DISTRICT COURT OF QUEENSLAND

CITATION:	*Davis v Ryan* [2018] QDC
PARTIES:	**STEPHEN JOHN DAVIS** (Applicant) v. **TERRY RYAN, STATE CORONER** (Respondent)
FILE NO/S:	D36/17
DIVISION:	Civil
PROCEEDING:	Application
ORIGINATING COURT:	District Court at Townsville
DELIVERED ON:	10 September 2018
DELIVERED AT:	Townsville
HEARING DATE:	7 November 2017
JUDGE:	Lynham DCJ
ORDERS:	**1. Application dismissed.**
CATCHWORDS:	Coroners Act, application to hold inquest where state coroner has refused the application, whether inquest would be "in the public interest".
LEGISLATION:	*Coroners Act* 2003 (Qld), s 3, 28, 30 *Mining Act 1978* (WA)
CASES:	*Beale v O'Connell & Ors* [2017] QSC 127 *Gentner v Barnes* [2009] QDC 307 *Hogan v Hinch* (2011) 243 CLR 506 *Lockwood v Barnes* [2011] QDC 84 *O'Sullivan v Farrer* (1989) 168 CLR 210 *Re Minister for Resources; Ex Parte Cazaly Iron Pty Ltd* (2007) 34 WAR 403
COUNSEL:	Mr Davis self-represented M T Hickey for the Attorney-General of Queensland as amicus curiae
SOLICITORS:	Crown Law for the Attorney-General of Queensland as amicus curiae

Introduction

[1] Kristine Susanne Davis was 61 years of age and had a diagnosis of generalised anxiety disorder and treatment resistant depression. Mrs Davis died on 7 August 2013. At the time of her death, Mrs Davis was under the care of a treating Psychiatrist, Dr Futter.

[2] Mrs Davis lived with her husband, Stephen Davis who is the applicant in these proceedings. Mr Davis makes application pursuant to section 30(6) *Coroners Act* 2003 (Qld) ("the Act") for an order that an inquest be held into the death of Mrs Davis pursuant to section 30(4) of the Act. Having applied to the State Coroner to hold an inquest into the death of his wife which was refused, section 30(6) permits Mr Davis to apply to this Court for an order that an inquest be held. The application was filed within the time prescribed in section 30(7) of the Act. Section 30(8) of the Act permits this court to order that an inquest be held if satisfied that it is in the public interest to do so.

Background

[3] The tragic circumstances of Mrs Davis's death were found by the Northern Coroner to have been as follows:

> "*On the morning of 7 August 2013 Mr and Mrs Davis went grocery shopping. Mrs Davis was uncharacteristically quiet. They returned home, had a coffee and, at about 11am, Mr Davis went downstairs. Mr Davis stayed upstairs and unpacked the groceries.*
>
> *At about midday Mr Davis went upstairs but could not find Mrs Davis. He went down an external set of stairs and found Mrs Davis hanging by the neck from a white rope tied around of the supporting posts of the staircase. He tried to undo the knot before returning upstairs and obtaining a knife which he used to cut the rope. Mr Davis immediately started CPR and called 000. Queensland Ambulance officers attended and also attempted to resuscitate Mrs Davis but were unable to do so. She was pronounced deceased at 12.41pm.*
>
> *Police conducted an investigation and concluded there were no suspicious circumstances.*
>
> *An autopsy confirmed Mrs Davis died from hanging. Her death was suicide. There was no overt evidence of a neurological disorder of the brain or any other significant disease"* [1]

[4] On 8 November 2013 Coroner Jane Bentley forwarded her findings to Mr Davis, advising that she did not propose to hold an inquest as the investigation had revealed sufficient information to enable her to make findings about Mrs Davis'

[1] Form 20A – Coroner's findings and notice of completion of coronial inquest dated 8 November 2013 (Coroner Bentley) – Affidavit of Paula Campbell exhibit PC-17

death and that there did not appear to be any prospect of making recommendations that would reduce the likelihood of similar deaths occurring in the future or otherwise contribute to public health and safety or the administration of Justice.[2]

[5] On 19 November 2013 Mr Davis forwarded a letter to Coroner Bentley in which he disputed her findings and asserted that in the circumstances further investigations were justified. In particular Mr Davis raised a number of concerns regarding the treatment provided to Mrs Davis and he contended that there was a public interest in establishing whether there was a need for procedures for the treatment of long-term sufferers of depression to be reviewed and improved.[3] On 2 December 2013 Coroner Bentley, in response to the concerns raised by Mr Davis in his letter, advised that she would conduct further investigations into the medication and treatment provided to Mrs Davis.[4]

[6] As part of those further investigtions, the Coroner's office requested the medical records from the Bowen Hospital relating to Mrs Davis' mental health, as well as records from Dr Anthony Mallett, Mrs Davis' general practitioner, and the records of Dr Graham Futter, Mrs Davis' treating Psychiatrist.[5]

[7] The Coroner's office also requested a Mental Health Review be conducted on Mrs Davis to assist in her investigation.[6] On 19 December 2014 a Mental Health Review conducted by Associate Professor John Allen, Director of Mental Health, was provided to the Coroner. It recommended that an independent review be undertaken by a consultant Psychiatrist on the basis that it was outside the role of the Director of Metal Health to comment on the prescribing of psychotropic medications to individual patients and that there was limited information which was available regarding Mrs Davis' mental health status and history.[7]

[8] The Coroner's office then sought further information from Dr Futter regarding his treatment of Mrs Davis. By this stage Coroner Priestly appears to have assumed carriage of the matter from Coroner Bentley. The request to Dr Futter was made by way of a letter sent to him on 30 March 2015.[8] A copy of that letter does not form part of the exhibits. On 13 April 2015 Dr Futter provided a detailed response to the Coroner's request which included details of his treatment of Mrs Davis. He also provided answers to a number of specific queries for which the Coroner requested further information.[9] In summary, Dr Futter stated that Mrs Davis was referred to him by her general practitioner Dr Mallett and she was first seen by him on 2 May 2013. The referral was in relation to generalised anxiety disorder, with symptoms having been present for the preceding four years. He was advised by Dr Mallett at

[2] Affidavit of Paula Campbell exhibit PC-17
[3] Affidavit of Paula Campbell exhibit PC-16
[4] Affidavit of Paula Campbell exhibit PC-14
[5] Affidavit of Paul Campbell exhibits PC-10, PC-11, PC-12, PC13 & PC-15
[6] Affidavit of Paula Campbell exhibit PC-9
[7] Affidavit of Paula Campbell exhibit PC-5
[8] Referred to in Dr Futter's letter dated 13 April 2015 – Affidavit of Stephen John Davis exhibit A (Document 3)
[9] Affidavit of Stephen John Davis exhibit A (Document 3)

the time of referral that Mrs Davis had previously seen a number of psychologists and psychiatrists and that she had been prescribed the following medications:

- Cymbalta 120mgs per day;
- Zyprexa 5mgs at night ; and
- Endep 50mgs at night.

Dr Futter noted that whilst Cymbalta and Endep are antidepressants, they were also used to treat anxiety.

[9] Dr Mallett had also advised Dr Futter that Mrs Davis had had increasing doses of the benzodiazepine anti-anxiety medication Xanex, which had good anti-anxiety effect, but which often leads to tolerance which can result in dosage increases that will eventually lead to the patient becoming unable to function. Dr Mallet had also advised him of various other medications which had been trialled on Mrs Davis but failed or were not tolerated by her.

[10] Dr Futter advised that at his first consultation with Mrs Davis on 2 May 2013 he confirmed the diagnosis of a generalised anxiety disorder and that he also concluded that Mrs Davis also had depression. He noted that Mrs Davis had admitted to having had suicidal thoughts in the past but never had a plan and that she was not suicidal either at the time of the first consultation nor at any other consultation he had with her.

[11] Dr Futter stated that he had decided to phase out the medication Endep which Mrs Davis was then prescribed and to commence her on the medication Avanza. He gave reasons for this, being that he felt that to have beneficial effect, Endep needed to be taken at a dosage that had an unpleasant side effect profile, and that Endep was also potentially toxic in an overdose. He indicated that he commenced Avanza as there was a proven beneficial interaction with the class of medication which Cymbalta falls into, this being a medication which Mrs Davis was already prescribed. He further opined that of all of the antidepressants, Avanza had the highest anti-anxiety effect and that this had also been a factor in his decision making.

[12] Dr Futter stated that when changing or adjusting dosages of medications, he kept in regular contact with the patient both by telephone and in face to face consultations. He noted that as Mrs Davis lived over 200 kilometres from his rooms in Mackay and face to face consultations were arranged on a monthly basis, it was important for him to maintain contact with Mrs Davis by telephone.

[13] Over the course of his treatment of Mrs Davis, Dr Futter had the following further clinical interactions with her following the initial consultation on 2 May 2013:

Date	Method of contact	Information received	Action taken
7 May 2013	Telephonic	Mrs Davis reported that she was not experiencing any side effects from the medication, but that there was little other change clinically	Increased Avanza dose to 30mgs at night.
14 May 2013	Telephonic	Mrs Davis reported that she was not experiencing any side effects but that the current dose of Avanza was not helping her sleep as much as the Endep had. Mrs Davis reported that her depression was possibly slightly better, but that the anxiety was still bad.	Zyprexa increased to 10 mgs at night because of its sedative effect and anti-anxiety effect.
21 May 2013	Telephonic	Mrs Davis reported that her sleep was good and the anxiety was slightly better but the depression was unchanged.	Regime maintained.
7 June 2013	Face to face consultation	Mrs Davis reported that there was no real improvement in her clinical condition, indicating that anxiety was the most significant problem.	Cymbalta begins to be replaced with similar medication Pristiq, which Dr Futter opines is superior.
11 June 2013	Telephonic	Mrs Davis reported that the medication changeover was going satisfactorily.	Cymbalta continued at 60mgs (reduced dose), Pristiq dose increased to 100mgs.
14 June 2013	Telephonic	Mrs Davis confirmed no adverse effects but reported that there had been no real change in her total clinical condition.	Mrs Davis instructed to discontinue Cymbalta after a further 3 days, and increase dosage of Pristiq to 150mgs per day.
26 June 2013	Telephonic	Mrs Davis reported no side effects from changeover	Pristiq dosage increased to 200mgs per day.
9 July 2013	Telephonic	Mrs Davis reported her tremor was getting worse, she felt that her depression was slightly better but that there was little change in her anxiety.	Avanza dosage increased to 45mgs. Pristiq noted to have a dosage ceiling of 200mgs.

16 July 2013	Telephonic	Mrs Davis reported that the latest dosage adjustment in Avanza was tolerable with no significant side effects. Mrs Davis reported her anxiety had improved a little bit.	Avanza dosage increased to 60mgs.
25 July 2013	Face to face consultation	Mrs Davis reported that her main concern was that despite all of the changes and adjustments, that there was little improvement in her anxiety.	Commenced Xanax at .5mgs twice a day and Oxazepam 30mgs once a day. This was indicated to be a short term medication.
1 August 2013	Telephonic	Mrs Davis reported no significant adverse effects from the benzodiazepines but little improvement in her anxiety.	Xanax increased to three times per day.

[14] In response to specific questions posed by the Coroner, Dr Futter provided the following information:

- The only other contact he had with Dr Mallett other than his referral was his report back to him.

- Dr Futter had undertaken a full diagnostic interview with Mrs Davis at their initial consultation during which he had explored her primary complaint of anxiety and also elucidated another diagnosis of depression. Dr Futter stated that he had explained the biology of depression with the use of aids in an attempt to alleviate any self-blame and assist Mrs Davis in understanding that she was suffering from an illness. At this consult he also explored lifestyle issues and whether Mrs Davis' work was a contributing factor in her depression and anxiety.

- Dr Futter reported that Mrs Davis was not enthusiastic about undertaking psychotherapy from a psychologist because of past less than optimal results.

- Dr Futter discussed Mrs Davis' treatment history with her and spoke about how she had previously been treated with single medications, rather than combinations of medications. Dr Futter indicated that he went through his rational with Mrs Davis for his treatment approach, and that she was aware there was not a "quick fix" to her anxiety and depression.

- Dr Futter stated that he made an assessment of Mrs Davis' suicide risk and that she did not present as an apparent risk of suicide at the first consultation. He said that if it had been apparent that Mrs Davis' depression was worsening and that suicidal thoughts were emerging she would have been managed as an emergency. He stated that he had discussed suicidal thoughts with Mrs Davis and emphasised that these are a symptom of depression and that these should be given precedence in consultations.

- Dr Futter advised that he had avoided medications with previous reports of side-effects, and had utilised Avanza (which had not been found to be effective previously) for its synergistic effects with other medications used.

- Dr Futter confirmed that Mrs Davis was warned of the risks of side effects and the risks of a worsened condition resulting in possible suicidal thinking (and the probable mechanism of this) as a result of the medications she was prescribed. Dr Futter stated that Mrs Davis' risk of such a scenario was reduced given she was already taking multiple medications, but that she was in any event warned and closely monitored with frequent telephone consultations.

- Dr Futter confirmed that Mrs Davis had requested to be taken off medication. He indicated that he advised Mrs Davis that in reality, they did not know how much the medication was doing, and therefore how she would feel without it. Dr Futter reported that it was because of this possible despondency regarding poor response to medication that he changed his focus to benzodiazepine medications in the short term as their anti-anxiety effect is usually more apparent to the patient.

- Dr Futter reiterated that Mrs Davis had consistently reported that her anxiety was the most significant problem and had not given any indication that her depression was worsening or that she was becoming despondent about the depressive component of her treatment. Dr Futter indicated that he did not broach other treatment strategies available with Mrs Davis as he had no reason to believe that Mrs Davis' depression was worsening and he did not gain an impression of suicidal symptomology worsening.

- Dr Futter confirmed that there was no consultation with Mrs Davis' family, as at no point did he perceive her to be at risk of suicide. Dr Futter reported that it had been emphasised to Mrs Davis that she was able to have family members involved in her treatment but she declined that offer.

- Dr Futter confirmed that no education was provided to Mrs Davis' family in relation to warning signs and risks to look out for. This was because he had no reason to believe that Mrs Davis' suicidal thoughts had re-emerged. Dr Futter advised that had suicidal thoughts emerged the only appropriate treatment would have been to hospitalise Mrs Davis so that she could be kept safe until she felt better.

- Dr Futter stated that as Mrs Davis and her general practitioner had both expressed a primary concern of anxiety with a further diagnosis of depression which was unchanging, he believed that as with any patient her rights to confidentiality and privacy were to be respected until such time as she might have been a danger to herself.

[15] Mr Davis was provided a copy of Dr Futter's report. On 11 May 2015 Mr Davis sent two emails to the Coroner's office detailing a number of concerns he had with

the report and the treatment provided by Dr Futter to Mrs Davis. In general terms, the concerns he raised included:[10]

- That Dr Futter did not act appropriately in his information gathering by failing to consult with other treating professionals and by not conducting a comprehensive assessment of Mrs Davis' condition;

- The lack of exploration of alternative treatment options;

- Reliance on information provided by Mrs Davis as to her own suicide risk and failure to consult with Mrs Davis' family regarding this and regarding her response to medication;

- Criticism of the medication regime which Mrs Davis was on, and the risk management undertaken given that medication regime.

[16] Mr Davis complained that there was a need for the psychiatric community to consult with Health and Safety professionals in order to establish an appropriate risk management framework and to recognise the need for treatment to become more holistic, including consultation with other medical professionals, and a patient's family where appropriate.

[17] Following the Coroner's consideration of the further submissions made by Mr Davis and additional materials received as a consequence of the investigation conducted in respect to the matters previously raised by him, on 3 September 2015 the Coroner's office wrote to Mr Davis informing him of the Coroner's proposed findings.[11] The proposed findings foreshadowed in this letter from the Coroner's office included a summary of a report provided by Dr Griffith, a Forensic Medical Officer. Dr Griffith had been engaged by the Coroner to review the psychotropic medications which had been prescribed to Mrs Davis. A copy of Dr Griffiths report does not form part of the court file but it appears to be summarised in some detail in the Coroner's letter to Mr Davis.

[18] As summarised, Dr Griffith appears to have generally concurred with the treatment path adopted by Dr Futter. He opined that it is likely that Mrs Davis had what he described as treatment resistant depression and that changing and increasing the doses of psychotropic agents was the norm in current psychiatric practice. Dr Griffith felt that Dr Futter was able to demonstrate that he had given considerable thought to the therapeutic steps used in his treatment of Mrs Davis. He commented on the individual medications that Mrs Davis had been prescribed during her treatment by Dr Futter and was again supportive of those psychotropic medications being prescribed to Mrs Davis and the reasons explained by Dr Futter for doing so.[12]

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[10] Affidavit of Stephen John Davis exhibit B (Document 3)
[11] Affidavit of Stephen John Davis exhibit C (Document 3)
[12] Affidavit of Stephen John Davis exhibit C (Document 3)

[19] The Coroner's office letter to Mr Davis summarised the Coroner's proposed findings as follows:[13]

> "*I find that Kristine Davis died on 7 August 2013. Her death was due to hanging and was suicide. I have reviewed the clinical management of Mrs Davis and find no evidence to suggest any missed opportunities for a better outcome.*
> *Coroner Priestley does not proposed (sic) to hold an inquest as the investigation has revealed sufficient information to enable findings to be made. Further, there does not appear to be any prospect of making recommendations that would reduce the likelihood of similar deaths occurring in future or otherwise contributing to public health and safety or administration of justice"*

[20] Mr Davis responded to the proposed findings of the Coroner, expressing his disappointment with the proposed findings and complaining that his concerns were largely not addressed either by Dr Griffith or by the Coroner in the draft findings.[14] Mr Davis queried whether the concerns he raised concerning Mrs Davis' treatment had been provided to Dr Griffith and if not, why not. Given that neither a copy of Dr Griffith's report nor a copy of any correspondence commissioning the report form part of the court file I am unable to comment on this. Mr Davis again reiterated his concerns with respect to the treatment of Mrs Davis and requested that the Coroner's office amend the final report to reflect the need for an overhaul of suicide risk assessment and management for sufferers of depression.

[21] In response to the concerns raised by Mr Davis in respect to the draft findings, the Coroner's office advised Mr Davis that a Consultant Psychiatrist with experience in coronial investigations would be engaged to conduct a review into the death of Mrs Davis.[15] Upon being advised of this Mr Davis requested the coroner that if possible that a risk management specialist be engaged to assist the review.

[22] The Coroner's office then engaged Dr Jacinta Powell, Consultant Psychiatrist, to provide a report to address the matters raised by Mr Davis. This request was made by way of correspondence dated 12 January 2016 however a copy of this correspondence does not form part of the court file. In her report dated 4 March 2016, Dr Powell responded to three specific questions she was asked to provide an opinion on, being: [16]

> 1. *Your opinion as to the appropriateness of the treatment of the risk of suicide as conducted by Dr Futter;*
>
> 2. *Any comment regarding the appropriateness of the medications (or the combination of medications) given to the deceased; and*
>
> 3. *Any other issues you may wish to comment on regarding the care of the deceased.*

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[13] Affidavit of Stephen John Davis exhibit C (Document 3)
[14] Affidavit of Stephen John Davis exhibit D (Document 3)
[15] Affidavit of Stephen John Davis exhibit E (Document 3)
[16] Document 3 Exhibit F

[23] In addressing the first question, Dr Powell commenced by opining that "*Based on the material presented and even with the benefit of hindsight, it would have been very unlikely that the suicide of Mrs Davis could have been predicted to occur either with respect to timing or method".* [17] However Dr Powell commented that despite this, she did have significant concerns regarding the lack of a comprehensive clinical assessment undertaken by Dr Futter following the referral of Mrs Davis to him by Dr Mallett. She identified the areas of information she would expect a Psychiatrist to obtain from a new patient at an initial consultation. Upon her review of Dr Futter's medical notes she raised concerns that much of the history she would have expected to have been obtained from Mrs Davis had not been taken.

[24] Dr Powell opined that Mrs Davis was suffering from treatment resistant depression, evidenced by her history of use over time of different antidepressants. She acknowledged that Dr Futter had discussed thoughts of suicide with Mrs Davis, but she raised concerns that it appeared that he did not take a history from Mrs Davis about some other aspects of her personal history such as any previous history of suicide attempts by her, family history of suicide and access to means. Dr Powell stated that assessing risk of suicide is very difficult and relies to some extent on gaining knowledge of a patient over time and also having time to develop a good working relationship with a patient. She stated that this is something that develops over months to years and cannot be fast-tracked. Dr Powell opined that while overall it is possible to say that a patient is at a higher risk of suicide, especially when they suffer from a depressive illness, that risk can change quickly depending on incidents and events in the life of a patient. She stated that it is usually not possible to ascertain which individuals will go on to attempt or commit suicide.

[25] Dr Powell opined that whilst Mrs Davis was generally at a higher risk of suicide due to her diagnosis, she felt that the history taken by Dr Futter was insufficient to ascertain potential predisposing, precipitating and perpetuating factors. Dr Powell also noted that in Dr Futter's submissions to the Coroner, he provided additional information concerning his assessment of Mrs Davis which was more comprehensive than what was contained in his notes. However, even having regard to this, in the absence of a psychosocial history and detail about the Mrs Davis' circumstances, Dr Powell considered the suicide risk assessment conducted by Dr Futter was "less than optimal." Dr Powell noted that the therapeutic relationship between Mrs Davis and Dr Futter was in its early stages, and was complicated by distance necessitating contact occurring by telephone. She opined that these factors would have complicated Dr Futter's ability to undertake a suicide risk assessment and that this would have impeded the development of a therapeutic relationship that might otherwise have contributed to reducing the longer term risk of suicide.

[26] In relation to the second question posed as to the appropriateness of the medication regime prescribed to Mrs Davis, Dr Powell opined that it was difficult to ascertain

[17] Affidavit of Stephen John Davis exhibit F (Document 3)

the appropriateness of that in the absence of sufficient clinical detail about Mrs Davis' psychiatric and development history. Dr Powell reiterated her earlier conclusion that Mrs Davis was suffering from treatment resistant illness, predominantly depression but also a significant history of anxiety, and referred to key questions which a psychiatrist should ask when dealing with a patient who has failed to respond to psychotropic drugs, which she said were outlined in the Therapeutic Guidelines, Psychotropic Version 7, 2013. These questions included confirming a correct diagnosis, correct adherence to a medication regime, underlying medical, psychosocial and personality factors, and interactions with other medications or other substance use.

[27] Dr Powell then undertook a review of the medications prescribed to Mrs Davis by Dr Futter. In her opinion:

- Dr Powell did not agree that the change of medication from Cymbalta to Pristiq was likely to yield any benefits as these medications belong to the same class. Dr Powell opined that evidence suggests that there is little difference between different antidepressants with regards to efficacy, noting that there can be substantial differences in relation to tolerability and adverse effects.

- Dr Powell opined that the decision to cease Endep was not unreasonable as it is an older medication. She indicated that it is often used at lower doses to assist with sleep, but that Avanza (the replacement used here) has similar side effects but is often better tolerated and was increased by Dr Futter to achieve antidepressant levels. She agreed that to have similarly increased Endep would potentially increase the risk of intolerable side effects.

- Dr Powell stated that the use of benzodiazepines as was used by Dr Futter towards the end of his contact with Mrs Davis was not unreasonable if used as a short term measure to reduce anxiety and assist with sleep. She went on to opine that it is unusual practice to commence two benzodiazepines at once as there would be considerable risk of dependence. Dr Powell indicated that this risk was increased given Mrs Davis' history of having increased her usage of prescribed medications to concerning levels. She stated however that it is unknown if Dr Futter was aware of this fact, but that this is information that may have been elicited in a comprehensive first assessment.

[28] Dr Powell, referring to a published review into medication for treatment resistant anxiety as well as a similar review currently being undertaken into medication prescribed for treatment resistant depression which had not been published, opined that there is little empirical evidence or guidance for psychiatrists in the treatment of patients with poorly responsive mood and anxiety disorders. Dr Powell however was of the opinion that general practice would entail the following:[18]

[18] Affidavit of Stephen John Davis exhibit F (Document 3)

> "*…ensure that doses of medication are maximised for a 6 week trial if the patient can tolerate this, then trials of antidepressants from different classes that have not been used before, then augmentation strategies such as the use of lithium, thyroxine and antipsychotic medication. Alternatives should also be explored including the use of transcranial magnetic stimulation (limited availability) and electroconvulsive therapy (requires at least a day stay hospitalisation and general anaesthetic).*"

[29] Dr Powell opined that the medication strategy undertaken by Dr Futter was not unreasonable in terms of changing antidepressants and ensuring doses are maximised. However she stated that it was unclear whether alternative treatment options had been discussed with Mrs Davis. Dr Powell noted that one of the tasks of a Psychiatrist treating a patient with a treatment resistant illness was to discuss with them that there are a variety of treatment strategies and to support them to maintain hope of an improvement whilst working through those options. Dr Powell stated that it was unclear whether Dr Futter had done so in this instance.

[30] In response to the specific concerns raised by Mr Davis as to there being no code of practice for suicide risk assessment to guide health professionals through the process of deciding on treatment options while ensuring the safety of patients, Dr Powell opined:

> *"Unfortunately there is no well validated way of assessing risk of suicide. Whilst many people including those with psychiatric disorders have thoughts of suicide and some will go on to attempt but survive suicide, the vast majority of these people will go on living. Whilst it is possible to ascertain who in the population is at higher risk of suicide (eg. Males, older people, people with psychiatric disorder, people with substance use problems, those with family history of suicide, past history of suicide attempts), most of these people will not die by suicide. The ability to accurately detect which individuals will go on to suicide is not possible either at this time. The best way of assisting any patient who is at risk of suicide is to undertake a comprehensive assessment as detailed above and to work with them to understand the situation they are in and assist them to understand the diagnosis and the therapeutic options available including medication, psychological strategies, environmental and social changes. Obtaining collateral history from other care providers such as the GP and from family members can assist with developing a complete picture but of course depends on the patient's willingness to involve other people. The ability to intervene and detect rising suicidality can be improved through the development of an ongoing therapeutic relationship with a psychiatrist. With time and regular contact, the psychiatrist gets to know the patient better and has the potential to be more attuned to the patient's mental state and detect changes. On the other side, the patient has time and exposure assisting them to get to know and trust the psychiatrist meaning they may reveal more or turn to the psychiatrist if they become acutely suicidal. Unfortunately with the short time frame and distances involved, this was presumably not able to occur between Ms Davis and Dr Futter although to his credit he ensured regular contact via phone."*

[31] Dr Futter was provided with a copy of Dr Powell's report. In a letter to the coroner dated 15 April 2016, in response to Dr Powell's report,[19] Dr Futter reiterated Dr Powell's comments that it is unlikely that even with the benefit of hindsight the suicide of Mrs Davis could have been predicted to occur and that there is no validated way of assessing risk of suicide. Dr Futter then detailed the information which he said he generally collected at an initial consultation with a patient as well as the specific information which he said he would have gathered from Mrs Davis and conclusions which he drew from that information. According to Dr Futter the information he elicited from Mrs Davis during the initial consultation was far more detailed than was recorded in his notes. Dr Futter said that he addressed with Mrs Davis the same points raised by Dr Powell in her report which he said he did with all patients. Dr Futter explained that he took a general history as to Mrs Davis' complaint and her previous treatment, her history of mental illness and social history, history of physical illness and use of substances, and a mental status assessment. He noted that Mrs Davis did not report any family history of mental illness or any significant trauma or abuse in her life. Dr Futter stated that Mrs Davis presented with a primary complaint of anxiety which had been ongoing for four years with no period of significant improvement.

[32] Dr Futter then responded to Dr Powell's comments on the medication regime. He provided further insight into the reasons behind the medication regime which he placed Mrs Davis on and confirmed that his reasons for doing so had been discussed with Mrs Davis. Dr Futter disagreed with Dr Powell's opinion that there was no difference between one class of antidepressant and another, asserting that changing from one antidepressant to another had the potential for better efficacy. He said his opinion in this regard was supported by medical literature. Dr Futter provided a further explanation for the use of two benzodiazepines (this being a matter raised by Dr Powell as a concern), explaining that this was done to alleviate the concern of Mrs Davis that her dose of Xanax was too high and that she was unwilling to increase it. He said that given this reluctance an alternative benzodiazepine was introduced in an evening dose to assist with sleep.

[33] Dr Futter went on to state that while he had advised Mrs Davis that there were other treatment options which had not been explored, he did not go into these in great detail as he felt they had not yet finished exploring medicinal options. Dr Futter reiterated that he had stressed to Mrs Davis that she was welcome to have her husband attend consultations or contact him by phone, but that as there was no reason to believe that Mrs Davis' suicide risk was worsening, he had not reason to insist on such contact.

[34] Dr Futter concluded by restating Dr Powell's observations that the medication regime was not unreasonable in terms of changing antidepressants and ensuring doses were maximised, that he had consistently and diligently followed up with Mrs Davis and that the therapeutic relationship was in its early stages. Dr Futter sought to draw the Coroner's attention to the fact that in the final two consultations Mrs Davis had identified her anxiety as her main concern, that her depression was

[19] Affidavit of Stephen John Davis exhibit S (Document 3)

reasonable and that this had caused a shift in focus demonstrated by the medication. Dr Futter again restated Dr Powell's comment that even with the benefit of hindsight, it would have been very unlikely that the suicide of Mrs Davis could have been predicted either with respect to timing or method.

[35] During this process Mr Davis continued to raise with the Coroner's office concerns which he had with the progress of the investigation and the nature of the experts involved, contending that he believed that risk management experts should be consulted by the Coroner.[20] Mr Davis provided the Coroner's office with a list of what he perceived were risk factors which were unknown to Dr Futter, including details about what he perceived was the causation of a tremor suffered by Mrs Davis, which in his opinion had been mischaracterised by Dr Futter leading to inappropriate prescribing.[21] Mr Davis also provided to the Coroner's office a report from Dr N McLaren, a Psychiatrist, dated 10 June 2016 which had been obtained by Mr Davis.[22] Dr McLaren noted that he had been provided a number of reports including those of Dr Futter which he reviewed for purposes of providing his report. Dr McLaren was requested to provide an opinion as to the possibility of medications of the type prescribed to Mrs Davis by Dr Futter inducing sudden, unexpected suicide attempts without warning. Dr McLaren stated that based on statistics provided by Medicare he had been assessed in the lowest 8th percentile of psychiatrists for prescribing antidepressants and that in reality he was more likely to have been in the lowest 2nd percentile. Consistent with those statistics, Dr McLaren made clear he was not an advocate for prescribing antidepressants and that he had never used ECT (electro convulsive therapy). Dr McLaren expressed the opinion that drug manufacturers have gone to great and dishonest lengths to "*convey the impression that their concoctions are safe and effective"* which he said was far from true for teenagers and adolescents. He said that all the evidence now showed that they were dangerous with serious side effects, that such drugs produced powerful addictive states and that those who consume them long term will die on average 19 years younger than their "*undrugged peers".*

[36] Dr McLaren also stated that there was ample evidence to suggest that psychotropic drugs cause a state of intense agitation and distress known as akathisia and that this side effect was associated with sudden, unexpected and out-of-character attempts at suicide and homicide. He stated that akathisia was made worse with polypharmacy and doses towards the upper limits of the manufacturer's recommendations which he said were both present in Mrs Davis' case. He concluded that he does not believe that any middle-aged, middle class person needed eleven different psychotropic drugs, and that if the drugs had failed so signally then a reassessment was needed. [23]

[37] On 30 June 2016 Coroner Priestly handed down his findings and notice of completion of coronial investigations.[24] This document was accompanied by a

[20] Affidavit of Stephen John Davis exhibits E & G (Document 3)
[21] Affidavit of Stephen John Davis exhibit G (Document 3)
[22] Affidavit of Stephen John Davis exhibit H (Document 3)
[23] Affidavit of Stephen John Davis exhibit H (Document 3)
[24] Affidavit of Stephen John Davis exhibit I (Document 3)

letter under the hand of the Coroner addressed to Mr Davis declining his request for an inquest.[25] The Coroner's findings were addressed in essentially the same terms as the draft findings but with the inclusion of further commentary on the Clinical Psychiatric review which had been undertaken, Dr Futter's comments in response to this review, and a discussion and analysis of the material before the Coroner.

[38] In the discussion and analysis Coroner Priestly stated as follows:

> *"I am assisted by the reports of Dr Griffiths and Dr Powell. The death occurred in the early stages of development of a therapeutic relationship. Both reviewing clinicians are not critical of the medication regime that Dr Futter initiated. Dr Powell reports about the desirability of considering other options, but Dr Futter reports he assured Mrs Davis other treatment options were available to explore in due course. It is clear that the suicide of Ms Davis could [not] have been predicted to occur either with respect to timing or method. There are screening tools for assessing the risk of suicide that are not dissimilar to that used by Dr Futter. But I accept there are no well validated way of assessing risk of suicide. Only this week, material came though my office prompting workshops about a particular form of suicidal risk assessment tool. There are many different types of such tools. I regularly review mental health records from hospitals with a mental health unit and particular risk assessment forms are there used, more often than not to guide non-medical staff. Psychiatric reviews do not typically involve the use of a particular form. Many people with psychiatric disorders have thoughts of suicide, some may make attempts but most will go on living, even those in the recognised high risk categories.*
>
> *Concern was raised about the quality of Dr Futter's assessment of Mrs Davis in the first consolation. For example, Dr Futter reported he would take a history of demographics including family history of mental illness and psychological history. He noted that Mrs Davis had no family history of mental illness nor could she point to anything in her childhood or her relationships that were of concern. However, Dr Mallet's patient records notes that there is a strong family history of mental illness. Mr Davis reported that Mrs Davis' father committed suicide, all of her brothers and sisters suffer from anxiety and depression, and that Mrs Davis suffered significant mental trauma in early childhood due to family violence. Dr Futter responded that he had no reason to doubt the veracity of Mrs Davis history or her answers to his questions. I note that it was early in the therapeutic relationship and on the face of the consultations, the complexity of the issues may not have warranted escalation of information gathering to seek corroborative material. Again, during reviews of records from hospital mental health units, I have seen many instances of where corroborative material was sought and Mrs Davis did not fit the clinical profile of somebody warranting that level of attention."*

[39] Ultimately Coroner Priestly issued findings that Mrs Davis died due to hanging, that her death was suicide and that no further investigation of her clinical

[25] Affidavit of Paula Campbell exhibit PC-4 (Document 6)

management was required. In his covering letter accompanying the findings, Coroner Priestly stated that he was thoroughly familiar with the risk management process and its application to the medical area including psychiatry. He referred to literature on suicide risk management and to Dr Powell's comments in her review as to the lack of a well validated tool for assessing risk of suicide. Coroner Priestly said that it was not the role of the Coroner to preside over an inquiry which gathers all national and internal effort at validating a suicide risk management tool and to then recommend for general application the one determined to be the best. He said that not only would that exceed the role of Coroner, it might also have serious negative implications for patients and for the cause of developing and implementing a well validated suicide risk management tool.

Application to the State Coroner for an order to hold an Inquest

[40] On 4 July 2016 Mr Davis applied to the State Coroner, the respondent in this application, pursuant to section 30(4) *Coroners Act 2013* (Qld) ("the Act"), for an order to hold an inquest into the death of Mrs Davis.[26] The application was accompanied by a submission by Mr Davis as to why it was in the public interest to hold an inquest. Also attached to the application were the report of Dr Powell, the findings of Coroner Priestly declining to hold an inquest and a further document prepared by Mr Davis containing what is referred to as a "hierarchy of controls".[27] Mr Davis submitted the public interest in holding an inquest into the death of Mrs Davis was justified for the following reasons:

- That there is no formalised risk assessment and management tool currently implemented generally by Australian Psychiatrists and there was not in the case of Mrs Davis' treatment;

- That Doctors in Australia misunderstand the purpose of formalised risk assessment and management strategies; and

- That a recommendation from the Coroner, in consultation with risk management specialists, in relation to the use of formalised risk assessment and management techniques or tools would be in the public interest.

[41] Mr Davis supplemented his submissions to the State Coroner with a number of further emails in which he sought to clarify various aspects in the findings of Coroner Priestly, elaborate upon the specific concerns which he had in relation to Mrs Davis' medication regime, provide the Coroner with an outline of the main points for consideration and to draw the Coroner's attention to another inquest which was then being held[28] and which Mr Davis felt may have been of relevance to the Coroner's considerations.[29] Specifically, whilst Coroner Priestly had referred

[26] Affidavit of Paula Campbell exhibit PC-3
[27] Affidavit of Paula Campbell exhibit PC-3; Affidavit of Stephen John Davis exhibits K & L (Document 3)
[28] Coroners Court of Queensland - Inquest into the death of Timothy Johns (findings delivered on 14 September 2017)
[29] Affidavit of Stephen John Davis exhibits M, N, O & P (Document 3)

to Mrs Davis' condition as not deteriorating, Mr Davis submitted that her condition was deteriorating. Mr Davis also provided examples of instances where he contended Dr Futter had prescribed outside of normal practice and manufacturers guidelines and asserted that given such risks were being taken, that risk management should have been beyond reproach and in his view was not so. Mr Davis provided extracts from manufacturer's guidelines and from the website "Drugs.com" to support these contentions.

[42] Mr Davis helpfully summarised the basis upon which he submitted that an inquest should be held into the death of Mrs Davis in one of his emails to the State Coroner as follows[30]:

"*I have provided evidence to show;*

1. *That Dr Futter prescribed combinations of medicines contrary to established practice and contrary to manufacturers' guidelines, in multiple instances.*
2. *That Dr Futter increased dosages contrary to a manufacturer's clear warning.*
3. *That Dr Futter did not closely monitor my wife's condition despite instructions from manufacturers. (Those instructions apply to monotherapy – combination raises the risk level even higher.)*
4. *That Dr Futter relies only on my wife for information, and so failed to uncover multiple factors that put her at high risk of suicide.*
5. *That clinicians who proscribe psychotropic medications are not trained in risk management, and have false perceptions as to the nature of risk assessment, its intent and its mechanisms.*
6. *That the care of patients with anxiety/depression should where possible, be a team responsibility, eg, psychiatrist, GP, and psychologist/counsellor. (This was a simple matter to arrange in my wife's case, but was not utilised.)*
7. *That no Risk Management Code of Practice exists to guide clinicians through the process of deciding on treatments while ensuring the safety of patients.*
8. *That if Dr Futter had been required to structure his treatment according to a Risk Management Code of Practice my wife might be alive today.*
9. *That a coronial inquest could be instrumental in establishing such a code and thereby reduce the unacceptable levels of suicides that currently exists. I am supported by Dr Robert Simon on this; "Systematic suicide assessment helps the clinician gather important information and piece together risk factors with which to construct a clinical mosaic of the suicidal patient."*
10. *That existing risk management tools currently in use under the Workplace Health and Safety Act can be inserted into a medical risk management arrangement with immediate effect. In other words, there is no requirement for a structure to be established from scratch; minor modifications only should be necessary."*

[43] Mr Davis also provided to the Coroner what he identified as four topics an inquest into his wife's death would be asked to consider:[31]

[30] Affidavit of Stephen John Davis exhibit O (Document 3)
[31] Affidavit of Paula Campbell exhibit PC-1

"*1. Did medications contribute to Kristine's death?*
2. Does a risk management Code of Practice exist to guide doctors in prescribing psychotropic medications?
3. Is a Code of Practice needed?
4. How should a Code be established?"

[44] After considering Mr Davis' application for an inquest to be held into Mrs Davis' death, on 10 February 2017 the State Coroner, Terry Ryan, provided a response to that application.[32] Coroner Ryan sought to address the various concerns raised by Mr Davis. He noted from the outset that neither of the expert reviews conducted for the Coroner indicated that there were any clear clinical management issues with respect to the treatment of Mrs Davis. Coroner Ryan acknowledged the concerns raised by Dr Powell in respect to the comprehensiveness of Dr Futter's initial consultation with Mrs Davis, but noted that these concerns likely arose in part because of poor record keeping by Dr Futter as was evidenced in Dr Futter's response to these concerns.

[45] Coroner Ryan stated that given Mr Davis' previously espoused concerns regarding the use of a psychiatrist to provide an expert review, that Mr Davis' request would be considered from a risk management perspective. He discussed the National Mental Health Commission's review of programs and services entitled "Contributing Lives, Thriving Communities" (2014) and the Australian Government response to this report and acknowledged that suicide prevention is an area which needs improvement at a practical level in the identification and management of suicide risk, including targeted responses for cohorts who are known to be at a higher risk, including persons with mental illness. Coroner Ryan stated that whilst Mrs Davis did not express any recent suicidal ideation, nor was there anything to suggest previous attempts, she had clearly been referred to Dr Futter because she was identified as being particularly vulnerable.

[46] In response to Mr Davis' concerns regarding the use of tele psychiatry by Dr Futter, Coroner Ryan stated that there is a range of training, practice standards and supporting guidelines published by the Royal Australian and New Zealand College of Psychiatrists which are designed to guide psychiatrists in the management of patients who they cannot see in person, and that these guides are likely to improve the ways these sessions are conducted.

[47] In response to Mr Davis' concerns in relation to Dr Futter's information gathering strategies and reliance on Mrs Davis as a sole source of information, Coroner Ryan agreed that it appeared that Dr Futter had not identified any background history of Mrs Davis which may have been a contributory factor with respect to her mental state prior to her death. Mr Davis was concerned that as Dr Futter had not consulted with Mrs Davis' family he was unaware of her father having committed suicide, her three brothers suffering from anxiety/depression or her being exposed to family violence as a child. Coroner Ryan agreed that it appeared that Dr Futter was unaware of Mrs Davis' background history and had he been made aware then this may have influenced his perception as to the validity of Mrs Davis' statements

and caused him to seek other sources of information with her consent including his future engagement with her. Coroner Ryan however also noted that according to Dr Futter he had no reason to suspect that Mrs Davis was not being truthful.

[48] Coroner Ryan then addressed what Mr Davis described as a noted deterioration in Mrs Davis' mental health condition shortly before her death and the daily cyclical nature of her mood and affect which Mr Davis described as Mrs Davis coming home and being cheerful and happy at night but by morning her behaviour changing and that she looked like "she had aged twenty years". Mr Davis also raised concerns as to the increase in Mrs Davis' tremors which Dr Futter said was associated with the medication she had been prescribed. The increase in tremors is one of the reasons identified by Dr Futter for the change he made in Mrs Davis' medication. Mr Davis believed that the tremors were an inherited condition which were worsened by the medication prescribed to Mrs Davis and that had Dr Futter been aware of Mrs Davis' deteriorating mental condition shortly before her death as well as pre-existing vulnerability this would have influenced his prescribing practice.

[49] Coroner Ryan found that it had not been established whether the deterioration of Mrs Davis' mental health condition shortly before her death described by Mr Davis was a sign of clinical deterioration, the effects of the medication she had been prescribed or was related to her underlying psychological illness. He also considered it questionable whether it would have changed the course of Dr Futter's prescribing because at that stage Dr Futter was still trying to identify the correct medication regime for Mrs Davis.

[50] Coroner Ryan also considered that the expert reviews commissioned by the Coroner appeared to demonstrate that Dr Futter did exercise due care in his prescribing and that he had made adjustments where symptoms and concerns were reported by Mrs Davis. Furthermore, Coroner Ryan noted that Dr Futter had advised that as a matter of routine he would always discuss his clinical approach with Mrs Davis and that he had changed medication which had been prescribed to Mrs Davis where it had an increased potential for overdose.

[51] Coroner Ryan was in no doubt that in broad terms coordinated case management, collateral information gathering and working with supportive family can all be elements of good practice. However he was satisfied that it had not been established as part of the coronial investigation whether this would have made a difference to the outcome in this case. In forming this view Coroner Ryan placed particular reliance on what was noted by Dr Powell in her review that Dr Futter had been treating Mrs Davis for only a comparatively short period of time which had affected his capacity to establish an effective therapeutic relationship with her. Coroner Ryan referred to the Australian Heath Minister's Advisory Council's *Framework for Reducing Adverse Medication Events in mental Health Services* and its consideration of the important role of carers with respect to medication management. He noted that this framework highlighted the importance of the

[32] Affidavit of Stephen John Davis exhibit Q (Document 3)

involvement of carers in a patient's care and the need for this to occur whilst respecting a patient's right to privacy and confidentiality and the relevant legal frameworks. Coroner Ryan further noted that whilst Dr Futter had advised Mrs Davis that she could involve her husband in her treatment, he did not feel the need to insist on such contact with Mr Davis because he had no reason to believe her suicide risk was worsening.

[52] Coroner Ryan also noted the steps which had been put in place to improve patient safety and that these acknowledged that a range of resources needed to be made available to community mental health services, psychiatrists and general practitioners to provide information to patients and carers to enhance the safety and effectiveness of medication use specifically associated with the treatment of people with mental health problems.

[53] Coroner Ryan also considered the concerns raised by Mr Davis in respect to the multiple medications which had been prescribed to Mrs Davis shortly before her death. He first noted that both expert review reports had concluded that Dr Futter's prescribing was acceptable by current clinical practice. As to Mr Davis' complaint that it can be presumed that the combination of medications prescribed to Mrs Davis may have contributed to her death either through a sense of despair that the medications were not working, that the known side effects of some of the medications may lead to suicide ideation or that her condition was not adequately being treated, he was of the view that this aspect of Mr Davis' complaint required consideration of whether there were opportunities for improvement in this area.

[54] Mrs Davis had raised concerns that "*medical professionals are not trained in risk management nor do they have a risk management code of practice to guide them*", which he said was based upon his own inquiries with therapists which he had made regarding Mrs Davis' death. Coroner Ryan, whilst satisfied that the side effects associated with certain psychotropic medications, including suicidal ideation, were well known and were clearly identified on relevant consumer medication information available to a patient, conceded that the risk of these medications inducing suicidal thoughts was less clear. In this regard he noted that the Black Dog Institute, in its guidelines for the management of changing antidepressant medication, described the management of changing antidepressant medication as being a "*work in progress".* Coroner Ryan also noted that patients will vary in their tolerance of medications, and that the likelihood of an adverse reaction is dependent on a range of individual characteristics such as age, weight and gender as well as the management of the transition between medications. Whilst acknowledging Mr Davis' concerns that Mrs Davis was sensitive to a range of substances including caffeine and alcohol which would make her more sensitive to any medication she was prescribed, Coroner Ryan noted that whether this may have increased Mrs Davis' sensitivity to the medication she was prescribed was not something specifically addressed as part of the coronial investigation. The Coroner also noted that compliance with the medication regime by a patient was also a relevant consideration with respect to treatment efficacy and that this may also have been a factor in this case unknown to Dr Futter.

[55] Coroner Ryan also noted that there can be adverse consequences to the abrupt withdrawal of certain medications and that this was likely a factor in Dr Futter reiterating to Mrs Davis that she should not cease taking her medication despite her request to do so. Coroner Ryan was satisfied that "c*omprehensive therapeutic guidelines for the administration of psychotropic medication do exist and are regularly updated"* and he referred to one such example of currently existing guidelines which supported this.

[56] Coroner Ryan acknowledged Mr Davis' concerns with respect to suicide risk assessment and management in clinical practice among psychiatrists. He accepted that this was an area not isolated to psychiatry and that there was a continued need for sustained practice change across all areas. However because the management of risk was dependent upon the roles and responsibilities of the service provider, the clinical environment and the patient's needs Coroner Ryan did not consider that these could easily be accommodated within a "singular code of practice."

[57] Noting that Dr Futter had conducted an initial assessment of Mrs Davis which included asking her for information with respect to any past or recent suicidal ideation, Coroner Ryan stated that clinical professional judgment is a recognised form of risk assessment, albeit one which can lack the reliability and validity of an actuarial tool. He considered that suicide risk was best conceptualised as a complex interaction of known risk factors and the absence of protective factors. However he stated that these factors are not causative or cumulative and that although a practitioner might be able to identify them when assessing whether a patient was at a heightened risk of harm, there is limited predictive validity with respect to most of the known suicide risk factors. Coroner Ryan referred to the list of risk factors specific to Mrs Davis identified by Mr Davis and noted that Mr Davis had inferred that had Dr Futter known of these risk factors he would have adopted a different approach to his clinical management of Mrs Davis. He expressed the view that whilst some of the background characteristics identified by Mr Davis were known risk factors others which were identified were not known risk factors that would be included in any risk management tool which might be developed. Coroner Ryan also noted that Mrs Davis had a number of known protective factors which he said were taken into account by Dr Futter including having no known recent or expressed plan or intent, she had a supportive family, was employed and was engaged in treatment.

[58] Coroner Ryan considered that the use of a Risklex Risk Score Calculator as proposed by Mr Davis could not be usefully applied in a psychiatric setting, and he expressed the view that the use of such a tool would likely lead to every patient being a "*false positive"* thereby limiting its validity as a predictive tool. Similarly, he also disagreed with Mr Davis that risk management tools used in a workplace health and safety environment could be easily adapted to a psychiatric setting. Coroner Ryan expressed concerns as to whether such a risk management process would ever be implemented even if recommended by a Coroner as it was not reflective of a "consensus evidence base in this area". He considered that at best there was the potential to consider at an inquest whether it would be viable to recommend routine screening by psychiatrists where a patient with mental illness

is taking medication which has a known side effect of increasing suicidal thoughts or ideation.

[59] Coroner Ryan noted that Dr Powell, in her review, had identified that there were limited factors to indicate that Mrs Davis was a high risk of suicide and that the assessment of suicide risk was an evolving area. He noted that psychiatry was not an exact science and that the effectiveness of treatment can largely depend upon the relationship between doctor and patient. In terms of ongoing management of suicide risk, Coroner Ryan noted that a patient unwilling to engage in or disclose also made it difficult to develop an effective therapeutic intervention. He also considered that confronting an unwilling patient too early or breaching their confidentiality could also be problematic as it had the propensity to cause a breakdown in the treatment relationship. Coroner Ryan also noted that had Dr Futter been aware of the deterioration of Mrs Davis' condition (as observed by Mr Davis) she may have been admitted as a voluntary patient, but that it was unlikely she would have met the requirements for an Involuntary Treatment Order which would have allowed more intensive treatment and monitoring to be provided to her.

[60] Coroner Ryan stated that "*while the Royal Australian College of Psychiatry does not appear to have a dedicated clinical guideline for suicide risk assessment and management, this issue is considered throughout each of the clinical guidelines relevant to a specific diagnosis and associated treatment options. This approach is likely to 'ground' suicide risk assessment and management in all elements of a psychiatrist's practice, meaning that it remains salient to their clinical decision making"*.

[61] Having reviewed the matters raised by Mr Davis, Coroner Ryan set out the principles relevant to determining an application made to the State Coroner under section 30(4) *Coroners Act* 2003 (Qld) for an inquest to be held into a death. Whilst he considered that it would be possible for an inquest to examine the issues identified by Mr Davis, in the circumstances he was not persuaded that it was in the public interest for an inquest to be held into the death of Mrs Davis. He noted that in particular any recommendation which a Coroner might make with respect to the risk assessment framework employed by psychiatrists would be of persuasive value only and unlikely to receive widespread support within the profession. He also noted that Queensland Health had already developed new suicide risk assessment and management guidelines but these would not have applied to Mrs Davis as she was a private patient. Mr Davis' application was therefore declined.

[62] Mr Davis responded to the decision of Coroner Ryan to decline his application to hold an inquest into the death of Mrs Davis by way of letter dated 13 February 2017.[33] Mr Davis raised what he described as "inconsistencies, misconceptions, misrepresentations and errors" in Coroner Ryan's report.[34] The concerns raised by Mr Davis included:

[33] Affidavit of Stephen John Davis exhibit R (Document 3)
[34] Document 3 Exhibit R

- That the Coroner had misrepresented Dr Powell's report, and that Dr Powell had expressed significant concerns in regard to the lack of a comprehensive clinical assessment by Dr Futter, that Dr Powell had also been critical of the prescribing of two benzodiazepines simultaneously, and that in his view Dr Powell had issued veiled criticisms of Dr Futter's use of polypharmacy.

- Whether the Coroner had checked the claims that Dr Futter demonstrated due care in his prescribing given the number of medications and alterations to dosage.

- That the Coroner's views in respect to the use of tele psychiatry ignored the fact that the manufacturer's instructions called for close monitoring of the patient, and that periods of up to 17 days between contacts had occurred, which he stated would not be accepted as "close monitoring".

- Disagreeing with the Coroner's position in respect to the reasonableness of Dr Futter's reliance on the information provided by Mrs Davis and Dr Futter's lack of insistence in involving Mrs Davis' family in the face of her not electing to do so. In relation to Dr Futter's failure to involve family, he indicated that the outcome of breaking confidentiality is preferential to patient death, and that in his view the choice to respect confidentiality is not supported by Dr Robert Simon, who he indicates is a recognised authority on suicide prevention.

- Questioned why his concerns with Mrs Davis' stimulant sensitivity was not addressed indicating that he felt that this was potentially highly significant.

- Disagreeing with the Coroner's acceptance of Dr Futter's refusal to cease Mrs Davis' medication, citing the principal of "*dignity of risk".*

- That any conversation which did not form part of Dr Futter's notes did not occur, and that reliance upon further information provided as part of the ongoing investigation is reliance on events which did not occur.

- Expressing frustration that his concerns regarding Mrs Davis' deteriorating condition was not identified as an issue in any of the reviews, stating that his two general concerns are incorrect prescribing of medications and failure to gather information. Mr Davis accused the Coroner of appearing partisan by failing to address this concern.

- Disagreeing with the Coroner's conclusion that a singular code of practice would not easily accommodate the necessary considerations such as the clinical environment, patient needs and the roles and responsibilities of the service provider.

- Expressing concern that the Coroner misunderstood the practice of risk assessment and that this lack of understanding necessitated the involvement of health and safety risk management experts in order to properly address the issue of risk management.

- Mr Davis outlined that the use of a risk score calculator could be used to create a generic score, rather than be used on individual patients, and that this generic score could be used to ensure that where a high risk exists, all possible measures are taken to minimise the risk. Mr Davis asserts that Dr Futter's risk management was not appropriate, and that the introduction of a hierarchy of controls into the training of doctors would have a significant impact on lowering suicide rates.

- Mr Davis claimed that the fact that the Coroner would only be able to issue recommendations which the Coroner felt would be unlikely to receive widespread support in the profession was not a valid argument against an inquest. Mr Davis indicated that he felt such recommendations would be enough for a responsible government to proceed with legislation.

- Mr Davis disagreed that it was not in the public interest for an inquest to be held given the prescribing of medications outside of manufactures recommendations and evidence that is widely practiced.

- Mr Davis criticised the lack of existing risk management processes, and the Coroner's approval of "works in progress" stating that no effective change from within would occur given what he perceived was a widespread lack of understanding of risk assessment and management. Mr Davis stated that effective change can only come through legislation.

[63] Mr Davis requested Coroner Ryan to reconsider his decision not to hold an inquest into Mrs Davis' death in light of his submissions. Replying to Mr Davis' further submissions, the Coroner's Office provided him with a copy of Dr Futter's response to the report of Dr Powell which he did not previously received and he was reminded of his right to apply to the District Court to have a decision of the State Coroner overturned if he was not satisfied with outcome.[35] On 17 February 2017, Mr Davis provided further correspondence to Coroner Ryan attaching a list of occasions in which Dr Futter failed to comply with drug manufacturer's instructions and reiterated the need for an inquest. [36] Ultimately the State Corner has declined Mr Davis' request for an inquest to be held into the death of Mrs Davis.

Principles which apply to the application

[64] Section 30(8) of the Act confers on this court the power to order that an inquest be held into the death of Mrs Davis "if satisfied that it is in the public interest to hold

[35] Document 3 Exhibit R
[36] Document 3 Exhibit T

the inquest". The test to be applied is the same as in section 28 of the Act which has application to when an inquest may be held. Section 28(1) prescribes that an inquest may be held into a death only where the corner "is satisfied it is in the public interest to hold the inquest." Section 28(2) then sets out a non-exhaustive list of relevant factors a coroner may consider in deciding whether it is in the public interest to hold an inquest. The section provides:

> "**28 When inquest may be held**
>
> (1) An inquest may be held into a reportable death if the coroner investigating the death is satisfied it is in the public interest to hold the inquest.
>
> (2) In deciding whether it is in the public interest to hold an inquest, the coroner may consider –
>
> (a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
>
> (b) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths."

[65] In determining this application I am bound to apply the express words of section 30(8) of the Act which prescribe that I may order an inquest into the death of Mrs Davis only if I am satisfied that "it is in the public interest to hold the inquest." The meaning of the term "public interest", when used in the context for the exercise of a statutory discretion such as exists in both sections 28 and 30 of the Act, was considered by Pullen JA in a different statutory context in *Re Minister for Resources; Ex Parte Cazaly Iron Pty Ltd* (2007) 34 WAR 403, where at [19] his Honour held:

> " [19] The expression "in the public interest", when used as the criterion for the exercise of a statutory discretion, usually imports a discretionary value judgment confined only by the subject matter and the scope and purpose of the legislation. The ascertainment of the subject matter and the scope and purpose of the legislation will enable a court to determine whether reasons which are given are definitely extraneous to any object a legislature could have had in view. See *O'Sullivan v Farrer* (1989) 168 CLR 210 at 216, and *Water Conservation Commission v Browning* (1947) 74 CLR 492 at 505: *McKinnon's case* per Hayne J at [55]: *Visnic v Australian Securities and Investments Commission* (2007) 81 ALJR 1175 at [36] per Kirby J. Although Jacobs J said in *Sinclair v Mining Warden at Maryborough* (1975) 132 CLR 473 at 487, that the public interest is an "indivisible concept", there may be competing aspects to the public interest. See *Re Queensland Electricity Commission; ; Ex parte Electrical Trades Union* (1987) 61 ALJR 393 at 400 and the examples given by Jacobs J in *Sinclair v Mining Warden* (supra). Jacobs J in *Sinclair* was considering the meaning of the words "public interest" in a regulation which required a Warden to recommend rejection of an application if, in his opinion,

> "the public interest or right will be prejudicially affected" by its grant. Jacobs J, at 487, referred to the width of the expression "public interest", and noted that the public interest in that case could tell against the grant of the mining lease even though particular interests of an individual were the only interests primarily affected."

[66] Buss JA in the same decision, considered that the term "in the public interest" should be interpreted as follows:

> "79 I turn now to examine the meaning of the expression, "in the public interest", in s 111A(1)(c).
>
> 80 In *O'Sullivan v Farrer* (1989) 168 CLR 210, Mason CJ, Brennan, Dawson and Gaudron JJ said, at 216:
>
> > "... the expression 'in the public interest', when used in a statute, classically imports a discretionary value judgment to be made by reference to undefined factual matters, confined only 'in so far as the subject matter and the scope and purpose of the statutory enactments may enable ... given reasons to be [pronounced] definitely extraneous to any objects the legislature could have had in view': *Water Conservation and Irrigation Commission (NSW) v Browning* (1947) 74 CLR 492 at p 505, per Dixon J."
> >
> > A question about "the public interest" will therefore rarely have only one dimension. See *McKinnon v Secretary, Department of Treasury* (2006) 80 ALJR 1549 per Hayne J at 1561 - 1562 [55].
>
> 81 Accordingly, whether it is "in the public interest", within s 111A(1)(c), that any land should not be disturbed or an application should not be granted in respect of any land involves a judgment about which reasonable minds may well differ. Compare *Right to Life Association (NSW) Inc v Secretary, Department of Human Services and Health* (1995) 56 FCR 50 per Lockhart J at 59; McKinnon at 1561-1562."

[67] Whilst the meaning of the term "in the public interest" applied in *Cazaly* was in relation to the use of that term in *Mining Act 1978* (WA), the meaning favoured in the decision provides guidance as to how the term should be defined in the Act under consideration here. The more recent discussion of the term by the High Court in *Hogan v Hinch* (2011) 243 CLR 506 is equally apposite, where it was held by French CJ at 536:

> "The term 'public interest' and its analogues have long informed judicial discretions and evaluative judgments at common law. Examples include the enforceability of covenants in restraint of trade, claims for the exclusion of evidence on grounds of public interest immunity, governmental claims for confidentiality at equity, the release from the implied obligation relating to the use of documents obtained in the course of proceedings, and in the application of the law of contempt. When used in a statute, the term derives its content from 'the subject matter and the scope and purpose' of the

enactment in which it appears. The court is not free to apply idiosyncratic notions of public interest." (citations omitted)

[68] In the same decision, the plurality, applying the principles stated in *O'Sullivan v Farrer*[37], affirmed at 548 that:

> "The expression "that it is in the public interest" imports a judgment to be made by reference to the subject, scope and purpose of the Act."

[69] The meaning of the term "is in the public interest" for purposes of section 30(8) of the Act is, consistent with an application of these principles, to be gained from the Act itself. The objects of the Act as contained in section 3 are to be considered, including that it is an object of the Act to:

> "(d) help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to -
>
> (i) public health or safety; or
>
> (ii) the administration of justice."

[70] The meaning of that term is also guided by the considerations in section 28(2) of the Act which include the extent to which drawing attention to the circumstances of a death may prevent deaths in similar circumstances happening in the future.

[71] In *Beale v O'Connell & Ors* [2017] QSC 127, Jackson J considered the meaning of the term "is in the public interest" as contained in section 28(1) of the Act. His Honour held:

> "[42] There is no dispute that on the proper construction of s 28(1), a coroner investigating a death must be satisfied that it "is in the public interest to hold an inquest" before he may do so. In other words, satisfaction that it is in the public interest to hold the inquest is a jurisdictional fact or condition precedent to exercise of the power to hold the inquest. The coroner must decide whether or not he or she is so satisfied.
>
> [43] What is in the public interest is a matter for the coroner to decide. The width of possible relevant considerations is apparent…."

[72] The exercise of the statutory discretion contained in section 30(8) of the Act to order that an inquest be held was first expressly considered by Robertson DCJ in *Gentner v Barnes* [2009] QDC 307. There his Honour, after reviewing a number of authorities from other jurisdictions which had considered the meaning of the term "in the public interest", concluded at [38]:

> "[38] The words of s.30(7)[38] are plain. It would be an error to simply apply the interpretation given to words used in the *Coroners Act* in other States

[37] (1989) 168 CLR 210 at 216-217

where the "test" is in different terms. In my opinion, the proper approach to this application should be governed by the following principles:

(i) The relief sought should be granted rarely or sparingly and regard should be had by this Court to the specialist nature of the office of Coroner and the specialist knowledge of the State Coroner and his office, and resourcing issues.

(ii) The phrase "in the public interest" involves a discretionary value judgment made by this Court based on the evidence before it constrained by reference to relevant Objects of the Act set out in s.3 (namely (c) and (d)), and to s.28(2) and the relevant guidelines referred to above.

(iii) It is not necessary that I conclude that the decision of the State Coroner was erroneous; however it is necessary that in order for the application to succeed there be such uncertainty or conflict of evidence so as to justify the use of the judicial forensic process, and/ or that the views of the family of the deceased are such that an inquest is likely to assist maintain public confidence in the administration of justice."

[73] Judge Robertson had earlier at [25] made the salient point that it must be kept in mind that this is an "application" to this court for an inquest to be held rather than an "appeal" from the State Coroner's decision to refuse to hold an inquest. Dorney DCJ explained the same point in *Lockwood v Barnes* [2011] QDC 84, when he observed at [24]:

> "I am of the view that, since the application is not for a review of any administrative decision (bringing into operation the various grounds upon which judicial review of administrative acts is based) and since the application is not an appeal from the decision of the State Coroner, the District Court is able to look at all material as it exists at the date the application is heard, subject to issues as to relevancy, weight, appropriate notice and, perhaps, an adjournment of the hearing of the application."

[74] In *Gentner v Barnes*, Robertson DCJ also observed at [28] with respect to the exercise of the discretion contained in what is now section 30(8) of the Act:

> "I am prepared to proceed on the basis that this Court should not lightly make a decision to hold an inquest in circumstances in which the State Coroner has refused one. The very fact that this is the first application made under s.30(7) suggests that such applications will be rare, and successful applications rarer still. As far as I can tell from my own limited research no Court in Queensland had this power prior to the commencement of the Act."

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[38] Section 30(7) of the Act as considered by Robertson DCJ (see paragraph [13] of the judgment) has through subsequent amendments become section 30(8) of the Act.

[75] In *Lockwood v Barnes*, Dorney DCJ, concurred with the principles identified by Robertson DCJ, and added at [25] that for purposes of determining an application under section 30(8) of the Act:

> "[25] With respect to the conclusions reached by Robertson DCJ, I agree that the relief sought should be granted rarely or sparingly, and that regard should be had to the specialist nature of the Office of the State Coroner, including resourcing issues. I also agree that the phrase "in the public interest" involves a discretionary value judgment of the kind identified in *O'Sullivan v Farrer* [1989] HCA 61; (1989) 168 CLR 210 in the judgment of Mason CJ, Brennan, Dawson and Gauldron JJ, at 216. But I do not agree that – while it is unnecessary to conclude that the decision of the State Coroner is erroneous – it is sufficient for an application to succeed that the views of the family of the deceased, or the local community, are such that an inquest is likely to assist to maintain public confidence in the administration of justice, unless one reads into the term "such" an unexpressed qualifier such as "in all the relevant circumstances". All these matters are discussed in paragraph [38] of Gentner. The last expressed conclusion was said to be in addition, or as an alternative, to establishing such uncertainty or conflict of evidence so as to justify the use of judicial forensic processes. I agree that the "views" of relevant persons are a factor to be brought into account and that such things as uncertainty or conflict in evidence are factors which will also affect the decision to be made. But it can only be that such views are to be taken in the context of the factual matrix of the circumstances of the death and of the investigation of it (if any) – in which uncertainty and conflict might play a part – to determine whether the touchstone of "public interest" has been triggered. It is only then that a decision can be made whether the views satisfy the required likelihood. Of course, in *Gentner*, the uncertainty and conflict of evidence, given the range and extent of it, when taken with the impact on public confidence (particularly having regard to the extent to which the views of the family were taken into account), justified the use of the procedures available for holding an inquest."

Issues raised by the applicant

[76] The applicant has filed written submissions in support of his application. Those written submissions were supplemented by further oral submissions. The Attorney–General for the State of Queensland appears in these proceedings as *amicus curiae* by Order of the Court made 19 April 2017.

[77] It will be apparent from the history of this matter that Mr Davis genuinely believes that it is in the public interest for an inquest to be held into the death of Mrs Davis. As would be obvious from the detailed submissions he has made both to Coroner Priestly, Chief Coroner Ryan and to this court, he has devoted considerable time and resources into researching the circumstances surrounding the death of his wife. He has consistently maintained that an inquest must be held into the death of his wife on the basis that her death demonstrates the need for risk assessment and management protocols to be created and implemented in relation to the treatment of mentally ill patients.

[78] Mr Davis has consistently raised the following concerns in respect to the circumstances surrounding his wife's death which he relies upon in support of his submissions that it is in the public interest to hold an inquest into his wife's death:

- The failure by Dr Futter to consult with other treating professionals and Mrs Davis' family which would have provided Dr Futter with a more comprehensive personal history of Mrs Davis which would have better informed him in treating her condition;

- The multiple medications prescribed to Mrs Davis, and the prescription of those in dosages and combinations which were contrary to the manufacturers recommendations and were inappropriate in all of the circumstances;

- That strict monitoring was required as a result of a high risk medication regime and appropriate monitoring of Mrs Davis was not undertaken;

- That there is a misunderstanding amongst health professionals as to the purpose and application of risk assessment and management tools;

- That there is a requirement for risk management and assessment tools to be implemented throughout the psychiatric profession in the treatment of mentally ill patients in order to reduce instances of suicide;

- That a recommendation by the coroner that formalised mental health risk management measures be introduced might be effective in reducing the risks associated with psychotropic medications.

[79] In support of his application, Mr Davis also relies upon some additional material relating to the primary concerns he has raised with respect to the circumstances surrounding the death of his wife. I have considered in determining this application, that additional material which includes:[39]

- Full copies of Manufacturer's product information for Pristiq, Mirtazapine, Alepam, Xanax and Zyprexa.

- Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders.

  (Mr Davis submits that while these guidelines are "extensive, detailed and useful in many respects" they include no instructions for minimising suicide risks other than the need for close monitoring by both clinician, family and carers.)

- Combination antidepressants Use by GP's and psychiatrists, Horgan D & Dodd S, 2011.

(Mr Davis submits that this paper confirms that the use of combinations of psychotropic medications to treat mood disorders is widely practiced.)

- Extract from the Australian Therapeutic Guidelines.

  (Mr Davis refers to an extract of this guideline which states "*there is little evidence supporting the use of combined antidepressants in treatment resistant depression, and there are significant concerns regarding the potential for serious drug interactions")*

- The Royal Australian and New Zealand College of Psychiatrists – Professional Practice Guideline # 4 (as replaced by exhibit SD-K in Affidavit of Stephen John Davis dated 23 June 2017).

  (Mr Davis submits that this guideline supports the above assertion.)

[80] By way of a further two affidavits deposed by Mr Davis, filed and dated 22 May 2017 and 23 June 2017 respectively, Mr Davis has attached the following:[40]

- The Royal Australian & New Zealand College of Psychiatrists – Telehealth in psychiatry;

- Medical Board of Australia Guidelines – Technology-based patient consultations (16 January 2012);

- Combination antidepressants in Australia: a right or wrong, David Horgan, 2011;

- Document of unidentified origin relating to polypharmacy;

- Update to TGA response to recommendations made by the Psychiatric Drug Safety Expert Advisory Panel;

- Therapeutic Goods Administration – Product Information.

[81] Finally, in his outline of submissions in support of the application, Mr Davis has identified the following areas which he argues demonstrates the public interest in holding an inquest into the death of his wife:

1. Did the treatment of Mrs Davis involve breaches of duty of care as a consequence of:

   a. A failure by Dr Futter to gather sufficient information;

   b. Deviations by Dr Mallett and Dr Futter from the manufacturers' product instructions when treating Mrs Davis;

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[39] Affidavit of Stephen John Davis filed 17 May 2017 (Document 9 and Document 10)
[40] Document 11 and Document 13

c. A failure by Dr Futter to follow therapeutic guidelines;

d. A failure by Dr Futter to adequately monitor Mrs Davis;

e. Whether the medication prescribed to Mrs Davis contributed to her death.

2. Does the absence of formal risk management protocols put all doctors at risk of failing to discharge their duty of care?

3. Is the Therapeutic Goods Administration's risk/benefit evaluation process that determines the suitability of products for use being undermined?

4. Are doctors given adequate advice to control risk?

[82] Mr Davis submits that each of questions one, two and three should be answered in the affirmative, and that question four would be answered in the negative. In the course of submissions Mr Davis noted that the Mood Disorder Guidelines, the Off-Label Prescribing Guidelines and the Therapeutic Guidelines were not placed before the respective Coroners by him as he was unaware of their existence and importance. Mr Davis has consistently maintained that there is a need for recommendations to be made by the Coroner for risk management protocols to be put in place.

Decision

[83] It will be obvious from the investigation of this matter by both Coroner Priestly and subsequently by Chief Coroner Ryan that the conduct of Dr Futter in his treatment of Mrs Davis has been extensively reviewed. Mr Davis has remained engaged in the coronial investigation and as a consequence of concerns raised by him regarding certain aspects of his wife's treatment further evidence was sought by the coroner with a view to addressing those concerns. This included obtaining expert reports from Dr Griffith and Dr Powell in relation to treatment provided to Mrs Davis by Dr Futter including a review of the medications she had been prescribed.

[84] The comprehensive review undertaken by the coroner has raised a number of issues relating to some aspects of the treatment of Mrs Davis by Dr Futter. In particular, the report of Dr Powell, who was engaged to provide an independent review of the treatment provided to Mrs Davis, highlighted a number of shortcoming in respect to the initial assessment and history gathering undertaken by Dr Futter following Mrs Davis' referral by Dr Mallett. Dr Powell opined that shortcomings in the assessment conducted by Dr Futter resulted in what she described as a "less than optimal" assessment of her suicide risk.

[85] However, as to the issues raised by Mr Davis in respect to Dr Futter prescribing multiple medications to Mrs Davis, Dr Powell ultimately concluded that this strategy was not unreasonable. The body of medical opinion obtained by the coroner is that Mrs Davis was suffering from what is described as treatment resistant depression. Dr Powell generally agreed with both the medications prescribed to Mrs Davis and changes in medication made by Dr Futter with the exception of the change from Cymbalta to Pristiq which in Dr Powell's view was unlikely to yield any benefits.

[86] There is clearly a difference of opinion amongst psychiatrists as to the efficacy of prescribing medications for the treatment of depressive conditions such as that suffered by Mrs Davis. Mr Davis obtained a report from Dr McLaren who clearly is less convinced as to the efficacy of prescribing antidepressants for such conditions having regard to the risks associated with such medications. That is obviously not a view shared either by Dr Griffith, Dr Powell or Dr Futter and it appears to reflect there are differing opinions in this area of psychiatry.

[87] In respect to whether the treatment of Mrs Davis involved a breach of duty by either Dr Futter or Dr Mallet, the principal complaints raised by Mr Davis relate to whether either doctor complied with relevant manufacturers product guidelines when prescribing the medications to Mrs Davis. There is a dispute on the evidence available as to the extent Dr Futter did elicit a personal history from Mrs Davis. As I have noted already, Dr Powell has raised a number of concerns in respect to the insufficiency of the history obtained by Dr Futter. Dr Futter has challenged those concerns and maintains that he did take a detailed history from Mrs Davis which guided him in his treatment of her. The other concerns raised by Mr Davis relating to what he alleges were deviations from manufacturers product guidelines when prescribing, failing to follow therapeutic guidelines including his use of tele psychiatry, Dr Futter's failure to properly monitor Mrs Davis when changing medication and whether the medication contributed to Mrs Davis' death are all matters for which again there appears to be legitimate differences of medical opinion.

[88] The opinions of Dr Powell in respect to these concerns raised by Mr Davis are, in my view, persuasive given that she can be regarded as an independent expert. Dr Powell emphasised that the suicide of Mrs Davis was very unlikely to have been something that could have been predicted either in respect to timing or method. She also emphasised that a patient's risk of suicide can change rapidly. Of particular relevance to Dr Powell was the impediments to a therapeutic relationship developing between Dr Futter and Mrs Davis, which she described as being in its early stages and that it was complicated by the fact that because Mrs Davis lived some distance from Dr Futter this necessitated him maintaining contact with Mrs Davis by telephone. Dr Powell raised no issues with contact being maintained by Dr Futter in this way and whilst I note Mr Davis' reference to the RANZCP guidelines in respect to tele psychiatry being consultations via video-link, it might not always be possible for this to occur as appears to be the case here. Dr Powell also accepted that the limited face to face contact necessitating telephone contact would have impeded the development of a therapeutic relationship that might

otherwise have contributed to reducing the longer term risk of suicide. It seems clear however that this was a regrettable consequence of the distance separating Dr Futter and Mrs Davis which precluded ongoing face to face contact.

[89] As to prescribing contrary to manufacturers guidelines, whilst Dr Powell did not specifically address the manufacturers' guidelines in her report, she was asked by the coroner to, and did, review the appropriateness of the medications and combination thereof prescribed to Mrs Davis. As I have noted earlier, whilst Dr Powell disagreed with Dr Futter as to the efficacy of changing from Cymbalta and raised concerns as to whether alternative treatment strategies had been discussed with Mrs Davis, she otherwise was of the view that the medication strategy employed by Dr Futter was not unreasonable. A similar opinion was also expressed by Dr Griffith.

[90] With the benefit of hindsight it would have been desirable for Mr Davis to have been included in the treatment of his wife. However Dr Futter has explained his reasons for not doing so and whilst I acknowledge the criticisms raised by Mr Davis as to efficacy of those reasons, the point remains that having been reviewed independently by Dr Powell and Dr Griffith, there is no basis to conclude that on the information available the treatment of Mrs Davis by either Dr Futter and Dr Mallett fell so far below the standard of care expected of treating practitioners that it demonstrates either were negligent in the care they provided to Mrs Davis. The treatment administered by Dr Futter would, on the evidence available, be consistent with currently accepted mainstream standards of psychiatric care, although I accept that even within the psychiatric profession there are contrasting opinions as to the efficacy of prescribing antidepressant medication given their proven potential side effects. Dr Powell's opinion as to it being unlikely that Mrs Davis' suicide could have been predicted is also a relevant consideration. Whilst I appreciate the various concerns raised by Mr Davis in respect to the treatment provided to his wife and whether that treatment might have involved a breach of duty of care which contributed to her death, there is insufficient evidence to conclude that any purported breach of duty of care raised by Mr Davis in respect to the treatment of his wife, including the efficacy of the medication she was prescribed, would warrant further investigation at an inquest.

[91] The absence of formal risk management protocols having application to medical practitioners is also a concern Mr Davis strongly holds. Coroner Ryan acknowledged that there are no risk management protocols currently existing which would assist medical practitioners, including psychiatrists, in assessing the suicide risk of patients being treated for mental illness or depression. Coroner Ryan accepted that whilst this is a matter that could be the subject of investigation at an inquest, he was not persuaded it was in the public interest to do so.

[92] It can be accepted that there are a number of potential side effects associated with the use of psychotropic medications including sudden and unexpected suicide risks. These risks appear to be well known within the medical profession and nothing suggested by Dr Futter was to the contrary. Mr Davis argues that these risks could be alleviated if medical practitioners were required to comply with a

risk assessment and management strategy when prescribing such medications to patients.

[93] In deciding whether it is in the public interest to hold an inquest, section 28(2) of the Act prescribes as one of the relevant considerations whether the extent to which drawing attention to a death may prevent deaths in similar circumstances in the future. The objects of the Act also include helping to prevent deaths from similar causes happening in the future by allowing a coroner to comment on matters connected with a death. In my mind commenting on the absence of generally applicable risk assessment and management strategy for the prescription of antidepressant medications would potentially fall within a subject matter capable of being investigated at an inquest.

[94] Whilst I accept this to be so, I am also cognisant of the reasons given by Chief Coroner Ryan for declining the request to hold an inquest into the death of Mrs Davis. Principally, Coroner Ryan, whilst accepting that there are concerns with suicide risk assessment and management in the prescription of antidepressant medications not only among psychiatrists but the medical profession more generally, concluded that such risks ultimately were best assessed by the treating practitioner and that any recommendations which might be made as part of an inquest would be of guidance only and unlikely to receive widespread support within the profession. Coroner Ryan was concerned that the lack of a "consensus evidence base in this area" would result in any risk management process not being implemented. A similar concern was also articulated by Coroner Priestly who considered that it was not the role of the coroner to preside over an inquest to assess which risk management strategy was best to recommend. It is clear from the reasons of both Coroner Priestly and Coroner Ryan that whilst they appreciated the concerns raised by Mr Davis as to the lack of any risk assessment applying generally to medical practitioners when prescribing antidepressant medications, they each concluded that an inquest into the death of Mrs Davis was not the appropriate vehicle to address that concern.

[95] The opinions expressed by Dr Powell are also relevant to this issue and whether or not an inquest could address the concerns raised in this regard by Mr Davis. Dr Powell reiterated in her report that there is no well validated way of assessing suicide risk and that the best way to of assisting a patient who is at risk of suicide is for the treating practitioner to undertake a comprehensive assessment of the patient as detailed in her report. Dr Powell also regarded the development of a therapeutic relationship between doctor and patient as being critical to intervening and detecting any rising risk of suicide in a patient. Coroner Ryan noted that psychiatry is not an exact science and that the effectiveness of treatment can largely depend upon the therapeutic relationship established. Whilst Coroner Ryan conceded that an inquest could inquire into the viability of recommending routine screening by psychiatrists of patients who are prescribed medications with known side effects, having regard to Dr Powell's report in my view this is something that a diligent and competent medical practitioner should already be doing as part of the initial comprehensive assessment described by Dr Powell.

[96] Mr Davis relies upon the inquest conducted into the death of Timothy John[41] as providing an example of an inquest that inquired into similar issues to those surrounding the death of his wife. I would note that the findings into the death of Mr John indicate that the inquest was held following a review conducted by Coroner Ryan which resulted in him directing that an inquest be held. Obviously Coroner Ryan has conducted a review into the death of Mrs Davis and concluded that no inquest should be held.

[97] Mr John took his own life in 2013. Some two weeks prior to his death Mr John had been prescribed by a general practitioner Champix, a prescription medication used to treat nicotine addiction. The inquest investigated whether Champix had contributed to Mr John's death and the adequacy of the care provided to him by his general practitioner when prescribing the medication to him.

[98] The coroner found that Champix did contribute to the death of Mr John and that his general practitioner had not provided adequate care to him when prescribing the drug. Findings were also made in respect to the adequacy of the product labelling and instructions relating to the drug and recommendations were made with respect to that. It was also recommended that the general practice community take note of the inquest findings and ensure that before prescribing the drug they provide advice to the family, carer or friend of the patient the need to monitor them for neuropsychiatric symptoms.

[99] The inquest into Mr John indicates that it is possible to conduct an inquest into a death associated with prescription medication with known potential side effects including suicide. There were however a number of issues which arose in that inquest which are not apparent here. First there was clear evidence that the general practitioner who prescribed the drug was unaware of, and therefore did not inform, Mr John of any potential side effects. This failure to warn was the subject of a specific finding by the coroner. Secondly, the consumer warnings on the drug packing were found to be inadequate. Thirdly, when Mr John had been prescribed Champix in 2013 the available evidence had been that the drug either did not increase the risk of suicide or, if it did, the increase was only slight. Shortly before the inquest was conducted however, a more comprehensive study had been completed which established that users of the drug with a history of psychiatric disorder had a discernible increased risk of adverse effects from using the drug.

[100] In respect to the death of Mrs Davis those same issues do not arise, at least to the extent under consideration by the coroner in the inquest into the death of Mr John. The potential side effects of each of the medications prescribed by Dr Futter to Mrs Davis are well known and are the subject of comprehensive manufacturer product information documents. On the available evidence Dr Futter did elicit at last some personal history from Mrs Davis, was aware that he was treating her for general anxiety, satisfied himself that she was not a risk of committing suicide and then continued to have regular contact (albeit predominantly by telephone) in order to assess her progress. Even accepting the criticism which have been raised as to the

[41] Coroner Hutton – delivered on 14 September 2017

adequacy of some aspects of Dr Futter's personal history taking, treatment of Mrs Davis, the issues raised in the inquest into Mr John's death as to the adequacy of the care provided by the general practitioner involved substantially different shortcomings which clearly justified further investigation in that case. Therefore, whilst I appreciate the basis upon which Mr Davis seeks to rely upon the inquest into the death into Mr John and why he submits it provides support for his argument that an inquest be held into his wife's death, in my view the issues which might be the subject of an inquest into the death of Mrs Davis would not be the same.

[101] Mr Davis also raises as an issue warranting an inquest whether the Therapeutic Goods Administration risk management guidelines for prescription medications are being undermined by medical practitioners prescribing antidepressant medications such as those prescribed to his wife without having regard to the guidelines. Further to this, Mr Davis also argues that the failure by medical practitioners to provide adequate advice to patients and their families as to the potential side effects of medications being prescribed, a recommendation that a mandatory risk management code be implemented would be one way of preventing future deaths in circumstances similar to those that resulted in the death of Mrs Davis.

[102] Again I understand the basis for the concerns raised by Mr Davis concerning compliance by medical practitioners with product information documents and the degree to which patients are adequately warned of potential side effects. But in determining whether it is in the public interest to hold an inquest into the death of Mrs Davis, a relevant consideration having regard to the extent to which drawing attention to her death may prevent deaths in similar circumstances is whether any recommendations that would be made at an inquest concerning, for example implementing a risk assessment tool, would be implemented or would likely receive general support within the medical community. Coroner Ryan concluded it would not be.

[103] I have set out earlier the relevant principles which I am required to consider in determining this application. I accept the principles considered by Robertson DCJ as correctly stating the law which I must apply here. As the authorities make clear, the granting of an application to order that an inquest be held will be rare and this court should not lightly order an inquest after the State Coroner has conducted a review of the evidence and determined in the circumstances that an inquest should not be held. Moreover, as was observed by Dorney DCJ in *Lockwood v Barnes*, regard should also be had to the specialist nature of the office of the State Coroner including resourcing issues

[104] Here, having regard to the objects of the Act contained in section 3 as well as the considerations prescribed in section 28(2), I am not persuaded that the matters raised by Mr Davis allow me to conclude that it is in the public interest to hold an inquest into his wife's death. The death of Mrs Davis was tragic. I have a great deal of sympathy for Mr Davis and commend him for seeking to have remediated the shortcomings which have been identified in the course of the coroner's

investigation relating to the treatment of his wife. However I am ultimately in agreement with the State Coroner Mr Ryan that whilst it would be possible to hold an inquest into the death of Mrs Ryan, the non-binding nature of any recommendations that might be made were an inquest held and the likelihood that they would not receive widespread support within the medical profession weigh against the holding of an inquest.

[105] In the circumstances I am not satisfied pursuant to section 30(8) of the Act that it is in the public interest to hold an inquest into the death of Mrs Davis.

Orders

[106] I order that the application be dismissed.