IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000029

Related cases:
COR 2024 004769
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. 3

Findings of:	Coroner Ingrid Giles
Deceased:	Mrs LV[1]
Date of birth:	[redacted] 1946
Date of death:	2 January 2025
Cause of death:	1a: MEDICATION ERROR RESULTING IN COMBINED DRUG TOXICITY
Place of death:	The Bays Aged Care 86 Victoria Street Hastings Victoria 3915
Keywords:	Medication error; residential aged care facility, medication safety standards, preventable death, national standards, recommendations

[1] This Finding has been de-identified by order of Coroner Ingrid Giles to replace the name of deceased with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

1. On 2 January 2025, Mrs LV was 78 years old when she died following the administration of another patient's medication to her at her residential aged care facility (**RACF**). At the time of her death, Mrs LV lived at The Bays Aged Care in Hastings Victoria (**The Bays**).

2. Mrs LV had a medical history of severe dementia and recurrent bronchitis. She was reportedly non-verbal and bed-bound. She had resided at The Bays since 2018.

THE CORONIAL INVESTIGATION

3. Mrs LV'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 Mrs LV's death to the Coroners Court, I directed for a statement to be obtained from her aged care facility, which was provided in February 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 Mrs LV. 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.[2]

[2] 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.

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, on 28 December 2024, Mrs LV was administered another patient's medication in error when the endorsed enrolled nurse (**EEN**) dispensing residents' medications became distracted with a telephone call. As a result, Mrs LV was administered a high dose of pregabalin in error, along with mirtazapine and paracetamol. It was the first day of the EEN working at The Bays.

9. Mrs LV required her medications to be crushed; however the other resident's medications were administered to her in whole tablet form.

10. Mrs LV reportedly faced a rapid deterioration and seizures, and did not fully regain consciousness as a result. She was examined by GP Dr Natasha Aylen (**Dr Aylen**).

11. Her family were advised of the circumstances and declined a hospital transfer. Mrs LV was afforded comfort measures and died on 2 January 2025.

Identity of the deceased

12. On 2 January 2025, Mrs LV, born [redacted] 1946, was visually identified by one of the staff members at the Bays Aged Care Facility.

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

Medical cause of death

14. Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 6 January 2025 and provided a written report of his findings dated 24 April 2025.

15. The toxicology analysis showed the presence of morphine and midazolam (in keeping with end-of-life care), mirtazapine and bromhexine. Pregabalin and paracetamol were not detected. Dr Burke opined that they may well have been cleared by the liver over the preceding five days.

16. Dr Burke requested analysis of hair for the presence of pregabalin (in order to gain an historical profile), but was advised the test was not available.

17. There was no post mortem evidence of any injuries which may have caused or contributed to death.

18. Dr Burke provided an opinion that the medical cause of death was *1(a) medication error resulting in combined drug toxicity*.

19. I accept Dr Burke's opinion.

REVIEW OF CARE

20. As noted above, I sought a statement from The Bays in order to assist me in determining the circumstances in which the medication error occurred.

21. The Bays stated that discussion with the EEN in question identified that:

    a. The EEN had parked the Medication Trolley in front of a neighbouring resident's room which she felt gave her appropriate cues as to who she was attending and administering medications to; and
    b. The EEN identified that she had received a phone call at the time of the medication administration. She recalled picking up the medication she had checked and dispensed into the medication cup, then transporting it to the wrong resident.

22. The Bays noted that there appeared to a number of factors contributing to the error. It was noted that this was the first shift for the newly employed EEN who was unfamiliar with the residents at The Bays. It also noted an issue with the placement of the medication trolley, and that the EEN took a phone call during the medication round '*which distracted her from her due diligence whilst performing her role*'.

23. The Bays noted that the Apollo Care RAC Medication Management Policy is primarily the governing policy regarding medication administration, and stated that it was reviewed and updated on 24 January 2025 to ensure correct identification of a resident prior to medication administration, following the incident. Changes were made to the effect that all residents who receive support with their medication from a member of the care team must have a current photograph (a photograph that looks like the person and enables identification) included with the medication stored with their medication chart for the reference of administering staff.

24. Further improvements were noted such as medication trolleys being stocked with Medibibs with a 'DO NOT DISTURB' inscription.

CPU REVIEW

25. On the basis that Mrs LV'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'.**

26. In relation to Mrs LV's death, I sought CPU advice on: (i) the care provided to Mrs LV 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

27. The CPU Health and Medical Investigation Team noted the statement provided by The Bays and 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.

28. The CPU noted that this case differed from some of the other cases I am investigating in which, in those two other cases, further active treatment was provided to the resident following the medication error, but the outcome was nonetheless fatal. In Mrs LV's case, while acknowledging the circumstances of the error were distressing, Mrs LV's family did not wish for Mrs LV to be transported to hospital for emergency care, given her overall state of poor health, and she died almost a week after the medication error.[5]

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[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.

[5] In this connection, it is relevant to note that, following Mrs LV's death, Apollo Care has (commendably) provided further guidance to staff about advanced care directives and the role of substitute decision-makers in such circumstances (see further below). I determined not to investigate the issue further in the circumstances.

29. However, given my prevention mandate, and the findings of the forensic pathologist Dr Burke that the medication error had caused Mrs LV's death, I considered it to be of some importance to see whether there are any prevention opportunities arising from her death.

Research and Policy team advice

30. 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 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.

31. 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*'.

32. 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

33. 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.

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

35. At the time of Mrs LV'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.

36. 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.[6]

37. 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

38. 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

39. 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*.

40. 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

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

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.

41. 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 and aged care providers more broadly to manage medication for older persons safely.[7] 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.

42. Those providing medications to people in aged care facilities also need to comply with the Medication Safety Standard (**the Standard**).[8] 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.

43. 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.

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

What are the gaps?

45. 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**)[9] 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:

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

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.

46. 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.

47. 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.

48. 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.

49. 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.

50. 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.

51. 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.

52. 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.[10]

NATURAL JUSTICE PROCESS

53. Apollo Care was provided with the opportunity to respond to my proposed findings that the medication error that led to Mrs LV's death could have been prevented, which was a finding it conceded.

54. Apollo Care emphasised that it has implemented a range of organisation-wide measures in response to Mrs LV's death, including:

    a. consultation and detailed consideration by the clinical governance group including its root causes, corrective actions and required policy amendments;

    b. implementation of the 'bestmed' medication management software across its residential aged care services;

    c. review and updating of its medication management policy across all facilities to reflect strengthened mediation administration practices, including: (i) reinforcing with staff the importance of maintaining focus during medication administration and minimising distractions, including from telephone calls (whether work-related or otherwise); and (ii) stablishing a resident identification protocol that is to be applied on all occasions of medication administration in all Apollo care homes; and

    d. review and updating of the choice and decision-making policy to strengthen guidance in relation to substitute decision-making and advance care planning, including: (i)

[10] 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 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.

clarifying the scope of authority of substitute decision-makers; and (ii) providing clearer guidance on the role and operation of different types of advance care directives.

55. I consider these improvements to be commendable.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mrs LV, born [redacted] 1946;

    b) the death occurred on 02 January 2025 at The Bays Aged Care 86 Victoria Street Hastings Victoria 3915, from 1*(a) medication error resulting in combined drug toxicity*; and

    c) the death occurred in the circumstances described above.

57. Having considered all of the circumstances, I am satisfied that Mrs LV died following a medication error in which she was administered another patient's medication, and which caused her death.

58. I find that, upon realising that a serious medication error had occurred, The Bays Aged Care took steps to notify her medical practitioner and her family members, who elected for her not to be transported to hospital in the circumstances.

59. While I consider that the medication error leading to Mrs LV's death was entirely preventable, I acknowledge the changes made by The Bays Aged Care Facility to the way in which medications are administered to residents in its care, including the steps to avoid distraction in the middle of medication rounds.

60. Together with the recommendation made in my finding, I am hopeful that the residents of aged care facilities, both Apollo Care-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.*'[11]

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

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

environment, at an RACF, there is seldom a doctor onsite 24/7 from whom to seek advice or 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 Mrs LV'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:

Senior Next of Kin

Apollo Care Alliance c/o Lander & Rogers

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

Constable Patrick Gellie, 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.