



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004040

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of: Coroner Leveasque Peterson

Deceased: Philip Alexander McHardy

Date of birth: 18 October 1950

Date of death: 13 July 2025

Cause of death: 1a : Probable respiratory failure in a man with advanced motor neurone disease in the setting of non-invasive ventilator use

Place of death: Calvary Health Care Bethlehem
476 Kooyong Road
Caulfield South Victoria 3162

Keywords: Motor neurone disease, end of life care, non invasive ventilation, NIV, human error, preventable death

INTRODUCTION

1. On 13 July 2025, Philip Alexander McHardy was 74 years old when he died in hospital following a five month admission.
2. In June 2024, Philip was diagnosed with bulbar onset motor neurone disease (MND)¹ and the disease progressed rapidly. He experienced increased falls due to muscle weakness and poor oral intake.²
3. Philip first engaged with Austin Health's Victorian Respiratory Support Service (VRSS) in September 2024. On 19 September 2024, he was provided with an at home medical ventilation device – a form of non-invasive ventilation machine (NIV). However, Philip's MND continued to progress leading to increased usage of the NIV, up to 16 hours per day.

THE CORONIAL INVESTIGATION

4. Philip'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.
5. 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.
6. 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.
7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Philip's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

¹ A form of MND which first affects the 'bulbar' region of the brainstem, affecting muscles controlling speech and swallowing.

² Philip was provided nutrition through a percutaneous endoscopic gastrostomy (known as a 'PEG' or 'feeding tube').

8. This finding draws on the totality of the coronial investigation into the death of Philip Alexander McHardy. 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.³

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

Circumstances in which the death occurred

9. On 5 February 2025, Philip was admitted to Calvary Health Care Bethlehem (**Calvary**) due to a decline in function and difficulty using his NIV. Clinicians concluded that his care needs were greater than what could be provided at home, and they organised for him to be discharged to a residential aged care facility once he became medically stable.
10. Philip's condition declined rapidly over the course of his admission. When admitted in February 2025, he could walk but he experienced increased unsteadiness resulting in falls. He could not speak and communicated through an iPad. He had stopped swallowing and was receiving nutrition through a feeding tube. Over the next five months, Philip lost the ability to walk, became bedbound, he could no longer communicate with an iPad or other aide and was limited to giving a 'thumbs up' or 'thumbs down' to express himself. It was evident to clinicians that Philip was not suitable to be discharged to a residential aged care facility, and he was transitioned to end of life care.
11. In the weeks leading up to his death, Philip was highly dependent on the NIV and could only tolerate short periods – up to several minutes – without ventilation. From June 2025, he was provided a continuous infusion of morphine to reduce the sensation of breathlessness, with additional doses given for breakthrough discomfort. That is to say, he had a very poor prognosis.
12. On 13 July 2025, between 7:45am and 8am, a nurse entered Philip's room and found him unresponsive and alerted the medical team. His NIV was turned off at the time. The nurse turned the NIV back on just after 8am.

³ 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.

13. Within approximately 20 minutes, the on-call ward clinician attended to Philip and found he had poorly responsive pupils, shut down peripheries, low oxygen saturation, and very low blood pressure. He remained unconscious despite the NIV having been turned back on.
14. Philip passed away at around 9am.

Identity of the deceased

15. On 13 July 2025, Philip Alexander McHardy, born 18 October 1950, was visually identified by his daughter, Alana Ryan.
16. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 18 July 2025 and provided a written report of her findings dated 25 July 2025.
18. The post-mortem computed tomography (CT) scan demonstrated slight cerebral atrophy and ventricular dilation. There were increased lung markings, minimal coronary artery calcification, a hypodense liver and extensive subcutaneous oedema.
19. Dr Glengarry stated that in patients with MND, death is most commonly due to respiratory failure and that this can manifest as a prolonged process, associated with increased drowsiness, or it can be sudden. Acute respiratory failure may occur in patients receiving NIV.
20. An autopsy examination cannot diagnose respiratory failure, nor can it provide a precise time of death. As a result, Dr Glengarry was unable to provide an opinion, based on the post-mortem findings along, whether the death occurred from respiratory failure due to NIV malfunction,⁴ or respiratory failure due to advanced MND.
21. Notwithstanding, the autopsy did not reveal any other possible causes of death; there was no evidence of significant cardiac disease, no evidence of choking or aspiration, no evidence of a pulmonary thromboembolism and no evidence of pneumonia.

⁴ I note in the preliminary stages of the investigation and at the time that Dr Glengarry provided her report, it was believed that the NIV had malfunctioned and this caused the cessation of NIV therapy.

22. Dr Glengarry provided an opinion that the medical cause of death was 1(a) *Probable respiratory failure in a man with advanced motor neurone disease in the setting of non-invasive ventilator use.*
23. I accept Dr Glengarry's opinion.

INSPECTION OF THE NIV

24. Following Philip's death, his NIV, associated masks and tubing was provided to the VRSS and underwent analysis and inspection. Dr Anna Ridgers (**Dr Ridgers**), a Specialist Physician in Respiratory and Sleep Medicine and then-Acting Director of the VRSS, provided a statement to the Court dated 18 November 2025 outlining the results of the same.
25. NIV therapy (also known as '*non-invasive positive pressure ventilation*') involves the delivery of oxygen into the lungs via positive pressure. NIVs do not need an endotracheal tube and is therefore suitable for at-home and in-hospital use in patients with both acute and chronic respiratory failure.⁵
26. During Philip's admission to Calvary, nursing staff alerted the VRSS that he was '*nearing the definition for ventilator dependence*' given that he was reliant on the NIV for upwards of 16 hours per day. On 13 February 2025, he was provided with a new NIV and external battery kit.⁶ The NIV had been checked and passed a performance test on the same day.
27. Dr Ridgers explained that the '*smart/start stop*' function on Philip's NIV was disabled. This means that without manual input, the NIV will not stop delivering oxygen therapy on its own. The NIV also records an activity log which documents when the NIV is on, off or an alarm is activated.
28. A loud alarm will be activated if the NIV mask is removed while the machine is still on. This is because the NIV is unable to deliver the prescribed therapy to the patient and it assumes that there is a leak of oxygen.
29. Dr Ridgers summarised the NIV activity log of 13 July 2025 as follows:
 - a) At 5:51am, the NIV's alarm was activated,

⁵ Yiran Gong, Abdulghani Sankari, 'Noninvasive Ventilation', *StatPearls Publishing* (2025) and accessible at: <https://www.ncbi.nlm.nih.gov/books/NBK578188/>.

⁶ The NIV was a ResMed Stellar Home Mechanical Ventilation Device.

- b) At 5:52am, the NIV was turned off and the alarm was cleared,
- c) At 8:03am, the NIV was turned on.
30. The activity log showed that no oxygen was being delivered to Philip between 5:52am and 8:03am – 2 hours and 11 minutes.
31. The VRSS replicated the documented activity using Philip’s NIV, tubing and mask. Within 10 seconds of removing the mask, the alarm was activated and it continued for 10 minutes until the test was manually stopped – that is, the NIV did not turn itself off when the alarm was allowed to continue.
32. Dr Ridgers provided a summary of her findings that:
- ‘The “smart start/stop” function was disabled and upon replication of the alarms noted in the device log, the [NIV] continued to provide therapy in testing conditions. From this testing and the device log denoting “Mask Off” (i.e. therapy ceased) at 5:52:31AM AEST no issues were identified that would lead to the machine’s malfunction, and it is reasonable to conclude that ventilation therapy was manually stopped.’ (emphasis added).*
33. I considered Dr Ridger’s statement in the context of Dr Glengarry’s findings at autopsy, specifically that respiratory failure cannot be diagnosed post-mortem. I interrogated the possibility that Philip died due to MND associated-respiratory failure while receiving NIV therapy and questioned whether his NIV could have automatically turned off in response, perhaps around 5:51-52am thereby accounting for the activity log of that morning.
34. At my request, Dr Ridgers issued a supplementary statement dated 12 February 2026 in which she explained that if a patient dies while receiving NIV therapy that *‘the device will continue to operate’* and that the machine *‘will not sound an alarm if the patient has died’*. She stated:
- ‘If the patient is no longer breathing because they have died, the device will continue to deliver breaths at the respiratory rate at which the clinician has set’.*
35. I am satisfied that had Philip died while receiving NIV ventilation, the machine would have continued to operate. It would not have automatically turned off and would have been unable to create the entries to the activity log of 5:51 and 5:52am.

THE USE OF NON-INVASIVE VENTILATION MACHINES AT CALVARY HEALTH CARE BETHLEHEM

36. I sought a statement from Dr Rowan Hearn (**Dr Hearn**), Director of Medical Services and Palliative Medicine at Calvary. In his statement, dated 19 December 2025, Dr Hearn addressed the complexities associated with long-term NIV use and how the machines are used by Calvary nursing staff.
37. Mouth care is an important care intervention for patients with MND, particularly those who are NIV dependent. As in Philip's case, MND can render it difficult or impossible for patients to swallow, leading to an increased risk of choking on saliva and secretions. According to Dr Hearn, mouth care is provided to *'remove accumulated secretions to prevent choking as well as moistening the inside of the mouth for comfort and to prevent ulcers and sores'*.
38. Mouth care is typically provided *'two to three times per nursing shift'* and requires the removal of the NIV mask.
39. Dr Hearn explained that some patients can tolerate the removal of the NIV mask for 10 to 15 minutes which allows nursing staff to tend to mouth care alongside longer tasks such as providing relief from pressure areas, shaving and dental hygiene. In the end stages of MND, attending to mouth care may require that the NIV mask is removed and replaced several times and that it only be removed for 10-30 seconds at a time.
40. According to Dr Hearn, Philip generally needed mouth care to be *'split into 20 to 60 second components in the week before he died, with occasional ability to tolerate some to many minutes off the ventilator'*.
41. Dr Hearn explained there *'was variation between the staff in the process of removing the [NIV] mask for mouth care'*. The two main approaches were as follows:
42. Some staff would turn off the NIV to prevent its alarm from sounding when the mask was removed to attend to mouth care. This would create an entry in the activity log that the mask was turned off and the alarm was cleared. Once mouth care had been delivered, the staff member would replace the NIV mask and turn the NIV back on. This would create an entry on the activity log that the NIV was turned on.
43. Alternatively, some staff would remove the mask while the NIV is still on and deliver mouth care while the alarm sounds. Once the mask is returned to the patient, the machine stabilises

and the alarm stops. This would create an entry in the activity log that the alarm has been activated, followed by an entry that the alarm has been cleared. There is no entry that the machine has been turned off or on.

44. Dr Hearn acknowledged that *'there is a risk inherent in the first method [. . .] that the staff member forgets to turn the [NIV] back into Active Mode to restart the therapy'*.
45. On one previous occasion, around 10 weeks before Philip's death, there was *'an episode of Philip's NIV not delivering therapy for around 6 hours'*. This was brought to ward staff's attention by Philip's family, together with concerns that he was not able to reach his call bell at the time.
46. Dr Hearn stated that *'following this incident, Philip had access to two nurse call bells'*.

EVENTS IMMEDIATELY PRIOR TO PHILIP'S DEATH

47. Having established that Philip's NIV did not experience a mechanical error, I turned to consider his medical management in the lead-up to 5:52am on 13 July 2025 and how his NIV came to be turned off.
48. During the night shift from 12 to 13 July 2025, the ward was staffed by six nurses – three of which were agency staff and three of which were Calvary employees. According to Dr Hearn, that night there was a *'standard mix of clinical complexity'* and the shift was *'busier than usual'*. He explained that it was uncommon to have three agency staff on a night shift – usually there was between zero and two.
49. Nurse A was assigned as Philip's primary nurse for the shift. Nurse A was a registered nurse and an agency employee; it was their first shift at Calvary.
50. At the beginning of the night shift, the Nurse In Charge provided Nurse A with an orientation and *'went through Philip's NIV with Nurse A at the bedside to ensure they were familiar with it'*. A handover was performed, and this *'included handover of Philip's NIV and communication needs and an instruction to complete hourly wards'*.
51. Dr Hearn described that:

'Nurse A was encouraged to ask questions by the [Nurse In Charge]. Nurse A indicated as part of the review of this incident that they felt confident with both the

morphine pump and ventilator machine and also felt confident to say if equipment was not within their scope of clinical practice.'

52. Between 9:30 and 10pm on 12 July 2025, Nurse A and Nurse B attended to Philip. Nurse B was a registered nurse and also an agency employee; they had worked approximately 20 shifts on the ward and had previously cared for Philip – it is unknown in what capacity.⁷
53. During this visit, Nurse A and Nurse B provided mouth care, pressure area care and checked Philip's morphine pump. The NIV activity log documented that the alarm sounded at approximately 9:52pm – consistent with the NIV mask being removed for care delivery.
54. The NIV's alarm sounded and the mask was turned off approximately 40 seconds after the alarm started. The mask was then re-positioned, and the NIV was turned back on. The machine's activity log demonstrates that the NIV was turned off for a total of six seconds.
55. Between 11 and 11:25pm, Philip pressed his call bell and was attended to several times. Dr Hearn acknowledged that *'the health care records do not identify who attended or what care was provided to him'*. While it would generally be expected that these details be recorded, he stated *'this may not occur for minor non-clinical attendances'*.
56. Hourly observations were performed and the Nurse in Charge saw Philip at approximately 5:30am on 13 July 2025.
57. At some time between 5:40 and 5:50am on 13 July 2025, Nurse A and Nurse B returned to Philip's bedside. Nurse A checked the urine bottle while Nurse B removed the NIV mask. According to Dr Hearn, both Nurse A and Nurse B later provided the following recollection:
 - a) *'They did not touch the ventilator during that intervention*
 - b) *They did not silence any ventilator alarms*
 - c) *They both provided care from the same side of the bed on the opposite side from the ventilator*
 - d) *The NIV was working normally when they left Philip's bedside; and*
 - e) *Philip did not indicate any distress before they left him.'*

⁷ Such as whether Nurse B had previously used or supervised Philip's NIV or had removed/replaced the mask to tend to his mouth (or other) care needs.

58. At around 6:30am, Nurse A attended Philip to administer some eye drops. Nurse A later indicated that *'the ventilator was running as normal, they did not touch it, and Philip was awake and gave a thumbs up'*. Philip did not activate either of his call bells after this time.
59. Between 7 and 7:30am, the day shift commenced and a handover was given. Between 7:45 and 8am, the nurse allocated to Philip for the day shift found him unresponsive. When the nurse realised that the NIV was not on, they turned it on which is consistent with the activity log entry at 8:03am.

INTERNAL REVIEW CONDUCTED BY CALVARY HEALTH CARE BETHLEHEM

60. Philip's death constituted a Sentinel Event and as such, Calvary conducted a review and produced a Serious Adverse Patient Safety Event (SAPSE) report.⁸ The SAPSE report was submitted to Safer Care Victoria, and a copy was provided to the McHardy family.
61. The SAPSE review panel considered both the events of 13 July 2025 and the episode which occurred approximately ten weeks earlier when the NIV was turned off for around six hours. The panel also asked staff members about their interactions with Philip and his NIV in the lead up to his death.
62. The SAPSE review panel made 13 findings, summarised below:
- a) A lack of formalised check lists, documentation and guidance for staff concerning the use, monitoring, and checking of the NIV led to inconsistent ventilator monitoring, which contributed to missed opportunities to identify and address issues affecting therapy delivery,
 - b) There was inconsistent training and competency levels among staff resulting in variable execution of NIV-related tasks such as mask removal and mouth care, directly impacting the safety and effectiveness of respiratory support,
 - c) Staff had a limited awareness of the NIV policy and therefore best practices for NIV management were not reliably followed, increasing the risk of unsafe care delivery,

⁸ Pursuant to the *Health Services Act 1988* (Vic). I note that SAPSE panel membership is governed by section 128Q of that legislation and requires that it must, in these circumstances, include a person not employed by Calvary and must not include anyone involved the events being investigated.

- d) There was no expectation that handovers occurred at a patient's bedside which led staff to default to '*corridor handovers*', contributing to reduced patient involvement and lack of opportunity to check if the NIV was functioning,
- e) There was a failure to follow the existing structured processes to reassess clinical changes in patients receiving NIV at end-of-life led to a failure to investigate a deterioration in condition, which contributed to missed opportunities to identify a failure in NIV therapy delivery,
- f) There was poor safety culture in ward leadership which led to a failure to initiate incident reporting and lack of follow up on the verbal request for incident reporting, contributing to the incident not being captured in the incident reporting system and not being investigated,
- g) There was an apparent assumption that entry to the incident reporting system alone would trigger appropriate follow up and resolution led to a lack of direct action or escalation, contributing to the issue not being addressed when the report was not submitted,
- h) There was poor cognitive design ergonomics affecting the NIV including unclear labelling and button identification, making it difficult to staff to operate the equipment safely and contributing to likely errors in setup and use,
- i) The allocation of agency nursing staff unfamiliar with the ward and its equipment to a complex NIV-dependent patient resulted in a mismatch between staff capability and patient care needs, contributing to unsafe care delivery,
- j) The use of geographical room-based allocation, not acuity based or skill-matched allocation led to inappropriate staff-patient assignments, contributing to the placement of inexperienced staff with complex patients,
- k) The decision to have to agency nurses manage care of a patient with complex care needs without involving a regular staff member resulted in a lack of ward-specific knowledge and oversight, possibly contributing to errors in NIV management and reduced patient safety.

63. The SAPSE review panel also made 17 recommendations, summarised below:

- a) Review the policy regarding NIV use in patients with MND,

- b) Develop and implement a checklist of hourly monitoring of NIV for patients highly dependent on NIV (categorised as above 22 hours of ventilation per day),
- c) Develop and implement a quick-reference sheet of NIV buttons and functions,
- d) Incorporate NIV training into Calvary's training program,
- e) Launch targeted awareness campaigns about NIV use in MND patients, procedure and NIV training,
- f) Include the policy regarding NIV use in patients with MND into onboarding,
- g) Agency staff are not to be allocated to patients that use NIV for more than 22 hours per day,
- h) Model and enforce expectations that handovers occur at the patient's bedside,
- i) Provide training and scripts to support staff in conducting bedside handovers,
- j) Incorporate assessment of NIV into the assessment to complete when clinical challenges occur, to exclude problems with therapy delivery,
- k) Embed safety leadership training into professional development,
- l) Establish safety huddles to discuss incidents, near misses, learnings and risks to reinforce a proactive safety culture,
- m) Re-introduce incident reporting metrics,
- n) Apply clear labels or overlays to NIV machines to improve button identification and reduce cognitive load,⁹
- o) Engage with equipment suppliers to improve design interface,
- p) NIV use for over 22 hours per day must be included in patient assessments of dependency and complexity to inform staffing allocation decisions,
- q) Calvary is to explore the possibility of NIVs being connected to a central alarm system to make the nurses' station aware if an NIV stops or malfunctions.

⁹ I note that the VRSS has taken responsibility for this recommendation.

64. Dr Hearn stated that immediately following the SAPSE review, Calvary formed a working group to implement all of the recommendations with the full support of the hospital executive team. Most actions, once implemented, will be audited to ensure their effectiveness. At the time of writing, the implementation of the recommendations remains ongoing.

DISCUSSION

The use and monitoring of NIVs at Calvary Health Care Bethlehem

65. There is clear evidence that staff at Calvary adopted inconsistent approaches when attending to the mouth care of NIV-dependent patients. One of these methods – to turn off the NIV while attending to the patient – necessarily introduced a higher risk of human error and cognitive load and carried potentially injurious or fatal consequences if the staff member forgot to turn the machine back on.
66. The NIV activity log demonstrated that Philip’s NIV was turned off at 5:52am and was not turned back on again until 8:03am. This is at odds with Nurse A and Nurse B’s recollections that (i) they did not touch the NIV at this time, (ii) they did not silence any NIV alarms and (iii) the NIV was working ‘normally’ when they left Philip’s bedside. It is also at odds with Nurse A’s recollection that the NIV was working ‘normally’ at around 6:30am.
67. If I accept Nurse A and Nurse B’s recollections, as a corollary, the NIV must have turned off on its own at some time between 6:30 and 8am when Philip was found unresponsive. This is not consistent with the activity log, with the settings on the NIV (that the ‘smart start/stop’ function was disabled) nor with the findings of the test which the VRSS conducted on Philip’s NIV. It is not consistent with Dr Ridgers’ conclusion that the NIV was manually turned off or that if Philip had died while receiving NIV therapy that the machine would continue to operate.
68. In weighing the competing evidence, I have taken into account the conclusion which Dr Hearn provided to the Court:

‘It remains unknown how the ventilator came to be manually stopped at 0551 [sic] hours on 13 July 2025. The most likely explanation is that a member of staff forgot to turn the ventilator back on after performing mouth care or pressed an incorrect button on the ventilator thinking that they were turning it back on. The SAPSE review was unable to identify the staff member responsible, and no staff member admitted responsibility.’

69. I do not accept the recollections of Nurse A and Nurse B. I prefer the evidence of Dr Ridgers and adopt Dr Hearn's conclusion.

Staffing allocations during the night shift from 12 to 13 July 2025

70. The SAPSE review panel appropriately identified that during the night shift from 12 to 13 July 2025, Philip's care was principally to an agency nurse that had not worked at Calvary before. He was also attended to by another agency staff who had completed around 20 shifts; they had previously cared for Philip - but it is unknown in what capacity.
71. Philip was a patient with very high care needs and was on constant ventilation. According to Dr Hearn's evidence, he had a variable tolerance for breathing without his NIV – at times he could only breathe independently for 10-60 seconds, while at other times, he could do so for '*several minutes*'. It follows that the nurse assigned to care for Philip or who provided assistance to Nurse A, ought to have been familiar with the ward, the use of an NIV in an end-of-life patient and with Philip himself.
72. I consider that only having two nurses with comparatively little or no experience with the hospital, the equipment and the patient, care for Philip was a missed opportunity for him to receive care and supervision which adequately met his care needs.
73. Additionally, the nurses' relative inexperience when managing NIV machines at Calvary may have been compounded by the machine's ergonomic design which Calvary identified (and made recommendations in response to) during its SAPSE review.

The SAPSE review conducted by Calvary Health Care Bethlehem

74. It is apparent that Calvary responded swiftly and in proportion to the seriousness of Philip's death. It conducted a comprehensive and independent review, which resulted in multiple findings and recommendations that have been set out in this Finding.
75. I commend Calvary and Dr Hearn for their acknowledgment of shortcomings which affected Philip's clinical course and dedication to improve its care delivery. I am hopeful that the changes arising from the SAPSE review and which are yet to be implemented will provide improved care for future NIV-dependent patients at Calvary. I will make an apposite recommendation in this regard.
76. Indeed, the comprehensive nature of Calvary's response has obviated the need for *viva voce* evidence in this matter, and I am comfortable that there has been a comprehensive review of

the issues affecting Philip's care. In this regard, I am aware of my obligation under section 7 of the Act to avoid the unnecessary duplication of investigations and I will not make recommendations which have already been made pursuant to the SAPSE review.

The preventability of Philip's death

77. It would be remiss of me not to acknowledge that Philip was a gravely ill man. He had lost control of many bodily functions including his ability to walk, eat independently and to use technology to communicate. His condition had rapidly declined since his diagnosis of MND only 1 year and 5 months earlier.¹⁰
78. According to Dr Hearn, at the time of his death, Philip's prognosis was '*days to short weeks*'. I accept that his death was imminent. I also note the evidence of Dr Glengarry that she could not determine, based on the autopsy findings alone, whether Philip's death was due to respiratory failure due to the cessation of NIV therapy, or was due to advanced MND. However, with the benefit of all of the evidence, I consider that the cessation of NIV therapy hastened Philip's death.
79. Had the NIV been turned back on shortly after 5:52am when it was turned off, it is likely that Philip would not have died the morning of 13 July 2025. On the basis of his general decline and poor prognosis it is unlikely that he would have lived for long. That being said, it would have provided an opportunity for his family and loved ones to be made aware of his imminent passing and for them to plan their last moments together. They were unfortunately deprived of the opportunity to say goodbye.
80. In this regard, I note Dr Hearn's evidence. He stated:

'The SAPSE review panel gave some consideration to what Philip's experience would have been like in the hours preceding his death. I know that this was also a concern for Philip's family.'

The subject matter experts on the SAPSE review panel agreed that the combination of low oxygen, high carbon dioxide and the continuous morphine infusion may have combined to result in Philip being unaware that his ventilator was not delivering

¹⁰ According to the Australian Journal of General Practice, the average period between an MND diagnosis and death is 3 years, with only 10% of patients living eight years after diagnosis. See Frank Brenna, Matthew Garinder and Manisha Narasimham 'Motor neuron disease: The last 12 months' *Australian Journal of General Practice*, 2022 51(5) and accessible at: <https://www1.racgp.org.au/ajgp/2022/may/the-last-12-months-of-motor-neuron-disease>.

therapy. While the panel agreed that it could not be said with absolute certainty, Philip may well have become increasingly drowsy before slipping into a coma and succumbing to respiratory failure without suffering any distress.'

81. I hope that Philip's family can take some small comfort in this.

FINDINGS AND CONCLUSION

82. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.¹¹ Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

- a) the identity of the deceased was Philip Alexander McHardy, born 18 October 1950;
- b) the death occurred on 13 July 2025 at Calvary Health Care Bethlehem 476 Kooyong Road, Caulfield South Victoria 3162, from 1(a) *Probable respiratory failure in a man with advanced motor neurone disease in the setting of non-invasive ventilator use*; and
- c) the death occurred in the circumstances described above.

84. I have considered all the evidence relating to Philip's death and the use of his NIV in the lead-up to the same. There is sufficient evidence to support a finding that nursing staff turned off his NIV to attend to his care needs and that due to human error, it was not turned back on. I do not suggest that this was an intentional omission.

85. I find Philip's death was therefore caused by inconsistent practice and inadequate supervision of his NIV at the time.

¹¹ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

86. There were multiple factors which contributed to the human error on the morning of 13 July 2025, not least the allocation of inexperienced agency staff to a high care needs, end-of-life patient that was on around-the-clock ventilation.
87. I have considered the comprehensive review which Calvary Health Care Bethlehem completed immediately following Philip's death and commend them for their swift and proportionate response.
88. I find that Philip's death was preventable.

RECOMMENDATIONS

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

1. I recommend that **Calvary Health Care Bethlehem** implement all recommendations arising from the relevant SAPSE review as a priority and without delay; and
2. I recommend that as part of its review into the policy governing non-invasive ventilation devices following the SAPSE review, **Calvary Health Care Bethlehem** do so with the view to prioritise the implementation of a consistent methodology for all staff removing a patient's mask to minimise the risk of human error.

I convey my sincere condolences to Philip's family for their loss and acknowledge the tragic circumstances in which it occurred.

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

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

Ms Petah McHardy, Senior Next of Kin

Calvary Health Care Bethlehem, c/- Lander and Rogers

Victorian Respiratory Support Service, Austin Health

Senior Constable Andrew Lawrence, Reporting member, Victoria Police

Signature:



Coroner Leveasque Peterson

Date: 12 June 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.
