CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**INQUEST INTO THE DEATH OF SUELLEN EDITH DAVIS**
Citation:	**[2018] ACTCD 10**
Court Attendance Dates:	7 September 2017, 31 January 2018
Date of Findings:	25 June 2018
Coram:	Coroner M. A. Hunter
Legislation and Authorities Cited:	*Coroners Act 1997* (ACT) s 3C(1)(c), s 13(1)(f), s 52 *WRB Transport v Chivell* [1998] SASC 7002 *Onuma v The Coroner's Court Of South Australia* [2011] SASC 218 *Briginshaw v Briginshaw* (1938) 60 CLR 336
Appearances and Representation:	Ms Baker-Goldsmith as Counsel Assisting Coroner Hunter Ms Musgrove for the Territory and Dr Ali, instructed by ACT Government Solicitor Mr Johnson for Dr Cameron, instructed by Minter Ellison
File Number:	CD 312 of 2013

CORONERS ACT 1997

IN THE CORONERS COURT
AT CANBERRA IN THE
AUSTRALIAN CAPITAL TERRITORY

FORMAL FINDINGS

An INQUEST having been held by me, **MARGARET ANNE HUNTER,** a Coroner for the Territory, including a hearing conducted at the Coroner's Court at Canberra in the Territory on the **7th September in the year Two Thousand and Seventeen and the 31st January in the year Two Thousand and Eighteen,** into the death of:

SUELLEN DAVIS

I find that Suellen Davis born 20 February 1956, died at 3/52 Ormond Street, Turner, in the Australian Capital Territory, at 15:56 hours on 18 December 2013, having been found by her son Alan Davis at 13:40 hours unresponsive, not breathing and with no palpable pulse.

I further find that the cause of her death was positional asphyxia caused by the combined effect of the consumption of several opiate containing medications, together with over the counter medications which led to sedation and respiratory depression.

DATED this **25th** day of **June, 2018.**

M. A. HUNTER OAM
CORONER

REASONS OF CORONER HUNTER:

1. I, Coroner Margaret Hunter, find that Suellen Davis born 20 February 1956, died at 3/52 Ormond Street, Turner at 15:56 hours on 18 December 2013.

2. I further find that the cause of her death was positional asphyxia caused by the combined effect of the consumption of several opiate containing medications, including Oxycodone, Fentanyl, Doxylamine, Promethazine and possibly Promethazine and Pregabalin which led to sedation, respiratory depression and positional asphyxia.[1]

Jurisdiction

3. A Coroner is required to hold an inquest into the manner and cause of death of a person who relevantly:

   "Dies and a doctor has not given a certificate about the cause of death; or the circumstances of the death are unknown" (see section 13(1)(c) and 1(f) of the *Coroners Act 1997* (ACT) ("the Act"), as it was at the time of Ms Davis's death.)

4. Ms Davis comes within my jurisdiction because her General Practitioner Dr Cameron was unwilling to give a certificate in relation to her death. The cause of her death at the time was unknown.

Circumstances

5. The Evidence surrounding the circumstances of Ms Davis's death are fully set out in Counsel Assisting's submissions at annexure A. I have reviewed that evidence and it will form part of my findings attached as annexure A to these findings.

6. I have also had regard to Submissions filed by the ACT Government Solicitor. I agree with their brief outline of the facts. However I disagree with their submission in relation to cause of death.

7. I have also considered the submissions filed by Solicitors for Dr Cameron.

8. In short there is not much upon which the parties disagree, except it appears how Ms Davis was found is controversial.

[1] Opinion of Associate Professor Parekh transcript p 91 31 January 2018.

Issues

9. Given how Ms Davis was found appears to be controversial, I propose to carefully consider the evidence surrounding that factor. This will include an examination of the evidence about the medications she was taking (both with and without the knowledge of the treating doctors), the toxicology report, the evidence from Associate Professor Parekh and the evidence from Mr Alan Davis.

10. I will consider whether the effect of consuming multiple opiate medication which had been prescribed, together with over the counter sedative medications, could lead to positional asphyxia causing death.

11. I will also consider:

    a. The post mortem toxicology report identified multiple opiate medications in Ms Davis's blood. There was no identification of Pregabalin in that report. Was it possible that Ms Davis consumed Pregabalin with the other prescribed medications and was this factor significant in the cause of her death?

    b. Whether Dr Cameron knew that Ms Davis was taking over the counter medications.

    c. What medications Ms Davis was taking prior to her death.

Scope of inquest

12. The scope of enquiry for this inquest is set out in the *Coroners Act 1997* in section 52:

> **52 Coroner's findings**
> (1) A coroner holding an inquest must find, if possible—
> (a) the identity of the deceased; and
> (b) when and where the death happened; and
> (c) the manner and cause of death; and
> (d) in the case of the suspected death of a person—that the person has died.
> (2) A coroner holding an inquiry must find, if possible—
> (a) the cause and origin of the fire or disaster; and
> (b) the circumstances in which the fire or disaster happened.
> (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
> (4) A coroner may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice.

13. The scope of enquiry available to a coroner is set out helpfully in the decision of *Onuma v The Coroner's Court of South Australia* [2001] SASC 218, a case in which the Court considered the scope of the Coroner's power under the *Coroners Act 2003* (SA) and applied *WRB Transport v Chivell* [1998] SASC 7002. The relevant phrase under consideration was "cause and

circumstances"; I note in this jurisdiction the relevant phrase is similar, namely "the manner and cause". In *Chivell* Lander J (with whom both Prior and Mullighan JJ agreed) said with regard to the meaning of the word "cause":

> *"Clearly enough the cause and the circumstances must be two different things if it was otherwise there would be no reason for Parliament to have included both words. ... The cause of a person's death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the coroner is not limited by concepts such as direct cause nor is the coroner limited to a cause which is reasonably foreseeable. The cause of a person's death in respect of the coroner's jurisdiction is a question of fact which, like causation in the common law must be determined by applying common sense to the facts of each particular case."*

I have taken these principles into account when making my findings in this matter.

14. I am also mindful that in making findings I must have regard to the principles espoused in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J:

> *"The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ... The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal."*

15. I am mindful of those words and will keep them in my contemplation when reviewing the evidence.

Consideration

16. I have set out in Annexure A the evidence given in the hearing surrounding this inquest into the death of Suellen Davis.[2] I will now consider the issues which arise as a result of Ms Davis's death as well as those matters that I consider to be relevant.

<u>How Ms Davis was found and the importance of that evidence</u>

17. Mr Alan Davis told Dr Eldridge, the Forensic Medical Officer who attended the death scene that he found his mother in the following position: *"found on couch, slumped forward with forward flexion of neck"*.[3] It must have been Mr Davis

[2] Counsel Assisting's Annexure A to her submissions.
[3] Death report of Dr Eldridge found in Exhibit C2.

who provided that description to Dr Eldridge because the body had been moved by Mr Davis in order to attempt CPR prior to ambulance officers and Dr Eldridge attending.

18. That description was made at the time of Mr Davis finding his mother in that position or very close to it. That description would have been fresh in the memory of Mr Davis.

19. This information is likely to have been provided to Dr Eldridge by Mr Davis who found his mother unresponsive and in that position.

20. Mr Davis gave evidence before me some 4 years after the event and described how he found his mother as *"with her head resting on the coffee table".* Later in his evidence he described how he found his mother as 'slumped forward head and upper body resting on coffee table with her arm out towards the telephone. Her knees were on the ground and she was between the coffee table and the couch. Her head was at a different angle to her bottom half'.[4] In my view that evidence is not inconsistent with the description he gave Dr Eldridge. That appearance is not inconsistent with positional asphyxia.

21. I also note the statement of Ambulance Officer Brendan Kelly tendered in the bundle of documents. Mr Kelly states at page 2 at point 25: *"It was noted during resuscitation, whilst establishing a more advanced airway (intubation), that the patient had quite a substantial amount of fluid (blood) in her airway. This was noted by myself and officers Bohun and Slater from ambulance vehicle 120. This sign alone suggested that she may have suffered from possible asphyxiation some time earlier."*

22. I also note that the autopsy report stated *"there was bilateral pulmonary oedema and congestion with no evidence of gastric aspiration or pneumonia*". Associate Professor Jain also noted the blood stained fluid in the airway but ascribed its source to insertion of oral airway. We know that it was present prior to intubation or oral airway (tracheal bronchial lumen and mouth) because of the statement of Mr Kelly.

<u>The medications and their combined sedative effect</u>

23. Ms Davis had been prescribed several powerful pain medications including Fentanyl (patch) in 2 different strengths, Oxycodone (Endone), Pregabalin (Lyrica), and Baclofen, all of which can cause drowsiness and sedation.

24. Ms Davis had been on these medications for some time and would have had a tolerance to them, which would affect how sedated they made her. The likelihood is she would not have been significantly affected if she took those medications as prescribed. This is confirmed by the toxicology report where the level of prescribed medication found on toxicology was within therapeutic range.

[4] Transcript 31/1/18 p 7.15.

25. On toxicology she was also found to have in her blood Doxylamine and Promethazine: two drugs which also cause sedation and drowsiness.

26. The Doxylamine was found in her blood at a toxic range. Doxylamine is available over the counter at pharmacies. There is evidence Ms Davis was taking increased doses of Dolased, a medication containing Codeine and Doxylamine.[5]

27. The Promethazine was at a range of therapeutic to toxic range. I note Promethazine is available as an over the counter medication.

28. Both of these drugs carry warnings of sedation. I have no evidence these two medication had been prescribed for Ms Davis and in fact Drs Cameron and Ali stated they were unaware she was taking them. In my view there is little doubt that these drugs taken in combination with her prescribed medication would cause significant sedation.

Opinion of Associate Professor Parekh

29. Associate Professor Parekh wrote 3 opinions each based on the material she received prior to writing those opinions. Her initial opinions were based on material which described that Ms Davis died as a result of respiratory depression from a combination of sedative medications prescribed and not prescribed.

30. Those reports did not detail how Ms Davis was found. Having been provided with the notes of Dr Eldridge, particularly his description of how Ms Davis was found, Associate Professor Parekh concluded that the most likely cause was positional asphyxia. That opinion was arrived at as a result of having all of the relevant evidence before her including how Ms Davis was found.

31. The evidence before me was that Ms Davis was increasingly taking more Dolased as well as taking over the counter pain medication such as Panadol Forte. Clearly she was also taking Promethazine as well. There was also evidence that Ms Davis was becoming more difficult to rouse from sleep.

32. Those medications together with her prescribed medications would have increased her sedation levels significantly. That is confirmed by the evidence that she was becoming more difficult to rouse from sleep.[6]

33. There was also evidence that Ms Davis was taking prescribed Pregabalin (Lyrica) but this was not detected in her toxicology results, most likely because it was not specifically tested for.[7]

[5] Transcript 31/1/18 p 8.9.
[6] Statement of Alan Davis Exhibit C3.
[7] See Associate Professor Parekh's evidence.

Positional Asphyxia

34. I have also considered the papers on positional asphyxia provided to me in this matter: *Conditions and circumstances predisposing to death from positional asphyxia in adults* authored by Roger Byard and Regula Wick;[8] and *Positional Asphyxia in Adults* by Bell, Rao, Wetly and Rodriguez.[9]

35. Dr Byard opines that:

> *"Positional asphyxia refers to a situation where there is compromise of respiration because of splinting of the chest and /or diaphragm preventing normal respiratory excursion or occlusion of the upper airway due to abnormal positioning of the body. … Victims of positional asphyxia do not extricate themselves from dangerous situations due to impairment of cognitive responses and coordination resulting from intoxication, sedation, neurological disease, loss of consciousness, physical impairment or physical restraint*."[10]

36. Those papers reveal that certain criteria must be present for a finding of positional asphyxia. I note that the study was not designed to be an epidemiological study, but was focused instead on the actual circumstances that predispose to lethal positional asphyxia.[11] Those are intoxication/sedation, loss of consciousness, inability to extricate oneself from a position which obstructs or occludes the respiratory tract, and exclusion of any other cause such as cardiac disease or gastric aspiration.

37. It is clear that positional asphyxia is a common known cause of death in persons who have been significantly intoxicated or medicated to a point where they cannot extricate themselves from the position they were in due to intoxication/medication.

38. There was no other cause of death found. Ms Davis did not have any cardiac conditions and none were found at autopsy. In fact no other causative factor was found on autopsy other than the toxicology findings. Associate Professor Jain opined that none of those medications by themselves were toxic or fatal.

39. Associate Professor Parekh opined that the medications taken together could have sufficient sedative effect to cause respiratory depression if the neck was flexed or the airway compromised because the person could not extricate themselves from their position because of that sedation. On that evidence positional asphyxia is certainly open as a cause of death in this matter.

[8] Journal of Forensic and Legal Medicine November 2008.
[9] The American Journal of Forensic Medicine and Pathology 1992 pp101-107.
[10] Journal of Forensic and Legal Medicine November 2008 Abstract.
[11] Ibid paragraph 1.

Over the Counter medications

40. Dr Cameron gave evidence that he did not know Ms Davis was taking over the counter medication.

41. Mr Alan Davis gave evidence that he attended at appointments with Dr Cameron with his mother in the 12 months leading up to her death. There was no dispute that he had attended those appointments, save for 2 or 3 he missed.[12]

42. The divergence of evidence lies in the evidence given by Mr Alan Davis that his mother had discussed with Dr Cameron whether she could get Panadeine Forte for break through pain. Dr Cameron advised that he would not prescribe Panadeine Forte but that she could get over the counter medication.[13]

43. It appears that the particular over the counter medication was never discussed with Dr Cameron, however, Mr Davis's evidence was the medication his mother told him was her understanding of over the counter medication was Panadeine Extra not just Panadol.

44. Dr Cameron gave evidence that he was surprised that Ms Davis was taking Dolased and Promethazine as he was unaware she was taking it. His evidence was that had he known he would have advised her to stop taking those medications.

45. Dr Cameron was surprised that certain drugs showed up in the toxicology report particularly Promethazine and Doxylamine as he did not believe she was taking that medication. Dr Cameron was also surprised that she had Codeine in her blood.[14]

46. Dr Cameron said had he known that she was taking these medications he would have advised her to stop them.[15]

47. I am satisfied on the evidence before me that both Dr Ali and Dr Cameron were not aware that Ms Davis was taking Dolased and Promethazine nor were they aware she was taking Codeine either.

48. I am satisfied that Ms Davis did not specify to Dr Cameron which over the counter medications she meant to use when she discussed her medication regime at consultations .

[12] Transcript p 4.35
[13] Transcript p5 .1
[14] Transcript p 67.1-10
[15] Ibid .12-14

Conclusions

49. I am satisfied that the effect of consuming the over the counter medications of Dolased and Promethazine found on toxicology together with her regular opiate medications caused Ms Davis to experience a significant sedative effect. That effect would have been increased if she was also taking Pregabalin (Lyrica).

50. I am also satisfied that the significant sedative effect of those medications would likely cause Ms Davis to be unable to extricate herself from the position in which she was found.

51. I am also satisfied that she was becoming more sedated than usual in the weeks prior to her death and that she was more difficult to rouse than before.

52. I am satisfied that the position which she was found in was capable of occluding or partially occluding her airway in a setting where she would have experienced respiratory depression as a result of the sedative effect of the multiple medications found on toxicology.

53. I am satisfied that the substantial amount of fluid (blood) found upon attempted intubation, seen by ambulance officer Kelly supports a finding of asphyxia.

54. I am satisfied there is no other cause of Ms Davis's death found.

55. I have considered the evidence and conclusions I have drawn from that evidence in a setting of considering the 2 articles referred to above.

56. Those findings together with the position Ms Davis's body was found in lead me to the inexorable conclusion that she died from positional (sometimes known as postural asphyxia).

57. On the evidence before me I am satisfied Ms Davis's cause of death is positional asphyxia due to the sedative effect her prescription medications and over the counter medications had upon her. I make the formal findings announced at the start of my reasons.

58. I express my thanks to Counsel Assisting me, and to Counsel for the parties, for their assistance in this matter.

59. I extend my condolences to Alan and Michelle, and Ben and Elizabeth, on the loss of their mother, as well as Ms Davis' other family and friends.

MARGARET HUNTER OAM

CORONER

Annexure A – Evidence given at Hearing

Alan Neville Davis

1. Alan Neville Davis was the son of Ms Davis. On 18 December 2013, Mr Davis found Ms Davis' body at their residence which they shared in Turner. He was also the last person to see her alive earlier that day.[16] A statement from Mr Davis dated 23 January 2018 was tendered as Exhibit C3.[17]

Medications and general health

2. Mr Davis stated that he had accompanied Ms Davis at a number of consultations with Dr Cameron at the Waramanga Medical Centre.[18] When questioned on how often Ms Davis had seen Dr Cameron in the 12 months leading up to her death, Mr Davis stated it was about every four weeks and that he had attended nearly all of them, adding up to nine or ten appointments in one year.[19]

3. When questioned on the contents of those appointments, Mr Davis stated that Ms Davis generally went to get scripts refilled, but that she also requested Panadeine Forte at each appointment, and Dr Cameron always declined, stating that over the counter medication was suitable.[20] Mr Davis was adamant about this evidence, but could not recall Dr Cameron's words verbatim.[21] (Dr Cameron however stated he had no recollection of conversations referring to Panadeine Forte or Dolased, nor did he recall suggesting over the counter medication.[22] He stated that if he had ever advised that he would have made a record in his notes.[23] In addition, he stated that if someone was being treated by the pain clinic, it would not be his general practise to make comments to the

[16] Police Report of Suellen Davis 'Incident Details'
[17] Transcript 31.01.18 P2 L30-32
[18] Transcript 31.01.18 P4 L14-16
[19] Transcript 31.01.18 P4 L24-28
[20] Transcript 31.01.18 P4 L10 – P5 L10
[21] Transcript 31.01.18 P17 39 – P18 L5
[22] Transcript 31.01.18 P83 L22-26 and P83 L28-32
[23] Transcript 31.01.18 P68 L27-33

effect that a patient should seek over the counter mediation for pain management.[24])

4. When questioned on what he believed his mother had understood by 'over the counter' medication, Mr Davis stated medications such as Panadol and Panadeine Extra, specifically not just Panadol.[25] When questioned on whether he had been present during any discussions of antihistamine use, Mr Davis replied in the negative. He stated that his mother's use of antihistamines was limited, and that when she did use it, Telfast was the particular type used.[26]

5. On cross-examination, Mr Davis was able to recall that Ms Davis had also been prescribed fentanyl patches after trialling Kapanol and Valium.[27] She also suffered from hypertension, high cholesterol and nausea.[28] He was unable to recall if she had suffered from reflux.[29] On re-examination, when the same question was posed but with 'indigestion' used in place of reflux, he was able to recall that she suffered from that condition.[30] He was not able to recall if she had been on medication for it.[31] He was not able to recall what medication she had been prescribed for her diabetes.[32]

6. In regards to Ms Davis' health conditions, Mr Davis was asked in cross-examination if he was aware Ms Davis was being treated for her conditions and not just pain management. He recalled that was true, from his presence in consultations with Dr Cameron.[33] In the 12 months prior to her death, she had been prescribed Kapanol and was then treated on fentanyl patch.[34] Mr Davis had conveyed to the police officer taking his statement, that Ms Davis had expressed a desire to be taken off the Kapanol trial and try an alternative.[35]

[24] Transcript 31.01.18 P68 L27-33
[25] Transcript 31.01.18 P5 L18-22
[26] Transcript 31.01.18 P5 L24-40
[27] Transcript 31.01.18 P12 L1-4
[28] Transcript 31.01.18 P12 L20-27
[29] Transcript 31.01.18 P12 L39-40
[30] Transcript 31.01.18 P17 L25-34
[31] Transcript 31.01.18 P17 L36-37
[32] Transcript 31.01.18 P12 L12
[33] Transcript 31.01.18 P12 L42–P13 L1
[34] Transcript 31.01.18 P13 L13-17
[35] Transcript 31.01.18 P13 L3-6

7. Mr Davis was also questioned about the medication Dolased which he had mentioned in his statement to the police.[36] He conveyed that he and Ms Davis discussed Dolased as a 'break through drug' that she was interested in using to treat her pain, rather than having Dr Cameron prescribe another medication.[37] He recalled that she would consume one Dolased with one Panadol whenever it was time to take medication. She would arrange her pills into the boxes of her medication drawer herself.[38] He estimated that she had been taking the Dolased '*every couple of days*' as that was how often Ms Davis would take her other medications.[39] On further questioning in re-examination, Mr Davis said that her Dolased use became more regular in the '*four months prior'* to her death ('*starting from July*').[40] (However, when asked about this observation in re-examination, Dr Cameron stated that he was not aware that Ms Davis' use of Dolased went from occasional to fairly regular.[41] Dr Cameron noted that if her Dolased intake had hypothetically increased over that period and if he had knowledge of it, he would have advised her to stop.[42] He would have reassessed the medications and sought further advice from Dr Ali, as an increase in Dolased intake would be suggesting that the current medication routine was not sufficient.[43])

8. In regards to Ms Davis' sleeping habits, Mr Davis recalled that Ms Davis was noticeably drowsy at a function she attended at her other son's house in the period before her death.[44] She was generally easy to rouse when she was sleeping but other times it was difficult, such as the function.[45] In regards to her daily sleeping habits, Ms Davis predominantly slept on the couch, as she preferred to nap during the day rather than night time. Mr Davis often observed

[36] Transcript 31.01.18 P7 L45-P
[37] Transcript 31.01.18 P8 L9-14
[38] Transcript 31.01.18 P8 L20-27
[39] Transcript 31.01.18 P9 L9-11
[40] Transcript 31.01.18 P16 L38 – P17 L4
[41] Transcript 31.01.18 P81 L42-44
[42] Transcript 31.01.18 P81 L8-10
[43] Transcript 31.01.18 P81 L12-16
[44] Transcript 31.01.18 P9 L21-31
[45] Transcript 31.01.18 P9 L28-33

this on his return from work each day.[46] Just prior to her passing, Mr Davis noted she was becoming noticeably more difficult to rouse from her sleep.[47]

9. In regards to Ms Davis' ability to carry out day to day activities in the 12 months leading up to her death, Mr Davis observed that she was able to rouse him at 4am for his work and complete all housekeeping for their residence without difficulty.[48]

10. On the day she died, Mr Davis found Ms Davis' body at their residence which they shared in Turner. After calling ACTAS, Mr Davis moved his mother into a different posture. Mr Davis was also shown Associate Professor Parekh's letter and its attachments (Exhibit C2) and specifically the attachment prepared by Dr James Eldridge as to the notes under the heading 'posture / positioning'. Mr Davis confirmed that the notes there reflected the position in which he had found his mother, and that he had told Dr Eldridge that information.[49] Mr Davis clarified in cross-examination that when he had located his mother, she was on her knees in between the couch and the coffee table, with her upper body slumped and twisted over the table, and her torso from her breast up were on the coffee table.[50]

Dr Imran Ali

11. Dr Ali is employed as an anaesthesiologist at the Canberra Hospital and also as an occasional chronic pain management clinician, and also held various qualifications.[51] He had been working in the chronic pain clinic for the past seven to eight years.[52] On examination, he described the purpose and function of the clinic and the process of pain management whenever a patient is referred.[53] He explained that when the clinic receives a patient referral, '*this will include the patient's pain condition, medications they've been on and any interventions which they have had before such as any x-rays or radiology*

[46] Transcript 31.01.18 P9 L42- P10 L1-2
[47] Transcript 31.01.18 P10 L14-23
[48] Transcript 31.01.18 P16 L16-30
[49] Transcript 31.01.18 P6 L22-44
[50] Transcript 31.01.18 P7 L15-43
[51] Transcript 31.01.18 P20 L6-13
[52] Transcript 31.01.18 P20 L17-20
[53] Transcript 31.01.18 P20 L22 – P21 L29

reports'.[54] When asked to explain the process of initial consultation with a patient at the clinic, he explained that he asks the patient to describe their pain condition.[55] He also asks the patient to describe their past pain management history and how they normally function on a day to day basis.[56] Aside from discussing medication, clinicians also recommend that patients attend a pain management programme and consult with the numerous in-house services that use alternatives to medications for pain management.[57] This includes physiotherapy, psychologist, occupation therapists and nurses.[58] Doctors at the pain clinic generally do not prescribe medication, but give recommendations and a plan.[59] In regards to desired outcomes for patient, Dr Ali said that he would normally look at the list of medications the patient was on and try to simplify it by removing medications that were unnecessary.[60] At the pain clinic, he would ask his patient to outline their medication history in relation to their pain, and then confirm the contents of this list at each subsequent visit.[61]

12. Dr Ali made a statement to police in relation to Ms Davis on 8 September 2016 which was Exhibit C1, tab M.[62] At the time he made the statement, he used medical records from the hospital to assist.[63] On examination, Dr Ali was asked if it would be fair to say that active memory of what was in the statement could possibly be affected by the passage of time, and his work load, he confirmed that was correct.[64]

Medical Treatment of Ms Davis

13. Dr Ali had also taken notes (ACT Health progress notes) at his consultations with Ms Davis (part of Exhibit C1).[65] When taken to these notes in examination, he said he could only recall the first occasion that he saw Ms

[54] Transcript 31.01.18 P20 L36-39
[55] Transcript 31.01.18 P20 L45 – P21 L8
[56] Transcript 31.01.18 P20 L45 – P21 L8
[57] Transcript 31.01.18 P21 L10-21
[58] Transcript 31.01.18 P21 L10-21
[59] Transcript 31.01.18 P21 L28-29
[60] Transcript 31.01.18 P22 L20-27
[61] Transcript 31.01.18 P27 L39-44
[62] Transcript 31.01.18 P20 31-38; Exhibit C1, tab M
[63] Transcript 31.01.18 P22 L6-8
[64] Transcript 31.01.18 P22 L2-4
[65] Transcript 31.01.18 P22 L29-35; bundle of records part of Exhibit C1

Davis by referring to them.[66] He explained he was concerned about Ms Davis' history of morphine abuse, and as a result decided that a fentanyl patch would be a better alternative to oral opioids.[67] The initial referral from the general practitioner revealed that Ms Davis had been taking up to 100 milligrams of oral morphine a day, but by the time she had been referred to Dr Ali she was only on the fentanyl patch form.[68] Dr Ali made two recommendations in relation to fentanyl patches, the first being that Ms Davis stay on the fentanyl patches, and the second that her general practitioner (Dr Cameron) increase the dose of the patches so she would not be too dependent on oral Endone that she was on at the time.[69] Dr Ali expressed that Endone was the main reduction he was aiming for, and that it was reduced by his review of her on 4 July 2011.[70] There was another appointment on 7 November 2011 where Dr Ali left Ms Davis's medications as they were and did not consider reducing the level of medications.[71]

14. In one consultation Dr Ali had made recommendations for Norgesic.[72] He made the recommendation after noticing muscle stiffness along her spine in their first consultation.[73] He believed the stiffness was contributing to her pain and that Norgesic was an appropriate muscle relaxant to help relieve the muscles.[74] Dr Ali noted that common side effects of opioid use are respiratory depression, and the risk is higher when given a combination of multiple opioids.[75] However, he noted that he was not concerned about the risk because Ms Davis had already been on opioids for more than ten years and was '*probably tolerant'*.[76] When asked to elaborate on her tolerance in cross-examination, he explained that he made this assessment based on her symptoms. She displayed a tolerance to the opioids common side effects such as drowsiness and blurring of vision and explained that this inference came from observation.[77] Dr Ali also

[66] Transcript 31.01.18 P23 L26-33
[67] Transcript 31.01.18 P23 L39-42
[68] Transcript 31.01.18 P23 L39-44
[69] Transcript 31.01.18 P24 L10-14
[70] Transcript 31.01.18 P36 L45 – P37 L10
[71] Transcript 31.01.18 P38 L16-20
[72] Transcript 31.01.18 P24 L25-32
[73] Transcript 31.01.18 P24 L25-32
[74] Transcript 31.01.18 P24 L25-32
[75] Transcript 31.01.18 P24 L34-40
[76] Transcript 31.01.18 P24 L37-40
[77] Transcript 31.01.18 P35 L27-33

ceased recommendation of Norgesic because he believed it was not working, so he prescribed a different muscle relaxant.[78]

15. On 5 March 2012, in addition to making recommendations to Ms Davis, he also commenced directly prescribing medication, in particular Pregabalin.[79] He intended that it would replace Endep, as either medication treats neuropathic pain.[80] He recommended reduction in Endep so Ms Davis would not suffer from too much drowsiness.[81] He explained that at that time, prescriptions for Pregabalin were only available from pain specialists or neurologists.[82] Dr Ali judged that Ms Davis possibly had neuropathic pain in addition to her spinal pain, and as a result prescribed Pregabalin.[83] Approximately one month later in April, he observed that the Pregabalin was easing Ms Davis' leg pain.[84] The prescriptions continued until 29 April 2013 because Dr Ali believed Pregabalin had become recognised on the PBS for neuropathic pain, meaning pain specialists were no longer specially required for prescription.[85] Endone was also recommended but only for break through pain and the dosage was reduced with the increase of the Fentanyl patch.[86]

16. Whilst consulting with Ms Davis, Dr Ali did not recall her ever mentioning Dolased.[87] This was confirmed when Dr Ali was taken to his hand written notes for that day.[88] He also confirmed that he was never aware that Ms Davis was in fact taking Dolased.[89] However, when asked if Ms Davis taking Dolased would have affected his medication recommendations, he expressed that 'It would not be something which I recommend Ms Davis take'.[90] This is because Dolased contains codeine, paracetamol and antihistamine which could increase the likelihood of drowsiness or respiratory depression if combined with the other

[78] Transcript 31.01.18 P25 L40-43
[79] Transcript 31.01.18 P25 L10-14
[80] Transcript 31.01.18 P38 L28-29
[81] Transcript 31.01.18 P38 L26-29
[82] Transcript 31.01.18 P25 L15-17
[83] Transcript 31.01.18 P25 L15-24
[84] Transcript 31.01.18 P25 L25-30
[85] Transcript 31.01.18 P25 L32-35
[86] Transcript 31.01.18 P25 L43-45
[87] Transcript 31.01.18 P25 L8-9
[88] Transcript 31.01.18 P28 L11-14
[89] Transcript 31.01.18 P28 L25-29
[90] Transcript 31.01.18 P28 L14-24

medications she was on.[91] In cross examination he could not recall if Ms Davis was drowsy or sedated, but if she had been he would have like written so in his notes.[92] Dr Ali notes that if Ms Davis had hypothetically been using antihistamines known to have a sedative effect, he would have noted it in his consultation and progress notes.[93]

17. When taken to his consultation notes from an appointment with Ms Davis on 21 February 2011, Dr Ali recalled that she had not been taking Panadeine Forte.[94] On cross-examination when he was asked to consider the possibility that the note was indeed reflecting a use of Panadeine Forte, he replied he would have recommended she not be prescribed Panadeine Forte.[95] When taken to the toxicology post mortem report of Ms Davis, he noted that the medications detected in her blood were oxycodone and Fentanyl.[96] Codeine, doxylamine and promethazine were also detected but he could not recall her being on these medications.[97] He noted that the effect of the combination and dosage may have caused Ms Davis to be drowsy.[98]

Interaction with Dr Cameron

18. When making recommendations, Dr Ali explained that he writes a letter to the general practitioner and will usually provide reasons for suggested dosages in the letter. Dr Ali expressed the proposition that general practitioners will follow the recommendation of the pain management unit.[99] On examination, Dr Ali was taken to letters he had written to Dr Cameron.[100] To his recollection, Dr Cameron had never contacted to discuss his recommendations.[101] The first referral made to Dr Cameron was on 13 January 2010, but he expressed there was some delay as the first consultation was not held until 21 February 2011.[102] When cross-examined, Dr Ali agreed that Dr Cameron had been a '*good*

[91] Transcript 31.01.18 P27 L20-23
[92] Transcript 31.01.18 P30 L27-30
[93] Transcript 31.01.18 P42 L5-7
[94] Transcript 31.01.18 P41 L19-28
[95] Transcript 31.01.18 P41 L19-22
[96] Transcript 31.01.18 P42 L37-40
[97] Transcript 31.01.18 P42 L37-40
[98] Transcript 31.01.18 P42 L42-45
[99] Transcript 31.01.18 P28 L45 – P29 L2
[100] Transcript 31.01.18 P26 L33-40; Annexure L
[101] Transcript 31.01.18 P27 L36-37
[102] Transcript 31.01.18 P29 L4

practitioner' through providing physiotheraphy, making referrals for scans and prescribing mediation'.[103] However when cross-examined by Ms Baker-Goldsmith, Dr Ali noted that Dr Cameron had never sent through an updated referral as expected from the treating general practitioner, once a year.[104] This prevented Dr Ali from having a full list of medications on which Ms Davis was on.[105] He expressed his opinion that general practitioners are the 'final prescriber' for the patient so it is up to them to decide what to do for the patient.[106] He agreed that there was no specific guidance given to Dr Cameron in respect of his recommendations.[107] He further commented that general practitioners very rarely abstained from the pain clinic recommendations.[108] On further enquiry in cross-examination he explained that general practitioners would normally contact him to advise if they believed Dr Ali's recommended medication would interfere with other drugs the patient was taking.[109]

19. In the latter part of Dr Ali's statement, he recommended on 2 September 2013 that Ms Davis' dosage of Pregabalin be raised, by 150 to 300 milligrams twice daily.[110] He also stated that it could possibly increase her drowsiness.[111] He noted that generally patients on Pregabalin or Lyrica report drowsiness as soon as they begin the drug, but the patient will cease taking the drugs if they are too drowsy or keep taking the drug once the drowsiness eventually subsides.[112] Dr Cameron noted that he was concerned about her heart, specifically about the side effects of drowsiness if the dosage was doubled.[113]

<u>Conclusion of evidence</u>

20. Dr Ali was asked to conclude his evidence by providing general comment on how his treatment of Ms Davis may have differed with the benefit of his current knowledge from the coronial investigation.[114] He advised that the combination

[103] Transcript 31.01.18 P30 L17-19
[104] Transcript 31.01.18 P31 L35-40
[105] Transcript 31.01.18 P32 L42
[106] Transcript 31.01.18 P33 L4-8
[107] Transcript 31.01.18 P33 L20-32
[108] Transcript 31.01.18 P34 L37-39
[109] Transcript 31.01.18 P35 L9-13
[110] Transcript 31.01.18 P31 L16-18
[111] Transcript 31.01.18 P31 L16-18
[112] Transcript 31.01.18 P31 L25-33
[113] Transcript 31.01.18 P83 L1-6
[114] Transcript 31.01.18 P43 L5-8

of the drugs she was on, including the ones he was not aware she was on, may have caused sufficient drowsiness to reduce her respiratory rate.[115] When asked if he had any recommendations or considerations to mention to the coroner, he advised that patients arriving at the pain clinic should include a completed questionnaire about all over the counter medications they have taken in the past.[116] He suggested it include a space to provide use of recreational drugs, herbs, vitamins and supplements as they have the potential to interact with medications.[117]

21. The family of Ms Davis also asked for explanation of the purpose of the medications Ms Davis was on, particularly Lyrica and Promethazine.[118] He also answered general questions about the pain management program. He explained that it acts as a comprehensive follow on from the one day pain education session.[119] He also advised that the waiting list for the two week pain management course was 'lengthy', and is scheduled every three to four months.[120] Ms Musgrove in re-examination presented the court with brochures on the various elective courses within the pain programme and tendered them into evidence as Exhibit C5.[121]

Dr John Michael Cameron

22. Dr Cameron started general practise in the ACT in 1993.[122] It was about this time that he first came into contact with Ms Davis and her family.[123] He prepared a statement to police dated the 12 July 2014.[124] At the beginning of examination, Dr Cameron wished to make an amendment to his statement. The last current medication listed was the sleeping tablet Melatonin. He wished to strike it off the statement because Ms Davis was not taking it at the time she died, to his knowledge.[125] The statement was amended as of 31

[115] Transcript 31.01.18 P43 L22-26
[116] Transcript 31.01.18 P43 L38 – P44 L1
[117] Transcript 31.01.18 P46 L16-22
[118] Transcript 31.01.18 P44 L23-31;P45 L32-35
[119] Transcript 31.01.18 P46 L31-40
[120] Transcript 31.01.18 P44 L33-40
[121] Transcript 31.01.18 P48 L11-12
[122] Transcript 31.01.18 P50 L13-17
[123] Transcript 31.01.18 P50 L13-17
[124] Transcript 31.01.18 P50 L13-17
[125] Transcript 31.01.18 P50 L34

January 2018.[126] He also expressed that when he was first made aware of Ms Davis' death, he was surprised but had assumed that a cardiovascular event was the most likely cause.[127]

23. Dr Cameron provided an extensive history of his experience and process in treating pain in his time as a general practitioner.[128] He originally practised in Jindabyne but relocated to Canberra with a much broader demographic of patients, and was subsequently involved chronic pain management for a variety of patients.[129] He explained that when a patient initially attends his practise with a pain complaint, he takes a history of their pain. He then performs an examination and order various tests if necessary to diagnose the source of pain, such as blood tests, x-rays, CT or ultrasound.[130] After he has formulated a treatment plan for a patient who has uncontrolled pain symptoms, particularly chronic, he offers a 'reasonable level of medication' but also suggests other forms of treatment. This could include acupuncture, massage, osteopathy and chiropractors.[131] If the pain management issue was particularly difficult, he would seek specialist advice. The issue was categorised as difficult if he had already prescribed a reasonable level of pain relief and had the patient see a physiotherapist with minimal result.[132]

<u>Interaction with Ms Davis</u>

24. When Dr Cameron started treating Ms Davis, she was under the supervision of a pain specialist, Dr Danta. He was a neurologist who provided '*adequate'* treatment in managing her pain. Dr Cameron had minimal treatment of her pain up until '*a certain point in time'*.[133] He explained that around the time of Dr Danta's retirement in 2007, Ms Davis had been on substantial doses of pain management medications. He highlighted that her treatment from Dr Danta differed substantially from how he would manage a new patient with a pain

[126] Transcript 31.01.18 P51 L10-13
[127] Transcript 31.01.18 P68 L1-6
[128] Transcript 31.01.18 P51 L37-45
[129] Transcript 31.01.18 P51 L37 – P52 L1
[130] Transcript 31.01.18 P52 L3-17
[131] Transcript 31.01.18 P52 L19-30
[132] Transcript 31.01.18 P52 L40-45
[133] Transcript 31.01.18 P53 L29-34

problem.[134] When Ms Davis came under Dr Cameron's care, she was on Kapanol, Serepax, Panadeine Forte and Temazepam. Dr Cameron agreed that it would be fair to say that when he took over Ms Davis' treatment, he wished to take steps to reduce the medication she was on.[135] Once she was in his sole care, he became aware she was on approximately 50 milligrams of Endep, four a day. He found this amount unusual.[136] One he was aware, he reduced the Endep to a lesser dose.[137] When taken to his notes from 5 February 2008, he recalled noting that if he were to prescribe Endep, he would usually choose a 10 milligram dosage once or twice a day. He noted 50 milligram seemed 'fairly substantial' but to take four of them is a lot.[138] He also did not prescribe Serepax or Temazepam to Ms Davis.[139]

2004

25. On cross examination, Dr Cameron was asked if he could recall Ms Davis' history of opioid use in 2004. He could not recall that or the fact that it resulted in her being hospitalised.[140] But by some point he was made aware of the episode, as proven by a letter he sent to the pain clinic on 21 January 2011. He noted that all the documentation regarding the episode that resulted in hospitalisation would have been received by Dr Danta.[141] He noted that most of Ms Davis' treatment in 2004 was handled by Dr Danta; Dr Cameron would treat her on the odd occasion if Dr Danta was unavailable and requested him to prescribe medications such as Kapanol.[142]

2005

26. On 8 March 2005, a chemist had cautioned Ms Davis about the dosage of Dolased she was taking. However, Dr Cameron was not aware of the caution prior to the hearing.[143] He expressed that if he had known about the caution,

[134] Transcript 31.01.18 P53 L35-44
[135] Transcript 31.01.18 P55 L33-37
[136] Transcript 31.01.18 P54 L1-8
[137] Transcript 31.01.18 P54 L10-17
[138] Transcript 31.01.18 P55 L17-21
[139] Transcript 31.01.18 P54 L19-25
[140] Transcript 31.01.18 P69 L20-23
[141] Transcript 31.01.18 P69 L39-42
[142] Transcript 31.01.18 P69 L44 – P70 L1
[143] Transcript 31.01.18 P66 L13-21

his treatment of Ms Davis around 2007 would have been impacted 'to some degree' and would have made him more cautious.[144]

2008

27. When taken to his notes referring to 19 June 2008, Dr Cameron recalled that Ms Davis had been seen by a Dr Tamoripio on 12 June 2008 regarding a fall. Dr Cameron then had a reviewal appointment with Ms Davis on 19 June 2008 and as a result prescribed 20 Panadeine Forte tablets.[145]

28. Dr Cameron also made further adjustments to Ms Davis' medication. On July 2008 he prescribed Mersyndol Forte. He intended that the Mersyndol Forte could replace some of the Panadeine Forte, particularly at night-time for its muscle relaxant effect.[146] He added that it was generally effective in managing Ms Davis' pain up until August and that her general mobility had improvement.[147] However, he ceased the Mersyndol Forte in 17 September 2008 because he did not want Ms Davis to be on it for a prolonged period. It was designed to relieve muscle spasm so Dr Cameron intended that once her pain came down to a certain level he would cease prescription.[148] Over the next 6 months since then, Ms Davis continued to have flare ups, which from time to time require further intervention, but was generally satisfied that her pain being managed.[149] On 17 September 2008 he stopped the Mersyndol Forte but then resumed it on 15 October 2008 due to exacerbation of her back pain.[150] By 10 December 2008 he had switched Ms Davis to the Mersyndol, for its lower dosage of codeine.[151]

2009

29. Dr Cameron described Ms Davis' general condition over 2009 as *'reasonably stable with inevitable sort of fluctuations'*. He also mentioned that his notes from 27 July stated that Ms Davis had seen another general practitioner Dr

[144] Transcript 31.01.18 P66 L23-28
[145] Transcript 31.01.18 P55 L45 – P56 L4
[146] Transcript 31.01.18 P56 L6-15
[147] Transcript 31.01.18 P56 L11-15
[148] Transcript 31.01.18 P56 L31-33
[149] Transcript 31.01.18 P56 L35-44
[150] Transcript 31.01.18 P57 L12-15
[151] Transcript 31.01.18 P57 L31-34

Pradit Nyrian on 27 July and a Dr Mara Rahim on 19 July.[152] On 25 July he noted that her pain levels were not in control and suggested Endone as a pain relief. She described her pain levels as being agonistic.[153] He had encouraged her to have an MRI but they were not readily available at the time and was too costly.[154]

30. He commented that shortly after the 25 July appointment, she had seen Dr Nyrian for a prescription of OxyContin and Endone which he believed to be a '*double dose of the OxyContin'*.[155] He observed that she had an apparent negative side effect from the OxyContin, as she slurred and appeared confused at her appointment on 30 July. stated that her last doctor had prescribed her Valium but Dr Cameron could not see that on the script, except from an appointment that was not her most recent one.[156] When taken to his notes on 31 July 2009, Dr Cameron recalled having prescribed her Valium for fear that she was already taking it and did not want her to suffer an adverse reaction to stopping it suddenly.[157] He expressed that he never intended for Ms Davis to use Valium for very long.[158]

31. Ms Davis' pain was generally controlled from July onwards. On 4 August Dr Cameron had encouraged Ms Davis to continue her exercises. She was also referred to the Calvary physiotherapist on 7 August 2009. At the stage he suggested an MRI again but was still too costly. Instead, he suggested that Ms Davis undergo a CT scan because it would be a better test for highlighting areas of inflammation, particularly in the spine.[159] Ms Davis then saw a Dr Tamoripio on 18 and 24 October 2009.[160] She was also seen by a Dr Paul Jones and then Dr Tamoripio again, who prescribed her Panadeine Forte and Valium. Dr Cameron assumed Ms Davis consulted with Dr Paul Jones was because he was probably on holiday leave at the time.[161] Ms Davis also underwent facet joint injections as a result of the CT scan and spec scan on 29

[152] Transcript 31.01.18 P58 L24-40
[153] Transcript 31.01.18 P58 L34
[154] Transcript 31.01.18 P60 L1-7
[155] Transcript 31.01.18 P58 L30-40
[156] Transcript 31.01.18 P58 L40-45
[157] Transcript 31.01.18 P59 L23-35
[158] Transcript 31.01.18 P59 L37-44
[159] Transcript 31.01.18 P60 L1-12
[160] Transcript 31.01.18 P60 L18-20
[161] Transcript 31.01.18 P60 L20-23

October.[162] The reason for the cortisone injections would have been to treat inflammation at those site identified by the scans.[163] Dr Cameron noted that upon injection the initial reaction will be that there has not been much difference to the pain, but after a few weeks the cortisone will generally settle down the inflammation.[164] He noted that after the injections there had been improvement in Ms Davis' pain levels. However in 2009 around October to November, Ms Davis felt her back pains were worse after unpacking some Christmas decorations.[165] He expressed that by November 2009, he felt he had exhausted all his tools to manage Ms Davis' pain.[166]

32. On 25 November Ms Davis reported that she had some improvement after the injection and overall, was feeling slightly better. As a result, Dr Cameron suggested he would refer her to the pain clinic at her next visit. He explained that referrals to the clinic are an issue because the process is '*really fraught*' and having the referral delayed would not make any different in terms the speed of review she would receive.[167] He later elaborated that his reason for eventually referring her to the pain management clinic was that the current management was not working and she was still having significant amounts of pain relief: Ms Davis was still reliant on Valium and some Panadeine Forte that was not keeping her pain at bay significantly.[168]

33. Over the period of a few months before the end of 2009, Ms Davis was being treated by several general practitioners. He expressed it was difficult to control Ms Davis' pain medication during that period. It was undesirable for someone in her condition to see multiple doctors who would not understand the complexity of her pain management and wider medical problems.[169] On October 2009, Dr Cameron had a discussion of a personal nature with Ms Davis dating back to 1993. He outline that he had dealings with members of her family, in particular her sister Kate who had similar chronic pain and back problems. Her management predominantly involved injections at increasing

[162] Transcript 31.01.18 P60 L25-32
[163] Transcript 31.01.18 P60 L25-32
[164] Transcript 31.01.18 P61 L1-4
[165] Transcript 31.01.18 P61 L6-8
[166] Transcript 31.01.18 P61 L10-14
[167] Transcript 31.01.18 P61 L16-25
[168] Transcript 31.01.18 P61 L40 – P62 L1
[169] Transcript 31.01.18 P61 L27-38

intervals. [170] He was not directly involved with Kate's pain management but knew of her conditions and remains unaware as to how she died at a relatively early age. He noted that Kate was often discussed at appointments with Ms Davis.[171]

2010

34. Dr Cameron began the process of completing the referral to the pain management clinic. He explained that his referral letters generally contained a list of medications, allergies, other medical history and a summary of both her general medical condition and specific details about her pain. He mentioned in the referral that Ms Davis had chronic pain problem and also would have advised the clinic that CT scans and injections had not produced satisfactory results.[172] He confirmed that there was delay from the date of referral to the date Ms Davis eventually went to the pain clinic. He did not assign blame to the clinic itself for the delay but noted that the wait times was 'diabolical' considering he made the referral in January 2010. He had to redo the referral in January 2010, and she was finally seen February 2011.[173] In the interim period between 13 January 2010 and 21 February 2011, Dr Cameron carried on with general discussions and monitoring. Ms Davis at some point was '*obviously having problems*' from being under the influence of a medication that was too strong.[174] His immediate aim was to put her on a medication that would relieve her pain and lessen the multitude of medications.[175] As a result he started Ms Davis on a transdermal patch called Durogesic and soon after tried to reduce the other medications she was taking.[176]

35. From around January 2010 up until the end of 2010, Dr Cameron's medical notes indicated that Ms Davis was not stable in her pain management medication.[177] She was having medical appointments every couple of day from other doctors and getting different scripts for Endone and OxyContin. In cross-

[170] Transcript 31.01.18 P62 L26-41
[171] Transcript 31.01.18 P62 L26-41
[172] Transcript 31.01.18 P63 L24-33
[173] Transcript 31.01.18 P63 L35-44
[174] Transcript 31.01.18 P64 L45 – P65 L8
[175] Transcript 31.01.18 P64 L1-8
[176] Transcript 31.01.18 P64 L10-12
[177] Transcript 31.01.18 P70 L14-16

examination Dr Cameron was taken to his notes on 31 August 2010 where he had written that Ms Davis had requested more Endone, even though her script was already suppling an adequate amount. Dr Cameron was also taken to his notes on 29 August 2010, where at one point another doctor "MAR", noted that Ms Davis was aware of the '*side effects...plus dependency*.'[178] In regards to these behaviours, Dr Cameron concluded that Ms Davis' behaviour could be interpreted as 'drug seeking behaviour' through that period.[179]

2011

36. Ms Davis was eventually seen by the pain clinic on 21 February 2011. Dr Cameron recalled that Ms Davis' medication were changed around as a result of her initial consultation.[180] This involved changing the strength of the patches from approximately 25 to 37.5 mcg. Dr Cameron recalled that the pain clinic recommended she try other tablet medications such as Baclofen and Norgesic. She was then placed on tablet form Pregabalin or Lyrica when Norgesic failed to ease Ms Davis' leg pain during an episode.[181] These tablets were only available through the hospital at the time. It was found that the effects of Lyrica, when overlapping with Endep made a big improvement to Ms Davis' pain management, so it was at that stage that Endep was removed.[182] Drug–seeking behaviour was alluded to again in re-examination, where it was put to Dr Cameron that perhaps Ms Davis was attending upon him to seek medication for an addiction rather than a pain purposes. Dr Cameron replied that that was not correct, before and during her attendance at the pain clinic.[183] He never had concerns that she was non-compliant in terms of taking her medication, as she would always turn up regularly to get the scripts.[184] She had never arrived unexpectedly, seeking additional scripts without an appointment.[185]

[178] Transcript 31.01.18 P70 L36 – P71 L1
[179] Transcript 31.01.18 P70 L23-24
[180] Transcript 31.01.18 P64 L14-17
[181] Transcript 31.01.18 P64 L14-18
[182] Transcript 31.01.18 P64 L25-28
[183] Transcript 31.01.18 P75 L25-29
[184] Transcript 31.01.18 P76 L16-26
[185] Transcript 31.01.18 P76 L16-26

37. In regards to possible '*organic'* causes of Ms Davis' pain, he did note that at one point, an ultrasound of her shoulder suggested she had bursitis.[186] Imaging also showed there was osteoarthritis, but Dr Cameron was not clearly able to recall the finer details of this. He did note that there were some signs she was suggesting from the condition, because she had an x-ray, an ultrasound and subsequently an injection.[187] Dr Cameron explained that the specific cause of her chronic back pain, was degenerative arthritis with facet joint, particularly facet joint involvement.

38. Dr Cameron was asked to explain his supervision of Ms Davis' S8 medication usage. He described his role as a supervisor of the S8 medication, and he would prescribe medication according to the pain clinics recommendations.[188] He explained that if he wished to prescribe an S8 type medication (at the time that Ms Davis was alive), he would need to seek approval from the pain clinic for each individual items. Dr Cameron believed he had an exact record of her S8 medications and the prescriptions.[189] The authority for prescriptions would be given for up to six months. Sometimes it could be done for up to three months but he was '*certainly not happy to be doing that with Suellen*.'[190]

Comments on the pain management clinic

39. Dr Cameron was asked to comment on the quality of the Ms Davis' treatment with the pain management clinic. In his statement he noted that the pain clinic had added Baclofen, Endone and Lyrica at some point in Ms Davis' visits. But when questioned in cross examination, he accepted that as of 25 July 2009 he had been prescribing her Endone. As a result, he retracted his statement that Baclofen and Endone had been prescribed by the pain clinic.[191] When taken to his statement, he agreed that after attending the pain clinic, Ms Davis was more inclined to manage her pain without immediately requesting extra doses of stronger analgesics.[192] He also noted that from the reading of the medical records that Ms Davis' medication seeking behaviour had changed dramatically

[186] Transcript 31.01.18 P75 L33-45
[187] Transcript 31.01.18 P75 L33-41
[188] Transcript 31.01.18 P64 L35-39
[189] Transcript 31.01.18 P64 L41 – P65 L8
[190] Transcript 31.01.18 P65 L10-16
[191] Transcript 31.01.18 P71 L32-40
[192] Transcript 31.01.18 P71 L3-7

for the better.[193] He noted that two adjustments had made a great difference to her pain: the increase of the Durogesic patch dosage and the placement on Lyrica.[194] He refrained from describing her pain as well controlled in the period that she was managed by the pain clinic, but that it was manageable.[195] He explained that this observation was based on Ms Davis' reports of her pain. He did note that care must be taken when dealing with reports of chronic pain, but that based on his knowledge of her, her general movements were '*not deteriorating consistently'*.[196] He noted that she was always alert and reasonable.[197] He was aware that to help her to deal with her pain, the pain clinic also advised that Ms Davis attend their advice clinic, known as the 'Jump' clinic, and she expressed she was enjoying their assistance.[198]

40. When questioned about Dr Ali's role, he felt that Dr Ali was mainly focused on pain management, and that Dr Cameron was to look after all the other issues. He acknowledged that Dr Ali's recommendations were only made in the context of pain, not the holistic broader view that Dr Cameron would have.[199] On re-examination, Dr Cameron conceded that was an onus on him to inform Dr Ali if there had been any significant changes in her medication.[200] He also added that there was some scope for him to exercise independent judgement to accept Dr Ali's recommendations, but that there was never a situation that required him to provide a different opinion.[201]

<u>2012 - 2013</u>

41. Dr Cameron was aware of Ms Davis' sleeping patterns and habits.[202] They were disordered, as she usually slept during the day and was awake in the

[193] Transcript 31.01.18 P71 L9-19
[194] Transcript 31.01.18 P65 L29-33
[195] Transcript 31.01.18 P65 L35-38
[196] Transcript 31.01.18 P65 L35-44
[197] Transcript 31.01.18 P66 L 2-4
[198] Transcript 31.01.18 P66 L8-11
[199] Transcript 31.01.18 P77 L32-39
[200] Transcript 31.01.18 P78 L9-20
[201] Transcript 31.01.18 P78 L34-36
[202] Transcript 31.01.18 P80 L9-13

night-time.[203] Dr Cameron removed Melatonin from her prescription, but he believed that was the extent to which he could address her sleeping issues.[204]

42. Dr Cameron noted that Ms Davis' pain was better controlled and manageable. He could not recall Ms Davis seeking appointments out of her monthly routine.[205] The records from July or August onwards, reflected a fairly regular pattern of attendance and standard prescription composing of Durogesic and Oxycodone.[206]

43. Dr Cameron expressed that in the weeks prior to Ms Davis' death, she had her usual pain related issues but nothing additional. He noted that her diabetes were actually better controlled in her last few months, and he took this as an indication that her activity levels were sufficient. She would have been reasonably mobile and doing a reasonable amount of exercise.[207] However, Ms Davis was a smoker and at her last appointment he noted that her pulse was sitting at 115 which was cause for concern. As a result he sent for her to have an ECG and requested urgent reporting. The report revealed that the level was quite high, so he kept a record of it in his notes and contacted Ms Davis via telephone that afternoon. He recalled that Ms Davis felt comfortable with her pulse as it had settled done by the time she arrived home.[208] He then arranged for Ms Davis to have a halter monitor, which revealed her average heart rate was 98. He was not immediately concerned about her heart rate, but had concern in regards to its combination with her blood pressure, cholesterol and diabetes.[209]

<u>Medication reviews</u>

44. When asked if Dr Cameron had undertaken a medication review of Ms Davis, he clarified that it was more of an ongoing process rather than a having a solely dedicated consultation for a medication review. He indicated that he did

[203] Transcript 31.01.18 P80 L9-18
[204] Transcript 31.01.18 P81
[205] Transcript 31.01.18 P80 L36-43
[206] Transcript 31.01.18 P81 1-3
[207] Transcript 31.01.18 P67 L24-25
[208] Transcript 31.01.18 P67 L30-40
[209] Transcript 31.01.18 P67 L37-40

reviews with patients on complicated medication regimes.[210] However he noted that he did not enquire if Ms Davis was taking over the counter medication at every consultation.[211] It was his practise to warn patients at the start of commencing medication and at review, to make them aware of the potential side effects.[212] When medications were prescribed, they were automatically logged against her medical record on the computer system. Dr Cameron explained that even when alerts popped up to indicate that any two medications may have adverse interactions, he was never concerned. This was because her prescriptions and general medications would almost always generate an alert.[213]

Comments on post-mortem results

45. When taken to the toxicology report in examination, Dr Cameron noted that he had reviewed the report. He noted that he was aware of the drugs found in her blood but was not an expert on the actual levels.[214] Based on the medication that he was aware she was taking at the time, he was surprised that Promethazine was present. He was surprised that Doxylamine was present because he did not believe Ms Davis was taking Dolased. Codeine was also found to be present which he did not expect.[215] When asked what action he would have taken if he had known Ms Davis was taking drugs containing Promethazine or Doxylamine, he said he would have advised her not to take them.[216]

46. When asked if his treatment would have been different with hindsight, he said he would not have put Ms Davis on the Durogesic patch and instead would have put her on Norspan because it is believed to be better tolerated.[217]

Associate Professor Vanita Parekh

[210] Transcript 31.01.18 P84 L3-15
[211] Transcript 31.01.18 P85 L4-5
[212] Transcript 31.01.18 P85 L38-43
[213] Transcript 31.01.18 P86 L45 – P87 L7
[214] Transcript 31.01.18 P66 L41-45
[215] Transcript 31.01.18 P67 L1-10
[216] Transcript 31.01.18 P67 L12-14
[217] Transcript 31.01.18 P87 L29-36

47. Associate Professor Parekh was a medical practitioner and the director of the forensic medicine unit at the Canberra Hospital.[218] She was briefed on behalf of the Coroner to produce an expert opinion.[219], which were tabs F, H, I, J in Exhibit C1 and a letter dated 7 September 2017 which was tendered as Exhibit C2.[220]

48. Associate Professor Parekh stated that her opinion now was the most probable cause of Ms Davis' death was positional asphyxia, but that this was in conjunction with the effects of multiple medications. She noted however, that all the other factors in positional asphyxia had to be investigated. At the time of her earlier reports, she did not have all the information that was subsequently available.[221] She explained that positional asphyxia relates to the compression of the chest, or the fact that the airway is sufficiently obstructed enough so that air flow cannot occur. It can happen often when a person has a flexed neck that is where the chin is very close to the chest. It is the most common instance of positional asphyxia, but that diagnosis is only made subject to the exclusion of other causes.[222]

49. Associate Professor Parekh made reference to a paper by Bell [(1992) 13(2) *Am J For Med & Path* 101-107] which outlines the criteria needed to fulfil the diagnosis of positional asphyxia.[223] When asked to compare the points raised in the criteria with the facts of Ms Davis' death, she made the following comments.

    a. She noted that Ms Davis had originally been moved by Mr Davis to facilitate cardiopulmonary resuscitation.

    b. Ms Davis was also on multiple sedative medication which included Oxycodone, Fentanyl, Codeine, Doxylamine and Promathazine. This number of substances had individual effects but also caused

[218] Transcript 31.01.18 P90 L
[219] Transcript 31.01.18 P91 L42-44
[220] Transcript 31.01.18 P91 L5-8 - Annexures F, H, I, J and Exhibit C2
[221] Transcript 31.01.18 P91 L22-30
[222] Transcript 31.01.18 P92 L4-9
[223] Transcript 31.01.18 P92 L11-20

drowsiness, incoordination and respiratory depression when combined.[224]

c. Ms Davis also had bilateral pulmonary oedema and congestion, which were common findings in respiratory depression but also positional asphyxia.

50. Associate Professor Parekh also drew upon a second paper by Roger Byard [(2008) 15 J For & Leg Med 415-419] which included a table outlining conditions and circumstances predisposing to death from positional asphyxia.[225] Professor Parekh directed the court to the conditions and circumstances which included intoxication or sedations, chronic injury and combinations of these factors. She noted the paper's relevance, since the post-mortem toxicology indicated multiple sedatives. She noted that care must be used when interpreting post mortem medication levels due to the phenomenon of post-mortem redistribution, in which the levels in the sample may not be completely accurate.[226] She noted that Ms Davis potentially had low level flexibility, and that her back problems would relate to the aspect of chronic injury.[227] She also noted that the paper identifies reason as to why someone would not be able to remove themselves from positional asphyxia such as intoxication, physical impairment or restraint, neurological impairment and combinations of these factors. She pointed to the elements of physical impairment and restraint as taken from Mr Davis' evidence about how he found his mother.[228]

51. On examination Mr Johnson took Associate Professor Parekh to Byard's six criteria.[229] In relation to Criteria 1, when Associate Professor Parekh completed a fourth report dated 7 September 2018, she had become aware of Ms Davis being found over the coffee table. She believed that it provided a potential positional aspect to the case.[230] However, she did not have doubt that Criteria 1 was satisfied because both of the positions described, (the couch slumped

[224] Transcript 31.01.18 P92 L30-43
[225] Transcript 31.01.18 P93 L3-5
[226] Transcript 31.01.18 P93 L5-14
[227] Transcript 31.01.18 P93 L18-22
[228] Transcript 31.01.18 P93 L26-32 – Table 2
[229] Transcript 31.01.18 P97 L36-37 (p. 147)
[230] Transcript 31.01.18 P98 L6-13

forward or on the coffee table) easily fulfilled the criteria. She did agree though that there was some degree of uncertainty about that aspect of the Bell criteria.[231] When taken to Criteria 3, Associate Professor Parekh noted that she did have some uncertainty in regards to drug intoxication of Ms Davis. She was unable to conclusively determine if intoxication was the cause of positional asphyxiation, and believed that the post-mortem report of Dr Jain had left open the significance of the drug levels.[232] She also noted that Pregabalin had not been tested for, but in order to validate the testing it was quite a complex process and not necessary.[233] In regards to Criteria 6, Dr Parekh had said there was no evidence of significant cardiac disease. She was not aware that Dr Cameron had treated Ms Davis in the month before her death for an episode of acute tachycardia.[234]

52. It was also asked if Associate Professor Parekh would have to be satisfied that each of the six criteria were fulfilled, in order to make a diagnosis of positional asphyxia. She indicated that she would have to, however her diagnosis was also based on the information she was provided with.[235] She also agreed that based on the concentrations of opioids in Ms Davis' blood and factoring in that she'd been on opioid medication for many years, the concentrations found in Ms Davis' system might not have been strong enough to cause intoxication, but that toxicology was not an exacting science and it would also depend on when Ms Davis took the drugs.[236]

53. Associate Professor Parekh then directed the court's attention to the Bell criteria and her analysis of the circumstances of death.[237] The criteria for diagnosis of positional asphyxia, included '*restrictive or confined spaces and specifically flexion of the head on the chest, partial or complete external airway obstruction and neck compression*'.[238] Professor Parekh did not think there was evidence to implicate another person in the event of the asphyxiation as per point 3 of the criteria. Therefore the victim was responsible for

[231] Transcript 31.01.18 P98 L26-27
[232] Transcript 31.01.18 P98 L29-43
[233] Transcript 31.01.18 P99 L6-13
[234] Transcript 31.01.18 P100 L1-4
[235] Transcript 31.01.18 P97 L27-31
[236] Transcript 31.01.18 P99 L22-25
[237] Transcript 31.01.18 P93 L26-32
[238] Transcript 31.01.18 P93 L34-44

inadvertently placing herself in that situation. The inability of the victim to extricate herself from the situation due to drug intoxication was also one of Associate Professor Parekh's considerations.[239] In relation to point 4 which discussed internal airway obstruction, Associate Professor Parekh said there was no evidence to suggest this from reading Dr Jain's report of any internal airway obstruction.[240] She also considered that there was no evidence of significant cardiac disease in the post-mortem findings.[241] The last table in the article discussed the autopsy approach to evaluating the possibility of positional asphyxia. She noted that it is not sufficient for one person alone to make a diagnosis. The judgement of the initial forensic medical officer, the police, post-mortem investigators and toxicologist would all need to be considered in order to make a diagnosis. Associate Professor Parekh believed that by using that approach combined with a review of all the documentation, that positional asphyxiation was the most logical cause for Ms Davis' death.[242]

Concluding part of proceedings

54. At the end of the proceedings, Ms Baker-Goldsmith tendered photographs of Ms Davis for the record and read out a letter from Ms Davis' daughter-in-law, Ms Elizabeth Anderson, which was also tendered as Exhibit C6.[243] Ms Anderson noted that after Ms Davis suffered the psychotic episode, Ms Davis had believed it was directly related to the medication regime she was taking, and she had become very mindful of her medications.[244] Ms Anderson also expressed a belief that Ms Davis greatly benefitted from physiotherapy, massage and osteopathy.[245] However Ms Musgrove noted the limitations of the statement as the author of the letter was not in a position to provide guidance as to what Ms Davis have benefitted from.[246]

[239] Transcript 31.01.18 P93 L38-44
[240] Transcript 31.01.18 P94 L1-6
[241] Transcript 31.01.18 P94 L6-10
[242] Transcript 31.01.18 P94 L10-16
[243] Transcript 31.01.18 P3 L5-10 –Exhibit C6
[244] Transcript 31.01.18 P101 45 – P102 L8
[245] Transcript 31.01.18 P101 L3-8
[246] Transcript 31.01.18 P101