SUPREME COURT OF QUEENSLAND

CITATION:	*Davis v Ryan, State Coroner* [2019] QCA 282
PARTIES:	**STEPHEN JOHN DAVIS** (applicant) **v** **TERRY RYAN, STATE CORONER** (respondent)
FILE NO/S:	Appeal No 3780 of 2019 DC No 36 of 2017
DIVISION:	Court of Appeal
PROCEEDING:	Application for Extension of Time s 118 DCA (Civil) Application for Leave s 118 DCA (Civil)
ORIGINATING COURT:	District Court at Townsville (Lynham DCJ)
DELIVERED ON:	3 December 2019
DELIVERED AT:	Brisbane
HEARING DATE:	19 August 2019
JUDGES:	Holmes CJ and Gotterson JA and Flanagan J
ORDERS:	**1. The time for filing of the application for leave to appeal is extended to 8 April 2019.** **2. The application for leave to appeal is refused.**
CATCHWORDS:	APPEAL AND NEW TRIAL – PROCEDURE – QUEENSLAND – TIME FOR APPEAL – EXTENSION OF TIME – WHEN GRANTED – where the application for leave to appeal was filed out of time – where the decision the subject of the application was forwarded to the applicant at the wrong email address – where the applicant acted promptly to file his application once he received the judgment – whether an extension of time should be granted for the application for leave to appeal ADMINISTRATIVE LAW – JUDICIAL REVIEW – REVIEWABLE DECISIONS AND CONDUCT – DISCRETION NOT TO ENTERTAIN APPLICATION – GENERALLY – where the applicant applied to the District Court for an order to hold an inquest into the death of his late wife – where the District Court judge was not satisfied under s 30(8) of the *Coroners Act* 2003 that holding an inquest would be in the public interest, and dismissed the application – where the applicant sought leave to appeal from the District Court judge's decision – whether leave is necessary in order to correct a substantial injustice – whether there is a reasonable

argument that the District Court judge committed *House v The King* error in forming the discretionary judgment that he was not satisfied that holding an inquest was in the public interest – whether the District Court judge misconstrued the term "public interest" in s 30(8) – whether the District Court judge took into account irrelevant considerations by having regard to the State Coroner's views as to the utility of an inquest and the availability of resources, and to opinion evidence from doctors – whether the District Court judge failed to have regard to a relevant consideration as to an alleged widespread dangerous prescribing practice or simply did not make the finding of fact the applicant sought

Civil Liability Act 2003 (Qld), s 21, s 22
Coroners Act 2003 (Qld), s 3, s 8, 11(2), s 27, s 28, s 30, s 46
District Court of Queensland Act 1967 (Qld), s 118(3)
Health Practitioner Regulation National Law (Queensland) 2009 (Qld), s 39, s 41

Aldrich v Ross [2001] 2 Qd R 235; [2000] QCA 501, cited
Clancy v West [1996] 2 VR 647; [1995] VICSC 207, considered
Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission (2000) 203 CLR 194; [2000] HCA 47, applied
Corporation of the City of Enfield v Development Assessment Commission (2000) 199 CLR 135; [2000] HCA 5, cited
Eclipse Sleep Products Inc v Registrar of Trademarks (1957) 99 CLR 300; [1957] HCA 86, cited
Gentner v Barnes [2009] QDC 307, considered
Hogan v Hinch (2011) 243 CLR 506; [2011] HCA 4, considered
House v The King (1936) 55 CLR 499; [1936] HCA 40, applied

COUNSEL:	The applicant appeared on his own behalf No appearance for the respondent P Morreau for the Attorney-General (Qld) as amicus curiae
SOLICITORS:	The applicant appeared on his own behalf No appearance for the respondent Crown Law for the Attorney-General (Qld) as amicus curiae

[1] **HOLMES CJ:** The applicant, Mr Davis, seeks an extension of time within which to apply for leave under s 118(3) of the *District Court of Queensland Act* 1967 to appeal the decision of a District Court judge refusing his application for an order for an inquest into the death of his wife. In accordance with the *Hardiman*[1] principle, the respondent State Coroner has taken no part in the proceedings and does not seek to be heard on this application. The Attorney-General of Queensland appeared at first instance as amicus curiae and sought leave to appear in that capacity once more on this application. In circumstances where the applicant is self-represented and the respondent cannot appropriately make submissions, the value of the Attorney-General's assistance to the court on the issues here is obvious. Leave was, accordingly, granted to the Attorney-General to appear as amicus curiae.

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1 *R v Australian Broadcasting Tribunal; Ex parte Hardiman* (1980) 144 CLR 13.

[2] I would grant an extension of time for the application for leave. It was filed some months after the judgment was delivered, but it appears that the judgment was forwarded to Mr Davis at the wrong email address, and once that error was corrected he acted promptly to file his application.

The tests for leave to appeal and appeal

[3] Leave to appeal under s 118(3) of the *District Court of Queensland Act*

> "… will usually be granted only where an appeal is necessary to correct a substantial injustice to the applicant, and there is a reasonable argument that there is an error to be corrected".[2]

Section 30(8) of the *Coroners Act* 2003 required the learned District Court judge, before exercising his discretion as to whether to order an inquest, to reach a state of satisfaction that it was in the public interest that an inquest be held. His Honour was not so satisfied. Guidance as how to characterise that decision-making process, and the nature of any appeal against it, is to be found in the High Court's decision in *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission*.[3] In that case, a member of the Industrial Relations Commission similarly had to reach a state of satisfaction as to a particular matter (that industrial action posed a threat to public welfare and the economy) before exercising his discretion to make orders. Considering the nature of an appeal from the decision, Gleeson CJ, Gaudron and Hayne JJ observed[4] that it involved, in fact, two discretionary decisions. The achievement of the necessary state of satisfaction "involved a degree of subjectivity" and could be described, broadly, as a discretionary decision; the Commission member, having achieved that state of satisfaction, had then to make a further discretionary decision, as to whether to make an order. It was necessary, in order to challenge those decisions, to identify error in the *House v The King* sense, which would be made out:

> "If the judge acts upon a wrong principle, if he allows extraneous or irrelevant matters to guide or affect him, if he mistakes the facts, if he does not take into account some material consideration …"[5]

The proposed grounds of appeal

[4] To obtain leave to appeal in the present case, then, Mr Davis must demonstrate a reasonable argument that the District Court judge committed *House v The King* error in forming the discretionary judgment that he was not satisfied the holding of an inquest was in the public interest. Before this court, Mr Davis identified three grounds on which the District Court judge dismissed his application, those being: that regard should be had to resourcing issues in deciding whether coronial inquests should be ordered; that applications refused by the State Coroner should not be granted lightly; and that the recommendations of an inquest in this case would be non-binding and unlikely to receive support from the medical profession. Each, he said, constituted an erroneous taking into account of an irrelevant consideration. In addition, he contended, his Honour had wrongly taken peer professional opinion into account, contrary to the *Health Practitioner Regulation National Law (Queensland)* 2009 and

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2 *Pickering v McArthur* [2005] QCA 294 at [3].
3 (2000) 203 CLR 194.
4 At 205.
5 *House v The King* (1936) 55 CLR 499 at 505.

the *Civil Liability Act* 2003, in considering the question of whether Mrs Davis' doctors had failed to meet their duty of care in treating her; and he had failed to have regard to evidence of a widespread practice of dangerous prescribing among doctors, which was a relevant consideration.

Relevant provisions of the Coroners Act

[5] Section 3 of the *Coroners Act* sets out its objects, which relevantly include

> "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; …"

Section 11(2) requires that a coroner investigate any reportable death.[6] Section 27 prescribes circumstances in which an inquest must be held, none of which apply here; but s 28(1) gives an investigating coroner a discretion to hold an inquest if satisfied it is in the public interest to do so. Section 46 closely reflects the object set out above; it enables a coroner who holds an inquest into a death to comment on anything connected with the death relating to

> "(a) public health or safety; or
>
> (b) the administration of justice; or
>
> (c) ways to prevent deaths from happening in similar circumstances in the future."

[6] Section 30(4) of the *Coroners Act* permits an application to the State Coroner for an order that an inquest be held where a coroner investigating the death has decided not to hold one. If that application is refused, a further application may be made to the District Court under s 30(6). The State Coroner or District Court judge, as the case may be, has a discretion to make such an order

> "… if satisfied it is in the public interest to hold the inquest."[7]

Section 28(2) of the Act, although not directly applicable to the exercise of discretion under s 30, gives some assistance as to considerations relevant to the question of public interest, because it deals with what a coroner investigating a death may have regard to:

> "…
>
> (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

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6 Mrs Davis' death was a reportable death, by virtue of s 8(3)(b) of the Act.

7 Section 30(8).

(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."

The State Coroner has issued guidelines for the purposes of s 28(2)(b). They include a very broad range of considerations.

Mr Davis' dealings with the investigating Coroner's office

[7] Mrs Davis committed suicide on 7 August 2013. She had in the past been treated for a generalised anxiety disorder, and over a period of about three months before her death had been under the care of a psychiatrist for that condition and for depression. Mr Davis had concerns about the treatment and medication given her, and more broadly about practices by psychiatrists at large in relation to suicide risk assessment and consultation in relation to patient care with other health professions and the patient's family. On the basis of those concerns, he sought to have the investigating Coroner revisit an initial conclusion that an inquest was unnecessary.

[8] In response to the issues Mr Davis raised, the investigating Coroner obtained medical records relating to Mrs Davis from a number of sources, put specific questions to Mrs Davis' treating psychiatrist about her history and his management of her, and sought a review by a Forensic Medical Officer of the medications prescribed to Mrs Davis. Subsequently, in response to further concerns raised by Mr Davis, particularly in relation to the lack of any code of practice for suicide risk assessment, a consultant psychiatrist was engaged to review the appropriateness of the treating psychiatrist's treatment of Mrs Davis' risk of suicide and of the medications given to her, and to make any comment thought appropriate on any matters regarding her care.

[9] The reviewing psychiatrist took the view that Mrs Davis was suffering from treatment-resistant depression and anxiety. While making some criticism of the treating psychiatrist's recording of Mrs Davis' history, she did not consider his medication strategy to be unreasonable. There was, she said,

"… no well-validated way of assessing risk of suicide".

The appropriate course was to establish a strong therapeutic relationship with the particular patient, obtaining, if possible, collateral history from other health professionals and family members. That had been difficult in the present instance because the treating psychiatrist had not been managing Mrs Davis' care for long, and, because she lived in a different regional town a considerable distance away, had principally had to maintain contact with her by telephone.

[10] The investigating Coroner then sought further comment from the treating psychiatrist. The latter elaborated on the way in which he had taken a history from Mrs Davis and gave some further explanation of the medication regime on which he had placed her. He said that he had encouraged Mrs Davis to have her husband attend consultations or speak to him, but had not pressed the matter.

[11] Mr Davis continued to raise concerns with the Coroner's office and provided a report which he had obtained from a psychiatrist who had reviewed some of the material gathered. That psychiatrist expressed disapproval of prescribing practices involving multiple drugs and he rejected the notion that Mrs Davis could have required prescription of 11 different psychotropic drugs; which, he understood, had occurred

over the four years before her death. In his opinion, psychotropic drugs caused a state of agitation and distress associated with unexpected attempts at suicide and homicide, particularly where prescribed in higher dosages and in combination, as in Mrs Davis' case. The investigating Coroner, however, declined to hold an inquest and found that no further investigation of Mrs Davis' clinical management was required.

The State Coroner's decision

[12] Mr Davis then applied to the State Coroner under s 30(4) of the *Coroners Act* for an order to hold an inquest into his wife's death, submitting that it would be in the public interest to do so. He expressed the view that important factors had been overlooked by Mrs Davis' treating doctor, which would not have occurred had there been an established risk management process for the use of psychiatrists. Subsequently, he proposed that an inquest examine whether medication had contributed to his wife's death and whether a risk management code of practice ought to be established to guide doctors in prescribing psychotropic medications. An additional concern was that the treating psychiatrist had relied on Mrs Davis' self-reporting in evaluating the risk of suicide and was unaware of information contained in her general practitioner's notes to the effect that family members had suffered from anxiety and depression, one of them committing suicide.

[13] The State Coroner extensively reviewed Mr Davis' submission. In the course of doing so, he identified existing guidelines and mental health initiatives on foot to improve patient care and medication safety. His Honour made some observations about Mr Davis' proposal for suicide risk assessment and management, noting that managing risk depended on the particular circumstances of the patient and the service provider and could not easily be accommodated within a code of practice. There was no consensus evidence base for implementation of risk assessment and management processes as suggested by Mr Davis. There were, on the other hand, clinical guidelines issued by the Royal Australian College of Psychiatry in relation to diagnosis and treatment which were relevant to suicide risk assessment and management.

[14] The State Coroner had regard to principles outlined by Robertson DCJ as applicable on an application for an order for an inquest in *Gentner v Barnes*;[8] to the public interest criterion contained in s 28(2)(a); and to relevant guidelines issued under s 28(2)(b). He summarised the effect of the last as follows:

> "… 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 are such an inquest is likely to assist maintain public confidence in the administration of justice."

[15] The State Coroner's conclusion was that the investigating Coroner had made findings into all matters required under the *Coroners Act*. He was not satisfied that it was in the public interest to hold an inquest. Any recommendations in relation to a risk assessment framework were unlikely to receive widespread support from psychiatrists, and no-one would be obliged to implement any such recommendations. On the other hand, there was movement towards improvement amongst the profession. Consequently, his Honour declined the application, noting also that only a small proportion of reportable deaths could go to inquest and it was his responsibility to

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8 [2009] QDC 307.

ensure that the system's resources were allocated to give priority to those deaths most needing an inquest.

The District Court judge's decision

[16] Mr Davis then applied to the District Court for an order for an inquest, identifying three questions which he said should be examined by an inquest: whether his wife's death was contributed to by breaches of duty of care on the part of her general practitioner and treating psychiatrist; whether an absence of formal risk management protocols put all doctors at risk of failing to discharge their duty of care; and whether further recommendations could be made which would overcome what Mr Davis described as accepted practice by doctors involving a failure to minimise risk. In particular, he proposed a mandatory risk management code of practice.

[17] The District Court judge reviewed at length the medical evidence, the matters raised by Mr Davis, and the State Coroner's response, before setting out the principles which he considered applied to the application. His Honour noted, uncontroversially, that the term "public interest" derived its content from the objects and purpose of the relevant Act, and referred in particular to the statement of French CJ in *Hogan v Hinch*[9] that in making the necessary judgment,

> "The court is not free to apply idiosyncratic notions of public interest".

In the present context, the term "public interest" was to be construed in the context of the objects of the Act, particularly those in s 3(d), with guidance also to be obtained from the considerations in s 28(2); including the extent to which drawing attention to the circumstances of a death might prevent similar deaths in the future.

[18] His Honour adverted to Robertson DCJ's decision in *Gentner v Barnes*.[10] Among other matters, Robertson DCJ had observed that

> "…[t]he relief sought should be granted rarely or sparingly and regard should be had by this Court to the specialist nature of the office of the Coroner and the specialist knowledge of the State Coroner and his office, and resourcing issues …"[11]

and that he was

> "… 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".[12]

[19] The District Court judge noted a difference of opinion as between the treating psychiatrist, the Forensic Medical Officer and the reviewing psychiatrist, on the one hand, and the psychiatrist whose opinion Mr Davis had furnished, on the other, as to the efficacy of prescribing medications for the treatment of depressive conditions. His Honour found the opinions of the reviewing psychiatrist persuasive. She was of the view, as was the Forensic Medical Officer, that the medication strategy which the treating psychiatrist had employed was not unreasonable. In her opinion, it was very unlikely that Mrs Davis' suicide could have been predicted, as to its timing or method.

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9 (2011) 243 CLR 506 at 536.
10 [2009] QDC 307.
11 *Gentner v Barnes* [2009] QDC 307 at [38].
12 At [28].

The reviewing psychiatrist had raised no issue as to the contact between the treating psychiatrist and Mrs Davis having occurred principally by telephone, while noting the effect of the limitations the lack of face-to-face contact posed for the development of the therapeutic relationship.

[20] There was, his Honour determined, insufficient evidence to conclude that Mrs Davis' treatment by her treating psychiatrist and general practitioner was negligent. The treating psychiatrist's treatment was consistent with currently accepted mainstream standards of psychiatric care, although there were different opinions held within the profession. The reviewing psychiatrist's view, that it was unlikely Mrs Davis' suicide could have been predicted, was also relevant. There was, as a result, insufficient evidence to conclude that any of the alleged breaches of duty of care which Mr Davis had raised as to his wife's treatment would warrant further investigation at an inquest.

[21] The District Court judge accepted that a risk assessment and management strategy for the prescription of anti-depressant medications could fall within an appropriate subject matter for investigation at an inquest. However, the State Coroner had taken the view that such risks were best assessed by the treating practitioner and that any recommendations would be of guidance only, and unlikely to receive widespread support amongst the profession. The investigating Coroner had also expressed concern about the appropriateness of a coroner's holding an inquest to assess which risk management strategy ought to be recommended. The reviewing psychiatrist had also been of the opinion that there was no well-validated way of assessing suicide risk and that the best course of action was for the treating practitioner to undertake comprehensive assessment of a patient and to develop a therapeutic relationship to enable detection of suicide risk and intervention.

[22] Mr Davis had referred to the findings of a 2017 inquest[13] conducted into the death of a man who had committed suicide after being prescribed Champix, a medication used to treat nicotine addiction. The coroner in that case had found that the medication had contributed to the death; the consumer warnings on the drug packing were inadequate; and the deceased's general practitioner had not provided adequate care in failing to advise him of side-effects. That inquest, however, was conducted in a context in which the potential side-effects of the medication were known; a study had recently drawn conclusions as to the increased risk of adverse effects to those users with a history of psychiatric disorder. The issues arising in the present case as to the adequacy of the care provided were not the same.

[23] His Honour accepted that the granting of an application to order an inquest was rare and should not be done lightly when the State Coroner had concluded that an inquest should not be held. Regard should be had to the specialist nature of the office of the State Coroner and to resourcing issues. He acknowledged Mr Davis' concerns as to medical practitioners' compliance with guidelines and product information documents. It was relevant, however, in determining whether it was in the public interest to hold an inquest, to consider whether doing so might prevent deaths in similar circumstances, and, in particular, whether any recommendations made, such as the implementation of a risk assessment tool, would be implemented or would receive general support within the medical community. His Honour agreed with the State Coroner's conclusion that the non-binding nature of any recommendations which might be made and the likelihood that they would not receive general support

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13 Findings, Inquest into the death of Timothy John, Coroner Hutton, 14 September 2017.

in the medical profession weighed against the holding of an inquest. He was not satisfied that it would be in the public interest to hold an inquest into Mrs Davis' death, and, accordingly, dismissed the application.

The argument in relation to public interest and relevant considerations

[24] Mr Davis argued that the District Court judge had misconstrued the term "public interest" in s 30(8) of the Act as involving a wide discretion, and had in consequence taken into account irrelevant considerations, some of which were drawn from the decision of Robertson DCJ in *Gentner v Barnes*.[14] *Gentner v Barnes* itself contained error in the statement that relief would be granted sparingly, with regard had to the specialist nature of the State Coroner and his office and to resourcing issues, because the Act itself did not identify those considerations as relevant. Robertson DCJ had had regard to a Victorian decision in *Clancy v West*,[15] in which it was said that the Supreme Court's jurisdiction in that State to overturn a coroner's decision refusing an inquest was one "exercisable sparingly";[16] that was an error because the Victorian legislation gave a wide discretion to coroners. In contrast, on Mr Davis' argument, the Queensland Act limited what could be taken into account. Section 28(2) should be read as containing an exhaustive list of relevant considerations as to what was in the public interest; or, if that were not so, as giving primacy over all else to prevention of deaths, because that was the first consideration mentioned in the provision, and it was also an object of the Act.

[25] The District Court judge had impermissibly taken into account the views of the State Coroner, a consideration for which the Act did not provide. To the contrary, s 30(8), it should be inferred, existed because of misgivings about the State Coroner's decision-making; and, Mr Davis asserted, the State Coroner's and the investigating Coroner's denial of his application showed in various ways that they did not have specialist expertise. As well, the decision in the present case did not have the status of a court decision, but was merely the opinion of the State Coroner. To take into account the State Coroner's view that recommendations would not receive support from the medical profession was contrary to the Act, which made no mention of the medical profession's views, and amounted to denial of the application on an "idiosyncratic notion" of public interest. The investigating Coroner and the State Coroner had both made unwarranted assumptions as to the nature of possible recommendations in advance of any inquest and the reaction of the medical profession to them; in fact, an inquest might recommend that the Medical Board use its existing powers to enforce compliance with approved codes and guidelines in order to help to prevent deaths.

[26] Resourcing issues were an irrelevant consideration, because to take them into account would entail drawing judges into the political sphere and making public safety secondary to financial considerations; was contrary to the object of the Act, of allowing coroners to comment; and would undermine the objective of preventing similar deaths.

[27] Those arguments are not tenable. Robertson DCJ in *Gentner v Barnes* made it quite clear that he did not interpret the provision conferring the discretion[17] by reference to

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14 [2009] QDC 307.
15 [1996] 2 VR 647.
16 At 653.
17 Then s 30(7) of the *Act*; now s 30(8), having been renumbered by s 29 of the *Coroners and Other Acts Amendment Act* 2009.

decisions in other States where the test was in different terms.[18] (In the Victorian legislation, the question was whether the court was satisfied that an inquest was "necessary or desirable in the interests of justice".) The considerations relevant to the formation of the discretionary judgment in s 30(8) are not narrowly confined as Mr Davis suggests. The issue of "public interest" which the section raises is properly considered, as the District Court judge in this case observed, by reference to the objects of the Act and with regard to s 28(2), since it uses the same term; but s 28(2) is clearly non-exhaustive and nothing in it or s 30(8) limits the considerations which may be taken into account. To the contrary, 28(2)(b) recognises that there may be many factors to be taken into account, and by permitting the establishment of guidelines, leaves it to the specialist expertise of the State Coroner to determine what those factors are.

[28] Robertson DCJ articulated the proposition that the discretion should be exercised sparingly in the context of regard's being had to that specialised knowledge in the State Coroner, and to the specialist nature of his office. Apart from the implicit recognition in s 28(2)(b) of the State Coroner as well-placed to identify what issues should be considered in the context of determining the public interest, it is generally the case that the opinion of a decision-maker with expertise in an area under consideration is properly taken into account on review of his or her decision.[19] The exercise of the s 30(8) discretion is not a review of the State Coroner's decision, but since it arises only where the State Coroner has declined to exercise his or her discretion under the same provision favourably, it follows that a different conclusion will not lightly be reached, having regard to the proper consideration that the State Coroner's exercise of discretion was informed by that expertise.

[29] Mr Davis had proposed the inquest on the basis that consideration should be given to recommending the establishment of a mandatory risk management code of practice for doctors. It could hardly be said to be irrelevant, then, for the State Coroner and the District Court judge to consider the utility of such a recommendation.[20] In reaching his conclusion, the District Court judge was entitled to regard the State Coroner and the investigating Coroner as having specialist knowledge. In particular, his Honour was entitled to be guided by the experience of the State Coroner's office and also by the views of the investigating Coroner in considering the feasibility of identifying a useful risk management strategy. The likely effectiveness of any recommendations which a Coroner might make was also a matter in which regard to the views of the State Coroner and investigating Coroner was justified, given that the making of such recommendations fell peculiarly within the remit of the coronial jurisdiction.

[30] To take into account the finite nature of resources as one consideration amongst others is not to politicise the judiciary or to disregard other relevant considerations. It is a proper consideration, consistent with the objects of the Act, because it is plain that a too-liberal granting of applications for inquests must necessarily affect the State Coroner's capacity to apply resources to matters with greater potential for prevention of future deaths. Again, the State Coroner could properly be regarded as having particular knowledge of the resourcing, capacity and workload of the court.

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18 *Gentner v Barnes* [2009] QDC 307 at [38].

19 *Eclipse Sleep Products Inc v Registrar of Trademarks* (1957) 99 CLR 300 at 321-322; *Corporation of the City of Enfield v Development Assessment Commission* (2000) 199 CLR 135 at 154-155; *Aldrich v Ross* [2001] 2 Qd R 235 at 257.

20 Mr Davis' suggestion that recommendations might instead be directed to enforcement of existing codes of practices and guidelines seems to have emerged only in this Court.

[31] For those reasons, I do not think that Mr Davis has any prospect of establishing that the District Court Judge erred in his construction of the term "public interest" in s 30(8) or that he erred by applying the principles set out by Robertson DCJ in *Gentner v Barnes* forming his judgment under that provision.

The argument that expert opinion was an irrelevant consideration

[32] Mr Davis argued that the District Court judge erred in finding that there was insufficient evidence of a breach of duty of care in the treatment of Mrs Davis which would warrant further investigation at an inquest. The judge had fallen into error in this regard, Mr Davis contended, because he had impermissibly had regard to peer opinion, in the form of the opinions of the Forensic Medical Officer and the reviewing psychiatrist, and because he had wrongly failed to have regard to provisions of the *Health Practitioner Regulation National Law (Queensland)* 2009 and the *Civil Liability Act* 2003, which rendered professional opinion inadmissible and required regard to be had instead to approved codes and guidelines. The peer professional opinions supporting his wife's treatment were, on Mr Davis' argument, contrary to such guidelines and, hence, on his argument, contrary to law.

[33] The relevant provisions of the *Health Practitioner Regulation National Law (Queensland)*, were s 39, which permits a National Health Practitioner Board to develop and approve codes and guidelines for the guidance of health practitioners and s 41, which provides that an approved guideline or code is admissible in proceedings under that legislation as evidence of what constitutes appropriate professional conduct or practice. Mr Davis also relied on s 21 and s 22 of the *Civil Liability Act*. Section 21 deals with the duty to warn the patient of a risk entailed in proposed medical treatment. Section 22 provides in relation to professionals generally that there is no breach of a duty if it is established that the individual acted in a way "widely accepted by peer professional opinion" unless the court considers the opinion to be "irrational or contrary to a written law".

[34] The guidelines on which Mr Davis relied concerning prescription of medication included a portion of a document which he identified in his affidavit as the Australian Therapeutic Guidelines in relation to treatment of depression with anti-depressants (the status of which is not clear, although the State Coroner referred to it as an example of information available to doctors in relation to the administration of psychotropic medication) and a Practice Guideline issued by the Royal Australian and New Zealand College of Psychiatrists in relation to the use of medication in dosages and indications outside normal clinical practice.

[35] In relation to the use of telephone consultations in psychiatric treatment, Mr Davis adverted to a document from the College, which, under the heading "Telehealth in Psychiatry", said

> "Telepsychiatry is a consultation between a patient and a psychiatrist conducted via video conference".

That seemed to be a statement, not a guideline, but Mr Davis contended it demonstrated that telephone consulting was impermissible. He referred to a guideline from the Medical Board of Australia in relation to patient consultations using technology, including telephone. He also sought to rely on the Medical Board's Code of Conduct in order to allege a number of breaches of it; but since that document, apart from Cl 6

(raised for the purposes of a different submission) was not before the District Court judge, the Court declined to receive it here.

[36] His Honour in dealing with Mr Davis' concerns, inter alia, in relation to alleged failures to follow guidelines had observed that these were matters as to which there appeared to be "legitimate differences of medical opinion".[21] Mr Davis contended that there could be no legitimate difference in medical opinion if an opinion flouted a code or guideline. He regarded the guidelines to which he referred as "written law", and argued that the treatment given to Mrs Davis breached them, so that the District Court judge should have regarded the medical opinions supporting that treatment as both "contrary to law" and "irrational".

[37] The submission that the *Health Practitioner Regulation National Law (Queensland)* and the *Civil Liability Act* had any bearing on what the District Court judge was entitled to take into account is misconceived. The former does not give codes or guidelines approved under it any mandatory effect; it makes them admissible solely for the purposes of proceedings brought under that legislation. It does not confer evidentiary status on them for any other purpose, much less dictate the evidence which a court may consider. The *Civil Liability Act* applies to civil claims for damages; it had no application or relevance here, and the guidelines relied on did not have the status which Mr Davis attributed to them. The learned District Court judge was entitled to rely on opinion evidence from the reviewing psychiatrist and the Forensic Medical Officer, both of whom were appropriately qualified and possessed expertise in a field requiring specialised knowledge, that being appropriate medical practice.

The argument as to failure to take into account a relevant consideration

[38] Finally, Mr Davis argued that the District Court judge had erred in not accepting evidence which he provided of what he described as "widespread dangerous prescribing practices", this being, on his argument, a relevant consideration. The evidence to which he referred was, firstly, a document which, according to his submissions, was the report of a Psychiatric Drug Safety Expert Advisory Panel; he complained that the District Court judge had failed to consider it. It contained the statement

> "… sub-optimal prescribing, such as potentially life threating polypharmacy, still occurs",

which Mr Davis interpreted as meaning that there were widespread systemic prescribing problems in the profession. The document was untitled and undated; it consisted of passages from what was evidently a longer document; and there was no evidence as to its provenance, status or purpose. Nor, accepting Mr Davis' submission that it was the work of an expert panel, was there any indication as to of what experts the panel was composed. It was not surprising, then, that his Honour referred only to it as an exhibit to Mr Davis' affidavit and did not identify it further. The second item was an editorial in the Australia and New Zealand Journal of Psychiatry referring to the potential usefulness of anti-depressants in combination, which, Mr Davis said, was contrary to proper prescribing guidelines. His Honour noted it but did not specifically refer to it in reaching his conclusions. The third piece of evidence consisted of the findings in the 2017 inquest relating to the prescription of Champix; which, according to Mr Davis, provided an example of the practice to which he referred, but which his Honour regarded as having no bearing on the issues before him.

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21 *Davis v Ryan* [2018] QDC at [87].

[39] The District Court judge was entitled to reach a view as to the value of this material collectively, without referring to it in detail. While acknowledging Mr Davis' concerns as to prescribing practices, he did not make any finding that there existed a widespread practice of dangerous prescribing. (Given the limitations of the material relied on, it would have been remarkable had he done so.) That was not a failure to take into account any relevant consideration; his Honour simply did not make the finding Mr Davis sought.

Conclusion on application for leave

[40] There can be no doubt that Mr Davis' motives in making this application are worthy, stemming from a genuine desire through the means of an inquest to make improvements in the way that the medical profession manages medication and risk in vulnerable patients. But he has no prospect of demonstrating error of the kind identified in *House v The King* in the District Court judge's discretionary judgment as to public interest, and hence no prospect of success on any appeal. For that reason I would refuse the application for leave to appeal.

Orders

[41] I would make the following orders:

1. The time for filing of the application for leave to appeal is extended to 8 April 2019;

2. The application for leave to appeal is refused.

[42] **GOTTERSON JA:** I agree with the orders proposed by Holmes CJ and with the reasons given by her Honour.

[43] **FLANAGAN J:** I agree with the orders proposed by Holmes CJ and with her Honour's reasons.