

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TRIM: D24-48535

Coroner Katherine Lorenz
Coroners Court of Victoria

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

Dear Coroner Lorenz

COR 2021 007004-Inquest into the death of Noah Andrew Souvatzis

Thank you for your letter on 6 August 2024 in relation to the coronial investigation into the tragic death of Noah Andrew Souvatzis on 31 December 2021 from *Streptococcus pneumoniae* meningitis after attending multiple public health services in regional Victoria.

Your findings include the recommendation *'that the Australian Commission on Safety and Quality in Health Care [the Commission] consider incorporating a question to be asked by clinicians about parental and carer concerns as a core vital sign in paediatric patients and recommend free text space to document these concerns.'*

The Commission's [National Safety and Quality Health Service \(NSQHS\) Standards](#) provide a nationally consistent statement of the level of care consumers can expect from health service organisations. The process to review the NSQHS Standards for development of the third edition has begun.

Currently, the Standards include actions in the Recognising and Responding to Acute Deterioration Standard, which require health service organisations to have protocols that specify criteria for escalating care, including but not limited to *'worry or concern in members of the workforce, patients, carers and families about acute deterioration'* ([action 8.06](#); known as the 'worried criterion'). Further, [action 8.07](#) states that, *'the health service has processes for patients carers and families to directly escalate care'*. The implementation of these actions depends on the health service organisation and the population they serve, the services they provide and the resources available to them.

The Commission has also published a [National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration \(2021\)](#). The Statement defines vital signs broadly to allow for health services to implement locally appropriate processes for monitoring and observation. The Statement asserts that *'charts or electronic tools need to include variations designed to address the needs or circumstances for specific populations such as maternity and paediatric patients or specific diagnoses, such as sepsis or stroke.'* The requirements for documentation are also clearly specified in *Essential element 5: Communicating for Safety*.

Nationally, observation and response charts refer to the 'worried criterion' as part of escalation processes and direct escalation via this process has generally placed the obligation of triggering a rapid response on the person, carer or family member. A change in emphasis to proactive checking by staff could support earlier recognition of deterioration.

A program of work that is currently underway in Victoria in collaboration with other states is focused on improving recognition of deterioration in children by specifically asking about parental concern at the start of observations and on rounds, which will test the efficacy of the approach advocated in your recommendation. The Commission will continue to monitor the progress and outcomes of this work to ensure that evidence and outcomes are used to inform

the review and development of the third edition of the NSQHS Standards and that all states and territories are aware of the emerging evidence and practice that can support better outcomes for children.

The Commission is also working in partnership with The George Institute for Global Health, Sepsis Australia and all states and territories to lead the National Sepsis Program. The program is an extension of previous work and aims to improve the awareness, recognition and support for people at risk of or diagnosed with sepsis in Australia. Part of this program includes supporting improvement in the recognition of paediatric sepsis. Initiatives specific to children include working with the Raising Children Network to include sepsis information on their website as well as a national public awareness campaign to coincide with World Sepsis Day and World Patient Safety day. The key message of the campaigns will encourage people to ask 'could it be sepsis?'

I hope this information is of use to you. Should you wish to discuss this response, please contact my office via: [REDACTED]

The Commission values the work of the Coroners Court and appreciates the opportunity to consider how comments and recommendations may help us to improve the safety and quality of healthcare.

Yours sincerely



Conjoint Professor Anne Duggan
Chief Executive Officer

20 September 2024