But never had he encountered a case like Vanessa's "in which almost every conceivable error or omission was detected and . . . continued to build, one on top of the other".

The Coroner identified 15 different factors in her treatment which combined to create "the worst possible outcome for Vanessa and her family".

A talented golfer, Vanessa was rushed to Hornsby Hospital after her skull was fractured by a stray ball during a tournament at Asquith in November 2005.

She was transferred to RNSH and diagnosed with a mild head injury - but died two days later.

Mr Milovanovich found the opiate painkillers she was given caused respiratory failure.

Two doctors prescribed the drugs - deemed by experts to be an excessive amount - without consulting senior specialists. One misread Vanessa's medication chart.

RNSH's investigation found the lack of pain management guidelines or clear lines of responsibility for prescribing drugs contributed to her death, which is under investigation by the Health Care Complaints Commission. Mr Anderson said costs were prioritised over care.

□ THE health system faces further embarrassment with the Coroner considering opening an inquest into a second patient who died at Royal North Shore Hospital last May.

The Daily Telegraph has learned the State Coroner is compiling a paper, which could determine if an inquest is held into how North Coast father Don Mackay died.

RNSH management has written an apology to his widow Therese Mackay and admitted it failed Mr Mackay, 56, who died of complications and suffered "appalling conditions" at RNSH. One day after he left hospital he died at home.

He was admitted for a routine operation to have his lungs drained but was exposed to "Third World conditions" and mistakes such as having his breathing monitor switched off, Mrs Mackay said.