IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 007004

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF NOAH ANDREW SOUVATZIS

Findings of:	Coroner Katherine Lorenz
Delivered on:	6 August 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	8-12 April 2024
Keywords:	Meningitis, Paediatric, Hospital Discharge, Parent and Carer Escalation, Locum doctors, Regional Health Care, Sentinel Event

Representation

Counsel Assisting the Coroner:	Megan Fitzgerald of counsel Instructed by Dr Declan McGavin, Coroner's Solicitor
Ben and Steph Souvatzis:	Paul Lamb of counsel Instructed by CBL Business Lawyers as agents of Monaco Compensation Lawyers

Northeast Health Wangaratta:	Dr Paul Halley of counsel
	Instructed by Meridian Lawyers
Royal Children's Hospital:	Fiona Ellis of counsel
	Instructed by Minter Ellison
Dr Grace Reynolds:	Wotton + Kearney
Ambulance Victoria:	Erin Gardner of counsel
	Instructed by HWL Ebsworth Lawyers

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INTRODUCTION

1. Noah Andrew Souvatzis was the 19-month old only child of Stephanie and Benjamin Souvatzis, who I will refer to as Steph and Ben. Noah was a delightful little boy who was deeply loved by Ben and Steph and their extended family.

2. Noah died on 31 December 2021 from *Streptococcus pneumoniae* meningitis after attending multiple public health services in north-east regional Victoria on 29 December 2021.

THE CORONIAL JURISDICTION

3. Noah'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.

4. 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.

5. 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.

6. The coronial jurisdiction is inquisitorial, and facts are established on the balance of probabilities.

7. I took carriage of the coronial investigation into Noah's death in 2023 and decided to hold an inquest about the medical care provided to Noah, in particular, his first presentation to the Emergency Department of Northeast Health Wangaratta (**NEHW**). The inquest took place over 5 days commencing 8 April 2024.

8. This finding is based on the Coronial Brief, the oral evidence of all witnesses who testified at inquest, any documents tendered at inquest and the final submissions of counsel who

appeared. It is unnecessary to summarise all this material. It will remain on the Court file, and I will refer only to so much of it as is relevant or necessary for narrative clarity.

IDENTITY AND CAUSE OF DEATH

9. The identity of the deceased is Noah Andrew Souvatzis, born 12 May 2020.

10. The cause of death was *acute meningitis* from the bacterial infection *Streptococcus pneumoniae*. This was associated with:

    a. Diffuse brain swelling;

    b. Patchy cerebritis and secondary haemorrhage; and,

    c. Cerebellar tonsillar herniation necrosis.[1]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. The oral and written evidence provided by Ben and Steph about the events leading up to Noah's death was not challenged by the other interested parties at inquest. Both of them were credible witnesses and gave honest and detailed accounts of Noah's illness and treatment path. I accept their accounts, noting their composure when recalling the tragic events leading up to Noah's death.

12. Their accounts of the factual circumstances of Noah's death, as well as other evidence provided by the relevant treating teams, were set out in closing submissions of Counsel Assisting which I have extensively reproduced as follows, with gratitude.

13. In December 2021, Noah was holidaying with his family near Myrtleford, in regional Victoria. On 20 December, Noah became a little unwell, with a feverish illness. He seemed to recover within a day or two.[2]

14. In the couple of days leading up to 29 December, Noah was again, not quite himself, not eating as well as usual and a little clingy. At about three in the morning on 29 December, Noah's parents woke to find Noah had vomited and had a high fever. Noah remained unsettled, distressed, crying for some hours, and vomited a few more times. Ben and Steph

[1] Neuropathology Report of Dr Linda Iles, Inquest Brief (IB) 12 and adopted in the Medical Examination Report of Dr Judith Fronczek, dated 23 March 2022, IB 3.
[2] Statement of Benjamin and Stephanie Souvatzis, IB 193; Statement of Stephanie Souvatzis, IB 333 (4)

contemplated returning home but were unable to obtain an appointment with any general practitioner local to their home. During the morning Noah seemed to improve.[3]

15. Shortly before noon, Noah was given a dose of Nurofen and offered a bottle, which he refused. He was then put down for his nap. Within an hour he woke up vomiting and with a high temperature. He was unable to settle.[4]

16. At about 1:45pm, Steph called Nurse-on-Call. The Nurse-on-Call nurse recorded that Noah had been vomiting since 2am; had a fever; was severely lethargic and quite drowsy when roused; having aches and pains; unable to tolerate fluid; had an episode of bile-stained vomit during the call; and became unresponsive. The Nurse-on-Call nurse advised Steph to present to the nearest health service, the Alpine Health Urgent Care Centre in Myrtleford (**Myrtleford UCC**).[5]

17. Ben and Steph drove Noah to Myrtleford, arriving at the UCC around 2:30pm. Steph recalled that Noah was drifting off in the car on the way there, which was unusual for him.[6]

18. At the relevant time, the Myrtleford UCC was staffed by nurses. A local GP could be called in where necessary but was not employed on site.[7] Nurse Liana Cooper took a history and triaged Noah under suspected COVID precautions. She triaged him as category 3 and went on to provide care to him in the respiratory hut situated outside the hospital and used for suspected COVID patients.[8]

19. Nurse Cooper recalled that:

"Noah was held by his mother for most of the assessment, as he became upset when attempts were made to sit him on the bed…throughout the assessment, Noah was resting on his mother's shoulder, and responded well to his parent's voices through eye contact.

[3] Statement of Benjamin and Stephanie Souvatzis, IB 193; Statement of Stephanie Souvatzis, IB 333-334 (4)-(8); Statement of Benjamin Souvatzis, IB 341 (3)-(6)
[4] Statement of Benjamin and Stephanie Souvatzis, IB 193; Statement of Stephanie Souvatzis, IB 334 (9)-(12); Statement of Benjamin Souvatzis, IB 341 (7);
[5] Statement of Dr Peter Baird, Amplar Health (contractor to Nurse-on-Call), IB 24-25
[6] Statement of Stephanie Souvatzis, IB 335 (15)-(16)
[7] Statement of Nurse Liana Cooper, IB 31 (39(i))
[8] Statement of Nurse Liana Cooper, IB 30 (30)

He was lethargic at times but would then appear alert. I recall that Noah cried at times while the assessment was being carried out." [9]

20. Nurse Cooper completed a set of vital signs and recorded them on a Victorian Children's Tool for Observation and Response (**ViCTOR chart**).[10] She formed the view that Noah's vital signs – in particular an increased heart rate of 157 and respiratory rate of 42-44 – along with the fact that he was unable to tolerate any oral fluids and displayed intermittent irritability, placed him in the moderate orange category on the ViCTOR chart and indicated that he might be deteriorating.[11]

21. Nurse Cooper's unchallenged evidence was that based on her usual practice, she most likely communicated her concern that Noah was possibly *dehydrated* and needed IV fluids and paediatric review as soon as possible.[12] Nurse Cooper's supervisor, Lisa Townsend also concurred that Noah should receive specialist paediatric care without delay.

22. At about 2.40pm, after discussion with Ms Townsend, Nurse Cooper recommended that Noah be driven to the Wangaratta Emergency Department. The nurses at Alpine Health were aware of ambulance delays at that time, so decided to recommend transport by private car as it would likely get Noah to the hospital sooner.[13]

23. At about 3pm, Noah and his parents left Myrtleford. Following their departure, Nurse Cooper telephoned the NEHW ED and provided a verbal handover.[14] There was no contemporaneous record of the information that was passed to NEHW ED. It is clear, however, that the verbal handover did take place, because both the NEHW ED Nurse in Charge, Sarah Smith, and triage nurse, Read Moreland, were expecting Noah's arrival.[15]

24. Ben and Steph drove to Wangaratta with a sense of urgency. During the drive Noah continued to vomit, although nothing was coming up. Noah was drowsing off, his eyes were unfocussed, and his head was rolling forward.[16] This was unusual, as he was a child

[9] Statement of Nurse Liana Cooper, IB 30 (35)
[10] Alpine Health Myrtleford VICTOR Chart, IB 211-212
[11] Statement of Nurse Liana Cooper, IB 31 (37)
[12] Statement of Nurse Liana Cooper, IB 33
[13] Statement of Nurse Liana Cooper, IB 31 (39)-(44); Statement of Nurse Unit Manager Lisa Townsend, IB 36 (24)-(25)
[14] Statement of Nurse Liana Cooper, IB 32-33 (46)-(49)
[15] Statement of Nurse Sarah Smith, IB 55-56 (2.4); Statement of Nurse Read Moreland, IB 60-61 (2.2)-(2.3)
[16] Statement of Stephanie Souvatzis, IB 335 (19)

who usually stayed awake and interactive in the car.[17] During the drive, Ben noticed that Noah began making a high-pitched whimpering noise, like he was in pain.[18]

25. Shortly before 3:45pm, the Souvatzis family arrived at Wangaratta Hospital.[19] While waiting in line, Steph was struggling to hold Noah. He seemed to groan less and be more comfortable if he was held "*lying down",* rather than upright but this was difficult for Steph to maintain, so she passed Noah to Ben.[20] It seemed to be uncomfortable for Noah to hold his head up.[21] Noah wasn't clinging to his parents when held.[22] At the inquest, Ben described his condition as:

"…he wasn't responsive…he'd look around at times, but it wasn't, if you say responsive to how he usually was. It wasn't like that at all…

…he was kind of floppy and pale and his eyes would be open at times, while he just pretty much laid on you, but when he did that, it's not like he was looking around or alert or wanting a cuddle. He was just very sick and exhausted, so he would just flop on you."[23]

26. Noah was triaged by Nurse Read Moreland, who had finished her shift but continued working on overtime to triage Noah, whom she had been expecting. Nurse Moreland assessed Noah's vital signs and recorded them on the triage summary as pulse of 114, temperature of 39.4, respiratory rate of 44, 100% oxygenation and, a capillary refill time of either less than 2 seconds or less than 3 seconds.[24]

27. In the triage assessment, Nurse Moreland recorded "*VOMITING/FLAT/ FEBRILE. 3 days of reduced intake. Onset of fevers and vomiting at 0300. Unable to keep any fluids/food down. Looks pale, hot and flat. Drowsy and difficult to rouse. No increased work of breathing.*" Nurse Moreland triaged Noah as category 2, which required him to have medical assessment within 10 minutes.

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[17] Statement of Stephanie Souvatzis, IB 335 (16); Statement of Benjamin Souvatzis, IB 342 (12)
[18] Statement of Benjamin Souvatzis, IB 342 (13)
[19] The triage summary, IB 226, records a time of 1545 hours, which Read Moreland stated was probably recorded at the end of the triage, rather than the beginning, IB 61 (2.8)
[20] Transcript (**T**) 39 (20)-(25) (Stephanie Souvatzis)
[21] T 44 (21)-(29) (Stephanie Souvatzis)
[22] T 45 (5)-(11) (Stephanie Souvatzis); T 24 (24)-(29) (Benjamin Souvatzis)
[23] T 24 (Benjamin Souvatzis)
[24] Triage summary, IB 226

28. In her evidence, Nurse Moreland recalled that Noah allowed her to take observations without protest, which was unusual for a toddler, and also that he was difficult to rouse to take his vital signs and quickly dozed off again.[25] In oral evidence Nurse Moreland expanded on this, saying:

"…He kept dozing off…and I think I even commented too that, to um Noah's parents that gee he really seems like he's struggling to stay awake."[26]

"…I do recall that there was response to the point of while I was doing things he was sort of aware I think that I was doing them. There wasn't the normal toddler moving like feet and fingers or hands depending where you're [measuring] saturations but it wasn't the same normal degree of resistance to that…but it was how soon he was not staying awake after I'd persistently bothered him and also with all the stimuli in the environment…"[27]

29. Steph stayed with Noah in the ED as, due to COVID-19 restrictions in place at the time, only one parent could accompany Noah into the NEHW ED.

30. Dr Paul Bumford, who was allocated to care for Noah during his first presentation to the NEHW ED, was rostered to the ED for his first shift as a locum on the afternoon shift on 29 December 2021. He was rostered as the second in charge, with Dr Douglas Devereux as the Senior Doctor in Charge.

31. Usually, the second in charge doctor commences an afternoon shift at midday, when there is an overlap of staffing for several hours. However, Dr Bumford was unable to start the shift until 4pm, which created difficulties in providing him with a thorough and unhurried induction. Dr Bumford arrived at 4pm and was receiving an introductory tour of the department from Dr Devereux when Noah was placed in cubicle 2 and an announcement of the category 2 paediatric patient was made.

32. At around 4pm, Dr Bumford first attended on Noah. Dr Bumford noted Noah's vital signs, recording them in a ViCTOR chart.[28] Noah's respiratory rate of 48 was tachypnoeic, his heart rate of 150 was tachycardic, and his temperature was high at 39.4 degrees. Dr

[25] Statement of Read Moreland, IB 61 (2.6)
[26] T 79 (10)-(20)
[27] T 80 (17)-(29)
[28] IB 224-225

Bumford obtained a history from Steph, including that Noah had been vomiting, was unable to keep anything down that morning, was miserable, was not tolerating anything orally and had reduced wet nappies. By Dr Bumford's observation, Noah's mouth was slightly dry, he was miserable but alert, following his movements around the room with his eyes.

33. Dr Bumford formed the view that the most likely diagnosis was viral gastroenteritis, with a differential diagnosis of COVID-19. He prescribed an immediate dose of ondansetron for nausea, along with paracetamol and ibuprofen. He decided on a plan of a trial of oral rehydration, using a syringe to give Noah frequent small amounts of water, along with a Hydrolyte icy pole. His clinical record also notes an intention to obtain urine for testing when Noah next passed it.[29]

34. At around 4:30pm Noah was given ondansetron and then paracetamol, which he immediately vomited up. Steph was advised to wait 10 minutes to let the ondansetron take effect before the paracetamol could be readministered, along with ibuprofen.

35. Having made a plan for a trial of oral rehydration, Dr Bumford provided Steph with a cup of water and a syringe. Steph was instructed to give Noah 8ml of water every 10 minutes.[30] Steph was also given a Hydrolyte icy pole for Noah, which ultimately melted and attempts were made to syringe it into Noah's mouth.[31] No arrangements were made by Dr Bumford or the NEHW ED nursing staff to keep a fluid balance chart or monitor Noah's intake or output. The only record of Noah's intake is of 40mls of fluids having been given. This appeared in a nursing progress note made at 5:40pm.[32]

36. Noah's vital signs were recorded on the ViCTOR chart for a second time at 4:35pm by nurse Phoebe Cotter.[33] Nurse Cotter also completed a primary survey, which appeared to correspond to the 40 degree temperature recorded in the ViCTOR chart at this time.[34] At this time Noah's respiratory rate remained high and within the 'orange zone' on the chart,

[29] IB 218
[30] T 48 (19)-(25) (Stephanie Souvatzis)
[31] T 50 (1)-(4) (Stephanie Souvatzis)
[32] IB 219
[33] IB 224-225 (VICTOR Chart)
[34] IB 228 (Primary Survey/Cubicle Assessment)

at 44 breaths per minute. His heart rate was then just within the normal range at 145 beats per minute, however the primary survey described Noah as tachycardic.

37. While the entry on the ViCTOR chart recorded no respiratory distress, the primary survey described increased work of breathing, an increased respiratory rate and use of accessory muscles. In the primary survey Noah was described as drowsy, febrile, lethargic and unwell. Nevertheless, the entry in the ViCTOR chart described him as alert. It is unclear why there is an apparent discrepancy between the observations recorded in these two documents.

38. At 4:50pm, Nurse Cotter made a further progress note, describing, among other things, Noah as tachycardic at 150bpm and noting a rash to his chest and left thigh. Steph recalled that the rash had faded considerably by the time Dr Bumford examined it and Dr Bumford made no record of the rash.

39. Steph recalled that from about 4:50pm, when Noah was first given medication and throughout the remainder of the admission, Noah was lying on the bed with his eyes shut most of the time. According to Steph when his eyes were open, he seemed unable to focus them and they were sometimes unevenly open.[35]

40. At about 5:30pm a further set of vital signs was obtained.[36] Aside from an ongoing high temperature, the vital signs were within normal limits as defined by the ViCTOR chart. A nursing note of the same time recorded, among other things, that Noah appeared "*more settled, not as distressed*".[37]

41. At 6:30pm, a final set of vital signs were taken and these were within normal limits.[38]

42. At 7:20pm, Dr Bumford made a clinical note that described Noah as "*Much improved post treatment. More alert. Tolerating oral fluids. Obs WNL, afebrile."*[39]

43. Soon after, Noah was discharged from the NEHW ED.

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[35] Statement of Stephanie Souvatzis, IB 337 (26) and (29)
[36] IB 224-225
[37] IB 219
[38] IB 224-225
[39] IB 219

44. Following his discharge from NEHW and after arriving in Benalla, due to the deterioration in his condition, Steph and Ben took Noah to the Benalla Urgent Care Centre (**Benalla UCC**).

45. The Benalla UCC, like the one in Myrtleford, was staffed by nurses, with doctors on call from the local GP clinic. On assessment, the nursing staff at Benalla UCC recognised that Noah was seriously unwell, presenting as floppy, lethargic and with a reduced Glascow Coma Scale score. Dr Grace Reynolds, the on-call GP, was contacted at 9:15pm and arrived at 9:30pm.[40]

46. Dr Reynolds took a brief history and observed that Noah was evidently unwell, with a low respiratory rate, hypothermia and bradycardia. Dr Reynolds inserted an IV cannula, which took three attempts, to which Noah was, worryingly, minimally responsive. Dr Reynolds obtained a blood sample for testing before commencing saline fluid resuscitation. Dr Reynolds contacted Ambulance Victoria to arrange transfer to a higher acuity facility and called the on-call paediatric registrar at NEHW. On the advice of the paediatric registrar, Dr Reynolds added empiric antibiotics to the IV, for presumed sepsis.[41]

47. At 10:38pm, Advanced Life Support paramedics Jessica Bakker and Ash Fookes arrived on scene. After their arrival Dr Reynolds then had an opportunity to contact the RCH Paediatric Infant and Perinatal Emergency Retrieval service, known as PIPER. After discussion, the PIPER consultant considered Noah to be sufficiently stable for road transport to Wangaratta Hospital and Dr Reynolds felt that transfer to Wangaratta would be preferable to awaiting PIPER retrieval, as it would result in earlier specialist paediatric care.[42]

48. At about 10:50pm, Clinical Support Officer and senior Mobile Intensive Care Ambulance paramedic Brendan Kinderis was awoken and asked to attend to assist at the Benalla UCC. Mr Kinderis was not on shift at the time but agreed to attend and was at the health service within about 5 minutes. On arrival, Mr Kinderis also considered the potential to transfer Noah to a tertiary hospital by way of Helicopter Emergency Medical Service (**HEMS**)

[40] IB 232
[41] Statement of Dr Grace Reynolds, dated 1 April 2023, IB 127-130; Dr Reynolds letter of referral to NEHW, IB 238
[42] Statement of Dr Grace Reynolds, dated 1 April 2023, IB 129

retrieval, but ultimately felt that transfer to Wangaratta by road would be lower risk and would result in Noah obtaining specialist care sooner.[43]

49. On the way from Benalla to Wangaratta, Noah began to suffer seizures. On arrival at Wangaratta, he was met by ED and paediatric staff who were expecting his arrival. Noah was extremely unwell, hypotonic, and suffering seizures. A CT Brain scan performed shortly after arrival was reported as normal but treating paediatricians considered it to show signs of meningitis or encephalitis. At 1:05am the paediatric team at Wangaratta Hospital determined that Noah's condition exceeded the facility's capabilities, and a PIPER team was dispatched.

50. At around 3am, the PIPER team arrived at Wangaratta. During the handover, Noah suffered a sudden deterioration and required resuscitation and intubation. At 6.45am, Noah arrived at the Royal Children's Hospital (**RCH**). Subsequent investigations confirmed bacterial meningitis from *Streptococcus pneumoniae*.

51. At 3.11pm on 30 December, Noah was confirmed brain dead. He was maintained on life support overnight and the following morning underwent organ donation procedures, following which he was given palliative care and died.

ISSUES AT INQUEST

52. There were no issues in relation to Noah's identity, nor the medical cause of death. As is often the case the primary focus of the coronial investigation and inquest into Noah's death was the circumstances of this death, including:

    a. whether Noah received appropriate care during his first presentation to the NEHW ED;

    b. the reasonableness of the decisions and actions taken by health service providers in relation to Noah's emergency retrieval from Benalla UCC and, later, from NEHW ED following Noah's second presentation there;

    c. whether, and how, staffing and resource constraints were a factor in Noah's death;

[43] Statement of Brendan Kinderis, dated 25 May 2023, IB 131-146

d. Parent and Carer Escalation (**PACE**) pathways in place at the time, subsequent changes, and best practice for PACE; and

e. Whether Noah's death was preventable and, if so, when was the opportunity for prevention?

Concession by NEHW

53. At the commencement of the inquest, NEHW, through its counsel, made the following concession:

"Northeast Health Wangaratta concedes that the care provided to Noah at the first presentation at the hospital was not appropriate. It apologises for the inappropriate care and expresses its sincere condolences to Noah's family and loved ones."[44]

54. While this concession was usefully made at the commencement of the inquest, it should have been made much earlier, preferably soon after Noah's death. Some of the shortcomings in care should have been identified immediately and NEHW should have communicated more with Ben and Steph during its sentinel event investigation process and full and transparent open disclosure made at that time. This did not occur.[45]

55. It is incumbent on health services in Victoria to make proper disclosure to families following critical incidents in health care, most particularly those incidents involving Sentinel Events,[46] such as in Noah's case. I note that open disclosure has been a patient and consumer right and a core professional requirement and health service obligation within the National Safety and Quality Health Service Standards for many years[47] and is now a legislated requirement.[48]

56. The evidence disclosed that not only was the contact between NEHW and Ben and Steph minimal following Noah's death, the family's involvement in the Sentinel Event Review

[44] T 17 (21)-(26)
[45] As set out in Ben and Steph's correspondence to the Court, IB 204-209.
[46] A Sentinel Event is when something goes wrong with a patient's care that causes them serious harm or death which could have been prevented. Health services must review Sentinel Events to understand what went wrong, how and why with an aim to reduce the change of something similar happening to someone else. See Safer Care Victoria Sentinel Event Guide, Additional Materials (**AM**) 48.
[47] See Australian Open Disclosure Framework at <https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework>
[48] *Health Services Act 1988* (Vic), s 128ZC(1)(a). I note that this section came into force after Noah's death.

(**SER**) into Noah's death was also minimal and inadequate. Further, the SER failed to recognise some of the key issues which were raised by Steph and Ben at the relevant time of the review which have subsequently been identified as critical issues during the inquest.

The first presentation to the NEHW ED

57. The Court heard evidence from four witnesses from NEHW who were involved in Noah's care during his first presentation to the ED.

58. Triage nurse, Read Moreland, gave evidence that she had a good recollection of Noah's presentation.

59. The Nurse in charge of the NEHW ED, Sarah Smith also gave evidence including about the broader issues in the operation of the ED at the time of Noah's presentation.

60. Dr Paul Bumford was a locum doctor who commenced his first shift in the NEHW ED at 4pm on 29 December 2021, which was about the same time that Noah arrived. Dr Bumford was allocated to care for Noah in his capacity as the second in charge doctor by Dr Douglas Devereux.[49]

61. Dr Bumford gave evidence at inquest and made broad and forthright concessions about his failings of care to Noah. He also properly conceded that his recollection was unreliable because he had been through an AHPRA investigation following Noah's death and was unable to confidently delineate between actual memories and memories which had been created by his involvement in that process.[50]

62. Dr Devereux was the doctor in charge of the NEHW ED at the time of Noah's first presentation. He gave evidence that he could not remember specifics of the shift during which Noah first presented to the NEHW ED, that the period was "*exceptionally busy*" and his "*memory of that summer blurs into one."*[51] I find it surprising, and indeed implausible, that Dr Devereux remembered nothing about Noah's presentation given he was in charge of the shift when Noah died in traumatic circumstances following his visit to the ED.

[49] T 172 (18)
[50] T 123 (1)-(12) (Bumford)
[51] T 165 (29)-(31)

63. In this regard, I note that Dr Devereux sent a long email to Dr Johann De Witt Oosthuizen, the Clinical Director Emergency Services at NEHW shortly after Noah's death, describing the circumstances during the shift. In the email Dr Devereux offered to discuss Noah's case "*to see if there are system failures that may have changed the outcome in this situation*."[52] Given Dr Devereux's email and the reflection contained within it, his lack of recall of the events at inquest was perplexing and unfortunate.

64. Further, Dr Devereux's lack of recollection during cross examination about the shift in question contrasted with other witnesses who had a far better recollection of the events on relevant day, including Nurse Moreland who gave evidence that the events had been cemented in her mind after she learned of the outcome shortly after her involvement in Noah's care.[53] The court was also in receipt of SMS messages between clinical staff following Noah's death which highlighted the depth of distress experienced by nursing staff as a result of the tragedy.

Dr Bumford's orientation to the NEHW ED

65. It is noteworthy that Dr Bumford was on his first shift at NEHW ED and had only commenced his shift 10 minutes or so prior to seeing Noah for the first time.

66. In this context, I accept the following submissions made by Counsel Assisting about Dr Bumford's induction to the NEHW ED:

    a. Dr Bumford was not given any written information, guidelines, or policies about the NEHW ED prior to or during his first locum shift;[54]

    b. Dr Bumford was not, during the induction or at any time during his shift on 29 December 2021, provided with any information about internal pathways for referral to inpatient units. Importantly, he was not informed that NEHW had a low threshold for ED doctors to seek the opinion of the paediatric unit and that the paediatric unit had a low threshold for admission;[55]

[52] IB 53.
[53] T 67 (16)-(31) (Moreland)
[54] T 144 (Bumford)
[55] T 141 (8)-(9) (Bumford)

c. Dr Bumford was not advised that the NEHW ED used the RCH clinical guidelines for paediatric patients or shown where to access those guidelines on the NEHW ED computers;[56]

d. Dr Bumford's induction to the NEHW ED provided by Dr Devereux, consisted of an introduction to Dr Devereux, a brief tour of the ED and short stay unit and login details for the computer system with a demonstration of how to complete essential documents such as discharge summaries;[57] and

e. the induction may have been as brief as 4 minutes[58] and was likely no longer than 10-15 minutes, given that Dr Bumford arrived about 10 minutes prior to the 4pm commencement of his shift; Noah was placed in a cubicle and announced as a category 2 patient by 3:49pm; and Dr Bumford had discussed with Steph a management plan by 4:07pm,[59] recorded vital signs at 4:10pm[60] and completed his first examination of Noah by 4:15pm.[61]

67. It was clear from the evidence that Dr Bumford's induction to the NEHW ED was inadequate and rushed. It was conducted in circumstances of an overwhelmed ED and by a doctor in charge who was not capable of providing adequate time and attention to the task and did not appreciate Dr Bumford's limited experience in the context of the role he was expected to perform.

68. I accept the submission of Counsel Assisting that the evidence disclosed that Dr Bumford felt some pressure to treat Noah due to the demands of other patients at the NEHW ED that day. However, regardless of the sense of pressure that Dr Bumford felt, it should also be acknowledged that he was able to attend upon Noah with adequate frequency and timeliness[62] and Dr Bumford candidly admitted he could have accessed the appropriate RCH guidelines had it occurred to him to do so.[63] With this in mind, the extent to which

[56] T 145 (Bumford)
[57] T 119 (Bumford)
[58] T 144 (13) – 145 (12)
[59] Photo Brief (**PB**) A9
[60] VICTOR Chart, IB 224-225
[61] IB 218
[62] T 54 (16)-(17) (Stephanie Souvatzis)
[63] T 114 (6)-(15) (Bumford)

the inadequate induction and overwhelmed ED contributed to Dr Bumford's errors in judgement and care is limited.

Dr Bumford's experience and suitability for the role

69. Prior to his shift at NEHW ED, Dr Bumford had spent one year working in a mixed ED in the UK and approximately 6 months performing largely unsupervised locum work in mixed EDs in Victoria. He had also worked for about 18 months in a Victorian adult ED. While he was aware of the existence of the RCH Sepsis guideline and Febrile Child guideline and capable of accessing each online, at the time of Noah's presentation he was not sufficiently familiar with the content of either guideline to make use of it from memory.[64]

70. I accept the submission of Counsel Assisting that Dr Bumford's experience and knowledge of local paediatric guidelines and best practice was substantially less than desirable when he was allocated to care for Noah, a category 2 paediatric presentation.[65]

71. Dr De Witt Oosthuizen gave evidence that NEHW often had to fill in shifts through locum agencies at short notice and that NEHW saw multiple locums on a daily basis.[66] Dr De Witt Oosthuizen went on to say that NEHW prefers to *"use doctors, even locum doctors, that have been there before because you know them [and] you know what their capabilities are"*.[67] However, particularly on very short notice, NEHW would accept somebody to fill a position who was less experienced because it was considered that having **a** doctor is better than having **no** doctor in the shift.

72. There is an important distinction to be made between a locum with high qualifications and a more junior locum hired to fill a senior role. Accordingly, it is vital that a senior in charge doctor in an emergency department makes reasonable inquiries with respect to new locums, no matter what the role, to gauge some sense of the locum's actual capabilities, regardless of the assigned role for that person.

73. I consider this to be a good risk management practice even without the known issue of filling more senior roles with less qualified locums because, and as acknowledged by Dr

[64] T 114 (6)-(15); T 116 (8)-(23) (Bumford)
[65] T 184 (2)
[66] T 327 (18)
[67] T 330 (18)-(20)

De Witt Oosthuizen, *"what's being said in the CV is not necessarily what the experience is."*[68]

74. This concern is now explicitly recognised in the updated NEWH ED Orientation Booklet which emphasises that, if you are a new locum, *"there is an expectation you will discuss your first 5 patients with the Senior Doctor In Charge to familiarise and establish your competencies at Northeast Health Wangaratta"*[69]

75. Dr Devereux also gave evidence that Dr Bumford had qualifications similar to those other doctors allocated to act as HMOs in the NEHW ED during the relevant shift. Dr Devereux defended the qualifications and experience of Dr Bumford in performing the role as second in charge of the shift.[70] Further, Dr Devereux considered it would not be standard practice for him to supervise a doctor in the same position Dr Bumford was in on his first shift whilst seeing his first few patients.[71]

76. Dr Devereux's evidence appears to have conflated the supervision of locums with high **qualifications appropriate for the role** with supervision of locums **employed in a senior role** when describing the standard practice to not initially supervise new locums for their first few patients.[72]

77. However, as pointed out by counsel for NEHW, there is a distinction between 'supervising' new locums and 'discussing' cases with new locums.[73] Dr Devereux acknowledged following Noah's death he would *"certainly actively discuss"* the first few patients when working with new locums.[74]

78. I do not consider the discussions that Dr Devereux had with Dr Bumford to be *active* discussions which would have had the additional purpose of gauging Dr Bumford's clinical capability and safe practice. Further, it is concerning that Dr Devereux, as the most senior doctor at the ED on the relevant day assumed that Dr Bumford could safely perform the

[68] T 331 (22)-(23)
[69] IB 413.
[70] T 172 (8)
[71] T 173 (8)
[72] T 172 (16)-(20); T 173 (8)-(10)
[73] T 173 (30)
[74] T 174 (13)-(16)

role as second in charge without having made any meaningful enquiries as to Dr Bumford's skills and experience.

79. I accept the submissions of Noah's family that Dr Bumford was too junior for the second in charge role, which required him to treat a complex paediatric category 2 patient such as Noah without any real supervision. Dr Bumford had the experience of a junior resident/HMO at the relevant time.

80. It was incumbent on Dr Devereux as the senior doctor that day to ensure that Dr Bumford was capable of treating a patient such as Noah. Further, Dr Bumford's induction was inadequate, and he did not have useful information available to him to provide appropriate clinical care.

81. I wholly reject the evidence of Dr Devereux that it was appropriate for Dr Bumford to perform the functions of the second in charge doctor. The staffing restraints and pressure on the ED did not excuse NEHW from its obligation to have appropriately skilled and experienced staff on shift or for junior staff to be placed in a position of treating patients without having a meaningful assessment of their qualifications and no proper orientation prior to the shift.

82. I do not accept Dr De Witt Oosthuizen's assertion that having someone in the second in charge shift is better than having no one in the shift, because in Noah's case, the consequence of having an underqualified doctor in a senior role meant that a senior review did not take place as a matter of course. I consider that a safer practice would instead be to reclassify the shift as having an additional HMO and ensure that senior review is undertaken in cases such as Noah's.

83. Generally, it is concerning to me that the senior doctors at NEHW did not acknowledge the significant risk of the reliance on locums and therefore have appropriate mitigation strategies in place, including re-classification of positions and better senior doctor review.

Verbal handover from Alpine Health

84. The evidence clearly disclosed that a verbal handover took place between Alpine Health and NEHW ED prior to Noah leaving Alpine Health. I further accept that although the handover from Alpine Health to NEHW specifically mentioned the need for IV fluids and

paediatric review, this information was not given to Dr Bumford. It is not clear why this did not occur.

85. However, at the time of Noah's presentation there was no system for verbal handovers from another health service to be automatically recorded in a patient's clinical file. While the system for recording and communicating verbal handovers at the triage stage has changed, it remains the case that the transfer of this information to the clinical file and to those providing clinical care within the NEHW ED remains dependent on the actions of the staff member receiving the verbal handover or the triage nurse.[75]

86. I accept Steph's evidence that she "*definitely*" told Dr Bumford that they had gone to the Myrtleford UCC before coming to Wangaratta.[76] However, as Dr Bumford had not appreciated the nature and severity of Noah's symptoms, it appears he did not act on this information or seek to find out more about the presentation to Alpine Health.

87. I accept the submission made on behalf of Noah's parents that had the specific concerns about dehydration and the need for paediatric review been recorded by NEHW it is likely that medical staff may have apprehended that Noah was a complex patient who needed a review by someone more senior that Dr Bumford and in fact required a proper paediatric review, in accordance with the 'low threshold' for paediatric review at NEHW.

88. The failure by NEHW to record the information conveyed by Alpine Health was a significant missed opportunity to prevent Noah's deterioration and subsequent death and a failure of care.

Issues with Noah's assessment and treatment during the first presentation at NEHW ED

89. There were several aspects of Noah's care during the first presentation which were sub-standard. These were broadly a lack of recognition of poor oral hydration, a lack of recognition that Noah was severely unwell, inappropriate discharge, and lack of senior clinician involvement.

The lack of oral hydration

[75] T 364 (De Witt Oosthuizen)
[76] T 43 (14)-(20)

90. Steph described Noah's inability to tolerate oral fluids as follows:

"…he was really um not wanting things near his face so that was the one place that he was really um resistant to having things on. So I was having to hold him in my lap and support his head because if I let go of his head it would flop and then I was having to have a cup that was on a hospital bed and not stable and trying to syringe water out then trying to support his head in a position that I could get the syringe in and then when I would it would then just come back out of his mouth anyway.

"…I tried to do that several times and then when Dr Bumford came back in I explained my difficulty and he then syringed a few in with me holding his head and then he came back in again and that's when I asked if I could syringe while he's lying down…he said I could but it was just pooling back out."[77]

91. While the actual volume of Noah's fluid intake was not measured, the evidence indicated that Noah's oral intake was grossly inadequate to be considered part of a successful trial of oral rehydration.

92. Further, there was no recording of Noah's fluid output. Noah had decreased urine output on arrival to the ED and did not urinate for the duration of his approximately three hour stay. This lack of urine output was indicative of ongoing dehydration. Furthermore, Noah vomited again shortly before his discharge. Steph described the vomiting as substantial[78] but given the apparent low volume of successful oral intake, any vomiting at all was indicative of a failed trial of oral rehydration.[79]

93. The trial of oral rehydration should have been considered a failure and Noah should not have been discharged in the circumstances.

Diagnostic failure

94. In oral evidence Dr Bumford conceded that he did not turn his mind to the possibility that Noah had a serious bacterial illness, including sepsis or meningitis and that this was a failing on his part.[80] He went on to accept that, at the time of his first examination, Noah

[77] T 49 (9)-(24) (Stephanie Souvatzis)
[78] IB 339 (43)-(45)
[79] T 142 (31)-143 (5) (Bumford); T 179 (5)-(17)
[80] T 128 (6)-(10), T 151 (19)-(24) (Bumford)

fulfilled a significant number of the features suggestive of an "unwell" child in the RCH Febrile Child guideline.[81] He accepted that it followed that, based on the features Noah presented with, he should have followed the pathway set out on the right-hand side of the algorithm for treatment of a febrile child who is "unwell" with "no clinically obvious focus", including blood tests, admission and consideration for empiric antibiotics.[82]

95. Had this pathway been followed, Noah likely would have received appropriate therapy, including antibiotics 5 or so hours earlier when the opportunity to change the course of his illness was still open. I agree with the submissions of Ben and Steph that had the RCH Febrile Child guideline been followed, Noah would likely have been under the care of one of NEHW's specialist paediatric doctors such as Dr McLean or Dr McAdam many hours earlier and hydration and other therapies would have been commenced.

The decision to discharge

96. At around 6:30 pm when Noah's final set of vital signs were taken, Dr Bumford had a second and final discussion with Dr Devereux.

97. Dr Bumford then had a conversation with Steph about his plan to discharge Noah. While Steph was not comfortable with the plan, she gave forthright evidence that she didn't vocally oppose it at that time.[83] However, shortly before 7pm Noah began to vomit again. Steph gave evidence that:

"…I remember feeling relief that Noah started vomiting again and pushed [the buzzer] 'cause I thought it would mean that he would no longer be making us leave…

…I was stressed that he was saying that we were going to be discharged because Noah had not improved um and he was…worse yeah and…then I remember feeling relieved that… because Noah has started vomiting again they're going to keep him and do something…

…I said, 'Does this, can this please stop, the discharge process.' I don't recall who I said that to, but I said it to a member of staff…and I thought that was enough for them to

[81] T 128-134 (Bumford); IB 375-380 (Febrile Child guideline in place at the time of Noah's presentation)
[82] See the algorithm at IB 379; T 134 (12)-(25), T 152 (1)-(18) (Bumford)
[83] T 57 (12)-(15) (Stephanie Souvatzis)

understand that I was concerned, and they didn't follow-up with, 'Oh why do you want that to stop?' It was more, 'No, he – he will still be going.''[84]

98. In deciding to discharge Noah, Dr Bumford conceded that he had put far too much weight on the previously normal vital signs observations when he should have been looking at the bigger picture.[85] He accepted that he must have been mistaken in his assessment of Noah's level of alertness,[86] and that other than Noah's vital signs observations having normalised when they were last taken at 6:30pm, there was nothing to support the matters documented in his clinical note made at 7:20pm.[87]

99. I accept the submission of Counsel Assisting that Dr Bumford's clinical note and the opinion expressed in it lacked any reasonable basis and that the opinion was formed and documented in the exercise of a serious error in clinical judgement.

100. At about 7:20pm, despite vomiting again, Noah's discharge went ahead and he left the hospital. It was conceded by NEHW that Noah should **not** have been discharged. Discharging Noah in these circumstances was a **clear failure** of NEHW's duty of care to Noah.

101. Ben saw Noah when he was discharged. He recalled that Noah had deteriorated since he had last seen him at the time of triage. Noah did not react to being reunited with his dad.[88] Ben gave evidence that:

"…when I picked them up and she came out with Noah, she said to me, 'You can take him but he can't – he can't hold his head up', so you had to hold his head because as soon as you let it go, it – it would flop around and he was very – very pale, as you can see in the photos…''[89]

102. At the inquest, Ben described putting Noah into his car seat, observing him to be floppy and not purposeful in his movements.[90] The Souvatzis family travelled to Benalla, where Ben had obtained accommodation for the night. When they arrived at the motel, according

[84] T 56 (30)-57 (24) (Stephanie Souvatzis)
[85] T 140 (1)-(3) (Bumford)
[86] T 149 (26)-150 (11) (Bumford)
[87] T 155 (14)-(31)
[88] T 30 (11)
[89] T 28 (4)-(9)
[90] T 29 (10)-(15)

to Ben, "*(t)here was no comfort for him…he was thrashing around, he – he did not know we were there helping him*."[91]

Lack of Senior Clinician Involvement

103. Prior to discharge, the conversation between Drs Bumford and Devereux was about Noah's disposition, particularly whether he could be discharged. Dr Bumford informed Dr Devereux that Noah's condition had improved, and he could be discharged.

104. Dr Devereux did not examine Noah, did not review the clinical records, nor otherwise inquire into the basis for Dr Bumford's opinion or the care that had been provided. While Dr Devereux had earlier "eyeballed" Noah while passing his cubicle, this was no more than a glance[92] and was an inadequate basis for him to form an opinion about Noah's clinical condition at the time or, indeed, sometime later when discussing the plan for discharge.

105. Further, Dr Devereux's description of Noah as being "alert" and looking around the cubicle was not consistent with the evidence given by others, including Steph, and not consistent with the photographs taken of Noah during his admission and immediately after discharge. The photographs, which were tendered at inquest, clearly show a very unwell child, who was not alert and engaged as Dr Devereux stated in his evidence.

106. In the circumstances that Dr Devereux:

    a. was the most senior doctor at the NEHW ED at the relevant time;
    b. was aware that Noah was a category 2 patient who had earlier transferred from Alpine Health;
    c. knew that Dr Bumford was performing his first shift at the NEHW ED;
    d. saw Noah in the cubicle;
    e. knew, or should have known, that the orientation provided to Dr Bumford was wholly inadequate and that specifically, Dr Bumford had not been informed that the NEHW ED adhered to the RCH guidelines and that the hospital's practice was for a low threshold referral to paediatrics and paediatric admission;

[91] T 30 (1)-(3)
[92] T 176 (Devereux)

f. knew, or should have known, that while Dr Bumford was placed in a senior role, his qualifications at the time were more similar to those of an HMO; then,

Dr Devereux ought to have examined Noah prior to discharge.

107. Dr Devereux's failure to examine Noah or review his records prior his discharge was a clear and significant failure on his part. Had he examined Noah to a reasonable standard, Dr Devereux, as an experienced and senior clinician in the emergency department, would have recognised that Noah was severely unwell and arranged for admission with paediatric referral.

Transfer of Noah from Benalla to NEHW ED

108. At inquest, evidence was given about the decision to transfer Noah to NEHW by road ambulance following his presentation to Benalla UCC. The evidence disclosed that the decision was reasonable and could not be found to have contributed to Noah's death.[93] I accept the submission of Counsel Assisting that the primary opportunity to change the outcome for Noah was during his first presentation to NEHW ED.

109. While arranging for retrieval from Benalla may have resulted in an earlier arrival at the RCH and the highest level of emergency paediatric intensive care, it would have postponed Noah's access to the paediatric care he received on his second presentation to NEHW. Delaying his departure from Benalla, where he was unable to access any specialised paediatric care, also carried great risk of deterioration that could not be managed with the resources and expertise on hand.

110. While an earlier retrieval to Melbourne may have changed his outcome, on the evidence this is was a speculative possibility at best.

Patient and carer escalation (PACE)

111. Steph gave compelling evidence to the court that she was not aware of any system in place during Noah's presentations to NEHW ED to escalate her concerns about Noah, including her valid concerns about discharge. Had she been made aware of any such system, she would have used it when Dr Bumford decided Noah could be discharged.

[93] T 298 (25)-(30) (Stewart)

112. During the coronial investigation, I sought a statement from NEHW about the processes for addressing and escalating parental concerns at the time of Noah's death and changes made since. The system in place now involves a three-step process and the escalation is to be documented on a patient, family, carer escalation form to be filed in the medical record.

113. The court also sought and received information from Safer Care for Kids regarding a proposed form of a state-wide PACE system to be introduced in Victoria and heard oral evidence from Professor Edward Oakley, Chief of Critical Care and a Paediatric Emergency Physician at the RCH regarding the RCH's pilot PACE program.

114. The Court heard that good communication between patients and families with their treating teams is essential for optimal health care and it is incumbent on health services to ensure that systems are in place for patients and their loved ones to advocate for appropriate care.

115. In Noah's case, Steph's evidence was unambiguous that Noah was not behaving as he usually did. His cries were different, and he was not responding to her. Had Steph been listened to, then Noah's care would have and should have been escalated early in his first admission to NEHW. This is likely to have changed his outcome.

116. I agree with the submissions of Counsel Assisting and Ben and Steph that a good PACE system in a hospital must place some onus on health care staff to enquire whether patients and their carers have concerns about their treatment or deterioration rather than placing the onus solely on the patient or carer.

117. This submission was supported by evidence of Dr McAdam and Professor Oakley. Further, any such system must be tailored to the health service it is situated within, taking into consideration such factors the available resources, location and patient cohorts.

Sentinel Event Review Process and Hospital's Investigation into Noah's death

118. As identified by Steph and Ben in statements they submitted to the court following Noah's death, there were fundamental and obvious flaws in the Root Cause Analysis process undertaken by NEHW in conjunction with the RCH.

119. Firstly, the facts in relation to the problematic first presentation at NEHW upon which the report relied were drawn from medical records, which were in many respects sub-standard and lacking in detail.

120. Secondly, treating staff including Nurse Moreland, and Drs Bumford and Devereux were not interviewed prior as part of the review. Plainly such a review could not have identified accurately the root causes of the adverse events which occurred during Noah's first presentation to NEHW without their input.

121. Thirdly, the evidence disclosed that Ben and Steph's involvement in the sentinel event review was sub-optimal.[94] Their detailed concerns about the review process and draft panel findings did not appear to be acknowledged by NEHW in the final report let alone addressed.

122. This lack of acknowledgement of the family's concerns was a recurring theme during Noah's presentations prior to his death and it is unfortunate that even after his tragic death, Ben and Steph's reasonable concerns were not addressed. Indeed, many of the concerns raised by Ben and Steph regarding the RCA process were those matters identified as issues during the coronial investigation and subsequent inquest.

Paediatric Infant Perinatal Emergency Retrieval (PIPER)

123. The Paediatric Infant Perinatal Emergency Retrieval (**PIPER**) service provide emergency advice and interhospital transfers for sick infants, children and high-risk pregnant women in Victorian health services. For critically ill infants and children, a PIPER retrieval team is mobilised to provide emergency stabilisation and transfer to the Royal Children's Hospital, Monash Children's Hospital, Royal Women's Hospital, Mercy Hospital for Women, Joan Kirner (Sunshine) as well as selected non-tertiary centres as appropriate.

124. The court sought evidence from Associate Professor Michael Stewart, who is the director of PIPER, as to what, if anything, PIPER could do to better support regional and rural health services when caring for children such as Noah.

125. In addition to increased use of videoconferencing technology between PIPER clinicians and the relevant hospital, I accept the submission of Counsel Assisting that PIPER could enhance its support of regional health services in situations where PIPER is involved and a patient is to be transferred from one regional health service to another, by:

[94] T 205

a. considering and canvassing with the first regional health service, whether retrieval should be planned and put in action to occur at the second regional health service;

b. commencing and maintaining a dialogue with the second health service who is expecting the patient; and

c. where PIPER is attending to retrieve a patient, it should communicate in advance as to any equipment or medication it will need the regional health service to provide so that this can be prepared before PIPER's arrival.

Was Noah's death preventable?

126. During the inquest, I asked Dr McAdam whether she considered if Noah's death was preventable in the context of her evidence about the various prevention opportunities which may have altered the outcome for him.[95] However, I was reminded by counsel for NEHW that by this stage of the inquest it had become apparent that Noah's initial condition was much more serious than previously appreciated by the hospital, particularly against what was captured in the medical records.[96] Dr McAdam's opinion on Noah's prognosis and whether his death was preventable would have then been erroneously based on a much more clinically well child.

127. Instead, I asked about the general prognosis of children with bacterial meningitis having been appropriately treated with antibiotics.[97] Dr McAdam said that whilst survival could not be guaranteed, early administration of antibiotics and supportive treatment, will provide the best chance of survival.[98]

128. At the time, I accepted Dr McAdam's evidence that the first presentation to NEHW ED was the best opportunity to alter the outcome.[99] Counsel Assisting made similar submissions that the potential to change the outcome for Noah was at its highest during his first presentation to NEHW ED and was the opportunity to intervene. After the first

[95] T 264 (5)-(14)
[96] T 264 (15)-(30)
[97] T 265 (8)-(15)
[98] T 265 (22)-(24)
[99] T 265 (2)-(3)

presentation, the evidence supports a finding that interventions were unlikely to have changed the outcome.

129. Counsel Assisting submitted that the evidence does not rise to the level of establishing, on the balance of probabilities, that Noah's death was preventable at the time of his first presentation to NEHW ED.

130. NEHW also submitted that the evidence did not allow for a finding that Noah's death was preventable at the time of his first presentation to NEHW ED.

131. Ben and Steph submitted that Noah's death was preventable. They also submitted that *"the evidence rises only to the level that, by the time Noah presented to Benalla UCC, some time after the departure from NEHW, the opportunity to change the outcome may have passed"*. They also noted that this point was made by Prof Stewart and was not explored in oral evidence.

132. I made additional enquiries about the statistics and general prognosis of children with meningitis. According to UpToDate,[100] reported mortality rates among children with bacterial meningitis in resource abundant settings are approximately 4 to 5 percent. Case-fatality rates stratified by organism suggest that mortality from *Streptococcus pneumonia* meningitis is between 7 to 15 percent. In untreated bacterial meningitis, mortality approaches 100 percent.[101]

133. I note that Noah did not have any underlying conditions that would have influenced his prognosis. While Noah was severely unwell, he was not critically unwell at the first presentation to NEHW ED. I am satisfied that the expected outcome with treatment for a child with meningitis, like Noah, is survival.

134. On the balance of probabilities, I find that Noah's death was preventable.

[100] An online evidence-based guideline database containing common presentations and clinical issues. It is one of the online resources recommended for clinicians in the NEHW ED Orientation Booklet (see IB 449).
[101] https://www.uptodate.com/contents/bacterial-meningitis-in-children-older-than-one-month-treatment-and-prognosis last updated 29 August 2023 and last reviewed for currency June 2024.

COMMENTS

I make the following comments connected with the death under section 67(3) of the Act:

Prevention Opportunities

1. The statements produced by staff of the NEHW ED raise serious issues about staffing and resource constraints that prevailed at the time of Noah's presentation. Noah presented at a time of year when the NEHW ED faces an influx of patients from the increased holiday population and when regular staff take leave.

2. Additionally, December 2021 marked a difficult point in the COVID-19 pandemic. The materials produced by nurses and doctors involved in Noah's care suggest that these factors had an impact on the way in which care was provided, and likely on the standard to which care was provided.

3. Dr Bumford rightfully made concessions that there was an element of personal responsibility, however, his conceded errors must be understood in this broader context. I accept NEHW's submissions that Dr Bumford was at great disadvantage because of this and also that:

    a. this was his first patient on his first shift at NEHW ED;

    b. he had not been provided with any written induction;

    c. he had not been provided with adequate onsite induction of the ED;

    d. he had not been informed that NEHW ED uses the RCH guidelines;

    e. he had not been informed of the local practice of having a low threshold for referral to paediatrics and paediatric admission; and

    f. he had come into an ED where there was an expectation that he would see patients independently.

4. I am satisfied that many of these issues have subsequently been addressed by NEHW. However, as submitted by NEHW, the ED continues to face issues of short staffing, particularly over holiday and long weekend periods. If a senior role is to be filled by a doctor at a more junior level, I suggest that NEHW consider reclassifying that role to reflect

the actual experience of that doctor or review other contingencies to make it clearer to other ED staff, particularly the Senior In Charge Doctor, of the actual experience held by each new locum.

Sentinel Event Reviews

5. Safer Care Victoria have produced updated materials and guides which makes it clearer that affected patients or their families and treating staff should be involved at the information gathering stage.[102]

6. I note that Safer Care Victoria's role is not regulatory, rather, it is advisory, and the onus remains on the individual health service to adequately investigate or otherwise review Sentinel Events.

Listening to Parents

7. During the inquest, it was axiomatic that parents know their children best: they know their reactions, they know how they usually are, and what their baseline is. The rationale for the proposed creation of a state-wide PACE system by Safer Care for Kids is based on the same proposition.

8. NEHW advised through submissions that since the inquest, the ED Orientation Guide now includes the following passage:

   "Parental concern is well recognised as a valid marker for escalation as parents know their child best and this should always be escalated to the ED DIC or Paediatric Registrar On Call. Posters are widely available throughout the department explaining the procedure to parents, carers or next of kin."

9. Allowing parents and carers to independently raise and escalate their concerns is an important safeguard to prevent unrecognised deterioration in children by clinicians. However, as was also evident during the inquest, it is equally important for clinicians to actively enquire about these same concerns as many parents may remain hesitant to speak up despite the existence, or proposed existence, of these escalation pathways.

[102] AM 13

10. Both approaches are required to foster a safe environment for parents and carers to effectively raise their concerns about their children and for clinicians to effectively and meaningfully respond.

11. Both approaches are required to reduce the number of preventable paediatric sentinel events, especially paediatric deaths, in our hospitals.

12. I have made the recommendation below to place some of the onus to recognise parent and carer concerns back onto health care staff.

13. Otherwise, I am satisfied that the changes made since Noah's death, particularly by NEHW, have obviated the need to make further coronial recommendations.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

(i) That the Australian Commission on Safety and Quality in Health Care 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.

(ii) That Safer Care for Kids consider incorporating a question to be asked by clinicians about parental and carer concerns into the ViCTOR chart as a routine vital sign with associated free text spaces to document these concerns.

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

I wish to convey my sincere sympathies to Noah's parents, Ben and Steph, for their loss. Noah's death was a heartbreaking and life altering tragedy for them and their family and friends. I commend them both for courageously pursuing an inquest to ensure that Noah's death had an appropriate and necessary public inquiry about the failings in care to Noah. At every stage of the investigation, they have shown remarkable fortitude, patience and integrity, and remained faithful to Noah's memory.

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

Ben and Stephanie Souvatzis

Alpine Health

Northeast Health Wangaratta

Benalla Health

Ambulance Victoria

Royal Children's Hospital

Safer Care Victoria

Australian Commission of Safety and Quality in Health Care

Australian Health Practitioners Regulation Agency

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Commission for Children and Young People

Signature:

Coroner Katherine Lorenz

Date: 06 August 2024

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 inquest. 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.