QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Walter HEDGES**
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FINDINGS OF:	Mr Michael Barnes, State Coroner
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REPRESENTATION:

Counsel Assisting:	Sergeant Jennifer Jacobsen
Greenslopes Private Hospital:	Ms Jennifer Rosengren
Ms Cornelia Empen:	Mr John Allen

Findings into the death of John Walter Hedges

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The Coroners Act 1958 provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of John Walter Hedges.

Introduction

On 23 March 2002 Mr Hedges was a patient of the Greenslopes Private Hospital. He had extensive and advanced malignancy in his vertebra, stomach, pancreas, ribs and lung. He was not expected to live long and was receiving only palliative care.

About 4pm on that day, he asked for and was given morphine for pain relief. He was given an overdose. He died shortly afterwards.

These findings seek to explain how the death occurred, determine whether any person should be charged with a criminal offence in connection with the death and consider whether any changes to the hospital's procedures are necessary to reduce the likelihood of similar deaths occurring.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Although the inquest was held in 2005 and 2006, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the hospital staff recognised that the death of Mr Hedges was unnatural or suspicious within the terms of s7(1)(a)(i)(iii) of the Act, they reported the death to police who were obliged by s12(1) to report it to a coroner. Section 7(1) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred, and

- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial, where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations[2], referred to as "*riders*", but prohibits findings being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted in a criminal trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)
[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation into the death.

The police officers who received the report of Mr Hedges' death attended at the hospital and arranged for his body to be transported to the John Tong Centre where an autopsy was subsequently conducted. They also sent the hospital records with Mr Hedges body to assist the forensic pathologists better understand the treatment he had been receiving.

Scenes of crime officers and detectives attended at the hospital and undertook interviews with all of the relevant witnesses including the nurse who administered the morphine to Mr Hedges immediately prior to his death.

The inquest

Sergeant Jen Jacobson was appointed to assist me. The operators of the Greenslopes Private Hospital (the GPH) were granted leave to appear as was Cornelia Empin, the nurse who administered the dose of morphine immediately prior to his death. The family of Mr Hedges was not separately represented but they consulted with those assisting me before and throughout the inquest.

The inquest commenced on 14 April 2005 and evidence was given on that day and the next and also on 30 May. There was then a considerable delay while the parties sought to finalise submissions and obtain extra material. Oral submissions were finally heard on 8 May 2006. Eight witnesses were called to give oral evidence and 38 exhibits were tendered.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

Background

Mr Hedges was 76 years of age at the time of his death. He was a RAAF veteran and former truck driver. He started smoking when he enlisted at 18 and smoked heavily for the next 50 years. He stopped smoking in about 1998.[9]

Medical history

His medical history included severe emphysema, hypertension, a total hip replacement, a tonsillectomy, hernia repairs, pneumonia and cancer of the bladder.[10]

As a result of Mr Hedges suffering persistent and severe back pain in 2001, he was admitted to the Greenslopes Private Hospital for investigations.

An MRI scan established that the back pain was the result of metastatic malignancy with destructive bony lesions of the vertebrae T5, T6 and T7. A CT scan also suggested a lesion on the right kidney and an ultrasound of the kidneys strongly suggested a neoplastic lesion. It was assumed the kidneys were the primary site - the location where the cancer commenced.[11]

The results of a biopsy on vertebra T5 showed a poorly differentiated malignancy with a pattern of staining compatible with the number of primary sites such as the stomach, biliary tree, lung or urothelial carcinoma.[12]

A bone scan indicated “hot spots” in the posterior seventh rib on the right. There was also concern about potential cord compression. Mr Hedges was assessed as a fairly poor operative risk and he hadn’t proceeded to spinal stabilisation.[13]

These investigations established that Mr Hedges’ condition was almost certainly terminal and that the most that could be achieved was management of his pain. His life expectancy was difficult to estimate but Dr Kay Lane, a pain management specialist, gave evidence that in her opinion in November 2001 Mr Hedges could only expect to live for another three months.[14]

Mr Hedges underwent palliative radiotherapy at the Wesley Cancer Care Centre between 15 and 21 November 2001. The radiotherapy covered a field from T4 to T8 and the adjacent ribs.[15]

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[9] Letter – Dr Allan Finnimore dated 27 July 2001 – Correspondence section medical records – part 2

[10] Letter – Dr Allan Finnimore dated 27 July 2001 – Correspondence section medical records – part 2

[11] Letter – Dr Barry Hickey dated 17 December 2001 - Correspondence section medical records – part 2

[12] Letter – Dr Barry Hickey dated 17 December 2001 - Correspondence section medical records – part 2

[13] Letter – Dr Allan Finnimore dated 20 November 2001 - Correspondence section medical records – part 2

[14] Transcript 171:44

[15] Letter – Marie Burke dated 21 November 2001 - Correspondence section medical records – part 2

The palliative radiotherapy was reported to have had a good result in that his pain could be controlled with MS Contin. However Dr Lane proposed that an intra-thecal catheter be inserted for pain relief if the radiotherapy didn't provide long term relief of his discomfort.[16]

Mr Hedges was encouraged to go home to be cared for by his long term partner and sister for as long as possible with a further option of readmission to GPH and eventually Mt Olivet.[17] He was discharged on 18 December 2001. Throughout the rest of December and most of January 2002 Mr Hedges condition was managed as well as could be expected by his family at home.

The final admission to GPH

On 23 January 2002 Mr Hedges presented at the GPH emergency centre. He reported a significant deterioration of his condition and increased pain which could not be adequately controlled with the analgesics available to him. He was subsequently admitted to ward 33 bed 25.

His General Care Plan (GCP) on the day of admission records the Mr Hedges was independently mobile, needed assistance with his hygiene only *"as required,"* and was able to eat a full diet. His mental state was described as alert and orientated and he was continent.

However, by 26 January 2002 Mr Hedges required assistance with his mobility (he was a noted falls risk), hygiene and nutrition and his mental state was alert and orientated although anxious.

On 1 February after a discussion between Nr Hedges' pain management team and his family his file was marked "*NFR*" – not for resuscitation – meaning that it was accepted that his death was imminent and that no invasive therapies should be implemented in an attempt to resuscitate Mr Hedges should he suffer a cardiac or respiratory collapse. This order was confirmed on 15 March.

By 2 February 2002 Mr Hedges had declined to the stage where he required a wheely walker with oxygen to be mobile, assistance with his nutrition which by then comprised a soft diet with thick fluids and his mental state was recorded as "*confused.*"

On 6 February 2002 an intra-thecal catheter was inserted to allow continuous and very gradual delivery of morphine to the cerebrospinal fluid in the intra-thecal space. Sufficient drug for 24 or 48 hours could be loaded into a Graseby pump that would deliver the medication at constant or variable flow rates allowing the clinicians to adjust the doses, minimizing patient discomfort. The pump was able to be programmed to deliver different doses at various times of the day to meet the patients' changing needs. A line connected the pump to a port-a-cath, a reservoir set under the skin of the patient. A line from the port-a-cath, embedded under the

[16] Letter – Dr Barry Hickey dated 17 December 2001 - Correspondence section medical records – part 2

[17] Letter – Dr Barry Hickey dated 17 December 2001 - Correspondence section medical records – part 2

skin, connected the port-a-cath to a catheter at the site at which the drug was to be administered; in this case the intra-thecal space.

By mid February 2002, Mr Hedges required assistance to stand and a wheely walker to assist mobility. He also continued to require assistance with sponge for hygiene and/or shower on a chair, incontinence pads and pants 24 hours a day and a catheter inserted for drainage of urine. At this time he was placed into isolation due to bacteria in his sputum. Mr Hedges remained in an isolation ward until his death. Because of the infection risk, whenever anybody attended on him they were required to a don gown and a mask to minimise the risk of contaminating others.

By 4 March 2002, Mr Hedges required full assistance with his hygiene and was only mobile for short periods and with active assistance. During this time Mr Hedges' mental state varied from "*alert and orientated*" to "*confused*" or "*vague.*"

By 7 March 2002, Mr Hedges was so ill that he could not be taken out of bed, he was being fed with fluids and a pureed diet and required full assistance with hygiene and toilet requirements.

Mr Hedges' pain management regime in his final days.

For the final month of so of his life, Mr Hedges had two sites for the administration of morphine. One was the intrathecal catheter described earlier which was serviced by the port-a-cath located on the right side of his abdomen. A Y shaped adapter was attached to about 100 mm of clear plastic tubing that ran external from the port-a-cath. From one prong of the adapter, a line of tubing ran to a Graseby pump. The second port or prong had a bung at the end into which a syringe could be inserted. However this side port was superfluous as Mr Hedges was not receiving anything via the port-a-cath other than the medication being fed through the Graseby pump. The port-a-cath was under the skin on the right hand side of Mr Hedges' abdomen.

In addition Mr Hedges could receive morphine via a subcutaneous catheter if his pain was not sufficiently controlled by the drug administered via the intrathecal route. The catheter removed the need for Mr Hedges to receive an injection into his skin every time he required break through pain relief, by enabling the nursing staff to inject the morphine into a bung in a similar Y shaped adaptor as that connected to the port-a-cath. The subcutaneous site was located on the left of Mr Hedges' abdomen.

The intra-thecal port-a-cath and the subcutaneous catheter were about 10 to 15 centimetres apart. Both had clear, two pronged or Y shaped adapters at the distal ends of a short tube. The port-a-cath adapter had a line running from one of its prongs to the Gaseby pump while the subcutaneous adapter had bungs in both prongs. Neither was labelled.

By 18 March 2002, Mr Hedges was receiving a 2.2mg intrathecal infusion of morphine over a 48 hour period and 10mg morphine subcutaneously as required.

On the days before his death, Mr Hedges' break through pain was so severe that he was receiving up 70mg of morphine subcutaneously a day.

Nurse Empen works at GPH

Cornelia Empen is a nurse who, in 2002 had been registered for a little over seven years. For much of that time she worked at the Holy Spirit Hospital in an oncology ward. She holds a bachelor of nursing degree and a post graduate certificate in palliative care.

In March 2002, Nurse Empen was working for an agency that supplied nurses to Greenslopes Private Hospital and she had, prior to the day of Mr Hedges' death, worked three shifts at the hospital.

She received minimal orientation or familiarisation with the hospital's policies or practices. It was assumed that because she was an experienced nurse no more was needed.

On 23 March 2002 she worked for the first time in ward 33 where Mr Hedges was a patient. She commenced her shift at 2.30 in the afternoon and was given a brief tour of the ward before getting a handover in relation to the three patients that were to be under her care. The handover consisted of the nurses coming on duty listening to a tape recorded message from the nurses who had just completed their shift describing the condition and nursing needs of the patients they had been caring for.

The shift team leader or clinical nurse consultant for ward 33 on that day, Nurse Jefferies, gave evidence that the nurse who had recorded the information in relation to Mr Hedges had a foreign accent that made it difficult to understand her. Therefore Nurse Jefferies stopped the tape at the point where it recorded information about Mr Hedges' pain relief equipment to make sure that those involved in his care were aware that he had an intrathecal line in place. She is sure, and Nurse Empen acknowledges, that Nurse Empen was aware of this situation. The tape was played in these proceedings and I am satisfied that the pain management system being employed to assist Mr Hedges was adequately described.

Nurse Empen attends to Mr Hedges

After the hand over, Nurse Empen went to see the three patients she was to be primarily responsible for. She said she read their charts and spoke to them. She said that during the first visit to Mr Hedges bedside she checked that his intrathecal machine was functioning. A blinking light confirmed it was. At 4.00pm, she measured the pump's contents to reassure herself that it was administering morphine at the ordered rate and she also asked Mr Hedges if he needed more pain relief. He indicated that he did.

In response, Nurse Empen went to the dangerous drugs room and with the assistance of Nurse Burston, she drew up 10 mgs of morphine into a syringe and they jointly signed the necessary paper work to verify that this had been done and checked by both. The drug was signed out at 4.00pm.

Both then went to the door of Mr Hedges' room. Nurse Empen put on the necessary gown and gloves and entered the room. In accordance with standard nursing practice, Greenslopes Hospital policies required both nurses to go the bedside to ensure that the drug was administered to the intended patient and given via the right route. Nurse Burston accomplished the first of these objectives by identifying Mr Hedges from the doorway of his room but she then left to attend to other duties.

Nurse Empen says that she went up to Mr Hedges and in accordance with appropriate practice aimed at maintaining the patient's dignity she did not lift his clothes to expose both infusion sites but rather took hold of a Y shaped adapter, or as she called it, "an intima", that appeared to her to be of the type usually attached to a subcutaneous catheter and injected half of the 10mgs of morphine into it. As she was doing this she felt a hard object under her hand and moved the gown to reveal the subcutaneous catheter. As a result of seeing that, she immediately realised that the side port she was injecting into was connected to the intrathecal port-a-cath. This meant that Mr Hedges received a bolus dose of 5mg of morphine into his intrathecal space when he was supposed to be receiving only 0.1mg per hour. Nurse Empen says that she gave the morphine to Mr Hedges at about 4.10pm

Reaction to the overdose

As soon as she realised what she had done, Nurse Empen knew that she had made a serious mistake and she says she panicked. For reasons she could not explain, she then injected the 5 mgs remaining in the syringe into the subcutaneous port, even though she knew she had already given Mr Hedges too much morphine via the wrong route.

She saw that immediately after this, Mr Hedges looked worse than before the injection. He was not responding to her questions in the same way as before the injection and he felt "*a bit cold*". She left the room and told Nurse Burston what she had done.

Both nurses then returned to Mr Hedges and Nurse Burston stayed with him while Nurse Empen went to advise the team leader and to get some Narcan in an attempt to counteract the effects of the morphine.

This was not immediately available as none had been previously ordered and the duty medical officer was not sure how much Narcan to order to counter act the effects of such a large dose of morphine that had been administered via the intrathecal route. A pain management doctor was therefore consulted and he gave the necessary advice and authority to administer 0.1mg of Narcan as often as required.

This was then administered by the pain management doctor in the presence of the three nurses. 0.1mg was given four times at one minute intervals. It produced no improvement in Mr Hedges' respiratory rate. His breathing continued to slow and he became unresponsive. His pallor was described as grey. The doctor therefore ordered that a further 0.4 mg dose be given, but it too failed to result in any

improvement in Mr Hedges' condition and he died shortly thereafter. The first dose of Narcan is recorded as having been given at 4.25pm and the last at 4.35pm.

The duty hospital co-ordinator was contacted as were all other relevant senior hospital managers and clinicians. The scene was appropriately preserved. The family of Mr Hedges were advised and the police were called. Detectives attended at about 9.00pm. They interviewed those involved in Mr Hedges' care including Nurse Empen who was given appropriate warnings about her right to silence and her right to seek legal advice. She chose to give a full and detailed interview and participated in a "walk through" that was video taped. Having viewed the tape I formed the impression that she was an honest and frank witness who was distressed and remorseful for her contribution to Mr Hedges' death.

Expert medical evidence

On 25 March 2002, an autopsy was conducted on the body of Mr Hedges by Dr Charles Naylor, an experienced forensic pathologist. He found that Mr Hedges was suffering from advanced malignant disease in many of his organs and bones. He also had severe emphysema. Dr Naylor opined that these diseases could have killed him at any time and were sufficient to account for his death at the time he died, although, in evidence, Dr Naylor said that he had not positively identified a terminal event or condition connecting the cancers to Mr Hedges' death. On the other hand he advised the court that it is not unusual for people to die of cancer and for the precise site or terminal effect of the cancer not be discoverable at autopsy.

Analysis of Mr Hedges' blood found a total morphine level of 0.85 mg/kg. Dr Naylor expressed the view that this level was near the middle of the fatal range but cautioned that "*such levels are not uncommon in patients with terminal malignancy who are on high continuous doses of morphine and in whom a degree of tolerance has developed*." Nevertheless, in view of the death occurring so soon after the overdose of morphine, Dr Naylor was of the view that the circumstances "*suggest at least a contribution from morphine toxicity."*

In his autopsy report, Dr Naylor listed the primary cause of death as *"carcinomatosis* (the widespread of cancer throughout the body) *and possible morphine toxicity."*

A report was also sought and received from a forensic toxicologist, Dr Olaf Drummer. He confirmed Dr Naylor's opinion that a tolerance develops in patients repeatedly receiving morphine which means that such patients can safely receive doses that would otherwise be fatal. There is no way to assess the degree of the tolerance that Mr Hedges may have developed, although the very high doses he was receiving in the days leading up to his death demonstrate that it was significant.

Accordingly, there is no blood concentration that is definitively therapeutic or toxic, that is, it can not be established with certainty what dose would necessarily be toxic and cause Mr Hedges to die.

However, Dr Drummer also advised that morphine is a particularly dangerous drug when used to excess and that is can rapidly lead to a narcotic sleep and coma. He advised that the mechanism of death would be the cessation of breathing.

In relation to the final dose given to Mr Hedges and its effect, Dr Drummer said this:-

> "*An intrathecal bolus of 5mg of morphine is far beyond that normally administered by this route as a single dose and would be expected to cause an immediate adverse effect on breathing and cardio vascular function.*
>
> *The rapid decline in respiration and ultimately his death are therefore consistent with the expected reaction to this dose given by the intrathecal route. However it is conceivable that other events contributed to his death."*

When he gave evidence Dr Drummer said "*It's hard to be certain that the morphine necessarily killed Mr Hedges. It may well have - and it possibly contributed to his death …"* And later in his evidence he says *"its hard to sort of be totally emphatic that the morphine was the final cause of his death."*

When he gave evidence, Dr Naylor was shown Dr Drummer's report which led him to consider that it was likely that the morphine overdose contributed to the death of Mr Hedges. He agreed with the suggestion that it was likely that had he not been given the overdose, Mr Hedges would not have died when he did.

Both experts stressed that Mr Hedges was terminally ill, near death when the overdose was given and that it was therefore impossible to rule out the possibility that one of his various co-morbidities or a combination of them caused the death. However both also accepted that having regard to the temporal connection between the overdose and the death and the symptoms observed after the morphine was given, it was likely that the morphine caused or at least contributed to the death.

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death.

As a result of considering all of the material contained in the exhibits and the evidence given by the witness I am able to make the following findings.

Identity of the deceased – The deceased was John Walter Hedges.

Place of death – He died at the Greenslopes Private Hospital, Greenslopes in Brisbane

Date of death – He died on 23 March 2002.

Cause of death – The cause of death was morphine toxicity and carcinomatosis.

The committal question

In addition to the findings concerning the particulars of the death that I have just pronounced, I am also required by s43(2)(b) of the Act to find whether anyone should be charged with murder or manslaughter as a result of the death.

It is not my role as Coroner to decide whether Nurse Empen is guilty of an offence in connection with the death of Mr Hedges or indeed, even whether the prosecutorial discretion should be exercised in favour of continuing with criminal processes by bringing the matter before a jury. Rather, I have to determine whether she should be committed for trial. That requires I consider whether a properly instructed jury *could,* on all of the evidence presented at the inquest reasonably convict her of an offence.[18]

The Criminal Code provisions concerning deaths in a medical setting

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 293 provides that any person who causes the death of another is deemed to have killed that person.

Section 296 deems that a person who does an act which hastens the death of another to have killed that person, even if the deceased person was labouring under some other disease or disorder.

Section 300 *Criminal Code* states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case."*

Insofar as is relevant to this case s302 defines murder as an unlawful killing where the offender intends to kill or do grievous bodily harm.

Section 303 provides that any person who unlawfully kills another in circumstances which do not constitute murder is guilty of manslaughter.

There is no evidence indicating that Ms Empen intended to cause Mr Hedges' death or to do him grievous bodily harm. On the contrary, when she gave him the morphine overdose she was motivated by a desire to ease his pain and made a mistake. The offence of murder therefore need not be considered further.

Therefore the only offence that needs to be considered is manslaughter by way of criminal negligence.

Section 288 of the Criminal Code needs to be considered when addressing that question. In so far as is relevant to this case it provides:-

[18] see *Short v Davey* [1980]Qd R 412

> *It is the duty of every person who…undertakes to administer surgical or medical treatment to any other person,… to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.*

In my view the effect of the statutory provisions I have referred to is that before a jury could convict Nurse Empen of the manslaughter of Mr Hedges the prosecution would need to satisfy them to the requisite standard of the following elements:-

1. by injecting the morphine into the intra-thecal port Nurse Empen failed to use reasonable care within the terms of s288, and

2. the injecting of the morphine into that port caused the death.

I shall now deal with each of those issues, but in reverse order.

Did the overdose cause or accelerate the death?

I found, for the purposes of s43, that morphine toxicity was the dominant cause of death but I was not required to be persuaded of the veracity or accuracy of that conclusion to the criminal standard of beyond reasonable doubt. Further, that finding is binding on no-one, even though it accorded with the opinion of the eminent experts who gave evidence in the matter. Neither my finding nor the opinion of the experts would bind a jury; they must make their own decision based on the evidence presented at trial if one is held. However, I am satisfied, that in view of the conclusion I reached as to the cause of death and the evidence on which I relied when reaching it, a properly instructed jury could be satisfied to the necessary standard without that decision being unreasonable. I am re-enforced in that view by the provisions of s296 concerning liability for hastening death, which mean that Mr Hedges' imminent death from cancer would not exculpate Nurse Empen.

Could Nurse Empem's conduct amount to criminal negligence?

There is no doubt that in choosing to inject Mr Hedges with morphine Nurse Empen is administering medical treatment and so she is required to have reasonable skill: the evidence of her qualifications and work history established that she does. She is also required to use reasonable care.

On their face, the words of s288 are redolent of civil negligence – *reasonable care, breach of duty* - but the courts have consistently, and understandably, held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress. The classic judicial articulation of this difference is found in *R v Bateman* [19] where Hewart LCJ said:-

> *In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime,*

[19] *R v Bateman* (1925) 94 LJKB 791; [1925] All ER Rep 45; (1925) 19 Cr App R 8

> *judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and* ***showed such disregard for the life and safety of others as to amount to a crime against the State*** *and conduct deserving punishment … It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (emphasis added)*

In *Taktak' case,*[20] Yeldham J examined some of the common law criminal negligence cases concerning a duty to provide medical assistance but focused mostly on the circumstances in which that duty arises – an aspect of the crime which is not in issue here. When considering whether negligence is sufficiently serious to amount to criminal negligence his honour quoted passages indicating that "*a very high degree of negligence*" is necessary, and "*indifference to an obvious risk*". Citing a passage from *Stone*[21] his honour indicated that the prosecution had to convince the jury that the defendant had a reckless disregard to the danger and that mere inadvertence would not be enough. In Taktak's case the accused did not seek medial assistance for a 15 year old girl as she lay on a bed under his watch and died of a heroin overdose. In deciding that Mr Taktak could not be held to have been guilty of such a serious departure from appropriate standards as to amount to criminal negligence, his honour referred to the short period of time over which the accused failed to seek medical attention – an hour or so - and his ignorance of the deceased's condition and the available remedies.

Another useful examination of the authorities and a formula or test for criminal negligence is contained in *Nydam v The Queen*[22]*,* a Victorian case which has recently been affirmed by the High Court in *R v Lavendar*.[23] In *Nydam*, the court said that to amount to criminal negligence the act causing death must have involved such a great falling short of the standard of care which a reasonable person would have exercised in the circumstances and which involved such a high risk of serious harm that the act merited punishment. Unfortunately the decision gives little guidance on how the magnitude of the lack of care is to be gauged. It may also be thought to be somewhat circular to suggest conduct amounts to a crime if it deserves a criminal sanction.

In a useful analysis of the relevant principles, Professor Yeo and Ms Callahan[24] suggest that the different functions served by the criminal law as distinct from the civil law have resulted in the courts requiring quite different degrees of negligence before a breach of the former can be proven. Those authors contend that in civil

[20] (1988) 34 A Crim R 334
[21] [1977] QB 354 at 481
[22] [1997] VR 430
[23] [2005] HCA 37
[24] Callahan R, Yeo S, *Negligence in medical manslaughter cases,*(1999) 6 Journal of law and medicine, 253

cases, any falling below the standard reasonably expected will found liability if it can be shown to be sufficiently connected with the harm sued for. In criminal cases however, the amount and degree of negligence determine whether a crime can be made out.[25]

The greatest difficulty remains identifying that degree. Indeed it was suggested as long ago as 1866 that criminal negligence is impossible to define and the distinction between civil and criminal negligence can only be gauged by looking at actual judicial examples.[26]

One such example that seems pertinent to this case is *R v Adomoko* in which the House of Lords upheld a conviction for manslaughter of an anaesthetist who failed to notice for six minutes that the oxygen supply to an anaesthetised patent had become disconnected.[27]

In this case it is clear that the act in question involved a risk of the most serious harm if done negligently as Mr Hedges' death demonstrates. Therefore a high standard of care can be expected.

There is ample evidence that the conduct of Nurse Empen fell short of the standard of care that a reasonable person in her position could be expected to exercise. Among the "5 rights" that are nursing mantra and part of GPH policy, is the requirement for two nurses to check that the drug is administered by the correct route. Nurse Empen did not insist on Nurse Burston accompanying her to the bedside and did not herself sufficiently check that she was administering the drug via the correct route.

The only issue then is whether the departure from this standard of care was of such magnitude as to amount to gross negligence such as would warrant societal condemnation and punishment. When considering this aspect of the matter it is not relevant to consider the consequences of the negligence – that has already been taken into account when setting the standard of care. What must be considered here is the degree of departure from it.

There is no evidence that Nurse Empen had too little regard for the wellbeing of Mr Hedges. She did not foresee the risk and none the less choose to chance it. Nurse Empen saw a port that looked very similar to the one she needed to inject the morphine into and assumed it was the correct one. The lines were not labelled. She knew that Mr Hedges had two infusion sites but assumed that she had hold of the port to the subcutaneous site without sufficiently checking. She says that she had never come across a port-a-cath in the position that this one was embedded in Mr Hedges and as a result of flawed hospital procedures, she was not given an adequate opportunity to familiarise herself with Mr Hedges' precise situation. Her immediate acknowledgment of her error does not of in itself necessarily mean that her carelessness could not be sufficiently serious to amount to criminal negligence, but her seeking of the antidote Narcan, even though it meant exposing her

[25] ib id p257
[26] R v Noakes (1866) 4 F & F 921 quoted by Callahan *et al, ib id,* at 258
[27] [1994] 3 All ER 79

mistake, supports the notion that Nurse Empen was not disregarding of the effect of her actions on Mr Hedges.

Although her actions were clearly poor practice, in view of the ease with which the mistake could be made and having regard to the short duration of her departure from the expected standard of care, I consider Nurse Empen's conduct can better be described as inadvertence rather than reckless disregard and that it would be unreasonable for a jury to conclude otherwise. Accordingly, I find that no one should be committed to stand trial in connection with the death.

I am aware that the Queensland Nursing Council is investigating the conduct of Nurse Empen. That would seem to me the more appropriate forum in which to address the shortcomings she displayed on the day in question.

Mr Allen for Nurse Empen also submitted that his client would be entitled to rely on a defence of mistake of fact under s24 of the Criminal Code. If I understood it correctly, his submission was to the effect that if Nurse Empen did an act - the injecting of the morphine - under and honest and reasonable but mistaken belief in the existence of a state of things - that she was injecting it into the subcutaneous line - she could not be held criminally responsible for the act to any greater extent than if things were as she believed - in which case she would have done no harm.

In support of this submission Mr Allen cited the Western Australian case of *R v Pacino* in which the Court of Criminal Appeal in that state held that a person charged with causing death by failing to use reasonable care to control four dangerous dogs could rely on s24 if he reasonably believed that the dogs weren't dangerous.[28] With all due respect to Mr Allen I don't believe that case has application to this situation. If I had found that the drug was injected into the wrong site due to a reckless lack of care to ensure the correct site was accessed, I can't see how I could also find that the mistake was reasonable. Applying the same reasoning to Pacino's case, that accused couldn't rely on s24 to say that he reasonably but mistakenly thought the dogs were safely confined if the Crown had proven that he had been grossly negligent in relation to the confinement. One can't be grossly reckless and **reasonably** mistaken about the same thing. However, in view of my finding earlier finding in relation to the principle issue, nothing now turns on that.

Issues of concern and recommendations

Pursuant to s43(5) of the Act I am authorised to make riders or recommendations designed to reduce the occurrence of similar deaths to the one investigated by this inquest. There are a number of issues of concern raised by the circumstances of this matter that suggest systemic failings contributed to the death. It is alarming that some of them were allowed to prevail. However the submission made by counsel for the hospital indicates that they have all been addressed.

For example:-

[28] WA CCA 14 & 15 of 1998

- In the weeks following Mr Hedges' death, the nurses attended a series of meetings in which the departures from proper procedures were discussed and the consequences highlighted.

- The circumstances of Mr Hedges' death have been incorporated in a case study that is part of the GPH continuing education program.

- A process of auditing compliance with hospital policies has been implemented.

- A policy of labelling intrathecal lines has been adopted and the use of lines with side ports has been stopped.

- Safety alert cards attached to pumps are now used to remind staff of the existence of an intrathecal line.

- Bedside handovers have been mandated.

- Narcan is now available on all emergency trolleys in the hospital.

- Procedures for orientating agency staff and the staff continuing development program have been reviewed and improved.

I consider that the hospital management has accurately identified the systemic issues that may have contributed to the death and I do not believe that I am in a position to recommend any further changes.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
15 June 2006