance of crews to act in accordance with the triage sieve, that is, to only provide certain lifesaving treatment and otherwise move on to treat and triage other patients, was noted.

9.169 It was iterated that these areas for improvement, whilst contributing to a delay in identification and initial treatment for some patients, did not have an impact on patient outcomes.

9.170 It was submitted that these identified issues could be addressed, to a significant extent, by the introduction of the TST. Further submissions were made in respect of the potential impact and utility of the TST and are set out in Part 10.

Findings

9.171 Based on the extensive evidence received by the Inquest, and the submissions made by Counsel Assisting, my findings with respect to the treatment and triage conducted by attending NSWA personnel are as follows:

(a) The treatment provided by attending NSWA personnel at WBJ was adequate and appropriate.

(b) None of the injuries of the victims who died were ultimately survivable, meaning that there was no first aid treatment or intervention that could have been administered by attending paramedics that would have affected the outcome for those who tragically died on 13 April 2024.

(c) The absence of triage tags being utilised by initial attending crews contributed to a number of victims being re-triaged, causing some delay in progressing the subsequent triage and treatment of casualties.

(d) A rapid sweep was not conducted at the scene. Insp Simpson conceded that this is something that ought to have been done. The experts agreed that it should

have been done. However, noting the nature of the environment, and concurring with the position of the experts on this point, there is no criticism of Insp Simpson in this regard.

(e) The absence of a rapid sweep assessment contributed to a lack of situational awareness of the casualties at WBJ. The lack of rapid sweep occurred, in part, due to the complex, large-scale and dynamic nature of the scene. These factors rendered it nearly impossible for Inspector Simpson, or any other single individual, to gain situational awareness.

(f) It is acknowledged that the desire to do as much as possible for the victims at the scene was a consequence of the attending paramedics' dedication to providing the utmost care to those in need. However, going beyond the expected triage for mass casualty events (that is, beyond only opening the patient's airway and controlling external bleeding) led to delay in the identification and initial treatment of patients yet to be initially triaged.

(g) The absence of triage tags, rapid sweep assessment, and strict compliance with the mass casualty triage and triage sieve procedures did not have an impact on patient outcomes.

(h) The equipment available to NSWA personnel was, generally, adequate and appropriate. I find that, but for the availability of TXA for all NSWA paramedics, attending clinicians were equipped with appropriate equipment to respond to a mass casualty incident.

(i) There is clear utility in providing TXA to all NSWA paramedic crews. It is acknowledged that NSWA are taking steps to implement this change and distribute TXA to all NSWA vehicles.

(j) With respect to the suggested provision of chest seals to all paramedics in NSW, I find that there is no significant utility in this proposal.

9.172 Lastly, compelling evidence was heard as to the potentially very significant benefits associated with the use of the TST.

9.173 This evidence included, but was not limited to, the ways in which the use of the TST could have addressed the issues identified above concerning NSWA's treatment and triage of patients at WBJ. This evidence and submissions ultimately form the basis of a proposed recommendation to consider the introduction of the TST in NSW. The substantive evidence, submissions, and my findings in respect of the TST are set out in Part 10.

Recommendations

9.174 Counsel Assisting proposed the following recommendation addressed to NSWA:

> **Recommendation 12**
>
> That NSW Ambulance confirm the introduction of Tranexamic acid will occur in 2025 as part of the standard products carried in NSWA vehicle equipment.

9.175 In oral submissions, Counsel Assisting noted that evidence received from NSWA is demonstrative of ongoing progress being made in relation to the issue of TXA. They nonetheless maintained that the proposed recommendation remains necessary or otherwise desirable.

9.176 Noting the support of NSWA for the introduction of TXA as a standard piece of equipment in all NSWA vehicles, the steps that have been taken to date to facilitate that introduction, and the evidence of DC McKenna (NSWA) as to the expected finalisation of that process, I make the following recommendation:

RECOMMENDATION
Recommendation 15: To NSW Ambulance
That NSW Ambulance confirm the introduction of Tranexamic acid (TXA) as part of the standard products carried in NSW Ambulance vehicle equipment.

E. Command and control

9.177 The implementation and application of NSWA "command and control" on 13 April 2024 was also considered at the Inquest. Against the backdrop of the NSWA policy and procedures concerning command and control at Major Incidents, and the chronology of events set out above, the Inquest heard evidence highlighting aspects of the NSWA response from which learnings might be derived. This section considers those aspects.

Establishment of command and control

9.178 Insp Simpson was the first officer, and the most senior on scene at 3:42:40pm. He was also the Forward Commander. Ambulance Officer 1, an Inspector and an experienced clinician, arrived at approximately 3:50pm.

9.179 There were two interactions between the two senior officers on scene at WBJ. Emergency physician and expert Dr Mazur opined that these interactions contributed to a lack of clarity in the initial "set-up" phase as to the command and control structure at WBJ.

9.180 At 3:50pm, Insp Simpson and Ambulance Officer 1 had their first interaction. Ambulance Officer 1 recalled meeting Insp Simpson inside WBJ and being immediately asked to return to the Oxford Street entrance to facilitate the management and transportation of two seriously injured patients. Ambulance Officer 1 stated that there was no information provided to him concerning the incident.

9.181 It is noted that at 3:58:07pm, Insp Simpson made a radio broadcast stating Ambulance Officer 1 was the staging officer "*at the staging point*"[1918] and that he had crews on their way to him. Insp Simpson did not recall having a conversation with Ambulance Officer 1 in the early stages of the incident, nor did he remember the information leading to the 3:58:07pm broadcast.

9.182 Insp Bibby was marked as arriving on scene at 4:07:58pm. Upon his arrival, he proceeded to the staging area on Oxford Street. At 4:11pm, Insp Saywell and Insp Mitchell also arrived and proceeded to the staging point where Insp Bibby was located. At this stage, Insp Simpson was still inside WBJ.

9.183 Insp Saywell stated that they (being Insp Mitchell, Insp Bibby and himself) attempted to obtain a situation report from Ambulance Officer 1 but that "*he hadn't gotten a grasp of the full situation at that time*."[1919] Insp Bibby similarly stated that he "*tried to get a brief sitrep from [Ambulance Officer 1]*" (which apparently did not yield much information).[1920] After this, those officers created designated zones at the scene in

[1918] Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 14 at p. 9.
[1919] Exhibit 1, Vol 11, Tab 598, Statement of Inspector Benjamin Saywell at [8].
[1920] Exhibit 1, Vol 11, Tab 594, Statement of Inspector Andrew Bibby at [12].

anticipation of receiving further patients. They determined the treatment area would be where they were standing (which was at the staging point).

9.184 Shortly after, at 4:25pm, Insp Bibby made a radio broadcast confirming the allocation of the key roles (which are noted above in Section C). At around the same time, Ambulance Officer 1 determined to enter the Centre to offer assistance to Insp Simpson.

9.185 Following a second interaction between Insp Simpson and Ambulance Officer 1 at 4:25:02pm, Ambulance Officer 1 was directed to, and then did, attend the NSWPF Forward Command Post. With respect to this second interaction:

(a) Insp Simpson, for his part and prior to the radio broadcast at 4:25:02pm, recalled speaking with Ambulance Officer 1 inside WBJ, near the Tommy Hilfiger store; he recalled giving a direction for him to attend the NSWPF Command Post as the NSWA communications/liaison officer "*to ensure that a representative of NSWA was embedded in the NSWPF command*".[1921]

(b) Ambulance Officer 1 recalled being directed to attend the NSWPF Command Post but stated his view that Insp Simpson would not engage in a meaningful conversation with him, apart from using a loud voice to direct him. Ambulance Officer 1 was ultimately escorted first to the NSWPF Command Post at the WBJ loading dock (the first command post) before then being escorted to the Second Command Post on Level 6, WBJ.

9.186 At some point between 4:22pm and 4:24pm, and by 4:25:40pm, AC Armitage arrived on scene. Around 4:28pm, A/Supt Cronan arrived at WBJ. He was the NSWA on-call Duty Superintendent for Sydney South and South East Sector that day (which covers Bondi Junction). These two officers were the most senior on scene.

9.187 As AC Armitage was the most senior of the two, he assumed the role of Ambulance Commander. A/Supt Cronan initially assumed the role of Deputy Ambulance Commander. However, he gave evidence that the scene had been set up in a "textbook manner", and the Inspectors did not need any additional guidance. As a result he remained on scene as an additional resource.

9.188 Around 4:40pm, Insp Bibby gave A/Supt Cronan a SITREP that covered the command structure established, and that Insp Simpson and Ambulance Officer 1 were still inside the Centre with an unknown number of patients and ambulance crews.

9.189 Insp Simpson recounted that when he exited WBJ at around 4:33pm and returned to the staging area, it appeared to him that Insp Bibby was in charge and was organising the crews; that Insp Saywell had all the stretchers lined up; and Insp Mitchell had organised the ambulances. Around this time, Insp Simpson, Insp Bibby, Insp Saywell and Insp Mitchell had a debrief concerning the known patients and the status of Level 6 of the

[1921] Exhibit 1, Vol 11, Tab 601C, Third Statement of Inspector Brett Simpson at [75]-[76].

Centre. This was the first substantive exchange Insp Simpson had with other NSWA commanders.

9.190 Insp Simpson gave evidence that he also provided a briefing to AC Armitage, providing the same information conveyed to Insp Bibby, Insp Saywell and Insp Mitchell. He also recalled having an exchange with AS Cronan including details of the injured patients who had been transported to hospital.

Expert review of the command and control structure

9.191 Expert evidence was received concerning the efficacy of the NSWA response having regard to the NSW AMPLAN processes and procedures and the roles set out within this document.

9.192 In his report, Dr Mazur ultimately identified a number of sub-optimal features of the pertaining to aspects of the NSWA response. The main issues identified by Dr Mazur are as follows.

9.193 First, Dr Mazur reviewed the interaction between Insp Simpson and Ambulance Officer 1 at or about 3:50pm, which occurred some two minutes after Insp Simpson declared a Major Incident, whilst he was moving through the scene with an NSWPF sergeant. Dr Mazur stated that "*there was a communication breakdown between these two senior clinicians in these early stages*."[1922] Dr Mazur opined that the initial meeting should have been a moment where their roles were expressed and clarified between them. As a consequence, he states that there appears to have been a period of "*leadership confusion/vacuum at the designated staging post from around [3:50pm] through to about [4:20pm].*"[1923] It is noted by Dr Mazur that this leadership vacuum more broadly led to other issues in relation to the AMPLAN roles, which he also summarised in his report.

9.194 Dr Mazur noted that whilst the command and control structure was established, it was delayed at least in part due to the lack of clear communication and role delineation in the early stages of the developing incident. He suggested that earlier establishment of the Casualty Clearing Station and a Loading Point, together with the Loading Point and Marshalling Commanders, would have prevented ambulances from being blocked in and simplified NSWA entrance and exit from the scene.

9.195 Notwithstanding this, Dr Mazur also acknowledged that although delayed in being established, the staging post, treatment area, marshalling area and loading points were developed and would have been invaluable had the scene progressed over a longer period with a greater number of casualties.

9.196 Secondly, there were differing accounts as to role allocation on scene:

[1922] Exhibit 1, Expert Volume, Tab 18, Report of Dr Stefan Mazur at [209].
[1923] Exhibit 1, Expert Volume, Tab 18, Report of Dr Stefan Mazur at [211].

(a) Insp Mitchell stated that shortly after arrival at the staging area, they (being Insp Bibby, Saywell and herself) "*quickly decided that [Insp Bibby] would be Forward Commander, [Insp Saywell] would be Triage and I would be the Marshall*."[1924]

(b) Insp Saywell recalled that Insp Bibby was tasked to be the Casualty Clearing Station Supervisor, Insp Mitchell was the Marshalling Supervisor, and he was the Loading Point Supervisor.

(c) Insp Bibby recounted an allocation of roles consistent with his broadcast at 4:25pm.

(d) AS/Supt Cronan also described the allocation of roles consistent with Insp Bibby's broadcast, save for describing Insp Bibby as the Casualty Clearing Officer (and stating that he had assumed the role of Forward Commander from Insp Simpson). The evidence does not indicate that Insp Bibby ever assumed the role of Forward Commander from Insp Simpson. Instead, he became the Site Supervisor at 7:00pm, taking over that role from Ambulance Officer 1.

(e) In a file note prepared following the incident, Ambulance Officer 1 referred to himself as the Forward Commander, and to Insp Simpson as the Incident Site Supervisor.

(f) AC Armitage described Ambulance Officer 1 as the Site Supervisor.

9.197 Dr Mazur offered the view that the diverging use of role titles may have led to confusion for other NSWA personnel who may have been unsure as to who they would get direction from. He opined that the confusion between Ambulance Officer 1 and Insp Simpson appears to have resulted in the aforementioned leadership vacuum. However, he does also note that it may be considered that, so long as all actions required of the roles are being undertaken, the mislabelling of roles is not a significant issue, but that this is only the case if the required actions are in fact being undertaken.

9.198 Somewhat relatedly, Dr Mazur also stated that it seemed as though those in leadership roles at WBJ, in many situations, identified themselves with wearing an orange vest. However, he notes that it is unclear from the evidence whether those vests had specific role labels attached. He opined that role labels may have further improved communication and structure within the incident. The use of vests or tabards to better identify those in command was also articulated by Dr Cowburn.

9.199 Thirdly, Dr Mazur offered the view that the specific tasks associated with the Forward Commander, Incident Site Supervisor and Staging Area Supervisor appeared to become intertwined, resulting in some functions not occurring, or occurring later than would be ideal (for example, the role allocation noted above).

[1924] Exhibit 1, Vol 11, Tab 621, Statement of Inspector Halcyon Mitchell at [10].

9.200 Evidence was heard concerning the fact that whilst Insp Simpson described himself as the Forward Commander, he conducted tasks inside the Centre, including triage, treatment and extrication, which are primarily the responsibility of the Incident Site Commander. In oral evidence, Insp Simpson agreed that the Forward Commander role should ideally be undertaken by someone outside the immediate incident zone, but that until around 4:25pm (when the alarm stopped sounding and he heard Insp Bibby's broadcast regarding role allocation), he had no real awareness of what was happening outside the Centre. Given this lack of awareness, he assumed and remained in the Forward Commander Role. On this point, Dr Mazur accepted that Insp Simpson possessed the bulk of the knowledge of the scene, and that significant difficulties would have occurred if he tried to extricate himself to appoint someone else to the role.

9.201 Security expert Scott Wilson also considered the NSWA command and control structure. In his report, he opined that once Ambulance Officer 1, Insp Mitchell, Insp Bibby and Insp Saywell arrived, one of them should have appointed themselves as Tactical Forward Commander, sought out their police equivalent and positioned themselves inside the Command Post. It is noted that Ambulance Officer 1 did attend the NSWPF Command Post as Police Liaison sometime after 4:25:02pm and by no later than 4:34:36pm.

9.202 In the pre-conclave meeting held on 16 May 2025, Dr Evens commented, with Dr Cowburn and Dr Mazur agreeing, that it is not possible once entering the scene to fulfil the role of either Ambulance Commander or Forward Ambulance Commander as described in the NSW AMPLAN. The doctors also agreed with Dr Mazur's view that it was not possible to undertake the Ambulance Commander role, which involves communications with other emergency services from within the scene.

9.203 In oral evidence, Dr Evens added that he did not see any other choice available to Insp Simpson but to enter the Centre and believed it to be "*absolutely*"[1925] the right choice. He noted that, because he entered the Centre, he was not physically able to fulfil some of the other roles of an Ambulance Commander. Dr Cowburn concurred with Dr Evens, stating that he thought Insp Simpson's initial actions were extremely commendable in enabling care to be delivered to those injured patients.

9.204 Most notably, the emergency physicians agreed that Insp Simpson's decision to deploy at WBJ saved lives. This sentiment was reiterated throughout the conclave of emergency medicine physicians.

9.205 Mr Wilson also opined that the actions of Insp Simpson were "*outstanding*"[1926], as were the actions of first responders under his direction, and that they should all be commended.

[1925] Transcript, D17 (Evens): T1515.9-11 (23 May 2025).
[1926] Exhibit 1, Expert Volume, Tab 20, Report of Scott Wilson at [10.1.2].

9.206 During the conclave, Dr Evens and Dr Mazur agreed that the command and control issues identified by them as a panel fed into broader systemic issues as to the NSWA command and control structure, but also as to interagency working.

9.207 The emergency physician experts agreed that a recommendation ought to be made to NSWA to:

> *... devise a command structure that is agile and effective with the functions to deliver optimal patient care and scene management. This will require training and practice as part of a multi-agency response for the commanders to gain competence and confidence.*[1927]

9.208 Further, Dr Cowburn noted the following specific matters as areas for consideration in relation to a recommendation to NSWA regarding the command and control response:

> ***NSWA Major Incident Response Plan***
>
> *I would recommend a review of the NSWA Major Incident Response Plan as a result of learning from the Westfield Bondi Junction incident, if that has not already occurred as part of the standard post incident learning process. It is essential that incident response plans mature and evolve as a result of learning. This should particularly focus on the roles and responsibilities of commanders and functional roles to ensure they are deliverable and effective.*
>
> *Any revision should be focussed on delivering optimal benefits to patients whilst maintaining a command structure to ensure the scene is managed and responders are not exposed to excessive risk.*
>
> ***Ambulance Command Roles***
>
> *I would strongly recommend that NSWA review the command structure roles with a particular focus on the training and exercising of commanders in these roles. This should include a structure to gain and maintain competency in these roles. This will require investment into training both as single agency, including other healthcare responders within the region, and multiagency partners.*
>
> *Alongside this I would recommend a revision of the command tabard system to identify commanders and functional roles such they can be easily identified by all agencies at scene.* [1928]

Evidence of DC McKenna

9.209 In response to Dr Cowburn's report and the recommendation proposed by the expert conclave, DC McKenna (NSWA) gave evidence that NSWA is currently considering, within the review and redevelopment of NSW AMPLAN, whether there are improvements

[1927] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 2-3.
[1928] Exhibit 1, Expert Volume, Tab 22A, Supplementary Report of Dr Philip Cowburn MBE at p. 51.

to be made regarding the way leadership roles in Major Incidents are defined and allocated, particularly in the initial stages.

9.210 In a supplementary statement, DC McKenna (NSWA) stated the following is under consideration by NSWA:

> ...
>
> *(a) the procedure to adopt if the initial Forward Commander is embedded into an incident scene on the front line, including in circumstances where there is compromised communications between the Forward Commander and the Command Post that is being set up further back (and ensuring that the Forward Commander, or their delegate, has an early and direct line of communication with the NSWPF Command Post); and*
>
> *(b) how best to get a senior liaison from NSWA to the NSWPF Command Post, as early as possible, and whether that person be a temporary Ambulance Commander, one of the Inspectors specifically appointed to that role, or the Forward Commander.*[1929]

9.211 Of note, DC McKenna (NSWA) also gave evidence that he agreed with the conclusions reached in the supplementary report of Dr Cowburn, and with the emergency physician conclave notes.[1930]

Submissions regarding command and control

9.212 Drawing on the summary of evidence noted above in relation to the divergence between the stated roles that were adopted at WBJ, and the expected actions of those roles as set out in the NSW AMPLAN, as against the reality of the operation of those roles on 13 April 2024, Counsel Assisting made submissions to the effect that consideration ought to be had to a review of the NSW AMPLAN.

9.213 In particular, it was submitted that a review of the NSW AMPLAN should factor in consideration of the roles and responsibilities of commanders and the functional roles they are to undertake (as set out in the NSW AMPLAN Action Cards); the command structure roles; the adequacy of the training for, and exercising of, commanders to ensure they obtain and maintain competency; and a new tabard system to better identify commanders on scene. It was submitted that a recommendation arising out of these issues is necessary and desirable.

9.214 In their submissions, Counsel on behalf of NSWA expressed the support of NSWA for this recommendation and noted that it is already in the process of considering these matters in its current review of the NSW AMPLAN. In addition, NSWA indicated that it has engaged with its counterparts in the UK to share and exchange information, which is now being reviewed in connection with the ongoing work on the NSW AMPLAN.

[1929] Exhibit 1, Vol 47, Tab 1607A, Supplementary Statement of DC Wayne McKenna at [15](a)-(b).
[1930] See Exhibit 7, Notes from conference of Dr Cowburn, Dr Evens and Dr Mazur.

Counsel for NSWA did not make submissions in relation to the leadership "*confusion/vacuum*" identified by Dr Mazur and highlighted by Counsel Assisting's submissions.

9.215 Further, and in relation to the NSWA personnel themselves, Counsel Assisting proposed that the Court acknowledge the confronting and traumatic circumstances for all NSWA staff (and their NSWPF counterparts) involved in the events of 13 April 2024. Additionally, that the Court would acknowledge the professionalism and skill of all NSWA staff. In particular, they called on the Court to commend:

(a) Insp Brett Simpson – who they submit distinguished himself with decisive and life-saving action entering WBJ in circumstances that he understood to be a Hot Zone with a view to salvaging as many victims as possible. It was noted that Insp Simpson's efforts were also acknowledged through conferral of the Commissioner's Valour Medal, the highest bravery award for the NSWA, for his action on that day;

(b) Each of the NSWA paramedics who responded to the incident – noting their dedication, skill and commitment in what were frightening circumstances. It was submitted that they unquestionably saved lives.

(c) Insp Bibby, Insp Saywell and Insp Mitchell – each of whom demonstrated commendable leadership and initiative in assuming command and control roles, later supported by their colleagues AC Armitage and A/Supt Cronan; and

(d) The NSWA Control Centre staff, both Triple 0 call-takers and also the dispatchers who discharged their duties with efficiency, compassion and professionalism.

9.216 The Tahir family also expressed their gratitude to all police, ambulance, specialist medical staff, and everyone else who responded to WBJ – acknowledging their bravery and the great personal cost to those people. The Tahir family also particularly expressed thanks to Insp Simpson, noting he acted with the utmost care and professionalism.

9.217 The Darchia family similarly expressed their thanks to NSWA and various other people and organisations who were involved in this tragedy.

Findings

9.218 The Inquest benefited from extensive evidence concerning the command and control executed by NSWA on 13 April 2024, and in particular, from the expert evidence of the emergency medicine physicians. This close analysis by them provides guidance for issues that ought to be considered by NSWA, and which are contemplated in the resulting proposed recommendation set out below.

9.219 With respect to the command and control issues experienced by NSWA at WBJ, I accept the submissions of Counsel Assisting and the views of the emergency medicine experts.

9.220 I find that there were issues with the command and control executed by NSWA on 13 April 2024. These issues were largely conceded, and/or there were no submissions made by Counsel for NSWA in relation to them. Notably, NSWA have given evidence that they are aware of areas for improvement and are taking active steps to consider appropriate amendments to the relevant policy, the NSW AMPLAN.

9.221 Notwithstanding NSWA's proactivity in considering amendments to the policy, I find that the following command and control issues arose:

(a) Due to a communication breakdown by attending senior ambulance personnel, there was a leadership "vacuum" or "confusion" in the initial period of the incident. Whilst the command and control structure was established, it was delayed at least in part due to the lack of communication and role delineation in the early stages of the developing incident. Although, if the length of time on scene or number of casualties increased, the staging post, treatment area, marshalling area and loading points that were developed would have been invaluable.

(b) There was some confusion as to role allocations, which may have led to confusion for attending personnel as to whom they were to receive direction from. To that end, it appears that not all senior NSWA personnel utilised their tabards or "orange vests" to identify themselves. More clearly identified role labels, such as through the use of the tabard system, may have improved communication and structure within the incident.

(c) There was an intertwining of some roles on scene at WBJ. This included the role of Forward Commander and Incident Site Supervisor. Whilst Insp Simpson was identified as Forward Commander, once he entered the Centre, it was practically impossible for him to execute all role-related responsibilities as set out in and directed by the NSW AMPLAN. I find no criticism of the actions of Insp Simpson in this regard. Rather, it was clearly articulated by the experts that his decision to enter the Centre was the correct one.

(d) The intertwining of certain roles demonstrated that there is a disconnect between the roles as stated in the NSW AMPLAN and the practical application of those roles or Action Cards.

9.222 Noting the complexity of the scene and the numerous actions that needed to occur, I find no basis for criticism of the individual responders. Rather, as the emergency physicians opined, these 'command and control' issues identified feed into broader systemic issues as to the NSWA command and control structure, and to interagency working. It is the systemic nature of the identified issues which is addressed in the recommendations.

9.223 I echo the sentiments articulated by Counsel Assisting and commend each of the NSWA paramedics who responded to the incident, the NSWA control centre staff, both Triple 0

call-takers as well as the dispatchers. They each demonstrated courage, skill and commitment to providing aid to those in need. I also commend each of Inspectors Bibby, Saywell and Mitchell for their leadership and initiative in establishing the command and control structure at the scene, and AC Armitage and A/Supt Cronan who provided further support and direction on the day. The bravery of these individuals, the care, and the professionalism demonstrated by all NSWA personnel is exemplary. It was submitted, and I accept, that these NSWA personnel unquestionably saved lives.

9.224 Particular recognition ought to be made of Insp Simpson. Insp Simpson also undoubtedly saved lives. Faced with a challenging and frightening environment, he demonstrated great courage, leadership and skill, prioritising the wellbeing and needs of the victims over the potential risk to himself and his crews. This is a view held and articulated by Counsel Assisting, echoed by Counsel for NSWA, and shared by the experts. I note that in December 2024, Insp Simpson was awarded the Commissioner's Valour Medal – NSWA's highest bravery award recognising distinguished performance of duties in circumstances of extreme peril. This is well deserved, and a reflection of the contribution Insp Simpson has made to the community.

Recommendations

9.225 Counsel Assisting proposed the following recommendation directed to NSWA:

> **Recommendation 9**
>
> That NSW Ambulance's current review of the NSW Ambulance Major Incident Response Plan (NSW AMPLAN) includes consideration of the following matters (as highlighted during the evidence received during the Inquest):
>
> (a) The roles and responsibilities of commanders and the functional roles they are to undertake (including as defined in the 'Action Cards');
>
> (b) The 'command structure' roles;
>
> (c) The adequacy of the training for, and exercising of, commanders to ensure they obtain and maintain competency;
>
> (d) A new command tabard system to better identify commanders and functional role on scene (drawing on the UK National Ambulance Service, Command and Control Guidance (dated February 2024) as relevant); and
>
> (e) appropriate training in relation to major incident management and the amended AMPLAN document.

9.226 In oral submissions, Counsel Assisting referred to the significant progress NSWA has already made as to a review of the NSW AMPLAN, which has notably included input form subject matter experts in the UK. However, they maintained that this recommendation remains necessary or desirable.

9.227 Noting the evidence received at Inquest, the submissions of Counsel Assisting, the NSWA's stated support for the recommendation, and my findings concerning the 'command and control' issues experienced by NSWA at WBJ, I make the following recommendation:

RECOMMENDATION

Recommendation 16: To NSW Ambulance

That NSW Ambulance's current review of the NSW Ambulance Major Incident Response Plan (NSW AMPLAN) includes consideration of the following matters (as highlighted during the evidence received during the Inquest):

(a) The roles and responsibilities of commanders and the functional roles they are to undertake (including as defined in the Action Cards);

(b) The command structure roles;

(c) The adequacy of the training for, and exercising of, commanders to ensure they obtain and maintain competency;

(d) A new command tabard system to better identify commanders and functional role on scene (drawing on the UK National Ambulance Service, Command and Control Guidance (dated February 2024) as relevant); and

(e) Appropriate training in relation to major incident management and the amended AMPLAN document.

F. NSWA Special Operations Team

Deployment of the Special Operations Team paramedics

9.228 A key summary of the involvement of the SOT paramedics is set out in Section C, above.

9.229 The AAO Work Instruction states that available SOT paramedics must be immediately deployed to an AAO incident. The NSW AMPLAN also provides that Forward Commanders need to assess the incident and make requests for specialist personnel, such as Special Operations Tactical Advisors, at the earliest opportunity, even if the details of the incident are uncertain.

9.230 Evidence heard at Inquest included that only SOT paramedics are permitted to enter a "warm" zone where an indirect threat is present, meaning that delays in the tasking of SOT paramedics and availability of SOT resources had the potential to negatively impact patient outcomes.

9.231 The AAO Work Instruction also states that the NSWA Control Centre must undertake the relevant notification and escalation procedure, including contacting the rescue/SOT duty phone. Notwithstanding this, SOT 1 (holding the SOT duty phone) only became aware of the WBJ incident at 3:46pm through incidental contact with the NSWA Operations Centre regarding another matter.

9.232 Evidence was given by Insp Simpson and SOT 1 to the effect that the ability to deploy SOT paramedics to a Major Incident, as required by the AAO Work Instruction, is impacted by three main issues:

(a) The SOT rostering system;

(b) Lack of available BPPE; and

(c) The rigorous recruitment process for the SOT, which leads to a small pool of potential SOT paramedics that can attend any given incident.

9.233 The evidence before the Court on these matters is summarised below.

9.234 First is the issue of SOT rostering. Ordinarily, two SOT paramedics are rostered to work with the NSWPF TOU each shift, ready to deploy as required. However, no SOT officers were rostered to work with the TOU on 13 April 2024.

9.235 SOT 1 gave evidence that there were only 10 out of the maximum 18 or 20 SOT paramedics available to be rostered. Of necessity, rostering decisions were made based on weather, geographical area and the likelihood of activity and the requirement for specialist resources. On Saturday, 13 April 2024, it was determined not to forward deploy or backfill the SOT paramedic ordinarily rostered with the TOU because greater

need was anticipated for the eastern seaboard and surrounding national parks that weekend.

9.236 Further, there were no SOT paramedics available in the Eastern Suburbs area for the initial response to the incident.

9.237 Presently, the Special Operations Unit (**SOU**), from which the SOT paramedics operate, is not a standalone unit within NSWA. Instead, paramedics with SOT designation form part of the workforce in different regions and stations. SOT paramedics are then seconded into the SOU from their substantive paramedic positions in metropolitan clinical operations.

9.238 In oral evidence, Insp Simpson expressed the view that the SOU is a chronically under-resourced unit. He noted that there is no requirement within NSWA for SOT rosters to be backfilled in circumstances where a SOT paramedic is unavailable or on leave.

9.239 In oral evidence, SOT 1 explained that the current SOT roster model requires a minimum of 41 paramedics, or 50 paramedics to allow resources to backfill any vacancies created by any leave taken. Whilst there are 57 qualified SOT paramedics in the metropolitan area, it is common to have only 35 SOT paramedics on each 10-week roster.

9.240 As to the staffing of the SOU, DC McKenna (NSWA) indicated that in principle support was provided by the Chief Executive of NSWA to consider the current structure of the SOU and further, that increasing demand for Special Operations capability may require a standalone response capability managed by a dedicated Special Operations management structure to ensure safety and continuity of this specialist capability.

9.241 In addition, DC McKenna referred to the recruitment of a project lead for the new standalone structure that would see SOT paramedics become a dedicated unit. This change would include the SOU having standalone rostering.

9.242 In oral evidence, Insp Simpson supported the proposal for SOT to be structured as a standalone unit.

9.243 Secondly, is the impact of the SOT recruitment process on the general availability of the SOT paramedics. In oral evidence, SOT 1 explained that the process requires continuous assessments and places a significant amount of stress on every applicant throughout the course. Applicants are required to prepare a written application, undertake barrier testing, aptitude testing and physical testing to determine suitability, and also attend interviews. This portion of the process typically yields 60 to 80 applicants. This number reduces to approximately 12 applicants, who are ultimately offered a position in the SOT course. SOT 1 gave evidence that it is very rare for all 12 to pass the course, with typically eight to 10 passing. Further, he said that there is generally a number of years between each recruitment process.

9.244 Given this, in oral evidence, SOT 1 stated that the SOU is under-resourced, and that there would be benefit in the recruitment process taking place more frequently.

9.245 Thirdly, evidence disclosed issues regarding the availability of BPPE, which is critical for SOTs to enter a Warm Zone. In April 2024, the SOU had 10 out of 30 serviceable BPPE Rigs for use when responding to tactical situations as requested by NSWPF. NSWA acknowledged the urgent need for the 20 replacement sets, particularly given the impact of limited equipment availability on a rapid response to events such as at WBJ.

9.246 DC McKenna (NSWA) gave written evidence to the effect that a purchase order for the supply of BPPE was provided for approval on 24 April 2025, with the order since made with the supplier. In oral evidence, DC McKenna also stated that delivery of those resources would be the end of July/August 2025. Distribution of the new BPPE to outlying SOT locations was anticipated to be completed within two weeks of delivery to the SOU.

9.247 In a further written statement dated 17 November 2025, DC McKenna (NSWA) provided a further update on the status of BPPE available for SOT paramedics, including that:

(a) An appropriate number of BPPE for use by the SOTs embedded with the TOU is collected at the beginning of each shift and remains with them for the duration of that shift. He gave evidence that the number of available BPPE correlates to the number of rostered staff members and allows for additional surge staff.

(b) NSWA has taken delivery of additional BPPE. It is in the process of being operationalised.

(c) Initial BPPE rollout has begun across metropolitan locations, with further deliveries occurring over the next fortnight (that is, between 17 November 2025 and 1 December 2025). He also gave evidence that distribution to outlying locations will follow, with the intent to have all BPPE fully deployed and secured at appropriate locations (being within areas of their deployment) by 31 December 2025, pending final logistics and storage readiness.

9.248 In his statement of 17 November 2025, DC McKenna (NSWA) also reiterated that work to fully establish the SOU as a standalone entity is progressing to plan. He gave evidence that foundational components of the standalone unit, including the creation of a dedicated cost centre, uplift of funded positions, and recruitment to the dedicated tactical roster are well advanced. Further, he stated that NSWA were targeting implementation by 31 December 2025, subject to completion of workforce transitions and finalisation of operational support arrangements.

Expert review of the SOT response

9.249 Expert evidence was received as to the tasking and response of SOT paramedics.

9.250 Dr Cowburn opined that the SOTs should have been tasked from the initial call or first update from the scene. He recommended a review of the structure and function of the SOT in relation to their ability to respond to an AAO incident. Further, he opined that the SOTs failed to adequately meet their aim of providing clinical care within the risk

environment within which they are intended to operate. Dr Cowburn based this on three reasons:

(a) There were insufficient numbers of SOT paramedics on duty. Dr Cowburn acknowledged that whilst the total number that did eventually attend was sufficient, this took approximately 100 minutes from the first call giving details of an AAO.

(b) Those on duty were not at an adequate state of readiness to respond in a timely manner given the lack of available BPPE. Furthermore, even when they attempted to obtain the protective gear, there was a delay which resulted in the request to use NSWPF ballistic protection.

(c) The mode of dispatch of the SOT was fragmented and inefficient. Dr Cowburn proposed that the first update from the scene from Insp Simpson or the declaration of a Major Incident should have generated a full deployment of all SOT available.

9.251 Dr Mazur stated that early notification to the SOT duty phone per the AAO Work Instruction was apparently missed and the Instruction should be re-enforced; and further, that the availability of SOT resources – that is, both BPPE and the specialist paramedics themselves – required review. In addition, he stated that the lack of resources could have had a greater impact in different circumstances, such as the occurrence of a prolonged Warm Zone.

9.252 Moreover, Dr Mazur noted that whilst the lack of immediately available BPPE did not have an adverse effect on 13 April 2024, its ready availability may need to be considered for potential future incidents.

9.253 In their pre-conclave meeting, Dr Evens, Dr Cowburn and Dr Mazur agreed that there is a need for the ready availability of NSWA BPPE, with Dr Evens adding that the staff requiring BPPE to perform their role should carry it with them whilst on duty.

Submissions regarding NSWA SOTs

9.254 In light of the evidence received throughout the Inquest, Counsel Assisting submitted that a number of factors led to a delayed SOT response, including rostering difficulties and availability limitations, and lack of access to critical BPPE equipment. It was submitted that these factors also impeded upon the nature and timeliness of NSWA's response to the events at WBJ. Further, it was submitted that there was a failure to notify the SOT Duty Officer of the unfolding AAO incident. Counsel Assisting proposed a recommendation to address these factors, considered further below.

9.255 Counsel for NSWA submitted that, consistent with the evidence of DC McKenna (NSWA) during the Inquest, NSWA supports the recommendation proposed by Counsel

Assisting. Further, they noted that establishment of the SOU as a standalone unit is well underway, and deployment of BPPE at appropriate locations is nearing finalisation.

Findings

9.256 With respect to NSWA SOTs, I agree with the submissions made by Counsel Assisting. In that regard, I find that:

(a) There are insufficient numbers of SOT paramedics available to be rostered. The potential for delayed response is ameliorated in circumstances where more SOTs can be better positioned across the state. This could also decrease the likelihood of encountering delays in SOT attendance to an unfolding scene.

(b) Evidence received from experts and lay witnesses cumulatively lends itself to the view that the SOU would benefit from being a standalone unit as it may lessen issues surrounding SOT availability and roster allocations. It is acknowledged that NSWA have taken steps to consider the transition of the SOU to a standalone unit, including the recruitment of a project lead for the new structure.

(c) Whilst there was a delay in SOT attendance at WBJ on 13 April 2024, I am of the view that the SOT rostering issues appeared to have had minimal impact on the incident. However, it is noted that if the incident had unfolded over a longer period of time or in different circumstances – for example, if there was prolonged Warm Zone - it may have had a more significant effect. Given the intention to derive learnings from the Inquest process, acknowledging the potential impact of the delay is important.

(d) There is a need for ready availability of necessary BPPE to enable SOT paramedics to perform their role (including, entering a Warm Zone). It is also acknowledged that NSWA has taken steps to purchase and distribute additional sets of this protective equipment, and that this process is nearing completion.

(e) Early notification to the SOT duty phone per the AAO Work Instruction was missed. As is set out above, the need for early notification has been addressed in the Updated AAO Work Instruction. In the circumstances of this incident, it is fortunate that SOT 1 became aware of the incident after contacting the NSWA Operations Centre concerning another matter and was then able to action a SOU response.

Recommendations

9.257 In their written submissions, Counsel Assisting proposed the following recommendation directed to NSWA:

Recommendation 10

That NSW Ambulance give further and expedited consideration to:

(a) The status of the 2024 review into the Special Operations Unit response capability, including the merits of the SOU operating as a standalone unit and with a view to increasing the capacity for SOT resourcing; and

(b) A review and audit (following recent steps to obtain new equipment) to ensure the immediate availability of serviceable Ballistics Personal Protective Equipment for all SOT operators as required, with such equipment being readily available – that is, in close proximity to their areas of deployment.

9.258 Following receipt of further evidence from NSWA by way of the further supplementary statement of DC McKenna (NSWA) dated 17 November 2025, in oral submissions, Counsel Assisting indicated that proposed recommendation 10(b) is no longer necessary. It was submitted that the lack of necessary BPPE for all SOT operators has now been addressed.

9.259 Given evidence has been received concerning the progress of the provision of BPPE, and noting Counsel Assisting no longer press it, I do not propose to make recommendation 10(b).

9.260 With respect to proposed recommendation 10(a), Counsel Assisting referred, in their oral submissions, to the progress that has been made by NSWA regarding the review and establishment of a standalone SOU. They maintained that this recommendation is necessary or otherwise desirable.

9.261 Accordingly, noting the above evidence, and my findings concerning the same, I make the following recommendation:

RECOMMENDATION

Recommendation 17: To NSW Ambulance

That NSW Ambulance give further and expedited consideration to the status of the 2024 review into the Special Operations Unit (SOU) response capability, including the merits of the SOU operating as a standalone unit and with a view to increasing the capacity for Special Operations Team (SOT) resourcing.

G. Zoning for an AAO incident

'Zoning' in the initial NSWA response

9.262 As set out above, the AAO Work Instruction requires that an AAO scene be classified into operating "zones".

9.263 The chronology leading to WBJ being declared a Hot Zone is also set out above. This chronology reveals that the risk level at the scene was assessed by attending paramedics, Insp Simpson as Forward Commander, and subsequently by AC Armitage, who made the Hot Zone declaration at 4:28pm.

9.264 In oral evidence, Insp Simpson explained that he understood the scene to be a Hot Zone when he first arrived at the Centre at around 3:42pm because he could not be certain that there were no other offenders involved. Insp Simpson also explained the distinction between a Hot (active threat) and Warm (potential indirect threat) Zone.

9.265 Notwithstanding this risk assessment, Insp Simpson recalls speaking with a police officer who was fairly confident that there was only one offender who had been contained. Insp Simpson stated he also knew that there were a number of critically ill patients inside. Balancing the patients' needs against safety, Insp Simpson decided to enter WBJ.

9.266 Insp Simpson gave further evidence that at the time the Hot Zone declaration was made and when he subsequently exited WBJ, he was confident that there were no patients left behind inside WBJ.

9.267 For his part, AC Armitage's evidence was that the Hot Zone direction at 4:28pm was based on intelligence provided by a NSWPF officer to the effect that the scene had not been completely cleared. It is understood that Sgt 2[1931] was the officer with whom AC Armitage spoke. At this time, AC Armitage also understood that there were no other patients known to NSWA that were being treated by NSWA crews inside WBJ.

9.268 As to the conversation that AC Armitage had with Sgt 2 upon arrival at the scene, AC Armitage recalled trying to ascertain the location of the police command post. He also recalled asking if the scene was "hot". In his written statement, AC Armitage stated that he was told the area had not yet been cleared by the NSWPF. A statement was obtained from Sgt 2. In response to being asked if it was still a Hot Zone, Sgt 2 recalled telling a senior commissioned paramedic that it was still an "active crime scene". AC Armitage did not recall that detail.

9.269 Further, in oral evidence, AC Armitage explained that shortly after he attended the NSWPF Command Post (between 5:03pm and 5:15pm), he was informed that they did not believe there was a second offender. He did not disseminate this information. AC

[1931] Sgt 2 is a pseudonym pursuant to non-publication order dated 28 May 2025.

Armitage accepted that upon becoming aware of the information from CI Whalley, the Hot Zone declaration should have been downgraded.

9.270 As noted above, AC Armitage gave evidence that he provided three separate briefings to all paramedics on scene on Oxford Street, including one after attending the NSWPF Forward Command Post, at around 5:30pm. AC Armitage did not explicitly state that he clarified the status of the possible second offender to crews on the ground, but did state that he provided *"detailed briefings of what I knew at the time"*.[1932]

9.271 Despite AC Armitage's evidence concerning these briefings, the prospect of an ongoing threat from a potential second offender remained a possibility for certain NSWA staff, as evidenced by two recorded phone calls between 5:48pm and 6:17pm, which referred to an active shooter at WBJ.

9.272 Notwithstanding this, AC Armitage gave evidence that his direction to withdraw crews from WBJ was in accordance with the AAO Work Instruction.

The "hot", "warm" and "cold" terminology

9.273 The Court heard that the evidence, as set out above, illustrated a significant disconnect between the NSWA and NSWPF positions concerning the classification of an AAO scene.

9.274 The AAO Work Instruction states that "*police will divide the incident into three zones*".[1933] However, in the ordinary course, NSWPF do not use the "hot", "warm" and "cold" terminology; nor do NSWPF unilaterally assess and characterise areas of risk at a Major Incident for NSWA.

9.275 In evidence, S/Sgt Watt explained that whilst NSWPF are generally aware of the distinction between the different zones, allowing them to liaise with their NSWA counterparts, they do not make the zone declaration. Instead, it is usually a decision made by a senior NSWA staff member. S/Sgt Watt said that police in an AAO incident would not give a direction to ambulance around the zoning of areas.

9.276 SOT 1 gave evidence that whilst he was aware of the AAO Work Instruction and the "hot", "warm" and "cold" terminology, when working with the TOU they would use phrases such as "*where is the areas of safety, or where is the area of risk*."[1934] He later noted that tactical police understand the concepts in his view and would sometimes use the Hot Zone terminology but not necessarily in every case. SOT 1 also added that the delineation between hot, warm and cold zones was very fluid when working with the TOU.

[1932] Transcript, D3 (Armitage): T55.25-27 (30 April 2025).
[1933] Exhibit 1, Vol 36, Tab 1214, Clinical Operations – Response to Active Armed Offender at p. 3.
[1934] Transcript, D4 (SOT 1): T245.36-38 (1 May 2025).

9.277 In his supplementary statement, DC McKenna (NSWA) stated that NSWA acknowledged:

> ...
>
> *(b) there is value in common terminology reflecting a common understanding as to the concepts of a "hot", "warm" and "cold" zone between NSWPF and NSWA (acknowledging that the wording of Section 3.3 "Scene management" of NSWA Work Instruction WI2023-095 Response to Active Armed Offender (**AAO**) and Public Disorder Incidents (14 December 2023) does not reflect terminology between the agencies); and*
>
> *(c) there is also value in a common understanding between NSWPF and NSWA as to who makes these determinations, and how the determinations are made, noting decisions regarding zoning are dynamic.*[1935]

9.278 Further, DC McKenna stated that "*NSWA welcomes an opportunity to develop a common language with the NSWPF regarding zoning*."[1936]

9.279 The review of the incident undertaken by the NSWA's EMU revealed that one of the challenges identified and an emerging insight arising from that review process was a lack of awareness about the AAO Work Instruction.

9.280 In particular, the review revealed that staff found it difficult to wait for the scene to be cleared and did not know whether the scene was declared safe or not. Staff identified that it was difficult to retain information from work instructions without the ability to practice implementing these skills. In oral evidence, DC McKenna (NSWA) acknowledged these difficulties. Evidence was received that, since the incident, training has been introduced on the topic of zoning. This change, amongst others, is set out below.

Executive conclave

9.281 During the NSWA and NSWPF 'executive' conclave on 26 May 2025, DC McKenna (NSWA) and Assistant Commissioner Peter McKenna (**AC McKenna**) (**NSWPF**) confirmed that the "hot", "warm", and "cold" terminology was used by NSWA, Fire and Rescue NSW, and the State Emergency Services (**SES**).

9.282 Notwithstanding discrepancies as to the terminology to characterise risk at a major incident, DC McKenna (NSWA) explained that it is the position of the NSWA that the NSWPF should be the lead agency to determine zoning at an incident (including an AAO incident) with NSWA input. AC McKenna agreed that the NSWPF should "*say what area is clear, safe or otherwise, albeit not the terminology that's been used at the moment*."[1937]

[1935] Exhibit 1, Vol 47, Tab 1607A, Supplementary Statement of Wayne McKenna at [24](b)-(c).
[1936] Exhibit 1, Vol 47, Tab 1607A, Supplementary Statement of Wayne McKeena at [25].
[1937] Transcript, D19 (P McKenna): T1770.22-24 (27 May 2025).

9.283 Further, both AC McKenna (NSWPF) and DC McKenna (NSWA) were familiar with the AAO Work Instruction. In terms of this policy indicating that police would "divide" the scene into the various zones (hot, warm and cold), DC McKenna agreed that this was a "*misunderstanding*"[1938] as to how things would in fact operate.

9.284 Both AC McKenna and DC McKenna accepted this as a situation where assumptions were held internally about how each agency would operate together, that would not hold in practice. DC McKenna and AC McKenna agreed that Part 3.3 of the AAO Work Instruction concerning zoning required clarification as a matter of urgency.

Expert evidence on zoning in major incidents

9.285 The expert conclave of Dr Mazur, Dr Cowburn and Dr Evens agreed that the erroneous Hot Zone declaration "*had the potential to cause further lives to be lost and harm to be caused*" and should be considered a "*near miss*".[1939] Additionally, they agreed that the circumstances presented a poignant lesson to learn about interagency inoperability.

9.286 As to zoning terminology, in the pre-conclave meeting, Dr Mazur, Dr Cowburn and Dr Evens were asked to consider whether they agreed on the need for common terminology reflecting a common understanding of the concepts of a "hot", "warm" and "cold" zone as between the NSWPF and NSWA. The doctors agreed that there are challenges with different understandings of zone descriptions and their varying impact on different emergency services. They also noted that the phraseology of zones can negatively impact the ability to make dynamic risk assessments.

9.287 Further, in respect of NSWA paramedic concerns about being prevented from entering WBJ to render patient assistance, Dr Mazur noted that crew safety has to be the number one priority and that it is not the role of health services to second guess the veracity of information provided by police as to the possibility of a second assailant. The information should be relied upon to keep their emergency services colleagues safe.

9.288 It is noted that the potential utility of a "Rescue Task Force" was also raised in evidence. The evidence concerning the use of such a task force to provide patient assistance in hostile environments is set out below, in Part 10.

9.289 More generally, Dr Cowburn provided a perspective from the UK regarding the zoning of scenes.

9.290 In his supplementary report, Dr Cowburn explained that the zoning of the scene of major incidents is well established in emergency service response. The classic application defines three zones – hot, warm and cold – based on the hazards. Dr Cowburn opined that the concept works very well for relatively static major incidents such as a building collapse or rail crash, or in situations where the major incident relates to hazardous

[1938] Transcript, D19 (P McKenna): T1732.28-38 (27 May 2025).
[1939] Transcript, D17 (Cowburn/Mazur/Evens): T1540.46-T.1541.37 (23 May 2025).

material. He gave examples of how the zones can be more readily defined and managed in these comparatively static environments.

9.291 However, Dr Cowburn went on to express the view that this concept does not adapt well to the dynamic and fluid threat of a Marauding Terrorist (being language used in the UK) or AAO. He stated that in the circumstances of an AAO, the zoning concept does not work well as the mobility of the threat means that an area that was "hot" may rapidly become "warm", or an area once "cold" could become "hot", if the attacker moves to it or there are multiple assailants.

9.292 Additionally, Dr Cowburn referred to lessons learned from the combination of failures identified during the Manchester Arena Inquiry, which included confusion as to who should enter the Hot Zone and the extent of the Hot Zone, despite reliable evidence there were no further offenders. This significantly prolonged the "Care Gap" (being the delay in responders delivering care to injured casualties which may result in the loss of salvageable lives) as few ambulance responders entered the area, which likely resulted in the death of one patient.

9.293 Dr Cowburn also stated:

> *The attempts to provide effective zoning with limited information in the early stages results in a tendency to make the Hot Zone very large as the exact location of the mobile attacker may not be entirely certain. This creates a large area in which victims will be without healthcare response, forming an expanded Care Gap. If the threat from the attacker is not rapidly contained or neutralised this prolongs the duration of the Care Gap.*[1940]

9.294 Dr Cowburn noted the operation of the Marauding Terrorist Attack Joint Operating Principles (**MTA JOPS**) in the UK, which have undergone various iterations over the years. These would be invoked as part of a JESIP response to an MTA that is usually precipitated by a police declaration of 'Operation Plato', being a specific counterterrorism response to an MTA that can only be instituted by the police.

9.295 The Court heard that the latest version of the MTA JOPS (2023, Version 3) incorporates recommendations from the Manchester Arena Inquiry, as well as other incidents. In this latest version, a revised approach to zoning was taken incorporating two fundamental modifications: first, that not all MTAs would require zoning if it were not felt to be beneficial to the response - thus defining "hot", "warm" and "cold" zones was not mandated; second, that both specialist and non-specialist responders could operate in any zone if safe enough to do so. This decision would be defined by the threat and attack methodology. Therefore, the previous doctrine of only armed responders being able to enter the Hot Zone was removed to reduce the Care Gap.

[1940] Exhibit 1, Expert Volume, Tab 22A, Supplementary Report of Dr Philip Cowburn MBE at p.18.

Submissions regarding zoning for an AAO incident

9.296 With respect to the declaration of WBJ as a Hot Zone and noting the information available to AC Armitage at the time, Counsel Assisting submitted that the declaration was reasonable. Further, it was submitted that the fact that NSWA lacked critical information – namely, that a minute prior to the declaration, NSWPF confirmed there was only one offender – indicated a critical learning for both agencies in relation to the need for inter-agency communication.

9.297 Supported by evidence from emergency medicine experts and institutional witnesses DC McKenna (NSWA) and AC McKenna (NSWPF), and whilst acknowledging the Hot Zone declaration had no impact on patient outcomes, Counsel Assisting characterised the absence of information sharing and Hot Zone declaration as a "near miss". This characterisation was made on the basis that it could not have been positively known to emergency services at that time that no further patients were inside the Centre.

9.298 Counsel for the Commissioner of the NSWPF disagreed with that characterisation of the "Hot Zone issue" and stated that they did not accept the suggestion that it was "fortunate" that the Hot Zone declaration had no impact on patient care. Whilst conceding it was a fast-paced, chaotic environment, Counsel for the Commissioner of the NSWPF submitted that the notion that it was luck does not accord with the evidence. They asserted that patient welfare was at the fore of the decision to make the declaration. Further submissions concerning the "near miss" characterisation are addressed in Part 10.

9.299 Notwithstanding this divergence of views, the NSWPF agreed that the "Hot Zone issue" represents a learning opportunity for both NSWPF and NSWA, and in particular, indicates a disconnect in understanding as to which agency would make any zoning declaration in the context of an AAO incident. Their submissions highlighted that both AC McKenna (NSWPF) and DC McKenna (NSWA) confirmed they had engaged in discussion about this and would continue to do so, with the aim of clarifying AAO Work Instruction Part 3.3 (being the portion relating to zoning of AAO incidents.

9.300 As noted above in part 9A, the Updated AAO Work Instruction, published on 11 July 2025, does clarify that "*based on information received from the Police or other sources, the Ambulance Commander may divide the incident into up to three zones. …*"[1941]

9.301 Counsel Assisting submitted that there is a lack of awareness of the AAO Work Instruction, as noted above. Stemming from this was the concern that there was a disconnect within the AAO Work Instruction between the role of police in dividing the scene into zones and the role that NSWA assumes in that process. Further, it was submitted that the zoning concept does not work well given the mobility of certain threats which can result in zones being determined that could quickly change in size and

[1941] Exhibit 1, Vol 54, Tab 1698, Further supplementary statement of Wayne McKenna at p. 12.

location, and which could contribute to expanding the Care Gap. Consequently, consideration of zoning in AAO incidents was put forth as a recommendation.

9.302 In their written submissions, Counsel for NSWA noted that, consistent with the evidence of DC McKenna (NSWA) during the Inquest, NSWA supports this recommendation.

9.303 Furthermore, Counsel Assisting submitted that the UK's MTA JOPS (whilst held at 'Official Sensitive' level within UK National Security) could include useful operational information for the consideration of NSWPF, and NSWA to a lesser extent, on the zoning approach.

Findings

9.304 Noting the expert and lay evidence adduced in relation to this topic, and the submissions received from the parties, my findings in relation to the issue of zoning at AAO incidents and at WBJ on 13 April 2024 are as follows:

(a) The Hot Zone declaration was made in circumstances where AC Armitage was faced with a fast-moving and chaotic environment and where a multitude of factors needed to be considered and weighed in a short period of time. Coupled with communication difficulties, the scale of the scene, and the spread of the victims, it is acknowledged that his decision-making process took place in a difficult environment.

(b) The Hot Zone declaration made by AC Armitage on 13 April 2024 was reasonable in the circumstances.

(c) The Hot Zone declaration did not have any adverse impact on patient outcomes at WBJ on 13 April 2024.

(d) The fact that NSWA lacked critical information at the time of the Hot Zone declaration is concerning and gives rise to consideration of the importance of inter-agency communication and interoperability. This has emerged as a significant issue in the Inquest, and is considered in detail in Part 10, below.

(e) There was a lack of awareness of the AAO Work Instruction at the time of the incident at WBJ. This has been acknowledged and is in the process of being addressed by NSWA through the introduction of additional training on the AAO Work Instruction through their MCPD course, which will enforce awareness of this policy and include an AAO scenario to further increase clinicians' exposure and experience with these scenarios. As at the time of the Inquest hearing, this training had been planned but not yet implemented. However, given the evidence that it is being implemented, a recommendation in relation to this is not necessary.

(f) With respect to zoning in an AAO incident, there was a disconnect between the roles of NSWA and NSWPF in relation to the responsibility of dividing an incident scene into the three zones.

(g) Whilst noting the evidence of DC McKenna (NSWA) in his written statement of 17 November 2025 and the publication of the Updated AAO Work Instruction, given the expert evidence of Dr Cowburn and the importance of minimising the Care Gap at AAO Incidents, consideration ought to be had to the application of the zoning concept more broadly, including the language used to delineate between zones of safety and risk, and the way in which the zones are determined. I commend the ongoing co-operation of the NSWPF and NSWA in their consideration and consultation on this issue.

9.305 With respect to the differing views as to the characterisation of the Hot Zone declaration as a "near miss", and my findings concerning the same, please see Section C of Part 10.

Recommendations

9.306 In written submissions, Counsel Assisting proposed the following recommendation directed to NSWA:

> **Recommendation 11**
>
> That NSW Ambulance review and revise 'Work Instruction WI2023-095: Clinical Operations – Response to Active Armed Offender (AAO) and Public Disorder Incidents'; and that such review and revisions consider input from the New South Wales Police Force as to the concept of zoning; and the appropriate approach to, and terminology for scene management in an AAO incident.

9.307 In oral submissions, Counsel Assisting indicated that proposed recommendation 11 is no longer necessary. As noted above, and as set out in DC McKenna's statement of 17 November 2025, the Updated AAO Work Instruction was published on 11 July 2025. Counsel Assisting noted that this evidence confirms that the review of the AAO Work Instruction has occurred (with consultation from the NSWPF). It was noted that this was fast work by the NSWA.

9.308 In a joint position paper prepared by the two agencies, NSWA iterated that they have amended the AAO Work Instruction following consultation with the NSWPF, and the NSWPF stated that they await correspondence from NSWA once the Updated AAO Work Instruction is ready for consultation.

9.309 Consequent to the above stated evidence, a recommendation in relation to the concept of zoning and the AAO Work Instruction, as previously proposed by Counsel Assisting, is not necessary.

H. NSWA changes since the events of 13 April 2024

9.310 Extensive evidence was given in relation to the reflections, changes and improvements that have been contemplated and implemented by NSWA in response to the events of 13 April 2024. This evidence is primarily detailed in the statement of DC McKenna (NSWA) dated 26 March 2025. These changes are noted below.

9.311 It is acknowledged that prior to this incident, NSWA appears to have been taking steps towards continuous improvement of its policies, practices and procedures. Written evidence tendered at the Inquest revealed that in 2021-2022, NSWA engaged KPMG to conduct two internal audits. From these audits, KPMG found that NSWA's *then* Major Incident Management Framework was inadequate and not fit for purpose. KPMG recommended that NSWA needed a clear workforce resourcing and training strategy aligned to the NSW Health emergency education framework. KPMG also noted that NSWA had not implemented a consistent formal procedure to capture lessons learned and to action findings from post mass casualty event reviews.

9.312 In response, NSWA developed the 'Emergency Management Training Plan' to address the lack of appropriately trained individuals for key roles during a Mass Casualty Event and the lack of Incident Management Team members. This plan was endorsed by the NSWA Emergency Management Committee on 7 November 2023. The plan includes the introduction and extension of mass casualty and Major Incident exercises during graduate induction training (over the course of a day), as well as competency units to be rolled out to staff as part of professional development.

9.313 The changes that have been contemplated and made by NSWA in response to the incident at WBJ are derived from NSWA's "lessons learned" procedure.

9.314 As noted, written evidence was received as to the impact of the NSWA's Emergency Management Unit (**EMU**). The EMU was in the process of expanding its operations in April 2024. The EMU implements the lesson management framework regarding NSWA's response to a Major Incident and the incident at Westfield Bondi was the first time this framework was enacted.

9.315 The EMU review of the Westfield Bondi incident identified emerging lessons for NSWA. These included the following:

(a) The need for shared interagency situational awareness, especially in terms of understanding other agencies' priorities and objectives;

(b) Scene congestion and convergence of vehicles creating challenges for egress and patient transport;

(c) The need for interagency training and exercises, including increased awareness of the capabilities of other agencies;

(d) The need for clarity in terms of command structures within NSWA and improved ability to identify commanders via the use of distinctive coloured vests;

(e) The need for improved mobile data terminal (MDT) functionality to easily identify and receive crucial information;

(f) The need for greater familiarity and confidence with using the SMART triage tag system;

(g) The need for additional internal training and exercises around Major Incident/mass casualty events, including a better understanding of roles and responsibilities; and

(h) The need for better internal situational awareness, especially within Control Centres, and improved processes for the sharing of crucial information.

9.316 NSWA also identified learning opportunities as to:

(a) The need for greater awareness of the NSWA policies for responding to AAO and Public Disorder Incidents; and

(b) The need for the Control Centre scribe to enter electronic notes about an incident in real time (rather than taking written notes which are later entered) to enable responders to see real time updates.

Changes to NSWA practices and/or policies and procedures

9.317 Notably, the abovementioned reflective process has led to changes to NSWA practices and/or policies and procedures.

9.318 In his written statement, DC McKenna (NSWA) set out these changes, including:

(a) Review of Major Incident training for new trainees and graduates;

(b) Introduction of Major Incident training for the new Station Manager role;

(c) Development of a new training program for potential incident commanders;

(d) Development of a training program for frontline management with respect to general incident and emergency management processes;

(e) Implementation of an 'Emergency Management Duty Officer' work instruction; and

(f) Review and update of the 'Operation Planning and Preparedness' Operating Procedure in relation to managing surge escalations.

9.319 DC McKenna also gave evidence that NSWA have also begun to review and redevelop the NSW Major Incident Response Plan (**NSW AMPLAN**) including with respect to:

(a) Alignment with the NSW HEALTHPLAN in terms of how emergency management support is provided in support of a Major Incident; and

(b) How NSWA will support other agencies in Major Incidents.

9.320 Further, NSWA have also reviewed its current 'Major Incident' training for new trainees and graduates joining the organisation.

9.321 In oral evidence, DC McKenna (NSWA) expanded on the lessons identified through the debrief and review process, which included the following:

(a) Given the difficulty some crews had identifying command roles due to NSWA staff wearing the same coloured vests, NSWA were looking at the JESIP model and the model used by the UK National Ambulance Resilience Unit (**NARU**) unit to consider how on-scene command roles could be clarified.

(b) Considering the efficacy of the debrief process, and following receipt of feedback, NSWA were amending procedures to reduce the timeline from incident to debrief, and to involve more staff earlier on in the process.

(c) The need to gain shared situational awareness across multiple agencies was identified as a challenge, and one which DC McKenna thought the JESIP framework may assist with. DC McKenna stated that this recognition has led, at least in part, to informal conversations about the issue. This is further addressed in Part 10 of these Findings.

(d) Training on site convergence and scene congestion is now part of the NSWA learning packages. These include the induction program and the MCPD training that all paramedics complete every six months. Training on the NSWA 'triage sort' and 'triage sieve' processes, as well as the use of triage SMART tags, are part of the current MCPD and induction trainings. However, DC McKenna acknowledged this training is something they've "*got to be able to revisit*".[1942]

(e) A two-day mandatory incident management training course was conducted in July 2025. Incident management is also addressed in the current MCPD training, and through the running of simulation exercises.

(f) In relation to access to incident records after an event to facilitate welfare checks, the NSWA system has been changed so that personnel seeking to access information (such as about which staff attended) are prompted, via an on-screen pop-up, to contact the relevant person to obtain access.

[1942] Transcript, D19 (W McKenna): T1781.27-40 (27 May 2025).

(g) NSWA are "*working through that AMPLAN to be able to change some of … the ways that we respond in these incidents*."[1943] DC McKenna referred to the development of the Medical Commander role, noting that paramedics (as registered health professionals), can undertake some of the roles that the Medical Commander role was doing at the time AMPLAN was first written. NSWA are also reviewing the UK NARU model to inform an understanding of how a medical advisor can assist the Medical Commander undertake that role.

(h) NSWA are taking steps to develop a new standalone structure for the SOTs and to rectify deficits in available ballistic PPE equipment for those SOT paramedics, noting that an order for replacement PPE was being lodged at the time of the Inquest hearing.

(i) In relation to training for Forward Commanders, NSWA are striving towards the credentialling that Ambulance Commanders undergo in the UK (as referred to in the evidence of Dr Cowburn).

9.322 In a further written statement of 17 November 2025, DC McKenna (NSWA) iterated the ongoing consideration and review of the NSW AMPLAN, which is a process he states commenced prior to the incident at WBJ that is now considering the learnings from NSWA's response to that incident.

9.323 In particular, DC McKenna iterated that the revised NSW AMPLAN and related Action Cards have been and will continue to be subject to rounds of consultation and feedback, including by the NSWA Executive Leadership team. Additionally, DC McKenna stated that both the NSWA Executive Leadership Team and key subject matter experts have participated in workshops and engaged with their UK counterparts to glean insights to further inform the roles and responsibilities of commanders, command structures, aspects of training, and the opportunities to further integrate JESIP principles (as discussed further in Part 10 of these Findings).

9.324 DC McKenna (NSWA) has given written evidence that the new response plan and associated action cards are schedule to be finalised and published in 2026.

Submissions

9.325 Counsel Assisting noted the positive impact of the above-mentioned EMU's analysis of lessons learned (outlined above). This analysis had meant that issues that might have otherwise been first identified at the Inquest, were instead distilled at an earlier point in time and changes actioned as a result. Counsel Assisting commended the level of reflection and proactivity demonstrated by NSWA and submitted that this was demonstrative of an agency with a deep commitment to ensuring that lessons are not only identified, but implemented, with a review and follow up thereafter.

[1943] Transcript, D19 (W McKenna): T1783.26-27 (27 May 2025).

9.326 Counsel Assisting submitted that the review process of the NSWA has obviated the need for recommendations that might otherwise have been considered necessary of desirable.

Findings

9.327 Noting the evidence concerning NSWA's response to the events of 13 April 2024 and the submissions of Counsel Assisting concerning the same, the critical analysis by NSWA of its own systems and processes has clearly had a positive impact on the agency and its operations.

9.328 I also commend their proactivity, their clear willingness to learn from this incident, and their commitment to action changes to improve the way the agency operates and responds to Major Incidents. It is this initiative and proactivity that mitigates the need for further recommendations.

Part 10 Emergency Services Interoperability

Emergency services interoperability

10.1 A central theme that emerged at Inquest regarding the response of emergency services (NSWA and NSWPF) to the events of 13 April 2024, was the concept of coordination between emergency services, or interagency interoperability, and relatedly, the UK concepts of Joint Emergency Interoperability Programme (**JESIP**) and the Ten Second Triage Tool (**TST**).

10.2 To address the evidence arising with respect to issues also highlighted within Parts 8 and 9 that relate to interagency interoperability, as well as the concept more broadly, this Part will be separated into the following sections:

Section A	Introduction and overview of interoperability
Section B	The Hot Zone issue
Section C	Multi-agency working in NSW
Section D	Joint Emergency Services Interoperability Programme (JESIP)
Section E	Consideration of the JESIP approach in NSW
Section F	Shared triage approach: Ten Second Triage Tool
Section G	Shared communications: Joint radio communications
Section H	Joint Rescue Task Force
Section I	Concluding remarks

A. Introduction and overview of interoperability

10.3 Interoperability essentially refers to the extent to which organisations can work together coherently as a matter of routine. In major incidents, joint agency interoperability relates to the ability of emergency services (or other involved agencies) to collaborate to enhance the multi-agency command, control and coordination of response to major incidents.

10.4 Relevant aspects of command and control, in the context of NSWPF and NSWA responding to a major incident (and an AAO scenario), are detailed in Parts 8 and 9.

10.5 As set out in Part 8, NSWPF has adopted the ANZPAA ICCS Plus into its own policy document, NSWPF ICCS Plus, which informs that organisation's approach to command and control.

10.6 As set out in Part 9, NSWA is guided by AMPLAN which sets out the relevant command and control approach, and the roles and responsibilities of NSWA staff at major incidents.

10.7 Unlike the "JESIP" model for interagency working – which is detailed further below – there is no policy or doctrine in NSW that specifies the principles for emergency services interagency working. This is a model distinct from those in documents such as the State Emergency Plan, which have a different function and do not set out the matters detailed in the JESIP doctrine.

Position in the United Kingdom

10.8 The Inquest heard extensive evidence concerning JESIP, the emergency services interoperability programme that operates in the UK.

10.9 JESIP emerged following the findings from several reviews of major national emergencies and disasters that demonstrated that emergency services agencies in the UK, whilst carrying out their individual roles efficiently and professionally, would benefit from common models and principles to help agencies work together in responding to emergencies.

10.10 In this context, the JESIP Joint Doctrine "*is intended to support the development of local training, policies and procedures, and seeks to improve interoperability through the application of simple common models and principles*."[1944]

10.11 JESIP principles for joint working, which are set out below, support the development of a multi-agency response to an incident, providing structure. Further, the JESIP Joint

[1944] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine at p.4.

Doctrine provides that when consistently applied, the JESIP principles will improve interoperability between organisations across all levels of command.

10.12 In reviewing the emergency interagency response to the events of 13 April 2024, the Inquest was assisted by the expertise of Scott Wilson and Dr Philip Cowburn, both of whom have significant experience in emergency management in the UK (as outlined in **Appendix 9**).

10.13 As identified above, in reviewing the "command and control" structure and joint agency interoperability of NSWPF and NSWA on 13 April 2024, both Mr Wilson and Dr Cowburn adopted the Gold/Silver/Bronze (**GSB**) hierarchy used in the UK as a comparator.

10.14 The Inquest heard that, in short, the GSB hierarchy is the generic response structure adopted by emergency response organisations in the UK and is used as

> *… a framework for delivering a strategic, tactical and operational response to an incident or operation… [allowing] processes to be established that facilitate the flow of information and ensures that decisions are communicated effectively and documented as part of an audit trail.*[1945]

10.15 The GSB model consists of three tiers:

(a) Gold (Strategic) command;

(b) Silver (Tactical) command; and,

(c) Bronze (Operational) command.

10.16 In the context of JESIP, this generic response structure is used to frame the levels of command when responding to incidents and the basic responsibilities at each level of command, noting the importance of "*a clear and identifiable commander or representative who is responsible for co-ordinating the activity of the organisation at each level of command.*"[1946]

The UK response to Marauding Terrorist Attacks

10.17 In the UK, the term "Marauding Terrorist Attack" (**MTA**) and code name Operation "Plato", is used to alert all agencies to an incident involving an offender that moves rapidly through a location aiming to find, kill, and injure as many people as possible. This is akin to the term AAO used in Australia, the definition of which is outlined in Part 5.

10.18 The emergency services' response to an Operation Plato declaration is supported by a set of agreed principles. These principles, the MTA Joint Operating Principles (**MTA JOPS**), have been developed to ensure there is an interoperable response. The latest

[1945] College of Policing (UK), Command Structures, 19 August 2025 available at https://www.college.police.uk/app/operations/command-and-control/command-structures.
[1946] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine at p. 36.

version of the MTA JOPS was published in 2023 and they are regularly reviewed in response to learnings from incidents and exercises.

10.19 The MTA JOPS will be invoked as part of the JESIP response to an MTA, usually precipitated by the declaration of Operation Plato by police. This is the specific counterterrorism response to an MTA which can only be instigated by them. It results in an immediate request for mutual aid from armed officers from other forces and mobilises national specialist assets.

10.20 In addition, Counter Terrorism Policing in the UK released guidance to the public that sets out three key steps for keeping safe in the event of an MTA. The advice is to "Run, Hide, Tell". A media campaign was launched in 2017 promoting this guidance and featured a wide range of UK-based celebrities, as referred to in Part 5, with the aim of educating and protecting members of the public when faced with threats in these scenarios. This is not dissimilar to the "Escape. Hide. Tell." safety procedure promoted by the NSWPF, and more broadly by state and national agencies across the country.

B. The "Hot Zone issue"

Relevance of the issue

10.22 The nature and efficacy of emergency services interoperability in NSW, including communications, was explored in relation to the "Hot Zone issue".

10.23 In particular, the Hot Zone issue gave rise to a closer analysis of multi-agency working between emergency services in NSW, in contrast to the approach which has operated in the UK since around 2013 – namely, through JESIP.

10.24 In very short form, at around 4:28pm, AC Armitage of NSWA directed that WBJ would be declared a Hot Zone in circumstances where there were concerns of a potential second offender. However, a minute prior at 4:27pm, CI Reimer of the NSWPF had broadcast over police radio confirmation of only one offender based on his review of CCTV footage in the WBJ CCTV Control Room. Thus, critical information was not conveyed by NSWPF to NSWA. The consequence being that NSWA proceeded on an erroneous basis to evacuate all paramedics from WBJ. The Hot Zone declaration was not downgraded and paramedics (other than those with the PORS team clearing WBJ) never re-entered the Centre.

10.25 At the outset, it should be appreciated that fortunately, there was no impact on the outcome for any patients. Notwithstanding this, the Hot Zone issue presents a critical opportunity to analyse how and why the declaration was made, and what course may be open to improve interagency working going forward.

10.26 A detailed overview of the relevant evidence on this issue follows below, including an amalgamation of the key events concerning both NSWA and NSWPF (noting that there is necessarily some duplication with the chronology of this issue as set out in Parts 8 and 9).

Chronology regarding the NSWA declaration of WBJ as a Hot Zone

10.27 Around 3:55pm, a broadcast was made on the NSWPF PORS radio channel, a separate radio channel on which only the NSWPF PORS team was operating. The broadcast included information that there was an offender "*outstanding*" with a "*black shirt, yellow striping*,"[1947] with the report appearing to have arisen from a photograph shown to NSWPF PORS Tactical Commanders by an unknown police officer.

10.28 At 3:58pm, a NSWPF officer (CLM 797) broadcast on police radio that he had been shown a photograph of someone with a knife, with a description different to that of the known offender.

[1947] Exhibit 1, Vol 10, Tab 585B, PORS Radio Transmission Transcript at p. 1.

10.29 At 4:00:28pm, NSWPF officer S/Cst Fricki, at that time *in situ* with Mr Cauchi on Level 5 of WBJ, whilst listening to his police radio, stated out loud "*possible second offender*."[1948] NSWA Paramedic Marshall was also on Level 5 of WBJ at this time.

10.30 At 4:01pm, CI Whalley (NSWPF), having arrived on Level 5 of WBJ, broadcast that he was in command of the scene.

10.31 At 4:01:46pm, Insp Simpson broadcast (NSWA) the following regarding a possible second offender:

> *Intelligence reporting at this stage, states that there is a second armed offender at the scene. All crews in place with patients are to remain in situ and not move until I get the all clear once I've spoken to Police. That's all crews to remain in situ with their patients and are not to move until I advise.*[1949]

10.32 At 4:01:55pm, Paramedic Max Marshall broadcast the following:

> *I have one male with gunshots to the head and the neck on Level 5, outside of Priceline. He is the offender, we believe, he has been shot. He is Code 4 [deceased]. We're getting reports of a second offender now that they're currently working on, on Level 5.*[1950]

10.33 At 4:02:38pm, NSWA broadcast a message for all cars responding to WBJ to hold their positions and to not enter WBJ.

10.34 At 4:06:16pm, Ambulance Officer 1 broadcast the following update:

> *Police information saying that there's two persons of interest that have firearms. We don't know where they are, or whether they're a threat to us. We have Police with us, we're just trying to confirm so that we can go out into the street and trying to establish whether there is a second [POI] or not.*[1951]

10.35 At 4:07pm, CI Whalley spoke with CI Reimer (Police Transport Command) and A/Insp Evans (Kings Cross Station) as to next steps, including the need to review CCTV to confirm the number of offenders involved. This was deemed to be an urgent task by CI Whalley. Around this time, Sgt 2 had also attended the WBJ CCTV Control Room, however he left a short time later, with no information to provide regarding the number of offenders.

10.36 Between 4:08pm and 4:19pm, there were multiple reports made concerning the possibility of a second offender. These reports were variably shared via the main NSWPF radio channel, the NSWPF PORS radio channel, or via updates on the NSWPF TIMS system.

[1948] Body Worn Video of Constable Robert Fricki at 16:00:28 (Sensitive not served).
[1949] Exhibit 1, Vol 11, Tab 601B, Supplementary Statement of Insp Brett Simpson at [36], Annexure I; Exhibit 1, Electronic Material, Item 6A, File K; Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 18 at pp.10-11.
[1950] Exhibit 1, Vol 11, Tab 647, Statement of Max Marshall at [11]; Exhibit 1, Electronic Material Item 6A, File L; Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 19 at p. 11.
[1951] Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 25 at p. 13.

10.37 At 4:13pm, AC Armitage alerted NSWA radio on the MIC that he was responding to WBJ, having been deployed to the scene as Ambulance Commander.

10.38 At 4:18:08pm, Insp Simpson broadcast the following (emphasis added):

> *I am still Forward Commander. I am inside Westfield on [L]evel four, close to the Oxford Street entrance. I am currently with police officers just trying to establish if we have any further casualties. I believe the last casualties should be coming out to the staging point now. I will confirm with you shortly.*[1952]

10.39 At 4:20pm, PORS8 broadcast on the NSWPF PORS radio channel that there was "*still confusion*" regarding a second POI, but PORS were continuing searches.[1953]

10.40 At 4:22pm, CI Reimer attended the CCTV Control Room on Level P4, Zone B of WBJ to review the CCTV.

10.41 Between 4:22pm and 4:24pm, AC Armitage arrived at WBJ.

10.42 At approximately 4:26pm, AC Armitage assumed control of the scene as Ambulance Commander.

10.43 At 4:27pm, AC Armitage spoke with a male police officer (believed to be Sgt 2) outside the Apple Store on Oxford Street regarding the possibility of a second offender located around the area of the cinemas on Level 6 of WBJ. AC Armitage gave evidence that this officer informed him that the scene was still considered "hot".

10.44 At 4.27pm, CI Reimer broadcast the following on NSWPF radio, from the WBJ CCTV Control Room (emphasis added):

> *JUST FOR EB10 THERE APPEARS TO BE THE ONE OFFENDER SO CONFIRMING THERE IS JUST THE 1 OFFENDER AND 9 VICTIMS – I AM IN THE SECURITY OFFICE*.[1954]

10.45 At 4:28:42pm, a direction was made by AC Armitage that WBJ was a Hot Zone. This direction was conveyed via NSWA radio by Insp Bibby as follows (emphasis added):

> *Clearing officer. I have a direction from the police. The scene is still hot, all our crews are to exit Westfield and return to the casualty clearing station. All our crews are to exit Westfield and return to the casualty clearing station immediately as directed by Superintendent Armitage.*[1955]

10.46 At 4:30:59pm, there was a further broadcast by NSWA radio stating that the area was still "hot" and directing all cars to exit the Centre and head to the Clearing Station.

10.47 Around 4:30pm, Insp Simpson exited WBJ via Oxford Street.

[1952] Exhibit 1, Vol 11, Tab 601B, Supplementary Statement of Insp Brett Simpson at [41], Annexure K; Exhibit 1, Electronic Material, Item 6B, File E; Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 37 at p. 21.
[1953] Exhibit 1, Vol 10, Tab 585B, PORS Radio Transmission Transcript at p. 4.
[1954] Exhibit 1, Vol 9, Tab 521A, CAD Police Radio Transcript: 264181-13042024 (Informant: Rachel Auteri) at p. 18.
[1955] Exhibit 1, Vol 11, Tab 594, Statement of Andrew Bibby at [17]; Exhibit 1, Electronic Material, Item 6A (B).

10.48 At 4:31pm, CI Reimer left the CCTV Control Room of WBJ and made his way to find CI Whalley to provide an update to him.

10.49 At 4:34:36pm, Ambulance Officer 1 broadcast the following update (emphasis added):

> *... the information is that there is one POI in custody. There's a possibility of a second POI but it hasn't been confirmed. They're doing a search for that at the moment...*[1956]

10.50 At 4:36pm, CI Reimer spoke to CI Whalley after reviewing the CCTV footage. He (again) confirmed that only one offender was involved in the incident.

10.51 At around 4:50pm, CI Whalley arrived in the Westfield Suite on Level 6 of WBJ, where the new Forward Command Post was then established.

10.52 At 5:14pm, a further note was made in the NSWPF Forward Command Log recording that a review of CCTV indicated one offender was involved.

10.53 Around 5.30pm (or some point prior), Ambulance Officer 1 was present at the NSWPF Forward Command Post, together with AC Armitage.

NSWA: AC Armitage's evidence regarding the Hot Zone issue

10.54 AC Armitage was at home on the afternoon of 13 April 2024 when he was requested to attend WBJ as Ambulance Commander. Whilst preparing to depart for the scene, he began listening to the normal NSWA operating radio channel for the area covering WBJ, on a portable radio.

10.55 As to his understanding of the incident prior to attending, AC Armitage heard the radio broadcast of Insp Simpson at 4:01pm on the portable radio in his possession. From this, he was aware of the possibility of a second offender and understood (following interactions with a NSWPF Sergeant) that NSWA paramedics were located within a Hot Zone. The evidence did not establish (and nor was AC Armitage asked) why he did not direct or suggest that NSWA crews be withdrawn at this time (noting however, that AC Armitage was not technically in control of the scene until shortly after his arrival at 4:26pm).

10.56 As AC Armitage's portable radio was on the normal operating channel (rather than the MIC), he was unaware of the broadcast of Paramedic Marshall at 4:01pm and the dispatch broadcast at 4:02pm regarding a potential second offender and a request by dispatch for all NSWA vehicles cars to hold their positions, as both transmissions occurred on the MIC. AC Armitage subsequently moved to the MIC and made a broadcast around 4:13pm identifying that he was responding to WBJ.

10.57 In his statement, AC Armitage stated that the effect of those broadcasts (although not heard by him), was to "*describe a situation where there was an active threat of harm*

[1956] Exhibit 1, Vol 54, Tab 1679, Transcript of select NSWA recordings, Item 54 at pp. 31-32.

such as that the scene would be declared a "hot zone" (even if they did not use those specific words) and resulted in all paramedic crews in WBJ remaining in situ, and no new crews being allowed in."[1957]

10.58 In oral evidence, AC Armitage agreed that the knowledge by NSWPF that there was only one offender was "*critical information*" that would have been relevant to his decision around 4:28pm to declare WBJ a hot zone. Had he received this information, AC Armitage gave evidence that (emphasis added):

> *With the benefit of hindsight, the area would not have been declared hot. I probably still would have withdrawn Inspector Simpson and the paramedics because there were no patients located within Westfield Bondi Junction at the time.*[1958]

10.59 AC Armitage's evidence was that within minutes of attending the NSWPF Command Post at around 4:30pm, he spoke with the police Forward Commander, CI Whalley. Around this time, AC Armitage believed he asked about a potential second offender and was told "*there was not [a second offender], to the best of their knowledge*."[1959] This information was not passed on to other NSWA resources via radio or otherwise. AC Armitage accepted that upon him becoming aware of the information from CI Whalley, the Hot Zone declaration should have been downgraded.

10.60 AC Armitage gave evidence that he provided three separate briefings to all paramedics on scene on Oxford Street, including one after he had attended the NSWPF Forward Command Post at around 5:30pm. AC Armitage did not explicitly state that he clarified the status of the possible second offender to crews on the ground, but instead gave "*detailed briefings of what I knew at the time*".[1960]

10.61 Despite this, the prospect of an ongoing threat from a potential second offender (indeed, an active shooter) remained a possibility as understood by certain NSWA staff, as evidenced by calls at 5:48pm and 6:16:33pm, transcripts of which were tendered as evidence in this Inquest.

NSWPF: CI Whalley's evidence regarding the Hot Zone issue

10.62 As outlined above, by 4:27pm CI Reimer confirmed over police radio that there was one offender only.

10.63 CI Whalley's evidence of conversations with the NSWA personnel at the Forward Command Post (after it was established on Level 6 of WBJ around 4:50pm) can be summarised as follows:

[1957] Exhibit 1, Vol 46, Tab 1605, Statement of AC Brent Armitage at [78].
[1958] Transcript, D3 (Armitage): T45.3-8 (30 April 2025).
[1959] Transcript, D3 (Armitage): T53.19-29 (30 April 2025).
[1960] Transcript, D3 (Armitage): T55.25-27 (30 April 2025).

(a) His first interaction with a senior NSWA officer would have occurred by around 5:00pm (within approximately 10 minutes);

(b) He could recall three senior NSWA officers being present at the Forward Command Post when he was the Forward Commander, including Ambulance Officer 1;

(c) He did not recall the details of any discussions nor having engaged with AC Armitage; and

(d) He did not have, nor was he asked to have, any discussions with NSWA officers in the Command Post about a potential second offender prior to the 5:30pm interagency briefing.

10.64 CI Whalley agreed that there was a critical need for interagency communication around key pieces of information, such as the status of a potential second offender.

10.65 CI Whalley agreed that the ICEMS, a mechanism where police radio CAD messages can be sent to NSWA CAD dispatchers, provided an opportunity for information to be shared with the NSWA regarding confirmation of a single offender as early as 4:27pm. CI Whalley agreed in evidence that there was capacity for NSWPF to share with NSWA, via ICEMS, the information as to one offender only, noting *"... I'm also aware that [T]riple-0 operators across the State were inundated with information in relation to this particular incident. The amount of information incoming was vast. But certainly, yes there's an opportunity for that information to be shared. Yes."*[1961]

10.66 In oral evidence, AC McKenna (NSWPF) explained that in a major incident, ICEMS is "*really significant. It's how quickly we get that information across to those other services that they need to attend*",[1962] but:

> *... once the incident is up and running... then the communication should come from the forward commander, generally speaking. So it's not anyone getting on a radio saying something. It doesn't just go across to another organisation and then that might not be 100% correct.*[1963]

10.67 Additionally, the information would only be brought to the attention of officers in the field if broadcast over police radio, given those officers are not reading CAD for ICEMS updates.

10.68 For his part, in terms of the utility of ICEMS to convey information about the "second offender issue", AC Armitage (NSWA) stated:

> *My suggestion would be that it would be best practice that the command functions are co-located to enable the communication between the services to be seamless. Again, reinforcing the fact that there would be a common operating picture and situational*

[1961] Transcript, D2 (Whalley): T143.49:T144.6 (29 April 2025).
[1962] Transcript, D19 (P McKenna): T1724.3-6 (27 May 2025).
[1963] Transcript, D19 (P McKenna): T1724.3-20 (27 May 2025).

> *awareness of what each other were doing and that information would have been passed between the agencies.*[1964]

Evidence of Critical Care Paramedic Chris Wilkinson

10.69 Between the initial broadcasts concerning the potential second offender and the Hot Zone declaration, CCP Wilkinson explained in oral evidence that outside WBJ, around the triage area, "*there were multiple police walking through and the general vibe was … they were looking for another offender.*"[1965] In oral evidence, CCP Wilkinson stated that he spoke to an officer stationed at the entrance of WBJ and was told it was an "*active situation*."[1966] He did not recall that officer using the term "Hot Zone", but understood that "*it was basically a [H]ot [Z]one and [they] weren't allowed in until it was secure.*"[1967] He "*got the sense that it was a Hot Zone*"[1968] from the police at the front doors, and that as far as he was concerned, that position never changed; that is, the zone remained "hot" and was not de-escalated. CCP Wilkinson expressed some frustration in relation to this circumstance.

10.70 CCP Wilkinson understood that in relation to a Hot Zone, any NSWA crews inside had to be "*specifically trained and have the appropriate PPE to allow them to be there*." CCP Wilkinson also stated: "*I knew one of the … TOU paramedics was on the outside with me. Yeah, I just felt there was a - quite a long time involved in decision-making for either paramedics to go in or those to come out.*"[1969]

10.71 Of the perceived delay in accessing patients, CCP Wilkinson expressed the following view in his statement, which he subsequently reiterated in oral evidence:

> *My personal thoughts are that there was far too long in allowing Ambulance to attend to some of those dying people within the premises. There needs to be much more of an emphasis in situations like this whereby those that are severely injured need to be treated and removed before they die. This is common with most of the disasters and incidents like this that we have had in Sydney. There was too much of an emphasis on scene safety over saving the dying patients and it needs to change. Whenever an incident like this occurs, everyone reverts to 'load and go', basically chuck them on a stretcher and drive as fast as you can. …*[1970]

10.72 Further to this, CCP Wilkinson stated:

> *… Somebody with my experience of 42 years, Special Casualty Access Team, critical care paramedic. I felt inadequate being forced to stay on the outside when I thought people may be [dying] on the inside*.[1971]

[1964] Transcript, D3 (Armitage): T44.43.T45.1 (30 April 2025).
[1965] Transcript, D3 (Wilkinson): T10.18-20 (30 April 2025).
[1966] Transcript, D3 (Wilkinson): T10.47-49 (30 April 2025).
[1967] Transcript, D3 (Wilkinson): T10.22-26 (30 April 2025).
[1968] Transcript, D3 (Wilkinson): T14.10 (30 April 2025).
[1969] Transcript, D3 (Wilkinson): T11.13-20 (30 April 2025).
[1970] Exhibit 1, Vol 11, Tab 636, Statement of CCP Chris Wilkinson at [16].
[1971] Transcript, D3 (Wilkinson): T16.16-20 (30 April 2025).

10.73 The concept of a "Rescue Task Force" (as outlined in the statement of S/Sgt William Watt) was raised with CCP Wilkinson. He supported it, stating that it was exactly what he was thinking on the day, that it would allow timely access to and treatment of critically injured patients. CCP Wilkinson further characterised this Rescue Task Force as both urgently needed and very necessary.

10.74 The concept of a Rescue Task Force is discussed further below in Section H.

Expert evidence concerning Hot Zone declaration

10.75 In his report, Dr Mazur opined that the Hot Zone declaration at around 4:28pm and subsequent withdrawal of NSWA personnel from WBJ was *"... fortuitously concordant with the last remaining casualties having already been extricated*."[1972]

10.76 In his supplementary report, Dr Cowburn opined that (emphasis added):

> *The perceived second offender being taken as credible information resulted in a large area of the incident scene being declared a hot zone, which led to the evacuation of responders. This had the potential to cause further lives to be lost and harm to be caused. It was fortuitous that no further salvageable patients remained within the scene when this decision occurred. This should be considered a near miss and it is essential that this learning is incorporated into future interoperable responses to prevent future deaths.*[1973]

10.77 DC McKenna (NSWA) agreed with Dr Cowburn's characterisation of the Hot Zone declaration as a "*near miss*" and as "*something that we should learn from*". AC McKenna (NSWPF) also agreed. [1974]

10.78 For his part, whilst Mr Wilson concluded that the lockdown and declaration of a Hot Zone "*did not cause any further suffering or loss of life*", he noted that if there had been hundreds of injured patients – for example, like the bombing at Manchester Arena – the Hot Zone declaration could have become "*very problematic, and lives could have been lost and victims would have suffered*."[1975]

10.79 S/Sgt Watt also agreed that the Hot Zone declaration did not have any impact on patient outcomes.

Submissions

10.80 Counsel Assisting submitted that there are five key points to take away from the Hot Zone issue.

[1972] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [234].
[1973] Exhibit 1, Expert Volume, Tab 22A, Supplementary Expert Report of Dr Philip Cowburn at p. 38.
[1974] Transcript, D19 (P McKenna/W McKenna): T1752.16-50 (27 May 2025); Transcript, D19 (P McKenna/W McKenna): T1752.40-50 (27 May 2025).
[1975] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [9.3.4].

10.81 First, that there was undoubtedly a near miss in relation to the Hot Zone declaration; that it had the potential to cause further lives to be lost and harm caused; and that this was clearly identified and agreed by the experts and institutional witnesses, DC McKenna (NSWA) and AC McKenna (NSWPF). Further, that it was fortunate that the operational silos that prevented effective communication between NSWA and NSWPF did not impact patient outcomes.

10.82 Secondly, that it is essential that lessons are learnt from this near miss in terms of future emergency services interoperability.

10.83 Thirdly, that it may be accepted that there were creditable instances of inter-agency working on 13 April 2024. To this end, it was noted that prior to the Inquest, AC McKenna (NSWPF) and DC McKenna (NSWA) conferred regarding issues arising from the expert reports, and in particular, regarding Dr Cowburn's views on the TST and JESIP framework. Counsel Assisting submitted that both institutional witnesses were impressive and commended their willingness to ensure that lessons are learnt from the incident at WBJ. Notwithstanding this commendation, it was submitted that there was a lack of coherent, underlying doctrine and a clear framework for interoperability as between NSWA and NSWPF in the response of 13 April 2024.

10.84 Fourthly, that the policy documents of each agency examined by the Inquest do not evidence a joint model of working underpinned by the key principles of interoperability. It was emphasised that, in contrast to the NSWPF and NSWA models, JESIP does provide an overarching philosophy, structure and doctrine for a multi-agency response across all levels of command. With respect to this submission, Counsel Assisting highlighted that wording of certain NSWPF policy concerning major incidents states it intends to "*foster interoperability*" but simultaneously states it is "*designed by police for police*".

10.85 Finally, although some ambulance officers were involved in the NSWPF Debrief process in June 2024, it did not appear that there was any formal review or debrief of interagency performance. It was submitted that, had this occurred, it would have likely uncovered the Hot Zone issue. Further, that a key component of the JESIP Joint Doctrine is "Joint Organisational Learning", which includes a "joint hot debrief" as soon as practicable after an incident.

10.86 Noting these five key points, Counsel Assisting submitted that the application of JESIP, or JESIP-like principles, could have ameliorated the "near miss" and the Hot Zone issue. It was accordingly submitted that it is timely and critical that the NSW Government draw upon these learnings, as reflected in the JESIP framework, to avoid potential failings which might ultimately result in a loss of life in future incidents.

10.87 In their submissions, Counsel for the Tahir family acknowledged the operational silos, identified by Counsel Assisting, which prevented the transmission of important information and the "near miss" in relation to the Hot Zone issue. In doing so, they recognised the views of AC McKenna (NSWPF) and DC McKenna (NSWA) on adopting a

common language, expressing some concern over what they characterised as a "hesitation" by NSWPF to adopt a common language espoused in METHANE.

10.88 In response to this, Counsel for the Commissioner of the NSWPF sought to clarify that the perceived hesitation expressed by AC McKenna (NSWPF) was made in relation to a previous proposal supporting the JESIP principles. Further, that the reason for that previous proposal not being adopted was that NSWPF already operated in accordance with principles very similar to JESIP. It was submitted, however, that this does not reflect any reluctance to adopt a common language such as METHANE.

10.89 Counsel for the Commissioner of the NSWPF iterated that, in any event, AC McKenna (NSWPF) confirmed that NSWPF would take into consideration any recommendation in relation to the JESIP principles, including the adoption of METHANE.

10.90 Whilst agreeing that the Hot Zone issue represents a learning opportunity for both the NSWPF and NSWA, it was submitted on behalf of the NSWPF that the evidence does not support a conclusion, which they say has been suggested by Counsel Assisting, that it was pure luck that the Hot Zone declaration had no impact on patient care. Rather, they submit that the Hot Zone declaration was made by AC Armitage in circumstances where he knew that there were no patients requiring treatment of paramedics still attending to patients. Moreover, the NSWPF point to evidence from AC Armitage and CI Whalley to the effect that they would have taken different steps if the circumstances were different.

10.91 Counsel for the Commissioner of the NSWPF submitted that Counsel Assisting appeared to invite a conclusion that it was mere luck that the Hot Zone declaration did not impact outcomes, and that this result could not have been predicated at the time the declaration was made. They submitted that neither conclusion is available on the evidence.

10.92 As noted above in Part 9, this point of contention was further addressed in oral submissions:

(a) Counsel Assisting reiterated their position and invited the Court to reject the analysis on behalf of the Commissioner, NSWPF. Counsel Assisting stated that the critical fact is that the scene at WBJ was violent and fast-moving. Further, that at the point of the Hot Zone declaration, large portions of the Centre were yet to be swept by police. Accordingly, it could not have been reliably known whether all patients had been extricated at the time of the declaration at 4:28pm. Counsel Assisting, therefore, asserted that the fundamental point remains the same, that the Hot Zone declaration was a near miss form which learnings must be taken. In furtherance of that, Counsel Assisting also reiterated the relevance of this issue to highlight the necessity for recommendations proposed concerning close review of emergency services interoperability in NSW.

(b) Counsel for the Commissioner of the NSWPF also re-emphasised their written position, that the suggestion that it was "fortunate" that the declaration had no

impact on patient care ought not to be accepted on the basis that AC Armitage made an informed decision. It was also submitted that police were sweeping the Centre to identify any potential yet undetected victims. Lastly, Counsel for the Commissioner submitted that this evidence made clear that patient welfare was of the utmost importance to both AC Armitage and CI Whalley.

10.93 It is noted that the Commissioner for the NSWPF accepted, in oral submissions, that the Hot Zone issue represents a learning opportunity for both agencies. The issue of the zoning terminology is considered in Section G of Part 9.

10.94 Relatedly, the Tahir family stated that they support all steps to enable the NSWPF and NSWA to work better in emergency situations. The Darchia family concurred with the submissions made by Counsel for the Tahir family.

Findings

10.95 Extensive evidence was received in relation to the Hot Zone issue. The issue itself is multifaceted and gives rise to a number of findings.

10.96 I accept the submission of Counsel Assisting that both DC McKenna (NSWA) and AC McKenna (NSWPF) were impressive witnesses and equally commend their willingness to consider this an opportunity for learning.

10.97 First, I find that the Hot Zone issue is appropriately characterised as a "near miss". As set out in the Part 9, the Hot Zone declaration did not have any adverse impact on patient outcomes, and AC Armitage's decision to make the declaration was reasonable in the circumstances. Notwithstanding this, it was fortunate that no victims requiring extrication remained within WBJ at the time the declaration was made.

10.98 Whilst evidence was received that steps would have been taken to attend to any patients if they were found within WBJ following the declaration, this would have been an even more difficult and dangerous situation. Hypothetical aside, the prevailing point is that the potential to be exposed to this scenario could have been avoided if critical information concerning the number of offenders, which was held by the NSWPF, had been shared with NSWA.

10.99 I accept the submissions of Counsel for the Commissioner of NSWPF that patient welfare was of the utmost importance to CI Whalley and AC Armitage. AC Armitage made a measured decision based on the information that he had available to him. The Hot Zone declaration was nonetheless a "near miss".

10.100 Secondly, I find that the fact that the NSWPF held critical information confirming that there was one offender only one minute prior to AC Armitage making the declaration to be demonstrative of the importance of inter-agency communication and the need for a framework which promotes and directs interoperability.

10.101 Thirdly, I find that there were instances of interagency working on 13 April 2024. However, I accept the submissions of Counsel Assisting and find that the incident at WBJ made clear that there is a lack of coherent underlying doctrine and a clear framework for interoperability as between NSWA and the NSWPF. Further, I find that a joint model of working, and the application of JESIP or JESIP-like principles, could have mitigated this Hot Zone issue.

C. Multi-agency working in NSW

NSWA: AMPLAN and the AAO Work Instruction

10.102 As set out in Part 9, the NSW AMPLAN is the document that guides the NSWA approach to the management of major incidents or emergencies.

10.103 In addition, the AAO Work Instruction outlines the policy framework for NSWA's response to an AAO. Compliance with this policy is mandatory.

NSWPF: ICCS Plus

10.104 As canvassed in Part 8, the NSWPF have adopted the ANZPAA ICCS Plus regarding the police approach to incident management.

10.105 Of note, the ANZPAA ICCS Plus expressly states that it was "*designed by police for police*" and is "*intended to foster interoperability between jurisdictions and facilitate inter-agency cooperation when responding to different types of incidents, regardless of size, scale or complexity*".[1976]

10.106 The NSWPF has adopted and incorporated the ANZPAA ICCS Plus into its own policy document entitled "Incident Command and Control Plus" (**NSWPF ICCS Plus**).

10.107 AC McKenna (NSWPF) gave oral evidence that CI Whalley was operating pursuant to ANZPAA ICCS Plus. As to the nomination of a "liaison officer" to communicate between agencies, AC McKenna stated there was flexibility in the ICCS Plus guidelines, and suggested that "*when you're in the same location you normally wouldn't have a liaison officer*".[1977] AC McKenna could not confirm whether a communications liaison officer was appointed at WBJ on 13 April 2024 and stated that "*nothing I've read tells me that occurred*".[1978]

10.108 As set out above, NSWA and NSWPF commanders were not ultimately co-located until sometime after 5pm (and certainly after the first agency briefing at 5:30pm). Whilst AC Armitage gave evidence that he was on scene at the first command post at around 4:50pm, he also gave evidence that he did not have a substantive interaction with the NSWPF commander at this time.

Multi-Agency Exercising

10.109 The Court received evidence concerning the multi-agency training that currently takes place between NSWA, NSWPF and other key stakeholders such as Scentre.

[1976] Exhibit 1, Vol 45, Tab 1602B, Statement of AC Peter McKenna APM at p. 45.
[1977] Transcript, D19 (P McKenna): T1748.24-34 (27 May 2025).
[1978] Transcript, D19 (P McKenna): T1748.36-37.1-27 (27 May 2025).

10.110 This evidence detailed the following relevant multi-agency exercising or collaboration:

(a) Crowded Places / Protective Security Forum;

(b) Joint Exercises with Scentre Group; and

(c) Emergency Services Multi-Agency Exercises.

10.111 In his written statement, AC McKenna (NSWPF) gave evidence concerning 26 multi-agency exercises that have been conducted during the period 2020 to 2025, 16 of which involved an AAO scenario and a further five involved mass casualties. In oral evidence, AC McKenna acknowledged that there have been significantly less interagency field exercises than discussion exercises in recent times. He explained that this was due to resourcing and costs but agreed that the exercises are very important.

10.112 In a supplementary statement, DC McKenna (NSWA) stated that:

> *NSWA is committed to strengthening its involvement in multi-agency training and working with the NSWPF, other emergency services, and key stakeholders (such as Scentre) to develop plans for future joint exercises.*[1979]

10.113 DC McKenna (NSWA) also explained that whilst some aspects of interagency training were rolled back due to the COVID-19 pandemic, NSWA and NSWPF have recommenced several joint exercises and avenues of communication, with a view to continuing to build interagency operability.

10.114 In conclave and in the context of the utility of an interoperability model across all agencies, DC McKenna (NSWA) stated:

> *The principles of JESIP, where it is a multiagency and multiagency training on these principles I think is paramount across New South Wales*.[1980]

10.115 DC McKenna (NSWA) and AC McKenna (NSWPF) both agreed that there was a need for more multiagency training. To that end, AC McKenna (NSWPF) stated that they need to bring in other emergency services as frequently as possible.

10.116 In his expert report, Mr Wilson underscored the importance of multi-agency training as follows:

> *To improve effectiveness and efficiency efforts should be made to enhance local multiagency testing and exercise program for the emergency services and partners. Regular multiagency exercising goes a long way in improving planning and preparation if combined with a multi-agency training package.*[1981]

10.117 The inter-agency working that has and does already take place in NSW highlights that the agencies are alert to the fact that interoperability is critical. Coupled with the evidence

[1979] Exhibit 1, Vol 47, Tab 1607A, Supplementary Statement of DC Wayne McKenna at [42].
[1980] Transcript, D19 (P McKenna/W McKenna): T1758.32-42 (27 May 2025).
[1981] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [12.14].

concerning issues of inter-agency communication and inter-agency working between the NSWPF and NSWA on 13 April 2024, it is clear that there is a need for a framework for interoperability, like JESIP.

D. Joint Emergency Services Interoperability Programme: JESIP

10.118 The Inquest received extensive written and oral evidence concerning the importance of joint agency interoperability. This evidence provided a comprehensive explanation of the principles and framework underpinning the programme, the practical application of those principles and framework, and the potential utility of JESIP in NSW. This Section provides a summary of what JESIP is and how it operates.

Interoperability

10.119 As outlined above, interoperability is defined as the extent to which organisations can work together coherently as a matter of routine.

10.120 In major incidents, joint agency interoperability refers to the ability of emergency services and other responder agencies to collaborate to enhance the multi-agency command, control and coordination of response to major incidents.

10.121 Since 2013, and subsequently to the inquiry into the London 7th July bombings and the Sheppey Bridge Disaster in 2013, agencies in the UK have been engaged in a process of collaboration, which ultimately led to the development of JESIP and relatedly, the JESIP Joint Doctrine: The Interoperability Framework (the **Joint Doctrine**).

10.122 The purpose of the Joint Doctrine is to provide responding agencies in the UK with generic guidance and principles for the actions to be taken when responding to a multi-agency incident of *any* scale. Following the Joint Doctrine should lead to the degree of interoperability that is essential to a successful joint response.

10.123 The Joint Doctrine stipulates five key principles, as illustrated in **Figure 37** below:[1982]

[1982] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine: The Interoperability Framework, Version 3.1 (April 2024) at p.12.

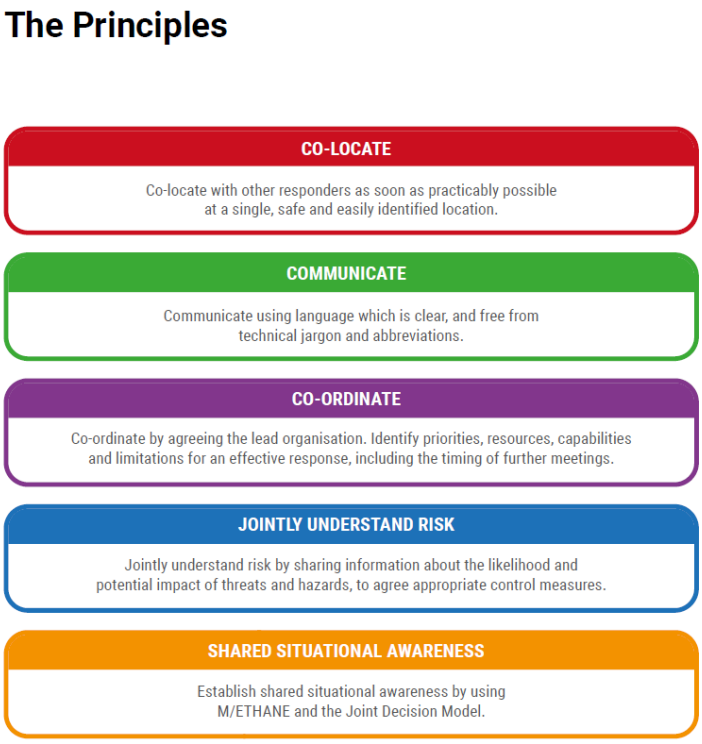

Figure 37: JESIP Doctrine Principles

Expert evidence on the JESIP model

10.124 Security expert, Scott Wilson, gave evidence to the effect that the principles for joint working should be used during all phases of an incident, regardless of scale. He explained that they support the development of a multi-agency response and provide structure during the response to all incidents. The principles set out above are presented in an indicative sequence only: they can be applied in a different order if necessary.

10.125 Dr Cowburn provided a detailed supplementary expert report which focused on an overview of the JESIP model and principles, and its potential utility to the incident at WBJ on 13 April 2024.

10.126 In oral evidence, Dr Cowburn stated the following (emphasis added):

> *I think that co-location at the operational scene is the key aspect... if that is delayed or not instigated or not maintained, that is when the, the truly, the truly effective, collaborative response will fall down. Once that is instituted, that forces people to communicate and leads to coordination, and it then is around the shared situational awareness that I think is the next most important of those principles.*
>
> *The risk, sharing the information around the risk and coming to an understanding of what that risk is in the mitigation is all part of that situational awareness. And then the decision making about what we are going – what should be done to maximise the saving*

> *of lives and the reducing of harm…that is where the real benefit comes in, but from an, an at-scene approach, it is the co-location that is key.*[1983]

10.127 Accepting that co-location requires commanders to agree upon and share a location, Dr Cowburn explained that in the early stages, the co-location can happen in an informal way as between commanders, in an "over the bonnet" huddle (that is, over a car bonnet). Importantly, the "bonnet huddle" can be instituted within a few moments.

10.128 Mr Wilson also gave evidence that (emphasis added):

> *… in a major incident it is of paramount importance that all of the senior personnel know exactly what role they are undertaking and this should be shared with all other ambulance staff and other multi-agency partners. There should be a clear and identifiable commander or representative who is responsible for co-ordinating the activity of their organisation at each level of command*.[1984]

10.129 The evidence made clear that this dovetails into the recognised principles of the GSB (Gold/Silver/Bronze) structure as applied in the UK across agencies, and as outlined above.

10.130 In the context of JESIP, the GSB generic response structure is used to frame the levels of command within an agency when responding to an incident. It emphasises, in accordance with the JESIP principles more broadly, the need for "*… a clear and identifiable commander or representative who is responsible for coordinating the activity of their organisation at each level of command*."[1985]

10.131 JESIP outlines a generic response structure including the basic responsibilities at each tier, as illustrated in **Figure 38** below:[1986]

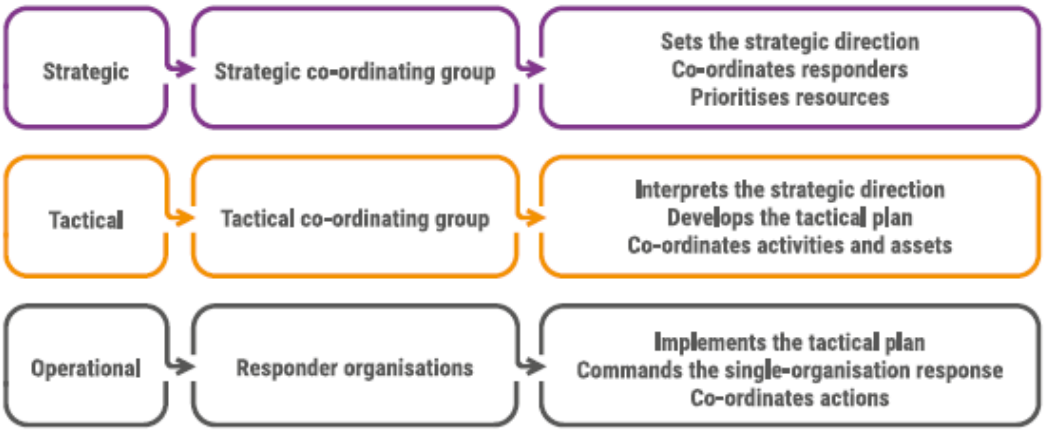

Figure 38: JESIP generic response structure

10.132 In addition to the above principles, the Joint Doctrine recognises that in the early stages of a response to a multi-agency incident, gathering information in a consistent manner

[1983] Transcript, D17 (Cowburn): T1547.43.T1548.8 (23 May 2025).
[1984] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [8.6.4].
[1985] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine: The Interoperability Framework, Version 3.1 (April 2024) at p. 36.
[1986] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine: The Interoperability Framework, Version 3.1 (April 2024) at p. 36.

assists agencies with the efficient establishment of operational structures and resources. For this reason, the METHANE model is used to provide "*structure and clarity to the initial stages of managing any multi-agency or major incident*."[1987]

10.133 A pictorial representation of the METHANE model is shown in **Figure 39** below: [1988]

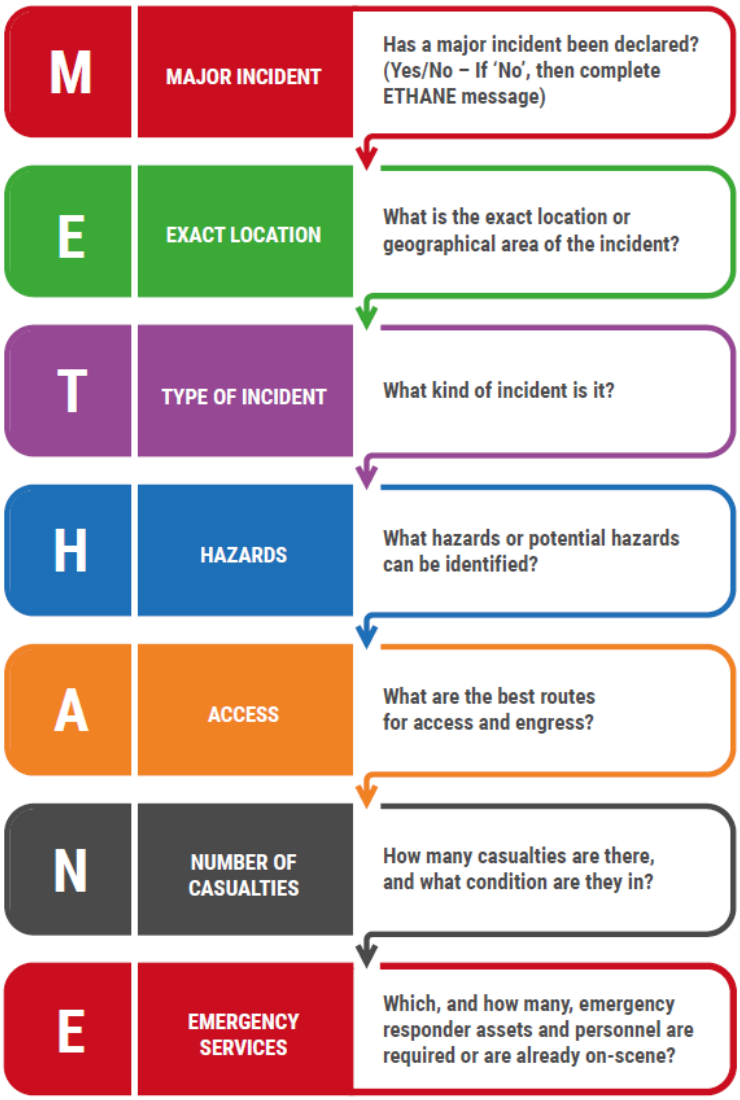

Figure 39: METHANE model

10.134 Dr Evens (giving evidence in conclave) explained that JESIP is something that has evolved over more than a decade. In his supplementary report, Dr Cowburn also noted that commissioned reviews of JESIP in the UK recognised the importance of JESIP and appreciated the focus on interoperable working. However, certain of those reviews have also identified ongoing lessons necessary for the effective application of the doctrine.

[1987] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine: The Interoperability Framework, Version 3.1 (April 2024) at p. 18.
[1988] Exhibit 1, Expert Volume, Tab 23, JESIP Joint Doctrine: The Interoperability Framework, Version 3.1 (April 2024) at p. 21.

10.135 A detailed review of the application of JESIP in the context of major incident response was undertaken as part of the *Manchester Arena Inquiry* into the 2017 terrorist attack. The report into the emergency response highlighted several failings in the multiagency response. These failings resulted in delayed deployment of emergency service responders in sufficient numbers into the City Room where the majority of critically injured patients remained following that attack. Dr Cowburn noted that the report "*... highlights the failings of JESIP during that incident*".[1989] He explained that the Chair of the Inquiry considered first, whether JESIP was ineffective due to an intrinsic failure in its concept, or, secondly, whether there was a failure to apply JESIP effectively, and had this not happened, the failings would not have arisen.

10.136 In oral evidence, Dr Cowburn explained that (emphasis added):

> *It was the failure to apply the five key principles that was the major issue. And for me, the co-location is the first step, it is the pivotal step. If the commanders do not co-locate – and when at scene that means being face-to-face – then the rest will fall down.*[1990]

10.137 Noting this, the evidence and submissions received were to the effect that the JESIP doctrine has withstood the scrutiny of a number of public inquiries, with the result that the underlying ethos of the doctrine is sound: the issue is with application and not the principles themselves.

The Pollock Report (UK) - 2013

10.138 In that context, an important review and report prepared in October 2013 by Dr Kevin Pollock, titled *Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986*, (the **Pollock Report**). This report looked at 32 major incidents within the UK (including for example, the Lockerbie Bombing in 1988; the Hillsborough Stadium Disaster in 1989; Harold Shipman and the "three inquiries" in 2000; and the London terrorist attacks in 2005), as well as the reports relevant to interoperability arising out of the same. The mandate of the report was to "*identify persistent issues that affect emergency responder interoperability*" as reported in a selection of inquiries, reviews, and other pertinent materials. It was noted that "*[t]he identification and analysis of these themes establishes a historical and contextual evidence base, to assist the Joint Emergency Services Interoperability Programme (JESIP).*"[1991]

10.139 In summary, the Pollock Report found that common causes of failures identified within the reports and relevant to interoperability included:

(a) Poor working practices and organisational planning;

[1989] Exhibit 1, Expert Volume, Tab 22A, Supplementary Statement of Dr Philip Cowburn at p. 14.
[1990] Transcript, D17 (Cowburn): T1546.45-48 (23 May 2025).
[1991] Exhibit 1, Expert Volume, Tab 22A, Supplementary Statement of Dr Philip Cowburn at Ref 2, Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986, Pollock, K, Emergency Planning College Occasional Papers Number 6, October 2013, p. 4, available at: JESIP.org.uk/uploads/media/pdf/Pollock_Review_Oct_2013.pdf.

(b) Inadequate training;

(c) Ineffective communication;

(d) No system to ensure that lessons were learned and staff taught;

(e) Lack of leadership;

(f) Absence of no blame culture;

(g) Failure to learn lessons;

(h) No monitoring/audit mechanism; and

(i) Previous lessons/reports not acted upon.

10.140 The Pollock Report identified that each of the reports reviewed included elements of clear relevance to JESIP. The major strategic issues identified were:

(a) *Doctrine* – provision of clear and easily understood guidance that ensures everyone is aware of their own and others roles and responsibilities;

(b) *Operational Communications* – the need for a common system used by all stakeholders with the capacity to deal with surges of activity associated with major incidents;

(c) *Situational Awareness* – the ability to quickly access and share information between stakeholders; and

(d) *Training & Exercising* – the need for continuous development of stakeholders to ensure sufficient capacity to cope with a prolonged event.

(e) Relevantly, and noting that the implementation of various JESIP work streams takes time, the Pollock Report found that the "*relevance of the current JESIP framework is supported by the findings [of the review].*"[1992]

10.141 Moreover, the Pollock Report sounded this note of caution (emphasis added):

> *The consistency with which the same or similar issues have been raised by each of the inquiries is a cause for concern. It suggests that lessons identified from the events are not being learned, to the extent that there is sufficient change in both policy and practice, to prevent their repetition.*[1993]

[1992] Exhibit 1, Expert Volume, Tab 22A, Supplementary Statement of Dr Philip Cowburn at Ref 2, Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986, Pollock, K, Emergency Planning College Occasional Papes Number 6, October 2013, p. 6, available at: JESIP.org.uk/uploads/media/pdf/Pollock_Review_Oct_2013.pdf.
[1993] Exhibit 1, Expert Volume, Tab 22A, Supplementary Statement of Dr Philip Cowburn at Ref 2, Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986, Pollock, K, Emergency Planning College Occasional Papes Number 6, October 2013, p. 7, available at: JESIP.org.uk/uploads/media/pdf/Pollock_Review_Oct_2013.pdf.

10.142 In oral evidence, Dr Cowburn offered the view that the Pollock Report contains a "*very powerful message*", and that JESIP is the beneficiary of the report as it led to the refinement and evolution of the JESIP Doctrine.

10.143 Whilst an equivalent review to the Pollock Report has not been conducted in Australia, in conclave, Dr Evens, Dr Mazur and Dr Cowburn agreed that:

> *There is no reason not to benefit from all of the learning that already exists for us in New South Wales as we consider what we do now.*[1994]

10.144 The evidence set out above demonstrates that JESIP is a well-established framework. It is unfortunate that the UK has experienced several major incidents requiring its application. However, as a result of these experiences, JESIP has evolved into a well-considered program and framework for interoperability. It would be remiss not to draw upon the lessons that have come from their experiences when considering the application of the framework – or a similar one – in NSW.

[1994] Transcript, D17 (Cowburn/Evens/Mazur): T1546.15-30 (23 May 2025).

E. Consideration of "JESIP" approach in NSW

Instances of multi-agency working and interoperability on 13 April 2024

10.145 The evidence disclosed several instances of multi-agency working and interoperability between NSWA and NSWPF at WBJ on 13 April 2024. This included the following:

(a) There were a number of instances of NSWPF officers assisting NSWA paramedics in the rapid extrication of patients, including police vehicles providing escorts;

(b) Information was exchanged at various points as between NSWPF and NSWA via the ICEMS system of joint dissemination (although not critical information as to confirmation of a single offender);

(c) Inside WBJ on Level 4 when Insp Simpson could not hear anything (given the volume of the alarm), he paired up with a NSWPF Sergeant for some 10 to 15 minutes to move through WBJ; Insp Simpson described this police officer as his "*conduit to obtain reliable information*";

(d) Insp Simpson sent Ambulance Officer 1 to the NSWPF Command Post to provide a form of liaison with police;

(e) Shortly after arrival on scene, AC Armitage requested that he be taken to the NSWPF Command Post; AC Armitage used NSWA radio to identify the location of the Forward Command Post and was ultimately escorted to that location by NSWPF officers sometime after 4:44pm. In oral evidence, AC Armitage explained that he sought to co-locate because it was a "*vital part of any operation*" for senior commanders to obtain a "*common operating picture and shared situation awareness of each other's priorities and what they're doing*";[1995] and

(f) At 5.30pm, there was a multi-agency briefing conducted on Level 6 of WBJ including at least NSWPF, NSWA and Scentre (as well as the AFP, amongst other agencies).

10.146 Notwithstanding the above, it appears that there was no specific framework, joint agency document or doctrine informing or guiding the above actions, or the timing of them.

10.147 As to the timing of the multi-agency briefing, CI Whalley explained that the timing was influenced by a range of factors, including his own arrival at WBJ at 4:00pm, the scope and magnitude of the scene, and the delay arising from moving the Forward Command Post. Additionally, CI Whalley stated that the briefing occurring at 5:30pm did not

[1995] Transcript, D3 (Armitage): T42.1-6 (30 April 2025).

"*suggest that there was… a delay in actions being undertaken"* and that there were *"a number of command level actions which have been undertaken in that period."*[1996]

10.148 AC McKenna (NSWPF) also disagreed with any criticism of the timing of the first agency briefing, noting it was a "*reactionary job*", with chaotic scenes and that CI Whalley had taken over command and control from the most senior officer.

10.149 Further, as noted above, the Court received evidence to the effect that there was a "near miss" given the "siloing" of information.

10.150 Findings regarding certain aspects of the response of NSWA and NSWPF to the events of 13 April 2024 have been considered in Parts 8 and 9 of these findings.

10.151 In considering the evidence regarding the response on 13 April 2024, and the information received concerning the operation of the JESIP model in the UK, the Inquest also considered how the JESIP model might have impacted interagency working on 13 April 2024. This aspect is considered immediately below.

Interagency briefing and co-location of a Forward Command Post

10.152 The Court received evidence concerning the way in which JESIP emphasises the importance of coordination of agencies by way of co-location of agency commanders as soon as possible.

10.153 In this regard, Mr Wilson stated:

> *The application of simple principles for joint working are particularly important in the early stages of an incident, when clear, robust decisions and actions need to be taken with minimum delay, often in a rapidly changing environment.* [1997]

10.154 As noted above, whilst there was a multi-agency briefing, the first one being at 5:30pm, Mr Wilson was critical of the delayed timing, stating:

> *This [was] almost 2 hours after the commencement of the incident and 1 hour and 52 minutes since Joel Cauchi was shot. This is far too slow for the first joint command meeting and should have taken place much quicker as senior personnel from Police, Ambulance and Scentre were all on scene within 30 minutes of the start of the incident.* [1998]

10.155 In Mr Wilson's view:

> *… This meeting should have commenced shortly after 16.00hrs when tactical representatives from NSWPF, Ambulance and Scentre were all present within the centre. This would have allowed shared situational awareness and a joint understanding of risk by sharing information about the likelihood and potential impact*

[1996] Transcript, D2 (Whalley): T139.26-29 (29 April 2025).
[1997] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [8.6.4].
[1998] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [10.1.6].

> *of any further threats and they could then quickly agree appropriate control measures.*[1999]

10.156 In a short supplementary report, Mr Wilson confirmed his view as follows:

> *There was limited co-location, coordination or communication between police and ambulance forward commanders until after 17.00hrs. They should have immediately come together at a Forward Command Post identified each other and sought out senior Scentre staff and provided clear and appropriate direction to staff. Having visited Bondi Junction there was a number of safe locations which could have been used as a Forward Command Post where emergency service commanders should have worked together.* [2000]

10.157 For his part, Dr Mazur stated (emphasis added):

> *In all interagency response incidents, the respective agency Forward Commanders (or service equivalent) need to meet early, identify concerns and requirements, establish the location of an incident command post and establish communication channels. This would have helped limit some of the interagency communication issues identified in this incident <u>when often it appeared information or misinformation was being shared across services within the scene rather than coming down from Incident Commanders of the respective agencies to their personnel</u>.*[2001]

10.158 In conclave, Dr Evens, Dr Cowburn and Dr Mazur were asked (in the context of the Hot Zone issue) about the significance of the lack of a shared incident command post in the initial stages of the incident. Dr Evens, with Dr Cowburn and Dr Mazur agreeing, stated that:

> *As a consequence, there was no shared mental model between Police and Ambulance Commanders and therefore there was no joint understanding of the risk or shared situational awareness. Consequently, information was not pushed between services as it became available to one service.*[2002]

10.159 Dr Cowburn described co-location as key and integral to effective interoperable working, without which the subsequent aspects of JESIP tend to fail. In this respect, Dr Cowburn gave the following evidence as to the timing of the first interagency briefing (emphasis added):

> *If the JESIP principles are truly embedded at a grassroots level, you could argue that that first JESIP huddle had started to occur already, in that Inspector Simpson had already met with the police and made a decision. <u>What, subsequently was that everybody was involved in delivering care further forward, and what was needed was a JESIP huddle on the periphery of this as more senior Commanders arrived.</u>*
>
> *Now that may mean that they hand over command or somebody steps back to maintain a command position while others go forward, and it is only through training and*

[1999] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [10.3.3].
[2000] Exhibit 1, Expert Volume, Tab 21A, Supplementary Report of Scott Wilson at p. 3, [1].
[2001] Exhibit 1, Expert Volume, Tab 18, Expert Report of Dr Stefan Mazur at [280]-[281].
[2002] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 7-8.

> *exercising that you can deliver that dynamic response, which, you know, you cannot write down as being dogmatic and this is the way you will do it. If that had occurred, you would have had this rolling ongoing sharing of information. And so that meeting, that first multiagency meeting at 17:30 would have been the culmination of a progression of smaller meetings that would have gained all of that information.*
>
> *And so, I would not wish to criticise that that tactical meeting occurring at 17:30, that was a completely appropriate meeting, but that would have been almost the closure of the active phase of that incident, rather than the first get together of all those multiagency commanders.*[2003]

10.160 Acknowledging that co-location of the Forward Command Post is not without issues and must be shared and agreed between the responding services, Dr Cowburn noted that it can happen in an informal way as between the commanders by way of an "over the bonnet" huddle on first arriving. It was explained that this enables commanders to have an early discussion, share information, assess the risk to their responders and establish an early plan.

Command and control structure (GSB) under JESIP

10.161 As outlined above, under JESIP, the GSB generic response structure is used to frame the levels of command within an agency when responding to an incident.

10.162 In practice then, Mr Wilson stated:

> *...so when you turn up, you know who your counterpart is. So I turn up at Bondi Junction and I'm the police chief, I'm CI, I am looking for my ambulance and fire equivalent, and I'm going to then meet up with them. The bronzes would always mix as much because the bronzes, they'll get maybe specific role at CCTV or investigation ...or whatever. But the silvers need to be together and the golds need to be together.*[2004]

Potential utility of the JESIP framework for multi-agency working in NSW

Evidence of NSWPF and NSWA executive witnesses

10.163 In a supplementary statement, DC McKenna (NSWA) stated the following as to the potential value of the JESIP framework (emphasis added):

> *NSWA welcomes the opportunity to consider the potential utility of JESIP ideology and framework for multi-agency interoperability for managing such incidents as between NSWA and NSWPF (and other agencies, as necessary), including in relation to co-location, communication, coordination, joint understanding of risk, and shared situational awareness are the key benefits.*

[2003] Transcript, D17 (Cowburn): T1552.5-24 (23 May 2025).
[2004] Transcript, D14 (Wilson): T1216.39-47 (19 May 2025).

> *Within the framework for multi-agency interoperability, I refer to and endorse the following paragraphs in the supplementary statement of Assistant Commissioner, Director of Control Centres, Brent Armitage, dated 29 April 2025:*
>
> *(a) Paragraphs 48 to 51, including:*
>
> *(i) NSWA is open to exploring the viability of an inter-agency channel for major incidents, albeit noting there are a number of potential limitations; and*
>
> *(ii) NSWA is also open to exploring the viability of "interagency talk groups" in which all emergency service commanders can link into their radio,*
>
> *(b) Paragraphs 115 to 120 regarding the importance of co-location, including that the delay of direct communication with the NSWPF Incident Controller and a co-located Command Post on 13 April 2024 affected the flow of information and communication with NSWPF until it was established at or around 17:30. This issue gave rise to a delay in the transfer of information, including about a potential second offender.*
>
> *It was noted in my meeting with AC Peter McKenna that the aforementioned approach utilising a framework such as JESIP, or similar, had the potential to assist in the prevention of operational silos developing in the future.*[2005]

10.164 In oral evidence, AC McKenna (NSWPF) outlined that he had:

> *Actually undertaken... what they call that MAGIC [Multi-Agency Gold Incident Command] course when the instructors from the UK came to Australia, so I've experienced the training for, for JESIP myself. To be honest, great concept, not so different to what we do now, and I understand a paper has gone up from [Superintendent] Rochester to our executive about adopting JESIP and METHANE. I understand it wasn't accepted at this point in time. ...*[2006]

10.165 AC McKenna (NSWPF) did not know the specifics of the paper sent to the NSWPF executive regarding the adoption of JESIP and METHANE but knew it was in 2024.

10.166 In conclave, AC McKenna (NSWPF) and DC McKenna (NSWA) were asked their respective views on aspects of JESIP, including the utility of the METHANE methodology. DC McKenna acknowledged the potential benefit of having a common language and reporting mnemonic. AC McKenna indicated he thought the NSWPF language used to report on an incident was more simplistic, but accepted that it is meritorious on its face, and something that the NSWPF would take on consideration.

10.167 Further, AC McKenna (NSWPF) and DC McKenna (NSWA) agreed that the five essential principles that comprise the JESIP model – communicate, co-locate, coordinate, jointly

[2005] Exhibit 1, Vol 47, Tab 1607A, Supplementary Statement of Deputy Commissioner Wayne McKenna at [29]-[31].
[2006] Transcript, D19 (P McKenna): T1729.37-43 (27 May 2025).

understand risk, and shared situational awareness – are critical principles that inform the practice of multi-agency engagement.

10.168 In terms of the utility of formalising those principles in a doctrine that is understood by all agencies in NSW responding to emergency situations, DC McKenna (NSWA) stated (emphasis added):

> *I think there's value in that, yes, and being able to explore that so that there is a common language amongst everyone and that's a framework that provides that... recognising that it is something that is used in the UK and has worked quite well, I think that we would be open to exploring that and, and certainly not just within the police environment, but amongst all agencies. I think it is something that would be applicable in a number of different scenarios. So we would [be] open to exploring that further, yes.*[2007]

10.169 For his part, AC McKenna (NSWPF) essentially agreed, stating the following (emphasis added):

> *So I don't disagree at all. It is certainly something we would consider. I would just make the point that from our perspective, this is what we would do now.*[2008]
> ...
> *I think the fact of the matter is that the police have a good understanding, but we – we're not sure if all our partners have the same understanding. And if you're taking some learnings from this inquest as, as we talked to, then that would be a good thing, that we all have the same understanding. And that's something the Deputy and I have sat down and discussed about future training, so that we are talking the same language, we are talking about the same necessities for things like co-locations, et cetera, and really pushing to make sure our, our senior staff understand the importance of that.*[2009]

10.170 As to any downside from introducing a framework like JESIP for joint interagency operability, DC McKenna (NSWA) stated: "*I don't know that I can find a downside*".[2010] He acknowledged however, that there were things that "*there's obviously things that we would need to be able to work through to be able to do that. ...*"[2011] (that is, how to implement such a framework).

10.171 AC McKenna (NSWPF) did not disagree with DC McKenna (NSWA) but stated that it would require consideration by subject matter experts. He also stated that for NSWPF operations, "*I don't think we're too far from it anyway*."[2012] Ultimately, AC McKenna agreed there were no "*downsides in scrutinising it and having a look would that improve things, for sure*."[2013]

[2007] Transcript, D19 (W McKenna): T1757.5-19 (27 May 2025).
[2008] Transcript, D19 (P McKenna): T1757.21-25 (27 May 2025).
[2009] Transcript, D19 (P McKenna): T1757.41-49 (27 May 2025).
[2010] Transcript, D19 (W McKenna): T1759.21 (27 May 2025).
[2011] Transcript, D19 (W McKenna): T1759.21-25 (27 May 2025).
[2012] Transcript, D19 (P McKenna): T1760.5-12 (27 May 2025).
[2013] Transcript, D19 (W McKenna): T1760.14-17 (27 May 2025).

Expert evidence

10.172 Expert evidence was received during the Inquest as to the potential utility of aspects of JESIP for multi-agency working in NSW.

10.173 As detailed above, Mr Wilson stated that "*following JESIP [would] achieve the degree of interoperability that is essential to a successful joint response*".[2014] In terms of the JESIP framework, Mr Wilson stated (in his first report):

> *When you examine Emergency Service joint working at Westfield Bondi Junction on the 13th April 2024 unfortunately a number of these principles were not achieved. JESIP models and principles should be considered by the Australian Authorities.*[2015]

10.174 Mr Wilson's first report also included a number of recommendations, which included the following concerning JESIP:

> *The introduction of the Joint Emergency Service Interoperability Principles to the emergency services would help achieve improved multi-agency response to active shooter events and other critical incidents. It is essential that joint organizational learning is accepted as the standard for multi-agency learning and is adopted by all response agencies to ensure interoperability is continually improved.*[2016]

10.175 In his supplementary statement, Mr Wilson stated:

> *Having read the transcripts and associated plans I feel that NSW Ambulance have a greater understanding of the benefits of multi-agency working and the UK concept of JESIP than NSWPF. NSW Ambulance use METHANE which is a multi-agency briefing tool. If delivered effectively it provides shared situational awareness between all responding organisations.*[2017]

10.176 In oral evidence, Mr Wilson reiterated the importance of JESIP, and amongst other matters, the utility of the METHANE framework to convey information to all agencies quickly and clearly.

10.177 In conclave, Dr Evens, Dr Cowburn and Dr Mazur agreed as to the potential utility of the JESIP framework for multi-agency interoperability when managing incidents, such as the incident at WBJ on 13 April 2024. The experts considered the principles of colocation, communication, coordination and joint understanding of risk and shared situational awareness as the key benefits of the doctrine.

10.178 Ultimately, Dr Evens, Dr Cowburn and Dr Mazur agreed with a proposed recommendation to this effect:

> *The NSW government strongly consider investing in an emergency services interoperability model, of which JESIP is an example. Noting that some components of*

[2014] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [8.5], Appendix D.
[2015] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at p. 67.
[2016] Exhibit 1, Expert Volume, Tab 20, Expert Report of Scott Wilson at [12.13].
[2017] Exhibit 1, Expert Volume, Tab 21A, Supplementary Expert Report of Scott Wilson at [6].

> *the JESIP framework, such as a 'joint decision making model' might not be appropriate in this type of incident.*[2018]

10.179 Further, whilst the Inquest focused on applying lessons learnt arising from the incident at WBJ in NSW, Dr Mazur stated the following in terms of the principles of emergency services interoperability (emphasis added):

> *I'm just hopeful that I understand where we're talking about New South Wales emergency services, but I would be hopeful that these discussions are reaching a wider audience Australia-wide. Because just because a border occurs doesn't mean that the principles don't apply over a river or down the street because it's now South Australia or, or Victoria or Queensland. So it would be nice if this discussion here reaches a broader audience, and then maybe gets to a higher level of government or authority to help implement that perhaps not just New South Wales-wide, but maybe we should be looking at this Australia-wide.*[2019]

Submissions

10.180 Counsel Assisting submitted that the above evidence provides a compelling basis for a recommendation relating to the consideration of JESIP in connection with emergency services interoperability in NSW (at least).

10.181 To that end, Counsel Assisting offered the following submissions in relation to the utility of JESIP.

10.182 As noted above in Section C, there is a lack of coherent, underlying doctrine and clear framework for interoperability as between NSWA and NSWPF. This was apparent in the response of 13 April 2024. If there had been such a policy and model, it is very likely that the operational silos that prevented transmission of the critical information as to "one offender only" would not have occurred.

10.183 JESIP provides an overarching philosophy, structure and doctrine for a multi-agency response across all levels of command.

10.184 Without intending criticism, it is notable that no "Liaison Officer" was assigned by NSWPF for the incident. Had this occurred, that officer could have had an important role in ensuring that critical information was conveyed from NSWPF to NSWA. In this regard, AC McKenna (NSWPF) accepted that any future incidents would likely benefit from enhanced communication between NSWPF and NSWA at an earlier stage. In contrast to the current approach by the NSWPF and NSWA, the UK JESIP framework provides a structured and cohesive joint agency prism and focus which enhances interoperability.

10.185 The JESIP model is the product of many lessons learned in the UK. Further, the ethos of the JESIP Doctrine has been closely scrutinised and refined in recent times. This analysis

[2018] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at p. 12.
[2019] Transcript, D17 (Mazur): T1523.22-30 (23 May 2025).

has confirmed that the issues identified to date in relation to JESIP have been with the application of the model, not with the principles themselves.

10.186 It was agreed by both DC McKenna (NSWA) and AC McKenna (NSWPF) that there would be no downside to introducing these principles (in an appropriate form) to interagency working in NSW. It may not be the case that the entire JESIP framework should be adopted and transplanted to NSW emergency services in full. Counsel Assisting noted the evidence of Dr Cowburn, that some of the JESIP principles may have greater efficacy than others. The experts were unanimous as to the importance and value of a model like JESIP for interagency working.

10.187 A joint agency interoperability framework and philosophy provides a model in which to implement the TST (which is addressed below).

10.188 Noting these submissions, Counsel Assisting submitted that there is some urgency to reviewing and implementing an appropriate framework, drawing on the JESIP model, in NSW. A recommendation was proposed concerning the same.

10.189 It is noted that Counsel Assisting also referred to evidence from Dr Mazur, that there might even be utility to broader consideration in Australia of such a doctrine for emergency services interoperability.

10.190 In their submissions, the Tahir family expressed wholehearted support for the introduction of JESIP and METHANE. Repeating some of Counsel Assisting's submissions on the value of adopting the JESIP principles, the Tahir family also reiterated the view that the application of JESIP would encourage both organisations (that is, NSWA and NSWPF) to always work together. The Darchia family also expressed support for the submissions made by the learned legal representatives for the Tahir family.

10.191 Counsel for the Commissioner of the NSWPF also made submissions in relation to this topic. In doing so, they noted that there were several "mini meetings" or "JESIP huddles" that took place at WBJ prior to the 5:30pm Command Briefing. These included between Insp Simpson and the NSWPF Sergeant moving through the Centre with him in the initial stages of the incident; at some time between 4:44pm and 5:00pm between AC Armitage and CI Reimer; and at approximately 5pm when AC Armitage and CI Whalley met at the Command Post on Level 6 of WBJ.

10.192 Notwithstanding this, the Commissioner accepted that the importance of interagency communication in large incidents is a key learning from the incident at WBJ and that the NSWPF supports consideration of an emergency services interoperability framework.

10.193 It is noted that the Court has benefitted from an extensive list of references to evidence received at the Inquest regarding consideration of and support for the implementation of an interoperability framework that was included in the submissions made by Counsel for NSWA.

Findings

10.194 The issue of interoperability emerged as a significant issue at this Inquest. The incident at WBJ effectively tested the agencies and the way in which they operate alongside one another. Admirable efforts were made to facilitate co-operation on the day and those in attendance did an incredible job in the circumstances. However, there are still lessons to be learnt that can be used to improve the policies, systems and processes relied upon by NSWA and the NSWPF to respond to incidents.

10.195 Noting the issues with inter-agency communication and co-location of the agencies, and the evidence set out across Parts 8, 9 and 10 asserting the same, I accept the submissions of Counsel Assisting and find that there is a lack of a coherent underlying doctrine or a clear framework for interoperability as between the NSWPF and NSWA. And I find there is value in considering and implementing formalised processes in order to strengthen the co-response of these agencies as well as potentially other agencies and entities that may respond to major incidents in the future.

10.196 The Inquest greatly benefited from the receipt of extensive evidence concerning JESIP and the importance of interoperability. I find that this evidence makes clear that there is value in considering and implementing JESIP, or a JESIP-like framework for interoperable working, in NSW. Furthermore, I find that there is some urgency in considering its implementation.

10.197 JESIP has been in operation in the UK since 2013, and has, unfortunately, been utilised in a considerable number of events in that jurisdiction. Further, it has been subject to commissions that have closely considered its use and proposed improvements for its application. This means that the implementation of JESIP, or a similar framework, in NSW could be done with the benefit of that experience and knowledge.

10.198 The JESIP framework and underlying doctrine would better equip responding agencies to respond to any major incident occurring in the future that requires a multi-agency response and could provide the guidance and support needed for involved agencies to respond even more efficiently and effectively, together.

10.199 In addition, the utility of JESIP, or a framework that equally fosters interoperability, is endorsed by the emergency medicine experts. Not dissimilarly, both institutional witnesses from the NSWPF and NSWA acknowledged that there would be no downside in introducing these principles for interagency working in NSW in an appropriate form.

10.200 NSWA and the NSWPF have already demonstrated ongoing cooperation. Between 13 April 2024 and the receipt of evidence during the Inquest, the agencies have met and consulted about the lessons that can be learnt from this incident. This cooperation is commendable and will hopefully continue as this issue is further considered and implemented by them.

10.201 This degree of cooperation between agencies, and the resounding evidence in support of the proposed framework for interoperability in NSW, is an exemplar of the impact of

the Inquest process and the actionable change that can come out of such a tragic incident.

10.202 In my view, it is imperative that the agencies consider and implement JESIP, or a similar framework. In doing so, there is the potential to significantly improve their response to major incidents, which could contribute to positive patient outcomes, and may ultimately help to save lives.

Recommendations

10.203 Counsel Assisting proposed the following recommendation addressed to NSWA:

> **Recommendation 13: To the Premier's Department**
>
> That the Premier's Department (in consultation with the Commissioners of the NSW Police Force, NSW Ambulance and Fire and Rescue and other emergency services agencies as appropriate) convene an urgent working group involving relevant representatives from emergency services to consider a) development; and b) implementation; of an emergency services interoperability philosophy, model and framework for NSW (including drawing on the evidence from the Inquest and from the Joint Emergency Services Interoperability Programme framework and doctrine in the United Kingdom, as appropriate) to provide a clear structure and framework for multiagency responses to major incidents.

10.204 The Tahir family and Darchia family both expressed support for this recommendation as proposed by Counsel Assisting.

10.205 Similarly, the NSWPF expressed support for this recommendation, adding that assessment of an emergency services interoperability framework would include consideration as to appropriate training, common languages being used between agencies, and co-location of Commanders to improve communication.

10.206 NSWA also expressed support for the implementation of an emergency services interoperability model to provide a clear structure and framework for multiagency response to major incidents. This was expressed in the evidence of DC McKenna (NSWA), all NSWA witnesses during the Inquest and in written submissions. Notwithstanding their support, NSWA were of the view that the best mechanism to develop such a model, and the extent to which the JESIP doctrine is adopted, is a matter for Government.

10.207 Noting the unanimous support, and the considerable evidence received concerning the utility of a framework for interoperability as between NSWA and the NSWPF, I make the following recommendation:

RECOMMENDATION

Recommendation 18: To the NSW Government

That the NSW Government (in consultation with the Commissioners of the NSW Police Force, NSW Ambulance, and Fire and Rescue NSW and other emergency services agencies as appropriate) convene an *urgent working group* involving relevant representatives from emergency services to consider a) development, and b) implementation, of an emergency services interoperability philosophy, model and framework for NSW (including drawing on the evidence from the Inquest and from the Joint Emergency Services Interoperability Programme (JESIP) framework and doctrine in the United Kingdom, as appropriate) to provide a clear structure and framework for multiagency responses to major incidents.

F. Shared triage approach: Ten Second Triage Tool

10.208 As outlined in the evidence set out above, the movements of Mr Cauchi throughout WBJ on 13 April 2024 were rapid and unpredictable. Within minutes, there were stabbing injuries to a total of 16 victims, including the six victims who tragically died.

10.209 As detailed in Part 9, in considering the issue of patient triage and treatment, emergency medicine expert Dr Mazur opined that an alternative triage system or tool, the TST, could have been used to expedite treatment of victims and enabled police emergency responders to assist with this task in a mass casualty incident, therefore enhancing the multi-agency response.

10.210 Upon receipt of Dr Mazur's report regarding the potential utility of this tool, the Counsel Assisting team made further inquiries as to the nature and provenance of it. As a result of those inquiries, Dr Philip Cowburn was engaged to provide insight into the TST.

The TST and Dr Philip Cowburn, MBE

10.211 Dr Cowburn, together with certain esteemed colleagues, had a key role in the development and refinement of the Ten Second Triage Tool. Dr Cowburn's distinguished medical career in emergency and retrieval medicine is detailed in **Appendix 9**.

Development of the TST

10.212 The TST was developed as a result of a working group created by the National Health Service England (**NHSE**) to review and reconsider the approach to major incident triage.

10.213 When the working group was established in 2020, two major incident triage tools were used by the UK health service in major incidents. Pre-hospital response, including the ambulance service and other healthcare providers, utilised the NASMeD/NARU Triage Sieve. Emergency departments utilised the MPTT-24 Triage Tool upon patient arrival.

10.214 An issue identified with the use of these two tools was that they could "*lead to inconsistency in triage priority and confusion amongst responders who worked in both domains*".[2020] Other tools, such as the Triage Sort model also demonstrated a significant degree of cognitive load on practitioners given the calculations required for triage priority, resulting in very high under triage rates.

10.215 Following field testing (outlined below), the TST was ultimately rolled out in 2024 to all emergency services in the UK, including search and rescue organisations and voluntary aid societies, following the recommendation of Sir John Saunders in the *Manchester Arena Inquiry*. It is now a freely available tool published by NHSE.

[2020] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 15.

10.216 Notably, the TST is also available for all emergency service responders via the online JESIP App, an application that can be downloaded (from the Android Play Store or Apple App Store) to a personal or work device.

What is the TST?

10.217 Dr Cowburn defined the TST as a "*novel triage tool designed to be used at any large-scale incident where patient numbers exceed the ability to deliver standard care*".[2021]

10.218 The TST is focused on the rapid prioritisation of patients and the delivery of immediate life-saving interventions during a major incident rather than "*absolute accuracy of triage*"[2022] in circumstances where the cognitive load on responders delivering care is very high. This is achieved by removing physiological variables, such as the rate of breathing or a pulse, and using the easily assessable variables of walking, talking and breathing.

10.219 Dr Cowburn described the TST as a "*quick and dirty*" rapid triage tool. It is designed so that "*any responder who was in the environment of the incident could use this tool to be able to deliver care*".[2023] In effect, the tool operates as a "*force multiplier*"[2024] in the initial stages of a large scale incident where the 'responder to patient ratio' is low.

10.220 Dr Cowburn clarified that the tool does not require a responder to commence and complete triage within 10 seconds. Rather, it is indicative of the ability to triage a variety of priority patients in an incident at an average rate of ten seconds per patient.

How is the TST used?

10.221 The TST is organised into "4 priorities", aligned with established major incident categories. These priorities are:[2025]

(a) Priority 1 (Red): Time critical and requiring immediate lifesaving treatment.

(b) Priority 2 (Yellow): Stable physiology and requiring treatment in 2-4 hours.

(c) Priority 3 (Green): Walking, and able to wait over 4 hours for treatment.

(d) Not Breathing (Silver): Requiring reassessment by a healthcare professional.

10.222 The triage decisions are organised into four "nodes", followed by "action diamonds". A pictorial representation is shown below at **Figure 40**. [2026]

[2021] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 6.
[2022] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 6.
[2023] Transcript, D17 (Cowburn): T1529.19-25 (23 May 2025).
[2024] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 6; Transcript, D17 (Cowburn): T1529.35-41 (23 May 2025).
[2025] Exhibit 1, Expert Volume, Tab 22, Expert Report of Philip Cowburn, pp. 6, 50.
[2026] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 50. Available also at https://www.england.nhs.uk/long-read/ten-second-triage-tool/.

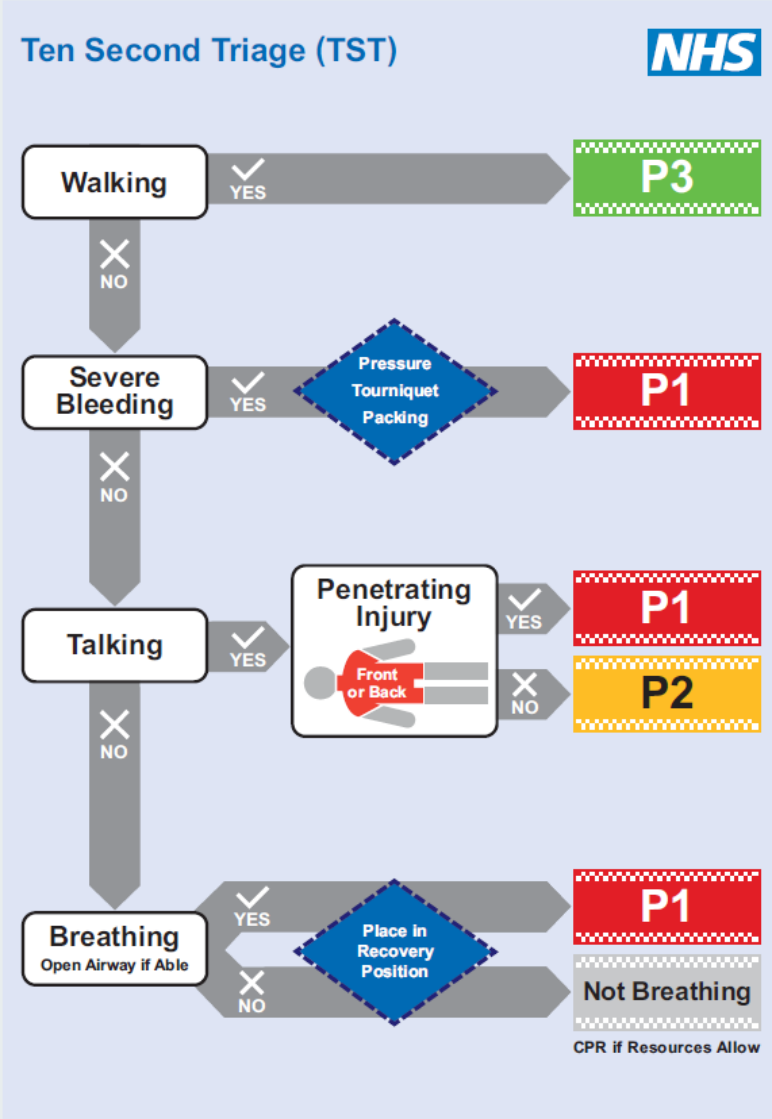

Figure 40: The Ten Second Triage (TST)

10.223 Dr Cowburn explained that "walking" was decided as the first decision node following learnings from the Manchester Arena attack. He stated that "catastrophic haemorrhage" or "severe bleeding" is often listed as the first priority in triage tools, however, this "common sense" node allows a responder to assume that those who are walking are not severely injured. Responders can therefore conduct "*very rapid screening*" and consequently "*focus on the more severe[ly] injured*". If the patient is walking, they are labelled with a "P3" priority.

10.224 The second decision node of the TST is "severe bleeding". This terminology is preferred over "catastrophic haemorrhage", which Dr Cowburn explained can be misapplied. If a patient has signs of severe external bleeding, the blue action diamond on the TST instructs a responder to apply direct pressure, apply a pressure dressing, a tourniquet or wound packing (depending on the skill level of and equipment carried by the responder). The patient is then marked as a "P1" priority.

10.225 The third decision node, "talking", was described by Dr Cowburn as "*a fairly easy thing for any responder to… understand*."[2027] Following the blue action diamond, if a patient is talking, a responder is instructed to undertake a rapid check for any penetrating wounds to the torso. Dr Cowburn explained that the responder would be "*trying to pick up patients that may have internal bleeding from a penetrating wound*".[2028] This is most likely to occur in the chest, abdomen, around the pelvis, across the back or at 'junctional areas' like the neck, armpits, groin and buttocks. These areas are highlighted in red on the TST. If a penetrating wound is present in the red coloured area, the patient is assigned "P1" priority otherwise, the patient is allocated "P2" priority.

10.226 Dr Cowburn described the final TST decision node, "breathing", as assessed using basic first aid airway manoeuvres. If not breathing, the patient is rolled into the recovery position and assigned the category "Silver, not breathing".

10.227 Further, Dr Cowburn explained that unlike previous triage tools, the new category 'Silver, not breathing" replaced the former category of "Dead" for three reasons.

10.228 First, it enabled the tool to be legally utilised in the UK by all emergency responders (not just healthcare professionals), noting that under UK legislation, non-clinicians cannot declare a patient deceased.

10.229 Secondly, it allows for resuscitation attempts to be undertaken if there are sufficient resources available and the number of "high priority" patients is small, thus recognising that some patients that are not breathing may be able to be revived.

10.230 Thirdly, in recognition of the "immense cognitive load" on the bandwidth of emergency responders in a large scale incident, the TST enables the triage of patients without the need for first responders to form the view that a patient should be triaged as "Dead." This appreciates that during a major incident, the cognitive load on emergency responders may lead to a "*failure to recognise very slow or shallow ventilation*"[2029] during the triage process. Under previous triage tools, a patient triaged as "Dead" could result in the loss of a potential opportunity to attempt resuscitation.

10.231 Relatedly, Dr Cowburn noted the "*potential adverse psychological impact on responders who may question their decision to triage [a patient] as 'Dead' following reflection, and the inevitable legal scrutiny could significantly affect their wellbeing*."[2030]

10.232 In oral evidence, Dr Cowburn explained that under the TST:

> *If the patient is not breathing, we still place them into the recovery position and we give them a tag which says, "Silver, not breathing." Now in previous triage tools, these patients would have been declared dead if they were not breathing with an open airway, but that is a very quick decision to make under a lot of stress, and it felt inappropriate to*

[2027] Transcript, D17 (Cowburn): T1530.24-25 (23 May 2025).
[2028] Transcript, D17 (Cowburn): T1530.25-29 (23 May 2025).
[2029] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at pp. 12-13.
[2030] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at pp. 12-13.

> *us that we were putting our responders under that level of pressure to make that decision so quickly.*[2031]

10.233 Dr Cowburn noted that only once TST had been completed and there were sufficient healthcare responders on scene, would the Silver "Not Breathing" category patients be reassessed. These healthcare professionals would consequently have "*the time and bandwidth to make an accurate decision around pronouncing life extinct or commencing resuscitation*."[2032]

10.234 Following the administration of TST, Dr Cowburn explained that the next step was for a senior clinician to review the highest priority patients that require "*more aggressive care*" so that they can be transported to definitive care rapidly.

Field Testing of the TST in the UK

10.235 The TST tool was field tested with responders of varying experience and skill from ambulance services, fire rescue services and police forces across the UK commencing around the UK summer of 2022. This testing adopted the variables from the field testing of an earlier "Major Incident Triage Tool" (**MITT**) developed by the working group.

10.236 The tool was tested with a mock MTA. The scene included a number of variables, including a deliberate vehicle attack, the use of bladed weapons and petrol bombs, a mix of adult and paediatric patients, and a variety of hypothetical injuries including blunt and penetrating traumas.

10.237 Earlier testing of the MITT indicated that the average time to triage per patient was quicker than using the NASMeD/NARU Triage Sieve. The quantitative results of the TST field test demonstrated that the tool was "*significantly quicker*" than the MITT.

10.238 In his first report, Dr Cowburn stated that (emphasis added):

> *... a rapid and effective triage tool utilised by all emergency services, such as TST, brings significant benefits in a patient centred multiagency response and interoperability model. It has been shown to be effective and applicable by all emergency service responders in field testing.*[2033]

10.239 Dr Cowburn ultimately recommended that the NSW Government strongly consider the introduction of the TST.

Dr Evens' (NSWA) assessment of the TST

10.240 In a supplementary statement, Dr Evens proffered the following view regarding the utility of the TST in a NSW context (emphasis added):

[2031] Transcript, D17 (Cowburn): T1530.45-T1531.1 (23 May 2025).
[2032] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 13.
[2033] Exhibit 1, Expert Volume, Tab 22A, Supplementary Expert Report of Dr Philip Cowburn at p. 50.

> *Dr Cowburn has described the Ten Second Triage as a tool embedded within a broader system approach which also comprises joint interoperability and communication, supported by extensive co-training between Emergency Services commanders and staff, and consideration of provision to the police of appropriate first-aid equipment to undertake the actions described in the Ten Second Triage. Inherent to the described system is a proactive approach to rapidly extricating casualties towards clinical staff, and rapidly zoning scenes to improve access of clinical staff to patients. Collectively, the tool, training, and other interventions offer opportunity to improve major incident response in New South Wales.*[2034]

10.241 In oral evidence, Dr Evens reiterated that implementation of the TST "*would not be effective without the adoption of interoperability principles*."[2035]

Expert conclave reflections on utility of TST

10.242 Emergency medicine experts Dr Mazur and Dr Evens agreed with Dr Cowburn as to the utility of the TST. Dr Mazur gave evidence that the model was "*definitely something that was worth looking at, given [his] previous experience of the current triage tools not being as fit for purpose as we'd like them to be*".[2036]

10.243 Dr Evens explained that NSWA currently uses a traditional "sieve and sort" model, which has been "*in existence for some time and has significant constraints with regards to applicability and… time*". He identified the benefits of a tool like the TST being utilised by all emergency services, including that it provides emergency service workers with the "*language to express to the person distributing the resources to the need that they see in front of them*" in the initial triage stage.[2037]

10.244 Dr Evens elaborated that the TST model means that "*ambulance does not have the monopoly*" on the provision of care in the first stages of an incident. In particular, Dr Evens stated that the inclusion of immediate lifesaving actions within the tool is "*not a small thing*", stating:

> *There is a small menu of lifesaving interventions which are not technically difficult which are relevant to a reasonably large proportion of the patients who are affected in incidents such as this, where it may be an intervention that prevents them from dying, but whereby the time that it is applied is a significant factor to whether it is effective.*[2038]

10.245 In conclave, Dr Evens, Dr Cowburn and Dr Mazur strongly agreed on the potential utility of the TST as the primary triage tool to be used by NSWA during mass casualty incidents but also noted that "… *one of the significant contributors to its potential effectiveness*

[2034] Exhibit 1, Vol 46, Tab 1606A, Supplementary Statement of Dr Thomas Evens at [33].
[2035] Transcript, D17 (Evens): T 1536:21-22 (23 May 2025).
[2036] Transcript, D17 (Mazur): T1534.37-40 (23 May 2025).
[2037] Transcript, D17 (Evens): T1534.47-50 (23 May 2025).
[2038] Transcript, D17 (Evens): T1535.20-26 (23 May 2025).

relates to it being able to be utilised across all emergency services, not just the Ambulance service."[2039]

NSWPF: Evidence of S/Sgt Watt regarding the TST

10.246 S/Sgt Watt, Co-ordinator of the NSWPF OSTG, had the opportunity to review Dr Cowburn's report and to consider how the TST might be used by NSWPF officers. In short, S/Sgt Watt stated (emphasis added):

> *I think it's an excellent system. I think it's very, very simple to use. I think it generates good characterisation, and I think it's worthwhile investing time and training in*.[2040]

10.247 S/Sgt Watt agreed that the TST provides police with a clear sequence to follow to triage patients and enables police to work with their paramedic colleagues to provide situational awareness about the status of patients.

10.248 In oral evidence, S/Sgt Watt agreed that he would "*absolutely*"[2041] be happy to train police on the TST, should it receive approval from the NSWPF.

Application of the TST to the incident at WBJ

10.249 Reflecting on the possible outcomes had the TST been embedded within both NSWA and NSWPF on 13 April 2024, Dr Cowburn stated that the "*first ambulance response… would have had confidence that people were being prioritised and lifesaving interventions were being delivered*."[2042] This was in circumstances where there were significant numbers of police who would have been able to communicate to healthcare providers the number of patients and prioritisation, allowing direction of incoming healthcare resources.

10.250 Applying the TST to patients who survived and those who died as a result of their injuries, Dr Cowburn estimated the following priority allocations: four patients as "Silver Not Breathing"; nine patients as "Priority 1"; and three patients as "Priority 3". No patients were identified as "Priority 2".[2043]

10.251 As set out in Part 9, the emergency physician experts agreed that the injuries sustained by all victims (with the exception of Faraz) were unsurvivable even with "*pre-hospital care of the most eminent level*."[2044] Further, they agreed that Faraz was extremely unlikely to survive "*even with immediate access to the highest-level of pre-hospital critical care working in a well-structured trauma system with rapid access to theatre or surgical intervention*".[2045]

[2039] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at p. 10.
[2040] Transcript, D18 (Watt): T1627.26-34 (26 May 2025).
[2041] Transcript, D18 (Watt): T1628.5-7 (26 May 2025).
[2042] Transcript, D17 (Cowburn): T1533.49-1534.10 (23 May 2025).
[2043] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philp Cowburn at p. 43.
[2044] Transcript, D17 (Cowburn): T1513.14-25 (23 May 2025).
[2045] Transcript, D17 (Cowburn): T1512.33-46 (23 May 2025). See also, Exhibit 7, Notes from Conference between Drs Cowburn,

10.252 Dr Cowburn noted in his first report that:

> *… whilst it is extremely unlikely the TST would have materially changed the outcome of any individual patient … had the TST been used at the point of first emergency service responder contact, the scale and severity of the incident would have been appreciated earlier.*[2046]

10.253 In conclave, Dr Evens (with Dr Mazur and Dr Cowburn agreeing), gave the following evidence as to the use of the TST at WBJ on 13 April 2024:

> *[It] would have helped to create wider situational awareness, and secondly, provided a common language to allow police officers to communicate their findings to other agencies as it is clear they recognised the severity of the cases but did not have the language to communicate it.*[2047]

Expert recommendation relating to the TST in NSW

10.254 As noted above, Dr Cowburn, Dr Mazur and Dr Evens agreed that there is potential utility in deploying the TST as the primary triage tool to be used by all emergency services during mass casualty incidents.

10.255 Dr Evens gave evidence that collectively, the tool "*would have a significant impact on the capabilities of the New South Wales Government's response to patients in an incident such as this, as manifested across all of its capabilities*".[2048] However, Dr Evens also noted that the tool would be "*quite a fundamental change in the way that all the emergency services undertake their activity and understand their obligations*",[2049] and would require training, including the field testing of the kind that took place in the UK, as described above, for assurance in the effectiveness of the process.

Submissions

10.256 Counsel Assisting submitted that the cogency of the above evidence supports a recommendation regarding the introduction of the TST in NSW. Further, there was resounding agreement amongst all witnesses – including expert, institutional witnesses, Insp Simpson and senior operational police – as to the value and potential benefits of introducing the TST in NSW.

10.257 Noting the support expressed throughout the Inquest, Counsel Assisting submitted that the following benefits would arise out of the TST's introduction:

(a) The TST model itself is quicker and more efficient than previous triage tools, with less cognitive burden on first responders.

Evens and Mazur at pp. 1- 2.
[2046] Exhibit 1, Expert Volume, Tab 22, Expert Report of Dr Philip Cowburn at p. 44.
[2047] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at p. 10.
[2048] Transcript, D17 (Evens): T1535.42-45 (23 May 2025).
[2049] Transcript, D17 (Evens): T151535.2-4 (23 May 2025).

(b) That the TST includes the "silver, not breathing" decision node (rather than "Dead"), which has a range of benefits including not requiring first responders to make the difficult call that a person is deceased, when the cognitive load and stress of a situation is so great.

(c) As a quick screening tool, the TST has the capacity to deliver situational awareness to first responders dealing with a major incident where there are multiple casualties.

(d) The simplicity of the TST means that it is easy to teach to all emergency services personnel.

(e) Relatedly, the simplicity of the TST means that it operates as a "force multiplier" meaning that all emergency services can use it where in a large scale incident, "*the responder to patient ratio is low*".

(f) The TST incorporates and focuses upon the inclusion of "immediate lifesaving actions", which are not technically difficult and are relevant to a large portion of patients affected by incidents such as that which occurred on 13 April 2024.

10.258 As noted above in Section E, and considering the expert evidence that the TST brings significant benefits in the context of a patient centred multi-agency response and interoperability model, it was put forward that the implementation of the TST is related to the introduction of a JESIP-like doctrine.

10.259 In their submissions, the Tahir family reiterated the submissions made by Counsel Assisting in relation to the TST, with support.

10.260 Similarly, NSWA expressed the view that there would be significant benefit in the adoption of the TST rapid screening tool by emergency services in NSW.

Findings

10.261 The evidence is clear on the fact that the TST brings with it significant benefits in a patient-centred multiagency response and interoperability model.

10.262 First and foremost, it provides for a rapid and effective triage process, which is on any view, a positive. The TST can be used by any emergency responder and can reduce initial triage time to approximately 10 seconds. Utilising the tool enables emergency responders to follow clear steps, which the Inquest heard are relatively uncomplicated, in order to expedite the provision of life-saving treatment to those in need. In addition, it can assist in minimising the cognitive load on responders who are faced with extremely difficult circumstances and decisions in these environments.

10.263 I accept the submissions of Counsel Assisting in relation to the benefits of the TST, and to the ways in which it could have assisted those responding to the incident at WBJ on 13 April 2024.

10.264 Put simply, I am of the view that the importance and significance of the TST cannot be overstated and NSWA should consider its implementation. The implementation should be considered by all emergency services. Moreover, that there is some urgency in its implementation, noting the potential good it could bring to the multiagency response at major incidents.

10.265 Notably, the implementation of the TST has unanimous support from NSWA, the NSWPF (as articulated by S/Sgt Watt), and by the emergency medicine experts who either have extensive firsthand experience with the triage tool, or with the NSW health system, giving them insight into how the TST might be used by emergency services in NSW.

10.266 The triage tool has also been tested in the UK. It has been successfully rolled out and is now used in that jurisdiction, supporting the position that its implementation is a worthwhile venture to undertake.

10.267 The Court was extremely fortunate to receive evidence from Dr Cowburn regarding the development and implementation of the tool which further highlights its potential benefits for the triage of patients in major incidents, including AAO incidents.

Recommendations

10.268 Counsel Assisting proposed the following recommendation addressed to NSWA:

> **Recommendation 14: To the Premier's Department**
>
> That the working group urgently convened by the Premier's Department (per Recommendation 13), consider the implementation of the 'Ten Second Triage' rapid screening tool by emergency services in NSW (including have regard to the expert evidence from the Inquest as to a) the significant benefits that may flow from use of the tool; and b) the need for utilisation of the tool within a broader model of emergency service interoperability (as referred to in Recommendation 13).

10.269 The Tahir and Darchia families both indicated support for Counsel Assisting's recommendation about the TST. Similarly, NSWA expressed support for this recommendation.

10.270 I note the evidence received at Inquest made clear that the implementation of the TST sits closely with the implementation of JESIP, or a JESIP-like framework for interoperability.

10.271 Based on the same philosophy of enabling shared working between responding agencies to streamline and improve the effectiveness of the overall emergency response at major incidents, this recommendation and recommendation 18 concerning the implementation of such a framework in NSW are equally important. I adopt the view expressed by Dr Evens that the TST will not be effective without adoption of the interoperability principles.

10.272 Noting the evidence set out above, Counsel Assisting's submissions on the TST, and my findings concerning the same, I make the following recommendation:

RECOMMENDATION

Recommendation 19: To the NSW Government

That the working group urgently convened by the NSW Government (per Recommendation 18), consider the implementation of the Ten Second Triage (TST) rapid screening tool by emergency services in NSW, including having regard to the expert evidence from the Inquest as to a) the significant benefits that may flow from use of the tool, and b) the need for utilisation of the tool within a broader model of emergency service interoperability (as referred to in Recommendation 18).

G. Shared communications: Joint radio communications

Interagency radio communications as between NSWPF and NSWA

10.273 The nature and extent of interagency communications – including via radio – was explored during the Inquest.

10.274 In terms of shared communication streams as between NSWA and NSWPF, the following evidence emerged:

(a) There is facility for interagency communications through ICEMS. The ICEMS protocol uses incident information already contained and validated by the CAD system of an individual emergency service (for example, NSWPF and NSWA); and it permits multiple agencies to receive and send communications regarding an incident. However, as the information is available on a CAD Workstation Screen, it requires responding personnel to be able to read the text updates (unless the information is otherwise broadcast over radio).

(b) At times, the NSWA Dispatch Supervisor may make telephone communications to his or her NSWPF counterpart to discuss matters (beyond those referred to in ICEMS).

(c) SOT paramedics embedded into any NSWPF operation (that is, together with TOU) have dual radio communications with police and ambulance. However, as noted by SOT 1, this can be a lot of information to receive at once. Given that, one channel is usually allocated for priority (generally, the police channel to ensure SOTs receive information as to any potential threat or evolving information from the scene).

(d) With respect to access to PORS radio transmissions, evidence was received that whilst PORS and TOU radio channels were not integrated at the time of the incident, following the events of 13 April 2024, access to a new combined and encrypted radio channel was rolled out in September 2024 to allow improved coordination and a more streamlined response by specialist tactical units.

Interagency radio communications in the UK

10.275 The lack of an inter-agency radio channel or clear communication protocols for sharing critical information is one factor that seemingly contributed to the delay in sharing the crucial information regarding the Hot Zone issue.

10.276 Dr Cowburn set out the shared radio communications that exist in the UK in his report, explaining that all emergency services in the UK use the same radio communication

system, "Airwave". There are thousands of channels available on this system and each service is allocated a number for routine use, with a number dedicated MICs for that service.

10.277 The Airwave system facilitates communication in two ways:

(a) On a channel via open speech; this allows everyone dialled into that channel to hear and speak; and

(b) "Point to point" dialling between handsets: where only those handsets can hear each other. This allows prolonged conversations without overloading the channel preventing others communicating.

10.278 Given this form of single system digital connectivity, in theory, any airwave set can speak to any other within the UK.

10.279 Dr Cowburn considers that this system allows effective communication between responders in the event of a major incident using two routes: namely, "Multiagency Interoperable Talk Groups" and "Single Service Major Incident Channels". He explained these concepts in evidence:

(a) *Multiagency Interoperable Talk Groups* enable all emergency service commanders to link via their radio. These pre-set channels are held open and monitored by agency control rooms at all times. This allows control rooms from different agencies to share information between each other, leading to improved interagency situational awareness; and

(b) *Single Service Major Incident Channels* function similarly to the MIC established for the incident at WBJ on 13 April 2024. However, when using this channel, all responders are "pushed" onto the channel by their agency's control room. Being "pushed" onto the channel reduces the cognitive load on responders when hearing and complying with instructions. It obviates the need for attending crews to hear the instruction to change to the MIC (something that some paramedics had difficulty doing at WBJ given the loud evacuation alarm).

Expert conclave reflections

10.280 In conclave, the emergency physician experts, Dr Evens, Dr Cowburn and Dr Mazur agreed that:

(a) A shared major incident channel would be "*valuable so long as commanders do not become overloaded*";

(b) The issue of "*overloading*" might be mitigated by "*attaching a communications officer or communications role to the Commander where resources allow*"; and

(c) Ambulance responders were not "*pushed onto*" the channel, but "*had to transfer themselves*" resulting in some staff not being aware of information.[2050]

Institutional positions of NSWA and NSWPF

10.281 In his written statement of 29 April 2025, AC Armitage stated that NSWA is open to exploring the viability of an inter-agency channel for major incidents. However, he identified potential limitations as follows:

(a) Each agency uses its own radio channels extensively to communicate with its own resources. Given the sheer number of radio broadcasts occurring within each agency in response to a major incident, adding other agencies to a single major incident radio channel could result in limited talk time being available for transmission of urgent messages and/or a potential risk of information overload;

(b) Whilst there are common radio codes and terminology, there is also variability across agencies in relation to terminology; and

(c) Each agency may have a different operational focus: for example, the focus of the NSWA is the treatment and transfer of patients in a pre-hospital care setting.

10.282 DC McKenna (NSWA) noted the limitations expressed by AC Armitage, but indicated that NSWA is open to exploring the viability of both an inter-agency channel for major incidents, and also 'interagency talk groups' where all emergency service commanders link in via their radio.

10.283 AC McKenna (NSWPF) also acknowledged the difficulty of putting all responding emergency services personnel on the same MIC. As to the potential viability of interagency talk groups, AC McKenna accepted that "in principle", the implementation of interagency talk groups is a "possibility" - although he "*couldn't actually speak to the technicality of it*".[2051] He suggested that interagency communication happens to a degree, given that operators can use their phones to communicate.

Submissions

10.284 Counsel Assisting acknowledged that the above evidence does not support the introduction of a shared major incident channel, not least due to the potential for overloading.

10.285 Notwithstanding this, Counsel Assisting submitted that the evidence emphasised the need for frequent radio communications between the NSWPF and NSWA "Control Rooms" as a means for achieving shared situational awareness. Such shared

[2050] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 8-9.
[2051] Transcript, D19 (P McKenna): T1723.32-44 (27 May 2025).

situational awareness could have clarified the Hot Zone issue and provided an avenue for early discussion of risk and critical information as it was received.

10.286 Of note in this regard, Counsel Assisting referred to the fact that the JESIP Doctrine promotes "Shared Situational Awareness" arising from Control Room communication. The doctrine directs that discussions between control rooms should be frequent and cover key points such as identifying each organisation lead, hazards and risks known by the parties, and a plan for ongoing communications between them.

10.287 Further, Counsel Assisting noted that Dr Cowburn provided a useful overview of the value of multiagency interoperable talk groups.

10.288 Ultimately, Counsel Assisting submitted that, given the evidence set out in the above, there is merit in considering improvements to interagency radio communications, which more broadly relates to the concept of enhanced emergency services interoperability. Accordingly, a recommendation to NSWA and NSWPF followed.

Findings

10.289 With respect to the issue of shared communications and the use of joint radio communications, I accept the submissions of Counsel Assisting. I find that there are some potential limitations to the use of a single inter-agency radio channel for major incidents, and that the evidence does not support the introduction of one.

10.290 Notwithstanding these limitations, I am of the view that there is a clear need for frequent radio communications between the NSWPF and NSWA Control Rooms during these major incidents as a means of sharing critical information and achieving shared situational awareness.

10.291 Evidence was received from Dr Cowburn as to the value of multiagency interoperable talk groups utilised in the UK, and to the correlation between the JESIP Doctrine and the promotion of shared situational awareness achieved via communication between Control Rooms.

10.292 I accept Dr Cowburn's evidence that shared situational awareness can facilitate a more efficient and effective co-response from the attending emergency services. The impact of an absence of communication between the NSWA and NSWPF Control Rooms was clearly demonstrated by the lack of shared situational awareness regarding the number of offenders at WBJ. Given this, I find that there is merit in considering improvements to interagency radio communications.

Recommendations

10.293 Counsel Assisting proposed the following recommendation addressed to NSWA:

> **Recommendation 15: To the NSW Police Force and NSW Ambulance**
>
> That NSWPF and NSWA conduct a joint review of existing interagency radio communication protocols and processes in relation to major incidents, to identify potential areas for enhancement or improvement (including having regard to the principles identified in the JESIP Doctrine regarding communications between Control Rooms), by way of developing or improving, joint operating protocols.

10.294 The Tahir and Darchia families expressed support for this recommendation made by Counsel Assisting. NSWA similarly expressed support for it. It is noted that NSWA compiled the relevant evidence concerning the issue of interagency radio communication as part of their written submissions which is outlined above.

10.295 Noting the evidence set out above, the submissions of Counsel Assisting, and the findings made in relation to the same, I make the following recommendation:

RECOMMENDATION

Recommendation 20: To the NSW Police Force and NSW Ambulance

That NSW Police Force and NSW Ambulance conduct a joint review of existing interagency radio communication protocols and processes in relation to major incidents, to identify potential areas for enhancement or improvement (including having regard to the principles identified in the JESIP Doctrine regarding communications between Control Rooms), by way of developing or improving joint operating protocols.

H. Joint Rescue Task Force

10.296 Arising from consideration of the nature and timing of the SOT response at WBJ on 13 April 2024 (and the evidence of CCP Wilkinson, set out above), was the suggestion of a "Rescue Task Force".

10.297 In this regard, S/Sgt Watt referred to a training demonstration in 2020 that NSWPF undertook with Fire and Rescue NSW and NSWA, with the intended purpose of demonstrating the concept of a Rescue Task Force. During the demonstration, a Rescue Task Force was utilised, consisting of police officers and paramedics. S/Sgt Watt explained the concept in these terms:

> *The protection provided by embedded police officers means that medical professionals can be injected into the situation before the location is considered safe.*
>
> ...
>
> *The rescue task force ensures that paramedics are protected, confusion is reduced and medical aid can be accurately directed to where it is most needed. This approach also improved information sharing and allows a better use of resources to stabilise injured victims and arrange their evacuation to a higher level of medical care.*[2052]

10.298 In oral evidence, S/Sgt Watt expanded on the demonstration, noting that in that scenario, paramedics were inserted into the scene and casualties were located much faster than extraction via police alone.

10.299 S/Sgt Watt explained that in the initial entry for the demonstration and in the concept of the task force generally, paramedics were escorted by police, who effectively created a "bubble" around them in an "indirect threat" scenario.[2053]

10.300 In terms of the incident on 13 April 2024, S/Sgt Watt gave oral evidence that the Rescue Task Force concept was "*effectively*" what Insp Simpson did by utilising police to protect him. He agreed that it would "*absolutely*" be better to put more structure around that concept, and that it would be "*relatively simple*" to train police in this manner.[2054]

10.301 S/Sgt Watt explained that the integrated Rescue Task Force model had been introduced in the US and as a result, the US "... *are getting professional medical care to [the] injured very quickly by standing up and inserting rescue task forces immediately once there are available resources on both the law enforcement and medical side of the response*."[2055]

[2052] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [73].
[2053] Transcript, D18 (Watt): T1628.26-40 (26 May 2025).
[2054] Transcript, D18 (Watt): T1629.38-49 (26 May 2025).
[2055] Exhibit 1, Vol 14, Tab 764A, Supplementary Statement of Senior Sergeant William Watt at [74].

10.302 In oral evidence, DC McKenna (NSWA) stated that while the concept of a Rescue Task Force is something that NSWA is "*open to look at*";[2056] it was not otherwise something that the agency had spent a lot of time exploring.[2057] DC McKenna agreed that consideration of a Rescue Task Force was connected to the NSWA policies regarding the zoning of a scene.

10.303 In a further statement of 17 November 2025, DC McKenna (NSWA) set out that, against the backdrop of the NSWA Executive Leadership Team and key subject matter experts engaging with their UK counterparts, there has been subsequent discussion and consideration within NSWA around the concept of the Rescue Task Force. DC McKenna notes that no formal progress has been made to date with NSWPF. He stated that NSWA remains open to consulting with NSWPF but noted that any potential model must go through rigorous processes to ensure patient and staff safety.

10.304 As set out above, CCP Wilkinson was concerned about the delay in paramedics accessing WBJ on 13 April 2024; he was supportive of the Rescue Task Force model, considering it both "*very timely*" and "*very necessary*."[2058]

10.305 AC McKenna (NSWPF) was asked for his views regarding the concept of a Rescue Task Force and stated "*It's more for the ambulance to consider I would say. From our point of view it would come down to training together*."[2059]

Expert conclave reflections

10.306 The expert conclave, namely Dr Evens, Dr Cowburn and Dr Mazur, expressed the view that "*there is an active role for police in enabling clinical staff to access patients, commensurate to the threat and that police presence can mitigate threats*."[2060] And further, that where *"the environment cannot be risk reduced sufficient to gain access with sufficient clinical resources, patients should be rapidly extricated to an appropriate location by any capable emergency service."*[2061]

10.307 However, in terms of a Rescue Task Force model, the conclave stated that they:

> *... Didn't collectively support the view that a 'Rescue Task Force was a necessary response to this incident' – the term referring to a static concept, with a specifically trained group of individuals which does not allow the flexibility required to access the scene apart from in a siege situation and the previously described dynamic approach to risk should allow rapid access of clinicians to patients appropriate to risk.*[2062]

[2056] Transcript, D19 (W McKenna): T1765.37-T1766.5 (27 May 2025).
[2057] Transcript, D19 (W McKenna): T1765.37-50 (27 May 2025).
[2058] Transcript, D3 (Wilkinson): T17.25-30 (30 April 2025).
[2059] Transcript, D19 (P McKenna): T1766.44-45 (27 May 2025).
[2060] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at p. 6.
[2061] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 6-7.
[2062] Exhibit 7, Notes from conference of Drs Cowburn, Evens and Mazur at pp. 12-13.

Submissions

10.308 Counsel Assisting submitted that the evidence heard at the Inquest highlights the obvious utility of a joint Rescue Task Force: it would enable rapid extrication of patients who may require initial lifesaving treatment from paramedics before removal from the scene as, under this model, paramedics can provide first aid in hostile environments under the protection of police.

10.309 In addition, Counsel Assisting submitted that there is, at least, utility in further consideration of the joint Rescue Task Force in circumstances where SOT paramedics are already injected into hostile environments with police (albeit with a focus on providing aid to police officers as required); and because, in any event, brave paramedics such as Insp Simpson (and his crew) entered the hot zone environment to provide patient care.

10.310 Moreover, it was noted that this concept is deployed successfully in other jurisdictions.

10.311 Given this, Counsel Assisting submitted that a permutation of the existing concept of TOU with SOT support, with a greater number of SOT paramedics focused on treating and rapidly extricating patients, is worthy of closer analysis. A recommendation to NSWA was accordingly proposed in relation to the same.

Findings

10.312 I accept Counsel Assisting's submissions that the basis for considering such a concept has the clear potential to enable rapid extrication of patients from a scene and provide a means to deliver potentially life-saving treatment in a more expedient manner.

10.313 Accordingly, I find that there is value in considering the utility of a Rescue Task Force being implemented in NSW.

Recommendations

10.314 Counsel Assisting proposed the following recommendation addressed to NSWA:

> **Recommendation 16: To NSW Ambulance**
>
> That the Commissioner of NSW Ambulance (in consultation with relevant personnel from the NSW Police Force) review the potential utility of a 'Rescue Task Force' concept, including having regard to models utilised in other jurisdictions, to consider the feasibility of such a model for NSW Ambulance.

10.315 Both the Tahir and Darchia families expressed support for this proposed recommendation made by Counsel Assisting.

10.316 The NSWPF also expressed support for the recommendation to review the potential utility of a Rescue Task Force as proposed by Counsel Assisting. However, indicated two points by way of clarification.

10.317 First, that the task force should take the form of that utilised in the US, in which police officers and paramedics form a group that together can be injected into a scene before it is otherwise considered safe to do so. In this US-based model, the sole role of police officers in the task force is to provide protection for the paramedics, who can then treat the injured. The model is designed such that general duties police officers arriving on scene can fulfil this protective role and is flexible, allowing for the size and composition of the task force to vary depending on the nature of the incidents. The NSWPF note that this approach is consistent with the expert emergency physicians' desired and supported approach to a rescue task force.

10.318 Secondly, the NSWPF stated that the rescue task force proposed by S/Sgt Watt and supported by the experts is not one that required paramedics to receive SOT training. Rather, the proposed model is such that general duties police officers and "standard" paramedics are able to be grouped into a task force as they arrive and immediately be inserted into the scene. Accordingly, they draw some distinction from Counsel Assisting's suggestion that the task force take the form of some permutation of the existing concept of the TOU with SOT support.

10.319 It was submitted on behalf of NSWA that although some NSWA witnesses expressed doubt as to whether a singular Rescue Task Force model would be appropriate for adoption in all situations, NSWA does not oppose considering the feasibility of such a model, as proposed in Counsel Assisting's recommendation on the same.

10.320 Evidence was received at Inquest about the different models which might make up the Rescue Task Force and which might assist in the agency in its consideration of the same. Ultimately, the precise nature of the Rescue Task Force would be determined by the relevant agencies.

10.321 Given the evidence and submissions noted above, I propose to make the following recommendation:

RECOMMENDATION

Recommendation 21: To NSW Ambulance

That the Commissioner of NSW Ambulance (in consultation with relevant personnel from the NSW Police Force) review the potential utility of a Rescue Task Force concept, including having regard to models utilised in other jurisdictions, to consider the feasibility of such a model for NSW Ambulance.

I. Concluding remarks

10.322 The above Parts 8, 9 and 10 have closely considered the response of the NSWPF and NSWA to the events of 13 April 2024. The intention of this process is to examine the actions taken on the day so that opportunities for improvement can be identified, and the agencies can learn from this deeply tragic incident.

10.323 I acknowledge the skill and expertise of the members of the emergency conclave and express my gratitude to them for their assistance.

10.324 It is important to note that the identified areas for improvement and recommendations made in these Parts are not intended to detract from the exemplary response of the NSWPF and the NSWA.

10.325 There were hundreds of emergency service personnel who responded to the events of 13 April 2024 with bravery and skill. Faced with a frightening and confronting scene, these individuals demonstrated professionalism, going above and beyond to demonstrate their commitment to helping their community, with many putting themselves in harm's way to render aid and protection to those at the Centre.

10.326 I commend and thank all emergency services personnel who attended the scene, and those who assisted remotely, in the response to the incident.

10.327 It should also be underscored that the attitude of both agencies to the Inquest was exemplary. This included the NSWPF, led by AC McKenna (but also informed by the evidence of S/Sgt Watt) and NSWA, led by DC McKenna (but also informed by the evidence of AC Armitage and Insp Simpson).

10.328 I echo Counsel Assisting's sentiments that there was deep thinking and constructive engagement with a view to learning all potential lessons from the tragic events of 13 April 2024.

10.329 I acknowledge that approach and commend the agencies and their representatives. As I have noted above, this degree of cooperation and engagement increases the likelihood that the Inquest process will result in actionable change that may impact both the agencies themselves and the wider community.

Part 11 Media reporting

Media reporting

11.1 To address the evidence arising in relation to consideration of issues 15 and 16 with respect to media reporting of the events of 13 April 2024, this Part will be divided into the following sections:

Section A	Introduction
Section B	The graphic nature of the media reporting and publication of sensitive images
Section C	Intrusions on privacy
Section D	Inaccurate and sensational reporting
Section E	The impact of media reporting on families
Section F	Governance of media reporting of deaths and mass casualty incidents
Section G	Submissions, findings, and recommendations

A. Introduction

11.2 The events of 13 April 2024 were the subject of extensive and prolonged media interest and coverage. This is understandable in the context of such a tragedy, the impact of which has been felt widely amongst the community and, of course, most acutely by those who lost loved ones that day.

11.3 It is important to recognise that just as the impacts of such an incident can be widely and deeply felt, so too can the impacts of the media reporting of that incident. As Counsel Assisting recognised in their submissions, the media plays a vital role in a functioning democracy, and what occurred at WBJ on 13 April 2024 was of rightful concern to the community and the proper subject of media reporting. There is, however, a balance to be struck.

11.4 The impact of the media reporting of this incident, and the conduct of some of the media in their interactions with family members of the deceased, has been a matter of significant concern to those families. The statements provided by the family members of the deceased in this Inquest tell of the distressing impact of that coverage and conduct.

11.5 This Inquest, like many others, was itself the subject of media reporting, and conscious of the capacity for that coverage to further impact upon the families, I remarked at the outset of the hearing:

> *Accepting that there is an important role for open justice in our society, I can only underscore, in the strongest terms, the need for empathy and sensitivity in the coverage of this Inquest, given the immense trauma that each family has suffered to date.* [2063]

11.6 Following engagement with the families of the deceased, two issues were incorporated into the Issues List for the Inquest in relation to media reporting:

(a) **Issue 15**: the general nature and content of the media response to the events at WBJ on 13 April 2024, including media reporting and media activities to obtain information and/or images; and

(b) **Issue 16**: the impact of media reporting on the families.

11.7 As noted above, the Court received evidence from family and friends of victims concerning Issues 15 and 16. The evidence was received in a de-identified form, with no media outlets or journalists expressly identified.

11.8 As set out further below, Counsel Assisting and Counsel representing certain family members proposed recommendations directed to the Australian Press Council (**APC**) and to the Australian Communications and Media Authority (**ACMA**).

[2063] Transcript, D1 (State Coroner): T4.25-28 (28 April 2025).

11.9 The APC and the ACMA were invited to comment on the proposed recommendations and have taken up that invitation.[2064] I have been assisted by their engagement, and my consideration of the recommendations proposed is set out at the conclusion of this Part.

[2064] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office; Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office.

B. The graphic nature of the media reporting and publication of sensitive images

11.10 One aspect of the media coverage of the events on 13 April 2024 raised by the families was the nature of the footage that was broadcast by media outlets. This included footage of Mr Cauchi traversing WBJ with his knife and footage of victims *in situ*. In some instances, injured victims were shown in images or footage receiving CPR or other aid. Generally, images of the victims were at least partially pixelated. The availability of such footage was facilitated by members of the public who filmed on their mobile phones during the incident.

11.11 The Inquest received evidence that some of the family members of victims observed media coverage of the event, which identified their loved ones as injured or deceased, and some family members and friends of victims learned of their loved one's death through other reporting by the media.

11.12 On the afternoon of 13 April 2024, Jade's brother, Peter Young, was reading media coverage on a news app regarding the incident. He came across an image of a woman lying on the ground. Mr Young believed the woman to have been Jade.[2065] He described having "*an immediate physical reaction to seeing this. I was nauseous and felt like vomiting. I was in disbelief. I felt like I had been punched in the stomach. I was in total shock.*"[2066]

11.13 At some point that afternoon, Jade's mother, Elizabeth Young, informed family members Toby Halligan and Elizabeth St Clair that "*something terrible*" had happened to Jade. That evening, as they were watching the news, a media outlet aired footage taken from within WBJ. The footage was uncensored and depicted Jade receiving CPR, with her husband, Noel McLaughlin, standing beside her. At this time, Mr Halligan did not know Jade was deceased.[2067] Mr Halligan stated, "*[s]eeing the footage … was how I found out for sure that Jade had been killed*."[2068]

11.14 Mr Halligan requested an explanation and an apology from the media outlet. An Investigations Officer responded that he was unable to locate the footage. Mr Halligan had taken screenshots of the footage and provided those to the officer. Subsequently, the broadcaster provided an apology to Mr Halligan and published that apology together with an acknowledgement of what had occurred on television and in an online article.[2069]

[2065] Exhibit 1, Vol 51, Tab 1632, Statement of Peter Young at [5].
[2066] Exhibit 1, Vol 51, Tab 1632, Statement of Peter Young at [6].
[2067] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [4]-[5].
[2068] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [5].
[2069] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [7]-[12].

11.15 On 30 April 2024, Mrs Young authored an article which was published in the Sydney Morning Herald, entitled "*My daughter was killed in the Bondi Junction attack. How my family found out is shameful*". In her article, Mrs Young wrote:

> *On the evening of Saturday, April 13, members of my family recognised Jade and her husband Noel in uncensored vision being played on a mainstream TV news feed, with vision of Jade lying on the ground at the shopping centre, receiving CPR. The vision, shared on social media and picked up – and used by – multiple news media programs shared my daughter's final moments with millions.*
>
> *Finding out that a loved one had been murdered is a horror that I do not wish on anyone. But seeing the vision of the last moments and knowing it has been broadcast to millions of people is an appalling breach of privacy and an insult to human dignity.*
>
> *It is profoundly alienating to realise that our family's very private grief was being commodified and turned into casual content. Why anyone with an ounce of humanity would think such an image was appropriate to capture and share, I cannot fathom. I point my finger at the individual for seeing fit to capture the moment and then sharing it, and the mainstream channel for putting it to air.*
>
> *We are scraping the bottom of the barrel of humanity when images of dead or dying or injured people are shared to air. For what reason? I can only think it is to satisfy the increasingly morbid curiosity of society.* [2070]

11.16 Ashley Wildey, Dawn's fiancé, who responded to the incident in his capacity as a Detective Senior Constable of NSWPF, gave evidence of feeling "*haunted*" by the sound of the alarm, and being triggered by the sound being used in an episode of a current affairs program.[2071]

11.17 Rebekah Giles, a close friend of Ashlee, and a principal of law firm Giles George, provided evidence of steps taken on behalf of Ashlee's family in the aftermath of the incident, including engagement with various media outlets with a view to "*protecting the privacy and dignity of Ash, Dan*" and their daughter.[2072] Ms Giles' examples of media reports included an article published at around 10:37pm on 13 April 2024 that featured embedded video depicting blurred footage of victims inside WBJ, footage of victims being loaded into ambulances, footage of people running and sounds of screaming, footage of Mr Cauchi running with a knife, and footage of Insp Scott standing over Mr Cauchi's body.[2073]

[2070] Exhibit 1, Vol 51, Tab 1632, Statement of Peter Young, Annexure A at p. 5.
[2071] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [66].
[2072] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [14], [16]-[20], [23]-[66].
[2073] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [16](c).

C. Intrusions on privacy

11.18 Following the events of 13 April 2024, there were instances of intrusive behaviour and other upsetting conduct by media personnel. These included the following:

(a) Both Mr Wildey and Julie Singleton described reporters waiting outside their home or the homes of their family members.[2074]

(b) Dawn's sister was approached by members of the media in the weeks following the incident as she travelled to and from school.[2075]

(c) Peter Young described being "*taken aback*", "*very angry*", and "*shocked*" when approached by journalists on 15 April 2024 while walking in his neighbourhood with Noel, and one of Noel and Jade's daughters.[2076]

(d) Mrs Young was photographed in an unmarked police vehicle while visiting the site of the incident.[2077]

(e) Mr Halligan and Ms St Clair described being "*inundated by communications from journalists*". Ms St Clair was approached via Facebook Messenger. She told Mr Halligan that "*she understood the journalist was just doing his job but it made her very sad as a reminder that for these journalists Jade was just part of a story*." Mr Halligan gave evidence that despite declining requests, some journalists persisted, including by trying to connect with him on Facebook and Instagram.[2078]

(f) Members of Jade's family in New Zealand were contacted by journalists, which they found "*intrusive*" and "*upsetting*".[2079]

(g) Murtaza Manzoor, Director of Falkon, observed a number of "*bloggers*" present at the funeral of Faraz and stated "*the way they were communicating, that was hard, hard heartening, but obviously I was, I was getting sad what they were reporting, so we need to have like some control on those things*."[2080]

(h) Reporters also attempted to contact Mr Wildey through his private social media accounts, which he considered "*highly inappropriate and lacking any genuine compassion.*"[2081]

(i) Julie Singleton gave evidence of reporters texting and calling her to seek comments or interviews, leaving "*so many voicemail messages that [her]*

[2074] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [30]; Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [28].
[2075] Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [31].
[2076] Exhibit 1, Vol 51, Tab 1632, Statement of Peter Young at [10].
[2077] Exhibit 1, Vol 51, Tab 1632, Statement of Peter Young at [11].
[2078] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [14].
[2079] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [15].
[2080] Transcript, D18 (Manzoor): T1704.43-47 (26 May 2025).
[2081] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [31], [33].

message bank was full" and leaving notes in her mailbox. Julie Singleton found this "*intrusive*" and "*unsettling*". This continued for months, and Julie Singleton described the attention as "*unwarranted and relentless*".[2082]

(j) Dawn's sister was messaged on social media by journalists, with some sending her footage from the incident.[2083]

(k) Mr Wildey gave evidence of use of private footage and images depicting Dawn taken from Dawn's (and her family's) social media without consent, which were published in promotional videos for a television program.[2084]

Announcement of Dawn Singleton's identity

11.19 A further instance of media reporting that caused distress to members of Dawn's family was her death being announced on air by a prominent radio announcer on the morning of 14 April 2024. Julie Singleton said that this occurred before Dawn's family had formally identified her, and before many of her friends had been informed of her death. Mr Wildey provided similar evidence. It was also said that the information was understood to have been released by NSWPF. [2085]

11.20 Evidence of relevant NSWPF media policies and guidelines was provided in a statement by DCI Marks.[2086]

11.21 Counsel for the Good, Singleton and Young families sought a finding in relation to the circumstances in which certain information was provided to the radio broadcaster who announced on air that Dawn had died and what, if any, role was played by NSWPF in providing information to the radio broadcaster.

11.22 I do not consider this issue to properly be within the scope of the Inquest, and relevant evidence in relation to the circumstances of any provision of information to the radio broadcaster was not received. Witnesses from whom I would be required to hear from to fairly determine this issue were not called to give evidence.

11.23 I note that Counsel for the Good, Singleton and Young families proposed the following recommendation: [2087]

> **Proposed Recommendation: To NSWPF**
>
> Consideration be given to implement regular training to police officers about the use and disclosure of confidential information in the course of their duties and, in particular, in circumstances involving intense media and public interest to facilitate

[2082] Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [28], [30].
[2083] Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [31].
[2084] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [57]-[60].
[2085] Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [12]-[14]; Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [19], [20]-[22].
[2086] Exhibit 1, Vol 1, Tab 30A, Supplementary Statement of Detective Chief Inspector Andrew Marks at [5]-[6], [9], [11]-[13].
[2087] Written submissions on behalf of the Good, Singleton and Young families at [5.51].

easy decision-making when faced with the requirement to manage confidential information in emergency situations.

11.24 In circumstances where this issue was not fully examined in the Inquest, I do not propose to make a recommendation under s 82 of the Act. However, I note, that as the Commissioner of NSWPF has indicated no objection to the proposed recommendation, he may wish to take steps to implement this recommendation by his own initiative.

D. Inaccurate and sensational reporting

11.25 Mr Wildey gave evidence of inaccurate and sensational reporting. This included inaccurate reporting of the purpose of Dawn's visit to WBJ on 13 April 2024, interactions Mr Wildey had with colleagues after the incident, that a certain person had met with Mr Wildey in the aftermath of the incident, and inaccurate reporting that suggested a childhood friend of Dawn and Mr Wildey was the alleged offender. Mr Wildey stated that it distressed him that many of these reports remained available online.[2088]

11.26 Ms Giles gave examples of inaccurate and insensitive reporting about Ashlee on personal topics, including that Ashlee's daughter (who was seriously injured in the incident) had passed away, and suggestions that Ashlee had struggled to become pregnant.[2089] One instance of sensationalised reporting in respect of Ashlee included a news headline: "*Victim's tragic final [social media] posts are revealed as witnesses described how she tried to throw her daughter to safety*."[2090]

[2088] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [40], [42], [45], [49], [52]-[53], [55], [65], [69].
[2089] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [16](a), [16](b).
[2090] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [16](e).

E. The impact of media reporting on families

11.27 The evidence from family and friends of the victims received by the Court described the adverse impact of media reporting, and the way in which some reporting served to compound their distress.

11.28 Mr Halligan recalled that when he saw images of Jade receiving CPR on television, he felt "*profound shock*" as though his brain had "*gone numb*". He described his concern for his mother (Ms St Clair), who was extremely distressed upon viewing the footage. Mr Halligan was worried she would have a heart attack. Mr Halligan felt "*an overwhelming sense of helplessness*", as he "*hadn't expected something so personal to hit [him] without warning*."[2091]

11.29 Mr Halligan expressed gratitude for receiving an apology from the broadcaster concerning the uncensored footage, nonetheless, he explained the impact on him, stating:

> *... it couldn't and didn't unwind the harm that I had experienced from having seen the vision of Jade... My job involves managing and monitoring media. But now I find it very difficult to watch certain kinds of stories, such as crime stories or stories involving violence against women. When I see these kinds of stories, I feel anxiety rising in me in a way I didn't previously. I have found it impossible to forget what I saw, and it still impacts me tremendously.* [2092]

11.30 Mr Wildey described the impact of media reporting in these terms:

> *The cumulative effect of the reporting has caused me and members of Dawn's family immense and immeasurable pain. The media have defended their manner of reporting as being in the 'public interest'. I can attest from my personal experience as a police officer responding to this incident on duty, and as a witness personally involved, the constant republication of graphic CCTV footage, the constant inaccurate reporting, and the replaying of the Westfield shopping centre emergency alarm in promotional videos and media content is indescribably emotionally damaging and triggering for me and no doubt for people personally involved in that incident. Not a day goes by where this does not dominate my thoughts and cause me distress. Every time that alarm is resounded, again and again on media promotional videos, the pain is resurfaced.* [2093]

11.31 Julie Singleton gave evidence that:

> *The morning after the day Dawn was killed, I had the TV on in my home. My children and I saw a report of the bodies of the victims who had been killed being moved out of the shopping centre and into waiting vans. This included footage of bodies on gurneys with a cover over them. It occurred to me that one of those bodies must be Dawn. I found this shocking and I was distraught. As Dawn's mother, I had been denied permission to see her in the centre. My family and I had been told that police could not tell us when*

[2091] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [6].
[2092] Exhibit 1, Vol 51, Tab 1631, Statement of Toby Halligan at [13].
[2093] Exhibit 1, Vol 51, Tab 1634, Statement of Ashley Wildey at [70].

> *her body would be moved out but that it could take days. Yet the media were permitted to film her body being taken out of the centre for transport to the morgue. It distressed me greatly that strangers were allowed to do this when Dawn's family had not even seen her yet. I also did not understand how this added anything informative or useful to the public reporting of what had happened. It felt like Dawn and the other victims were being used as a device to make the story more shocking …*
>
> *I do not want the public, or my family and friends, seeing footage of Dawn's killer in the course of committing these terrible acts. To my mind, this kind of coverage cannot serve any kind of proper purpose and would only add to the trauma that this tragic event has caused. Apart from the loss of Dawn, media attention has had a profound effect on me. I have become an anti-social person, and I limit speaking about Dawn to my family and a very small circle of friends in order to protect the privacy of my family and of Dawn.*[2094]

11.32 Ms Giles described the media use of social media content from Ashlee's social media profiles caused her and Ashlee's family "*extreme distress and upset*" and stated her belief that "*Ash would not have wanted images from her social media used by the media in the context of her murder or the grievous injury of her 9-month-old baby*". She stated: "*Ash was protective of and committed to her loved ones and would have fiercely resisted any step or action that would have caused them pain*."[2095]

[2094] Exhibit 1, Vol 51, Tab 1633, Statement of Julie Singleton at [29], [33]-[34].
[2095] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [9]-[12].

F. Governance of media reporting of deaths and mass casualty incidents

11.33 Ms Giles, who was assisting the Good family in the aftermath of the incident, gave evidence that she conducted searches for policies or codes of conduct from the ACMA, the APC, and the Media, Entertainment and Arts Alliance (**MEAA**) which might have been applicable to the incident on 13 April 2024. She was unable to locate any documents concerned with the reporting of deaths, the identification of victims and use of their images, or the reporting of private health information of injured or deceased victims.[2096]

11.34 She was able to locate the following:

(a) *Code of Ethics*, MEAA, including a general requirement to "*[r]espect private grief and personal privacy*";[2097] and

(b) *Statement of Principles*, APC, including requirements that journalists:

> ...
>
> *5 Avoid intruding on a person's reasonable expectations of privacy, unless doing so is sufficiently in the public interest; and*
>
> *6 Avoid causing or contributing materially to substantial offence, distress or prejudice, or a substantial risk to health or safety, unless doing so is sufficiently in the public interest.* [2098]

11.35 Ms Giles was unable to locate any particular guidance in relation to the reporting of deaths or mass casualty incidents.[2099]

11.36 The APC is:

> *... the principal body with responsibility for setting and promoting high professional standards for publisher members and for considering, dealing with and responding to complaints about material in Australian newspapers, magazines and associated and stand-alone digital outlets.* [2100]

11.37 Its objectives are "*to promote freedom of speech through responsible and independent print and digital media, and adherence to high journalistic and editorial standards.*"[2101]

[2096] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [73].
[2097] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [74](a).
[2098] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [74](b).
[2099] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [74].
[2100] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 1.
[2101] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 1.

11.38 The APC has issued *Standards of Practice* which are comprised of the Statements of General Principles, the Statement of Privacy Principles, and Specific Standards which relate to such matters as the coverage of suicide.[2102]

11.39 The APC covers approximately 450 print and online mastheads, and the Statements of General Principles and Statement of Privacy Principles are binding on all member publishers.[2103]

11.40 The APC has also developed Advisory Guidelines to supplement the Statements of General Principles. Advisory Guidelines "*provide specific guidance on issues such as reporting on family and domestic violence, religion and ethnicity, and reporting on people with diverse sexual orientation*."[2104]

11.41 ACMA is responsible for developing Codes of Practice in consultation with relevant industry groups such as radio and television broadcasters.

11.42 Co-regulatory arrangements are established by the *Broadcasting Services Act 1992* (Cth) (BSA), under which TV and radio broadcasters are expected to develop and regularly review industry codes of practice.[2105] The broadcasting codes only apply to terrestrial broadcast. Commercial free-to-air and subscription TV, and on-demand and streaming services are not subject to these codes. Commercial radio delivered through internet radio and podcasts are generally also exempt.[2106]

11.43 Code reviews are expected to be developed in consultation with, and taking account of any relevant research conducted by, the ACMA, among other requirements. The co-regulatory system places responsibilities on broadcasters to balance protecting audiences from harmful content with appropriately informing audiences about matters in the public interest including, for example, violent incidents and terror attacks. The ACMA registers, oversees, and monitors the codes, and can conduct its own motion investigations, as well as investigate unresolved complaints. However, the ACMA can only decide not to register a revised code in limited circumstances and cannot amend existing code provisions.[2107]

11.44 In 2024, the ACMA published its views on the free-to-air commercial TV code, which, relevantly, included that broadcasters should consider strengthening or adding code provisions on the reporting of distressing material, privacy, corrections, and misinformation. In that publication, the ACMA referenced how commercial TV broadcasters had inadvertently amplified misinformation about the identity of the perpetrator of the events of 13 April 2024 at WBJ.[2108]

[2102] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 2.
[2103] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at pp. 1-2.
[2104] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 3.
[2105] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2.
[2106] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2.
[2107] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2.
[2108] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2.

11.45 While the ACMA does not have formal regulatory powers regarding online disinformation or misinformation, it oversees the self-regulatory Australian Code of Practice on Disinformation and Misinformation (the voluntary code), which has several major digital companies as signatories and regularly communicates with digital platforms.[2109]

11.46 As noted above, those assisting me sought engagement from both the APC and ACMA in relation to the media issues that arose in this matter and were provided a copy of Counsel Assisting's proposed recommendations for comment. I am grateful for, and was assisted by, their respective responses.

[2109] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2; See, for example: Australian Communications and Media Authority, "Digital platforms' efforts under voluntary arrangements to combat misinformation and disinformation: Third report to government" September 2024 at p. 30.

G. Submissions, findings, and recommendations

11.47 Counsel Assisting submitted that the events of 13 April 2024 attracted significant and intense public interest. Counsel described the attendance at local shopping centres by Australians as "*a ritual of some form … that is almost universal across Australia*" and observed that this ritual was "*irreparably marred with such terrible violence*". This served to increase public interest in what had occurred, and the media responded to that interest.[2110] Counsel Assisting submitted that the media play a critical and vital role in a functioning democracy.[2111]

11.48 Counsel Assisting submitted, however, that the media reporting in this case was extremely distressing for families and their loved ones, exacerbating their tremendous shock and extreme grief.[2112]

11.49 Counsel Assisting submitted that it is not readily apparent what legitimate purpose was served through some of the reporting, in particular, the repeated display of footage of Mr Cauchi proceeding through the Centre, or footage of the injured victims.[2113]

11.50 Counsel Assisting further submitted that "*the conduct of <u>certain</u> media outlets in the aftermath of 13 April appears to be a wholly unjustified intrusion upon the privacy of the families and friends of the deceased*" (emphasis in original) and that this compounded the grief and torment of those affected by the events of 13 April.[2114]

11.51 Counsel Assisting submitted that there was no clear public interest served by:

(a) Journalists approaching Peter Young and Noel McLaughlin and one of Mr McLaughlin's daughters nearby the family home and requesting a statement;[2115]

(b) Reporters ringing Julie Singleton (to the point that her inbox was full) and leaving notes in her mailbox, seeking comment and information for a story;[2116] and

(c) The frequent (and repeated) approaches by reporters on various social media platforms seeking comment from family members of victims.[2117]

11.52 Counsel Assisting observed that the above behaviour may not be in compliance with the MEAA *Code of Ethics* or the APC *Statement of Principles*, however submitted that the coronial jurisdiction is not the appropriate forum for determination of such complaints, and they are ultimately best left to be determined by the governing bodies.[2118]

[2110] Written submissions of Counsel Assisting at [2801].
[2111] Written submissions of Counsel Assisting at [2802].
[2112] Written submissions of Counsel Assisting at [2803].
[2113] Written submissions of Counsel Assisting at [2803].
[2114] Written submissions of Counsel Assisting at [2804].
[2115] Written submissions of Counsel Assisting at [2805](a).
[2116] Written submissions of Counsel Assisting at [2805](b).
[2117] Written submissions of Counsel Assisting at [2805](c).
[2118] Written submissions of Counsel Assisting at [2806].

11.53 In oral submissions, Counsel Assisting noted that in the course of the Inquest there appeared to be a genuine attempt from the media to listen to the concerns of the families, and to the comments made by Counsel Assisting and the Court regarding sensitivity in reporting. Counsel Assisting referred to one instance where a graphic image was posted by a media outlet, apparently in error, and was immediately taken down when the outlet was alerted. This shows that the media can be responsive, and it is possible to balance the public's desire to know with the need for sensitivity and discretion.[2119]

11.54 Counsel for the Good, Singleton and Young families supported the submissions of Counsel Assisting and raised certain additional matters, being media reporting of health information about victims, and media conduct in obtaining information from the social media accounts of the deceased.[2120]

11.55 In relation to the first matter, Counsel for the Good, Singleton and Young families referred to media reporting about the injuries sustained by Ashlee's young daughter on 13 April 2024,[2121] and noted Ms Giles' evidence regarding the following:

(a) An article that included information about which hospital Ashlee's daughter had been taken to and that she was still there in serious condition, and which described Ashlee's final moments of life;[2122]

(b) An article referring to the hospital where Ashlee's daughter was being treated, and which described Ashlee's final moments of life;[2123] and

(c) An article published in the media which reported, without the consent of her father, that Ashlee's daughter had been moved out of the ICU.[2124]

11.56 Counsel noted the relevant Policy Directive of NSW Health "Public Communications Procedures", included processes for consultation with the media designed to assist in clarifying roles in relation to patient privacy. These processes involved referral of enquiries to the relevant media officer who must receive consent from a patient's Authorised Representative prior to releasing information about the patient.[2125]

11.57 Counsel noted the Inquest received no evidence concerning the process of the release of patient information concerning Ashlee's daughter.[2126] Notwithstanding this, Counsel submitted that media reports regarding Ashlee's daughter's care and treatment and Ashlee's final moments have compounded the grief of the Good family.[2127]

[2119] Transcript, Closing Submissions D1: T1941.44-T1942.2 (25 November 2025).
[2120] Written submissions of Counsel for Good, Singleton and Young Families at [5.2]-[5.3], [6.1].
[2121] Written submissions of Counsel for Good, Singleton and Young Families at [6.1]-[6.10].
[2122] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [16](c).
[2123] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [16](e).
[2124] Exhibit 1, Vol 51, Tab 1635, Statement of Rebekah Giles at [29].
[2125] Exhibit 11, NSW Health Public Communication Procedures, of relevance, see: "Public Communication Procedures: 4.1 Requests for patient information", "Public Communication Procedures: 4.2 Media requests for patient condition reports" at pp. 17-18.
[2126] Written submissions of Counsel for Good, Singleton and Young Families at [6.6].
[2127] Written submissions of Counsel for Good, Singleton and Young Families at [6.6]-[6.8].

11.58 In relation to the issue of media outlets obtaining information from the social media accounts of the deceased, Counsel for the Good, Singleton and Young families submitted that neither Ashlee nor Dawn were public figures prior to their deaths, and that their families have been subjected to the additional trauma of having their social media accounts and those of their deceased loved ones trawled for images and footage by third-party media outlets.[2128]

11.59 Counsel submitted that the evidence indicates that photographs were extracted from social media pages of Dawn and Ashlee and their loved ones and published without their knowledge or permission for use in stories about the incident and "*to promote and sensationalise media coverage of what is already an extremely distressing and traumatic event*."[2129]

11.60 Counsel submitted that the reproduction of material from social media accounts of Dawn and Ashlee, as well as material from the social media accounts of their families, without permission, was and is unethical and immoral, serves no legitimate journalistic purpose, and compounds the grief and distress of the families. Counsel submitted it ought to be curtailed.[2130]

11.61 Counsel for the Tahir family indicated they were grateful for the support they had received from the media, but acknowledge that was not the experience of other families. The Tahir family did, however, expressly endorse the submission of the Good, Young, and Singleton families in relation to the use of material obtained from social media.[2131]

11.62 Counsel for Falkon submitted that Mr Manzoor's evidence of his concerns about privacy invasions by media and social media at Mr Tahir's funeral was not "*an attack on any one person or entity*", but reflective of the tension between "*what is considered an appropriate standard of behaviour*" and "*how is that standard to be enforced*".[2132]

11.63 Counsel noted the instantaneous nature of information flow through modern media platforms, "*whether it be factual or false*",[2133]and submitted that moral and ethical considerations are "*seemingly placed to one side in favour of attracting audience attention*", and objective standards of "*common decency*" are eroded.[2134]

11.64 As Counsel Assisting observed, the nature of some of the reporting and media conduct subsequent to the events of 13 April 2024 does not seem to be in keeping with the MEAA *Code of Ethics* or the APC *Statement of Principles*, however this Inquest is not the appropriate forum to determine those matters.

11.65 Nevertheless, it is clear that some of the media reporting and conduct of the media has had a profound effect on the families. Those families were already traumatised by the

[2128] Written submissions on behalf of the Good, Singleton and Young families at [5.14] and [5.23].
[2129] Written submissions on behalf of the Good, Singleton and Young families at [5.23].
[2130] Written submissions on behalf of the Good, Singleton and Young families at [5.24]-[5.25].
[2131] Transcript, Closing Submissions D2: T2007.8-14 (28 November 2025).
[2132] Written submissions on behalf of Falcon Manpower Solutions Pty Ltd at [15].
[2133] Written submissions on behalf of Falcon Manpower Solutions Pty Ltd at [16].
[2134] Written submissions on behalf of Falcon Manpower Solutions Pty Ltd at [17].

events of 13 April 2024, and it would seem, in some cases, they were retraumatised by the manner in which some of the media reporting was conducted. Every effort was made during the Inquest to make it clear to the media that the families had been affected by aspects of the reporting of the incident and what had happened subsequent to that. This made it even more important that, during the Inquest, the media remained mindful of the manner in which they reported on the Inquest, and for the most part, the media did seem to comply with what was asked of them from the first day.

11.66 There is one exception to this that I note.

11.67 In the course of the Inquest, the Court was informed that a media outlet had not adhered to a non-publication order made by this Court in relation to the identities of particular QPS officers. As was submitted on behalf of the relevant QPS officers, these witnesses were, as a result, subject to "*unnecessary, unreasonable,* [and] *sensational reporting*."[2135]

11.68 In relation to the issue of use of social media posts in media reporting concerning the incident, this was the subject of a proposed recommendation by the Singleton, Young and Good families which I consider further below.

11.69 In light of the above, Counsel Assisting submitted that the evidence establishes that a systemic issue arises as to whether the ethical guidance and statements of principles presently operative in Australia are sufficiently clear to ensure that the media outlets extend the necessary sensitivity to families in the aftermath of a mass casualty event.[2136]

11.70 Counsel Assisting drew attention to the Standards Code published by the United Kingdom's independent press regulator, the Independent Monitor for the Press (**IMPRESS**).[2137] That Standards Code relevantly provides:

> *7.2 Except where justified by the public interest, publishers must:*
>
> ...
>
> *(c) take all reasonable steps not to exacerbate grief or distress through intrusive news gathering or reporting.* [2138]

11.71 Counsel Assisting submitted the above obligation is "*clearly formulated with greater specificity and in stricter terms than that contained in the APC Statement of Principles.*"[2139]

11.72 Counsel Assisting further submitted that the evidence indicates that: there are presently no specific guidelines applicable to media reporting of mass casualty incidents; the guidelines that do apply are described in general terms; and the applicable guidelines

[2135] Transcript, Closing Submissions D1: T1954.31-39 (25 November 2025).
[2136] Written submissions of Counsel Assisting at [2807].
[2137] Written submissions of Counsel Assisting at [2808].
[2138] Written submissions of Counsel Assisting at [2808].
[2139] Written submissions of Counsel Assisting at [2809].

do not accommodate both the significant public interest that comes with a mass casualty incident, nor the widespread grief.[2140]

11.73 Accordingly, Counsel Assisting proposed the following recommendation to the APC:[2141]

> That the Australian Press Council (APC):
>
> (a) Review the Statement of Principles relating to privacy and the avoidance of harm (#5 and #6), particularly having regard to international best practice, including the IMPRESS Standards Code to consider whether any amendments are necessary and appropriate, having regard to the evidence received during the Inquest (and as canvassed in these Findings); and
>
> (b) Consider developing guidelines to apply to media reporting of 'mass casualty incidents'. Such guidelines should, amongst other matters, balance the need and desire for accurate, timely, and informative reporting of such incidents against the significant distress and grief reporting (including graphic/inaccurate reporting) may have on victims and families and/or friends of any deceased.

11.74 In response the APC noted that, consistent with what was discovered by Ms Giles during her searches, they considered that General Principles 5 and 6 are of most relevance to this matter.[2142]

11.75 The APC further identified that General Principle 7 is also of relevance. General Principle 7 directs APC members to "*[a]void publishing material which has been gathered by deceptive or unfair means, unless doing so is sufficiently in the public interest*."[2143]

11.76 Certain Privacy Principles were also considered by the APC to be relevant. These were:

> ...
>
> - *Privacy Principle 1 (Collection of personal information) which provides that in seeking personal information journalists should not unduly intrude on the privacy of individuals and should show respect for the dignity and sensitivity of people encountered in the course of gathering news.*
>
> - *Privacy Principle 2 (Use and disclosure of personal information) which provides that personal information gathered should only be used for the purpose for which it was intended.*
>
> - *Privacy Principle 3 (Sensitive personal information) which provides that media organisations should take reasonable steps to avoid causing or contributing materially to substantial offence, distress or prejudice, or a substantial risk to health or safety, unless doing so is sufficiently in the public interest. It further*

[2140] Written submissions of Counsel Assisting at [2810].
[2141] Written submissions of Counsel Assisting at [2811].
[2142] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 2.
[2143] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 2.

> *provides that members of the public caught up in newsworthy events should not be exploited.* [2144]

11.77 The APC stated that in light of the principles already in effect (which have been set out above) they are already well equipped to address concerns of the type referred to in the submissions.[2145]

11.78 The APC also noted that it uses its complaints data together with community and stake holder engagement to identify trends that may indicate broad community concern with the reporting on particular issues and develops Advisory guidelines to supplement its binding Statements of General Principles.[2146]

11.79 Upon receipt of the response from the APC, Counsel Assisting revised their proposed recommendation. Counsel Assisting now propose that the APC consider developing an advisory guideline to apply to the reporting of mass casualty incidents.[2147] That guideline should, inter alia, balance the need and desire for accurate, timely and informative reporting against the significant distress and grief that the reporting may have on victims, families of those who passed away, and members of the wider community who may be impacted by such incidents.[2148] The revised recommendation was in the following terms:

> **(Revised) Recommendation 18: that the Australian Press Council**
>
> Consider developing an advisory guideline to apply to the report of mass casualty incidents. The guideline should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

11.80 Counsel for the Good, Young, and Singleton families submitted that there may be some utility in having a specific guideline in relation to the reporting of mass casualty incidents.[2149]

11.81 In order to cover television and radio, Counsel Assisting proposed a corresponding recommendation to the ACMA which was as follows:[2150]

[2144] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at pp. 2-3.
[2145] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 3.
[2146] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 3.
[2147] Exhibit 1, Volume 54, Tab 1695, Letter in reply to Australian Press Council.
[2148] Transcript, Closing Submissions D1: T1941.17-37 (25 November 2025).
[2149] Transcript, Closing Submissions D2: T2012.39-48 (28 November 2025).
[2150] Exhibit 1, Vol 54, Tab 1695A, Letter to Australian Communications and Media Authority (excluding enclosures).

Recommendation 18.A: that the Australian Communications and Media Authority (ACMA)

Engage in consultation with the relevant broadcasting industry representatives to consider whether their Code(s) of Practice should be amended to expressly include provisions that govern the reporting of mass casualty incidents. The Code(s) of Practice should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

11.82 In its response, the ACMA noted it has been working with industry bodies to review the broadcasting industry codes of practice, including to consider strengthening provisions on the reporting of distressing material, privacy, corrections, and misinformation. This work has been informed by concerns identified about the reporting of violent and distressing incidents from a 2019 investigation report into the coverage of the Christchurch terror attack and a 2022 position paper on audience expectations.[2151] The ACMA's view on the reporting of violent and distressing incidents is:

> *There is general expectation within the community that content providers make careful and context-appropriate editorial decisions so that the use of any distressing, high-impact content is proportionate to the public interest. While there is an evident public interest in reporting on events that may be distressing to a general audience — such as the Bondi Junction incident — it is not in the public interest to cover a distressing story in a manner that could be considered exploitative or gratuitous.*[2152]

11.83 The ACMA indicated that while it would engage with industry on these issues in line with the proposed recommendation, it noted there are limits on its ability to make or compel changes to industry codes of practice within the co-regulatory system established under the BSA, and there has been reluctance from industry to strengthen or add new content safeguards.[2153]

11.84 The ACMA noted the existing codes may be relevant to the matters considered in this inquest. For example, it provided that the free-to-air commercial TV code requires commercial television broadcasters to:[2154]

(a) Exercise care in selecting material for broadcast (in relation to news and current affairs programs that are exempt from classification), having regard to the likely audience of the program and any identifiable public interest reason for presenting the program (2.3.3);

[2151] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 1.
[2152] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 1.
[2153] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at pp. 1-2.
[2154] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at pp. 2-3.

(b) Not include material likely to seriously distress or seriously offend a substantial number of viewers having regard to the likely audience of the program, unless there is a public interest reason to do so (3.2.1a);

(c) Include spoken warnings before segments that contain material likely to seriously distress or seriously offend a substantial number of viewers, having regard to the likely audience of the program (3.2.1b);

(d) Exercise sensitivity in broadcasting images of or interviews with bereaved relatives or people who have witnessed or survived a traumatic incident (3.2.1d); and

(e) Have regard to the feelings of relatives and viewers when including images of dead bodies or people who are seriously wounded, taking into account the relevant public interest (3.2.1e).

11.85 Relevantly, the ACMA had requested information from signatories and non-signatories to understand how digital platforms were addressing misinformation on their services following the incident on 13 April 2024. While most signatories responded and provided useful information voluntarily, without formal powers the ACMA is constrained from obtaining information.[2155]

11.86 Ultimately, in respect of Counsel Assisting's proposed recommendation to ACMA, the ACMA provided:

> *In relation to radio and television broadcasting, we consider that the recommendation is aligned with our ongoing engagement with the sector to ensure it has in place appropriate community safeguards, including for those affected by mass casualty events.* [2156]

11.87 I have considered the submissions of Counsel Assisting and Counsel for the families and the responses provided by the APC and the ACMA, for whose assistance I am grateful.

11.88 Having regard to the evidence concerning the experiences of the families, and in circumstances where a mass casualty event is likely to attract significant public interest, media coverage, and widespread grief, I consider that it would be beneficial for there to be a specific media guideline, or more specific guidance, in relation to the reporting of mass casualty events. Accordingly, I propose to make the revised recommendation to the APC and the recommendation to ACMA proposed by Counsel Assisting.

[2155] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 2; See, for example: Australian Communications and Media Authority, "Digital platforms' efforts under voluntary arrangements to combat misinformation and disinformation: Third report to government" September 2024 at p. 30.
[2156] Exhibit 1, Vol 54, Tab 1695B, Letter from Australian Communications and Media Authority to Crown Solicitor's Office at p. 1.

RECOMMENDATIONS

Recommendation 22: To the Australian Press Council

That the Australian Press Council consider developing an advisory guideline to apply to the reporting of mass casualty incidents. The guideline should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

Recommendation 23: To the Australian Communications and Media Authority

That the Australian Communications and Media Authority engage in consultation with the relevant broadcasting industry representatives to consider whether their Code(s) of Practice should be amended to expressly include provisions that govern the reporting of mass casualty incidents. The Code(s) of Practice should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

11.89 In light of evidence set out above regarding the use by media of information obtained from social media accounts of the deceased, Counsel for the Good, Singleton and Young families proposed an additional limb to the initial recommendation to the APC proposed by Counsel Assisting being that they:

> Consider implementing policy requiring media outlets to obtain consent from the owner of any social media account as a necessary prerequisite to using any material posted in that account for the purpose of public media reporting or, alternatively, at the very least, requiring media outlets to obtain the consent from the next of kin of the owner of any social media account as a necessary prerequisite to using any material

> posted on that account for the purpose of public media reporting about the person's death or injury. [2157]

11.90 In relation to the above, the APC considers that publications are able to publish material that has been posted to a publicly accessible media account. However, the APC does not consider that publications should publish information simply because it has been posted to social media.[2158]

11.91 The APC noted that it does not have the remit to direct its publisher members to change or implement certain business practices and, accordingly, that I may wish to seek comment on the merits of this proposal from publishers.[2159]

11.92 It is not clear that, having regard to the functions and powers of both the APC and the ACMA, a recommendation in the terms proposed by Counsel for the Good, Singleton and Young families would be workable. Further, the feasibility of such a recommendation was not explored in this Inquest with publishers. For these reasons, I do not propose to make that recommendation.

11.93 Notwithstanding the above, I acknowledge the distress experienced by the families when seeing content obtained from their loved ones' social media published in connection with reporting on this incident, and I continue to encourage the media to be sensitive to the impact of reporting on victims' families.

[2157] Written submissions on behalf of the Good, Singleton and Young families at [5.26].
[2158] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 3.
[2159] Exhibit 1, Vol 54, Tab 1694, Letter from Australian Press Council to Crown Solicitor's Office at p. 4.

Part 12 Concluding remarks and list of recommendations

Concluding remarks and list of recommendations

12.1 The events of Saturday 13 April 2024 were an unimaginable tragedy that devastated our community, but, in particular, the families of Dawn, Jade, Yixuan, Ashlee, Faraz, and Pikria, who will forever be impacted by the unfathomable loss of their loved one that day.

12.2 I would like to again express my sincere condolences and deepest sympathy to the families of Dawn, Jade, Yixuan, Ashlee, Faraz, and Pikria and acknowledge the strength and dignity they have shown in their participation and contributions to this Inquest.

12.3 I would like to acknowledge once again Detective Chief Inspector Andrew Marks of the New South Wales Police Force, and his team, for their dedicated and thorough investigation of the circumstances of this matter.

12.4 I would also like to acknowledge my Counsel Assisting team - Dr Peggy Dwyer SC, Ms Emma Sullivan, and Mr Christopher Murphy - instructed by Ms Amber Doyle of the Crown Solicitor's Office and supported by an extended team of dedicated solicitors. Their commitment to the preparation and conduct of this Inquest has been invaluable.

12.5 Similarly, I also acknowledge the legal representatives of the interested parties in this Inquest, who worked constructively and collaboratively to assist the Court in conducting this Inquest efficiently and thoroughly. The contributions of these representatives, and the persons and organisations they represent, have informed recommendations that I hope will lead to significant change, and ultimately, save lives in the future.

12.6 The following is a list of recommendations arising from this Inquest. The evidence and conclusions underpinning each recommendation are contained in the relevant Parts of these findings.

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

Recommendation 1: To the Health Ombudsman of Queensland

I recommend that the Health Ombudsman of Queensland review Dr Andrea Boros-Lavack's care and treatment of Mr Joel Cauchi.

Recommendation 2: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The document entitled "*Clinical practice guidelines for management of schizophrenia and related disorders*" contains a watermark stating: "*This document is more than five years old and is under review*".

Prompt attention should be given to an amendment of the Guidelines on the management of schizophrenia and related disorders, which should include the following matters (as appropriately formulated by those undertaking the review):

(a) An outline of the types of psychotic disorders described in the DSM-5-TR, including schizophrenia; schizophreniform disorder; schizoaffective disorder; brief psychotic disorder and delusional disorder;

(b) A description of the disorder known as schizophrenia;

(c) A definition of "Treatment Resistant Schizophrenia";

(d) That evidence demonstrates a significant risk of relapse for patients with schizophrenia who cease medication;

(e) That patients with chronic forms of schizophrenia who have relapsed after ceasing medication should be advised to stay on medication indefinitely, given the high risk of relapse; and

(f) That if a patient with treatment resistant schizophrenia elects to cease their medication, they should be monitored indefinitely if possible, and in accordance with the separate practice guideline on "deprescribing" antipsychotic medication.

Recommendation 3: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The RANZCP should draw up and distribute a separate professional practice guideline on "deprescribing" antipsychotic medication, where a patient with schizophrenia declines to remain on medication, or is deliberately deprescribed. Such a guideline should be based on expert opinion and contemporary evidence.

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

Such a Guideline should include:

(a) Advice to the patient on the risk of relapse and the longitudinal clinical adversity associated with relapse (that is, not only is the patient likely to relapse, but each time they do, the illness has greater long term impacts on their outcomes);

(b) Advice to the patient on how to recognise early warning signs of relapse;

(c) A contingency plan articulating appropriate actions to be taken and pathways to care, should a person or their support network find evidence of early warning signs;

(d) Advice on who to contact in the event of signs of relapse;

(e) Advice on how to educate family and friends to recognise the signs of relapse;

(f) The requirement for a written discharge letter on handover of a patient with treatment resistant schizophrenia, with the following minimum requirements:

i. A history of the patient's illness and treatment;

ii. Overview of symptoms in last six months of treatment;

iii. Findings from the most recent mental state examination;

iv. Probability of relapse;

v. Advice as to early warning signs of relapse;

vi. Any relevant support persons who are available to assist the patient and contact details; and

(g) Advice that regular review by a psychiatrist should be included in any management plan for the patient.

Recommendation 4: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

That the RANZCP collaborate with the Royal Australian College of General Practitioners (RACGP) to develop shared care guidelines to optimise the

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

management of patients with chronic schizophrenia, including treatment resistant schizophrenia, and that the RANZCP assume the role of lead organisation in this process.

Recommendation 5: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Commissioner of the NSW Police Force and the Commissioner of the Queensland Police Service

That the Commissioner of the NSW Police Force and the Commissioner of the Queensland Police Service convene with relevant representatives from the RANZCP to form a working group to consider the nature and role (if any) of psychiatrists in preparing assessments of fitness for weapons licensing, and whether that role should be incorporated into weapons licensing legislation (including in the form of a Multi-Disciplinary Assessment Panel or other such panel of experts), including having regard to the following matters:

(a) The extent to which the RANZCP "Professional Practice Guideline 23 – Firearms Risk Assessment" (2023) provides appropriate guidance for psychiatrists and firearms licensing authorities;

(b) The extent to which persons with chronic mental health disorders involving psychotic episodes (such as schizophrenia) should be permitted to have any access to firearms; and

(c) The views expressed in the evidence of the expert psychiatric panel obtained during the Inquest hearing.

Recommendation 6: To the Royal Australian College of General Practitioners (RACGP)

That the RACGP collaborate with the RANZCP on the development of shared care guidelines to optimise the management of patients with chronic schizophrenia, including treatment resistant schizophrenia (noting the RANZCP is the lead organisation in this process).

The Guideline should include:

General Recognition that:

(a) General practitioners have a key role in supporting patients with schizophrenia.

(b) General practitioners have a role in the early detection of prodromal symptoms, monitoring and preventing risks, including relapses, and providing high-quality primary and secondary prevention and treatment of common physical problems. However, this must be done in

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

conjunction with the patient's specialist mental health service/consultant psychiatrist, who have an important role assisting general practitioners, patients and carers to understand the risks and presentation of relapse for each patient.

(c) Effective care requires a thorough understanding of local specialist services, cardiometabolic and other effects of pharmacotherapies, familiarity with psychosocial interventions and proactive multidisciplinary chronic disease management. This must be led by the patient's specialist mental health service/consultant psychiatrist who commit to informing the patient, carers and the patient's general practitioner to assist them to provide care in a collaborative framework effectively.

(d) The general practitioner should ensure that they liaise with specialist mental health teams/consultant psychiatrists to obtain advice with respect to the matters outlined below, and to ensure that advice is passed on to the patient and carers. Such advice should cover:

i. Advice on the risk of relapse if not medicated;

ii. Advice on how to recognise early warning signs of relapse; and

iii. Who to contact in the event of signs of relapse.

Regarding Treatment Resistant Schizophrenia

(a) Treatment resistant schizophrenia is uncommon, and general practitioners should not be expected to have thorough knowledge of this condition. Specialist mental health services/consultant psychiatrists must provide the patient, carers and the patient's general practitioner with the following:

i. A definition of treatment resistant schizophrenia;

ii. Advice as to the circumstances in which a general practitioner can prescribe clozapine, noting that options and requirements may be different in each state. This must include ongoing support from the patient's mental health service/consultant psychiatrist;

iii. A clear understanding that a psychiatrist should be involved in the ongoing management of patients with chronic schizophrenia, including treatment resistant schizophrenia;

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

iv. Advice that it is preferable for persons with treatment resistant schizophrenia to remain on medication;

v. An indication regarding the risk of relapse for patients with treatment resistant schizophrenia, who cease medication (for example, expressed as an "extremely high risk" or by way of percentage) and associated risks with regard to harm to self and others; and

vi. Advice about risks with regard to driving and access to/use of heavy equipment/machinery and weapons.

Minimum standards for a general practitioner on initial intake of a patient with treatment resistant or chronic schizophrenia

(a) Once ongoing shared care of a patient with chronic schizophrenia (including treatment resistant schizophrenia) has been actively accepted by a general practitioner, the specialist mental health team/consultant psychiatrist must provide the patient, carers and the patient's general practitioner with the following:

i. All relevant records from the public/private sector carer involved (including all recent discharge summaries and specialist outpatient letters);

ii. Information to assist with ongoing assessment of the current risk of relapse and other risks for the patient;

iii. The likely signs/symptoms of relapse; and

iv. The early warning signs/symptoms of relapse.

(b) These aspects of care are a shared responsibility between specialist mental health services and general practitioners and require appropriate and timely clinical handover/communication.

(c) The specialist mental health team/consultant psychiatrist has an important role in ensuring that they review the person at regular intervals appropriate for each patient in collaboration with the patient's general practitioner.

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

Minimum clinical handover standards for a general practitioner when the care of a patient with treatment resistant or chronic schizophrenia is transferred to another provider

On transfer of a patient with treatment resistant or chronic schizophrenia to another general practitioner, the current treatment team (specialist mental health services/consultant psychiatrists/general practitioner) have a responsibility to:

(a) Explain to the patient, carers and the patient's new general practitioner the need for ongoing medical care and regular review by a general practitioner and psychiatrist;

(b) Prepare a comprehensive clinical handover letter, outlining:

i. The patient's current mental health status;

ii. The risk of relapse and any other risks (for example, self-harm, suicide, homicide, access to weapons, driving, ability to adhere to medications) at the time of discharge;

iii. The early warning signs and symptoms of relapse;

(c) Provide the patient with a copy of the letter; and

(d) Provide the patient, and (where possible) the patient's family/friends, with the contact details of other support services and the options for psychiatric care.

Recommendation 7: To the NSW Government

That the NSW Government:

(a) Model the need for short term accommodation in the greater Sydney area for those experiencing mental health issues and homelessness, and then establish and support those services.

(b) Support the establishment and ongoing evaluation of long term accommodation for those experiencing mental health issues and homelessness, with on-site or easily accessible long term mental health care, based on the models delivered by Habilis (NSW) and Haven (Victoria).

Recommendation 8: To the NSW Government

(1) That the NSW Government, over the next 12 months:

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

(a) Obtain advice from NSW Health on the decline of and related demand for mental health outreach services in NSW, and on the work being done in this area;

(b) Obtain advice from NSW Health as to the additional resources that are required to meet the need for outreach psychiatric services that can effectively collaborate with stakeholders to evaluate and engage people with severe untreated mental illness - including people without housing; and

(c) Obtain advice from NSW Health as to a realistic timeframe to achieve those additional resources/services, noting the need to recruit skilled staff and build service capacity.

(2) Having regard to evidence that some patients with treatment resistant schizophrenia are cared for by community health centres (CHCs), and then discharged to general practitioners after episodes of care, the NSW Government, over the next 12 months:

(a) Obtain advice from NSW Health on what is required to provide a model to care for persons suffering complex, severe mental illness, with a risk of relapse;

(b) Obtain from NSW Health a comprehensive report advising of options to improve the current system in which public mental health services are provided to consumers, including:

i. The need for additional resourcing for CHCs;

ii. The need for a better understanding amongst private practitioners as to the treatment and support pathways already available within the NSW Health system that they can draw on;

iii. More constructive engagement in collaborative care between mental health services and the primary care sector; and

iv. A mapped timeframe for achieving those reforms, setting out the steps required to build frameworks and workforce capacity, and

(3) For the assistance of CHCs, NSW Health should ensure clinicians have ready access to contemporary evidence based "deprescribing" guidelines, noting potential risk inherent when consumers, including those with treatment resistant schizophrenia cease prescribed psychotropic medication. In order to facilitate this goal, NSW Health should liaise with RANZCP in relation to the

Part 2: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

development of deprescribing Guidelines referred to at Recommendation 3.

Part 3: Mr Cauchi's interactions with QPS

Recommendation 9: To Queensland Health

That Queensland Health give consideration to an amendment to s 157B of the *Public Health Act 2005* (Qld) to:

(a) Refer to "immediate risk of serious harm to others", rather than only referring to "immediate risk of serious harm to self";

(b) Expand the example in the provision beyond that of suicide; and

(c) Provide further clarification on the definition of "serious harm" for the purposes of the provision.

Recommendation 10: To the Commissioner of the Queensland Police Service

That the Commissioner of the Queensland Police Service:

(a) Evaluate the service needs for Mental Health Intervention Coordinators (MHICs) in each region; and

(b) Give consideration to increasing staff in the Darling Downs region, an area of recognised need.

Recommendation 11: To the NSW Government

That the NSW Government consider options to support the roll-out of appropriate co-responder models so that they are more widely available throughout NSW.

Part 4: Mr Cauchi's movements in NSW from 2023-2024 and his interest in knives

Recommendation 12: To the NSW Government

That the NSW Government monitor and assess the trial of the amendments to the *Law Enforcement Powers and Responsibilities Act 2002* (NSW) in respect of "wanding", including whether:

(a) Such a trial should be made permanent; or

(b) The law should apply to certain "crowded places" without the need for a declaration to be made.

Part 5: Active Armed Offender (AAO) events

Recommendation 13: To the NSW Government

That the NSW Government actively promote, by way of an advertising campaign, the principles of "Escape. Hide. Tell.", including by encouraging operators and owners of Crowded Places to disseminate the messaging amongst staff, retailers, and attendees.

Part 6: The Events of 13 April 2024

Recommendation 14: To the Council for the Australian Bravery Decorations

Given the evidence disclosing exceptional bravery on the part of a number of individuals who confronted Joel Cauchi on 13 April 2024, I recommend that the Council for the Australian Bravery Decorations review the relevant evidence in the Inquest and consider an appropriate award in recognition of their actions on that day – namely: Inspector Amy Scott; Ashlee Good; Noel McLaughlin; Damien Guerot; and Silas Despreaux.

Part 9: Response of NSWA to the events of 13 April 2024

Recommendation 15: To NSW Ambulance

That NSW Ambulance confirm the introduction of Tranexamic acid (TXA) as part of the standard products carried in NSW Ambulance vehicle equipment.

Recommendation 16: To NSW Ambulance

That NSW Ambulance's current review of the NSW Ambulance Major Incident Response Plan (NSW AMPLAN) includes consideration of the following matters (as highlighted during the evidence received during the Inquest):

(a) The roles and responsibilities of commanders and the functional roles they are to undertake (including as defined in the Action Cards);

(b) The command structure roles;

(c) The adequacy of the training for, and exercising of, commanders to ensure they obtain and maintain competency;

(d) A new command tabard system to better identify commanders and functional role on scene (drawing on the UK National Ambulance Service, Command and Control Guidance (dated February 2024) as relevant); and

Part 9: Response of NSWA to the events of 13 April 2024

(e) Appropriate training in relation to major incident management and the amended AMPLAN document.

Recommendation 17: To NSW Ambulance

That NSW Ambulance give further and expedited consideration to the status of the 2024 review into the Special Operations Unit (SOU) response capability, including the merits of the SOU operating as a standalone unit and with a view to increasing the capacity for Special Operations Team (SOT) resourcing.

Part 10: Emergency Services Interoperability

Recommendation 18: To the NSW Government

That the NSW Government (in consultation with the Commissioners of the NSW Police Force, NSW Ambulance, and Fire and Rescue NSW and other emergency services agencies as appropriate) convene an *urgent working group* involving relevant representatives from emergency services to consider a) development, and b) implementation, of an emergency services interoperability philosophy, model and framework for NSW (including drawing on the evidence from the Inquest and from the Joint Emergency Services Interoperability Programme (JESIP) framework and doctrine in the United Kingdom, as appropriate) to provide a clear structure and framework for multiagency responses to major incidents.

Recommendation 19: To the NSW Government

That the working group urgently convened by the NSW Government (per Recommendation 18), consider the implementation of the Ten Second Triage (TST) rapid screening tool by emergency services in NSW, including having regard to the expert evidence from the Inquest as to a) the significant benefits that may flow from use of the tool, and b) the need for utilisation of the tool within a broader model of emergency service interoperability (as referred to in Recommendation 18).

Recommendation 20: To the NSW Police Force and NSW Ambulance

That NSW Police Force and NSW Ambulance conduct a joint review of existing interagency radio communication protocols and processes in relation to major incidents, to identify potential areas for enhancement or improvement (including having regard to the principles identified in the JESIP Doctrine regarding communications between Control Rooms), by way of developing or improving joint operating protocols.

Recommendation 21: To NSW Ambulance

That the Commissioner of NSW Ambulance (in consultation with relevant personnel from the NSW Police Force) review the potential utility of a Rescue Task

Part 10: Emergency Services Interoperability

Force concept, including having regard to models utilised in other jurisdictions, to consider the feasibility of such a model for NSW Ambulance.

Part 11: Media reporting

Recommendation 22: To the Australian Press Council

That the Australian Press Council consider developing an advisory guideline to apply to the reporting of mass casualty incidents. The guideline should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

Recommendation 23: To the Australian Communications and Media Authority

That the Australian Communications and Media Authority engage in consultation with the relevant broadcasting industry representatives to consider whether their Code(s) of Practice should be amended to expressly include provisions that govern the reporting of mass casualty incidents. The Code(s) of Practice should, amongst other matters, balance the need and desire for accurate, timely and informative reporting of such incidents, against the significant distress and grief that reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.

Appendix 1: Legal Team Assisting the State Coroner

NAME	CHAMBERS/OFFICE
Counsel Assisting	
Dr Peggy Dwyer SC	Forbes Chambers, Sydney
Emma Sullivan	Forbes Chambers, Sydney
Christopher Murphy	Alinea Chambers, Sydney
Solicitor Assisting	
Amber Doyle (for the NSW Crown Solicitor)	Crown Solicitor's Office (NSW)
Legal Team Assisting	
Bronwyn Lorenc	Crown Solicitor's Office (NSW)
Taylor Bird	Crown Solicitor's Office (NSW)
Mark McAlary	Crown Solicitor's Office (NSW)
Alana Galasso	Crown Solicitor's Office (NSW)
Isabella Jiang	Crown Solicitor's Office (NSW)
Alexandra Richardson	Crown Solicitor's Office (NSW)
Catherine Pinnell	Crown Solicitor's Office (NSW)
Jessica Wang	Crown Solicitor's Office (NSW)
Marissa Wong	Crown Solicitor's Office (NSW)

Appendix 2: Coroners Court of NSW officers

NAME	DEPARTMENT/OFFICE
Coroners Court of NSW Registry and Court Officers	
Iain Watt	Coroners Court of NSW, Sydney
Robyn Short	Coroners Court of NSW, Sydney
Jennifer Bronfenbrener	Coroners Court of NSW, Sydney
Rana Lakkis	Coroners Court of NSW, Sydney
Bradley Lachowicz	Coroners Court of NSW, Sydney
Georgette Isaac	Coroners Court of NSW, Sydney
Shaun Flint	Coroners Court of NSW, Sydney
Coronial Information and Support Officers	
Lara Mina	Coroners Court of NSW, Sydney
Nancy Huynh	Coroners Court of NSW, Sydney
Misty Koulianos	Coroners Court of NSW, Sydney
Amy Vincent-Pennisi	Coroners Court of NSW, Sydney
IT Support Staff	
Anthony Donlon	Department of Communities and Justice

Appendix 3: Legal representatives for Interested Parties

INTERESTED PARTY	COUNSEL/ SOLICITOR	LEGAL REPRESENTATIVE	CHAMBERS/FIRM/OFFICE
Family of Jade Young; Family of Ashleey Good; Family of Dawn Singleton	Counsel	Sue Chrysanthou SC	153 Phillip Barristers
		Tanya Harris-Roxas	13 Wentworth Chambers
	Solicitor	Patrick George and Jeremy Marel	Giles George
Family of Faraz Tahir	Counsel	Lester Fernandez SC	Forbes Chambers
	Solicitor	Paul Townsend (acting as junior counsel) and Melissa Chu	Legal Aid NSW
Family of Yixuan Cheng	Counsel	Daniel Roff	Garfield Barwick Chambers
	Solicitor	Jenny Xu	KPT Legal
Family of Pikria Darchia	Counsel	Daniel Roff	Garfield Barwick Chambers
	Solicitor	Paul Blake	KPT Legal
Scentre Shopping Centre Management Pty Ltd	Counsel	Dean Jordan SC	Forbes Chambers
		Ann Bonnor	Forbes Chambers
	Solicitor	Michael Selinger and Ashleigh Mills	Holding Redlich
Glad Group Pty Ltd	Counsel	Adam Casselden SC	Greenway Chambers
	Solicitor	Leighton Hawkes and Howard Mullen	McCabes Lawyers
Falkon Manpower Solution Pty Ltd	Counsel	Linda Clarke	Orange Chambers
	Solicitor	Numair Malik	i-Global Lawyers
Dr Andrea Boros-Lavack	Counsel	Mark Lynch	
	Solicitor	John Kamaras	Avant Law
Dr Richard Grundy	Counsel	Ragni Mathur SC	Maurice Byers Chambers
	Solicitor	Kelly Poh and Suzanne Wallace	Moray and Agnew Lawyers

INTERESTED PARTY	COUNSEL/ SOLICITOR	LEGAL REPRESENTATIVE	CHAMBERS/FIRM/OFFICE
Commissioner, NSW Police Force	Counsel	Sophie Callan SC	12 Wentworth Selbourne Chambers
		Amber Richards	12 Wentworth Selbourne Chambers
	Solicitor	Katherine Garaty and Rebecca Atherton	Office of the General Counsel, NSW Police Force
Commissioner, QLD Police Service	Counsel	Dr Ian Freckleton AO KC	Castan Chambers, Melbourne
		Christine Melis	12 Wentworth Selbourne Chambers
	Solicitor	Carolyn Harrison	Queensland Police Service, Legal Division
NSW Ambulance	Counsel	Hilbert Chiu SC	Tenth Floor Chambers
		Maddison Summerhayes	Sir Owen Dixon Chambers
	Solicitor	Danielle Ashton	Makinson d'Apice Lawyers
Dr Sagir Parkar	Counsel	Ragni Mathur SC	Maurice Byers Chambers
	Solicitor	Kelly Poh and Suzanne Wallace	Moray and Agnew Lawyers
Dr John Pietsch	Counsel	Ben Wilson	Maurice Byers Chambers
	Solicitor	Marianne Nicolle	Meridian Lawyers
Dr Nathan Ruge	Counsel	Ragni Mathur SC	Maurice Byers Chambers
	Solicitor	Kelly Poh and Suzanne Wallace	Moray and Agnew Lawyers
RN Andrea Brooks	Counsel	Sally Robb KC	Carbolic Chambers, Brisbane
	Solicitor	Evonne Smyth	QNMU Law
RN Clare Schwarz	Counsel	Sally Robb KC	Carbolic Chambers, Brisbane
	Solicitor	Evonne Smyth	QNMU Law
QPS officers: Constable Roy Avenell;	Solicitor	Calvin Gnech	Gnech and Associates

INTERESTED PARTY	COUNSEL/ SOLICITOR	LEGAL REPRESENTATIVE	CHAMBERS/FIRM/OFFICE
Senior Constable Hope Porter; Senior Constable Peter McDiarmid; Senior Constable Matthew McDonnell; Sergeant Tracy Morris			
NSW Health	Counsel	Hilbert Chiu SC	Tenth Floor Chambers
		Madison Summerhayes	Sir Owen Dixon Chambers
	Solicitor	Danielle Ashton	Makinson d'Apice Lawyers
Queensland Health	Solicitor	Esther Fletcher	Queensland Health, Legal Branch
SafeWork NSW	Counsel	Justin Pen	Greenway Chambers
	Solicitor	Tom Sorrenson	Department of Customer Service (NSW)

Appendix 4: NSWPF Coronial Team

NAME	SQUAD/ROLE
Investigation Team	
Detective Chief Inspector Andrew Marks (Officer in Charge and Senior Critical Incident Investigator)	Homicide Squad, State Crime Command
Detective Sergeant Paul Mangan	Homicide Squad, State Crime Command
Detective Senior Constable Brendon Coppola	Homicide Squad, State Crime Command
Detective Senior Constable James Bale	Homicide Squad, State Crime Command
State Technical Investigation Branch	
Senior Constable Narayan Holden	State Technical Investigation Branch
Family Liaison Officers	
Detective Sergeant Toni Procter	Family Liaison Officer Coordinator
Senior Sergeant Michelle Hallett	Family Liaison Officer
Sergeant Emily Bonnici	Family Liaison Officer
Detective Senior Constable Christopher Abela	Family Liaison Officer
Detective Senior Constable Leah Collins	Family Liaison Officer
Senior Constable Kylie Brown	Family Liaison Officer
Senior Constable Tanya Montouri	Family Liaison Officer

Appendix 5: Issues List

Notes:

- **This Issues List is non-exhaustive and provided an indication of the matters that would be the focus of the inquest hearing.**
- **The below were proposed for consideration only, and without limitation as to other potential matters that may be the subject of potential recommendations.**

No.	ISSUE
A.	**Statutory findings under s 81 of the *Coroners Act 2009* (NSW)**
1.	The statutory findings required under s 81 of the *Coroners Act 2009* (NSW) – namely, the identity of, and the date, place, manner, and cause of death of each of the deceased.
2.	Related to (1), the chronology and circumstances of the events on 13 April 2024.
B.	**Joel Cauchi**
3.	Relevant background relating to Mr Cauchi, including the circumstances in which he came to move from Queensland to NSW in December 2023, and relevant events in the period prior to 13 April 2024.
4.	What mental health condition(s) was Mr Cauchi suffering from on 13 April 2024, and the nexus (if any) to the events on that date.
5.	Related to (4), Mr Cauchi's state of mind prior to and on 13 April 2024, including: (a) Whether and to what extent (if any) there was identifiable motive(s) or planning; and (b) Whether Mr Cauchi targeted any particular individuals or groups.
6.	Whether treatment received by Mr Cauchi for his mental health condition(s) was adequate and appropriate, including, in particular: (a) The circumstances in which Mr Cauchi ceased the use of psychotropic medication to treat his mental health condition(s); and (b) The management of Mr Cauchi's mental health from February 2020 onwards, including any treatment(s) received.
7.	Mr Cauchi's interactions with NSW and Queensland Police, and the status of his mental health at those times, including whether there were opportunities for early intervention in relation to those interactions.

No.	ISSUE
C. Response to events on 13 April 2024	
Scentre Group and other subcontractors	

8. The nature and timing of the response of Scentre Group (and security subcontractors Glad Group and Falkon Security) to the events on 13 April 2024, including:

   (a) The first point in time when staff in the CCTV Control Room at Westfield Bondi Junction became aware of an active armed offender (**AAO**) in the Centre;

   (b) The actions and timing of actions taken by security staff thereafter;

   (c) The communications as between security staff in relation to an AAO;

   (d) The nature and timing of the alerts and alarms that followed;

   (e) The nature and timing of evacuation instructions given to shoppers within the centre;

   (f) The response of security guards within Westfield Bondi Junction to the AAO; and

   (g) The nature of communications as between staff and emergency responders.

---

9. The adequacy of the response of Scentre Group (and security subcontractors Glad Group and Falkon Security) to the events on 13 April 2024, including having regard to:

   (a) The applicable policies and procedures for dealing with an AAO at Westfield Bondi Junction, and the currency and adequacy of such policies and procedures to deal with the events that occurred on 13 April 2024 (including having regard to the subcontracting of security services);

   (b) The training of relevant staff (including retail staff) within Westfield Bondi Junction to address the circumstances of an AAO (including the extent of any drills or scenario training);

   (c) The status of CCTV security monitoring at Westfield Bondi Junction and related procedures and policies;

   (d) The efficacy of the alarm and warning systems at Westfield Bondi Junction in the scenario of an AAO;

   (e) The adequacy of the training of security guards (including general security training, training for dealing with an AAO, first aid training, and any site-specific training);

   (f) The adequacy and appropriateness of equipment available to security guards in an AAO scenario (including protective and first aid equipment); and

   (g) The nature and adequacy of the subcontracting of security services at Westfield Bondi Junction to Glad Group and Falkon Security.

No.	ISSUE
NSW Police Force (NSWPF)	
10.	The circumstances in which Inspector Amy Scott discharged her firearm, leading to the death of Mr Cauchi, including whether such use of force was justified, reasonable and appropriate.
11.	The nature and timing of the NSWPF response to the events on 13 April 2024, including: (a) How and when NSW Police first became aware of an AAO at Westfield Bondi Junction; (b) The timing and response of NSW Police to emergency calls; (c) The nature of communications between NSW Police, Scentre Group staff (and subcontractors) and NSW Ambulance; (d) The nature and timing of any evacuation instructions given by NSW Police to shoppers within the Centre; (e) The organisation and implementation of a command structure at Westfield Bondi Junction by NSW Police; and (f) Whether there were impediments to the response by NSW Police.
12.	The adequacy of the response of NSW Police to the events on 13 April 2024, including having regard to: (a) Applicable policies and procedures relevant to an AAO and/or mass casualty incident as it is unfolding, including whether those policies and procedures were complied with, and the adequacy of such policies and procedures to deal with the events that occurred on 13 April 2024; (b) The adequacy and appropriateness of equipment available to NSW Police (including in particular, whether NSW Police were suitably equipped to attend to injured victims); (c) The appropriateness and efficacy of any first-aid rendered by NSW Police; (d) The effectiveness of communications as between NSW Police and each of NSW Ambulance and Scentre Group; (e) The suitability of the command structure implemented by NSW Police at Westfield Bondi Junction; (f) The identification of potential additional AAOs, including communications in respect of this and the dissemination of related information, and the impact this had (if any) on the response by NSW Police and NSW Ambulance; and (g) The adequacy and timing of communications with families of the deceased in the aftermath of events on 13 April 2024.

No.	ISSUE
	NSW Ambulance
13.	The nature and timing of the NSW Ambulance response to the events on 13 April 2024, including: (a) How and when NSW Ambulance became aware of the events at Westfield Bondi Junction; (b) The timing and response of NSW Ambulance to emergency calls; (c) The nature of communications between NSW Ambulance, Scentre Group staff (and subcontractors) and NSW Police; (d) The declaration of Westfield Bondi Junction as a "hot zone" and the circumstances in which this occurred; and (e) Whether there were impediments to the response by NSW Ambulance.
14.	The adequacy of the response of NSW Ambulance to the events on 13 April 2024, including having regard to: (a) Applicable policies and procedures relevant to an AAO and/or mass casualty incident, including whether those policies and procedures were complied with and the adequacy of such policies and procedures to deal with the events that occurred on 13 April 2024; (b) The effectiveness of communications as between NSW Ambulance and each of NSW Police and Scentre Group; (c) The first aid provided and the treatment decisions of NSW Ambulance paramedics (including the adoption of "mass casualty procedures"); and (d) The adequacy and appropriateness of equipment available to NSW Ambulance (including whether paramedics were equipped with appropriate equipment to respond to a mass casualty incident).
	Media reporting in the immediate aftermath of the events of 13 April 2024 and impact upon the families of the deceased
15.	The general nature and content of the media response (in de-identified form) to the events at Westfield Bondi Junction on 13 April 2024, including media reporting and media activities to obtain information, images and/or footage in the immediate aftermath.
16.	The impact of the media reporting at (15) upon the families of the deceased persons.

No.	ISSUE
D.	**Recommendations under s 82 of the *Coroners Act 2009* (NSW)**
17.	Pursuant to s 82 of the *Coroners Act 2009* (NSW), whether it is necessary or desirable to make any recommendations in relation to any of the following subject areas: (a) What, if any, alternatives are available or could be implemented for the treatment of persons suffering from chronic schizophrenia; (b) The extent to which there should or could be restrictions imposed on the sale of weapons (including Ka-Bar USMC utility knives and equivalents). (c) The utility or desirability of providing additional equipment to security contractors (whether offensive or defensive), including any other appropriate security measures that should be implemented at commercial shopping centres; (d) The training of security staff at commercial shopping centres to deal with mass casualty events; (e) How best to educate, advise and alert members of the public who are put at risk by a mass casualty event; (f) The coordination of emergency services; (g) Communication protocols for NSW Police (including the possibility of a central hotline) for the efficient and effective provision of information to families and friends in the aftermath of a mass casualty event; and (h) The adequacy and appropriateness of industry policies/and or codes of conduct to the media reporting applicable to mass casualty events.

Appendix 6: Witness List

No.	NAME	ORGANISATION/ROLE	DATE CALLED
1.	Detective Chief Inspector Andrew Marks	NSW Police Force (Officer in Charge)	28 April 2025
2.	Inspector Amy Scott	NSW Police Force	29 April 2025
3.	Silas Despreaux	Civilian	29 April 2025
4.	Damien Guerot	Civilian	29 April 2025
5.	Chief Inspector Christopher Whalley	NSW Police Force	29 April 2025
6.	Christopher Wilkinson	NSW Ambulance	30 April 2025
7.	Assistant Superintendent Brent Armitage	NSW Ambulance	30 April 2025
8.	SOT 1	NSW Ambulance	1 May 2025
9.	Chief Inspector Colin Green	NSW Police Force	1 May 2025
10.	Senior Constable Roy Avenell	QLD Police Service	5 May 2025
11.	Senior Constable Matthew McDonnell	QLD Police Service	5 May 2025
12.	Senior Constable Hope Porter	QLD Police Service	5 May 2025
13.	Senior Constable Peter McDiarmid	QLD Police Service	5 May 2025
14.	Senior Sergeant Tracy Morris	QLD Police Service	6 May 2025
15.	Inspector Bernard Quinlan	QLD Police Service	6 May 2025
16.	Joseph Gaerlan	Scentre Group	7 May 2025
17.	Jerry Helg	Scentre Group (formerly of Glad Group)	7-8 May 2025
18.	Andrew David	Glad Group	8 May 2025
19.	Lulu Fatima	Glad Group	8 May 2025
20.	Inspector Brett Simpson	NSW Ambulance	9 May 2025

No.	NAME	ORGANISATION/ROLE	DATE CALLED
21.	Cameron Stuart	Glad Group	9 May 2025
22.	Bradley Goldberg	Scentre Group	9 May 2025
23.	RN Clare Schwarz	Nurse (Mi-Mind Centre)	12 May 2025
24.	RN Andrea Brooks	Nurse (Mi-Mind Centre)	12 May 2025
25.	Dr Andrea Boros-Lavack	Psychiatrist (Mi-Mind Centre)	13-14 May 2025
26.	Dr Nathan Ruge	GP	14 May 2025
27.	Dr Amitava Sarkar	Psychiatrist	14 May 2025
28.	Dr Richard Grundy	GP	15 May 2025
29.	Dr Sagir Parkar	Psychiatrist	15 May 2025
30.	Dr John Pietsch	GP	15 May 2025
31.	Scott Wilson	Expert (Security)	19 May 2025
32.	John Yates	Scentre Group	20 May 2025
33.	Professor Olav Nielssen	Expert (Psychiatrist)	22 May 2025
34.	Professor Edward (Ed) Heffernan	Expert (Psychiatrist)	22 May 2025
35.	Professor Anthony Harris	Expert (Psychiatrist)	22 May 2025
36.	Professor Merete Nordentoft	Expert (Psychiatrist)	22 May 2025
37.	Professor Matthew Large	Expert (Psychiatrist)	22 May 2025
38.	Dr Thomas Evens	NSW Ambulance	23 May 2025
39.	Dr Stefan Mazur	Expert (Emergency physician)	23 May 2025
40.	Dr Philip Cowburn	Expert (Emergency physician)	23 May 2025
41.	Dr Hester Wilson	Expert (GP)	23 May 2025

No.	NAME	ORGANISATION/ROLE	DATE CALLED
42.	Dr Edwin Kruys	Expert (GP)	23 May 2025
43.	Senior Sergeant William Watt	NSW Police Force	26 May 2025
44.	Steve Iloski	Glad Group	26 May 2025
45.	Murtaza Manzoor	Falkon Manpower Solution	26 May 2025
46.	Assistant Commissioner Peter McKenna	NSW Police Force	27 May 2025
47.	Deputy Commissioner Wayne McKenna	NSW Ambulance	27 May 2025
48.	Acting Deputy Commissioner Mark Kelly	QLD Police Service	28 May 2025
49.	Dr Brendan Flynn	NSW Ministry of Health	28 May 2025
50.	Superintendent Kirsty Hales	NSW Police Force	28 May 2025

Appendix 7: Exhibits

EXHIBIT NUMBER	DESCRIPTION
1.	Brief of evidence
2.	Annotated plan
3.	Crowded Places Forum promotional material
4.	"DCER"
5.	Oxford Clinic Psychiatric Consent Form
6.	Professor Matthew Large and Professor Olav Nielssen, 'Schizophrenia and Homelessness can be a deadly combination' (Sydney Morning Herald, online, 15 April 2024)
7.	Notes of conference between Dr Cowburn, Dr Evens and Dr Mazur
8.	Email from Michele Cauchi to Mi-Mind Centre
9.	ABC Report, 'Push for police to be removed from mental health crisis responses' (27 May 2025)
10.	Footage of Faraz Tahir and another security officer during Scentre Group induction
11.	"New South Wales Health Public Communication Procedures" Policy Directive
12.	Portfolio Committee No. 2, NSW Legislative Council, 'Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales' (Report No. 64, June 2024)
13.	NSW Government Response to 'Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales' (Report No. 64, June 2024)

Appendix 8: Inquest Statistics

INQUEST STATISTICS	
Court Proceedings	
Directions hearings	12 November 2024 and 7 April 2025
Date range of hearing	28 April 2025 to 29 May 2025
Total number of hearing days (excluding directions hearings)	21
Number of witnesses who gave evidence	50
Number of legally represented interested parties	27
Brief of Evidence	
Approximate total number of pages in brief of evidence (excluding audio-visual electronic evidence)	35,417
Approximate number of tabs in brief of evidence	2,079
Approximate number of statements in brief of evidence	795
Transcript	
Total number of pages of transcript for hearing	1,871

Professor Alison Jones is a specialist general physician and clinical toxicologist with over 20 years of experience. Professor Jones' roles have included:

- Director of Medical Education, as well as a consultant physician and clinical toxicologist, for the Fiona Stanley and Fremantle Hospitals Group and the South Metropolitan Area Health Service in Perth.
- Executive Director of the Sunshine Coast Health Institute in Queensland. Professor Jones has also provided clinical care to patients at the Sunshine Coast Hospital.
- A toxicology advisor to NSW Health for more than 12 years.
- Acting Chief Medical Officer for the Western Australian Department of Health from 2021 to 2022.
- Staff Specialist in Clinical Toxicology at Blacktown Hospital from 2011 to 2021 and a Staff Specialist in General Medicine at Maitland Hospital from 2009 to 2014.
- Various roles at the University of Wollongong from 2011 onwards, including as Deputy Vice-Chancellor (Health & Communities) and Executive Dean (Science, Medicine & Health Faculty). She was also a Clinical Academic in General Medicine at The Wollongong Hospital from 2014 to 2021.
- Director of the National Poisons Information Service Guy's and St Thomas' Hospitals, UK.

She has extensive experience providing expert opinions as a toxicologist in coronial inquests since 1998. Professor Jones has also published widely.

Professor Jones holds a Bachelor of Medical Sciences (Biochemistry) with Honours; Bachelor of Medicine, Bachelor of Surgery; and a Doctor of Medicine (by Research).

Appendix 9: Expert qualifications and experience

Notes:

- **The qualifications and experience set out in this Appendix for each expert are in summary form only. They represent an abridged curriculum vitae intended to summarise key aspects of their relevant background and experience.**

Scott Wilson IPM

Mr Wilson has 31 years of policing experience in the UK including senior roles (including at the rank of Detective Chief Superintendent) for the Metropolitan Police Service at New Scotland Yard and the National Counter Terrorism Headquarters. Mr Wilson has been the Senior Investigating Officer for over 50 homicide and counter terrorism inquiries.

Mr Wilson has also held the following roles:

- National Co-ordinator for "Protect and Prepare" under the CONTEST strategy between 2014 and 2018.
- Bronze Commander for the Metropolitan Police Service at the London 2012 Olympic and Paralympic Games, which included responsibility for multi-agency emergency planning for 26 sporting venues and delivery of the testing and exercising program for those venues.
- Head of the Metropolitan Police Service's Emergency Preparedness, Business Continuity, CBRNE and DVI in 2010.

Mr Wilson was awarded the 9/11 International Police Medal for Counter Terrorism in 2016.

Mr Wilson has been an expert in a number of inquiries, including as a counter terrorism and police response subject matter expert assisting the Chair of the *Manchester Arena Inquiry* (until January 2022) and as an expert engaged by families in the *Royal Commission of Inquiry into the terrorist attack on Christchurch Mosques on 15 March 2019*.

Mr Wilson has a Masters degree in Critical Incident Management, is a Fellow of the Institute of Civil Protection, and is a Senior Associate Lecturer at the Cabinet Office Emergency Planning College. He also has experience as a trainer and speaker internationally.

Dr Philip Cowburn MBE

Dr Philip Cowburn MBE is a UK-based Emergency Medicine specialist with experience in pre-hospital and emergency care since 2004. Dr Cowburn was awarded an MBE in 2021 in recognition of his service and contribution to pre-hospital emergency care.

Dr Cowburn's roles have included:

- Consultant in Emergency Medicine at the British Royal Infirmary (University Hospitals Bristol and Weston NHS Foundation Trust) since 2009 and Consultant Trauma Team Leader at the regional Major Trauma Centre at North Bristol NHS Trust since 2012.
- Co-founder of the Great Western Air Ambulance in 2007 (and Medical Director from 2011-2013).
- Qualified Ambulance Service Commander (Operational, Tactical and Strategic levels) and National Interagency Liaison Officer (NILO).
- Medical advisor to the National Ambulance Resilience Unit (NARU) since 2021.
- Medical advisor to regional specialist police units and a member of the National Police Clinical Governance Group.
- Civilian Ambulance Service advisor to the UK Military Sub-Specialty Board for Pre-Hospital Emergency Care.

Dr Cowburn has responded to more than ten major incidents in a clinical or Command capacity and has supported the debrief of several national major incidents. He has also developed, delivered and debriefed multi-agency major incident exercises at local, regional and national levels.

Dr Cowburn was an expert in pre-hospital care assisting the Chair of the *Manchester Arena Inquiry* as well as an expert assisting the Chair of the *Dawn Sturgess Inquiry* (into 2018 Novichok poisonings).

Dr Cowburn's qualifications include a Bachelor of Medicine, Bachelor of Surgery (with Commendation); Bachelor of Science (with Honours); Diploma in Immediate Medical Care; and Diploma in Health Emergency Preparedness, Resilience and Response (2023). He has also contributed to the development of a Diploma in Pre-Hospital Care at the Edinburgh Royal College of Surgeons.

Dr Cowburn has published numerous publications, including regarding the Ten Second Triage tool.

Dr Stefan Mazur

Dr Stefan Mazur has over 20 years of experience in Emergency Medicine and pre-hospital care and retrieval, in Australia and the UK. His roles have included:

- Consultant Emergency Physician since 2003, including as an Emergency Medicine specialist with The Royal Perth Hospital in Western Australia (a Major Trauma Centre); Townsville Hospital in Queensland (a Regional Referral Centre for Northern and Far Northern Queensland); and The Royal Adelaide Hospital in South Australia (a Major Trauma Centre) since 2010.

- Pre-Hospital and Retrieval Medicine (PHRM) physician since 2006, including with: Medflight in South Australia; CareFlight in Queensland (as well as being the State Director of training); and the London Helicopter Emergency Medical Service in the UK.

- PHRM and Medical Retrieval Consultant with the South Australian Ambulance Service Medical Emergency Retrieval & Transport Service (SAAS MedSTAR) since 2010. He was the Chief Medical Officer for the SAAS from 2012 to 2016.

Dr Mazur is also an Associate Professor at the School of Public Health and Tropical Medicine at James Cook University.

Dr Mazur has published widely in peer-reviewed journals and textbook chapters.

Dr Mazur's qualifications include a Bachelor of Medicine, Bachelor of Surgery; Postgraduate Certificate in Academic Medicine and Education; Diploma in Immediate Medical Care; Diploma in Retrieval and Transfer Medicine; and a Graduate Certificate in Clinical Ultrasound.

Dr Edwin Kruys

Dr Edwin Kruys has 21 years of clinical experience as a GP (including 19 years practicing in Australia) and has held roles within Queensland Health and the Royal Australian College of General Practitioners (RACGP). Dr Kruys is currently based in Queensland.

Dr Kruys is a GP with Special Interest (GPSI) in Mental Health within the Gympie Hospital's Mental Health Department. He has been Co-Chair of the Queensland GP Liaison Network since 2021 and a GP Liaison Officer within the Sunshine Coast Hospital and Health Service since 2018.

Dr Kruys was the Chair of the RACGP Queensland from 2015 to 2017. He was also Vice President of the RACGP from 2016 to 2017.

Dr Kruys' other roles have included:

- Member of the Australian Institute of Health and Welfare's Primary Health Care Advisory Committee since September 2025;
- Member of the Central Queensland, Wide Bay, Sunshine Coast Public Health Network's "Country to Coast" Clinical Advisory Council since 2024;
- Various other roles within Queensland Health over eight years, including as a member of the HealthPathways Steering Committee, Smart Referrals Clinical and Business Working Group, Surgical Advisory Committee, and Non-Admitted Reform Group; and
- Various other roles within the RACGP over nine years including as Chair of the Reference Group for Medication Management & Supply in 2018 to 2019, Chair of the Data Governance Advisory Group in 2020 to 2023, and member of the Expert Committee on Funding and Health System Reform from 2018 to 2024.

Dr Hester Wilson

Dr Hester Wilson is a GP and Addiction Medicine specialist and has over 30 years of clinical experience. Since 2024, Dr Wilson has been the Chief Addiction Medicine Specialist for NSW (NSW Health).

Dr Wilson's other roles have included:

- A GP in private practice in Sydney;
- Clinical Advisor to Population and Community Health, Clinical Director of AOD services, and Staff Specialist in Addiction (within local health districts);
- Clinical Advisor to the NSW Agency for Clinical Innovation from 2016 to 2017; and
- Chair of the Royal Australian College of General Practitioners (RACGP)'s Specific Interests Addiction Medicine Network.

Dr Wilson has provided expert opinion in inquests/inquiries, including the *Inquest into the death of six patrons of NSW music festivals* (2019), and the *Special Commission of Inquiry into the Drug 'Ice'* (2020) as a member of its Health Responses Roundtable.

Dr Wilson is a Conjoint Senior Lecturer at the University of New South Wales.

Dr Wilson holds a Bachelor of Medicine (with Honours), Masters degree in Mental Health, and a Diploma of Family Planning. Dr Wilson is undertaking a Doctor of Philosophy (PhD) at the University of New South Wales School of Population Health.

Professor Anthony Harris AM

Professor Anthony Harris AM is a psychiatrist with over 30 years of experience, including in community youth mental health and research into schizophrenia and associated psychoses.

He was appointed a Member of the Order of Australia in 2024 in recognition of his significant service to mental health as both a clinician and an academic.

Professor Harris has been a Senior Staff Specialist within the Western Sydney Local Health District (WSLHD) since 1998, including in its Prevention Early Intervention and Recovery Service and Community Youth Mental Health Service.

He is also a Clinical Director of the Brain Dynamics Centre at the Westmead Institute for Medical Research.

Professor Harris has been a Director of the non-government organisation, Mind Australia since 2023. Mind Australia provides mental health and wellbeing support to people in the community. Mind Australia also provides "housing with support", via Haven residences (which are provided in partnership with Mind Australia's subsidiary, community housing provider The Haven Foundation).

From 2017 to 2023, Professor Harris was Chair of One Door Mental Health (formerly known as the Schizophrenia Fellowship of NSW Research Trust Fund).

Professor Harris is a Professor of Psychiatry and Head of the Specialty of Psychiatry at the University of Sydney.

Professor Harris has also authored articles, chapters and web resources covering topics including first-episode psychosis and schizophrenia.

Professor Harris holds a Bachelor of Medicine, Bachelor of Surgery, and a PhD.

Professor Edward (Ed) Heffernan

Professor Edward (Ed) Heffernan is a psychiatrist with over 25 years' experience, including in relation to people with a mental illness who encounter the criminal justice system.

Professor Heffernan is the Director of the Queensland Forensic Mental Health Service.

He is also Clinical Lead of the Queensland Police Communications Centre Mental Health Liaison Service (PCC MHLS), which supports police in responding to people in a mental health crisis.

Professor Heffernan's roles have also included being a member of the Queensland Mental Health Review Tribunal, Deputy Chair of the Psychiatric Assessment Tribunal, and a psychiatrist in the Australian Army Reserve.

Professor Heffernan is a Professor at the University of Queensland. He is also Head of the Forensic Mental Health research stream and Veterans' Mental Health research stream within the Queensland Centre for Mental Health Research.

Professor Heffernan has extensive experience as an expert in inquest matters, incident analysis, reviews and investigations in multiple Australian jurisdictions.

Professor Heffernan holds a Bachelor of Medicine, Bachelor of Surgery; a Bachelor of Science with Honours; Master of Public Health; and a PhD.

Conjoint Professor Matthew Large

Professor Matthew Large is a psychiatrist with approximately 30 years of experience in emergency, inpatient and outpatient mental health settings in both the public and private sectors.

Professor Large has been Medical Superintendent of Mental Health at the Eastern Suburbs Mental Health Service, based at The Prince of Wales Hospital, since 2010 (and was the Clinical Director from 2017-2024). Professor Large has also been a Senior Staff Specialist at The Prince of Wales Hospital since 2009.

Professor Large has been a Conjoint Professor of Psychiatry and Mental Health at the University of New South Wales since 2015. Professor Large's work has been widely published in peer-reviewed journals.

Professor Large has provided expert evidence in over 300 legal matters involving aspects of medical and psychiatric care and has provided external consultancy to public hospitals and health services between 2018 and 2021. He has provided expert opinion in coronial proceedings and in external reviews of fatal outcomes in all Australian jurisdictions. Professor Large has also been a member of professional standards committees.

He holds a Bachelor of Science; a Bachelor of Medicine, Bachelor of Surgery; and is a Doctor of Medical Science.

Professor Olav Nielssen

Professor Olav Nielssen is a psychiatrist with over 35 years of experience. He is a visiting psychiatrist at St Vincent's Hospital, Sydney where he has worked since 2004. Professor Nielssen has also been a visiting psychiatrist at the Matthew Talbot Hostel clinic (which supports men who are homeless or at risk of homelessness) since 2006.

Professor Nielssen is the founder of Habilis, which provides purpose-built long-term homes in Sydney for people with a chronic mental illness who may otherwise face homelessness. The Habilis model also involves onsite clinical care for residents.

Professor Nielssen has also been a consultant psychiatrist for MindSpot (an online treatment service operated by Macquarie University) since 2012.

Professor Nielssen has been a Clinical Professor of Psychiatry at Macquarie University since 2016. He was previously a Conjoint Senior Lecturer in Psychiatry at the University of New South Wales from 2006 to 2020.

Professor Nielssen has acted as an independent and court-appointed expert forensic psychiatrist in a significant number of criminal trials, coronial inquests and mental health hearings. He was also a member of the NSW Mental Health Tribunal from 2006 to 2016.

Professor Nielssen has authored or co-authored numerous research works. He was also a member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Committee involved in developing the "*Clinical practice guidelines for the management of schizophrenia and related disorders*" (2016).

He holds a Bachelor of Medicine, Bachelor of Surgery; a Masters of Criminology; and a PhD.

Professor Merete Nordentoft

Professor Merete Nordentoft is a psychiatrist, and in 2025 was awarded the World Health Organisation's Sasakawa Health Prize for her pioneering research and implementation of early support systems in Denmark, which have influenced models for suicide prevention and early intervention internationally.

Professor Nordentoft is a consultant psychiatrist for the Mental Health Services in the Capital Region of Denmark.

Professor Nordentoft has also been the President of the Danish Psychiatric Society since 2021. This role has involved developing a Danish national ten year plan for psychiatry, advising the National Health Agency, and acting as a representative on various taskforces including in relation to psychosis in adults and the prevention of suicide and suicide attempts. As part of this role, Professor Nordentoft was also appointed by the Danish Ministry of Health as a member investigating the conditions leading to the Copenhagen Mall Shooting in 2022.

Professor Nordentoft has been a Professor of Psychiatry at the University of Copenhagen since 2009 and a Director of Research for Mental Health at CoRE (Copenhagen Centre for Health Research in the Humanities) since 2021. She has published widely and collaborated with researchers internationally.

Professor Nordentoft has been the principal investigator for many large randomised clinical trials, including the Danish OPUS trial (of early intervention services for people with first episode psychosis).

Professor Nordentoft holds a Doctor of Medicine; Masters degree in Public Health; a PhD; and a Doctor of Medical Science.

Professor Alison Jones

Professor Alison Jones is a specialist general physician and clinical toxicologist with over 20 years of experience. Professor Jones' roles have included:

- Director of Medical Education, as well as a consultant physician and clinical toxicologist, for the Fiona Stanley and Fremantle Hospitals Group and the South Metropolitan Area Health Service in Perth.
- Executive Director of the Sunshine Coast Health Institute in Queensland. Professor Jones has also provided clinical care to patients at the Sunshine Coast Hospital.
- A toxicology advisor to NSW Health for more than 12 years.
- Acting Chief Medical Officer for the Western Australian Department of Health from 2021 to 2022.
- Staff Specialist in Clinical Toxicology at Blacktown Hospital from 2011 to 2021 and a Staff Specialist in General Medicine at Maitland Hospital from 2009 to 2014.
- Various roles at the University of Wollongong from 2011 onwards, including as Deputy Vice-Chancellor (Health & Communities) and Executive Dean (Science, Medicine & Health Faculty). She was also a Clinical Academic in General Medicine at The Wollongong Hospital from 2014 to 2021.
- Director of the National Poisons Information Service Guy's and St Thomas' Hospitals, UK.

She has extensive experience providing expert opinions as a toxicologist in coronial inquests since 1998. Professor Jones has also published widely.

Professor Jones holds a Bachelor of Medical Sciences (Biochemistry) with Honours; Bachelor of Medicine, Bachelor of Surgery; and a Doctor of Medicine (by Research).