



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 004362

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Alan Gordon Wolstenholme
Date of birth:	30 June 1952
Date of death:	29 July 2024
Cause of death:	1(a) Complications of suspected upper gastrointestinal tract haemorrhage, hospital acquired pneumonia/aspiration pneumonia and renal impairment in a man with multiple comorbidities following the administration of multiple opioids
Place of death:	Ballarat Hospital, 1 Drummond Street North, Ballarat, Victoria
Key words:	Medication error, gastrointestinal tract haemorrhage, hospital acquired pneumonia/aspiration, pneumonia, renal impairment

INTRODUCTION

1. On 29 July 2024, Alan Gordon Wolstenholme was 72 years old when he died in hospital following a medication administration error. At the time, Mr Wolstenholme lived in Alfredton.
2. Mr Wolstenholme's medical history included ischaemic heart disease, non-ST elevated myocardial infarction, atrial fibrillation/flutter, chronic kidney disease, chronic obstructive pulmonary disease, cerebrovascular accident, peripheral vascular disease, gastro-oesophageal reflux disease, and squamous cell lung carcinoma with liver metastases.
3. According to his records from Carn-Brae Clinic, Mr Wolstenholme's usual medications were apixaban¹ 5mg twice per day, bisoprolol fumarate² 10mg, digoxin 62.5 mcg, oxycodone³ 5mg PRN (as needed), furosemide⁴ 20 mg, pantoprazole⁵ (as sodium sesquihydrate) 40mg PRN, ramipril⁶ 10 mg, doxylamine⁷ succinate 25 mg, salbutamol inhaler 100 mcg PRN, and tiotropium⁸ inhaler 2.5 mcg PRN.

THE CORONIAL INVESTIGATION

4. Mr Wolstenholme's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

¹ Apixaban is an anticoagulant.

² For high blood pressure.

³ Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used to treat moderate to severe pain.

⁴ Frusemide is a loop diuretic used to treat oedema and mild to moderate hypertension.

⁵ Proton pump inhibitor that lowers stomach acid.

⁶ For high blood pressure.

⁷ Doxylamine is an antihistamine agent and sleep-inducing agent.

⁸ Inhaler for chronic obstructive pulmonary disease.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. This finding draws on the totality of the coronial investigation into Mr Wolstenholme's death. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.⁹

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

8. On 29 July 2024, Alan Gordon Wolstenholme, born 30 June 1952, was visually identified by his daughter, Toni Ashmore, who signed a formal Statement of Identification to this effect.
9. Identity is not in dispute and requires no further investigation.

Medical cause of death

10. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 31 July 2024 and provided a written report of her findings dated 6 August 2024.
11. The post-mortem examination was consistent with the reported circumstances. The post-mortem CT (computed tomography) scan demonstrated no intracranial haemorrhage or skull fracture, left nephrolithiasis (kidney stone/s), prostatic calcification, coronary and aortic calcifications, and bilateral pleural effusions, and increased lung markings, more so the left than the right.
12. Routine toxicological analysis of ante-mortem samples detected as follows:
 - (a) sample collected at 1.25pm on 22 July 2024: caffeine,¹⁰ doxylamine, apixaban, ibuprofen,¹¹ frusemide, paracetamol;¹²

⁹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

¹⁰ Caffeine is a central nervous system stimulant present in cocoa beans, coffee, guarana berries, holly leaves, kola nuts, and tea leaves. Secondary physiological effects include cardiorespiratory stimulation, coronary vessel dilation, and diuresis

¹¹ Ibuprofen is a non-steroidal anti-inflammatory agent and analgesic.

¹² Paracetamol is an analgesic drug.

- (b) sample collected at 9.30am on 24 July 2024: oxycodone, pregabalin,¹³ doxylamine,¹⁴ prednisolone,¹⁵ metoprolol,¹⁶ apixaban, ondansetron,¹⁷ melatonin;¹⁸ and
- (c) sample collected at 7.45am on 25 July 2024: oxycodone, pregabalin, doxylamine, metoprolol, apixaban, ondansetron, metoclopramide,¹⁹ melatonin.

13. Dr Ho provided an opinion that the medical cause of death was *“1(a) Complications of suspected upper gastrointestinal tract haemorrhage, hospital acquired pneumonia/aspiration pneumonia and renal impairment in a man with multiple comorbidities following the administration of multiple opioids”*.
14. I accept Dr Ho’s opinion.

Circumstances in which the death occurred

15. On 22 July 2024, Mr Wolstenholme was admitted to Ballarat Base Hospital with lethargy, fatigue, and vomiting. He was noted to be in rapid atrial fibrillation. The clinical impression was that his symptoms were likely due to his metastatic cancer, and a plan was made for review by the oncology and palliative care teams.
16. Mr Wolstenholme was subsequently mistakenly charted multiple medications on his admission including a buprenorphine²⁰ patch 30 mcg/hour, pregabalin 150 mg BD (twice daily), escitalopram²¹ 10 mg, OxyContin (oxycodone) 10 mg BD, and prednisolone 5 mg daily. Mr Wolstenholme was usually only prescribed oxycodone IR (immediate release) 5 mg on a PRN basis which he rarely used. He was also given digoxin 125 mcg once daily and metoprolol 50 mg BD for atrial fibrillation.
17. At about 12.50pm on 23 July 2024, a buprenorphine patch was applied in addition to the other incorrect medications.

¹³ Pregabalin is clinically used for treatment of partial seizures and neuropathic pain.

¹⁴ Doxylamine is an antihistamine agent and sleep-inducing agent.

¹⁵ Prednisolone is a synthetic corticosteroid with glucocorticoid and anti-inflammatory action.

¹⁶ Metoprolol tartrate is an anti-hypertensive drug.

¹⁷ Ondansetron is indicated for post-operative nausea and vomiting cancer chemotherapy

¹⁸ Melatonin is used as a sleep-inducing agent.

¹⁹ Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

²⁰ Opioid medication which can be given in long-acting patch form to treat chronic pain

²¹ Anti-depressant belonging to Selective Serotonin reuptake Inhibitors (SSRIs), used to treat major depression and anxiety.

18. When he was reviewed by the oncology registrar at 9.00am, Mr Wolstenholme had a high heart rate despite having taken his regular digoxin and metoprolol. He was for review by the cardiology team.
19. At 10.40am, Mr Wolstenholme was reviewed by the palliative care team and encouraged to use oxycodone IR for back pain. They also suggested temazepam or melatonin to help with sleep and melatonin 2mg was charted.
20. The cardiology team reviewed Mr Wolstenholme at 4.45pm and suggested an increase of metoprolol from 50 to 75mg BD, to check digoxin levels, and optimise electrolytes. They also suggested investigation of any driving cause for the atrial fibrillation, such as infection.
21. On 24 July 2024, Mr Wolstenholme reported better sleep but appeared tired. A hospital medical officer reviewed Mr Wolstenholme at 6.30pm for an episode of hypotension. Mr Wolstenholme reported feeling dizzy and his blood pressure medications (ramipril and furosemide) were withheld until reviewed by oncology team the next day.
22. At 7.50am on the morning of 25 July 2024, Mr Wolstenholme was the subject of a MET (medical emergency team) call for a reduced Glasgow Coma Score²² of 3 and unresponsiveness. Opioid narcosis was recognised and the buprenorphine patch was removed. Naloxone 400 mcg IV (intravenously) was administered at 10.35am to reverse the effects of narcosis and another 400 mcg of naloxone IV was administered at 10.57am. Oxycodone was withheld.
23. The Intensive Care Unit (ICU) registrar reviewed Mr Wolstenholme at 11.00am and recognised that he was opioid naïve and usually only used a maximum of oxycodone IR 20mg/day as PRN medication, that is on an as needs basis. However, in hospital, he had been given a buprenorphine patch 30 mcg/hour and oxycodone slow release 10mg twice daily and oxycodone IR PRN. Worsening drowsiness had been noticed in the preceding 12 to 24 hours.
24. Serial boluses of naloxone had been given with minimal effect. Naloxone 400 mcg was given during review by the ICU registrar, but he was still somewhat unresponsive requiring light sternal rubbing to open his eyes. The ICU consultant suggested that naloxone be continued on

²² The Glasgow Coma Scale (GCS) is the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury. A score of less than 8 indicates a severe brain injury; a score of 9 to 12 indicates a moderate injury; and a score of 13 to 15 indicates a mild injury such as concussion.

the ward (PRN 200 mcg) if Mr Wolstenholme's respiratory rate fell below 10. An acute kidney injury was also noted.

25. Mr Wolstenholme was transferred to the ICU at about 2.00pm for ongoing administration of naloxone and monitoring. A naloxone infusion was commenced at 17.30pm.
26. On 26 July 2024, the oncology team reviewed Mr Wolstenholme in the ICU. Mr Wolstenholme's GCS was fluctuating between 15 (normal consciousness) and 14 with agitation and confusion. Anaemia secondary to suspected upper gastrointestinal tract bleeding was noted, the nasogastric tube was aspirated and had a coffee ground appearance. Mr Wolstenholme was started on pantoprazole 80 mg to be given twice daily via IV.
27. The nephrology team was consulted about Mr Wolstenholme's acute kidney injury. They opined that this was compounded by hypovolaemia and sepsis as well as a possible upper gastrointestinal tract bleed. A plan was made for IV fluid resuscitation and monitoring of kidney function. The ICU team also diagnosed hospital acquired pneumonia/aspiration pneumonia, which was treated with IV Cefepime 2g BD and doxycycline 100mg BD (both are antibiotics).
28. On 27 July 2024, the general surgery team was consulted and suggested an inpatient gastroscopy. Mr Wolstenholme's haemoglobin was stable, so the upper gastrointestinal tract bleed was thought to have likely resolved. Continuation of high dose proton pump inhibitors was suggested, and Mr Wolstenholme was 'nil by mouth' awaiting a gastroscopy which did not subsequently eventuate. The oncology team also reviewed Mr Wolstenholme and noted he was drowsy.
29. On 28 July 2024, the general surgery team consulted at 3.30pm. They noted that Mr Wolstenholme was delirious and had pulled out his nasogastric tube. He was started quetiapine, clonidine, and haloperidol increments for delirium.
30. On 29 July 2024, Mr Wolstenholme was transferred from the ICU to the ward. He experienced ongoing delirium, pulling out his high flow nasal prongs; hypokalaemia treated with IV potassium replacement; and ongoing tachycardia (a high heart rate, at 128 beats per minute). The oncology registrar was consulted and opined that Mr Wolstenholme's deterioration was likely secondary to poor rate control for atrial fibrillation and dehydration. He advised administration of digoxin 62.5mcg and continuation of electrolyte replacement.

31. At 8.20pm that evening, Mr Wolstenholme was subject to a MET call due to unresponsiveness. Given his medical history and pre-assigned goals of care, no resuscitation was commenced and he passed away at 8.30pm.

FURTHER INVESTIGATION

32. Given the incorrect charting and administration of medication, I obtained the following statements from Grampians Health (the health service that manages Ballarat Base Hospital):

- (a) Dr Joshua Seldis, Medical Administration Registrar, dated 11 December 2024;
- (b) Jodie Crellin, Assistant Director of Safe Systems and Performance, dated 3 February 2025;
- (c) Dr Caitlin Webb, Emergency Department Chief Medical Officer, dated 22 August 2025;
- (d) Aleesha Lindsay, Pharmacist, dated 12 September 2025;
- (e) Jessica Jerez, Registered Nurse, dated 17 September 2025;
- (f) Dr Cintia Fornaso, Junior Registrar – Oncology team, dated 23 September 2025; and
- (g) Dr Rosemarie Eyre, Deputy Chief Medical Officer, dated 19 May 2026.

33. I also received:

- (a) the Grampians Health Ballarat Clinical Practice Protocol, dated 14 August 2021; and
- (b) In-Depth Case Review, undated.

How a patient's usual medications are charted at Grampians Health

34. Dr Seldis provided the usual process for charting patients' medications which relies on multiple potential sources of information including:

- (a) a patient-provided medication summary which is sometimes assisted by a patient bringing their medicines or a webster pack with them to hospital;
- (b) their previous medical record;

- (c) if within business hours, clinicians can request a medical summary/prescribing summary from the patient's general practitioner; and
 - (d) it is sometimes possible to access a patient's My Health Record prescribing summary.
35. He went on to explain that the patient's Best Possible Medication History (**BPMH**) is recorded on admission to Grampians Health Ballarat, which is then made available electronically within the medical record. This is usually completed by a pharmacist, however, outside normal business hours, this does not occur until pharmacy staff are available.
36. Dr Seldis that it did not appear that this procedure was following in Mr Wolstenholme's case:

It is not clear from the medical record whether this process was followed. It does not appear in the preceding admission or record that Mr Wolstenholme had been prescribed these medicines before, and when in the Emergency Department it is documented that Mr Wolstenholme refused these medicines as they were not normal for him. The decision making in this process is not clear from the notes. On admission, the pharmacist was unable to access the patient's medication chart and so could not complete a full BPMH. It was not until after the first MET Response [25 July 2024] when it was highlighted that the patient was suffering from Opioid toxicity that a pharmacist completed documentation to advise that multiple medicines had been prescribed by mistake.

How medications were charted for Mr Wolstenholme

37. Dr Webb indicated that the records indicated she was Mr Wolstenholme's initial primary treating clinician in the emergency department although she had no independent memory of the case. She was unable to recall how she obtained his list of regular medications, but noted:

... my usual practice is to check with the patient, especially if they have brought their medications with them, and then I routinely confirm with My Health Record and if this is not available, a recent Best Possible Medication History (BPMH) or discharge script. I note according to Mr Wolstenholme's file, he does not have a My Health Record and thus it would be likely that I would have used either of the other two methods to determine his regular medications.

38. Dr Webb additionally explained that in performing an initial assessment and management in the emergency department, she would only prescribe medications required for initial

management and did not routinely prescribe ongoing regular medications. She opined that it was likely she prescribed digoxin due to Mr Wolstenholme's presentation with rapid atrial flutter. She also prescribed paracetamol and oxycodone for analgesia, as well as PRN oxycodone if required. She added:

I note that I documented that the patient had not been taking his regular analgesia and the GCS is documented at 15. Thus PRN would have been chosen rather than regular analgesia as it would allow the patient to dictate with staff when and how much analgesia they require, with a maximum dose of 40mg set. I would routinely set the maximum dose depending on overall opioids prescribed, in this instance I note that it is prescribed on the basis that there were no other opioids prescribed at the time. I have also prescribed ondansetron which I would routinely prescribe for patients with nausea or on opioid medication. I have listed Mr Wolstenholme's regular medications.

The remainder of the chart would have been completed by the admitting team or other treating clinicians. This is routine practice within the hospital.

39. Dr Webb did not believe she would have asked another doctor to complete the drug chart as that task is considered a routine part of patient admissions for the admitting team to complete the drug chart with regular medications and any further PRNs that may be required.
40. Dr Fornaso noted she reviewed Mr Wolstenholme as part of the oncology team once it was decided he required admission under oncology for further management of pain with review by the palliative care team. She explained as follows:

I completed the admission paperwork including the medication chart at the patient's bedside.

The medications chart was reviewed by 2 different Oncology consultants and the oncology Advanced Trainee on the daily ward rounds on 23/07/24 and 24/07/24.

The medication chart was also reviewed by the palliative care team that had been seeing him on his previous admissions to hospital for pain and tiredness.

There was no pharmacist review in ED on admission – but he was reviewed by the Oncology pharmacist the following morning 23/07 – no modification was made or issue raised until the 25/07.

41. She also went on to note that all findings and management decisions regarding Mr Wolstenholme's care were documented in the medical record, reviewed, and supervised by the senior doctor in charge. No decision was taken without consultant approval.

Pharmacist review of Mr Wolstenholme's charted medications

42. Ms Lindsay was the clinical pharmacist for the oncology/haematology inpatients on the day of Mr Wolstenholme's admission and was involved in his care.
43. She highlighted the *Grampians Health Best Possible Medication History (BPMH), Medication Reconciliation and Review Clinical Procedure* as follows:

The electronic Best Possible Medication History and Reconciliation form MR 701.1 should be completed on BOSSnet for every patient within 24 hours of admission to Grampians Health. Ideally the BPMH is undertaken prior to prescribing or administering any medication, or prior to performing any procedure that may interact with a patient's medications.

A Best Possible Medication History (BPMH) is a medication history is a record of all the medicines actually taken by the patient in the period before admission or presentation for the episode of care and includes information about previous adverse drug reactions (ADRs), adverse medicines events and allergies and recently ceased or changed medicines. The record is confirmed using a number of different sources. Obtaining a best possible medication history involves reviewing background information and conducting a patient/carer medication history interview.

A medical officer or pharmacist can complete the BPMH form.

Medication reconciliation of patients' pre-admission or pre-transfer medications will be completed by a pharmacist as soon as practical after admission. Reconciliation is recorded on the Best Possible Medication History and Reconciliation Form (MR701.1). Medication reconciliation is a formal process intended to prevent medication errors and medicines-related problems at transition points in patient care (admission, discharge and transfer). The process involves comparing a patients best possible medication history with the current medication orders in the context of the patient's current condition, their treatment plan and medication management plan in order to identify if any unintended changes to the patient's medications have been made. Medication reconciliation also involves addressing and resolving the identified

discrepancies and/or medication-related problems and documenting information regarding resolutions and/or recommendations made.

44. Ms Lindsay explained that Mr Wolstenholme's BPMH was commenced on 23 July 2024 and updated throughout the admission. Mr Wolstenholme advised that his wife managed his medication. Ms Lindsay was unable to contact Mr Wolstenholme's wife to discuss his medication until 25 July 2024 after which medicine reconciliation was completed.
45. Ms Lindsay was unable to explain how the five incorrect medications (buprenorphine patch, oxycontin, pregabalin, escitalopram, prednisolone) came to be on Mr Wolstenholme's medication chart.
46. Ms Lindsay was asked whether she had any suggestions as to how the charting error could have been prevented. She proffered the following:

Implementing systems that would enable the BPMH to be completed prior to prescribing or administering any medications, for example:

- Improving access to clinical pharmacists, or other trained staff, to enable BPMHs to be completed, and medications charted for administration in hospital reconciled, prior to administration.*
- Increasing resourcing for Partnered Pharmacist Medication Charting (PPMC), which has been proven to reduce medication errors on admission.*

Regular medication safety training for all staff responsible for medication management, including specific training on high-risk medications.

Mr Wolstenholme's own recognition that he was being given incorrect medication

47. On the evening of 22 July 2024, Ms Jerez was allocated to nurse Mr Wolstenholme. She noted that he received IV therapy and medication to reduce his heart rate and 5mg of Endone to relieve his pain. He was then pain free for the remainder of the shift. As regards the 8.00pm medication round, Ms Jerez stated:

... I had given his regular apixaban dose and explained that the oncology team has charted regular analgesia that he was due for. Patient then stated they were not his regular medication, and the Dr hadn't spoken to him about the new medication prior to prescribing. He stated that he currently isn't in any pain and didn't need to take

them. I then did not give the medication as per the patients request. As this was toward the end of my shift I handed over to the next nurse coming on to duty that the home team were not aware of the medications not given.

48. Ms Jerez explained that Grampians Health did not have a policy about what to do when a patient refuses medication(s):

There is a clinical practise protocol, medication administration. This does talk about considering the right to refuse under the right of medication administration. It does not specify notifying the home team. In the drug chart, there is a statement saying to notify the prescriber if a patient refuses. Due to the high acuity of that shift, I could not contact the medical team to inform them. I did hand this information on to the next nurse taking over care.

49. Ms Jerez confirmed that she told the night shift nurse at 9.00pm that when Mr Wolstenholme went to the ward, staff needed to provide education to him about his new medication. Further, she had no reason to believe Mr Wolstenholme had been prescribed the wrong medication. Rather, she thought clinical staff had not explained to Mr Wolstenholme that he had been prescribed different analgesia.

Grampians Health internal review

50. Mr Wolstenholme's death was referred to Safer Care Victoria (SCV) as a sentinel event and the Ballarat Quality and Safety Department completed a Root Cause Analysis (RCA).
51. The review indicated that the oncology registrar was very busy, they were covering two specialities, they had three admissions to complete, Mr Wolstenholme's admission was late in the day, and the ED was under-staffed:

The oncology registrar recalls receiving a folder containing all the patient's background medical paperwork in it, including the medication list.

52. The In-Depth Case Review indicated appeared Mr Wolstenholme's medications were not reviewed by a pharmacist until after the incident was identified:

The pharmacist recalls reviewing the patient on the ward round with the oncology registrar and the medical student. The pharmacist recalled that there were a lot of doctors away and that the registrar present on the ward round was the registrar who had undertaken the admission. The pharmacist recalled that during the ward round

she only had the medication chart with her and did not have a Best Possible Medication History (BPMH) form. The pharmacist recalls signing off the medication chart orders whilst talking during the medication round and noted that this was a different process to what she would normally undertake, because she would usually sign off medication orders when completing medication reconciliation against the BPMH. The Pharmacy Department Work Instruction states that annotating a national inpatient medication chart by signing initials within the “Pharmacy Use” box implies that the clinical pharmacist is satisfied with the medication order and endorses administration as it is charted. The pharmacist further recalls conducting the BPMH patient interview later when the patient highlighted concerns regarding two of his medications, furosemide and doxycycline. Following the ward round the pharmacist recalls returning to the patient to complete the BPMH when they were informed by the patient that his wife looks after his medications. The pharmacist stated that they went to phone the wife regarding the medications but was delayed when the nurse took the patient’s folder away. The pharmacist then recalls that they imported the patient’s medications into the electronic BPMH and documented a note to follow up with the wife. The pharmacist stated that submitting this information into the BPMH at this stage was not their usual practice and that they would normally not submit the electronic BPMH until it was entirely completed

53. The In-Depth Case Review identified three ‘cause and effect’ findings arising from this case:
- (a) Mr Wolstenholme received the wrong medications due to the following contributing factors:
 - (i) incorrect medications being prescribed;
 - (ii) the prescriber took information off a supplied list (however, it is unclear what this list referred to);
 - (iii) verification with pharmacy did not occur and current pharmacy staffing hours do not match organisational trends in inpatient admissions;
 - (iv) the prescriber did not consider alternate sources to verify and there was competing priorities and cognitive bias;

- (b) the BPMH was partially completed by the pharmacist:
 - (i) computer access was restricted due to other staff using equipment and charts (fragmented health information system);
 - (ii) there was poor adherence to BPMH policy across the service (competing demands and time-consuming task); and
- (c) the nurse only documented in the emergency record that the patient refused medications as they were not his usual medications;
 - (i) the refusal was not viewed as urgent and there was no policy regarding escalation and follow-up in these scenarios.

54. Ms Credlin indicated the following findings and recommendations were made in the RCA:

- (a) current pharmacy staffing does not adequately support timely medication review in the setting of increased numbers of admissions from the emergency department after 5.00pm. Recommendation: Evaluate after hours admissions to determine if adjustments to pharmacy service provision is necessary to improve efficiency and patient care;
- (b) clarification of the BPMH prior to prescribing a medication is resource intensive which can result in other competing demands taking priority. Recommendation: Audit current compliance of completion of BPMH within the Emergency Department to determine if there are systemic gaps in compliance and report to medication Safety and Governance Meetings;
- (c) completion of the BPMH and medication reconciliation needs access to both paper-based chart and the electronic BPMH form. Challenges arise when staff simultaneously need access to these records. Recommendation: Medication safety committee will review current key performance indicators around BPMH and develop an action plan for optimising these results;
- (d) BPMH completion was inadequate as it was time consuming and not prioritised. This contributed to the patient receiving incorrect medication. Recommendation: Establish clear standardised guidelines for managing patient medication refusal detailing who is responsible for each step; and

- (e) inadequate organisational approach for medication refusal which contributed to the prescription error not being addressed promptly. Recommendation: Regular training sessions for healthcare staff on importance of following protocols for medication refusal.
- 55. Dr Seldis noted that the due date for the recommendation monitoring report was 6 March 2025. Ms Credlin noted that the above recommendations were due for implementation by April 2025 at the latest.
- 56. This case was also reviewed by the Organisation-wide Mortality Review committee in August 2024.
- 57. A family meeting including Statutory Duty of Candour took place on 23 August 2024.

Coroners Prevention Unit review

- 58. To assist my investigation, I obtained advice from the Coroners Prevention Unit²³ (CPU) about the medical care provided to Mr Wolstenholme before his death and any prevention opportunities.
- 59. Following a review of the voluminous medical records, the CPU identified the following circumstances relevant to Mr Wolstenholme's death:
 - (a) the Emergency Department notes for 22 July 2024 were completed by 'C Webb' who documented Mr Wolstenholme's medications as: salbutamol, tiotropium, olodaterol,²⁴ pantoprazole, ramipril, frusemide, apixaban, digoxin, and metoprolol;
 - (b) there were multiple outpatient notes and previous admissions in 2024 in the medical records which also documented these same medications;
 - (c) the 'Acute Admission Form' documented the medications listed at (a) above;
 - (d) on 24 July 2024, the oncology ward round again documented the same medications;

²³ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

²⁴ Inhaler for chronic obstructive pulmonary disease.

- (e) the medication chart from 22 July 2024, completed by what appeared to be ‘Forman’ (likely ‘Fornaso’), listed allergies and PRN medications. Some ‘once only’ medications were completed by ‘C Webb’ who completed the Emergency Department note. The remainder of the medication chart was completed by someone else. The following additional medications charted by ‘Fornaso’ included the following medications that Mr Wolstenholme had not been on before: escitalopram 10mg, oxycodone XR 10mg twice daily, pregabalin 150mg bd, buprenorphine patch weekly, and prednisolone 5mg daily;
- (f) at 8.00pm on 22 July 2024, Mr Wolstenholme refused the oxycodone XR (extended release) 10mg, pregabalin 150mg, and the buprenorphine patch. The following note appears in the Emergency Department nursing record: *“patient refused remaining 2000 medications as they were not his regular medications and was happy to stick with what he usually has.”*
- (g) on 24 July 2024 a Riskman incident entry at 4.05pm noted, *“0800hrs oxycodone XR was not administered. S8 record checked – found not administered. Notified AM, PM, ANUM and NUM. Medication administered at 1535 hrs. Patient denied pain. Alert and pleasantly confused. Riskman lodged. Nil other issues.”*;
- (h) the BPMH was completed on 26 July 2024 by staff member ‘agl’. The following comment appears next to the oxycodone 5mg as required, *“rarely takes, states has box but hasn’t used in ages. Last dispensed Jan 2024”*. It also states, *“Alan gives himself his medicines but wife and daughter assist”*;
- (i) there were also multiple mentions of ‘acopia’ in the medical record from a variety of clinicians including medical, nursing, and allied health. More appropriate terminology would be ‘functional decline’; and
- (j) the medication chart was checked by a pharmacist (purple ink). It appears this reconciliation took place on 27 July 2024 by ‘#4768’.

Contributing factors

60. The CPU indicated the key issue was that the medication chart on admission was completed incorrectly despite his ‘correct’ medications being documented multiple times in the medical record when he had a number of admissions and outpatient appointments during early 2024.

61. On 22 July 2024, the medication chart completed by two different clinicians – ‘C Webb’ who was the doctor who presumably assessed Mr Wolstenholme in the Emergency Department and the regular medications by another doctor, ‘Fornaso.’ The risk of incorrectly completing a medication chart increases when multiple clinicians are involved, especially if they have not seen the patient and/or are very busy. The CPU noted that the In-Depth Case Review did not discuss how the medication chart was completed (that is, why it was completed by two different doctors).
62. The CPU also highlighted that it was documented Mr Wolstenholme was alert and orientated, refused the additional medications in the Emergency Department and told the nurse they were not his usual medications (22 July 2024). The CPU considered this was a missed opportunity to trigger review the medication chart and correction of the error.

Conclusion

63. Mr Wolstenholme was a man with multiple co-morbidities including metastatic cancer. He was charted and given multiple medications, including opiates, by mistake. On the evening of 22 July 2024, Mr Wolstenholme refused the incorrect medications in the Emergency Department (as they were not his regular medications). This was a missed opportunity to correct the error.
64. The error was identified following a MET call and he was subsequently transferred to ICU for monitoring. However, the medication error was unlikely to have caused gastrointestinal bleeding, pneumonia, and kidney failure which ultimately to his death.
65. Grampians Health conducted an internal review and determined the likely cause for the error was that a BPMH was not completed upon admission.
66. Whilst the internal review acknowledged pharmacy staffing was a problem, at the time of the CPU review, this had not been addressed or put on a risk register to acknowledge this as a problem to address in the future. The CPU noted that in comparison, Ballarat Base Hospital Emergency Department sees more patients per month than St Vincent’s Hospital Emergency Department which has at least three pharmacist shifts per day from 7.30am to 9.00pm. This suggests that improved pharmacist staffing in the emergency department would be a key factor in preventing similar incidents in the future, as well as review of the system for performing a BPMH to see if this can be made more user friendly.

67. The CPU considered that auditing compliance (recommendation 2) did not solve the identified issue, and a new key performance indicator (recommendation 3) is not the same as improved usability.
68. The health service has implemented measures in place to audit completion of BPMH and protocols for medication refusal but has not investigated ways to make the system more user-friendly and to ensure critical information is handed over appropriately.

Update from Grampians Health

69. In light of the CPU's advice, I obtained a further statement from Grampians Health about implementation of the In-Depth Case Review recommendations and updates to relevant guidelines.

Evaluation of the impact of after hour admissions to determine if adjustments to pharmacy service provision is necessary to improve efficiency and patient care

70. Dr Eyre indicated a snapshot audit of BPHM completion 'after hours' versus 'business hours' was completed for all patients admitted to Grampians Health Ballarat on Tuesday 27 May 2025 revealed the following:
- (a) a total of 301 patients were included which represents all inpatient admissions across acute, subacute, and mental health services at Grampians Health Ballarat;
 - (b) the BPMH completion rate within 24 hours post admission for patients admitted after hours, or to a clinical unit/ward with no clinical pharmacy service was 32.8%; and
 - (c) the BPMH completion rate within 24 hours post admission for patients admitted to clinical areas with a rostered clinical pharmacy service and during business hours was 84.6%.
71. In 2024, Grampians Health undertook a survey of staff and patient about perceptions of the clinical pharmacy services provided by the Grampians Health Ballarat Pharmacy Department, which revealed the following:
- (a) low satisfaction from all healthcare professional groups in response to the question, "the hours the clinical pharmacy service is staffed allows for adequate patient care during weekdays, weekends, and public holidays";

- (b) 65% of all responding health professionals identified the need for an extended hours clinical pharmacy service. This included extending service hours Monday to Friday and in particular, weekends and public holidays;
- (c) 52% of responding health professions reported improving clinical pharmacist accessibility for tasks such as patient review, discharge flow, and participation on ward rounds as the second highest priority for improvement; and
- (d) pharmacist access was frequently noted as an area for service improvement by patients, with several comments focussing on delays to first review by a pharmacist, and that consultation with a pharmacist as soon as possible after admission would assist patients by explaining medication changes and ensuring their medication list was up to date.

Audit of compliance of completion of BPMH within the Emergency Department

72. Dr Eyre informed me that an audit of BPMH completion within the Emergency Department from February to April 2025 demonstrated the following:

- (a) 25% of patients admitted from emergency department to the ward had a BPMH completed in the emergency department;
- (b) for patients with an emergency department length of stay of greater than 24 hours, the BPMH completion rate was 47% by midnight the day after the presentation commenced; and
- (c) the average time to completion of a BPMH from the start of the emergency department presentation was 21 hours if completed in emergency department and 52 hours if completed on the ward.

73. A further retrospective audit of BPMH completion for long stay patients²⁵ in the Ballarat Emergency Department was conducted from 1 July 2025 to 30 September 2025, which revealed 57 of the 80 audited patients did not have a BPMH completed in the emergency department. While most had their BPMH completed on the ward, 8 of the 80 patients did not have a BPMH completed in emergency department or on the ward at all.

74. The report concluded that the audit had highlighted key gaps in the timely completion of BPMH for patients experiencing long stays in the emergency department at Ballarat. While

²⁵ A long stay in emergency was defined as a length of stay is greater than 24 hours.

BPMHs were completed in emergency for less than one-third of audited cases, most were finalised following ward admission, and a small number were not completed at all. The report noted that the findings did not indicate that patient presentation in clinical pharmacy hours correlated with BPMH completion.

75. Dr Eyre indicated a further BPMH audit in the emergency department is scheduled in the July to September 2026 quarter and will include the time/day to provide clarity around the impact of the absence of pharmacists after hours.

The medication safety committee will review the current key performance indicator for BPMH

76. A review of the Grampians Health BPMH related KPIs was undertaken in May 2025. The following three BPMH related KPIs were identified:

- (a) percentage of patients with BPMH/Medication Management Plan (MMP) documented by the end of the next calendar day after admission;
- (b) percentage of patients whose current medicines are documented and reconciled by the end of the next calendar day; and
- (c) percentage of patients with a BPMH/MMP completed during their admission

77. Dr Eyre advised that the review identified that all three KPIs were consistently underperforming and not meeting KPI target levels, and some campuses were not achieving tolerance levels. A number of contributing factors were identified including availability of clinical pharmacists, especially after hours and in the emergency department, and timely access to the patient's medical record.

Establish standardised organisational guidelines for managing patient medication refusal and staff training

78. Grampians Health has incorporated the procedure for managing patient medication refusal into the Medication Administration clinical procedure.
79. Mandatory training for nurses and midwives includes a renewed Medication Safety session. This session includes managing and escalating refused medications.

Implementation of recommendations

80. The report addressing Recommendations 1 to 3 was tabled at the Medication Safety Governance committee meeting on 26 June 2025. This report included 11 proposed actions with three areas of focus: KPI audit, clinical pharmacy services, and digital health. The Medication Safety and Governance committee all agreed to support the 11 proposed actions, which included the following:
- (a) Action 3: Create a new medication safety KPI for emergency department patients with length of stay beyond 24 hours, to match inpatient target for BPMH completion of 80% by midnight the day after presentation;
 - (b) Action 6: Implement a prioritised extended hours clinical pharmacy service trial utilising Partnered Pharmacist Medication Charting (**PPMC**) principles;
 - (c) Action 7: Develop a business case for staged expansion of weekend/public holiday clinical pharmacy services and weekday clinical pharmacy services for clinical units currently not serviced or under-resourced, to embed clinical pharmacy services into admission pathways;
 - (d) Action 9: Include clinical pharmacy service access in Grampians Health 7-day service planning; and
 - (e) Action 11: Implement an electronic medical record (**EMR**) to enable simultaneous access to patient records, improving workflow efficiency and reducing delays in BPMH and medication reconciliation.
81. Dr Eyre also noted that pharmacy staff had increased to at Ballarat Base Hospital Emergency Department to 2.8 Equivalent Full-Time.²⁶

FINDINGS AND CONCLUSION

82. Pursuant to section 67(1) of the Act I make the following findings:
- (a) the identity of the deceased was Alan Gordon Wolstenholme, born 30 June 1952;

²⁶ Pharmacy staffing at the Ballarat Base Hospital Emergency Department was 2.0 Equivalent Full-Time at the time of Mr Wolstenholme's death.

- (b) the death occurred on 29 July 2024 at Ballarat Hospital, 1 Drummond Street North, Ballarat, Victoria;
 - (c) the cause of Mr Wolstenholme's death was complications of suspected upper gastrointestinal tract haemorrhage, hospital acquired pneumonia/aspiration pneumonia and renal impairment in a man with multiple comorbidities following the administration of multiple opioids; and
 - (d) the death occurred in the circumstances described above.
83. Mr Wolstenholme had a number of existing significant co-morbidities when he presented to Ballarat Base Hospital emergency department on 22 July 2024 for lethargy, fatigue, vomiting, and rapid atrial fibrillation.
84. Following his presentation, Mr Wolstenholme was prescribed and administered several medications in error. Despite Mr Wolstenholme alerting his nurse that the medications were not his usual medications, a medication review was not triggered. The medication error was thus not recognised until 25 July 2024 when he was found unresponsive. Following recognition of opioid narcosis, steps were taken to reverse the effects of narcosis.
85. Whilst Mr Wolstenholme's GCS increased to 14 and 15 by 26 July 2024, he remained agitated and confused. He also developed anaemia secondary to an upper gastrointestinal tract bleed. In addition, he was diagnosed with acute kidney injury, compounded by hypovolaemia and sepsis, and hospital acquired pneumonia/aspiration pneumonia.
86. Over the following days, Mr Wolstenholme remained confused and/or drowsy and his atrial fibrillation poorly controlled despite treatment. He continued to deteriorate until his passing on 29 July 2024.
87. Following Mr Wolstenholme's death, Grampians Health has undertaken several detailed reviews and audits outlined above which have revealed the circumstances in which the medication error occurred, multiple issues regarding timely completion of BPMHs, and staff and patient dissatisfaction with pharmacy staffing, including pharmacy hours. Further auditing is due to be undertaken shortly.
88. In response to these issues being identified, Grampians Health has devised some reasonable action items, including a trial of extended pharmacy service hours.

89. The implementation of these improvements *should* assist in reducing similar medication errors and increase the opportunities to identify such errors to prevent patient harm. For this reason, and at this juncture, I do not propose addressing any formal recommendations to Grampians Health for further action to minimise the risk of a similar medication error occurring in the future.
90. While it is clear that the medication error occurred, the available evidence does not support a finding that the medication error caused or contributed to the natural disease processes implicated in Mr Wolstenholme's death, namely gastrointestinal bleeding, pneumonia, and kidney failure.
91. I convey my sincere condolences to Mr Wolstenholme's family and friends for their loss.

PUBLICATION

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION

I direct that a copy of this finding be provided to the following:

Susan Wolstenholme, senior next of kin

Toni Ashmore (care of Maurice Blackburn Lawyers)

Grampians Health

Sergeant Christopher Taylor, Victoria Police, reporting member

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 27 July 2026

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day

on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
