IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5085

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**PHILLIP HARRY PARKER**
Date of birth:	**15 September 1956**
Date of death:	**29 September 2017**
Cause of death:	**Pneumonia**
Place of death:	**Monash Health- Kingston Centre, corner of Warrigal Road and Heatherton Road, Cheltenham Victoria 3192**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Phillip Harry Parker was a 61-year-old man who was a resident at McGregor Gardens Aged Care (**McGregor Gardens**), located at 11 McGregor Road, Pakenham Victoria 3810.

2. On 5 September 2017, Mr Parker was administered a slow acting opioid medication. Mr Parker became unconscious and was transported to Monash Health- Casey Hospital Emergency Department (**ED**), located at 62-70 Kangan Drive, Berwick Victoria 3806.

3. Mr Parker spent the following eight days in Monash Medical Centre, Intensive Care (**ICU**), located at 246 Clayton Rd, Clayton Victoria 3168, before being given further care in the general ward and making a partial recovery.

4. On 25 September 2017, Mr Parker was moved to Monash Health- Kingston Centre located on the corner of Warrigal Road and Heatherton Road, Cheltenham Victoria 3192, where his health steadily declined.

5. On 28 September 2017, Mr Parker passed away in the presence of his family.

6. The death of Mr Parker was a late report to Coronial Admissions and Enquiries, occurring on 5 October 2017.

7. Mr Parker's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

INVESTIGATIONS

Forensic pathology investigation

8. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Mr Parker, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83.

9. Dr Parsons commented that the post mortem CT scan showed a previous craniotomy and clips in situ, right lower lobe consolidations and increased lung markings in the lower lobes.

10. Dr Parsons noted that the medication administered immediately prior to Mr Parker's admission to the ER was administered a month prior to his death. It was, therefore, unclear whether it contributed to Mr Parker's death. She noted Mr Parker had multiple comorbidities. An autopsy was considered unlikely to have assisted in determining this possibility.

11. Dr Parsons considered the cause of death on the medical certificate appropriate.

12. Following her external examination upon Mr Parker's body, review of the E-Medical Deposition Form, medical certificate of death, Form 83 and post mortem CT scan, Dr Parsons ascribed the cause of death to pneumonia.

Police investigation

13. Senior Constable (**SC**) Douglas McKiggan was the nominated Coroner's Investigator.[1] At my direction, SC McKiggan investigated the circumstances surrounding Mr Parker's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, care providers, treating clinicians and various clinical and care records.

14. During the investigation, it was learned that in 1994, Mr Parker underwent neurosurgery for a ruptured arteriovenous malformation (**AVM**)[2] at the Alfred Hospital. Complications occurred, resulting in Mr Parker sustaining cognitive impairment, dysphagia, personality change, epilepsy and frequent bouts of pneumonia.

15. Mr Parker was initially cared for at home, until 2007 when he asked to be admitted to McGregor Gardens.

16. Mr Parker had good health until early 2017, when he seemed to deteriorate. Specifically, he became more depressed with increasing functional decline. Mr Parker would often refuse to eat and started losing weight. Additionally, in 2017 he had two hospital admissions[3] for chest infections.

17. On 3 September 2017 at approximately 2.02pm, Mr Parker was showing signs of being tired and lethargic. He was resting in bed and his temperature was taken by the registered nurse (**RN**), reading "37.4".

18. McGregor Gardens progress notes entry for 3.56pm detail that Mr Parker was still sleepy and lethargic. His observations included a respiratory rate of 40 per minute, blood

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

[2] AVM- brain aneurysm. Brian aneurysm clipped September of 1994 (right side) and January 1995 (left side), both resulting in haemorrhage and acquired brain injury.

[3] Admitted to Casey Hospital on 26 February 2017 until 8 March 2017 and on 22 April 2017 for a day with exacerbation of pneumonia. Intravenous antibiotics were administered before he was sent home with oral antibiotics. Mr Parker had also been reviewed by Monash Health In-Reach service.

pressure (**bp**) of 100/70 mmHg[4] and oxygen saturation of 91% on air room[5]. A Locum doctor was requested to review Mr Parker[6].

19. At 4.20pm, Mr Parker was administered medications that included Tapentadol Slow release (**SR**) 100 milligrams[7] by a patient care worker (**PCW**)[8].

20. At 4.30pm, the PCW realised that Mr Parker had received another patient's medication. The PCW immediately informed the RN and at 4.38pm, Mr Parker was reviewed by National Home Doctor Service (**NHDS**) locum doctor, Dr Syam Navuru. Dr Navuru identified right basal creps and moist sounding chest. He documented the drug administration error and considered Mr Parker had lower lobe pneumonia and prescribed antibiotics with 15 minute observations. The progress notes document "patient was in respiratory distress before the medication was given in error".

21. At the request of the RN, a second locum doctor, Dr Bijene Rajbhandari, attended on Mr Parker. Dr Rajbhandari diagnosed Mr Parker with lower respiratory tract infection and requested that Mr Parker continue with observations at McGregor Gardens.

22. Observations were continued and Mr Parker was stable until 5.40pm, when the RN assessed Mr Parker's bp increase and respiratory rate decrease. He became unresponsive and emergency services were called at 5.58pm. Ambulance Victoria arrived at 6.03pm.

23. At 6.10pm, Mr Parker's observations included a respiratory rate of 6 with oxygen saturations of 78%. Mr Parker's Glasgow Coma Scale (**GCS**)[9] was 6/15[10].

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[4] This reading is borderline low pressure. Mr Parker's bp had improved when reviewed by nurse Navuru at 4.38pm to 110/70 mmHg.

[5] This is lower than usual expected levels. Oxygen via nasal cannula at four litres was placed, this was decreased to two litres when oxygen saturations improved to 96%.

[6] An advanced care plan was completed in April of 2017. The requests regarding treatment in an acute event was not signed as to determine whether Mr Parker wanted treatment at the time of an event or sudden deterioration.

[7] Tarde name Palexia SR. A schedule 8 opioid analgesic. As it is a slow release tablet it is designed to relieve pain gradually over several hours. Schedule 8 drugs are classified as drugs of dependence. Tapentadol is excreted by the kidneys and has a half life on average of five to six hours.

[8] PCW or patient care assistance (**PCA**) or assistants in nursing are used interchangeably.

[9] An objective scale of neurological assessment, ranging from three (deep unconsciousness) to fifteen (no impairment).

[10] E2 V1 M4: Eyes open to pain; no verbal response and withdrawal to pain. Score is determined by responses to eye opening (E), verbal response (V) and motor response (M). Maximum score is E4 V5 M6 (15/15).

24. Mr Parker was conveyed to Monash Health- Casey Hospital ED, arriving at approximately 7.00pm. He presented with altered conscious state and type two respiratory failure[11]. Mr Parker had a venous blood gas obtained on arrival and demonstrated a carbon dioxide (**CO2**) level of 178[12] and GCS of 4/15.

25. At 7.24pm, 7.27pm and 7.45pm, Mr Parker received three doses of naloxone[13] respectively. At 7.46pm, a naloxone infusion was commenced and ceased on 4 September 2017.

26. At 11.30pm, Mr Parker was transferred to Monash Medical Centre ICU with class two respiratory failure. He was treated for aspirate pneumonia[14], requiring non-invasive ventilation[15], atrial fibrillation[16] and hypotension[17] requiring intravenous fluid administration and noradrenaline[18].

27. On 11 September 2017, Mr Parker was transferred from the ICU to the medical ward.

28. On 25 September 2017, Mr Parker was transferred to Monash Health- Kingston Centre for rehabilitation. His health, in particular his respiratory function complicated by severe bronchiectasis and frailty, continued to deteriorate.

29. Monash Health geriatrician, Dr Jasmine Morey detailed Mr Parker's physical decline, including his refusal to engage with major supplementary efforts to attempt to correct his weight loss.

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[11] Inadequate gas exchange by the respiratory system, with the result that levels of arterial oxygen, carbon dioxide or both cannot be maintained within their normal ranges.

[12] Partial pressure of carbon dioxide (PaCO2) is a respiratory chemical buffer in the blood that aids control of the pH. Normal PaCO2 level is between 35 and 45 mmHg.

[13] Opioid antagonist. Naloxone is a drug used to counter the effects of opiate overdose and has a short half-life of approximately one hour. No opioid antagonist was administered at McGregor Gardens.

[14] Aspiration pneumonia involves the inhalation of saliva and/ or gastric contents into the airways and lungs.

[15] Non-invasive positive pressure ventilation refers to positively pressure ventilation delivered through a non-invasive interface, such as nasal mask, face mask or nasal plugs. On 5 September 2017, Mr Parker required BiPAP due to PCO2 increasing to 80 mmHg.

[16] Atrial fibrillation (**AF**) is the most common cardiac arrythmia, whereby disorganised, erratic and rapid electrical signals cause the atria heart chambers to contract irregularly.

[17] Low blood pressure.

[18] Noradrenaline is a hormone that is produced naturally by the body. It is given by injection/ infusion to treat life-threatening drops in blood pressure.

> […] he had become malnourished[19] and further deconditioned due to recurrent chest infections, believed to be due to recurrent aspiration in the setting of chronic dysphagia and an ineffective cough and chronic fibrotic lung disease.
>
> […] His oral condition was modest but not enough to sustain him or reverse his conditions without major supplementary efforts that he declined.

30. On 29 September 2017, Mr Parker's condition had deteriorated "as evidenced by reduced oral intake, increased heart rate, Shortness of breath and elevated temperatures, consistent with recurrent chest infections".

31. The decision was made to provide palliative care[20].

32. Mr Parker died at 6.00pm.

Coronial investigation

33. As part of my investigation, I forwarded this matter to the Coroners Prevention Unit (**CPU**) for an assessment of the medical care afforded to Mr Parker in the period proximate to his death.

34. The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the forensic pathology report and any particular concerns which have been raised.

35. The CPU considered the Victorian Police Report of Death, Form 83, the VIFM Medical Examiner's Report, the Coroners Court of Victoria E-Medical Deposition Form, the coronial brief and statements from care providers and treating clinicians in the period proximate to Mr Parker's death.

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[19] Dr Morey's statement includes Mr Parker had a naso-gastric feeding tube in place, which was removed by Mr Parker and not reinserted at Mr Parker's request.

[20] This discussion had previously occurred earlier in the year with Mr Parker and his family relating to his wish not to be resuscitated but did want to be comfortable. Whilst in Kingston Centre, a conversation held regarding resuscitation and advanced planning indicated that Mr Parker did not wish to be bed-bound and in the event that he was not going to recover his function, then palliative care only was to be provided.

36. Mr Parker had a medical history of bronchiectasis[21], pulmonary fibrosis[22] (with recurrent chest infections), dysphagia[23], epilepsy acquired brain injury, behavioural disturbance[24], congestive cardiac failure[25], paroxysmal atrial fibrillation[26], depression, obsessive compulsive disorder and spasms. Mr Parker was noted to be frail, independent but requiring some assistance with his activities of daily living.

37. At the time of his death, Mr Parker was cachectic[27] with a body mass index (**BMI**)[28] of 14. Mr Parker's health management plan, dated 28 August 2017, indicates that Mr Parker's weight was 47.7 kilograms (**kgs**) and height, 1.68 centimetres. Mr Parker's weight was documented as 52.3kgs on 28 November 2016. McGregor Gardens progress noted detail he was reviewed by a dietician in January of 2017. The review indicated "frequent food refusal behaviours, often declines to come to dining room […] can also be extremely slow or non-compliant with medications. Mr Parker was referred to speech pathology in January of 2017 and reviewed in May of 2017 for concerns over his increased difficulty with swallowing.

38. Mr Parker had several allergies including morphine[29], Rulide, Voltaren and phenytoin.

39. On 11 September 2017, Mr Parker's daughter, Allison Parker, and McGregor Gardens facility manager, Dion Kimutai[30], had a meeting to discuss the circumstances leading up

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[21] Bronchiectasis is a lung disease that occurs when the walls of the breathing tubes or airways widen due to chronic inflammation and/ or infection. This results in irreversible damage to the lungs, which allows mucus to pool in the damaged airways.

[22] Causes the lungs to become scarred and stiffened.

[23] Difficulty swallowing.

[24] Physical, verbal aggression and sexually inappropriate at times. Mr Parker "agreed to a referral to Aged Care Persons Mental Health Care for review re ongoing management of manipulative behaviour".

[25] A chronic condition whereby the ability of the heart to effectively pump blood is reduced. Common symptoms include breathlessness, fatigue and limb oedema.

[26] Paroxysmal atrial fibrillation (**PAF**), also termed intermittent atrial fibrillation (**AF**), is defined as recurrent (two or more) episodes of AF that terminate spontaneously in less than seven days, usually less than 24 hours.

[27] Wasting syndrome is loss of weight, muscle atrophy, fatigue, weakness and significant loss of appetite in someone who is not actively trying to lose weight. The formal definition of cachexia is the loss of body mass that cannot be reversed nutritionally.

[28] BMI is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as weight in kilograms divided by the square of the height in metres (**kg/m2**). According to the World Health Organisation, the normal range is 18.5 to 24.99.

[29] Documentation in the Monash Health scanned records detail that Mr Parker had stayed at Willow View Facility. The medication chart documents a verbal statement from Mr Parker that "morphine did cause his left arm to become swollen".

to his death. Ms Parker was informed that her father had been given the wrong medication by a PCW.

40. During the course of the coronial investigation, several queries were raised by Mr Parker's family. At my request, the CPU undertook to further investigate the issues raised. For ease of reading, I have addressed each issue in separate subheadings below.

<u>The incorrect drug administered to Mr Parker was crushed, leading to inappropriate delivery of a slow acting medication and therefore, increasing the risk of harm.</u>

41. Mr Kimutai's statement was unable to provide an answer as to whether the medication was crushed or not.

42. I do, however, note that the crushing of the medication was noted in the E-Medical Deposition Form and that this document is a contemporaneous document to Mr Parker's death.

<u>Despite Mr Parker's frailties, he may have lived longer if the medication error did not occur.</u>

43. Prior to the medication error, Mr Parker's observations were noted to include a high respiratory rate, borderline blood pressure and low oxygen saturations. Mr Parker was also noted to be lethargic and resting in bed. These observations resulted in the request for the attendance of a locum doctor to review Mr Parker. This request occurred before the medication error.

44. On identification of the medication error, the PCW informed the RN. Mr Parker was reviewed by two locum doctors. Their notes indicate that they were both aware of the medication error. Observations were maintained and when Mr Parker deteriorated, emergency services were called.

45. The information provided to the CPU indicates that Mr Parker was unwell on the day of the medication error on the background of functional decline throughout 2017. Mr

[30] Evidence and correspondence throughout the coronial process has been received in the name of Dion Kimutai and Dion Mutai. Despite the discrepancy in surname, I consider all evidence in both names as being from the same individual. For the purpose of consistency throughout this Finding, all references to this person will be in the name of Dion Kimutai (Mr Kimutai).

Parker had been reviewed by two doctors on the day of the medication error, both of whom considered Mr Parker to be suffering pneumonia.

46. In the Medical Examiner's Report, Dr Parsons detailed that given the medication was incorrectly administered a month prior to Mr Parker's death, it was unclear whether it contributed to his death, noting that Mr Parker had several comorbidities.

47. Given Mr Parker's decline throughout 2017, the fact that he was noted to be unwell prior to the medication error and the fact that consideration had been given for Mr Parker to attend rehabilitation, I am unable to solely determine that the medication error exacerbated Mr Parker's frailty and ultimate demise.

How did Mr Parker receive the incorrect drug?

48. In his statement, Mr Kimutai detailed that the PCW had commenced the medication round and had prepared medication to give to another resident, however, when the PCW entered the resident's room, the resident was not there.

49. On the way to Mr Parker's room, the PCW assisted another resident with toileting. When she attended Mr Parker's room after this, the PCW reported a lapse in concentration and provided Mr Parker with the other resident's medication.

50. When the PCW went to sign for the medication administration on the medication chart, she realised the error in administration and immediately notified the RN.

51. The statement from Ms Parker details information that was relayed to both Mr Parker's wife, Heather Parker and Ms Parker during the 11 September 2017 meeting with Mr Kimutai. Specifically, Ms Parker states,

> The staff member that was administering the medication that night had a busy night with another resident having had a fall and another one in palliative care and she had been pulled away a few times and the medication administration had been interrupted. She was also not normally working in that ward.

52. Mr Kimutai further stated that the medications were administered orally and, therefore, not administered via the wrong route.

53. In addition to the concerns identified by Mr Parker's family, I considered there to be several other issues that I tasked the CPU with investigating. For ease of reading, I have addressed each issue in separate subheadings below.

Was the medication administration current and within best practice?

54. Mr Kimutai provided detail that on the evening of 3 September 2017, the staff ratio was one RN, two enrolled nurses and nine PCWs. The online information for McGregor Gardens states that the facility can accommodate 90 residents with an 18 bed memory support unit[31].

55. Mr Kimutai stated,

> PCWs only administered medication on medication administration aids prepared by the pharmacist.
>
> […]
>
> All staff administering medication complete annual (theory and practical) medication competency.
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> […]
>
> Regularly prescribed Schedule 8 medications are packed in administrative aids (Webster packs) with other regular prescribed medications.

56. McGregor Gardens quality and clinical operations manager, Cathy Klomp, detailed that McGregor Gardens has a "strict process" in place to educate PCWs in correct medication administration. This includes checking the qualifications of the PCW to ascertain if they have been previously educated in "checking procedures for medication administration". If the PCW has, then additional education is provided, followed by practical competency being checked by an RN. Upon successful completion of the abovementioned, the PCW is then supervised for two shifts to ensure safe administering practices.

57. The *Australian Prescriber*[32] states,

[31] The coronial investigation did not identify whether McGregor Gardens was at capacity on 3 September 2017.

[32] Jackson, J. and Welsh, E. (2017). Medication charts in residential aged-care facilities. *Australian Prescriber*, accessed 8 May 2019.

> All jurisdictions require a registered nurse or enrolled nurse to be responsible for the drugs given in a residential aged-care facility. However, in some circumstances, trained nursing assistants are able to help residents to self-administer medicines. […] If the drug is supplied in a dose administration aid, the staff member who assists a resident to self-administer or who administers the contents must sign for doing so without the responsibility of identifying each drug.

58. The Australian Nursing and Midwifery Federation state,

> Assistants in nursing or personal care workers are not qualified to give medicines. They can help people who are able to take their own medicines from a pre-packaged medicine container, but nothing more.
>
> […]
>
> As a part of their training, every registered nurse learns how medicines should be used. They know how to give them safely and in the way the laws say they should be given. They know about the changes that happen to a person's body as they get older and about different chronic illness.
>
> Registered nurses also have expert knowledge about what different medicines do, so they know what to look for to see if the medicines are having a good or bad effect.

59. Ms Klomp stated that McGregor Gardens undertook an investigation. The investigation identified that the PCA administered medication on her first unsupervised medication round, having completed all the requirements detailed in paragraph [56].

> On this occasion the PCA had failed to follow the correct procedure. In addition, all staff had their medication administration competencies re-assessed, the home has implemented a new and improved medication course[33] and there has been a focus on employing enrolled nurses to administer medications.

60. The CPU is aware that the provision of PCWs assisting residents with medications is a current practice within many aged care facilities.

61. In this matter, the CPU considered the PCW did not identify the initial resident for whom the medication was to be provided to prior to the medications being dispensed and inadvertently provided the medications to Mr Parker.

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[33] Mr Kimutai was unable to locate the medication education package which was utilised at the time of the medication error.

62. Mr Kimutai was asked if there had been practice improvements within McGregor Gardens since Mr Parker's death and the subsequent investigation. Mr Kimutai stated,

> […] the PCA was removed from administering medications completely. In addition, all staff had their medication administration competencies re-assessed, the home has implemented a new and improved medication course and there has been a focus on employing enrolled nurses to administer medications.

63. In an additional statement to the Court, Mr Kimutai confirmed,

> […] recruit more EENs[34] and utilise only EEN and RN for medication administration. Change medication administration training and competency to 'Choice Aged Care' package. Implemented 'MEDICATION ROUNDS DO NOT DISTURB' vest to minimise disruption of staff during medication administration rounds.

Was the response to the medication error timely?

64. The CPU considered that on identification of the medication error, the response was immediate, appropriate and timely with open disclosure occurring.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Mr Parker had resided at McGregor Gardens for ten years. It is well documented that his health and function deteriorated from early 2017, with significant weight loss and increasing requirements for assistance with daily living.

2. Mr Parker was administered another resident's medication. The medication administration included a Schedule 8 drug. On realisation of the medication error a short time after, a registered nurse was informed, who then sought to have Mr Parker medically reviewed. Mr Parker was reviewed twice before Ambulance Victoria was called due to his deterioration. An incident form was completed and sent to the general practitioner.

[34] Endorsed enrolled nurse.

3. Having reviewed the evidence before me, I consider the patient care worker's lack of experience, knowledge and the interruptions experienced by her prior to the medication error, contributed to the incorrect administration of medication to Mr Parker.

4. Having reviewed the evidence before me, I also consider system failures including staffing level, skill mix and workload to have contributed to the medication error.

5. Mr Parker died 26 days after the medication error. He had received medical treatment over the preceding days to treat pneumonia initially and then received input from allied services. For the majority of his time at Monash Health, Mr Parker was alert and responsive, although at times confused.

6. An opportunity for rehabilitation was provided to Mr Parker, however, due to his significant medical history and recent deterioration, including weight loss and frailty over the previous nine months, a decision was made to provide palliative care.

7. There is no evidence available to me to suggest the medication error caused or contributed to Mr Parker's death, instead indicating that his death was in the setting of significant functional decline in the months preceding his death. I nonetheless, consider the medication error to be an issue of significant public interest.

8. In September of 2017, a report from the New South Wales Nurses and Midwives association noted that medication management was among the top five complaints received by the Aged Care Complaints Commissioner in 2015/2016. The report stated,

> AiNs[35] being given medication competency training by trainers who aren't competent themselves, and RNs being given the impossible task of overseeing medications for up to 200 residents in a facility where residents are housed.

9. On 9 October 2017, the Australian Commission on Safety and Quality in Healthcare stated,

> Previous estimates indicate between 2%-3% of all Australian hospital admissions are medication related […] Medication errors can occur for a number of reasons, including human and other factors affecting how medicines are prescribed, dispensed and administered.

[35] Assistants in nursing.

10. I acknowledge McGregor Gardens undertook prompt and transparent open disclosure of the medication error to Mr Parker's family, including the meeting held on 11 September 2017.

11. I further acknowledge the introduction of the *do not disturb* vest to minimise interruptions during medication rounds.

12. APINCH[36] medications are recognised as particularly dangerous medications. Whilst many patients self-administer opioids in their own home, hospitals adhere to a strict protocol of obtaining the controlled drug, documentation, patient checking and administration. This process is undertaken by suitably qualified staff, commonly two registered nurses and not by an untrained and unregulated workforce.

13. Conversely, in aged care facilities, regular opioid medications appear to be placed in the resident's Webster pack. These Webster packs are placed in a "medications trolley" and the trolley is taken around the residents' rooms, creating the potential for systems risk for both inadvertent error and human factor risk, particularly when underqualified staff are used to administer high-risk medication. The difference in medication practices between hospitals and aged care facilities are difficult to reconcile, particularly when regard is had to the vulnerabilities of this cohort. For this reason, I have chosen to include the Royal Commission into Aged Care Quality and Safety and the Aged Care Quality and Safety Commission in the distribution list of this Finding.

[36] High-risk medications, Antimicrobials; potassium and electrolytes; Insulin; Narcotics (opioids) and other sedatives; Chemotherapeutic agents; Heparin ad other anticoagulants. Errors with these medications are not necessarily more common than with other medications, however, as they have a very narrow margin of safety, the consequences with these medications can be more devastating.

FINDINGS

1. I find that Phillip Harry Parker, born 15 September 1956, died on 29 September 2017 at Monash Health- Kingston Centre located on the corner of Warrigal Road and Heatherton Road, Cheltenham Victoria 3192.

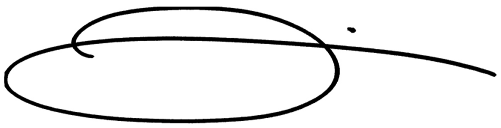
2. I accept and adopt the cause of death ascribed by Dr Sarah Parsons and I find that the cause of Phillip Harry Parker's death was pneumonia.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Heather Parker
Cathy Klomp, McGregor Gardens
Danielle Grant-Cross, Director, Counselling, Enquiry and Correspondence, Royal Commission into Aged Care Quality and Safety
Senior Constable Douglas McKiggan

Signature:



AUDREY JAMIESON
CORONER
Date**: 22 October 2020**