IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 006756

Related cases:
COR 2024 004769
COR 2025 000029

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

RACF Medication Error Finding No. 1

Findings of:	Coroner Ingrid Giles
Deceased:	Rosemary Elsie Harriet Jacoby
Date of birth:	02 March 1931
Date of death:	20 September 2025
Cause of death:	1a: DRUG TOXICITY (BACLOFEN, GABAPENTIN, OXYCODONE, PREGABALIN, ZOLPIDEM) 2: CONGESTIVE CARDIAC FAILURE, PULMONARY HYPERTENSION, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Place of death:	Box Hill Hospital 8 Arnold Street Box Hill Victoria 3128
Keywords:	Medication error; residential aged care facility, medication safety standards, preventable death, national standards, recommendations

INTRODUCTION

1. On 20 September 2025, Rosemary Elsie Harriet Jacoby (**Rosemary**) was 94 years old when she died at Box Hill Hospital following the administration of another patient's medication to her at her residential aged care facility (**RACF**). At the time of her death, Rosemary lived at Faversham House in Canterbury, Victoria (**Faversham House**).

2. Rosemary commenced residing at Faversham House following a fall in 2019, when she was 88 years of age. Rosemary was a social person and made many friends at Faversham House, including staff members, and had an active social life despite the decline in her cognitive functioning in the years before her death.

3. Rosemary had a medical history that included Alzheimer's disease, stroke, heart failure, a permanent pacemaker and pulmonary hypertension.

4. At the time of her death, her reported medications were mirtazapine, pregabalin, spironolactone, memantine, warfarin, paracetamol, metoprolol, carbimazole, furosemide and Movicol. Her medications were kept in a Webster-pak which included her name, photograph and her room number. Her medications were taken morning and night.

THE CORONIAL INVESTIGATION

5. Rosemary'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.

6. 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.

7. 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.

8. Following the report of Rosemary's death to the Coroners Court, I received a medical deposition from Box Hill Hospital and a report dated 2 January 2026 from the Aged Care

Quality and Safety Commission (**ACQSC**), which had conducted its own investigation into the circumstances occurring in the lead-up to Rosemary's death. I have considered and relied upon this report and investigation materials in accordance with my obligations under section 7 of the *Coroners Act 2008* to avoid unnecessary duplication of inquiries and investigations.

9. I have also received a number of materials through Coronial Investigator Detective Senior Constable Milly Osborne (**DSC Osborne**), including CCTV from Faversham House, as well as a statement from the Inspector-General of Aged Care.

10. This finding draws on the totality of the coronial investigation into the death of Rosemary Elsie Harriet Jacoby. 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

11. On 17 September 2025 between 8:20 and 8:30pm, an agency Registered Nurse (**RN**) reported to the Faversham House After-Hours Coordinator (**A-H Coordinator**) that she had inadvertently administered to Rosemary another resident's prescribed medications. The medication incident occurred at 7:58pm and the error was identified by the RN's colleague.[2]

12. The medications administered to Rosemary included Schedule 4 and Schedule 8 medications. She was administered baclofen, diazepam, duloxetine, gabapentin, Targin (oxycodone and naloxone), paracetamol, periciazine, and zolpidem in error.

13. CCTV depicts that, in the lead-up to the incident, the RN was in the medication room and had dispensed five sets of different residents' medications into five separate unmarked cups and placed them on the medication trolley, stacking a number of the cups together. The RN left

[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] I note that various documents provided to the Court do not bear consistent timing as to when the medication misadministration occurred and was reported to the A-H coordinator (including in reports to Ahpra, which state the time of the medication misadministration as 8:30 or 8:31pm). I have relied upon CCTV footage provided by the Coronial Investigator and the Incident Investigation Report of Faversham House ('Att 2 SIRS effective-serious-incident-investigations-RJ FINAL (1).pdf') which both record the incident occurring at 7:58pm, and which I consider to be the most reliable records of timing available to me, given the latter document also refers to the CCTV timestamps.

the cup with Rosemary's medication on the trolley, then entered Rosemary's room and provided her with another resident's medication.

14. The RN explained that she was interrupted while preparing the medications, mistakenly taking a cup of medications belonging to another resident (who was recorded as not to be cared for by an agency nurse) and administering it to Rosemary in error.

15. Reports from Faversham House note that Rosemary's vital signs were within normal limits, and she was placed on half-hourly monitoring while a locum GP review was arranged.

16. Just before 9:00 pm, the A-H Coordinator attended Rosemary's room and found her in a deep sleep and unresponsive to pain, with concerning vital signs: blood pressure 92/47 mmHg, pulse 47 bpm and oxygen saturation 88–90%. Emergency services ('**000**') were called. The A-H Coordinator returned to Rosemary's room at 9:13pm and observed further deterioration.

17. A statement from an Ambulance Victoria (**AV**) paramedic notes that AV arrived on scene at 9:34pm. Rosemary was treated and the paramedic arranged to transfer her urgently to hospital.

18. Rosemary arrived at Box Hill Emergency Department (**ED**) at 10:05pm. Her daughter Caroline attended the ED at approximately 11:25pm following a call being made to her by a staff member at Faversham House.

19. In the ED, Rosemary received further treatment in a resuscitation bay. She initially responded to naloxone however went on to develop seizure activity and medically reached her ceiling of care.

20. A decision was made for palliative measures, and Rosemary died on 20 September 2025.

Identity of the deceased

21. On 20 September 2025, Rosemary Elsie Harriet Jacoby, born 2 March 1931, was visually identified by her daughter, Caroline Jacoby.

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

Medical cause of death

23. Forensic Pathologist Adjunct Associate Professor Hans H. de Boer (**Adj. Assoc. Prof. de Boer**), a forensic pathologist from the Victorian Institute of Forensic Medicine (**VIFM**)

conducted an external examination on 22 September 2025 and provided a written report of his findings dated 6 January 2026.

24. Toxicological analysis was performed on ante-mortem specimens obtained on 17 September 2025 at approximately 23:36 hours (approximately 1 hour after admission to hospital):

    a) This analysis confirmed the presence of baclofen, gabapentin, oxycodone, periciazine, paracetamol, and zolpidem, which were not prescribed to the deceased but reportedly erroneously administered prior to hospitalisation.
    b) In addition, the analysis detected memantine, metoprolol, mirtazapine, paracetamol and pregabalin, which were known to be prescribed to the deceased.
    c) The analysis also detected ondansetron. This may have been administered in the context of hospitalisation.
    d) Multiple of the above drugs, especially baclofen, gabapentin, oxycodone, pregabalin and zolpidem have sedative properties. Such effects are dependent on habituation, and therefore are more pronounced in naive users. There is an additive sedative effect with the concurrent use of multiple sedative drugs.

25. Adj. Assoc. Prof. de Boer opined that the findings of a postmortem CT scan and external examination were consistent with the reported circumstances. There were no remarkable findings.

26. Based on the medical history, circumstantial information, clinical presentation and post-mortem findings, it is reasonable to attribute the clinical deterioration and death to the effects of drug overdose, against a background of known cardiovascular disease and advanced age.

27. Adj. Assoc. Prof. de Boer provided an opinion that the medical cause of death was *1(a) drug toxicity (baclofen, gabapentin, oxycodone, pregabalin, zolpidem)*, with contributing factors being *congestive cardiac failure, pulmonary hypertension, atherosclerotic cardiovascular disease*.

28. I accept Adj. Assoc. Prof. de Boer's opinion.

FAMILY CONCERNS

29. Caroline Jacoby, Rosemary's daughter, articulated concerns of care to the Court. In a statement provided through the Coronial Investigator, she stated, '*My brother and I hope that the nurse who so seriously breached normal medication practices not be allowed to do this to*

anyone else and that procedures for supervising agency staff are improved, to help prevent other avoidable deaths'.

30. Caroline also noted issues as to communication from Faversham House which included delays in communication from Faversham House senior management about the incident and an apparent lack of awareness from staff about what had transpired.

31. Caroline noted her sadness at her mother's death and the way in which her life ended. '*I feel very sad that mum's life ended in the way it did. Mum had had a series of health challenges during her life which she overcame and to [die following] someone not following basic nursing protocols is horrifying to me*'.

FURTHER INVESTIGATIONS

i. Aged Care Quality and Safety Commission

32. A complaint was made about the medication error to the Aged Care Quality and Safety Commission (**ACQSC**), and a swift and thorough investigation was conducted.

33. As part of this investigation, Faversham House acknowledged that incorrect medication was administered to Rosemary by an agency nurse and confirmed that the incident was managed as a serious medication error.

34. An internal incident report was completed on the day of the incident, and mandatory notifications were made to relevant external authorities, including Victoria Police, the Serious Incident Response Scheme (**SIRS**), Australia Health Practitioner Regulation Agency (**AHPRA**) and WorkSafe, with subsequent updates provided to each entity.

35. Faversham House commenced an internal investigation, which included a review of available information and staff interviews. The service undertook a series of actions, including the issuance of internal communication to staff reinforcing medication management procedures.

36. In the course of the investigation, it was noted to the Coronial Investigator that standard procedure and expectations for medication rounds are as follows:

- The medication trolley is to be taken to each patient;
- The nurse is to check the photograph on the computer screen, the photograph of the blister pack, and the appearance of the person in front of them to ensure they are administering the medications to the correct patient; and

- The nurse is to dispense the medication, provide to the patient, then move on to the next patient.

37. The RN failed to adhere to these procedures by:

- Dispensing several cups of medication at a time;
- Dispensing medications in the drug room, rather than in the presence of the patient;
- Administering multiple cups of medications at one time; and
- Administering medication without verifying identification of the patient, especially as an agency nurse who is not familiar with the patients.[3]

38. Following the incident, Faversham House completed a Medication Management Audit, which identified several areas for improvement across medication management systems, staff competency, documentation, and governance arrangements.

39. In response to the audit findings, Faversham House developed and commenced a Medication Error Continuous Improvement Plan, which was updated in May 2026. Actions included strengthening agency staff orientation oversight, updating escalation pathways for medication errors to include access to external medical advice, reinforcing medication rights practices, and commencing transition to a new digital medication management system. The service information shows that a number of actions have been completed, while others are ongoing.

40. The ACQSC noted the seriousness of the medication error and, based on the information provided to it, found that it was satisfied that Faversham House acknowledged the medication error, accepted responsibility, and met its mandatory reporting requirements. Further, the ACQSC found that the completion of a comprehensive medication management audit and the implementation of a structured continuous improvement plan demonstrate that Faversham House has identified systemic gaps and taken actions to strengthen medication management, staff governance, and escalation processes.

ii. CPU review

41. On the basis that Rosemary'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

[3] The Med Mobile Digital Platform was not used to confirm Right resident, Right medication, Right dose, Right time, Right route etc.

broadly, I determined to refer the case to the Coroners Prevention Unit (**CPU**)[4] 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'.**

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

43. The CPU Health and Medical Investigation Team (**HMIT**) agreed with the findings of the ACQSC and internal Faversham House review. 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)[5] 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.

44. CPU also addressed my concern about the nature of the Faversham House response to the medication error, with staff initially arranging for a GP locum review rather than calling '000'.[6] Further, according to CCTV, the medication error occurred at 7:58pm and '000' was not called until 9:12pm, which was triggered when the A-H Manager checked on Rosemary at 8:56pm, almost one hour after the incident occurred. By this time, Rosemary's vital signs were deeply concerning. Despite this, she was found by paramedics upon arrival at 9:34pm alone and unconscious, with staff reportedly unable to provide a clear handover to paramedics of what had transpired.[7] By this time, the RN had finished her shift and had gone home.

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[4] 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.

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

[6] It also appears that the RN who made the medication error initially phoned a personal friend for advice, who was also a clinician, rather than focusing on escalating the incident internally. The friend reportedly reassured the RN that, following the medication error, Rosemary would be sleepy that night but fine the next day.

[7] I also note that no naloxone was available at Faversham House to be administered at an earlier point to Rosemary, and which she was administered when she arrived at Box Hill Hospital to reverse the effects of the opioids she had been administered.

45. The CPU agreed that '000' should have been called immediately following the incident and that Rosemary should have been closely and continuously monitored by staff in the interim. The CPU opined that greater clarity about when and how to escalate medication errors, and the importance of ongoing patient monitoring, would have assisted staff in this instance.

Research and Policy team advice

46. 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.

47. 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*'.

48. 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

49. In detailing the investigation undertaken into the events in the lead-up to Rosemary's death, the ACQSC also 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.

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

51. At the time of Rosemary'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.

52. 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.[8]

53. 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

54. 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.

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

Safety standards for medication administration in residential aged care facilities

55. 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*.

56. 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.

57. 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.[9] 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.

58. Those providing medications to people in aged care facilities also need to comply with the Medication Safety Standard (**the Standard**).[10] 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.

59. 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.

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

What are the gaps?

[9] Available: https://anmf.org.au/media/h4ybjath/anmf-best-practice-guidance-for-medicines-use-by-nurses-in-aged-care-2025.pdf
[10] Available: https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/medication-safety-standard

61. 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**)[11] 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.

62. 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.

63. 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.

64. 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.

65. 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.

66. 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.

[11] Available: https://www.igac.gov.au/resources/2025-progress-report-implementation-recommendations-royal-commission-aged-care-quality-and-safety

67. 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.

68. 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.[12]

NATURAL JUSTICE PROCESS

69. Faversham House / BassCare was offered an opportunity to respond to my proposed findings that Rosemary's death could have been prevented, that the medication error had a causal role in her death, and that '000' should have been called immediately upon the erroneous administration of the medication rather than arranging for GP review. Further documentation was provided to the Court, but no response was received on my proposed findings. However, I note that these findings are consistent with the review of the incident conducted by Faversham House and that BassCare was otherwise highly responsive to the Court's requests for information and documentation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Rosemary Elsie Harriet Jacoby, born 02 March 1931;

[12] 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.

b) the death occurred on 20 September 2025 at Box Hill Hospital 8 Arnold Street Box Hill Victoria 3128, from *1(a) drug toxicity (baclofen, gabapentin, oxycodone, pregabalin, zolpidem),* with contributing factors of *congestive cardiac failure, pulmonary hypertension, atherosclerotic cardiovascular disease*; and

c) the death occurred in the circumstances described above.

71. Having considered all of the circumstances, I am satisfied that Rosemary died following a medication error in which she was administered another patient's medication, which, combined with the effects of her own prescribed medication, caused her death three days later. While she had a significant burden of natural disease including congestive cardiac failure, pulmonary hypertension and atherosclerotic cardiovascular disease that contributed to the fatal outcome, it was the administration of another resident's medications to her on 17 September 2025 that triggered her rapid deterioration and ultimate death.

72. I find that, despite realising that a serious medication error had occurred, Faversham House failed to appropriately escalate Rosemary's care, and that '000' should have been called immediately following the misadministration of medications to her, rather than the initial plan of arranging for locum GP review. The failure to do so meant that the treatment Rosemary needed to address the effects of the medications was unacceptably delayed.

73. I find that the care and treatment provided to Rosemary once she arrived at Box Hill Hospital was reasonable and appropriate, but that at that stage, her clinical trajectory was sadly irreversible.

74. I find that Rosemary's death was preventable.

75. While the circumstances of Rosemary's death give rise to deep concern, I acknowledge the changes made by Faversham House to the ways in which medications are administered to its residents since the time of her death, including via its Medication Management Audit, the appointment of a Quality Data & Clinical Governance Officer, and the development of a Medication Error Continuous Improvement Plan. Together with the recommendation made in this finding, I am hopeful that the residents of aged care facilities, both at Faversham House 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. Caroline, Rosemary's daughter, describes the circumstances of her mother's death as '*horrifying*'. The language of the Inspector-General of Aged Care is similar, noting 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.*'[13]

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, it is relevant to note that, even if such requirements had been in place at the time of Rosemary's death, they would not have provided an additional layer of safety in the care she received, as the medications given to her in error were indeed given to her by a registered nurse.

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

7. That nurse's conduct in failing to adhere to the Faversham House medication procedures is deeply concerning, and, noting the limits of the coronial jurisdiction, falls more appropriately within the purview of the Australian Health Practitioner Regulation Agency (**AHPRA**).

8. However, there are broader systemic issues here that are squarely within my purview to consider and address.

9. In examining those systemic issues, I make comment that 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 RACF staff are adequately supported to perform their roles safely.

10. My investigation has revealed that those administering medications to residents at RACFs may not always be familiar with the residents or their medication regime (particularly where clinicians are agency staff), 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 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.

11. 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.

12. 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 Rosemary's family for their immeasurable loss. Rosemary is remembered by her daughter Caroline as a keen gardener who loved music, singing and her pets. Rosemary was also a passionate educator who, earlier in her life, had run her own private school, and whose passion for teaching others has left a profound imprint and legacy on those whose lives she touched.

I would like to acknowledge the diligent and comprehensive efforts of Detective Senior Constable Milly Osborne, Coronial Investigator, and her helpful colleagues at the Boroondara Crime Investigation Unit, in the investigation of this case.

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:

Caroline Jacoby, Senior Next of Kin

Aged Care Quality and Safety Commission

Eastern Health

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

Detective Senior Constable Milly Osborne, 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.