2025

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

ELEVENTH ASSEMBLY

Coroner's Court of the Australian Capital Territory

Inquest into the death of Sharyn Kaine

Government Response

Presented by
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INTRODUCTION

Coroner Ken Archer handed down his final report following the Inquest into the death of Ms Sharyn Kaine on 16 September 2024 and made one recommendation.

The ACT Government acknowledges the distress felt by the family and friends of Ms Kaine and sincerely apologises to her loved ones.

The ACT Government is committed to improving the safety and quality of care delivered to consumers of ACT public health services. Canberra Health Services agreed to Coroner Archer's recommendation and has completed this work.

Ms Kaine was admitted into the care of the ACT Government on 2 October 2021, following an assessment of her condition on presentation to the Emergency Department at Calvary Public Hospital in Bruce. The surgical intervention needed for Ms Kaine's presenting condition required Ms Kaine to be transferred to Canberra Hospital on the same day.

At Canberra Hospital, Ms Kaine had the necessary surgery which improved her condition and was prescribed paracetamol to assist with her recovery and the management of her pain. The dosage of paracetamol should have been adjusted for Ms Kaine's body weight. Instead, Ms Kaine was prescribed a standard adult dosage of paracetamol. The cumulative effect of receiving the inappropriate dose of paracetamol over coming days resulted in Ms Kaine collapsing on 7 October 2021. On admission to the Intensive Care Unit (ICU) it was identified that Ms Kaine was suffering from liver failure due to potential paracetamol toxicity.

Unfortunately, efforts by the ICU to stabilise and treat Ms Kaine's condition were unsuccessful, and she continued to deteriorate. The treating team determined that her organ failure was not survivable, and sadly Ms Kaine died in Canberra Hospital on 9 October 2021.

Ms Kaine's death was referred to the ACT Coroner by Canberra Health Services on 10 October 2021. The process of undertaking an inquest commenced with Counsel assisting appointed in March 2022.

CORONER'S REPORT

Coroner Archer's report outlines that at the time of Ms Kaine's death, Canberra Health Services (CHS) did not have specific procedures or guidelines in place with respect to paracetamol administration. As such, Coroner Archer found that a matter of public safety arose following the inquest into Ms Kaine's death:

1. At the time of Ms Kaine's death, the warning functionality within the Electronic Medication Management (EMM) application was not sufficiently robust;
2. The ACT Government should consider adopting guidance like other jurisdictions with a focus on the level of risk of paracetamol as well as associated dosage processes.

During the inquest, Coroner Archer acknowledged the ACT Government's submission and the improvements that the Digital Health Record (DHR) has made to patient care in the Territory, compared with the processes and procedures that existed at the time of Ms Kaine's death.

As a result of these findings and acknowledgements, Coroner Archer made the following recommendation:

1. That Canberra Health Services publishes statistical material that identifies trends in adverse medication outcomes (including non-fatal outcomes) at Canberra Hospital since the introduction of the DHR, including adverse outcomes involving paracetamol.

GOVERNMENT RESPONSE

The ACT Government acknowledges Coroner Archer's findings and accepts the recommendation made following the inquest into Ms Kaine's death.

<u>Recommendation 1:</u> That CHS publishes statistical material that identifies trends in adverse medication outcomes (including non-fatal outcomes) at Canberra Hospital since the introduction of the DHR, including adverse outcomes involving paracetamol.

ACT Government Position	Implementation Timeframe
Agreed	Completed

The CHS Quality and Safety Dashboard has an indicator that measures rates of medication incidents per 1000 bed days. This dataset is sourced from the Clinical Incident Register (RiskMan) and updated monthly. The clinical incident management system promotes the reporting and review of clinical incidents and supports a culture of safety, learning and improvement. This information is reported through CHS governance committee structures.

CHS, in collaboration with the ACT Health Directorate (ACTHD), implemented the DHR across all public health facilities on 19 November 2022. DHR matches medication dosage against relevant considerations (such as weight) and patient requirements and has introduced hard stops and alerts in the system to support safe prescribing and medication administration.

CHS is continuing to leverage opportunities within DHR and will continue to seek additional data and reporting solutions to tailor the delivery of health care in the ACT. This includes a plan to explore future automation of identification of medication incidents in DHR as a further enhancement.

The CHS Annual Report will also include publication of the rate of serious adverse medication incidents (harm score 1 and 2 incidents). This includes non-fatal outcomes and will commence with CHS Annual Report 2024-25.

CONCLUSION

The implementation of the DHR has introduced electronic medication safety alerts to safeguard against errors such as the ones highlighted in Coroner Archer's report. The DHR now provides automated dosage range checking and has a series of alerts to support clinician decision-making.

Whilst in the care of CHS, Ms Kaine's medication dosage was adjusted appropriately for her weight at a point in time, but the systems and processes at the time did not ensure that the dosage reduction carried forward. This resulted in Ms Kaine being provided a standard adult dose of paracetamol, not the adjusted dose. The functionality now provided in the DHR significantly reduces the risk of administration of an inappropriate dosage, due to the settings in place within the medication management modules of the system.

CHS acknowledges and apologises for the shortcomings in Ms Kaine's care and provides assurance that, through the implementation of the DHR, the health service has made significant improvements to medication safety.

The ACT Government deeply regrets the deficiency in Ms Kaine's care and apologises to her family and loved ones.