Media Release

Coroners Court of Victoria

Wednesday 29 July 2026

Coroner calls for the development of a national medication safety standard in residential aged care facilities

Victorian Coroner Ingrid Giles has called for the development of a national medication safety standard for safe prescribing, dispensing and administration of medications in residential aged care facilities (RACFs).

The recommendation comes after the deaths of three women who were given another resident's medications at their respective RACFs in 2024 and 2025:

- On 17 September 2025, Rosemary Jacoby, 94, was administered another resident's medication in error by a registered nurse at Faversham House in Canterbury. Shortly after the error occurred, a locum GP review was organised, but Rosemary's vital signs deteriorated, and she was transferred by ambulance to Box Hill Emergency Department for treatment. She was subsequently palliated, and she died on 20 September 2025.
- On 28 December 2024, Mrs LV, 78, was a resident at The Bays Aged Care in *Hastings*. She was administered another resident's medication when the endorsed enrolled nurse dispensing the medication was distracted by a phone call. Mrs LV's condition declined rapidly following the error. She was provided with comfort care and died on *2 January 2025*.
- On 4 August 2024, Lynette McHarry, 68, was mistakenly administered medication from another resident's Webster-pak by a psychiatric services officer (PSO) at Mooraleigh Hostel in Bentleigh East. Lynette alerted the PSO of the error and was placed under monitoring following review by a locum GP. Her condition deteriorated after an unwitnessed fall in the early hours of 5 August 2024, and she was transferred by ambulance to Casey Hospital Emergency Department where she was transitioned to comfort care and died on 15 August 2024.

Data provided by the Coroners Prevention Unit and included in the findings published today, shows there have been six deaths of residents in Victorian RACFs due to medication administration errors from 2021 to the present, including Rosemary, Mrs LV and Lynette. Four additional deaths were identified where medication errors were reported, but the impact of the error on the death was unclear, along with a further five deaths where a medication error occurred before death but was not considered to be causally related.

Information provided by the Aged Care Quality and Safety Commission (ACQSC), which conducted its own investigation into Rosemary's death, confirmed that there are no national medication safety standards that are specific to RACFs. ACQSC pointed to existing resources including the non-prescriptive *Guiding principles for medication management in residential aged care facilities,* published in 2022 by the Department of Health, Disability and Ageing, as well as the *Aged Care Quality Standards* which Coroner Giles noted do not prescribe the specific systems and processes required for safe administration of medication in aged care.

The Inspector-General of Aged Care (Inspector-General) also provided a statement to assist Coroner Giles' understanding of the broader systemic issues at play. The Inspector-General opined that, despite the intent of the Royal Commission into Aged Care Quality and Safety established in 2018, national standards and clear policy frameworks are not yet in place to support the safe prescribing, dispensing and administration of medications in RACFs, and that older people will continue to be at risk until this is addressed.

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The Inspector-General also expressed concern that current reporting systems may not be adequate to determine the extent to which medication mismanagement is a systemic issue in aged care settings.

In her findings, Coroner Giles said, “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.”

Her Honour recommended 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.

In her findings, Coroner Giles commented “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”.

The finding into the death of Rosemary Jacoby can be accessed here
The finding into the death of Mrs LV can be accessed here
The finding into the death of Lynette McHarry can be accessed here

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