Date: 10 September 2026

Coroner Leveasque Peterson

State Coronial Services Centre

Southbank

VICTORIA 3006

By email: cpuresponses@coronerscourt.vic.gov.au.

Dear Coroner Leveasque Peterson

COR 2025 004040 - Investigation into the Death of Philip McHardy

I refer to your letter dated 12 June 2026 and to the Finding without Inquest in relation to the death of Philip McHardy.

I write to provide a response to the recommendations pursuant to section 72(3) of the *Coroners Act 2008 (Victoria)*.

Recommendations

Calvary is responding to 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.**

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 a view to prioritising the implementation of a consistent methodology for all staff removing a patient's mask to minimise the risk of human error.**

I confirm that both recommendations have been implemented.

Recommendation 1

The Serious Adverse Patient Safety Event (**SAPSE**) report made 17 recommendations, several of which had been implemented immediately following Mr McHardy's death. I confirm the remaining recommendations have now been implemented. Evidence and detail of the implementation is provided below.

Recommendation	Status	Evidence to support
1. Review 'NIV for Patients with Neuro Muscular Disease' procedure (**NIV Procedure**).	Complete July 2026	Updated procedure published 31 December 2025..
2. Develop and implement checklist for hourly monitoring of NIV therapy delivery in NIV highly-dependant patients (use >22 hours per day).	Complete August 2025	**4 Point Safety Checklist** implemented in July 2025 and audited in August 2025.
3. Develop and implement quick-reference sheet of ventilator buttons and functions for staff to refer to at the bedside when caring for patients on NIV.	Complete February 2026	Piloted in February 2026, now part of standard practice.
4. Establish NIV training to be incorporated within the hospital's training program.	Phase one complete July 2026	Development of NIV Training program has commenced in collaboration with Victorian Respiratory Support Service. Phase one 'Train the trainer' occurred on 11 August 2026. Tier specific training is being developed currently, and is expected to commence roll out by end of 2026. Calvary will maintain a register of completed staff competencies.
5. Launch targeted awareness campaigns about NIV Procedure and NIV training.	Complete July 2026	Multiple staff updates through the year about procedure and training via newsletters, team huddles, 'Short and Sharp' education sessions..
6. Include NIV Procedure orientation in onboarding.	Complete July 2026	NIV Procedure is included in on-boarding checklist.
7. Agency staff are not to be allocated NIV dependent patients who use NIV > 22 hours daily.	Complete 15 July 2025	Agency staff orientation checklist amended. Allocation sheets are regularly reviewed to ensure compliance, the August 2026 audit found 100% compliance with the requirement not to allocate agency nursing staff to highly dependent patients.
8. Model and reinforce expectations that handover occur at bedside via Ward Nursing Leadership Team during daily operations.	Complete Procedure approved 1st September 2026	Clinical Handover Procedure amended and published, audits are ongoing and demonstrate significant improvement. There has been a noteworthy positive shift in ward culture around bedside handover.

9. Provide training and scripts to support staff in conducting bedside handover.	Complete January 2026	Training delivered by Ward Nursing Leadership Team. Templates posted on doors of patient rooms. Audited regularly.
10. Incorporate assessment of ventilator into the assessmments to complete when clinical changes occur to exclude problem with therapy delivery.	Complete March 2026	NIV Procedure endorsed and 'Recognising and Responding to Acute Deterioration' procedure amended to incorporate assessment of ventilator when clinical changes occur to exclude problems with therapy delivery.
11. Embed safety leadership training into professional development for the Ward Nursing Leadership Team.	Complete July 2026	This recommendation has been addressed predominantly through supporting changes in culture and clarifying role responsibility. Further, there is now additional online mandatory training in Managing Safety and the Nursing Leadership Team now investigate and close out any incident forms submitted during their shift.
12. Establish safety huddles in the Ward Staff Meetings to discuss incidents, near misses, learning and risks, reinforcing a proactive safety culture.	Complete February 2026	Safety huddles are now taking place at the start of each shift as well as at the start of Ward Team meetings. Specifically, for emerging risk/hazard identification as well as identifying complexity/potential risk on the ward.
13. Re-introduce incident reporting metrics in Ward Nursing Leadership Team meetings.	Complete May 2026	Nursing Leadership Team review incident trends and metrics including falls, medications safety, response to call bells and risks contained within the NUM monthly reports. Outcomes from these discussions result in Short and Sharp education sessions, dissemination in team huddles or feedback to working parties.
14. Apply clear labels or overlays to NIV machines to improve button identification and reduce cognitive load.	Handed to VRSS 2025	The Victoria Respiratory Support Service (**VRSS**) has ownership of this recommendation as they are responsible for the NIV Machines. The VRSS has commenced a program to label ventilators as they come in at the time of clinical review or if the ventilator is returned for servicing. Expected completion – end 2026.
15. Engage with equipment suppliers to improve interface design.	Complete November 2025	Feedback provided to equipment suppliers.
16. NIV > 22 hours must be included in accessment of dependency/complexity to inform allocation decisions.	Complete February 2026	Hours of NIV use is being used as a measure of complexity as a stand-alone tool. It is now part of standard care and communicated by all clinicians at the hospital when NIV is in use. It is listed on all handover sheets for staff and is used to inform allocation decisions.

17. Hospital to explore possibility of ventilator being connected to central alarm system to make the nurses station aware if a ventilator stops or malfunctions.	Complete July 2026	Feasbility report from Director of Property and Shared Services submitted to hospital executive. NIV machines are unable to be connected to central alarm system at this time.

Recommendation 2

Calvary Bethlehem cares for patients on a spectrum of NIV dependence. Some patients will insist on the ventilator being turned off for the 30-40 minutes the mask is removed, to silence the alarms and pressured air flow. At the other end of the spectrum, are highly dependent patients who become breathless if the mask is removed for 10-20 seconds and who will insist on the ventilator staying on, with loud air flow and alarms beeping, while the mask is removed. This spectrum of patients means that no one methodology for the removal of masks will be appropriate in every situation, and there will always need to be a clinical decision made in consultation with the patient.

All instances of mask removal (whether leaving the ventilator on or turning it off) must now involve the common and consistent methodology of the **4-point safety check** to ensure therapy is being delivered following the intervention and reduce the risk of human error. This 4-point safety check is referenced in the SAPSE recommendation number 2 and involves:

- Check the patient: look for rise and fall of the chest
- Check the air flow: feel for air flow at the small ventilation holes in the mask
- Check the NIV home screen: Ensure the green bar rises and falls appropriately
- Check the communication tools: Ensure the call bell, buddy buttons, and any other means of communication are within reach of the patient.

The 4-point safety check has been taken up as standard practice by staff at Calvary Bethlehem in circumstances where the mask or ventilator is interferred with for the purposes of providing an intervention, regardless of hours of use.

Should you have any questions, please contact Dr Rupert Strasser, rupert.strasser@calvarycare.org,au.

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Calvary Health Care Bethlehem