



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7th, 8th, 9th, 10th and 13th days of May 2019 and the 21st day of June 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Janet Ann Cook.

The said Court finds that Janet Ann Cook aged 79 years, late of 22 Ringwood Road, Morphett Vale, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 30th day of September 2015 as a result of multi-organ failure as a result of ischaemic and valvular heart disease with urinary tract infection and complicated by the effects of hydromorphone. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

- 1.1. Mrs Janet Ann Cook died on 30 September 2015. She was 79 years of age. She had been admitted to Flinders Medical Centre on 25 August 2015 for end stage cardiac failure complicating liver and renal failure. She was mistakenly given the medication hydromorphone on 21 September 2015 and subsequently became unresponsive. She was commenced on palliative care and died nine days later.
- 1.2. An autopsy was conducted by a pathologist at Forensic Science South Australia who gave the cause of death as multi-organ failure as a result of ischaemic and valvular heart disease with urinary tract infection and complicated by the effects of hydromorphone, and I so find. Plainly enough, a principal focus of this inquest was to ascertain how Mrs Cook came to be mistakenly given hydromorphone, which is a strong opioid medication. In fact, the medication was intended for another patient.

2. Relevant information with respect to Ward 5D and medication policies

- 2.1. Mrs Cook was the occupant of a single room on Ward 5D at the Flinders Medical Centre. Her room number was 26. Room 28 was two doors away and the occupant of that room was a lady by the name of Norma Cook.
- 2.2. It is as well to describe the relevant aspects of the layout of the ward. As I have said, rooms 26 and 28 were two doors apart on the same side of a passageway. On the opposite side of the passageway from room 26 was a room which has been variously described in the inquest as the DDA room¹, or the drug room, or the medication room. I will refer to it as the drug room. Within that room there was a locked cupboard containing, amongst other drugs, the opioid medication hydromorphone.
- 2.3. The locked drug cupboard in the room could only be opened by a key in the possession of one or other of the registered nurses on the ward. Indeed, it was only one of the registered nurses who was permitted under the policies and practices on the ward to draw up the medications kept within that cupboard, and at least one registered nurse had to be present with the patient at the time of the administration of the drug to the patient. The other nurse could be an enrolled nurse, but at least one of them had to be a registered nurse.
- 2.4. The evidence showed that the requirement that a registered nurse be present by the patient's bedside also applied to the administration of IV, or intravenous medications. As it happened, Mrs Cook was a patient who required both hydromorphone, a drug that was kept in the locked cupboard because it was an opioid, and also the intravenous medication hydrocortisone. Thus each of those two medications required the presence of at least one registered nurse during the administration of the medication to Mrs Cook. The deceased, Mrs Cook, was not prescribed either hydromorphone or hydrocortisone.
- 2.5. There were, on the evidence, two nurses present at the bedside when Mrs Cook was mistakenly administered the hydromorphone, which was in the form of a tablet or pill. Those nurses were enrolled nurse Trafford Csorba and registered nurse Michelle Bottger. Each of those nurses gave evidence at the inquest.

¹ An abbreviation for dangerous drugs of addiction

3. **The evidence of Mr Csorba**

- 3.1. Mr Csorba was as I have said an enrolled nurse who commenced in employment at the Flinders Medical Centre in 2008. Mr Csorba gave evidence that on both 18 and 21 September 2015 he was assigned the task of nursing the four patients respectively in rooms 25, 26, 27 and 28 of Ward 5D. Those rooms were in line with one another on one side of the corridor to which I have already referred. Mr Csorba was the nurse primarily responsible for the care of those four patients. Each of the shifts on 18 and 21 September 2015 being worked by Mr Csorba were morning shifts, starting at 7am and finishing at 3:30pm.
- 3.2. Mr Csorba made entries in the progress notes of Mrs Cook² at approximately 10:45am on each of the days he nursed her. The notes reveal that she was at times alert, but she was also confused. She required assistance with all of her activities of daily living, for example she had to be sponged in bed because she could not walk to the shower.
- 3.3. By contrast, Mr Csorba said that Mrs Cock was alert and orientated and ambulant and did not require assistance for all of her activities of daily living, including the shower. He also said that they were physically quite different. Mrs Cock being a larger lady and Mrs Cook being thinner, particularly around the face.
- 3.4. Mr Csorba had been the subject of an inquiry by the Australian Health Practitioner Regulation Agency (AHPRA) as a result of the death of Mrs Cook. He was interviewed twice by AHPRA investigators, firstly on 4 February 2016³ and secondly on 12 February 2016⁴. In his first record of interview he set out his version of what occurred at the bedside⁵. He said that he and Ms Bottger were only administering the hydromorphone pill and there was no other medication in the room. He also said that Ms Bottger was the person who administered the medication to Mrs Cook, Ms Bottger having carried the pill in a pill cup into the room. He said that as he was looking at the drug chart to see the patient's name, date of birth and UR number he was waiting for Ms Bottger to call out those points of identification when he looked up and saw that Ms Bottger:

'... had already given the tablet, and I said she hadn't called out the identity numbers. And then that's when we found out it was the wrong patient.'⁶

² Exhibit C5

³ Exhibit C9g

⁴ Exhibit C9h

⁵ Exhibit C9g, page 13

⁶ Exhibit C9g, page 13

- 3.5. Mr Csorba adhered to this version of events initially in his oral evidence in this Court. In his evidence in chief he said that because it was necessary to have a registered nurse assist him with the hydromorphone he approached Ms Bottger, but she was busy at the time. He said that he waited for her in the drug room to obtain the hydromorphone. He said that Ms Bottger was in a hurry for lunch⁷ and that having dispensed the medication Ms Bottger left the drug room and went into room 26⁸. He said that at that stage he was trying to get ready for her to call out the UR number and that he '*mistakenly walked, followed her and walked into bed 26*'⁹. He said that the identification on '*one of her charts wasn't readable*'¹⁰ and that was why he was occupied with looking at the chart. He then said that he looked up and realised that it was the wrong patient, but by that time the medication had been administered to her. He conceded that he should have realised that he had entered the wrong room¹¹, however that was as far as he was prepared to go in acknowledging fault on his part at that stage. He claimed that he realised that it was the wrong patient when he looked up from the drug chart and saw that the name on the bed card did not match the name on the drug chart¹². He acknowledged that if he had looked at the patient he would have realised that it was not Mrs Cook because of the physical difference between the appearances of Mrs Cook and Mrs Cock¹³. He claimed that he did not see the hydromorphone tablet actually being given to Mrs Cook, but only looked up after that had happened¹⁴. He said that he told Ms Bottger that it was the wrong patient and she was shocked and tried to get the pill out Mrs Cook's mouth¹⁵. He was adamant that at no stage did Ms Bottger call out the UR number or the date of birth or the name before she administered the pill to Mrs Cook and said that it was her role to read those things out for him to check¹⁶.
- 3.6. Mr Csorba's story changed during cross-examination. He gave evidence about the first day he nursed Mrs Cook and Mrs Cock – 18 September 2015, three days before the medication error. He claimed that on 18 September 2015 when he was assigned the

⁷ Transcript, page 20

⁸ Transcript, page 21

⁹ Transcript, page 21

¹⁰ Transcript, page 21

¹¹ Transcript, page 22

¹² Transcript, page 22

¹³ Transcript, page 23

¹⁴ Transcript, page 23

¹⁵ Transcript, page 25

¹⁶ Transcript, page 25

patients he noticed that they had similar names and that he asked the clinical nurse consultant, Jason Cloonan, to place stickers on the patients' respective medical records and also alerts next to the respective names on the patient journey board, which is a whiteboard kept in the nurses' station¹⁷. He also claimed that on 21 September 2015 he raised the issue again with Mr Cloonan and said that he said the same thing again¹⁸. I pause to note that on no previous occasion prior to cross-examination had he mentioned these conversations with Mr Cloonan. He also claimed that as an enrolled nurse he was not permitted to place the stickers on the whiteboard nor to place warning stickers on the patient's records.

- 3.7. Mr Csorba was asked whether he or Ms Bottger greeted Mrs Cook in some way prior to the administration of the medication. He said that Ms Bottger did not greet the patient. It was put to him that he did not greet the patient himself. He said that Mrs Cook noticed him because he had been looking after her and then he said that he normally did greet patients when he went in. He appeared to be explaining that because Mrs Cook recognised him he did not feel the need to specifically greet her. He was then questioned about the point at which Mrs Cook looked up and saw him with apparent recognition. He was asked if it was before the medication was administered and he responded that it was '*when the medication was being administered*'¹⁹. It was then put to him that he did observe the medication being administered, and although logic would suggest otherwise, he denied seeing that²⁰. It was put to him that for him to say that Mrs Cook glanced or looked at him, he must have also looked at her and noted that she appeared to recognise him²¹. He finally conceded these things²². This was the first occasion when he conceded that he had in fact looked at the patient at or about the time that the medication was given and conceded that it was an opportunity for him to realise that she was the wrong patient²³.

¹⁷ Transcript, pages 34-35

¹⁸ Transcript, page 36

¹⁹ Transcript, page 62

²⁰ Transcript, page 62

²¹ Transcript, pages 62-63

²² Transcript, page 63

²³ Transcript, page 63

- 3.8. Counsel for Ms Bottger suggested to Mr Csorba that Ms Bottger had indeed read out the UR number and the date of birth and that he had said ‘yep’. He denied these things²⁴.
- 3.9. Mr Csorba was then questioned about the matter of the hydrocortisone. It was put to him that he had drawn up a syringe of hydrocortisone in the drug room, but he denied this²⁵. It was also put to him that it was only after the hydromorphone was administered and the two nurses noted that there was no IV cannula in Mrs Cook’s arm for the purposes of administering the IV hydrocortisone, that they realised that they had the wrong patient, and he denied this also²⁶.
- 3.10. Mr Csorba was asked why he said that no hydrocortisone was drawn up when both medications were due at the one time and he responded:

‘Because you don’t do a DDA and an IV medication at the same time. I was always taught that.’²⁷

He was adamant in claiming that it would be routine for both nurses to go into the patient’s room, administer the opiate medication together and then together walk out of the room and go back to the drug room all over again and then draw up the IV drug and then go back to the patient²⁸. He said that he would not tell the registered nurse about the need to administer the IV medication until after the hydromorphone had been administered²⁹. He said that he would not tell the registered nurse about the need for an IV medication prior to the administration and delivery of the opioid medication in order to avoid ‘*medication errors*’³⁰.

- 3.11. Mr Csorba was challenged about this peculiar assertion later in his cross-examination. He was asked why the registered nurse could not be entrusted with the knowledge that there was a need for an IV drug to be administered at our about the same time as the hydromorphone on the basis that it would be natural to say to the registered nurse that the two drugs needed to be administered while they were together in the drug room and that both of the medications could have been dispensed from the drug room at that time

²⁴ Transcript, page 65

²⁵ Transcript, page 67

²⁶ Transcript, page 68

²⁷ Transcript, page 69

²⁸ Transcript, page 69

²⁹ Transcript, page 69

³⁰ Transcript, page 70

and taken simultaneously into the patient. At first he was steadfast in maintaining his initial position³¹.

- 3.12. Mr Csorba claimed that he waited in the drug room for some 20 minutes before Ms Bottger joined him there. However, he conceded that this was contrary to what he had told the AHPRA investigators³². He told them that she followed him immediately into the drug room. He then said that his memory had improved between 2016 when questioned by AHPRA and 2019 when he gave his evidence at the inquest³³.
- 3.13. Mr Csorba was asked by counsel assisting to confirm his assertion that when he and Ms Bottger entered room 26 the only things Ms Bottger had in her possession was a pill cup with a hydromorphone pill in it and that Mr Csorba himself only had the medication folder and that there was no tray and no hydrocortisone. He said that he was sure about these things³⁴. He was then taken to his second interview with AHPRA³⁵ and it was pointed out to him that he had told the AHPRA investigator that he did in fact ask Ms Bottger to draw up the hydrocortisone IV medication. When this was put to him by counsel assisting he claimed that he only asked Ms Bottger to do that after the hydromorphone had been given to Mrs Cook. The difficulty with that position was that he could not logically maintain that he had asked Ms Bottger to draw up the IV medication at that point because it was immediately after the administration of the hydromorphone that on his account the two nurses realised they had the wrong patient. It would hardly be tenable for him to maintain in those circumstances that he had then asked Ms Bottger to draw up the IV medication so that that also could be administered to the wrong patient³⁶. It was then pointed out to him that he had also told the AHPRA investigator that Ms Bottger drew up the hydrocortisone and took it into the room together with the hydromorphone³⁷, and his response was that he had told AHPRA the wrong thing³⁸. It was then pointed out to him that he must have told AHPRA a

³¹ Transcript, page 116

³² Transcript, page 122

³³ Transcript, page 122

³⁴ Transcript, page 126

³⁵ Exhibit C9h

³⁶ Transcript, page 129

³⁷ Transcript, page 129

³⁸ Transcript, pages 129-130

falsehood. Finally he conceded that Ms Bottger did indeed take the hydrocortisone into the room along with the hydromorphone pill³⁹.

- 3.14. Despite having earlier given evidence about how Mrs Cook glanced at him and he saw her doing so at or about the time she was given the hydromorphone pill, he again suggested⁴⁰ that he did not see the pill being given because he was looking at the chart while Ms Bottger, with the pill cup, had taken the pill out with her hand, put it in the patient's mouth, given the patient some water and got the patient to drink it, while all the time he was looking at the chart. After what can only really be described as an attempt to deceive the Court he finally acknowledged that he did in fact see the hydromorphone pill being put into Mrs Cook's mouth and that he failed to notice that the patient was not the correct patient, namely Mrs Cock⁴¹. It was then suggested to him that it was only when Ms Bottger went to administer the hydrocortisone but was unable to find a point of IV access on Mrs Cook's arm or elsewhere, that he and Ms Bottger realised that it was the wrong patient and he agreed⁴². However he maintained his denial that Ms Bottger had read out the identifying information from Mrs Cook's wristband and that he had acknowledged affirmatively that it was the correct patient by the use of the word 'yep', which was, as will presently be seen, the version of events proffered by Ms Bottger.

4. The evidence of Ms Bottger

- 4.1. Ms Bottger was a registered nurse employed at the Flinders Medical Centre. She had been on annual leave for the week prior to 21 September 2015 which was her first day back. Prior to that day she had not had occasion to nurse either Mrs Cook or Mrs Cock. On 21 September 2015 she was rostered on the same shift on Ward 5D as Mr Csorba. She was assigned responsibility for patients who were in beds 17 to 20. She said that at approximately midday she was asked by Mr Csorba to assist in the administration of medication to one of his patients⁴³. She said that shortly after 12 noon on that day she administered one tablet of hydromorphone to Mrs Cook⁴⁴. At approximately 12:40pm

³⁹ Transcript, pages 130-131

⁴⁰ At transcript, page 134

⁴¹ Transcript, page 136

⁴² Transcript, page 139

⁴³ Transcript, page 156

⁴⁴ Transcript, page 166

she made an entry in Mrs Cook's progress notes and at approximately 3:30pm she made a report in SLS⁴⁵.

4.2. The nursing note that Ms Bottger made was in the following terms:

'Patient given 16mg hydromorphone by mistake that was meant to be given to another patient. Patient's obs are stable and heart failure intern has been notified. Patient is confused therefore has not been notified. Jason CSC has been notified and will contact family. SLS will be attended.'

4.3. The SLS entry made by Ms Bottger was in the following terms:

'Nurse asked me to given patient's hydromorphone (sic) and hydrocortisone that was due at 1200. Nurse presented the chart with the hydrocortisone and we proceeded to get the hydromorphone (sic) from DDA cupboard. So went to side room went to glove and gown and was then told that the patient was not on precautions. The went into the room. Patient is confused so unable to confirm name and DOB. The read out the UR name and DOB from the wrist band and 2nd nurse replied "yep." So then gave the tablet to the patient who swallowed with lemonade. Then went to look for IV access and there was none. So 2nd nurse said "it must have fallen out I will have to get someone to put a new one in" so then we walked out the room and that's when nurse said we have given the tablet to the wrong patient. Shift co-ordinator and CSC were notified. 2nd nurse did a set of observations and I contacted the home team intern to let them know of the event. Home team came and reviewed patient about 1330.'

4.4. On or about 28 September 2015 Ms Bottger wrote a document setting out her version of the events of 21 September 2015⁴⁶. In that document she recorded that sometime around 12 midday Mr Csorba came to her and asked if she could help him with a patient who was due to have IV hydrocortisone and hydromorphone. She said that he walked back towards the drug room and she attended to another patient. She joined him in the drug room soon after. She said that they got the 16mg hydromorphone tablet from the cupboard and put it into a pill cup and then put the pill cup onto a white tray where the IV hydrocortisone was already placed. She said that she walked out of the drug room with the medications ahead of Mr Csorba and that she '*just happened to walk to the first room I saw which happened to be room 26*'. She said that she thought that there was a need for her to glove and gown and started to do that. After a short time it was clarified that this was not necessary. She said that they walked into the room and she had the medications and Mr Csorba had the drug chart. She said that she woke

⁴⁵ The computerised Safety Learning System, Transcript, page 174

⁴⁶ Exhibit 12c

Mrs Cook and sat her up and that she was mumbling something which Ms Bottger could not understand. Ms Bottger stated:

'That's when I would have read her name, DOB and UR number out and I remember Trafford saying "yep".'

She continued to record that reading those things from the patient's wristband was a procedure she always went through when administering medications. She said that neither she nor Mr Csorba asked Mrs Cook her name because she was confused. She said that she then went to hand the medication to Mrs Cook, but she dropped it, so in the end Ms Bottger placed the tablet into her mouth. She said that Mr Csorba handed her a bottle of lemonade to help swallow the tablet and at that point Ms Bottger looked for the IV access to give the hydrocortisone, but could not find an IV. Mr Csorba said that the IV cannula must have fallen out and that he would have to get someone to put a new one in. She said that at that point they left the room and Mr Csorba had the chart and that was when he turned to her and said '*we have given the tablet to the wrong patient*'. Ms Bottger recorded that she then said '*but didn't we just check the patient?*' and he said '*yes*'. She said that she then said '*but then how could we have got it wrong*' and she did not remember his answer.

- 4.5. Ms Bottger said that when Mr Csorba asked for her assistance he did not mention Mrs Cock's name or Mrs Cook's name, he simply mentioned the patient in room 28.
- 4.6. Ms Bottger's oral evidence in chief was consistent with the above accounts, except that she said that having played the event over and over again in her mind she was unable to say in evidence whether she did or did not check the wristband. She said she honestly could not remember either way, although she felt that she would have done it because it was her normal practice⁴⁷. As to the matter of Mr Csorba's affirmative response, she said:

'I remember Trafford saying 'yep', you know that's a recollection. So again I've gone over it, over it in my mind is it a 'yep' to that or is it a 'yep' to another question that I might have asked him that I can't remember that I've asked him. So I just don't know.'⁴⁸

- 4.7. Ms Bottger maintained the position as summarised above throughout her cross-examination. It was to her credit that she was prepared to admit that she could not be certain at the time of giving evidence that she had indeed read out the identification

⁴⁷ Transcript, page 165

⁴⁸ Transcript, page 166

information from the wristband. By contrast, I regard Mr Csorba's evidence with grave reservation. There were multiple inconsistencies in his account and his version of events changed. Under the pressure of cross-examination he conceded that his earlier evidence was false.

- 4.8. In addition to Mr Csorba and Ms Bottger I heard evidence from other nursing staff including Ms Pawlikowski and Mr Cloonan. From their evidence it was apparent that there were other respects in which Mr Csorba's evidence should not be relied upon. For example, his evidence that he had discussions with Mr Cloonan about the use of red alert stickers on the whiteboard and the patient records was flatly denied by Mr Cloonan. Mr Cloonan made it plain that these were conversations that he would absolutely remember if they had occurred and he was adamant that they did not⁴⁹. I have no hesitation in accepting Mr Cloonan's evidence in preference to that of Mr Csorba.
- 4.9. While I am dealing with Mr Cloonan's evidence it should be mentioned that he was asked whether Mr Csorba or Ms Bottger indicated to him how the mistake had occurred when describing the episode to him. He said they did not explain how the mistake had occurred in detail, but merely said that they had given the medication to the wrong patient⁵⁰.
- 4.10. I think it is significant that Mr Csorba did not make any positive assertion in the aftermath of the episode that Ms Bottger had not read out the patient details before administering the hydromorphone pill to Mrs Cook. That he did not do so is apparent from the evidence of Ms Bottger⁵¹, from the evidence of Ms Pawlikowski⁵², from the evidence of Mr Cloonan⁵³ and from an affidavit given by registered nurse Anthea Way⁵⁴. I accept the submission of counsel for Ms Bottger that if Mr Csorba honestly held the belief as at 21 September 2015 that Ms Bottger did not read out Mrs Cook's details from the wristband he had a number of opportunities to put that on record, but he failed to do so. The evidence is clear that he had a confrontation in the aftermath of the incident with registered nurse Anthea Way in which she recalled him stating that there were two patients with similar names⁵⁵. She must have assumed that he was

⁴⁹ Transcript, pages 271-272

⁵⁰ Transcript, page 265

⁵¹ Transcript, page 171

⁵² Transcript, page 224

⁵³ Transcript, page 265

⁵⁴ Exhibit C15, paragraph 11

⁵⁵ Exhibit C15, paragraph 10

proffering the similarity of the names as some reason for the medication error because she stated:

'I recall saying to Trafford that I said that there was no excuse and that it should not have happened as the patient details were read out to him. I cannot recall what he said but I do not recall him saying that the details were not read out to him and I would recall something like that.'⁵⁶

In my opinion it would have been highly likely that Mr Csorba would have expressed his disagreement with what was effectively an accusation being levelled at him by Ms Way at that time. If in fact the patient details had not been read out to him it beggars belief that he would not have made that point in response to Ms Way's accusation. Furthermore, as I have said, he failed to point it out to either Ms Pawlikowski or Mr Cloonan.

4.11. Mr Csorba did not make any written record of the event in the immediate or medium aftermath. He was aware that an SLS report was made and he certainly became aware of its contents within a reasonably short time. Those contents, as quoted above, explicitly say that Ms Bottger read out the identifying information and that Mr Csorba replied affirmatively. Mr Csorba claimed not to be aware that he himself could make an SLS entry. The fact of the matter is that he could have done so, and he could have advanced his contention if he genuinely held it at the time that Ms Bottger never uttered the patient identification details from the wristband. It beggars belief that he would not have taken that opportunity either by making an SLS incident report or by making a record to that effect in the patient notes, or at the very least, by making a written record in the immediate aftermath or sometime in the ensuing weeks. He did none of those things and waited until much later before he first mentioned his contention that Ms Bottger never read out the patient identifying information.

4.12. His basic version of events, namely that he was preoccupied with looking at the drug chart to establish the patient's name and identification details for a protracted period during which Ms Bottger had the opportunity to actually administer the pill to the patient and get her to swallow it with a drink is inherently unlikely. It collapsed in his evidence in this Court when he admitted that he had made eye contact with Mrs Cook and that he had appreciated that she recognised him. His assertion that the

⁵⁶ Exhibit C15, paragraph 11

hydrocortisone drug was not brought in simultaneously with the hydromorphone, coupled with his inherently improbable but stubborn insistence that he would never entrust the information that an IV drug was required until after the registered nurse had administered the hydromorphone meant that he simply could not explain how he had come to admit to AHPRA that the hydrocortisone was present in the patient's room with him and Ms Bottger. That was consistent with Ms Bottger's version of events, namely that the hydrocortisone was present in the room and that it was only after IV access could not be found on the patient that they realised the error. I infer that Mr Csorba was trying to discredit Ms Bottger's version of events, and hence his position that the hydrocortisone did not come into the room with the hydromorphone. In any event, his explanation that it was standard practice to only tell the second nurse about the need for a further intravenous drug after the administration of the opioid medication, together with its inherent inefficiencies and implausibility, was not supported by any other witness. I reject his evidence on that point, as with so many others, as self-serving.

5. Conclusion on the reason for the medication error

- 5.1. Having regard to Ms Bottger's uncertainty about whether she did or did not read out the information from the wristband, it is tempting to suggest that the evidence does not permit a finding that she did indeed do so and that Mr Csorba responded with the word 'yep'. However, in her earliest accounts of the event Ms Bottger was more confident that she had indeed read out the patient identification. Her gradual development of doubt about whether she did or did not is understandable. The process of reading out the identification information from a wristband is the sort of routine act that a nurse would perform many times each day, and hundreds if not thousands of times over a period of, say, a year. It is the sort of action that might be performed automatically without a conscious realisation that it has been done on one particular occasion. It is in a similar category to the hesitation one might experience about whether the iron was turned off on leaving the house. Ms Bottger was an inherently honest witness who was prepared to admit that she had a doubt. In my opinion, the acceptance by her that she cannot now be certain, does not detract from her evidence about her usual practice that she always reads out the wristband information when performing that part in the process

of administering medication. She certainly was firm and unwavering in her evidence that that was her usual practice.

- 5.2. On the other hand, Mr Csorba's evidence was self-serving and unsatisfactory in so many ways that no reliance can be placed upon it. Having given the matter careful consideration I am satisfied that Ms Bottger did indeed read out the patient details. It would appear that Mr Csorba was not paying attention and permitted the drug administration to occur. It is apparent also that he observed the pill being administered to Mrs Cook who, had he been concentrating, he would have identified as the wrong patient, having nursed both Mrs Cook and Mrs Cock that morning. Certainly the patients were quite different in their presentation and the differences ought to have been apparent to him. If he had been paying proper attention he would immediately have recognised Mrs Cook was not Mrs Cock. It is consistent with that state of inattention that he would also have failed to listen carefully to the identification as read out from the wristband. That, in summary, is my finding as to the explanation for the medication error in this instance.

6. The evidence of Professor Cade

- 6.1. The Court obtained an expert report from Professor Cade in this matter. Professor Cade is Emeritus Specialist in Intensive Care at the Royal Melbourne Hospital and a Professorial Fellow at the University of Melbourne. His expertise was accepted, and properly so, by all counsel and I have no hesitation in regarding him as an expert in respect of the evidence he gave.
- 6.2. It was absolutely clear from Professor Cade's evidence that the medication error materially shortened Mrs Cook's life expectancy. Professor Cade stated as to the contraindicators for the administration of hydromorphone to Mrs Cook as follows:

'Q. Is hydromorphone used for elderly patients.

A. That's one of the contraindications for hydromorphone. There are five reasons why it wouldn't be given in a case such as this, you've alluded to one of them, that's an opiate naïve patient. You wouldn't give it to somebody who didn't have pain, wouldn't give it to somebody with liver impairment, you wouldn't give it to a frail elderly patient and you wouldn't give it in error.'⁵⁷

⁵⁷ Transcript, page 247

6.3. Professor Cade said that the medication error would have shortened Mrs Cook's life expectancy and said that 16mg of hydromorphone would have '*flattened her*'. It is no coincidence that her health dramatically deteriorated in the hours following the administration of the hydromorphone.

7. Recommendations

7.1. I have no recommendations to make in this case. Counsel for the State of South Australia tendered relevant policies and procedures regarding procedures for the avoidance of medication errors. There is nothing defective about those policies and procedures. The fact is that with the best policies and procedures in the world, human error can still produce an adverse outcome and that is what occurred on this occasion. No recommendation could prevent human error of the kind described above.

Key Words: Hospital Treatment; Inattention; Incorrect Medication

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 21st day of June, 2019.

State Coroner