IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004769

Related cases:
COR 2025 000029
COR 2025 006756

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

RACF Medication Error Finding No. 2

Findings of:	Coroner Ingrid Giles
Deceased:	Lynette Patricia McHarry
Date of birth:	18 November 1954
Date of death:	15 August 2024
Cause of death:	1a: EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ISCHAEMIC HEART DISEASE IN THE SETTING OF CLOZAPINE ADMINISTRATION
Place of death:	Monash Health - Casey Hospital, 62-70 Kangan Drive, Berwick Victoria 3806
Keywords:	Medication error; residential aged care facility, medication safety standards, preventable death, national standards, recommendations

INTRODUCTION

1. On 15 August 2024, Lynette Patricia McHarry (**Lynette**) was 69 years old when she died at Casey Hospital following the administration of another patient's medication to her at her residential aged care facility (**RACF**). At the time of her death, Lynette lived at Mooraleigh Hostel in Bentleigh East, Victoria (**Mooraleigh Hostel**), a RACF operated by Monash Health.

2. Lynette had a medical history of asthma / chronic obstructive pulmonary disease **(COPD)**, dementia, schizoaffective disorder and obesity, and was under investigation for ischaemic heart disease.

THE CORONIAL INVESTIGATION

3. Lynette'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.

4. 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.

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

6. Following the report of Lynette's death to the Coroners Court, I directed for a statement to be obtained from her aged care facility, and was provided in February 2025 with a detailed Serious Adverse Patient Safety Event (**SAPSE**) review conducted by Monash Health, which details the circumstances of the medication error that preceded Lynette's death (**SAPSE Report**), along with a comprehensive statement from Dr Adam Mohd Idris (**Dr Idris**) of Monash Health, dated 24 June 2025. I also obtained a statement from the Inspector-General of Aged Care.

7. This finding draws on the totality of the coronial investigation into the death of Lynette Patricia McHarry. 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.[1]

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

Circumstances in which the death occurred

8. According to the evidence before me,[2] on Sunday, 4 August 2024, at 7pm, Lynette was mistakenly administered clozapine 300mg from another resident's Webster-pak (a dose administration aid in the form of a pre-prepared medication pack). This error occurred when another resident's clozapine was inadvertently placed in Lynette's pill cup due to distraction during the medication administration process. The staff member who administered the clozapine was a psychiatric services officer (**PSO**).

9. Lynette alerted the PSO that she had not recognised one of the medications that she had just taken. The PSO realised the error and reported it to the charge nurse, who further escalated the error to the offsite nursing coordinator.

10. Lynette was reportedly drowsy after the clozapine administration, though initial observations were reportedly within normal limits, including Glasgow Coma Scale (**GCS**) of 15/15. Lynette was reviewed by a doctor from a locum general practitioner (**GP**) service at 21:40, and her vital signs were still found to be within normal limits. The plan was to continue monitoring her vital signs and arrange for transfer to hospital if she deteriorated. There was no treatment given for the clozapine ingestion.

11. Lynette's vital signs reportedly remained stable prior to 04:30 (Monday 5 August), when she had an unwitnessed fall and was found lying next to her bed. Her vital signs were a GCS 14/15 (eyes open to speech, oriented to time, place, person and obeying commands), heart rate 105 beats/min (high), blood pressure 140/95mmHg , oxygen saturation 93% on room air (normal for Lynette), respiratory rate of 20 breaths/min and blood glucose level 6.7 mmol/L (N: 3-

[1] 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.

[2] This includes the medical deposition from Casey Hospital, autopsy report, statement from Dr Adam Mohd Idris of Monash Health, and the SAPSE Report. In relation to the latter, I have previously issued rulings to the effect that, in accordance with the provisions of the *Health Services Act 1988*, SAPSE reports may be used and relied upon by a Coroner investigating a death – see '*Rulings regarding use of SAPSE documents*' in the matter of the inquest into the death of Christopher Keisler, COR 2023 4999, available here and here.

7.7). Lynette was assisted back to bed, and the nurse in charge, locum GP and family were notified.

12. At 05:30, her GCS was 8/15 (no eye-opening, incomprehensible sounds, localising to pain), and the nurse in charge called the ambulance. The ambulance arrived at 06:30 and found the resident to have a GCS 9/15, T 39.4°C (high) and a heart rate of 105 beats/min.

13. Lynette was transferred to the Emergency Department (**ED**) of Casey Hospital at 07:35 and was admitted to ICU overnight for close observation for clozapine-related sedation and treatment of likely chest sepsis secondary to aspiration pneumonia in in the setting of a decreased conscious state from the clozapine overdose. She had initial improvement in her conscious state but deteriorated despite ongoing treatment with antibiotics, bronchodilators, steroids, diuretics and a brief period of non-invasive respiratory pressure support.

14. On Tuesday 13 August 2024, Lynette developed type 2 respiratory failure and continued to deteriorate.

15. After several medical emergency team (**MET**) calls and discussions between the consultant and her family, Lynette was transitioned to comfort care, and died on Thursday, 15 August 2024, at 20:08.

Identity of the deceased

16. On 15 August 2024, Lynette Patricia McHarry, born 18 November 1954, was visually identified by her son, Stephen McHarry.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Joanne Ho (**Dr Ho**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 August 2024 and provided a written report of her findings dated 5 February 2025.

19. Toxicological analysis of antemortem blood showed clozapine, aripiprazole and risperidone (including metabolite hydroxyrisperidone). Dr Ho explained that clozapine is a second generation (atypical) antipsychotic drug. Serious adverse effects of clozapine include arrhythmias, coma, elevation of liver enzymes, hematologic disorders, respiratory depression,

seizures, and tardive dyskinesia (a neurological syndrome that involves involuntary movements).

20. Dr Ho explained that clinically, Lynette was thought to have chest sepsis likely due to aspiration pneumonia and type 2 respiratory failure then a likely infective exacerbation of her airways disease. No infective changes were identified at autopsy (and notably she had a clear chest x-ray on admission), however, this does not entirely exclude a component of aspiration or infection at the time of admission.

21. The autopsy showed bilateral pleural effusions (fluid within the lung cavities), chronic bronchitis and focal mucus plugging within the lungs, an enlarged heart (cardiac hypertrophy) and severe atherosclerosis of the left anterior descending coronary artery. There was no post mortem evidence of any injuries which may have caused or contributed to death.

22. Dr Ho provided an opinion that the medical cause of death was *1(a) exacerbation of chronic obstructive pulmonary disease and ischaemic heart disease in the setting of clozapine administration*.

23. I accept Dr Ho's opinion.

SAPSE REVIEW

24. As detailed in the statement of Dr Idris of Monash Health and the SAPSE Report, the SAPSE review panel included two findings regarding the incident, with a number of lessons learned.

i. Clozapine was administered to the wrong resident in error

25. The review panel found that clozapine was administered to Lynette when the PSO became distracted during the medication round, which is conducted in a kitchen facility to '*provide a home-like environment*'. At the time of the incident, there were limited strategies in place to mitigate distractions faced by the PSO. Since this time, Monash Health has implemented two strategies to decrease distraction during medication administration, namely:

    a) Using visual alerts (such as staff donning a 'Medication Bib') which alerts residents that a medication round is occurring; and
    b) Installation of automatic closing doors for the kitchenette medication cupboards, which close shortly after opening. This slows down the medication round, further optimising focus on the task, and limits access to any other residents' medications at the time of dispensing for an individual.

26. The SAPSE review panel also found that psychiatric medication should be administered by a registered nurse only, and as result of this review, only registered nurses are administering clozapine at Monash Health Residential Care Homes.

ii. There was a delay in managing the clozapine medication error

27. The review panel also found that medical and nursing staff did not recognise that a clozapine administration error requires timely management. Clozapine (an antipsychotic agent) is a high-risk medication that requires nuanced expertise from psychiatry and pharmacy when incorrectly administered and requires urgent treatment when given in error.

28. Further, clozapine was not included in Lynette's medication 'alert list', despite a past medical history of 'myocarditis related to clozapine'. Had the medication alert been documented, staff may have recognised and expedited earlier transfer and treatment. The panel noted the lack of electronic prescribing system at Mooraleigh Hostel, which can result in increased transcription errors. With this in mind, Monash Health is transitioning to an electronic prescribing system for all residential aged care facilities.

29. The panel commented that the significance of a clozapine administration error is commonly known amongst mental health trained clinicians, but not well-known outside of this group. The panel considered that there are further opportunities to optimise training of the management (and inadvertent administration) of clozapine for registered nurses. All registered nurses at Monash Health Residential Care Homes are now required to complete training in relation to clozapine annually which includes inadvertent administration.

30. Finally, the panel considered that at the time of the review there was no formal procedure to guide nursing and medical staff in the management and escalation of medication errors. It indicated that there is work underway to review the Medication Administration procedure for this context. The panel advised that any future clozapine medication errors in residential care should be reported to the aged person's mental health team or psychiatrist on call after hours.

Conclusion of SAPSE Review

31. The panel concluded that the outcome of this case '*may have been prevented*' and determined that the delay to transfer to hospital resulted in a missed window of opportunity for gastrointestinal decontamination which resulted in absorption of a highly sedating drug in a large dose. This contributed to Lynette's clinical deterioration and death.

CPU REVIEW

32. On the basis that Lynette's death is one of three deaths I am investigating in 2024 and 2025 which followed the erroneous administration of another patient's medication to a different resident at a RACF, and which forms part of a pattern of medication errors in RACFs more broadly, I determined to refer the case to the Coroners Prevention Unit (**CPU**)[3] for advice. Following receipt of this advice, I clustered the three cases together for examination of the common issues – and prevention opportunities – as the '**RACF Medication Error Cluster'.**

33. In relation to Lynette's death, I sought CPU advice on: (i) the care provided to Lynette in the lead-up to her death; (ii) whether there are any systemic issues that underpin medication errors in residential aged care facilities; and (iii) whether there are any clear prevention opportunities to address the risk of medication errors occurring in RACF settings.

Health and Medical Investigation Team advice

34. The CPU Health and Medical Investigation Team agreed with the findings of the SAPSE review and did not identify any further opportunities for prevention in Lynette's case. The CPU opined that this was a case of human error where there was a lack of adherence to the six 'rights' of medication administration (patient, medication, dose, time, route and documentation)[4] and which includes similar contributing factors of clinician distraction to other cases being investigated by the Court. The CPU opined that human error may be reduced in RACFs if clear standards are developed to support, amongst other things, these six 'rights' of medication administration.

35. The CPU agreed that '000' should have been called immediately following the incident. The CPU opined that greater clarity about when and how to escalate medication errors would have assisted staff in this instance.

Research and Policy team advice

36. In terms of data, the CPU Research and Policy Team identified six medication administration error-related deaths of residents in residential aged care facilities in Victoria between 21

[3] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists coroners with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas, including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[4] *See for example* Aged Care Quality and Safety Commission 'Transcribing and dispensing errors', 20 June 2023, available here.

October 2021 and October 2025. Three concerned a situation in which the resident had been mis-administered another resident's medication (all three of which are the subject of my current cluster investigation) and three concerned an incorrect dosage of the resident's own prescribed medication. The CPU also identified four potentially relevant deaths where there was either conflicting evidence or insufficient evidence to establish whether the deaths were related to medication administration errors.

37. Finally, the CPU identified five deaths of RACF residents where a medication administration error occurred in the RACF but the forensic pathologist and/or coroner concluded that the cause of death was unrelated to the error. The CPU included the latter set of deaths in its dataset '*because they demonstrate that medication errors in RACFs are more widespread than the deaths would appear to indicate*'.

38. In light of this data, and of the fact that fatal medication errors in RACFs are also apparent across other Australian jurisdictions, I determined to obtain further evidence on the broader policy and regulation landscape in which staff at RACFs are operating to assist in determining what prevention opportunities there might be to reduce the incidence of medication errors.

AGED CARE QUALITY AND SAFETY COMMISSION

39. The ACQSC addressed, at my request, the question of whether there are any aged-care specific national medication safety standards that exist to support safe medication administration to those in RACFs.

40. In response, the ACQSC noted that **there are no national medication safety standards specific to residential aged care facilities**.

41. At the time of Lynette's death, the ACQSC regulated Commonwealth funded aged care services under the *Aged Care Act 1997* (Cth), including oversight of approved providers' compliance with the Aged Care Quality Standards. Approved providers were required to comply with the Aged Care Quality Standards, including Standard 3, which required providers to deliver safe, effective and quality personal and clinical care, including the effective management of high-impact or high-prevalence risks associated with the care of each consumer. Medication management falls within this broader clinical care and risk management framework. **The guidance in Standard 3 was not clinical guidance and did not prescribe how care must be delivered**. Providers were responsible for implementing their own policies, procedures and systems to support the safe delivery of care.

42. Whilst this is not a national medication safety standard *per se*, the 'Guiding principles for medication management in residential aged care facilities', published in 2022 by the Department of Health, Disability and Ageing is a useful resource for providers.[5]

43. From 1 November 2025, the aged care legislative framework transitioned to the *Aged Care Act 2024* and strengthened Aged Care Quality Standards (**Quality Standards**). These Quality Standards apply to registered providers delivering care in residential aged care facilities and include Standard 5 – Clinical Care and outcome 5.3 – Safe and quality use of medicines. The Court notes that again, even the strengthened Quality Standards do not prescribe the specific systems and processes required to ensure safe and appropriate use of medicines.

INSPECTOR-GENERAL OF AGED CARE

44. To complement my understanding of the broader systemic issues at play, and given there appeared to be no national medication safety standards for RACFs, the CPU obtained a statement from the Inspector-General of Aged Care, Ms Natalie-Siegel Brown (**Inspector-General**). The Inspector-General, and the Office of the Inspector-General of Aged Care (**the Office**) were established under the *Inspector-General of Aged Care Act 2023* to provide independent oversight of the aged care system.

Safety standards for medication administration in residential aged care facilities

45. The Inspector-General stated that identifying and reducing medication errors in residential aged care facilities is essential to the delivery of safe, rights-based person-centred high-quality care for all older people; a promise of the new *Aged Care Act 2024*.

46. The Inspector-General stated that, when administering medication, aged care providers need to ensure their workforce adheres to the best practice guidelines and standards. In residential aged care facilities, Registered Nurses (**RNs**) manage and administer complex medications. Enrolled Nurses (**ENs**) can also administer medications if they have completed requisite training, and usually under RN supervision. Personal Care Workers (**PCWs**) can assist with simpler forms of medication (some tablets and creams) after receiving specific training.

47. The Australian Nurses and Midwifery Federation Best Practice Guidance for Medicines Use by Nurses in Aged Care 2025 (**ANMF Guidelines**) provide guidance for RNs, ENs, PWCs

[5] Available: https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities?language=en

and aged care providers more broadly to manage medication for older persons safely.[6] The ANMF Guidelines are designed in accordance with the *Health Practitioner Regulation National Law Act 2009* and the Nursing and Midwifery Board of Australia (**NMBA**) standards for practice to support the quality use of medicines in residential aged care.

48. Those providing medications to people in aged care facilities also need to comply with the Medication Safety Standard (**the Standard**).[7] The Standard is intended to ensure qualified clinicians safely prescribe, dispense, and administer appropriate medicines, and monitor medicine use across Australia. Compliance with the Standard also requires consumers to be informed about medicines, including personal risks and medicine requirements.

49. The Standard addresses areas of medication management that have a known risk of error and provides health service organisations with sound governance for safe and quality use of medicines, intended to reduce medicine-related incidents.

50. Critically, the Inspector-General noted that, there are still gaps and major concerns lie in regulation and implementation.

What are the gaps?

51. The Inspector-General's 2025 Progress Report on the Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety (**2025 Progress Report**)[8] addresses critical concerns about the absence of current strategies, policies, or guidance to identify and reduce medication errors in residential aged care facilities. The Inspector-General has called for the development of:

    a) National medication safety standards for aged care, noting that the current standard covers health settings broadly – it is not aged care-specific;
    b) Introduction of mandatory reporting of medication incidents; and
    c) Better integration of pharmacists into aged care teams to help reduce errors.

[6] Available: https://anmf.org.au/media/h4ybjath/anmf-best-practice-guidance-for-medicines-use-by-nurses-in-aged-care-2025.pdf
[7] Available: https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/medication-safety-standard
[8] Available: https://www.igac.gov.au/resources/2025-progress-report-implementation-recommendations-royal-commission-aged-care-quality-and-safety

52. The Inspector-General noted that medication errors can occur at any stage: in procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering, and monitoring the effects of medicines.

53. The Inspector-General opined that without aged care-specific national medication safety standards and supporting policy frameworks, the risk of medication errors in residential aged care will remain. Furthermore, the Inspector-General considers that when errors do occur, the current reporting systems may not be adequate to enable to determine the extent to which medication mismanagement is a systemic issue in aged care settings.

54. The *Aged Care Act 2024* legislates a rights-based system of aged care, entitling recipients to 'high quality care'. The Act exhaustively defines 'high quality care' (section 20), but chiefly, it requires that aged care services should prioritise, amongst other things, the delivery of high-quality nursing services by sufficient numbers of qualified and experienced direct care staff members.

55. The Inspector-General considers repeated failures to address medication mismanagement, including the delivery of medications and reporting of errors, are clearly contrary to the delivery of 'high-quality' care.

56. The Inspector-General has also noted that the deaths I am investigating represent an opportunity to determine whether these deaths point to a more widespread problem with medication misadministration, and if so, where intervention and reform would be most effective.

57. The Inspector-General acknowledged the reforms undertaken by government following the Royal Commission into Aged Care Quality and Safety (**Royal Commission**) to strengthen the quality of aged care services in Australia and to protect the health and wellbeing of older people.

58. The Inspector-General opined, however, that despite the intent of the Royal Commission, national standards and clear policy frameworks are not yet in place to support the safe prescribing, dispensing and administration of medications in residential aged care, and expresses concern that, in the absence of same, older people continue to be at risk of harm.[9]

[9] I note that this observation has been made despite the introduction of strengthened Aged Care Quality Standards as of November 2025. I understand why. Notably, while there is a standard on Clinical Care, this does not prescribe the specific systems and processes required of staff to ensure safe and appropriate use of medications in RACFs. While different states

NATURAL JUSTICE PROCESS

59. Monash Health was provided with the opportunity to respond to my proposed findings that the medication error that occurred at Mooraleigh Hostel had a causal role in Lynette's death, and that '000' should have been called immediately upon the erroneous administration of the medication.

60. Monash Health noted that these findings are consistent with those in the SAPSE Report, and that the lessons and recommendations from that review have been implemented at all Monash Health-operated RACFs.

61. Monash Health also noted that Mooraleigh Hostel, where Lynette resided in the lead-up to her death, has since been decommissioned. A new RACF named 'Boollam Boollam' has since opened, which includes features such as a dedicated medication room to assist staff in preparing medications without distraction.

FINDINGS AND CONCLUSION

62. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    a) the identity of the deceased was Lynette Patricia McHarry, born 18 November 1954;

    b) the death occurred on 15 August 2024 at Monash Health - Casey Hospital, 62-70 Kangan Drive, Berwick Victoria 3806, from 1(a) *exacerbation of chronic obstructive pulmonary disease and ischaemic heart disease in the setting of clozapine administration*, and

    c) the death occurred in the circumstances described above.

63. Having considered all of the circumstances, I am satisfied that Lynette died following a medication error in which she was administered another patient's medication, and which had a causal role in her death. While she had a significant burden of natural disease including chronic obstructive pulmonary disease and ischaemic heart disease, it was the administration

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and territories have their own legislative requirements, the lack of specificity in the Quality Standards and reliance on guidance across a number of separate documents risks creating difficulties in auditing RACFs and difficulties in understanding what specific measures are in fact required to ensure safe prescribing, dispensing and administering of medications in RACFs for aged care providers, staff, family members and residents alike. The latter is important to recall, given that a critical part of the new *Aged Care Act 2024* is a right-based, person-centred framework that centres around the resident.

of another resident's clozapine to her on 4 August 2024 that triggered her deterioration and ultimate death.

64. I find that, despite realising that a serious medication error had occurred, Mooraleigh Hostel failed to appropriately escalate her care, and that '000' should have been called immediately following the misadministration of clozapine to Lynette. The failure to do so meant that the treatment she needed to address the effects of the clozapine – in relation to which she had a known adverse reaction – was unnecessarily delayed.

65. I find that the care and treatment provided to Lynette once she arrived at Casey Hospital was reasonable and appropriate, but that at that stage, her clinical trajectory was sadly irreversible.

66. I find that Lynette's death was preventable.

67. However, I commend Monash Health for the detailed review it undertook following Lynette's death, which comprehensively identified the issues in her care and appropriate prevention opportunities, and acknowledge the positive changes it has made to the way in which medications are administered to residents in Monash Health facilities since the time of Lynette's death. The depth and quality of that review have obviated the need for extensive coronial comment or recommendations.

68. The systems improvements made by Monash Health since Lynette's death include environmental changes to the storage areas for the medications to reduce the risk of reoccurrence of an error, the creation of dedicated medication rooms, and the completion by all Residential Aged Care staff of a medication competency course to ensure that there is a known level of competence with medication administration requirements.

69. Together with the recommendation made in my finding, I am hopeful that the residents of aged care facilities, both Monash Health-operated and beyond, will have better systems in place to ensure a significantly reduced risk of medication errors, the outcome of which can be fatal.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The Inspector-General of Aged Care has noted that the deaths of the three elderly women by way of medication misadministration that I have examined in this cluster to be '*horrific*'. I have found that the medication errors that preceded these three deaths to have been entirely

preventable. The fact that these fatal medication errors occurred in relation to a cohort of older persons, in the twilight of their lives, does not lessen the seriousness of the outcome; given their dependence on others for their care, it amplifies it.

2. Indeed, I consider that these three cases highlight that much more can, and should, be done to ensure safety of members of our community who can often be highly vulnerable – our elderly.

3. I note that the Victorian Government has taken recent action to improve medication safety for residents of RACFs in Victoria, mandating that, from 1 July 2026, registered aged care providers in Victoria will be required to ensure only nurses (or other registered health practitioners) administer prescribed and dispensed drugs of dependence and Schedules 4, 8 and 9 medications to residents of their homes. The requirement is through amendments to the *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

4. The rationale includes that '*as the final checkpoint before medication is given, nurses play an important role in ensuring the correct medication has been prescribed and dispensed. This requires medical literacy, and physiological understanding and knowledge of how medications affect older people - skills nurses develop through their education.*'[10]

5. I consider this to be a positive step towards enhanced medication safety for Victorian residents of RACFs, bringing Victoria into line with other jurisdictions.

6. However, medication misadministration in aged care facilities is a broader issue that requires urgent reform. My investigation has revealed that, despite the existence of organisation-based medication protocols and national guidance, RACFs are in urgent need of clearer medication safety standards that are specific to the unique environment staff are operating in, including post-error escalation and reporting protocols, to help ensure the patchwork of current guidance is clarified and standardised so that all RACF staff are adequately supported to perform their roles safely.

7. My investigation has revealed that those administering medications to residents at RACFs may not always be familiar with the residents or their medication regime, may become distracted when attempting to multi-task, and may not fully appreciate the effects of the (often high-risk) medications that are being administered. Unlike a hospital or other clinical environment, at an RACF, there is seldom a doctor onsite 24/7 from whom to seek advice or

[10] See https://www.health.vic.gov.au/sites/default/files/2026-06/guidance-medication-administration-in-rac-june-2026.pdf.

escalate care to when a medication error occurs. Concerningly, in two out of three of the cases I investigated, staff delayed escalating the incident to '000' in circumstances where time was of the essence.

8. The Inspector-General of Aged Care has noted that, despite the intent of the Royal Commission into Aged Care Quality and Safety, national standards and clear policy frameworks are not yet in place to support the safe prescribing, dispensing and administration of medications in residential aged care, and expresses concern that, in the absence of same, older people continue to be at risk of harm.

9. As submitted by the Inspector-General and by the Coroners Prevention Unit, I consider that this ongoing risk points to the need for a national medication standard in residential aged care facilities as a matter of urgency.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) That the **Department of Health, Disability and Ageing** urgently progress the development of a clear national medication safety standard to support the safe prescribing, dispensing and administration of medications in residential aged care facilities, along with clear standards on requirements for any post-error emergency response and reporting mechanisms for the same.

I convey my sincere condolences to Lynette's family for their profound loss.

ORDERS AND DIRECTIONS

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

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

Stephen McHarry, Senior Next of Kin

Monash Health

Aged Care Quality and Safety Commission

Inspector-General of Aged Care

Australian Health Practitioner Regulation Agency

Victorian Department of Health

Commonwealth Department of Health, Disability and Ageing

Australian Commission on Safety and Quality in Health Care

Senior Sergeant Catherine Mussared, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 29 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.