



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Pippa Mae White
Hearing dates:	1 st -4 th July 2024 (tranche 1) and 26 th -28 th May 2025 (tranche 2)
Date of findings:	29 September 2026
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Judge Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, Paediatric Sepsis Pathway, delayed diagnosis, escalation of care
File number:	2022/00226435
Representation:	Counsel assisting, Jake Harris instructed by Leanne Kohler, NSW Crown Solicitor's Office Richard O'Keefe SC with Peerce McManus, instructed by Julie Mahoney for the family Ben Bradley instructed by Jacinta Smith and Jack Holohan for the Western New South Wales Local Health District and the Sydney Children's Hospital Network Matthew Hutchins instructed by Maddalena de Vecchio for Dr Adam Buckmaster Jackie Sandford instructed by Sarah Wallace for Dr Christopher Morris Kim Burke instructed by Judith Alderson for Dr Suhail Mir Richard Perla instructed by Breannon Bailey for Dr Elena Cavazzoni (tranche 1 only)

Representation (cont.)	Patrick Rooney instructed by Claudia Chaffey for Dr Madhav Pendyala (tranche 1 only) Paul Madden, NSW Nurses and Midwives Association for Nikota Potter-Bancroft and Roslyn Sadler (tranche 2 only)
Findings:	Pippa Mae White died on 13 June 2022 at Orange Health Service, Orange NSW 2800. Pippa died of sepsis, caused by an aggressive bacterial infection on a background of Group-A Streptococcus infection after several clinicians failed to recognise the seriousness of her condition. By the time it was recognised, Pippa was gravely unwell and she did not then receive the organised, timely and urgent care that she required.
Recommendations:	To the Chief Executive, Western New South Wales Local Health District: 1. Consider amending policy WN_PD2020_004 “vCare – Referral of Children and Adolescents for Specialist Care and/or Transfer” to require that: a. Prior to transport, a patient’s observations should be taken, and b. Any deterioration in the patient's condition should be brought to the attention of both the referring clinician and receiving clinician. 2. Consider whether alternative technologies, including mobile phones, could be used by a specialist to review a patient remotely by video, and, if considered appropriate, develop guidelines for their use. 3. Develop training for junior doctors working in emergency departments or paediatric wards, based on the facts of Pippa’s death, incorporating the videos of Pippa that were taken at Cowra and Orange Hospitals.

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Introduction

- 1 This inquest concerns the death of Pippa Mae White.
- 2 Pippa was born on 6 August 2019 and was aged 2 years and 10 months when she died on 13 June 2022 at Orange Health Service (**Orange Hospital**), in the state of New South Wales.
- 3 Pippa died from sepsis, caused by an aggressive bacterial infection, likely Group A Streptococcus.
- 4 Pippa's identity and the date and place of her death are not in dispute. This inquest has focused on the manner and cause of Pippa's death and the relevant contributing circumstances.
- 5 Pippa was the much-loved daughter of Annah and Brock White. She was the twin sister of Leo and the younger sister of Lucy, twins Sophie and Tamika and Bodhi. Her family refer to her as Pip or Pippa.
- 6 Pippa's family and friends have been constant advocates for her and have been unwavering in their determination to ascertain the reasons for her untimely death. Various family members and friends have participated and contributed during these proceedings, and I acknowledge the profound loss and anguish felt and experienced them. I would like to express my sincere condolences for their loss.
- 7 According to her mother, Pippa was:

"different to other little girls her age. She had this old-world charm about her. Her favourite colour was yellow. She had the most stunning curls that would bounce as she walked. She had beautiful big brown eyes, porcelain skin and the most angelic smile. Pip loved dressing up and would always have this royal lady aura around her. She had such a kind-hearted soul which she showed through her love of dolls. At any one time she could have 8 dolls lined up, taking care of them all so perfectly. Pippa was the mediator amongst the kids, she was always defusing issues and making sure everyone was okay. We were blessed to spend so many special memories with Pippa".
- 8 I hope that Pippa's memory has been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

The Coroner's role

- 9 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity, as well as when and how the person died. A coroner is also required to identify the manner and cause of a person's death. In addition, a coroner can make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.
- 10 Pippa's death was not initially reported to the Coroner as the hospital determined that her death was not a reportable death pursuant to the *Coroners Act 2009* (NSW). A reportable death in a NSW hospital requires a determination to be made by the hospital that the death of a patient was an unexpected outcome of a health-related procedure. A Medical Certificate of Cause of Death was prepared by Dr Ling Wei Hee at Orange Hospital on 13 June 2022.
- 11 Pippa's parents applied to the State Coroner to assume jurisdiction of Pippa's death and requested an inquest. On 2 August 2022, I assumed jurisdiction of Pippa's matter. As Pippa's death was not reported to the Coroner, no autopsy was performed and no conclusive cause of death could be determined by a Forensic Pathologist.
- 12 These proceedings were conducted in two tranches. A 7-volume brief of evidence containing statements, videos, photographs and other documentation, was tendered in Court and admitted into evidence. In addition, oral evidence was adduced from:
 - a. Dr Suhail Mir;
 - b. Dr Christopher Morris;
 - c. Associate Professor Adam Buckmaster;
 - d. Registered nurse Nikota Potter-Bancroft;
 - e. RN Roslyn Sadler;
 - f. Adrian Fahy (WNSWLHD);
 - g. Dr Kathryn Carmo (NETS); and
 - h. Experts in conclave:
 - Professor Warwick Butt, Paediatric Intensive Care Physician
 - A/Professor Adam Irwin, Paediatric Infectious Diseases Physician
 - Professor Simon Craig, Paediatric Emergency Physician
 - A/Professor Phillip Braslins, Infectious Diseases Physician
 - Dr David Morton, General Practitioner

- 13 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Mr Jake Harris, Mr Richard O’Keefe SC with Mr Peerce McManus on behalf of Pippa’s family, Mr Ben Bradley on behalf of the Western New South Wales Local Health District and the Sydney Children’s Hospital Network, Mr Matthew Hutchins on behalf of Dr Adam Buckmaster, Ms Jackie Sandford on behalf of Dr Christopher Morris, Ms Kim Burke on behalf of Dr Suhail Mir and Mr Paul Madden on behalf of registered nurses Nikota Potter-Bancroft and Roslyn Sadler.
- 14 I have also been greatly assisted by Mr Matthew Robinson of counsel who coordinated an expert conclave and prepared a joint expert report prior to the second tranche of the inquest.
- 15 I have drawn extensively from Counsel Assisting’s submissions in relation to noncontentious factual matters and issues. I am grateful for this assistance.

A brief overview of Pippa’s medical history

- 16 Pippa and her twin brother Leo were born on 6 August 2019 at Orange Hospital. At that time her parents, Annah and Brock, were living in Cowra, about 60 kilometres from Orange.
- 17 Pippa had four siblings, in addition to her twin brother.
- 18 Leo was born with a laryngeal cleft that required surgery, and there were concerns soon after her birth that Pippa may have had a heart murmur. Further investigations confirmed that this was not the case.
- 19 Pippa attended an Emergency Department on two occasions prior to her death. The first related to a suspected fractured arm, which was not confirmed. The second presentation on 3 February 2021, concerned Pippa developing a “respiratory wheeze”. Pippa was given Ventolin.
- 20 In January 2021, Pippa underwent planned surgery for a blocked tear duct.
- 21 Pippa was fully immunised, took no regular medications, and had no allergies.
- 22 Pippa’s medical records confirm that she attended her GP on various occasions with flu-like symptoms. Pippa was also tested on several occasions for COVID-19, returning negative test results.
- 23 In May 2022, Pippa’s whole family contracted COVID-19, although Pippa appeared to be asymptomatic.

- 24 In the days immediately prior to Pippa’s presentation to Cowra Hospital, the following information was discerned from various sources:
- a. On Thursday, 9 June 2022, Pippa attended her day care centre with two of her siblings. She was described as happy and well.
 - b. On Friday, 10 June 2022, Pippa woke up and appeared a little ‘grizzly’. She did not want to attend her regular dance class and stayed home with her brother. Later that day, she developed a temperature and her father gave her Panadol, Nurofen and Hydrolyte. She vomited during the afternoon, had a high temperature, lethargy, a runny nose and a moist cough, reduced oral intake and urine output and diarrhoea.
 - c. On Saturday, 11 June 2022, Pippa was again febrile, although her father thought she improved as the day progressed.
 - d. On the morning of Sunday, 12 June 2022, Pippa appeared to have improved. However, after returning to bed, she woke at around 12.40pm with a high temperature and diarrhoea. Her mother returned home from work and noticed that Pippa appeared “very lethargic, miserable, with high temperature and had a grey skin tone” and her breathing was not normal. Annah decided to take Pippa to Cowra Hospital at around 1.30pm.

Background

Cowra Hospital

- 25 Cowra Hospital is a 24-bed inpatient facility with a 24-hour Emergency Department (ED). It is administered by the Western New South Wales Local Health District (WNSWLHD). In June 2022, it was usually staffed by a GP or a GP Registrar who were often locums. Typically, a locum would be on call from 3.30pm Friday until 7.30am on Monday.
- 26 Sunday, 12 June 2022, fell within the Queen’s Birthday long weekend. NSW was also in the midst of the COVID-19 pandemic.
- 27 On 12 June 2022, Cowra Hospital ED was staffed with 2 nurses and a doctor. It was an “especially busy and eventful day” and an assistant in nursing (AIN) was allocated to the ED to assist.
- 28 Annah and Pippa arrived at Cowra Hospital at 1.30pm.
- 29 Most significantly, a 10-year-old child had suffered a cardiac arrest and was being transported to hospital under active CPR. NSW Ambulance contacted the hospital at 1.40pm to advise that they were *en route* and expected to arrive at 2.10pm.

- 30 That patient was later transferred to Westmead Children's Hospital at around 5.45pm. Dr Suhail Mir, the visiting medical officer (**VMO**) or general practitioner in the ED that day, was largely occupied with the treatment of this patient from just after 2pm until 5.45pm.
- 31 Annah recorded the first of several videos of Pippa at 1.46pm, shortly prior to Pippa being triaged in the ED. The video was nine seconds in duration and depicted Pippa sitting up in the waiting room, with audible breathing sounds.
- 32 At 1.53pm, Annah recalled being told that there was a long queue of patients already waiting in ED and that if their attendance was not urgent, they should go home and would be contacted by the hospital later.
- 33 At 1.57pm, Annah sent a message to Brock stating, "She is working hard to breathe."
- 34 At around 2pm, RN Potter-Bancroft took Pippa and Annah from the waiting to the triage room. She then commenced an assessment, taking a history from Annah. Pippa remained on Annah's lap, although she was able to stand to be weighed. RN Potter-Bancroft recorded her triage note at 2.06pm:

Triage Presenting Information : Fevers, cough, vomiting and lethargy

Additional Presenting Information : BIB mum with 4/7 day history of fevers, cough (moist), runny nose. Had covid 2/52 weeks ago. Mum has been controlling fevers with regular paracetamol and Ibuprofen - needs to take on time or spikes temp. Bub is miserable and lethargic. Has also had some vomiting - mum has been given PO Ondansetron with good effect. Oral intake is decrease. Reduced urination and having diarrhoea today. Mum said when she asked where its hurting she holds her head. Bub upset during triag. Nil signs of respiratory distress. Tachycardic. Afebrile. Mouth appears moist. Otherwise well. No regular medication. Vaccines UTD.

- 35 Pippa's observations were taken by AIN Williams. These were recorded in the notes at 2.06pm: heart rate 171 (red zone), oxygen saturation 95% in room air, respiratory rate 25, temperature 36.6.
- 36 Annah contended that the observations were taken at 2.21pm and noted the following:
- "Oxygen was at 90, tachycardic, high temperature, lethargic, skin tone off pale and increased work of breath (sounded like grunt/pant)."*
- 37 RN Potter-Bancroft allocated Pippa an Australian Triage Scale (**ATS**) 3, due to her presenting symptoms, including tachycardia. The ATS is a five-point scale designed to prioritise patients and allocate relevant time frames for medical assessment after triage. An ATS 3 score meant that Pippa should have been seen within 30 minutes. However, it was unlikely that Pippa would ever have been assessed within that time period as the ED doctor was busy with the incoming 10-year-old patient.

- 38 RN Potter-Bancroft was a relatively junior nurse, with about 2.5 years' experience. She had received training on triage, the 'Between the Flags' program and the Sepsis Pathway. She was aware the Paediatric Sepsis Pathway existed; however, she had never previously used it on a paediatric patient. She had used the adult Sepsis Pathway and had seen the Paediatric Sepsis Pathway in training (although not at Cowra Hospital). RN Potter-Bancroft gave oral evidence that she did not think Pippa met the criteria to be placed on the Paediatric Sepsis Pathway at that time.
- 39 RN Potter-Bancroft also spoke with Dr Mir to obtain an order for an anti-emetic (Ondansetron) due to Pippa being upset and nauseous. RN Potter-Bancroft says she provided a handover to Dr Mir. She did not recall the specific words she used, but said it would have included the triage information, including Pippa's heart rate.
- 40 Dr Mir commenced his assessment at about 5.30pm. He took a history from Annah and then examined Pippa. He reviewed the triage note and became aware of Pippa's early high heart rate. He asked that a second set of observations be taken.
- 41 At the time of the review, Pippa's observations included a heart rate of 89, oxygen saturation of 92% on room air (yellow zone), respiratory rate 22, mild respiratory distress, blood pressure 108/62. Dr Mir only recorded Pippa's heart rate and oxygen saturations in his own note, although other observations were recorded by the nurse.
- 42 Dr Mir recorded the following in relation to Pippa:

2.5 year old BIB mom
B/G - Nil medical issues.
No regular medications

HOPi:
patient has been unwell for the last 4 days, with URTI symptoms including cough, runny nose, fevers, feeling generally unwell, low on energy.
Parents needing to give regular paracetamol + ibuprofen to control temperature.
Has had decreased intake last 24-48 hrs.
While in ED9 Long wait) patient has persisted to unwell with looking miserable, clinging to mom, not feeding, barely passed urine, failed oral fluid intake encouragement.
No spikes in temperature though.

O/E:
Looking miserable, unsettled.
OBS - HR 170s initially- improved to 90 now.
Sats 92% on RA
Other obs OK.
No pallor, icterus, oedema, cyanosis.
Slight increased WOB.
ENT - Congested oropharynx and b/l ear drums.
Chest- diffuse b/l chest crepitations.
Reasonable air entry.
CVS, Abdo- NAO
Imp - Ac Viral illness
Physiologic compromise likely secondary to dehydration.
Treatment | Management

Plan.
Discussion with O/C Peads at OBH.
Advised encourage oral hydration.
Transfer to ED Orange for further assessment, monitoring and management by Peads team

- 43 Dr Mir called Dr Adam Buckmaster via the vCare service at about 6.10pm. By this stage, he had already decided that Pippa was not well enough to go home. As a paediatric patient, she could not be admitted at Cowra Hospital and needed to be transferred to Orange Hospital.
- 44 Dr Buckmaster was a general paediatrician with 27 years' experience. He commenced his first on-call shift as a locum paediatrician at Orange Hospital on 10 June 2022.
- 45 In addition to Dr Mir's note, which records aspects of this call, there was a brief note recorded by RN John Kiernan from vCare who facilitated the call between Dr Mir and Dr Buckmaster:

12/06/2022 18:10 Care handover using ISBAR
Since presentation child lethargic
Miserable looking
Airway congestion
Dry, has past urine
Plan:
- _ Transfer to Orange Base. MAT 3 hrs.
Clas B Ambulance

- 46 During the call, Dr Mir recalled that someone turned on the overbed camera at Cowra Hospital, which was equipped with a microphone.
- 47 At the time of the call, Dr Buckmaster was out for dinner. He was unable to gain access to the Critical Care Advisory Service, which would have allowed him to view patient notes and the Critical Care Overbed Network giving him access to patient cameras, from outside the hospital. He had lodged a request about this. In his oral evidence he indicated that did not have a laptop with him at dinner, and in his view a lack of access to the system did not impact Pippa's care at that time.
- 48 During the call, Dr Mir provided a handover. He said that he told Dr Buckmaster Pippa's history, presentation and observations, including her initial high heart rate and reduced oxygen saturation.
- 49 Dr Buckmaster recalled being told Pippa had been unwell for a few days, with fever, vomiting and more recently diarrhoea. There had been a gap in her observations due to another emergency at Cowra. He recalled being told she had "crackles" in both sides of her chest. He did not recall being told of Pippa's high heart rate, although, if he had been told, he said he would have been reassured that it had improved, and it

would have constituted part of the overall picture. Equally, he was not overly concerned about the yellow zone oxygen saturation in the context of a viral illness.

50 The two doctors agreed that their diagnostic impression pointed to a viral illness. Dr Buckmaster said that sepsis was “in the back of my mind” for all children who present unwell with a fever, but that he did not entertain that Pippa was septic at that point. He agreed Pippa should be transferred to Orange Hospital and recommended a medically agreed timeframe of 3 hours.

51 Following the call, Dr Mir asked nursing staff to book an ambulance. He said he also asked nurses to keep an eye on Pippa and to inform him if her observations deteriorated.

52 At about 7pm, Dr Buckmaster sent a message to Dr Christopher Morris, to notify him of Pippa’s pending arrival:

... There's a 2½ year old girl coming from Cowra with a presumed viral illness bilateral crackles miserable and a bit dry. She'd been there for hours because they were managing another patient that was an 8 year old that had had a presumed out of hospital cardiac arrest. Feel free to call me once you've seen her

Transfer to Orange Hospital

53 The ambulance arrived at Cowra Hospital at 7.18pm. Pippa’s observations were taken at 7.20pm and 7.55pm. Pippa had a temperature of 38, which was slightly elevated though still in the “white zone”, a heart rate of 169 (yellow zone) and oxygen saturations of 92% (yellow zone). Paramedics obtained Panadol for Pippa’s temperature, which was given at 7.35pm, before she was transported.

54 No further observations were taken by nursing staff, following those taken during Dr Mir’s review at 6.10pm. Dr Mir confirmed that had he been told Pippa had become tachycardic or had a temperature, he would have been clinically concerned. He said he would have taken bloods, started fluids and called Dr Buckmaster.

55 Dr Buckmaster was also not made aware of Pippa’s changed observations. He agreed that if the whole picture had changed then he would expect to be called back. However, he would not necessarily expect to be called if only one parameter had become slightly worse. He did not consider Pippa’s temperature of 38 to be a “spike” in temperature.

56 The ambulance left Cowra at about 7.55pm and arrived at Orange Hospital at 8.55pm. This occurred within 3 hours of the call to Dr Buckmaster and therefore within the medically agreed timeframe.

Orange Hospital

- 57 Pippa arrived at Orange Hospital, the largest hospital in the WNSWLHD, at 8.55pm and was triaged at 8.58pm by RN Mason Reyes. RN Reyes recorded a heart rate of 161 and oxygen saturations of 93%, both in the yellow zone. He allocated Pippa ATS 4, which required her to be seen within 60 minutes. He believes he would have discussed this with the nurse-in-charge. He also understood that Pippa had been given Ventolin, and was to be placed in a bed where she would be closely observed in the ED.
- 58 Dr Christopher Morris first reviewed Pippa soon after her arrival at Orange, at around 9.15pm. In June 2022, Dr Morris was a 3rd year doctor, employed as a Senior Resident Medical Officer in the paediatric ward at Orange Hospital. He had commenced at Orange as an intern in 2020. Although referred to as a “registrar”, he was not on the training program to become a paediatrician. His paediatric experience was a residency term of 10-11 weeks in paediatrics, and then 3 of the previous 4 months on the paediatric ward. He also had experience working in the Orange ED, where up to 25% of patients were paediatric.
- 59 In 2022, the paediatric ward at Orange Hospital had a roster system where 2 junior doctors would work from 8am to 2pm and then be on call. It was frequently the case that doctors would be required to stay beyond the rostered hours or be called back. Dr Morris ultimately worked from 8am on 12 June 2022 to about 10am on 13 June 2022 (25 hours). That shift was the first of three 24-hour shifts that winter.
- 60 While Dr Morris could not say whether he felt fatigued at the time, he accepted that the length of time he worked that day could have affected his professional judgment; and on his reflection, it must have. For this reason, he strongly supported changes to the roster system at Orange Hospital. The hospital did ultimately make changes to the rostering system so that currently the paediatric ward has two junior doctors each working a 12-hour shift, with no on-call shifts.
- 61 Dr Morris recalled reviewing Pippa’s notes from Cowra Hospital, including Dr Mir’s note, the pre-arrival note and the triage note. He was aware of Pippa’s history and observations, including her high heart rate on presentation to Cowra.
- 62 Dr Morris did not review the ambulance record, although it was printed at 9.02pm and is found in the Orange Hospital medical records. Dr Morris said he usually looked for this but did not see it on this occasion. Accordingly, he did not become aware of Pippa’s elevated heart rate and slightly raised temperature on leaving Cowra.
- 63 During his review, Dr Morris took a history from Annah and then examined Pippa. Pippa was miserable and upset. He denied she was “floppy”. She had two abnormal

observations recorded at the time of the review, being an elevated heart rate of 152 (yellow zone) and low oxygen saturations of 92% (yellow zone). She also had some work of breathing. He performed a capillary refill test, which was 3-3.5 seconds (normal). He formed the view that Pippa had mild-to-moderate dehydration. He listened to Pippa's chest and heard bilateral crackles. He rejected the proposition that he had simply relied on the notes from Cowra regarding this.

64 Dr Morris's impression was that Pippa had a viral illness. This was Dr Mir's impression and Dr Buckmaster's text referred to a "presumed viral illness". He noted that sepsis was always "front of mind" when treating a sick child. However, Pippa presented like many other sick children that winter. Her heart rate was elevated, but she was being monitored continuously, and he recalled her heart rate to be in the 140s at the time of the review. He formed the view it could be explained by her dehydration. The bilateral crackles were a reassuring sign, given an infection would result in more focal sounds.

65 At 9.34pm, Dr Morris recorded Pippa's history and examination as follows:

2yo F with fevers, vomiting, increased work of breathing and lethargy

HPI:

Unwell for 4 days

Fevers >38 daily, responsive to paracetamol

Associated rhinorrhea and dry cough

Vomiting predominantly for 3 days and then today has developed diarrhoea with 7 loose stools so far

Vomit of any attempted oral intake or analgesia

No bilious vomits, no haematemesis

Small volume, green, watery stools. No blood, no mucous

Significantly reduced oral intake of fluids for 4 days but much more reduced for last 24 hours

Normally toilet trained for urine but wearing nappies for last 24 hours. Only one or two small volume wet nappies

Now 1 day of increased work of breathing with abdominal breathing. Quite lethargic and disinterested in play for last 24 hours No abnormal movements or behaviours

No sick contacts in household

However attends daycare and has had notifications of flu and gastro outbreaks from centre

Whole family had covid 2 weeks ago, Pippa recovered in between

PMHx:

Born at term (37+6)

Twins, delivered vaginally

No resus, not admitted to SCN

No previous serious illnesses/hospitalisations

Meeting developmental milestones

IUTD

Brother has laryngeal cleft and has had multiple surgeries

No similar issues for Pippa

Medications:

Nil regular

Allergies:

Nil known

Social Hx:

Lives in Cowra with parents and twin sibling
Parents both work in mine (week on/week off) so one parent always home
Attends daycare

O/E:

Obs on arrival:
- T 36.7, HR 152, RR 43, BP 117/84 (MAP 95), Sats 92% on RA
Appears lethargic
Mild-mod work of breathing with abdominal breathing and some subcostal recessions
Bibasal scattered creps but no wheeze
HSDNM
Warm centrally and peripherally
CRT 3-3.5 seconds
No tears when crying
MM slightly dry
No strawberry tongue or cracked lips
Pharynx erythematous with Grade II-III tonsils, no exudate seen
Right TM pearly, left TM partially wax obstructed, looks mildly erythematous
Small left sided cervical lymphadenopathy
Abdomen soft, non-tender, not distended
No hepatomegaly
Normal bowel sounds
No rash on hands or feet

Faint fine blanching rash on abdomen

Investigations:

COVID/Flu/RSV- pending

Impression: Symptoms consistent with viral URTI initially and now perhaps pneumonitis

Initially vomiting and now onset of diarrhoea

With gastro and resp overlap ?Flu ?enterovirus ?adenovirus

Mild-mod dehydration

- 66 Dr Morris called Dr Buckmaster at 9.55pm. They had worked together briefly during ward rounds over the previous 2 days. Dr Buckmaster considered Dr Morris to be a “very empathetic, capable doctor” who had a good thought process and was able to present patients well in terms of coherence and the information being provided, and that he was thorough.
- 67 Dr Morris recalled a “two-way conversation”, where he provided the history and results of his examination and that he and Dr Buckmaster worked through a plan together. Their shared impression was that Pippa had a viral illness. They did not explicitly discuss differential diagnoses, although there was at least a general discussion of these. Dr Morris indicated that sepsis was always “front of mind”, though he considered it significant that the hospital had been seeing severe RSV presentations that winter. This appears to have contributed to his impression that Pippa had a viral illness.
- 68 Dr Buckmaster did not have a specific recollection of the details of this phone call in his oral evidence. He recalled Pippa’s history and observations being provided and that she had “coryzal” symptoms. He recalled being told she had bilateral crackles

in her chest, which was reassuring, as bacterial pneumonia would present with more focal sounds. When asked about the two yellow zone observations, Dr Buckmaster considered these were “not particularly abnormal” and “very much in keeping still with somebody who’s been unwell for three to four days, who’s had a reduced fluid intake and is likely to be a little bit dehydrated”. He noted dehydration increases the heart rate to that level.

69 A significant aspect of the discussion was about rehydration. This was central to the doctors’ shared impression that Pippa’s raised heart rate was due to her dehydration (a consequence of reduced intake and output, fever and diarrhoea). Dr Buckmaster recalled a “very detailed discussion” about the pros and cons of nasogastric tube (NGT) or intravenous (IV) rehydration. There were advantages to NGT rehydration (safety, opportunity to provide nutrition, or milk). The one disadvantage was that it did not provide an opportunity to take blood, whereas inserting an IV did. Dr Buckmaster indicated that had he considered bloods were indicated, he would have ordered them. He did not think they were. He also noted that some families have a strong preference, and if that were the case, he would concur with their views.

70 Retrospectively, Dr Buckmaster regretted the decision not to provide IV rehydration. Had that occurred, blood tests would have been ordered.

71 Dr Morris recalled that Dr Buckmaster did not have a strong preference either way, regarding rehydration. He did not recall the reference to the family’s views, although if a family did express a preference, he agreed that he would have concurred with them.

72 A plan was then discussed, and recorded by Dr Morris in his note as follows:

Plan:

Admit Paeds (Buckmaster)

Chase COVID/Flu/RSV swab

Add on resp viral panel if rapid swab negative

Aim sats >92% with FiO2 titrated for same

NGT to be inserted please

Rapid NG rehydration following RCH protocol

- 150ml/hr for first 4 hours then maintenance overnight (50ml/hr)

Simple analgesia (can go down NGT once inserted)

Urine for UA + MCS

Stool for MCS + pathogen PCR

If doesn’t pick up with rehydration or becomes more unwell then next step will be IVC + bloods and consideration of antibiotics

73 The plan was to commence rehydration, and if Pippa did not improve, then an IV line would be placed, blood taken and consideration given to antibiotics.

74 Following this discussion, Dr Buckmaster had no further contact from Dr Morris until 4.15am, about 6 hours later.

- 75 Pippa remained in the ED for about 1½ hours. Aspects of the plan were commenced in the ED. After Dr Morris had finished his review, RN Jessica Hill observed that Pippa's oxygen saturation levels had fallen to 91%. She consulted Dr Morris, who suggested sitting Pippa up to see if that had any effect. It did not, and so RN Hill asked if she should commence oxygen. Dr Morris agreed. Oxygen was commenced via nasal prongs at a rate of 0.5L/min at 9.55pm. Pippa's oxygen saturation improved to 95%.
- 76 Dr Morris asked RN Hill to insert an NGT. This was performed by RN Hill at 10,35pm. Pippa did not initially tolerate the NGT and brought up mucous and vomit. RN Hill again contacted Dr Morris, who charted an anti-emetic, Ondansetron.
- 77 At 10:42pm, Dr Morris altered the calling criteria, with the result that Pippa would be considered to have "normal" oxygen saturations above 92%, and yellow zone saturations above 88%. Observations were taken at 10.42pm, showing an elevated heart rate of 157 (yellow zone). Other observations were normal.
- 78 A bed became available for Pippa in the paediatric ward at around this time. Pippa's heart rate was still elevated. RN Hill again called Dr Morris, who explained that he thought Pippa needed rehydration on the ward. RN Hill then called RN Roslyn Sadler on the ward, who agreed to accept Pippa's transfer.
- 79 At around 11pm, RN Hill took Pippa to the paediatric ward in a wheelchair.
- 80 Once on the paediatric ward, Pippa came under the care of RN Sadler, a nurse of over 45 years' experience. She had worked in the paediatric ward since 2012. She was the nurse-in-charge for the shift.
- 81 RN Sadler understood that Pippa was a respiratory patient, was probably dehydrated, had a history of COVID-19 and had been transferred from Cowra that day. She had an NGT in situ but had not started rehydration. RN Sadler accepted care and noted Pippa appeared miserable. She was allocated to bed 15 and placed on a continuous monitor, which could be viewed from the nurses' station.
- 82 At 11.21pm, RN Sadler took Pippa's observations, which included an elevated heart rate of 157, oxygen saturation of 95% and mild work of breathing (**WOB**), with a note that recorded "use of accessory muscles". RN Sadler also increased Pippa's oxygen to 1.0L/min via nasal prongs.
- 83 Dr Morris came to review Pippa on the ward at about midnight. He had been dealing with other patients in the ED. He was not called to review Pippa and attended to see how she was progressing. RN Sadler does not recall being present for the whole of this review, but she recalled discussing Pippa's care with Dr Morris.
- 84 No observations were formally recorded during this review. Dr Morris recalls that Pippa's heart rate was in the "low 150s" when she was settled (yellow zone). Her

WOB was mild-to-moderate. Dr Morris recalled discussing Pippa's care with RN Sadler. He considered himself to be "very strongly guided" by RN Sadler's experience. RN Sadler noted Pippa had only just commenced rehydration and that she wanted to see how she went after rehydration. Dr Morris had discovered Pippa had attended Canowindra previously with a viral induced wheeze and believed it would be worth trying Ventolin if Pippa's mild-to-moderate WOB continued. He charted that medication at 11.30pm.

85 Dr Morris prepared his note for this review at 12.18am as follows:

Reviewed on the ward

Respiratory effort settling with quite mild WOB whilst asleep NGT in situ with hydralyte at 150ml/hr (as per rapid protocol). When settled HR low 150s

Discussed with RN Sadler on ward looking after Pippa with consensus for below plan:

- Rehydrate for a few hours
- If remains tachycardic, if work of breathing persists or if otherwise not improving with rehydration then will be for review to consider bloods
- If WOB mild-moderate and continues to have oxygen requirement then to consider burst of ventolin and see if improves
- RN Sadler wants to see how she goes with hydration first which I think is not unreasonable
- Not brought up by mum during history but in notes I do see that has had a presentation to Canowindra with VIW

I am happy to be called overnight for advice or review/investigations if needed (#7403)

86 The above represented a departure from the plan that had been agreed with Dr Buckmaster at 10pm. Pippa had not improved. She continued to have mild-to-moderate WOB and an elevated heart rate. On reflection, Dr Morris agreed that this was an opportunity to escalate Pippa's care back to Dr Buckmaster. However, he noted it was not a detailed review, that Pippa was asleep and that he did not want to wake her and that rehydration had only just commenced.

87 Dr Buckmaster had an expectation that if Pippa did not improve, Dr Morris would contact him as per their agreed plan. He did not have an expectation that the delay in commencing rehydration would be brought to his attention. He did not consider it unreasonable that Dr Morris decided to try Ventolin without reference to him, although it represented a change in the plan.

88 However, an increase in Pippa's oxygen requirement was something Dr Buckmaster considered should have been escalated back to him. In his view, it was a "clear sign that this was more than where we were at before".

89 At 1am on 13 June 2022, RN Sadler increased Pippa's oxygen to 1.5L/min. A note records "tracheal tug, use of accessory muscles" which was a change from the entry at 11.21pm. Pippa's oxygen saturation had fallen to 92%. RN Sadler's note records

that Pippa was “unsettled and [had] increased WOB” and that “O2 increased to 1.5L/min to maintain O2 sats within altered criteria”.

- 90 RN Sadler called Dr Morris and discussed Pippa’s condition. She did not specifically recall this discussion in evidence and neither did Dr Morris. Nonetheless, it was agreed RN Sadler would give Pippa “stacked” Ventolin, as had been discussed an hour earlier, which she did, at 1.15am and 1.35am.
- 91 Pippa’s condition had deteriorated since the last set of observations at 11.21pm. However, RN Sadler did not increase the frequency of observations (though Pippa was on continuous monitoring at the time). The next set of recorded observations were at 2.35am.
- 92 Dr Buckmaster was asked about what his decision would have been, in retrospect, if he had been contacted at this time. He said he would have taken blood and started antibiotics.
- 93 At about 2.10am, Pippa started “grunting” and had abdominal distension. RN Sadler called Dr Morris, who was attending patients in the ED and was unable to attend immediately. He agreed in evidence that the report of grunting was a significant and concerning sign and a change from the last review. RN Sadler did not specifically recall this call, either in her statement or in evidence, but accepted she made multiple calls to Dr Morris that evening. She called Dr Morris when she heard Pippa grunting and was concerned that she was in pain.
- 94 Annah recorded two videos of Pippa at 2.19am and 2.25am. These show Pippa in the hospital bed, with audible breathing sounds and some movement in the muscles in her neck.
- 95 At 2.35am, RN Sadler took Pippa’s observations. She now had a heart rate of 196 (red zone), a respiration rate of 34 and her oxygen saturations had fallen to 90% (yellow zone). RN Sadler increased Pippa’s oxygen to 2.0L/min. A note records “tracheal tug, use of accessory muscles”. RN Sadler also administered Ventolin.
- 96 RN Sadler made a further call to Dr Morris at this time, when he was on his way to the ward.
- 97 At 2.40am, Dr Morris arrived on the ward to review Pippa. On attending, he said Pippa’s presentation had clearly changed. She had a high heart rate and low oxygen saturations, which he said were between 86 and 90 at the time of his review. She was “grunting” and had abdominal breathing and intercostal recession. He listened to her chest and found her to have sharper breathing sounds on the right and duller on the left.

98 His retrospective note of that review is as follows:

2yo F with fevers, vomiting, increased work of breathing and diarrhoea

Impression from ED review was of likely viral illness with crossover of gastrointestinal and more recently respiratory symptoms. Based on history and exam, on-call Paediatrician agreed with impression. Decision was for NG rapid rehydration and to re-assess

On the ward commenced on NG rapid protocol at 150ml/hr for 4 hours. Seemingly settling slightly with first 2 hours My plan was if rehydration going well but remains tachypnoeic, has work of breathing or persistent O2 requirement then trial Hudson burst

Called by RN Sadler with thanks when seeing patients in ED. Advised that had mild-mod work of breathing and persistent O2 requirement – decision for burst Ventolin therapy and I would attend ward when able to assess

Then called approx. 0230 to advise that patient now grunting, has increased WOB, a distended abdomen and tachycardic ~200 Attended ward to review patient with above findings on examination

O/E (approx 0240):

Obs: T 37.4, HR 196, RR 34, Sats 90 % on 2L via NP

Alert, a bit subdued but reactive to examination

Grunting with abdominal breathing and some intercostal recession

Scattered bibasal creps, reasonable air entry to bases, no focal areas of coarse creps, breath sounds

sharper on right

HSD, no murmur appreciated

Warm and vasodilated

Confluent blanching erythematous rash across torso

Central CRT 2 seconds

Abdomen distended, tympanic to percussion, bowel sounds present

No focal peritonism or focal point of tenderness, no rebound tenderness, no percussion tenderness

Decision at that point that Pippa was becoming more unwell despite our treatment with NG rehydration and bronchodilators

For IVG + bloods and consideration of antibiotics

99 During the hearing, Dr Morris was played Annah's videos from 2.19am and 2.25am. He agreed that the manner of Pippa's breathing, as depicted in the videos, was the same at the time of his review.

100 Dr Morris did not call Dr Buckmaster at that point. He accepted that he ought to have done so. He said it was not a deliberate decision not to call Dr Buckmaster, but an oversight and an error of judgment. His explanation was that he was trying to be "diligent", namely, to obtain further information, including the results of blood tests,

prior to calling Dr Buckmaster. As a junior doctor, he had been coached or encouraged to be “diligent”. It was his belief that the senior doctor would ask for blood test results. Accordingly, he sought that information first.

- 101 Dr Buckmaster considered that the signs of Pippa “grunting” with a heart rate of 196 were very significant developments. His expectation would have been for Pippa’s care to be escalated back to him promptly. He agreed that the videos at 2.19am and 2.25am showed “grunting”, although he noted that where there was continuous WOB, it would be expected that Pippa’s respiration rate would be abnormal. He said that, if he had been called at 2.40am, he would have commenced antibiotics.
- 102 Dr Morris acknowledged that the red zone heart rate suggested Pippa was in septic shock. Although he did not document it, he said his diagnosis at that point was sepsis.
- 103 He further acknowledged that the red zone heart rate required a Rapid Response to be called, pursuant to the CERS policy. He did not believe RN Sadler had called him as a Rapid Response. In retrospect, he wished he had called a Rapid Response, as this would have resulted in the attendance of more senior clinicians.
- 104 At 2.54am, Dr Morris called the surgical registrar. This was because he had seen him while in the ED and wanted to check that he was still available in case Pippa had abdominal pathology. He told the surgical registrar he planned to arrange blood tests.
- 105 Blood was then taken from Pippa for testing. This procedure took longer than expected and was initially unsuccessful. First, Emla cream was applied to Pippa’s hand to prepare for the cannula. At 3.10am, Pippa was taken to the procedure room to have blood taken. That was about 6 hours after she had presented to Orange Hospital and over 13 hours after presenting to Cowra.
- 106 Dr Morris attempted to introduce a cannula but could not advance it into Pippa’s vein. A small amount of blood was obtained and sent for testing. This coagulated and was unsuitable. A further cannula was introduced and another sample was taken. Dr Morris took the blood to pathology himself. That was processed at 4:01am.
- 107 Dr Morris’s note of this is as follows:

Brought to procedure room for IVG approx 0310

- 22g IVG attempt dorsum of right hand, bloods collected but IVG unable to be advanced into vein or flushed in
- VBG, FBC, EUC, CRP, culture sent
- 22g IVG successfully inserted into right cubital fossa, secured and flushed
- Prior bloods checked and noted that VBG and FBC unable to be processed
- VBG and FBC re-collected from right CF IVG

- 108 At 3.59am, a further set of observations were taken by RN Sadler showing that Pippa's heart rate was still high (191, red zone), with an elevated respiration rate (50) and oxygen saturations of 90% (yellow zone).
- 109 Dr Morris became aware of Pippa's blood test results at around 4.15am. They showed a high lactate level of 4.4, which he said was "immediately concerning", being a marker of serious infection. The results also included a low white cell count of 2.8 and a raised C-reactive protein (**CRP**) of 258.
- 110 Dr Morris called Dr Buckmaster when he received the blood test results. He had last contacted Dr Buckmaster six hours prior. He said he was critically concerned about Pippa. He gave the lactate result and believed he referred to "sepsis" (possibly "septic shock"). Dr Buckmaster says he was also provided with Pippa's observations and CRP and that he also considered Pippa "may well have sepsis". There was then a discussion about the plan, which included providing empirical antibiotics (ceftriaxone and gentamycin), disconnecting the NGT, administering a fluid bolus, increasing to 14L/min oxygen, organizing a chest X-ray and repeating blood tests in one hour. Dr Buckmaster recalled asking Dr Morris if he would like him to come in. Dr Morris said he did not specifically ask Dr Buckmaster to come in, nor did he decline. Instead, Dr Morris acknowledged he had a "clear plan" of what to do.
- 111 On reflection, Dr Buckmaster agreed that he should have gone to the hospital, rather than asking Dr Morris if he wanted him to come in. He agreed that he did not have a clear understanding of Dr Morris's capabilities, or those of Orange Hospital. However, in his view, the management plan would have been the same.
- 112 Dr Morris's note is as follows:
- Bloods checked (0415)**
- significantly elevated lactate (4.4) on VBG
Call immediately to Dr Buckmaster as Pippa becoming clinically more unwell and now has concerning investigations
Whilst on phone further bloods returned with CRP of 262 one of the first results returned
Now considering Pippa as being unwell with sepsis
Decision with Dr Buckmaster to start empiric IV antibiotics
- 50mg/kg ceftriaxone and 5mg/kg gentamicin
- For 10ml/kg NIS bolus and re-assess
- Radiographer called in for eXR
- Pippa put on 14L via Hudson mask
- 113 Antibiotics were commenced at 4.42am and oxygen was increased to 14L/min at 4.55am. A further lactate test was obtained at 5.32am and was still elevated at 3.8.
- 114 The chest X-ray was taken at about 5am. While Dr Morris was present, he had previously been told not to rely on the small image on the radiographer's machine and instead to await the formal image. He did so and accessed the image at about 5.30am. It showed what was later formally reported as a "complete opacification

left hemithorax” with a “possible mass effect suspicious for a large left pleural effusion”.

- 115 On reviewing the chest-X-ray image, Dr Morris called Dr Buckmaster and told him that Pippa had showed no significant improvement and that the chest-X-ray showed pneumonia and a probable effusion. Dr Buckmaster told him to add a further antibiotic, Vancomycin, further fluids and commence oxygen via High Flow Nasal Prongs. He said he would attend the hospital and arrived at about 5.45am.
- 116 Dr Buckmaster reviewed Pippa and formed the view that she had bacterial pneumonia and septic shock. Her oxygen saturations were 85-88% at the time of his review. He ordered further blood tests and antibiotics. He also formed the view that Pippa would require transport to the Children’s Hospital at Westmead and intended to call the Newborn and Paediatric Emergency Transport Service (**NETS**). He discussed this with Annah.
- 117 Dr Bath, the ICU registrar, attended and asked if the anaesthetist had been contacted in case Pippa required intubation. She offered her assistance.
- 118 At 6.10am, Dr Buckmaster made the first of five calls to NETS. During this call, he spoke with Dr Raj Angiti (retrieval specialist) and Dr Elaine Zaidman (paediatric intensivist). It was planned for the oncoming NETS team, commencing at 7am, to travel to Orange. Dr Zaidman recommended fluid boluses and indicated that Pippa would likely require intubation and inotropic support. Dr Zaidman advised that Pippa’s pleural effusion would need to be drained, although the NETS team did not know if Orange had the capacity to do this. During the call, Dr Bath performed an ultrasound and Dr Buckmaster reported that a large pleural effusion had been confirmed. Dr Zaidman noted that “the work of breathing’s not going to resolve until that gets drained”.
- 119 Arrangements were then made for the attendance of the NETS team.
- 120 Dr Bath contacted the anaesthetist (Dr Hanna) and the intensivist (Dr Madhav Pendyala). High flow oxygen via nasal cannula was administered at 24L/min from 7am. At about 9am, Dr Buckmaster spoke with emergency physician, Dr Shamus Shepherd and intensivist, Dr Pendyala. They discussed interventions for Pippa, including the need to drain the pleural effusion, where to perform this safely and the staff required for her ongoing care. Consideration was given to transferring Pippa to an operating theatre, although it was in use. A decision was ultimately made to transfer Pippa to the adult ICU. Arrangements were then made for her transfer, including gathering staff and equipment. Transfer to the ICU was achieved at about 10am.

- 121 Once Pippa was in the ICU, she was intubated at about 10.30am. This coincided with the attendance of the NETS team. Interventions for Pippa continued in the ICU, including vascular access and administration of inotropes.
- 122 At 11.54am, Pippa suffered a cardiac arrest. There was a return of spontaneous circulation at 12.06pm. Further advice was sought from NETS at this point.
- 123 At 12.39pm, Pippa suffered a second cardiac arrest. Despite the efforts of staff, she could not be resuscitated. She was declared deceased at 1.11pm.

Issues considered during the inquest

- 124 The following list of issues was prepared before proceedings commenced and provided focus during the inquest hearing, namely:
- a. Was adequate and appropriate care provided to Pippa at Cowra Hospital?
 - i. Was Pippa appropriately triaged?
 - ii. Did Pippa have clinical signs and symptoms indicative of sepsis at the time of her admission to the emergency department at Cowra Hospital?
 - iii. Was the sepsis pathway followed? If not, should it have been, and how would this have affected the care provided to Pippa?
 - iv. Was Pippa reviewed in an appropriate timeframe? If not, what were the reasons for the delay?
 - v. Was Dr Mir's assessment adequate? Did he undertake appropriate investigations?
 - b. Regarding the transfer to Orange Hospital:
 - i. Was it reasonable in the circumstances to transfer Pippa to Orange Hospital? Would it have been appropriate and practicable to treat Pippa at Cowra Hospital instead? Did Cowra Hospital's emergency department have the resources and capacity to treat Pippa?
 - ii. Was Pippa transferred to Orange Hospital in a timely manner?
 - iii. Was adequate information conveyed between the two hospitals?
 - c. Was adequate and appropriate care provided to Pippa at Orange Hospital?
 - i. Was Pippa appropriately triaged?
 - ii. Was the sepsis pathway followed? If not, should it have been, and how would this have affected the care provided to Pippa?
 - iii. Was Dr Morris's assessment adequate?

- iv. Why was no blood test or X-ray undertaken initially? Should this have occurred?
 - v. Was the initial management plan appropriate, in light of information known at the time?
 - vi. Why was rehydration delayed?
 - vii. Should a clinical escalation have occurred (A) when Pippa began to show signs of respiratory distress (B) when a red zone heart rate was recorded; and/or (C) when blood test results were first returned?
 - viii. Was there an adequate, appropriate and timely escalation of care, after the working diagnosis of sepsis was made at about 4.15am on 13 June 2022?
- d. Was adequate and appropriate medical care provided to Pippa by the Neonatal and Paediatric Emergency Transport Service (NETS)?
- i. Was it appropriate to seek medical retrieval of Pippa in the circumstances?
 - ii. Was an appropriately skilled and qualified team assembled?
 - iii. Did the team attend Orange Hospital as soon as reasonably practicable?
 - iv. Was adequate care provided during efforts to resuscitate Pippa?
- e. Is it necessary or desirable to make any recommendations in relation to any matter connected with Pippa's death?

The evidence of Mrs Annah White

- 125 Annah provided a statement to police dated 14 September 2022. Annah was not called to give evidence in these proceedings, however, gave compelling family statements, together with her husband and other family members.
- 126 Annah also documented Pippa's care and treatment on 12 and 13 June 2022, with videos, photographs, text messages and phone calls. These documents have proved to be invaluable in determining many issues which have been raised for determination in these proceedings. Without that primary source material, it is highly likely that this inquest would have come to different conclusions.
- 127 Prior to attending Cowra Hospital with Pippa on 12 June 2022, Annah had accompanied Pippa's twin brother, Leo to Westmead Children's Hospital for significant medical interventions. Annah was reasonably familiar with hospital

triage and general medical treatment. In addition, her mother, Ms Marianne Stonestreet was a retired RN.

- 128 Annah recalled in her statement that when they presented at Cowra Hospital at 1.30pm on 12 June 2022, Pippa had “a high temperature, low oxygen, foot drop, inactive, fatigued.”
- 129 At 2.21pm, Annah recalled that Pippa’s observations included “Oxygen was at 90, tachycardic, high temperature, lethargic, skin tone off pale and increased work of breath (sounded like a grunt/pant).”
- 130 At 2.45pm, Annah indicated that she was told by the nurse that she should take Pippa home as there was a cardiac patient arriving soon and they would call her on her mobile phone when they could see Pippa. Annah recalled enquiring if she should take Pippa to another hospital and was told to go home and wait.
- 131 Annah returned to the hospital at 3.30pm due to her concern about Pippa’s appearance. Annah recalled being told by the nurse at the door to the ED that Pippa “wasn’t that bad” and to “go home.”
- 132 Annah also recalled that at about 4.30pm, she asked a nurse for the REACH contact number for their hospital as there was “nothing on the walls of the ED regarding the REACH service”. Annah stated that “REACH is a system that helps patients, carer/s and families to escalate their concerns with staff about worrying changes in a patient’s condition. It stands for Recognise, Engage, Act, Call, Help is on its way).” Annah was not provided with any details for REACH by the nurse and was told to go home.
- 133 Annah stated that at 4.40pm, a doctor and nurse came out to the waiting room and said, “Please go home if your medical needs can wait, it’s going to be a long wait”.
- 134 At 5.17pm, a similar call was made by the doctor and nurse to the patients waiting in the ED. The doctor said to Annah, “You have been here a long time I will try and see you sooner”.
- 135 At 6.20pm, Pippa saw a doctor. At that time, Annah recalled that Pippa had low oxygen, a high temperature, an elevated heart rate, dehydration, vomiting, tiredness and an off complexion. An ambulance was booked to transport Pippa to Orange Hospital as Cowra Hospital did not have the capacity to admit paediatric patients.
- 136 At 6.39pm, Annah stated that the doctor made a comment that if the ambulance was too much longer, he would commence doing some tests. He was also said to have told her that, “Orange will do blood work and x-rays when you get there”.
- 137 At 7.40pm, the ambulance officers arrived and Annah indicated that they were not happy with Pippa’s temperature and administered additional Panadol.

138 At 9.20pm, Pippa was seen by a doctor “straight away”. Annah described Pippa’s appearance at that time as “Low oxygen, tachycardic, high temp, lethargic, skin tone horrible, dehydrated, vomiting and super flat. My mother Marianne Stonestreet and grandmother of Pipp, attended Orange Hospital”.

139 Annah recalled that Dr Morris said Pippa looked very sick, but he believed that she had a viral infection and the first thing they needed to do was rehydrate her. Annah indicated that Dr Morris discussed the two rehydration methods being an NGT and a canula. Annah said she told him her preference was an IV so they could do tests and that he responded indicating that:

“an NG was a more natural way of hydrating the body and that he believ[ed] it was only a viral infection that blood works probably weren’t necessary. I asked him about four times to do blood test and go over the top with testing.” Dr Morris told her that he had been working for the last 24 hours and would “run it all past the head paediatrician on call”. Dr Morris returned a short time later and told Annah that, “his boss was in agreeance with him that it was just a viral infection and to rehydrate via the NG. The nurse had already put numbing patches on both Pippa’s arms and hand preparing for the canula. I asked again if we could do the canula to get blood work done, saying I would prefer to go over the top and check everything out rather than go with the NG”.

140 At 10.35pm, the NGT was put in by a nurse in ED who said it was the first time that she had placed a paediatric NGT. At this time, Ms Stonestreet was asked to leave as visiting hours had finished.

141 At 11.21pm and 1am on 13 June 2022, Annah noted that Pippa’s oxygen level had dropped despite receiving oxygen via nasal prongs. At 1am, Annah stated, “Pippa’s oxygen was still dropping, high heart rate, high temperature, miserable, grunting and breathing was shocking. They tried Ventolin with no improvement”.

142 Annah recalled at 2.17am:

“Pippa’s oxygen was still crashing, heart rate still high, temperature still high, no improvements at all. I made the comment her belly looks distended, and both the nurse and doctor agreed. He made a comment he will get another colleague that is a surgeon to come and check her out (he later told me that he had gone home). Pippa’s breathing sounded terrible, she was grunting and sounded shocking. Nurse Ros kept pointing to the ‘emergency’ button and saying to the doctor if he doesn’t do something more, she will press it”.

143 Annah continued to document the treatment Pippa received from 2.45am, including Dr Buckmaster’s arrival at the hospital at 6.10am.

- 144 Annah recalled arguments between ICU and surgical ward staff and that the environment was “frantic and chaotic”.

The evidence of Dr Suhail Mir

- 145 Dr Suhail Mir provided two statements in these proceedings dated 13 December 2022 and 18 March 2024. In addition, he gave oral evidence on 1 July 2024 and 4 July 2024.
- 146 Dr Mir confirmed that he had been working as a VMO at Cowra Hospital since 2020. He indicated that the ED at Cowra at that time was staffed by one doctor and that he would commence his locum shift in the afternoon on the Friday and continue to be responsible for the ED until Monday morning. He would be present in the hospital during the day and on-call throughout the night during that period.
- 147 Dr Mir recalled being advised by NSW Ambulance that a seriously ill paediatric patient was being transported to Cowra Hospital. On presentation to the ED there was “active CPR and resuscitation happening”. Dr Mir commented that this patient’s presentation was “as serious as it can get” and that he was unable to “move out of the bedside of that patient for those hours, being from just after 2pm until that patient became more stable sometime before being medically evacuated to Westmead Hospital at around 5.45pm”.
- 148 Dr Mir confirmed that during that period, he was able to view the ED waiting area via a CCTV camera. He saw Pippa and her mother and he became:
- “especially aware of Pippa being in her Mum’s lap. And that kind of left an impression with me that she wasn’t well because she was in her lap most of the time, or pretty much all the time.... Normally kids, when they come to the hospital, if they are unwell, they are usually clingy to their parents. And once you’ve given them some medication and a bit of a hydration, they just perk up and they just kind of start exploring the waiting area. And I was aware of the fact that she’s been there for a few hours and that hasn’t happened. So that just kind of left an impression in me that she wasn’t very well”.*
- 149 Dr Mir recalled being told by the triage nurse, RN Potter-Bancroft, that there was a 2–3-year-old in the waiting room that who presented with a history of vomiting and fever. He also recalled that nurse sought his permission to administer Ondansetron. Dr Mir enquired as to the child’s weight and prescribed 2mg of Ondansetron, as it is “generally a safe drug, especially in a kid. The only thing you kind of worry about is make sure you’ve got the right dose”. Dr Mir did not recall being told by RN Potter-Bancroft about Pippa’s heart rate or any other detail.

- 150 Dr Mir confirmed that he became aware at some point that Pippa had been allocated an ATS 3 score. He did not recall any other patient with a higher score, although he thought there may have been “a couple more 3s”.
- 151 Dr Mir recalled entering the ED waiting room at around 4pm and informing the waiting patients that, “It’s going to be a long wait”. He could not recall entering the waiting room on another occasion and repeating that message. He denied that he told the waiting patients, “Please go home if your medical needs can wait”.
- 152 Dr Mir confirmed that he began his assessment of Pippa at 5.30pm and that he completed his progress note approximately one hour later after he had discussed Pippa’s case with Dr Buckmaster.
- 153 Dr Mir stated that he reviewed the earlier triage notes prepared by RN Potter-Bancroft and took a history from Pippa’s mother. He confirmed that the triage notes recorded Pippa’s peripheral pulse rate at 171 bpm just after 2pm. He agreed that that reading reflected an abnormal heart rate.
- 154 Dr Mir confirmed that he was familiar with the Standard Paediatric Observation Chart (**SPOC**). He also confirmed that medical practitioners, including doctors and nurses, who observed a red zone reading, such as a heart rate of 171 bpm, were required to follow the Paediatric Sepsis Pathway on the assumption that the patient may have sepsis.
- 155 Dr Mir indicated that Pippa’s earlier pulse rate of 171 bpm concerned him and that he requested a second set of observations which were completed by nurse “April” in his presence. He noted that April had taken Pippa’s pulse both manually and with “the machine”.
- 156 He agreed that Pippa’s oxygen saturations were 92%, which he recognised as being “slightly lower than normal”. He confirmed that that reading was in the yellow zone on the SPOC. He said he performed a capillary refill test which he recalled was normal, although he had not recorded this test in his clinical notes. He also said that Pippa was not pale nor did she have mottled skin.
- 157 He agreed that a history of fever may be masked by the administration of Panadol or Ibuprofen by Pippa’s mother prior to presenting to hospital. He did not accept that he had been told by Pippa’s mother that she had administered Ibuprofen at about 4.30pm. Instead, he said he had been told that Pippa’s last dose of Panadol/Ibuprofen was that morning.
- 158 Dr Mir denied that he had noticed a rash on Pippa.
- 159 Dr Mir stated that he had noted that Pippa had a “slightly increased WOB” and that he then listened to Pippa’s heart with a stethoscope. He recorded in his notes that Pippa had bilateral chest crepitations and reasonable air entry. He denied that he

did not auscultate Pippa's chest and back with a stethoscope during his examination of her.

160 Dr Mir opined that:

“the most likely reason for her presentation is an acute viral illness. And because she had that tachycardia initially, which had settled, then I also thought that tachycardia could be a combination of the effects of the viral infection, including fever and dehydration, especially given the fact that her food intake had decreased over the past 24 hours, and she had had diarrhoeas (sic) that morning so she was losing fluid as well and not feeding. So I thought all that was contributing to the bit of a physiological compromise that she had earlier, although it wasn't there when I saw her, but referring to what happened earlier”.

161 Dr Mir explained that the change in Pippa's heart rate from 171 to 90 was consistent with his impression that she was dehydrated due to earlier vomiting and diarrhoea and that he understood that she had been given an ice block while in the waiting room.

162 Dr Mir stated that despite his impression that Pippa was suffering from a viral illness, he also considered a differential diagnosis, given that a “number of things that can present with those symptoms – things like pneumonia, sepsis, appendicitis, even urinary tract infections”.

163 Dr Mir commented that even though he said that he had considered sepsis as part of a differential diagnosis, he did not generally make a note of differential diagnoses:

164 Dr Mir accepted that if he thought a patient had sepsis, they should be administered antibiotics on a priority basis. That said, he did not believe that Pippa met the diagnosis of sepsis and decided to keep her under observation and seek a second opinion from Dr Buckmaster.

165 Dr Mir was asked about his use of the Paediatric Sepsis Pathway. He agreed that he was reasonably familiar with the pathway. He was asked:

Q. Do you actually refer to this document as part of your usual practice, or do you sort of have it in mind -

A. No.

Q. ..the advice that it gives?

A. No we – we do. Normally, when the nurses have identified somebody who fits in the criteria, they would fill this form (as said) and attach it to the documentation for that patient. So it usually comes kind of - this thing is already started by the time I've seen the patient. It usually gets red flagged to me, Oh, we've got sepsis happening.” Many times it so happens that I could

see a patient and then realised that we need to follow the sepsis pathway here. This could be sepsis. So yeah, it can happen either way, but it's generally initiated by the nurses.

Q. Do you, if the nurse hasn't already initiated the pathway, in an appropriate case, will you initiate it?

A. Yeah.

- 166 Dr Mir agreed that he was aware of the high level of parental concern being expressed by Pippa's mother and its relevance as a risk factor. He denied that Pippa exhibited decreased alertness, stating that she appeared to be "low on energy, but when I was examining her, she followed my instructions". He also said that he had checked her for a rash, and there was none.
- 167 Dr Mir accepted that at the time he assessed Pippa, her low oxygen saturation fell within the yellow zone, and she potentially had an additional yellow zone criteria being her reduced urine output, although he had not been able to quantify the amount she had passed during the afternoon.
- 168 Dr Mir accepted that a patient with possible sepsis should have repeat observations to ascertain if any pattern was present. He agreed that it was not satisfactory that a patient in that situation should only have observations hours apart.
- 169 Dr Mir stated that before he contacted Dr Buckmaster, he had decided that Pippa needed to be admitted for further assessment at Orange Hospital.
- 170 Dr Mir contacted the Virtual Care (**vCare**) service and utilised the handover protocol known as Identification, Situation, Observation, Background, Assessment and Recommendation (**iSoBAR**) which provided a structured framework to present information about a patient. He said that he provided information about Pippa's previous high heart rate along with other information.
- 171 Dr Mir was ultimately put in touch with Dr Buckmaster whom he asked if blood should be taken for testing. He recalled being told by Dr Buckmaster that he should "encourage oral hydration at the moment. If there's another spike in temperature, then we put a cannula and get some bloods". He also recalled that they discussed that a 3-hour timeframe for Pippa's transportation by ambulance was appropriate.
- 172 Dr Mir also confirmed that Dr Buckmaster had told him that a cannula should be inserted if there was a spike in Pippa's temperature so that intravenous hydration and blood testing could be performed and antibiotics administered. He accepted that he had not recorded this detail in his progress notes, however, he maintained that he had a clear recollection of the conversation some 6 months later when he prepared his first statement.

- 173 Dr Mir denied Annah's recollection that she was told by him, "if the ambulance was going to be too much longer [I] will start some tests and put her on oxygen and administer an IV for fluids...Orange will do blood work and x-rays when you get there". Dr Mir said that that was not the plan that he had discussed with Dr Buckmaster and that delayed transport would not alter the plan.
- 174 Dr Mir stated that he did not see Pippa again after his consultation with her as he was attending to another patient. He was therefore unaware that Pippa's temperature had risen to 38 degrees after the arrival of the paramedics. He was also unaware that at 7.20pm paramedics measured Pippa's heart rate to be 169 bpm.
- 175 He confirmed that he had an expectation that the nursing staff would inform him that Pippa's heart rate and temperature had risen when she was being assessed by paramedics for transportation to Orange Hospital. He said that observations taken by paramedics are used to assess whether a patient is suitable for transportation.
- 176 At 6.40pm, Annah sent a text message to Brock relaying that Pippa was vomiting and her skin was blue. Dr Mir indicated that he would have expected to have been notified by nursing staff if Pippa was observed to be blue and that this would have prompted a further assessment by him of Pippa.
- 177 Dr Mir indicated that had been made aware of Pippa's increased temperature and heart rate prior to her transfer, he would have taken bloods and started fluids.
- 178 Dr Mir confirmed that Cowra Hospital had the capacity at the time to perform blood tests on site, including lactate and CRP tests. He stated that the test results would usually be available within 1.5 to 2 hours. He further confirmed that there was a mobile x-ray machine at Cowra in 2022 which could produce a result in less than one hour.
- 179 Dr Mir was shown a video which had been filmed by Annah at 1.46pm on 12 June 2022. He agreed that he could hear Pippa making a grunting sound, which would have concerned him if he had heard it.
- 180 He denied that he heard Pippa making a similar grunting sound when he assessed her at around 6pm. He stated that, "If she was like that, she would have tachycardia and she would have had tachypnoea, which was not there. So, as soon as you've got respiratory distress, your body compensates by increasing your respiration and increasing your heart rate, which wasn't there when I saw her".
- 181 Dr Mir did not agree that the heart rate recorded at the time of his assessment, being 90 bpm, was inaccurate, stating, "The nurse checked it in my presence. Two ways of checking it. The probe and the pulse. Why are we suggesting that it was erroneous?"

- 182 Although the visiting paramedics recorded Pippa's heart rate as 169 bpm at 7.20pm, Dr Mir opined, "I would suggest heart rate is a very dynamic thing. It changes, especially in kids. It changes big way".
- 183 Dr Mir was then shown a video recording made by Pippa's mother at 5.14pm. He agreed that he could hear Pippa making grunting sounds, however, he did not agree that she was making similar sounds when he conducted his assessment. He stated:
- "I have seen her in detail. In fact, I have picked up signs of her being unwell in spite of her having a normal set of observations, exact a slightly decreased heart rate, and her examining normally. I've still been able to discern the fact that she is not as well as she looks as per the numbers".*
- 184 Dr Mir was shown a photograph taken by Pippa's mother at 6.27pm. He agreed that Pippa appeared to have flushed cheeks but did not concede that Pippa appeared to be pale on the "other parts of her face". Dr Mir did not recall Pippa's mother speaking to him about her concerns regarding Pippa's colour but recalled that he did assess her colour and that there was "no mottling, there is no shutdown in causing pallor and there's no rash. That's the kind of the things that I'm looking for as signs of concern in a patient with fever".
- 185 Dr Mir denied that for much of his assessment of Pippa, he was at his desk rather than being bedside. He stated, "I assessed Pippa, went back to my monitor where that's where my phone is which connects to the vCare and during that time I was on the call to the vCare team."

The evidence of RN Nikota Potter-Bancroft

- 186 RN Potter-Bancroft prepared a statement dated 10 May 2023 and gave oral evidence during the inquest on 26 May 2025.
- 187 RN Potter-Bancroft had been a qualified registered nurse for a period of about 2.5 years as at June 2022.
- 188 On 12 June 2022, RN Potter-Bancroft was rostered to work the shift from 0700 hours until 1530 hours in Cowra Hospital ED. She recalled that the shift was particularly busy and it was a "hectic day" where she performed her duties without a break.
- 189 At approximately 1.50pm, the two RNs rostered on for the afternoon shift arrived, together with AIN Scout Williams. The two RNS, RN Amelia Vicary and RN April Cary began preparing to receive the ten-year-old child that was being brought in by ambulance. AIN Williams and RN Potter-Bancroft then went to the waiting room and commenced triaging the waiting patients.
- 190 RN Potter-Bancroft confirmed that she had completed the NSW Health triage package and some additional training. She had been trained on the different ATS

categories and the “Between the Flags” program. She said that she was aware of the SPOC and had been trained in relation to the sepsis pathway.

191 RN Potter-Bancroft confirmed that she became aware of the Paediatric Sepsis Pathway as part of her training with the DETECT junior training program. She had never seen a copy of the Paediatric Sepsis Pathway form in the ED at Cowra Hospital, although she had used the pathway form for adults. In her evidence, RN Potter-Bancroft agreed that she could have accessed the Paediatric Sepsis Pathway form on the intranet.

192 RN Potter-Bancroft stated that due to her training she was aware that she was supposed to use the Paediatric Sepsis Pathway form, but only “if I thought the pathway was appropriate, yes, then I would be using it.”

193 At 2.06pm, RN Potter-Bancroft brought Pippa and her mother into the triage room, where she was provided with a history of a recent COVID-19 infection and a four-day history of fever, cough, runny nose and some vomiting. She had been told that Pippa had been given regular Panadol and Nurofen and that she was now “was worse, with an onset of vomiting, diarrhoea, reduced intake and output”. RN Potter-Bancroft recalled that Pippa did not appear to have a fever and had a moist mouth:

“[She] looked unwell, she looked like tired, and she was upset. She was clinging on to Mum, she didn’t want us to touch her”.

194 RN Potter-Bancroft said that AIN Williams took Pippa’s observations in her presence, and the readings included heart rate of 171 bpm, a temperature at 36.6 degrees and oxygen saturation of 95%. RN Potter-Bancroft did not recall Pippa’s oxygen saturation to change from 95% to 90% during the triage process.

195 RN Potter-Bancroft noted in her triage notes, “Nil signs of respiratory distress”. During her evidence, she was played the video of Pippa taken by her mother at 1.48pm on 12 June 2022. She said that the sound Pippa was making in the video may have been grunting but was probably, “like rapid breathing almost. I don’t know if that would be called a grunt...It sounded fast”.

196 Later in her oral evidence, RN Potter-Bancroft agreed that the noise Pippa was making could be described as “panting”, however she stated that, “I didn’t see that breathing, no”.

197 RN Potter-Bancroft indicated that she triaged Pippa as ATS 3, “Because she had the decreased oral input, diarrhoea, vomiting, a history of fevers, moderate risk of dehydration because she had the vomiting, diarrhoea, and she was tachycardic”. Notwithstanding, RN Potter-Bancroft did not expect Pippa to be seen by a medical officer within 30 minutes, because “we were so busy with the oncoming, well, the

other patients that we already had, plus the category 1 that we were about to receive”.

198 RN Potter-Bancroft stated that she then went to speak with Dr Mir just after 2pm and provided him with an ISBAR handover and requested that he consider prescribing Ondansetron. RN Potter-Bancroft also said that she told Dr Mir at that time that Pippa had a heart rate of 171 bpm but did not mention that Pippa’s breathing was affected, as she had not witnessed grunting sounds nor any unusual breathing patterns. RN Potter-Bancroft conceded that it would have been a significant oversight on her part to have failed to inform Dr Mir about such a respiratory development.

199 RN Potter-Bancroft could not recall if she had told Dr Mir that she had allocated a ATS 3 to Pippa’s triage. She agreed that a heart rate of 171 would place the reading within the red zone of the SPOC which should then have led to a rapid response being called. She explained that she did not call a rapid response at that time, because:

“Cowra ED, we don’t have a separate rapid response team. We don’t have an alternative team that we can call on. Our rapid response team is the team that is already triaging, treating, you know, caring for all the other patients. So the reason the I didn’t call a rapid response during triage is I’m just I’m not sure how relevant that particular situation is to triage because my role there is to allocate a category based on clinical urgency and that almost, like, comes separately to that escalation response”.

200 RN Potter-Bancroft also noted that had she called a rapid response, the ATS 1 patient would have had priority.

201 RN Potter-Bancroft confirmed that she did not form the view that Pippa’s matter required a rapid response as there was a singular high heart rate reading, despite the LHD policy requiring one. She said that Pippa “didn’t look like a toxic child to me”, although she accepted that if Pippa had been making grunting noises that would have been a sign of toxicity.

202 RN Potter-Bancroft agreed that tachycardia, lethargy and a high level of parental concern were all matters of significance in deciding if a patient may be septic. She also agreed that a repeat set of observations should have been undertaken within 15 minutes of the first set of observations, however, this did not occur as “I was extremely busy.” RN Potter-Bancroft indicated that the first set of observations took approximately seven minutes.

203 RN Potter-Bancroft agreed that a blood test could have been performed at Cowra Hospital at this time and would have produced results within 1-2 hours. She also

confirmed that chest x-rays could have been performed at that time and on a weekend “if the radiologist is called in”.

Local Operating Protocol at Orange Health Service – June 2022

- 204 The “Clinical Escalation Response System (**CERS**) for the patient who is clinically deteriorating” was a policy operational at Orange Hospital in June 2022. The policy was devised for the recognition and management of patients who a clinically deteriorating and applied to all medical, nursing and allied health staff employed by Orange Health Service”. The policy defines a CERS as a “predefined communication process to summon a team of expert clinicians to attend the patient”.
- 205 A CERS is mandated when one or more patient vital observation fall into the red zone on the SPOC or staff, the patient and/or family have serious concern.

The evidence of Dr Christopher John Morris

- 206 Dr Morris provided a statement dated 14 March 2023. He gave oral evidence on 2 and 3 July 2024.
- 207 Dr Morris was employed as a senior resident medical officer (**SRMO**) in the Paediatric Department at Orange Hospital at the time of Pippa’s admission on 12 June 2022. On that day, he worked the 8am to 2pm shift and was then “on call”. During his on-call component, Dr Morris was required to remain at the hospital. Dr Morris commenced his shift at 8am on 12 June 2022 and finished his shift at 10am on 13 June 2022, some 26 hours later.
- 208 Dr Morris confirmed that he had completed his residency in paediatrics, which was approximately 10 or 11 weeks in duration, and that role was focused on the care of babies. He said that 2024 had been a particularly prominent year for RSV infections, as well as COVID-19 and influenza.
- 209 Dr Morris confirmed that he was aware that sepsis can be a life-threatening condition and a time-critical medical emergency. He was also aware that sepsis can present in various types of infections.
- 210 Dr Morris said that he first became aware of Pippa’s case when he received a text message from Dr Buckmaster at around 7pm. This was five hours after his shift had finished and he was still at the hospital. He noted that the reason for her presentation was presumed to be due to a viral illness.
- 211 Dr Morris continued to see other patients and indicated that he had perused Pippa’s notes from Cowra Hospital prior to her arrival. He was aware that Pippa had had a reported high heart rate of 171 bpm. In addition, he was aware that she had an oxygen reading of 92%, which he accepted would have placed her within the yellow zone on the SPOC.

- 212 Dr Morris confirmed that he had commenced his review of Pippa at around 9.15pm and that it would have taken about 20 minutes. He noted that Pippa was upset and looking to her mother for comfort. He also noted her history, which included references to her being quite lethargic, having a cough, vomiting for three days, having developed diarrhoea, and having a significantly reduced oral intake of fluids for four days. He was aware that Pippa's mother had administered Panadol and Nurofen. He also noted that Pippa had been described as having increased WOB for the last 24 hours.
- 213 On examination, Pippa's heart rate was 152 bpm, placing her in a yellow zone, and her oxygen saturation on room air was 92%, attracting a second yellow zone reading. Her respiratory rate was 43 placing her within the normal range and her blood pressure was 117/84, which was normal for her age. He performed a capillary refill test which, at 3-3.5 seconds, was "slightly prolonged, but not significantly prolonged". Dr Morris indicated that a capillary refill of three seconds or less was a normal measurement. He also noted that Pippa had bilateral chest crepitations which he concluded did not warrant a chest x-ray.
- 214 Dr Morris confirmed that his "working diagnosis...provisional presumption or provisional diagnosis" or "impression" was that Pippa was suffering from an acute viral illness, consistent with a viral upper respiratory tract infection or perhaps pneumonitis. He also confirmed that he wrote out his progress notes prior to calling Dr Buckmaster.
- 215 Dr Morris recalled first speaking with Dr Buckmaster for about 15-20 minutes. He was asked to reflect on whether they had discussed a potential differential diagnosis, and he indicated:
- "I think we talked about several causes of fevers particularly, you know, within my history and exam there's things I point to....at least a general discussion about differentials and importantly from my perspective, about what investigations would or would not be appropriate based on those differentials. I just can't recall the explicit specifics".*
- 216 Dr Morris recalled that they discussed whether blood tests were required. Instead, he noted that the discussed treatment plan focused on Pippa's rehydration using a NGT, with simple analgesia and that if Pippa did not "pick up with rehydration or becomes more unwell then next step will be IVC+ bloods and consideration of antibiotics".
- 217 In relation to the NGT, Dr Morris said that "if a child is mildly to moderately dehydrated then a nasogastric tube is the safest way to rehydrate the child, if it can be tolerated". He agreed that the other method commonly used for rehydration is

intravenous rehydration, which has the advantage of also permitting the taking of a blood sample for testing.

218 Dr Morris did not recall accessing or reading the NSW Ambulance notes relating to Pippa's transfer from Cowra Hospital. He was shown a copy of the ambulance notes which bore a printing time stamp of 9.02pm. He opined that the notes may have been added to the "little basket on the end of each emergency bed" and agreed that he had subsequently read them in the coronial brief.

219 He agreed that the ambulance notes recorded Pippa's heart rate at both 169 and 161 bpm, with reduced oxygenation at 92% and 93% respectively. He also agreed that those observations were abnormal and that if he had been aware of those readings at the time of Pippa's presentation it "perhaps" would have affected his impression of her.

220 In relation to sepsis, Dr Morris indicated in his statement that:

"Sepsis is always front of mind when treating a sick child. However, Pippa presented like many of the other children I had seen across this role with common winter day-care viral infections...I have been taught that sepsis should be strongly considered when a child has an altered level of consciousness, which Pippa did not have. Pippa was a bit miserable, but she was quite alert".

221 During his evidence, Dr Morris was shown a copy of the Paediatric Sepsis Pathway form which was in use in EDs during June 2022. He said that he knew the form existed but could not, "say that I was ever specifically drawn to this exact document". He further indicated that, "the paper pathway forms probably to this day are often stored at the triage area, the nurses' stations and hidden away amongst files and files of various paper forms."

222 In relation to his orientation to Orange Hospital, Dr Morris commented that

"I received a general hospital orientation at the start of internship...I cannot tell you from my memory one way or the other whether that pathway document was provided to us...I do not believe that any supervisor, senior administrator ever provided a copy of that document to me as a junior doctor having worked in any of the spheres that I'd worked...from an intern a resident or in that SRMO orientation."

223 He further agreed that the Paediatric Sepsis Pathway document was not contained within Pippa's medical notes. He said that nursing staff would often complete the paperwork. Dr Morris indicated that he has used the pathway since Pippa's death.

9.15pm assessment

224 Dr Morris accepted that several Pippa's observations at 9pm were in the yellow zone, including a raised heartrate of 152 bpm, an oxygen saturation of 92% and a significant level of parental concern. He agreed that given the these, the Paediatric Sepsis Pathway form required him to obtain a senior clinician review within 30 minutes and to obtain blood.

225 Dr Morris accepted in his oral evidence that the appropriate action under the pathway would have been to take bloods and have them tested:

"I agree looking at this now that yeah, that's – that's the way to interpret...that's what the pathway says. Yep."

226 Dr Morris could not recall Pippa's mother telling him during the assessment that Pippa had a fever at Cowra Hospital which had been detected by the paramedics and that they would not transport Pippa until she had been provided with Panadol and her fever had improved. Dr Morris said that he had been taught that "Panadol or Nurofen won't mask a serious illness, won't mask a serious fever". Later he said:

"the response of a fever or a temperature response to Paracetamol or Ibuprofen is just another piece of information and it's not one that – what I'm trying to say is, if there's a fever and it goes away with paracetamol, that to me does not carry weight around the severity of whatever is causing the fever. That is just a factor. Sometimes a fever will respond to paracetamol and sometimes it will not".

227 In relation to Pippa's rehydration, Dr Morris could not recall discussing the two available options with Annah. He also could not recall that RN Hill had placed Emla numbing patches on Pippa's hand in preparation for a canular and was unable to comment whether the patches were removed after he returned from speaking to Dr Buckmaster. Dr Morris noted that "it was a common practice that [Emla] was applied often, very early in the presentations, as a just in case, if you will".

228 Dr Morris agreed that in June 2022 he could order blood tests, including lactate, blood gas and CRP tests. He said that depending on the type of test ordered, a result would usually be available in 1-2 hours and that this included full blood counts and CRPs.

229 Dr Morris did not recall Annah asking him on four separate occasions to give Pippa intravenous fluids and to take blood for testing. He also could not recall Annah saying that she "would prefer to go over the top and check everything out, rather than go with the NGT". Dr Morris agreed that if a family expressed a strong preference for a procedure, that that should be respected, if appropriate. He said

that, “if I felt like Mrs White had a strong preference, then I would’ve put that in my discussion with Dr Buckmaster”.

- 230 Dr Morris could not recall being told by Annah that she was very concerned about the colour of Pippa’s skin. He also could not recall Annah raising her concerns that Pippa had a stiff abdomen or her requesting that he arrange for an abdominal x-ray or an ultrasound.
- 231 He did recall that Annah raised concerns that Pippa had a fine rash on her abdomen. He also recalled that Annah raised her significant concerns around Pippa’s WOB.
- 232 Dr Morris did not recall Annah telling him that she thought that Pippa was flat and miserable but accepted that he may have been told that. He also did not recall Pippa’s grandmother, Marianne being present during the assessment.

Later presentations on 12-13 June 2022

- 233 After Dr Morris’ assessment at around 9pm, vital sign observations were recorded in Pippa’s medical notes at 21.55 hours, 22.42 hours, 23.21 hours, 01.00 hours and at 02.35 hours.
- 234 Dr Morris confirmed that the NGT was placed at around 11.30pm. He said that there had been some discussion with the nursing staff as to whether the hydration should be started once Pippa had been moved to the paediatric ward. He agreed that at that time, Pippa’s heart rate was still in the yellow zone. He said he was:

“heavily, heavily influence by the nurses being in agreement about moving the patient.....My memory of the phone call to me was – was something to the effect of a mention that the heart rate was still elevated, the nasogastric was in, and I think at that time had been in for a while, but rehydration had not started....the impression that I had and I felt I shared with Dr Buckmaster....was that dehydration was a primary issue, and that the rehydration may help modify the abnormal observations, being the tachycardia, being the capillary refill, being the - the lethargy, and you know, lots of the pertinent signs and symptoms, I felt we shared an opinion would be, or at least potentially could be modified by the rehydration, and that conversation about moving the patient in my mind relied on, or was heavily influenced by the fact that the rehydration had not commenced”.

- 235 Dr Morris reviewed Pippa on the paediatric ward at 12.18am on 13 June 2022. He recalled that she was asleep, was being continuously monitored electronically and was being rehydrated. He also recalled that her heart rate was still in the low 150s, which was a yellow zone observation, and that she was being cared for by RN Sadler, the in-charge paediatric nurse, whom he described as “incredibly experienced.”
- 236 Dr Morris confirmed that the plan at that time was to continue the rehydration for:

“a few hours” to see if the tachycardia and the work of breathing settled. If there was no improvement, then Pippa would need blood tests. Dr Morris said that this was specifically with sepsis in mind, stating “I regret not writing it down so explicitly, but absolutely, that’s what that means to me...is that it was with sepsis in mind, yeah”.

237 He further indicated that if, “WOB mild to moderate and continues to have oxygen required, then to consider a burst of Ventolin and see if improve.”

238 Dr Morris relayed that his conversation with RN Sadler was:

“a kind of shared opinion, I suppose, on giving the rehydration time to see if it would modify the heart rate because I, I guess implicit is that we both viewed that as a key issue. Of course, on reflection of the case, you know, it’s easy to see that as misguided but it was genuinely what we, we seemed to share as an opinion at the time....and we both seemed to acknowledge that there was a tachycardia issue that we were both at least thinking could be essentially hydration or sepsis, and, and that’s the reference to bloods and there being a work of breathing issue. Yeah, and, and how to balance treating both of them”.

239 Dr Morris agreed that the original plan discussed with Dr Buckmaster was that “If doesn’t pick up with rehydration or becomes more unwell, then the next step will be IVC and bloods and consideration of antibiotics”. He further agreed that by midnight, Pippa had been provided with hydration for about half an hour, with no improvement in her heart rate or WOB. He also conceded that the reference to a “burst of Ventolin” was not something that he had discussed with Dr Buckmaster in their earlier discussion. He indicated that his understanding was that local paediatricians “seemed agreeable to us as SRMOs” administering Ventolin without the need for further discussion with the senior paediatrician.

240 Dr Morris conceded in his evidence that this was an opportunity to escalate Pippa’s case management back to Dr Buckmaster. He said that he had not been asked to attend the paediatric ward, but felt he was invested in Pippa’s care.

241 Dr Morris confirmed that he received a telephone call from RN Sadler at 1am and was advised that Pippa “remains tachycardic”. He could not recall being told specifically by RN Sadler that Pippa’s heart rate was 168 bpm and that her oxygen saturation was 92%, despite the ongoing rehydration which commenced at least 1.5 hours earlier. Dr Morris said that he had two paediatric patients in the ED at that time.

242 At 2.10am, RN Sadler rang Dr Morris again and advised that Pippa’s presentation had changed. Specifically, Dr Morris indicated that he was told that she was grunting and had abdominal distension. Dr Morris confirmed that both changes in her presentation were significant. Dr Morris attended on Pippa between 2.35-2.40am.

- 243 Dr Morris agreed that Pippa's presentation had clearly changed. Her heart rate was recorded to be 196 bpm which placed her within the red zone and represented a significantly higher rate compared to her earlier readings in the low 150s. Pippa's oxygen saturation readings were also lower, fluctuating between 86 and 90%. She was also grunting.
- 244 Dr Morris confirmed that he listened to Pippa's chest with a stethoscope and could hear that there was now a difference in the sound of her breath between the right and left lungs. He agreed that unequal lung sounds should have promoted him to order a chest x-ray.
- 245 Dr Morris was challenged in his oral evidence as to whether he should have called Dr Buckmaster at that time, given these very significant changes in Pippa's presentation. He conceded that. "On reflection, I should've. I was at the time I was trying to be diligent, I was trying to gather information".
- 246 Dr Morris agreed that the Paediatric Sepsis Pathway mandated that a red zone observation, such as Pippa's heart rate at 2.40am, was suggestive of severe sepsis or septic shock in a patient. He agreed that in those circumstances, a rapid response should be called.
- 247 Dr Morris said that he had reflected on why he had not called a rapid response at that time. He said that there were other people who could have also made the call for a rapid response, although he accepted that it was "an oversight. It was an error of judgment. I will accept that. But it was – it was not deliberate". Dr Morris also accepted that he could have contacted Dr Buckmaster.
- 248 Dr Morris called the onsite surgical registrar and asked for his advice. He recalled that they discussed Pippa's distended and tender abdomen, and that the registrar confirmed that Dr Morris should "do the bloods. Call me if you need me to come back in from home to see her".
- 249 Dr Morris then recalled bringing Pippa into the procedure room, where he unsuccessfully attempted to place a cannula into her hand. A second cannula was introduced, and blood was taken by him to pathology for testing. Unfortunately, the first blood sample clotted and another sample was required.
- 250 At 4.03am, Dr Morris received the first of Pippa's blood results, which showed an elevated lactate level of 4.4mmol/L, with any reading above 2mmol/L being significant for a sign of a serious infection.
- 251 At 4.15am, Dr Morris called Dr Buckmaster and recalled telling him that he was "critically concerned because of this blood result". He recalled that he may have said that "she has sepsis, maybe shock". Thereafter, they discussed the treatment

plan, which was to start antibiotics and commence a higher oxygen flow rate. In addition, a chest x-ray was to be obtained.

252 Dr Morris recalled Dr Buckmaster asking him, “Do you want me to come in,” to which he replied, “I think I have got a clear plan of what to do”. Dr Morris said that there was an agreement “in some fashion that he wasn’t going to come in then”.

253 At 5.04am a mobile x-ray was performed which showed the left side of Pippa’s chest was white. Dr Morris said that he received the electronic confirmation of the x-ray about 10-5 minutes later and agreed that this was a very concerning sign and a medical emergency.

254 At 5.35am, he called Dr Buckmaster and advised him of the blood test and chest x-ray results. He recalled being told by Dr Buckmaster to add a further antibiotic and that he would come to the hospital. He arrived about 15 minutes later.

255 Dr Morris said that he assisted Dr Buckmaster after his arrival and remained on site until about 10am.

256 Dr Morris was asked about his understanding of the concept of diagnostic anchoring and if he had been anchored in his assessment of Pippa. He stated that he

“didn’t feel at the time that I was anchored. I think it’s hard to argue with it as a point in retrospect because of the facts...I didn’t feel like I’d closed my mind to this only being one thing, I really didn’t feel like I done it in my history of my examination in looking for features that could point towards a range of different things...But I guess these anchorings and biases and things are often subconscious.....signs that can be part of things like dehydration that I discussed with nurses, discussed with seniors.... They’re also signs of sepsis...like I didn’t feel anchored, but clearly I - I made an error of judgment or laid the weight of certain signs in the wrong direction”.

257 Dr Morris was questioned about whether he felt fatigued when he first assessed Pippa just after 9pm, having been on shift for 13 hours without a lunch break. He said that he had had some snacks during the shift, and that he did not feel fatigued. Dr Morris was asked if he felt fatigued between 9pm on 12 June and 5pm on 13 June 2022, such that his professional judgment was impacted. He responded:

“I accept that it could have. I don’t know if it did. From my opinion – I’ve said that I’ve run over this case a million times before. I can’t help but feel that it must’ve. It might’ve played a role but that’s my opinion”.

Videos of Pippa grunting

258 Dr Morris was shown a video of Pippa, taken at 1.46pm on 12 June 2022. He agreed that he could hear her making a “grunting sound in association with her breathing”.

He was shown another video of Pippa taken at 5.14pm on 12 June 2022 and said, “that’s an abnormal sound. That’s less of a typical grunt, but yes, I think you could probably use that term. Yes”.

- 259 It was suggested to Dr Morris that Pippa’s breathing was also exhibiting signs of grunting when he assessed her at 9pm. Dr Morris said that if he had heard Pippa breathing in a similar fashion:

“I would’ve documented that, and I would’ve discussed that with the consultant because that is how I practice and as I’ve expressed, that sound that I can hear in those videos is concerning and it’s quite similar to the sound that from my best recollection that I first heard on the ward when I attended at approximately 2.40am”.

- 260 Dr Morris did not accept that Pippa was making similar sounds from the afternoon of 12 June until she was taken to the ICU on the morning of 13 June 2022. He said that the first time he heard Pippa making a similar “grunting” noise was when he attended on her at approximately 2.40am.

- 261 Dr Morris was then played two further videos taken at 2.19 am and 2.25am on 13 June 2022 which also depicted Pippa grunting.

- 262 Dr Morris asserted that he had not been provided with a copy of the CERS policy during his orientation at Orange Hospital. He further indicated that at no point was he called by nursing staff to attend on Pippa for a clinical review nor was his attendance on the ward requested for a rapid response.

The evidence of Roslyn Margaret Sadler

- 263 Ms Sadler prepared a statement in these proceedings dated 4 May 2023 and gave oral evidence on 26 May 2025.

- 264 Ms Sadler was a registered nurse, until her retirement in July 2022. She was first registered as a nurse in 1977 and as a paediatric nurse in 1988.

- 265 Ms Sadler confirmed that she had been rostered on as the nurse in charge of the paediatric ward commencing at 9.30pm on 12 June 2022 until 7.30am on 13 June 2022. The paediatric ward had a capacity of 10 beds, however, Ms Sadler could not recall how many patients were present in the ward during her shift, although she could recall that it was a busy night.

- 266 Ms Sadler first became aware of Pippa when she was called by RN Hill from the ED at around 11pm. RN Hill indicated that they were wanting to transfer Pippa from the ED onto the ward to commence rehydration. Ms Sadler recalled that she was told that Pippa’s observations were “within the flags” except for her heartrate which was tachycardic.

- 267 Ms Sadler confirmed that Pippa was placed in an observation bed, close to the nurse's station. The bed had continuous monitoring equipment, which included monitors which displayed vital signs which were visible both at the bedside and in the nurse's station. The display included heartrate, oxygen saturation and respiratory rates.
- 268 Ms Sadler gave oral evidence to the effect that in June 2022, no automatic alarm prompt would be activated if an abnormal observation was entered into the electronic medical record (**eMR**) system. She agreed that the bed monitoring machine may alarm, although "it wasn't always a specific alarm".
- 269 Ms Sadler agreed that the observations performed at 23.21 hours showed Pippa's temperature at 36.6, her heartrate at 157 bpm, her respiratory rate at 36 and oxygen saturation of 95%. Ms Sadler recalled that Pippa was miserable and her breathing was not normal. Ms Sadler did not recall whether Pippa was making abnormal breathing noises at this time. Pippa was commenced on an NGT feed of Gastrolyte at 150mls/hour for 4 hours in accordance with the medical order.
- 270 Ms Sadler indicated that she was not aware that in 2022 the medical profession generally accepted that sepsis was a time-critical medical emergency.
- 271 At 12.20 pm, Pippa was reviewed by Dr Morris. Ms Sadler indicated in her statement that she could not recall if she was present for the review but did recall Dr Morris saying that stacked Ventolin was to be administered in 3 doses of 6 puffs, 20 minutes apart.
- 272 At 1.01am, Ms Sadler's clinical note indicated, "unsettled and increased WOB, remains tachycardic and mild WOB". Ms Sadler also noted that Pippa had a tracheal tug and was breathing with the use of accessory muscles. Pippa's heartrate was now 168 bpm, and her oxygen saturations were down to 92%. Ms Sadler indicated that she increased Pippa's oxygen to 1.5 litres per minute, which is permissible up to a limit of 2 litres per minute before requiring a medical officer's approval.
- 273 At 2.35am, Ms Sadler recorded Pippa's vital observations in the eMR. Her heart rate was now 196 bpm and her oxygen saturation was 90%. Ms Sadler accepted that her heart rate was in the red zone for a child, and she said that she "probably would have rung Dr Morris".
- 274 At 2.45am, Ms Sadler noted that:
- "Pippa remained miserable, afebrile and tachycardic. I observed that she was grunting and her mother stated that she thought Pippa was in pain." Ms Sadler stated in her oral evidence that at this time Pippa had "mild work of breathing, but she was – we'd look at the other things, whether they have a tracheal tug, or*

subcostal recession, or intercostal recession, and all of those. And some of those things are intermittent, and some of them are ongoing”.

- 275 Ms Sadler was played the video of Pippa time stamped 2.19am. When asked, she responded that “It was not a typical grunting sound, but it was a respiratory sound, and looking at her otherwise, she looked reasonably settled with her dummy in her mouth”. Ms Sadler could not remember if the video was consistent with Pippa’s appearance on 12 June 2022. She reiterated that “I wouldn’t describe it as a definitive grunt, but it was an obvious noise”.
- 276 Ms Sadler was familiar with the SPOC chart and was asked if she accepted that the onset of grunting was identified as an indicator of severe respiratory distress. She responded that “It was an indication of increased work of breathing”.
- 277 Ms Sadler accepted that a red zone heart rate of 196 bpm should have resulted in an escalation of care, including calling a rapid response as part of the hospital’s protocol.
- 278 Ms Sadler recalled that Dr Morris was contacted and attended on the ward.
- 279 It was suggested to Ms Sadler that in presence of Dr Morris and Annah, she kept pointing to the emergency button and saying to Dr Morris that if he did not do something more, she would press the button. She responded, “I couldn’t remember. Sorry”. Later in her evidence, she said, “It is possible, but I don’t recall.”
- 280 Ms Sadler was asked why she did not initiate the CERS alarm or call Dr Buckmaster. She responded:
- “Because I did not know him, I did not know how he would react to a phone call from the registered nurse and not the doctor.” Ms Sadler indicated that she was not “scared” to call, however “I was a bit tentative about calling him”.*
- 281 Ms Sadler stated in her oral evidence that with the benefit of hindsight, “we should have escalated sooner.”
- 282 Ms Sadler agreed that she was aware that Pippa’s mother had asked for blood tests to be performed while waiting in the ED. She also recalled seeing a rash on Pippa’s trunk when she was admitted to the ward.
- 283 Ms Sadler did not recall seeing Dr Morris fatigued during her interactions with him during the morning of 13 June 2022.
- 284 Ms Sadler could not recall seeing the relevant Paediatric Sepsis Pathway form as at June 2022. When shown a copy, she said, “I have never seen this document at all, this version, and I hadn’t seen the version that was brought out in 2023 either.”

The evidence of A/Professor Adam George Buckmaster

- 285 Dr Adam Buckmaster is a general paediatrician. He was employed as a senior staff specialist paediatrician at Gosford Hospital and was working as a VMO paediatrician from 11-18 June 2022. He had not previously worked at Orange Hospital.
- 286 Dr Buckmaster provided a statement dated 13 March 2023 and gave oral evidence on 3 July 2024.
- 287 Dr Buckmaster recalled meeting Dr Morris prior to Pippa's presentation when they may have done a ward round together and discussed some patients. He formed the view that Dr Morris was "a very empathetic, capable doctor who had a good thought process and was able to present patients well in terms of coherence of the information being provided and that he was thorough".
- 288 Dr Buckmaster recalled receiving a call from Dr Mir via vCare. Dr Mir told him that Pippa had been unwell for a few days with fever, vomiting and diarrhoea. He was also advised that due to another emergency at the hospital, there had been a gap in observations of Pippa.
- 289 He recalled being told that Pippa appeared to be improving as she was now sitting up in bed and having a Gastrolyte ice block. He was advised that Cowra Hospital did not have the resources or capacity to treat Pippa.
- 290 Dr Buckmaster was of the view that Pippa may have a virus, but as she had a history of being unwell for four days, he believed she should be transported to Orange Hospital for further review.
- 291 Dr Buckmaster could not recall if he had been told by Dr Mir that Pippa had an elevated heart rate earlier in the day which appeared to have resolved. Dr Buckmaster confirmed that at the time of the telephone conversation he did not have access to any clinical notes from Cowra Hospital, as he was not at the hospital or his home.
- 292 Dr Buckmaster was asked whether he was concerned at that time that Pippa had an oxygen saturation of 92%, placing her in a yellow observation zone. He responded:
- "No, not in the context of many children with viral illnesses, RSV, pneumonitis, COVID, a number of viruses, adenoviruses that were going around in wintertime at that stage".*
- 293 Dr Buckmaster indicated that he thought Pippa may have had a viral illness, likely gastroenteritis. That said, "in the back of my mind, sepsis is always present for all children presenting with fever, being unwell. Specifically at that time, I wasn't entertaining that she was septic at that point".

- 294 Dr Buckmaster could not recall discussing whether an IV line should be placed for the trip to Orange, but he was now of the view that it was not necessary on the available information.
- 295 Dr Buckmaster said that he then called Dr Morris at around 7pm to tell him that Pippa was being transported from Cowra Hospital. He agreed that he may have sent Dr Morris a text message with the details of Pippa's presentation at Cowra Hospital and asking him to call back when she arrived.
- 296 Dr Buckmaster recalled speaking with Dr Morris at around 9.45-10pm. They had a detailed conversation for about 15 to 20 minutes during which Dr Morris advised him of Pippa's examination. Dr Buckmaster recalled being told that Pippa had been unwell for four days with fever, vomiting and diarrhoea, with a recent COVID-19 exposure. She had a soft abdomen and bilateral crackles in her chest.
- 297 Dr Buckmaster was made aware that Pippa had two yellow zone observations, being her oxygen saturations and her heart rate. When asked about these, he said:
- "So, yes, they're abnormal. They're not markedly so....They're not particularly abnormal, but they are abnormal, and my impression was that they were very much in keeping still with somebody who's been unwell for three to four days, who's had a reduced fluid intake and is likely to be a little bit dehydrated and one of the early features of dehydration is your heart rate goes up a bit to that sort of level...So, my impression was still this is in keeping with somebody who's got a viral gastroenteritis plus affecting the lungs and pneumonitis process going on".*
- 298 Dr Buckmaster confirmed that he was familiar with the 2022 Paediatric Sepsis Pathway form. He was then asked the following questions,
- Q. Had clinical concern been raised at that point, you'd agree, wouldn't you, that the 2 yellow zone observations would have required first of all, a senior clinician review, but also bloods to be taken, that's what the pathway in front of you shows?
- A. Yes, if you've established that you're wanting to... you feel that the person in front of you meets the criteria for going on the pathway and you've got concerns, this is a suggested approach to try and elicit as much information as possible, and to help us identify every possible child who's got sepsis.
- Q. You said, suggested, so how do you view the guidance that's in front of you. Do you see it as suggestive only, do you see it as a mandatory approach that you need to follow in cases where it applies or something in the middle?
- A. I see it as a guideline, and guidelines aren't a policy in order to ensure that everyone must do X, Y, Z. They're particularly helpful at the most junior level, they're also helpful for senior people in unusual circumstances, but they are a

guideline and they're - mostly I'm in favour of - of guidelines and - and following them unless there's a reason not to. This is one of the most troubled areas of creating a guideline. I've had 25 years clinical experience, I still work very clinically with sick babies, sick children, I teach sepsis, I teach it through APLS, I've been on an expert committee as recently as two years ago on the development of the new sepsis pathway for neonates. Despite all of that, it is fraught with extreme difficulty at getting the wording right, at trying to be inclusive, but not being so inclusive that everybody gets treated unnecessarily or inappropriately.... Do I apply that and have I applied that subsequently, and do my colleagues apply that rigorously like a policy statement that you must, then the answer's no. So I see it as a guideline, it's there as a reminder, hey if you're thinking sepsis, think about these things, if there's other factors, you probably ought to do some bloods, look at her lactate, look at your CRP and – and then if you're really still convinced they've got sepsis, crack on and give antibiotics and some fluid”.

- 299 Dr Buckmaster said that he did not believe that it was necessary to obtain blood tests after Dr Morris’ first assessment.
- 300 He indicated that he had no preferred method of rehydration, and he expected to see an improvement in Pippa’s presentation over a two to four hour period, including seeing her heart rate settle, an improvement in her capillary refill time and for her to become more alert and less lethargic.
- 301 Dr Buckmaster said that if Pippa did not improve over the 2-4 hour period, “she would need an intravenous cannular, blood investigations including a venous FBC and electrolytes and antibiotics”.
- 302 Dr Buckmaster said that the delay in administering Pippa’s rehydration was “disappointing...but various delays occur” and “it’s disappointing that those delays occurred, because we had another hour and a half before the initial treatment process was even commencing”.
- 303 Dr Buckmaster was taken to the fact that Pippa’s WOB did not improve during and after the time that she was rehydrated. In addition, Pippa was given supplementary oxygen from around 10pm and over the next few hours. Dr Buckmaster said that given those issues, he would have expected to have Pippa’s case escalated to him.
- 304 Dr Buckmaster said that Dr Morris’ decision to give Pippa three doses of Ventolin at about 1.00am in 20 minute intervals was “not an unreasonable thing for somebody at a junior doctor’s level in a hospital to try and see whether you’re going to settle that work of breathing down, reduce oxygen requirement, reduce wheeze”.

305 Dr Buckmaster agreed that at 2.35am when Pippa's heart rate was recorded as being 196 bpm, placing her in the red zone, as well as grunting, were very significant developments. He indicated that those developments should have been escalated to him promptly.

306 Dr Buckmaster confirmed that he was called by Dr Morris sometime between 4.15 and 4.30am, with the blood tests results, which included elevated lactate and CRP readings. At that time, Dr Buckmaster concluded that Pippa may now have sepsis, with the presumption that she had a bacterial infection.

307 Dr Buckmaster conceded that he should have attended the hospital after receiving that phone call from Dr Morris. He said:

"I wish I'd come in. I don't think it would've changed the outcome because my management plan was exactly – would've been exactly the same, but it would be less of a contentious thing when we look at a guideline that says senior clinician must attend".

308 Dr Morris called Dr Buckmaster again at 5.30am with the chest x-ray results, which were in keeping with pneumonia and a probable effusion. These also indicated to him that Pippa was now in septic shock. Dr Buckmaster attended the hospital and contacted NETS. He was of the view that Pippa's pleural effusion was:

"less of an issue. The effusion wasn't stopping her from oxygenating...Having put her on nasal high-flow, there was some relief of that work of breathing...the effusion became not a focus at that stage. It wasn't critical to drain the effusion".

309 Dr Buckmaster was then taken to the transcript of the recording between the NETS paediatric intensive care fellow, Dr Zaidman, Dr Angiti and himself, where Dr Zaidman is recorded as stating, "To be honest, I suspect with that information about the fact that there's a significant effusion there, the work of breathing is not going to resolve until that gets drained. It's a big enough effusion to be drained". He accepted Dr Zaidman's conclusion.

310 Dr Buckmaster was shown the two videos of Pippa time stamped 1.46pm and 5.14pm. In relation to the 1.46pm video, Dr Buckmaster was asked if the sound Pippa was making would be of concern to him as a clinician. He said:

"It is so short and so limited that the answer is I don't know. I can't tell whether she's got a, a, a cough that she's "urgh", urgh" or whether this is a true, what we would term, grunt. A medical term whereby somebody is supporting their own breathing by pushing against as you breath out, "Urgh, urgh". If you've got a grunt, you usually have, you know, tracheal tug...it could be a grunt in which case I'd be concerned. It could be a, a brief coughing that's going on. It could be other sounds that are going on and I – I just can't tell in isolation".

- 311 Dr Buckmaster was shown the video time stamped 5.14pm. He said that “It, it may well be a grunt and in, in, in retrospect knowing what we now know, that may well be a more significant symptom and feature”.
- 312 Dr Buckmaster was also shown a photograph of Pippa, taken at Cowra Hospital. He commented that Pippa “looks flushed. So, red in the cheeks. That she – she looks in the posture that she has, that she is lethargic”.
- 313 Dr Buckmaster said that he had not been provided with the CERS protocol that related to the Orange Hospital in 2022. He indicated that every local health district has a CERS protocol, although they are all slightly different. He agreed that if he had been aware that the protocol for Orange Hospital required a paediatric registrar and consultant to be called and for them to attend the hospital in the event of a rapid response being called, he would have attended the hospital after the 4.30am call from Dr Morris.

Expert evidence

- 314 Eight medical experts provided expert reports prior to the commencement of the inquest.
- 315 Several of the parties to these proceedings qualified their own expert or experts. Three experts were physicians specialised in paediatric infectious diseases (A/Professor Irwin, A/Professor Starr and Professor Curtis), one specialised as a paediatric intensive care physician (Professor Butt), one specialised as a paediatric emergency physician (Professor Craig), one specialised as an infectious disease physician (A/Professor Braslins), one specialised as an emergency physician (A/Professor Raftos) and one as a rural and regional practitioner, Dr Morton.
- 316 To assist with the preparation of their reports, the experts were provided with statements and medical records which formed part of the coronial brief. They were not provided with copies of the hospital videos of Pippa filmed by Annah, due to a miscommunication.
- 317 Each expert was furnished with copies of the other expert reports prior to their attendance at the pre-inquest conclave, held on 3 and 5 February 2025. Dr Morton was not in attendance at the preliminary conclave as he provided his expert report after the conclusion of the first conclave.
- 318 At the conclusion of the first conclave, a Joint Expert Report was prepared and endorsed by each of the experts in attendance. The Joint Report was tendered in these proceedings.
- 319 Six of the experts also gave oral evidence during the inquest. Professor Curtis and A/Professor Starr were unavailable. Again, the experts gave their evidence in conclave.

First Expert Conclave

320 The seven experts were asked the following questions at the first conclave:

- i. Was it reasonable to allocate Pippa to ATS 3 at triage (at Cowra Hospital)? Did that decision have any significant impact on her care?
- ii. Did Pippa meet the criteria for activation of the Paediatric Sepsis Pathway during her presentation to Cowra Hospital?
- iii. Was Dr Mir's assessment adequate?
- iv. Was the initial management plan reasonable? Should further investigations or assessments have been undertaken at Cowra?
- v. Was it reasonable to transfer Pippa to Orange Hospital?
- vi. Was it reasonable to allocate Pippa to ATS 4 at triage? (at Orange Hospital) Did that decision have any significant impact on her care?
- vii. Did Pippa meet the criteria for activation of the Paediatric Sepsis Pathway during her admission to Orange Hospital?
- viii. Did Pippa meet the criteria for activation of the clinical escalation response system (CERS) protocol during her admission to Orange Hospital?
- ix. Was Dr Morris' initial assessment adequate?
- x. Was the initial management plan reasonable? Should further investigations have been undertaken?
- xi. When would it have been reasonable to take blood tests? Is it likely that the results at that stage would have indicated a serious infection?
- xii. Was the plan to administer stacked Ventolin at about 1am reasonable in the circumstances?
- xiii. When Pippa's pulse rate was recorded in the "red zone" at 2.30am on 13 June 2022, what action should have been taken?
- xiv. When should empirical broad-spectrum antibiotics have been commenced? Is it likely that this would have affected the outcome?
- xv. When should Dr Buckmaster have attended the hospital?
- xvi. Was there an adequate and timely escalation of care, after the diagnosis of sepsis had been made (at around 4.15am on 13 June 2022)? If not, what other care should have been provided, and is it likely to have affected the outcome?
- xvii. Was the advice provided by NETS to Dr Buckmaster reasonable and appropriate?
- xviii. Was the care provided to Pippa in the ICU reasonable and appropriate? If not, what other care should have been provided, and is it likely to have affected the outcome?

321 The first conclave was facilitated by Mr Matthew Robinson, a barrister with no prior association with this matter. No other legal representatives were present during the

two-day conclave. The purpose of the conclave was to permit free discussion between the experts, to clarify the matters in dispute and those that were agreed to by some or all.

322 On several occasions during this conclave, experts indicated that they understood and empathised with the difficulties faced by less experienced clinicians, with comments such as, “We’re all hesitant to criticise a colleague and a junior doctor,” and “anything I comment on is not meant as a personal criticism to any of the clinicians involved in this tragic case”. Similarly, the experts noted that Mr Morris had been on duty for around 26 hours.

323 Mr Robinson confirmed with the experts that the relevant Paediatric Sepsis Pathway being considered during the conclave was the Pathway that was current during 2022. That Pathway has since been amended in various ways.

Question 1: Was it reasonable to allocate Pippa to ATS 3 at triage (at Cowra Hospital)?

324 In response to the questions relating to Pippa’s care and treatment at Cowra Hospital, the experts’ responses were considered and nuanced.

325 In relation to the appropriateness of the allocation of a triage category ATS 3, the experts noted Pippa’s heart rate of 171, which placed her within the red zone. As such, the experts expressed varying opinions indicating that the ATS rating could be either category 2 or 3.

326 They noted that an ATS 2 rating would require Pippa to be assessed within 10 minutes, whilst an ATS 3 would mean an assessment within 30 minutes. The experts acknowledged that in Pippa’s case the assessment time frame was never going to be met due to the imminent arrival of another critically unwell child.

327 The experts did however debate whether that allocation of a category ATS 2 should have emphasised and recognised that Pippa was also a seriously ill child and that this may have changed the trajectory of her treatment.

328 A/Professor Raftos noted:

“Pippa presented with a febrile illness going on for four days. She had a heart rate of 171. That meant that the triage nurse should have initiated the sepsis pathway. That heart rate was in the red zone so that was an absolute criteria for initiating the sepsis pathway...the paediatric sepsis pathway was developed by a group of experts using the best available evidence; it’s purpose was to identify those children who may have sepsis so that they can receive prompt treatment. It’s a tool that should be used by the triage nurse and it’s not open to nuance. If the HR is in the red zone, whether it be by one, two, three or ten beats, it’s in the red zone. If the heart rate is in the red zone, then the Paediatric Sepsis Pathway

should be activated. It was 171, which is red zone, and therefore the Pathway should have been activated”.

329 Professor Butt commented further on this point, stating;

“When you take the history, the child had a viral infection, improved a bit with some simple paracetamol and ibuprofen, and then on the next day had a substantial deterioration. She develops a fever, more importantly she’s lethargic and mother says grey, so she’s got poor perfusion. We’ve got a clear picture of a child with a viral infection and then secondary deterioration, and in this case the possibility of a secondary bacterial infection....She turns up with poor perfusion and HR of 171.....the starting point of everything that follows is the lack of appreciation of the reasonable possibility of a secondary bacterial infection....Everyone is making exceptions because of staffing and the majority of children won’t have bacterial infection, but it’s a real possibility given the history and the mother’s interpretation. That sets the tenor of the case”.

330 A/Prof Irwin agreed that:

“[the] Paediatric Sepsis Pathway should have been initiated at Cowra. That wouldn’t have affected the triage category. All it would have done is make clear that a senior clinician should have assessed Pippa sooner. The point of the Pathway isn’t necessarily to initiate treatment for sepsis, and I’m not convinced there was definitive evidence of sepsis at this time. But what the Sepsis Pathway would have done is encourage the clinical team to take a full set of observations and ensure the most senior clinician available made an assessment about whether sepsis was present. I think the most senior clinician available did make this assessment, though it happened later than it might otherwise have”.

331 A/Professor Braslins said that Pippa should have been transferred to a facility that was staffed with paediatric clinicians. He was not of the opinion that Dr Mir was a “senior clinician from my perspective”.

Question 2: Did Pippa meet the criteria for activation of the Paediatric Sepsis Pathway during her presentation to Cowra Hospital?

332 All experts agreed that:

“Pippa emphatically met the criteria for initiation of the Paediatric Sepsis Pathway which is a process of screening and recognition which ought to have triggered senior clinician review per the pathway” by reference to the Pathway that was in place in 2022.

333 The experts did not unanimously agree that the activation of the Sepsis Pathway required the initiation of treatment.

334 A/Professor Irwin indicated that the:

“appropriate use of the Paediatric Sepsis Pathway would demand it was triggered in this case. There were elements in Pippa’s history and triage examination that suggested a Paediatric Sepsis Pathway should have been initiated.... The pathway starts with screening and recognition. Firstly, it’s a tool to improve recognition. So Pippa met the criteria to initiate the Pathway....There’s a great deal of published evidence to say that a single clinical sign is not very diagnostic of sepsis, or has limited diagnostic utility in sepsis. I think the consensus would be that sepsis pathways are most helpfully used when they direct the right children to senior clinician assessment”.

335 Professor Butt noted that “the whole point of the guideline is to provide a minimum standard of care to direct a process”.

336 Professor Curtis stated that:

“We keep ignoring the context of the child, which is that she was lethargic with decreased alertness and arousal, etc. It’s not the role of a medical assessment to think ‘what’s more likely’, rather it’s to think ‘what could I be missing’. You should be asking whether it is plausible she has sepsis: your job as a clinician is to consider what’s the most serious potential diagnosis. The most important question is ‘could this be sepsis?’”

337 A/Professor Braslins indicated that:

“there should be no exceptions, and yes Pippa did fit the criteria to go on the pathway. We’ve all said we agree with that. It would have triggered various steps in terms of further assessment. Blood tests were an important part of the senior clinician assessment. Once a patient is on the Paediatric Sepsis Pathway, it provides the trigger for blood tests, imaging, and senior clinician assessment. If I’d been asked to assess this young girl, I would have asked for a blood test. That would have sent us down a whole different pathway. The last point I want to make is that we seem to have focussed on the pulse rate of 171 as a single criteria, but it’s much more than that (parental concern, history of secondary deterioration etc)”.

338 A/Professor Starr stated:

“A single vital sign, or a single history, is not enough to make a diagnosis. It’s essential that there be senior clinician review. Not to say a senior clinician will get it right, but if we went down the path of putting a line in and doing gas and blood on every child in the red zone, we would be doing a lot of tests...Working in emergency, our role is to pick the needle in the haystack and work out who needs

further assessment and blood tests. That's not easy and this presentation was absolutely consistent with a viral lower respiratory tract infection".

339 Professor Craig stated that there were:

"At least two points where sepsis pathway could have been initiated. First, at triage, and second, when Dr Mir saw the patient. Arguably, the third after the elevated temperature was recorded in the ambulance bay. Equally, I strongly agree with A/Professor Starr's comment that tachycardia at triage in a child that's noted to be upset is not taken the same way as multiple episodes of tachycardia or persistent tachycardia. It is a flag. A child who is febrile, tachycardic, and grumpy would probably be given antipyretics like Panadol and then rechecked rather than everyone jumps on every child with an initial tachycardia as being absolutely septic at that point. So if you go exactly to the letter of this Paediatric Sepsis Pathway there's no argument that if you have a red zone, the Pathway requires senior clinician review and antibiotics. I think there's disagreement amongst the experts as to whether a single measurement of a rapid heart rate at triage should be enough to trigger the pathway. I think practice would not support every child having antibiotics because of a single red zone heart rate, particularly in the context of being upset on arrival in the emergency department".

Questions 3 and 4: Was Dr Mir's assessment adequate? Was the initial management plan reasonable? And should further investigations or assessments have been undertaken at Cowra?

340 A/Professor Irwin noted that:

"We've got to decide to the best of our ability how reasonable and appropriate it was. If Dr Mir had concluded that Pippa had probable or likely sepsis, he ought to have initiated a bundle of care, including antibiotics and intravenous fluids. If on the other hand he made an assessment as he appears to have done that this was a self-limiting viral infection, transfer to a paediatric ward may have been appropriate. That's at the core of whether or not Pippa received appropriate care...

I felt that what was being documented appeared consistent with a viral lower respiratory tract infection. But the videos are striking, and in the context of the red flags (re-presentation, unexplained pain), sepsis ought to have been suspected. I don't know Dr Mir's level of experience with paediatrics, but one would have to say that having made that assessment of lower respiratory tract infection, no one subsequently deviated from that conclusion...It's obvious people anchored to Dr Mir's diagnosis and held onto the diagnosis of viral lower respiratory tract infection, but I don't know that Dr Mir can be held responsible for that. When Pippa arrived at Orange Base Hospital, she ought to have been assessed

independently and appropriately. Had sepsis been considered in the context of the Paediatric Sepsis Pathway, then at assessment, it would have been appropriate to ask are we now at the stage where our suspicion is sufficiently high that we should treat for sepsis...

I expressed the caveat in my report that I wondered whether clinical signs were erroneously documented or missed. I thought the documented heart rate of 90 seemed incongruous and discordant with the other observations, and I wondered whether that was erroneously measured. Secondly, the clinical assessment of the auscultation of the chest which found bilateral crackles, given the later assessment of unilateral signs on the ultrasound and Dr Buckmaster's examination, I wondered whether that clinical assessment was erroneous.

But assuming Dr Mir had appropriate clinical skill, what was documented was consistent with the differential diagnosis of a viral lower respiratory infection. The videos (which we were not provided with at the time of writing our report) raise the possibility that important clinical signs were not recognised. The grunting is clear, Prof Curtis used the word 'toxic'. Pippa appears flushed. Those signs ought to have been given greater weight. There were clinical features not being appreciated, but equally they were not appreciated when she arrived at Orange Base Hospital and was assessed by a senior paediatric registrar".

341 Professor Craig commented that:

"Dr Mir's assessment based on what's written seems thorough. The striking thing about the videos is the grunting. The grunting video taped by Mum at 3.00pm in the afternoon was clearly present and interpreted as respiratory distress, which led to him think that Pippa had a viral chest infection. The grunting, along with everything else, certainly pushes us towards think that Pippa is at high risk of sepsis. The grunting was really striking for me. It was missed not only by Mr Mir, but many others (for example, nursing staff at Cowra, nursing staff at Orange, ED medical staff at Orange, paediatric staff at Orange), and wasn't really documented as being present until after midnight. I think for Dr Mir's training and experience, his assessment was adequate but not perfect. And his treatment plan was adequate based on the assessment that he made. If he had appreciated the grunting for what it was, it's much easier to suspect sepsis and easy to then do the rest (blood tests, antibiotics, urgent referral, etc)".

342 Professor Curtis commented:

"We're all in agreement that in the video, Pippa is clearly a septic child. There were enough signs that sepsis should have been considered. One has to conclude therefore that the assessment was inadequate. I was also going to raise the incongruent HR and the auscultatory findings not fitting with the later x-ray.

It's clear that sepsis was not considered. There was no documentation of capillary refill which is a basic part of the assessment of a sick child. We know it was documented normal later, but no evidence it was normal at that time. This suggests that it wasn't thought important. The whole issue of re-presentation and parental concern also was not given sufficient weight. When we're all in agreement that the video clearly shows a septic-looking child, we have to say the assessment was inadequate. We might consider that is understandable because the doctor wasn't sufficiently experienced or senior enough; I have sympathy for him, but that's not the question".

343 Professor Butt concluded that:

"Dr Mir made many mistakes. He was the most senior clinician there and tries to do his best, but he is clearly not a senior clinician and lacking senior support. I believe his approach impacted the perception of Pippa's severity of illness at Orange Hospital. We keep coming back to it, but it's about attention to detail. He ignored the history of the secondary deterioration. We've all said that in some way. His approach created a bad mindset for the junior doctor at Orange. If he had some discussions with Dr Buckmaster that this might not have been a simple viral infection, or if the Paediatric Sepsis Pathway has been initiated I'm thinking it's more likely than not that Dr Buckmaster might have been there when Pippa arrived. If there had been a more senior clinician than Dr Morris, there might have been early blood tests, better assessments, and so on. That's the theme coming to me strongly".

344 Later he commented that:

"Dr Mir did ring and speak to a paediatrician, so he did seek some advice. More questions could have been asked of him by that person. But at the end of the day, he performed to his level and wasn't able to get advice to help him".

345 Professor Butt continued later, stating:

"She had lung disease shown by grunting, and she was dehydrated. If you're thinking her tachycardia was partially a result of dehydration, then I wouldn't be filling that stomach up with liquid, I'd be running it through an IV".

346 The experts commented on the videos, with Professor Craig noting:

"If the grunting had been appreciated, there definitely should have been an IV. Should the grunting have been appreciated is the crux of it. Junior doctors don't get everything right. The videos are striking. Pippa was pretty sick. But this wasn't noted by ambulance officers, or at triage, or by Dr Mir, etc. Six people missed it, not just Dr Mir. But the failure to appreciate it led to an impression of a viral illness...It depends whether you hold inexperienced junior doctors to the same

standard of a senior experienced clinician or not as to whether they ought to get everything right. The reason you're a junior doctor is because you're not an expert yet and you can't get everything right. There were further opportunities for other clinical staff to note it and they didn't. Everyone's failure to pick up on the grunting has a cascading effect. Other people anchored".

347 A/Professor Starr noted that:

"The very first video does not show a child who is septic. The second one is more concerning. If the timing is correct, the second video is around the time Dr Mir assessed the child. That child is sleeping though, and the only thing to say is that it's not a static thing. The child might not have been grunting when Dr Mir assessed her. I can't say Dr Mir's assessment was inappropriate. He seems to have taken an adequate history and examined the child and he says this could be a viral illness. What he's gone on to do is speak to a paediatrician, and that was appropriate too. I agree in part with what Prof Craig said, but we can't assume that what is seen in the video is what Dr Mir saw".

348 A/Professor Raftos stated:

"If there had been a different assessment, I think the management plan would have been very different".

349 A/Professor Braslins strongly advocated for the installation of video monitoring equipment at Cowra Hospital as follows:

"so senior clinicians can have access and view a sick child when they are being assessed. Yes, Dr Mir was the most senior clinician there, but there were other clinicians who might have been available to consult (by phone, or by video). If they'd had access to that video, the child would have been treated in a very different way".

350 Professor Curtis opined that:

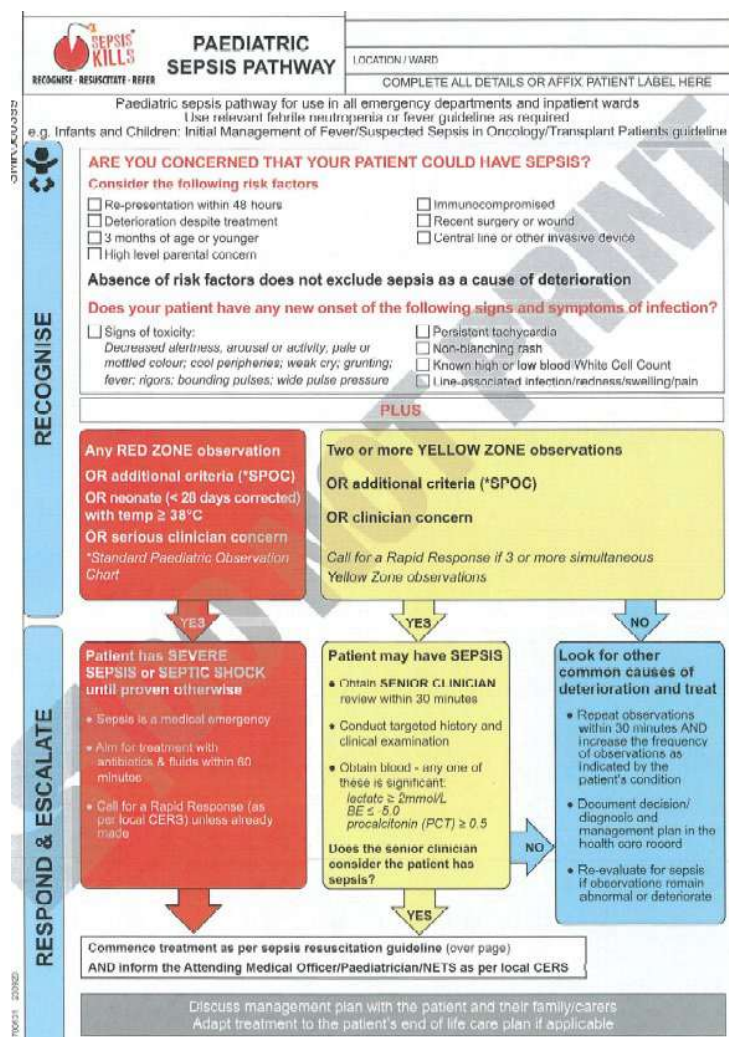
"although the assessment was inadequate, another recommendation from this case might well be that a junior doctor with that little paediatric training and experience shouldn't be put in a position where they have to make a decision on a potentially very sick child".

Question 5: Was it reasonable to transfer Pippa to Orange Hospital?

351 The experts unanimously agreed with the proposition that it was reasonable to transfer Pippa to Orange Base Hospital.

Questions 6 and 7: Was it reasonable to allocate Pippa to ATS 4 at triage? Did that decision have any significant impact on her care? Did Pippa meet the criteria for activation of the Paediatric Sepsis Pathway during her admission to Orange Hospital?

- 352 The experts did not all agree that ATS 4 was appropriate, however, they all agreed that Pippa should have been placed on the Paediatric Sepsis Pathway, which required a senior clinician review within 30 minutes in any event.
- 353 The experts agreed that if the following Paediatric Sepsis Pathway was the appropriate version of the pathway at the time of Pippa's presentation, and that Pippa should have been placed on that pathway and blood testing undertaken.



Question 8: Did Pippa meet the criteria for activation of the clinical escalation response system (CERS) protocol during her admission to Orange Hospital?

- 354 Professor Craig stated that:

"The CERS Protocol is the emergency response. It's when you have red zone criteria, and yellow zone which mandated clinical review. Pippa marginally

crossed into the red zone at 0100 hours. The HR was right on 170 just after 1.00am, and after that in the red zone consistently until intensive care. Any time after 1.00am, and definitely from 2.00am, there is no argument she met the criteria for activation of the CERS Protocol”.

355 The other experts all agreed with this assessment.

356 A/Professor Irwin added:

“According to the narrow question, Professor Craig is right, she met the criteria for CERS but I think there was evidence of deterioration which ought to have initiated an escalation sooner according to the Paediatric Sepsis Pathway”.

357 All the experts agreed with this further comment.

Question 9: Was Dr Morris’ initial assessment adequate?

358 A/Professor Raftos was of the view that had Dr Morris properly assessed Pippa’s vital signs; he would have appreciated that she had two yellow zone readings and should have commenced her on the Paediatric Sepsis Pathway and taken blood.

359 Professor Butt agreed, further stating:

“there was also increased work of breathing to moderate work of breathing level....and some subcostal recession, so he hasn’t accepted the deterioration in clinical signs, hasn’t accepted the deterioration from Cowra, hasn’t understood the importance of his examination findings. He should have, at a minimum, taken bloods and he should have contacted the senior doctor to attend. There would have been a different result had he done that”.

360 Professor Curtis agreed, and added:

“the only minor thing I would add was...the discrepancy between the auscultatory findings compared with what we subsequently know from the chest x-ray”.

361 A/Professor Irwin stated that Dr Morris made a detailed assessment. However, he went on to comment:

“But there were omissions and probably errors in the assessments. I’ve made reference to the auscultatory findings, I don’t think he adequately explained the prolonged capillary refill which he documented. He doesn’t make reference to pain which is clear in the maternal ? statements and was documented by the triage nurse at Orange Base Hospital. Those matters ought to have made him think about sepsis. Plus, we’ve seen the videos subsequently. All those matters, taken together with her appearance, ought to have brought sepsis to the fore. Even if Doctor Morris had concluded this was likely to be a viral lower respiratory

tract infection, the differential should have included sepsis. Sepsis should have been explicitly considered. The Paediatric Sepsis Pathway should have been initiated. It would have triggered bloods and I think the conversation with the consultant paediatrician would have been different with sepsis front and centre”.

362 Professor Craig opined:

“I think Dr Morris made a thorough and detailed assessment but he didn't appreciate some of the clinical findings including grunting, fine blanching rash, poor capillary refill, and lethargy. In terms of the chest findings, there's been some discussion. When you hear noises throughout the whole chest, it makes you think more a viral illness than a localised pneumonia. On Doctor Morris' documentation, it appears that he heard bilateral crepitations (noises throughout both sides of the chest). At 02.00 hours it was different. It may be that findings changed over the course of six hours with deterioration. I don't think his assessment was incorrect, but putting it all together, particularly having regard to Annah's statement, it sounds like the parents were keen for blood tests I think it was a missed opportunity to do bloods. Assessment itself was detailed but not perfect. Again, this is a junior doctor not training in paediatrics who has been awake for quite a while at that point”.

363 A/Professor Starr did not agree with the other experts, stating:

“I thought Doctor Morris' assessment was very good. He obtained a detailed history and performed a thorough examination. There was an appropriate diagnosis of viral lower respiratory tract infection with possible pneumonitis and mild to moderate dehydration, which was consistent with the presentation. He considered other causes and then he went on to make an appropriate management plan in conjunction with the consultant paediatrician, which was to rehydrate the child and observe them. There was not an indication at that time to do blood tests, nor a chest X-ray, based on his assessment. Pneumonia guidelines recommend that we try and avoid irradiating children with likely pneumonia but treat empirically. All in all, Doctor Morris' assessment was good, very good”.

364 A/Professor Starr also rejected the contention that Dr Morris didn't appreciate the level of concern being expressed by Pippa's mother regarding taking a blood sample. He indicated:

“I make a judgment about whether blood tests are required, not a parent. Parents can express their concern, serious concern about how sick a child is, but I can't be persuaded by parents wanting tests. They don't have the knowledge to know if a test is required or not.”

Question 10: Was the initial management plan reasonable? Should further investigations have been undertaken?

365 Professor Craig indicated that:

“I think given the diagnosis they were thinking, it was a reasonable management plan. The plan to admit, do some rehydration, and if she doesn’t pick up or becomes more unwell, put a cannula in, do bloods, give antibiotics. It was pretty reasonable. It would also have been reasonable to do bloods and antibiotics. The fact is they were thinking about it, and if things got worse they would have done it but if you refer to the Paediatric Sepsis Pathway, probably not the optimal plan, but reasonable and very understandable based on what they were thinking”.

366 Professor Starr agree with Professor Craig’s assessment.

367 Professor Curtis stated:

“the spirit of the question is whether the management plan was reasonable for this child. It wasn’t. This child needed blood tests and antibiotics. Further investigations should have been undertaken. That’s based on the fact that I disagree on the adequacy of the assessment. In summary, the management plan was not reasonable, because the assessment was inadequate. The child should have had blood tests done and antibiotics started”.

368 The remaining experts agreed with Professor Curtis.

Question 11: When would it have been reasonable to take blood tests? Is it likely that the results at that stage would have indicated a serious infection?

369 All the experts agreed that, on the balance of probabilities, had blood tests been performed at Cowra or on admission to Orange Base Hospital, they would have indicated abnormalities suggesting a serious bacterial infection/sepsis.

370 A/Professor Starr expanded on his earlier comments, stating:

“...the guideline protects the junior doctor. I run the clinical practice guidelines out of Victoria....We don’t all follow guidelines because we have a lot of accumulated experience, but for junior doctors probably should. So whilst earlier I said Dr Morris’ assessment and management was reasonable, and he did discuss it with a paediatrician, nowhere does anyone say ‘Sepsis’. What should come out of this review is sepsis needs to be considered, even if there are no investigations which follow. I continue to think it was reasonable for Dr Morris not to do blood tests on initial assessment, but to pursue hydration and observation. That was not according to the guidelines. Guidelines are there to provide a framework; a sepsis pathway is more than that. It’s a protocol which should have

been followed. If there were features which mandate blood tests being done based on the pathway, they should have been done”.

371 Professor Butt, Professor Curtis and A/Professor Braslins all opined that the blood tests should have been performed at Cowra.

372 A/Professor Irwin commented:

“We can be confident that bloods would have been abnormal, and suggestive of sepsis at 9.00pm when Pippa arrived in Orange. What Dr Braslins said about Dr Buckmaster not getting the information may be true. But Dr Buckmaster as the senior clinician discussing an evidently unwell child ought to have prompted consideration of the differential of sepsis. That would have made Dr Morris say “I don’t think this is sepsis”, or alternatively, if there was uncertainty, driven investigation and intervention”.

Question 12: Was the plan to administer stacked Ventolin at about 1.00am reasonable in the circumstances?

373 All the experts agreed that it was not reasonable or appropriate.

374 Professor Craig, A/Professor Starr and A/Professor Braslins stated additionally that “it was understandable given the management plan”.

375 Professor Butt commented that:

“It was not understandable. Nowhere in the notes is there evidence of hyperinflation, expiratory wheeze, or airflow obstruction. Doing it over the phone without examining a child is not understandable in light of everything else that is going on. It was wrong”.

376 A/Professor Irwin agreed with Professor Butt, stating:

“this was a clinician observing deterioration such that they needed to intervene, but so anchored to original diagnosis that they didn’t consider what was happening”.

377 A/Professor Raftos noted:

“the plan for stacked Ventolin draws into focus the illogic of the doctor’s diagnosis of bronchiolitis. No one ever heard a wheeze which is the clinical features of bronchiolitis. In the absence of a wheeze, the diagnosis of bronchiolitis wasn’t sustainable. Certainly the decision to give Ventolin was inappropriate”.

Question 13: When Pippa's pulse rate was recorded in the "red zone" at 2.30am on 13 June 2022, what action should have been taken?

378 Professor Craig responded:

"... that pulse met criteria for a CERS response. That would have notified the paediatric consultant which would have led to consultant attendance at the bedside. In terms of treatment, if it hadn't been done before then, which it probably should have, IV access, blood, blood gas, and antibiotics had they not been given earlier. It's likely further resuscitation in the way of fluid boluses and respiratory support was also necessary".

379 The other experts agreed with Professor Craig.

380 Professor Butt further stated:

"If you go back to 9.00pm the night before, there was agreement that certain things would happen if there was deterioration. I still feel that deterioration occurred and nothing much was done...So by 2.30, yes there should have been a CERS response, but at some point we need to accept (1) there was a lack of understanding of the trajectory of the illness of the child. This child was getting sicker and sicker and sicker and they were just bumbling along...They kept doing the same thing. They were anchored".

Question 14: When should empirical broadspectrum antibiotics have been commenced? Is it likely that this would have affected the outcome?

381 A/Professor Raftos responded, stating that antibiotics should have been administered to Pippa at 2.06pm at Cowra, at about 5pm when she was seen by Dr Mir and again when she presented at Orange Hospital at 9pm on 12 June 2022.

382 He further stated that:

"in response to each of the deteriorations culminating in the deterioration at about 01.00 hours the next day, sepsis should have been diagnosed and IV antibiotics should have been given, and if antibiotics had been given on any of those occasions, Pippa would more likely than not have survived".

383 Professor Butt, A/Professor Braslins and Professor Curtis agreed with A/Professor Raftos' opinion.

384 A/Professor Starr indicated that it was not reasonable to commence antibiotics considering Pippa's 171 bpm heart rate. He was concerned that this would mean that many children would be treated unnecessarily with antibiotics. He confirmed that by 0230 hours on 13 June 2022, Dr Morris should have commenced antibiotics.

385 Professor Curtis responded to A/Professor Starr, stating

“...these guidelines are very sensitive but not specific, and therefore this means children are treated who don’t need treatment. But that’s the whole point of the guidelines. They’re designed to be sensitive to protect patients and doctors so that cases aren’t missed, particularly by juniors without the benefit of experience. They’re designed to ‘over detect’ and ensure cases like this aren’t missed. So, particularly in smaller hospitals and with junior doctors, they’re useful and this case illustrates beautifully why they should be followed. Secondly, the videos were only provided recently. We need to take account of those. I suggest some of my colleagues might want to change their view or opinion of when antibiotics should have been started having now seen the very strong evidence from these videos. I’d be interested to hear what my colleagues think, looking at the videos, particularly that in the late afternoon, together with the other things we know about the observations and history, particularly parental concern, re presentation, unexplained pain, and the other well documented features. Am I correct in saying that we all agree antibiotics should have been started at that point? It’s not a discussion about pathways; this is a sick child with clear symptoms and signs of a serious bacterial infection”.

386 Professor Butt, A/Professor Braslins and A/Professor Raftos agreed that antibiotics needed to be started at the time of the videos.

387 A/Professor Irwin provided the additional comment:

“I am of the opinion the written documentary evidence could support a diagnosis of a lower respiratory tract infection.....It is also my experience, those signs that were documented were not definitive of sepsis. Context matters. Those signs documented in the context of a child who looked red, and hot and toxic and grunting, the assessment is different. My perception would likely have been different. I’m very much more comfortable accepting A/Professor Raftos, Professor Butt and Professor Curtis’ determination that antibiotics should have been started at 5:00 PM with the evidence of those videos. In the absence of those videos, I was comfortable with the clinical plan that the differential was a lower respiratory tract infection and the necessary plan of action was observation and intervention if there was a deteriorating trajectory (though that intervention did not happen). But with the evidence of the videos, there was clearer evidence that Pippa had a serious likely bacterial infection very much earlier, and that it was not necessary to wait for that deterioration to occur, so the videos would have made a difference”.

388 A/Professor Starr and Professor Craig agreed with A/Professor Irwin’s opinion above.

Question 15: When should Dr Buckmaster have attended the hospital?

389 By way of background, Dr Buckmaster indicated that although he was informed that Pippa had two yellow zone criteria, he was of the opinion that this was in keeping with a child who had been unwell for three or four days and was dehydrated.

390 Each of the experts provided an opinion to the effect that Dr Buckmaster should have attended Orange Hospital at 9pm given that he had been informed that Pippa met the yellow zone criteria, meaning she needed to be reviewed by a senior clinician. They also accepted that Dr Buckmaster should have also attended at 0230 hours and 0400 hours on 13 June 2022.

391 A/Professor Irwin commented:

“When called at 5.00pm, It appears as though he may not have been given a sense of urgency or the sickness of the child, but as the consultant on call, there may have been a responsibility on the consultant to say to a rural generalist, ‘are you worried about this child’, ‘do you think this child could have a serious infectious’, ‘do you think this could be sepsis, because that’s a time critical medical emergency. One of my criticisms of the case is that sepsis is not documented until septic shock manifests. The paediatric consultant on call could have prompted consideration of sepsis as a medical emergency...The paediatric consultant on call ought to have taken into consideration that the registrar on the ground was overworked and tired. That’s another reason for Dr Buckmaster to go in and facilitate review of Pippa”.

392 Professor Butt noted:

“But to add further weight, when he received a call from Cowra, he spoke to Dr Mir and should have got a history. When physicians are trained, 90% of diagnosis is made on the history. So if you just stick to history, it’s a three or four day illness with a secondary deterioration. The child was incredibly lethargic and mother thought the child was grey. History tells you this is not a simple viral infection; there is a possibility of a secondary deterioration. Incumbent on him to get that history by asking and to have then considered the possibility of sepsis”.

Question 16: Was there an adequate and timely escalation of care, after the diagnosis of sepsis had been made (at around 4.15am on 13 June 2022)? If not, what other care should have been provided, and is it likely to have affected the outcome?”

393 A/Professor Starr commented:

“... But if we look at what was done, they did take steps towards that, but it was a bit slow Dr Buckmaster called NETS at 0600, but they all took too long they did some things. They put a line in, gave antibiotics, gave fluids, called NETS. So,

there was an initial escalation that was appropriate, but was it adequate or timely? No. They were a bit slow to continue that escalation. At 0600 hours, they did speak to NETS as the first line. NETS didn't advise to escalate further”.

394 Professor Craig opined:

“One of the frustrations reading this case is Pippa was reviewed by an anaesthetic registrar and an intensive care registrar, both of whom had bosses who can help, or skills in resuscitation themselves, but neither took ownership of this horribly sick child. There's a bit of inertia. A lack of urgency. I think that inertia probably made the difference in Pippa's outcome. Whether this is because they are registrars and there's a paediatric consultant running things who is not critically care trained, or whether it was just a combination of inertia and a lack of decision making, I don't know. The emergency consultant didn't go to Pippa's bedside until asked to in an arrest or peri-arrest situation. The intensivist didn't go to Pippa's bedside; didn't see her until she was in ICU. If either of them had gone to the bedside and seen Pippa at that point, they'd have seen she was sick and need to get on and do stuff and resuscitate and I don't think that happened. Between 0700 and 1000 (hours) is probably where we went from a potential potentially reversible shocked state two way reversible state”.

395 Professor Butt agreed, stating:

“The inertia was important. It was probably reversible even at 1000 (hours) if they'd drained the effusion and had the line in a bit quicker. It's hard to say the exact moment it became irreversible”.

396 A/Professor Irwin commented:

“The period from 0400 hours to 1000 hours is where we went from a reversible shock state to irreversible”.

397 A/Professor Irwin noted:

“When Dr Buckmaster was told 0415 that Pippa was in septic shock, that was an opportunity to be by the bedside and to drive resuscitation. It's an hour and 45 later that Dr Buckmaster actually sees Pippa...There are two hours at least where that coordination of ICU input is inadequate because Dr Buckmaster isn't beside the child, so I think that's problematic. Then of course there's evidence of sepsis before 0400. By the time bloods taken, it's clear (if it wasn't clear a long time before) that antibiotics should have been given and supportive care should have been given. There was no reason to wait for the blood tests”.

398 Professor Butt noted:

“That’s a good point about 0400 hours. That two hours becomes critical when you think what the initial NETS response was. The NETS the arrival was delayed because it was close to the shift change by the time the need for retrieval was understood. Had the call occurred at 0400 or 0430, not close to shift change, NETS would have been more likely to have gotten to Orange by approximately 0700 hours, so that then trained people are present capable of dealing with all the things that we’re talking about”.

Question 17: Was the advice provided by NETS to Dr Buckmaster reasonable and appropriate?”

399 Professor Butt opined that “It was lacking in intensity.”

400 Professor Craig stated:

“I think the specific things that worried me was the lack of specificity in some of the recommendations, particularly on the second call when clear Pippa has become more unwell. I think, and I’ll defer to Professor Butt in terms of optimum over the phone advice, but the three things that were needed were (1) intubation (2) blood pressure support (3) drainage of the effusion. There seems to be an emphasis on getting a central line in ahead of clear direction to support the blood pressure with peripheral inotropes”.

Question 18: Was the care provided to Pippa in the ICU reasonable and appropriate? If not, what other care should have been provided. And is it likely to have affected the outcome?

401 Professor Butt commented:

“They should have come to her. But having said that, once she arrived they got the tube in quickly. NETS arrived around 1030 just after tube in. They made efforts to put in a central line. The first cardiac arrest was at 1100 hours. She was reasonably well resuscitated. Second arrest is at 1200, that was unrecoverable. They should have drained the effusion but would that have made a difference by the time she was in ICU? Probably not. She was in fulminant shock”.

Second Expert Conclave – Oral Evidence

402 The experts involved in the earlier conclave gave oral evidence, again in conclave, at the inquest on 28 May 2026. They were joined by Dr Morton. A/Professor Raftos gave his evidence at the conclusion of the conclave due to being in a significantly different international time zone.

403 The experts were again questioned in relation to the various topics explored during the first conclave and referred to above. I do not propose to review the entirety of

their oral evidence, but focus on the areas where there was a divergence of opinion or a contentious conclusion.

The Paediatric Sepsis Pathway

404 Professor Irwin commented that the:

“Paediatric Sepsis Pathway is a pathway of screening and recognition, and so the paediatric sepsis pathway is designed to be used in any child who may have sepsis. It’s not a diagnosis of sepsis. It’s a tool to support the recognition of sepsis, and on that basis I believe she met the criteria for initiation of the pathway.....The intention is to draw attention to many of the children who may have sepsis, to highlight the key features that make sepsis more likely, and to escalate the evaluation of those children to the most senior clinician”.

405 A/Professor Braslins agreed that Pippa met the criteria to qualify for the initiation of the pathway, stating:

“one of the purposes of the sepsis pathway is to protect patients against clinical error that might arise from inexperienced, understanding that sepsis can be very difficult to diagnose and to detect early in the case, and may mimic other illnesses. So being an oversensitive tool is not really a valid criticism of the tool, because of its purpose which is to protect patients against missed diagnoses”.

406 The experts agreed that the advantage of placing Pippa on the Paediatric Sepsis Pathway and its associated strict criteria would result in a full set of observations and an immediate review by a senior clinician. It was also noted that the first reference to sepsis in the medical records occurred at 4am on 13 June 2022.

407 Professor Craig stated:

“so, a single set of abnormal vital signs doesn’t necessarily mean you pull the trigger on everything. Like, in clinical practise, what we’d normally do is make a reassessment and if there’s persistent abnormalities, it really pushes you down “this child’s really unwell”, and if the abnormalities are becoming less abnormal over time, then you are becoming - you are less concerned about the child, and you have more time to then do a full evaluation”.

408 Professor Butt indicated he agreed with Professor Craig, although noted the videos which showed Pippa ‘grunting and some work of breathing. He indicated that:

“the repeated observation, clearly, would have shown the development of a new and very important symptom, and increased work of breathing, and respiratory rate over 40, which would have meant it’s time to seriously consider antibiotics and blood tests”.

The grunting videos

- 409 The experts were then questioned about their perception of the videos showing Pippa “grunting”. Professor Craig noted that grunting is:

“a type of breathing that’s pretty abnormal and is a sign that the child’s pretty sick...and that sort of breathing in that manner is often thought to be related to potentially pneumonia and other chest infections and possibly sepsis, and just becoming more unwell due to an infection. So the presence of grunting wasn’t appreciable reading the medical and nursing notes for quite some time....I would assume the grunting would have been there probably more often than not, because it’s a response that your body’s trying to do to essentially assist your breathing and assist the function of your lungs. It can be louder and softer at different times, and I think you know as you’ve noticed we’re all reasonably experienced, we’ve been around for a while, and as a junior doctor I may not have appreciated grunting as much as I do having been in practice for 20 odd years...there are signs that are clearly abnormal to relatively untrained people, and there are people that have done more training, more experience, that more things are obvious due to that experience. So I think you know was it missed or was it difficult to recognise. I don’t have a clear answer to that, but it wasn’t classically obvious to every you know medical student upwards sort of thing, it’s something that I think the more senior you are the more obvious it is because you’ve just seen more really sick kids”.

- 410 Professor Butt commented:

“I think grunting is a very impressive sign, even mild. So when see people describe breathing out and say increased work of breathing which means the ribs are sucking in and there’s energy and that reflects stiff lungs, but grunting is worse because that’s what’s called end-expiratory breathing....It is a very bad sign. Anybody who’s grunting has major lung disease, and I don’t accept that it was missed. You can’t not see – it’s a noise that’s so different. So they may not have appreciated the interpretation in the busy ED. I can’t speak for that, but that was a fundamental sign that reflects rapidly progressive and severe lung disease”.

- 411 A/Professor Irwin noted:

“that the video at 5.14 which also revealed Pippa was flushed, which is another somewhat subtle but a discriminatory finding that indicates bacterial infection. So if the clinicians involved had considered that most likely Pippa’s respiratory infection – because I’m sure that’s what they thought she had – was likely and made it much more – suggested that she had serious bacterial infection plus or minus sepsis”.

412 Dr Morton suggested that a clinician may not have heard Pippa grunting in a busy ED.

413 Professor Craig responded, stating:

“I agree with Dr Morton in that you probably wouldn’t notice grunting in the context of walking and working in an Emergency Department seeing lots of other things and other things going on in the waiting room. However, one-to-one of a child, if it can be picked up on a video, it can probably be picked up by the doctor facing the patient. So it would be my view that if it was present at the time that Dr Mir saw the patient or the nursing staff saw Pippa, then grunting would have been identifiable by a clinician at the time. Even if what’s happening around. When you’re in the room seeing a patient you can probably appreciate that, because it’s sort of a visible as well as audible thing going on”.

414 Each of the other expert witnesses agreed with Professor Craig’s opinion.

Dr Mir’s assessment

415 The experts differed as to whether Dr Mir’s assessment was adequate and whether he should have documented his consideration of sepsis as a diagnosis.

416 Professor Craig opined that:

“I think all of us that are on the panel would agree that she had signs that were concerning for sepsis when she arrived at Cowra, and continued to have signs, and these signs became more obvious over time as she became unwell. I think every child that you see, there’s a part of you that thinks, well, could this be sepsis, but that part is very small initially, unless there is more and more evidence that gets to the point.... So I don’t consciously document this is not sepsis or this is sepsis every time I assess a child with a fever. So I don’t think - not document - I don’t think it was mandatory to document a risk for sepsis each time that Pippa was assessed”.

417 A/Professor Irwin commented:

“I believe that what was documented is only part of the differential, and what documented tells a fairly credible story, that Doctor Mir had reached the conclusion that the most likely diagnosis here was a self limiting viral respiratory infection and the observation and the examination fit that diagnosis.....Dr Mir may have been able to say my conclusion is that this is most likely a viral lower respiratory infection, I have considered the possibility of sepsis, I have not been able to elicit any signs of sepsis, and so my plan is to refer to the paediatrician at orange for supportive care. And so an explicit recognition of sepsis in the differential would have changed the approach. I also think that it would have challenged Dr Mir to consider some of those features of the history that I don’t think were documented, those things that relate to parental concern, that relate

to a complaint of pain that wasn't really explored through the history or the examination. And then, I also raised, even before seeing the videos, the possibility that the examination that was documented was somewhat discordant from what had been documented previously. The heart rate of 90 just seems to me a little implausible. There's not a single observation that's documented that's similar to that through the 18 or more hours that we're recording Pippa's heart rate. The auscultation findings, they fit the diagnosis that doctor mere had concluded, a lower respiratory infection, but they seem somewhat unlikely, one can't be sure but somewhat unlikely, given the examination findings at 4:00 AM where there's dense consolidation and a significant effusion. And if those findings had been elicited, or indeed the finding of grunting and severe respiratory distress that we saw on the video, Dr Mir's had said, then I think that Dr Mir's assessment and differential diagnosis would have been much less credible”.

418 Professor Butt noted:

“I think, if we go back to the beginning, I think the history is not being presented as the mother presented it. So this child had three days of viral infection with a bit of a cough, and responded to antipyretics and seemed to be OK. She goes to work at night and comes back the next morning, and there's a high fever and the child looks grey. So that's a new, important thing, reflecting poor perfusion. So she goes to sleep, wakes up, and the child still looks grey. And so it's not just fever with an abnormal heart rate, it's also the child looks grey and experienced mother is now very worried...The mother is worried the child is now grey so that hasn't been, to me that struck me in the history.

So that's not about examination or experience, that's just listening to the mother. She then represents 3 times. So she's now got another red flag for worrying about what's wrong with the child. There's new symptoms in the afternoon of difficulty breathing. Forget about how important they are, there's a new symptom. He seeks help, good on him, but there's just been no click. There's no click here that says, this is worrying about the possibility of sepsis. So whatever his examination, he hasn't, I don't think appropriately got the history right in his head, admittedly tainted by lots of people, maybe it's not his- I'm not trying to blame him, I'm just trying to look at the facts - and also just before the child gets in the ambulance, the temperature is now 38.7, get some Panadol. So I think, has he done the right thing and sought help? Absolutely. Of course he has he presented the information?

Well, that's an issue between him and the paediatrician. Perhaps it could have been presented the way I just did, which was actually I believe the truth. Then, maybe the paediatrician might have said, look, just before you go, put in a drip,

take some bloods and give some antibiotics. So the paediatrician may have had a different perspective. So I think that's really important".

419 Dr Morton noted that he had not been aware of Pippa's three presentations, nor that Pippa's mother had expressed her concern about Pippa appearing to be grey in colour, and "that certainly raises my level of concern for this child".

420 The expert witnesses all agreed and recognised the importance of video teleconferencing to assist a clinician to assess a patient and that access in Pippa's case may have led to a different outcome.

Dr Morris' assessment

421 The experts were asked to comment on Dr Morris' initial assessment of Pippa at Orange Hospital.

422 Professor Craig noted that Dr Morris had elicited several symptoms during his:

"fairly detailed and thorough assessment, however, his "interpretation in the whole context of what was going on with Pippa was not the correct interpretation...So I think he got most of the signs and symptoms, but did not put it together in a way that a senior clinician would have".

423 Professor Butt stated:

"No, he got some things wrong. He didn't appreciate that there'd been progression of diseases, the saturation had dropped a little to 92%, heart rate was in the 150 so that's the yellow zone and that was just not appreciated, there had been an increase in the work of breathing. He probably missed signs on that left hemothorax. That effusion didn't happen in 10 minutes, and that the things Simon described very well were signs of sepsis and early toxic shock. So I think he may have done a thorough examination and I think he missed a lot and he didn't appreciate what was going on and I don't understand the discussion with Dr Buckmaster with those things. I wonder why he didn't actually come in and see the patient".

424 A/Professor Irwin opined:

"I agree. I think there were a number of features of serious infection that were documented and unfortunately I think they were anchored in the diagnosis that had already been reached, which was a self-limiting viral infection, and for far too long that anchoring - they were anchored to that diagnosis and they failed to take account of the deterioration and of course signs that challenge that diagnosis".

425 The experts concurred that at this point, Pippa should have been placed on the Paediatric Sepsis Pathway, and an IV inserted and blood tests ordered.

426 The experts considered Dr Morris' treatment plan at 9.30pm, which noted if Pippa's condition did not improve with hydration or she became more unwell, the next step was to be an intravenous cannula and "bloods and consideration of antibiotics".

427 Some of the experts agreed that Pippa should have been placed on antibiotics and her blood taken prior to 1am on 13 June 2022.

428 All the experts agreed that by 1am (and most certainly by 2am) there was a deterioration in her presentation and Dr Morris' treatment plan should have been implemented. Professor Butt commented:

"At 1 o'clock we can all agree there was a deterioration. For the life of me I don't understand why they didn't follow their plan. Where did this salbutamol come from? It wasn't going to be a positive thing. So even at that stage if they had just followed the plan I think we would have had a better outcome. I just don't understand why they didn't".

429 The conclave agreed that at 2.35am, a Rapid Response should have been called by Dr Morris, with Professor Craig noting that "whatever you think the diagnosis is, if your vital signs reach that point when you're in the red zone, then that's a clear indication to call a rapid response team to the bedside," and to notify the paediatrician.

430 The experts further agreed that once Pippa's condition had deteriorated at 2.35am, there was no reason to wait for blood test results before implementing an intervention. A/Professor Irwin stated:

"I think it shows a real misunderstanding, unfortunately, at this time, in these circumstances, the deterioration that was occurring could almost only be attributable to sepsis. There was no value in waiting for blood tests. The intervention should have occurred and it introduced unnecessary delay".

431 Similarly, Professor Craig responded to Dr Morris' explanation in his oral evidence that he wanted to ensure that he was presenting the complete picture to Dr Buckmaster prior to contacting him. He said:

"I think there is a hierarchy in medicine generally and you want to project a complete picture to someone that you're calling who's more senior. But I think in an emergency setting or in a setting where there is, you know, deterioration then notifying the deterioration is more important than waiting for the blood tests".

432 The experts agreed that it was a reasonable hypothesis that the Pippa may have been infected by the invasive Group A Streptococcus that resulted in the development of her symptoms. A/Professor Irwin commented:

“Yes, that’s entirely plausible and certain Group A Strep is one of three likely bacterial pathogens and I agree with the opinion that at that time a number of different jurisdictions in countries were all observing an increase in rates of invasive Group A Strep in this sort of post-pandemic period. There were various hypotheses as to why that might be. I think it’s entirely possible that Group A Strep was the causative pathogen here”.

- 433 Each of the experts was asked and commented on Pippa’s treatment as follows:
- a. A/Professor Irwin stated, “Yeah, I would agree that there seems to be a system failure. There were, there appeared to be a failure of recognition by individual clinicians and probably of communication”.
 - b. Professor Butt indicated, “I believe the death was preventable and that means that the system failed her”.
 - c. A/Professor Braslins noted, “I agree that the death of Pippa was preventable and that reflects a system failure”. Professor Craig agreed.

The evidence of A/Professor Kathryn Carmo

- 434 A/Professor Kathryn Carmo was the Deputy State Director of NETS NSW in June 2022. A/Professor Carmo is a specialist neonatal intensive care physician and specialist in neonatal and paediatric critical care retrieval.
- 435 A/Professor Carmo was notified of Pippa’s death as part of NETS’ policy. She reviewed the team’s case notes and listened to the calls made between the clinicians at Orange and the NETS team.
- 436 A/Professor Carmo prepared a statement dated 12 December 2023 and gave oral evidence in these proceedings on 27 May 2025.
- 437 A/Professor Carmo confirmed that Dr Buckmaster called NETS at 6.10am on 13 June 2022 and spoke with the duty NETS retrieval consultant and Dr Zaidman, the Fellow from the paediatric intensive care unit (**PICU**) at Westmead Children’s Hospital.
- 438 Dr Zaidman asked for an ultrasound of Pippa’s chest to be performed, which showed a solid consolidation of the lung and a large pleural effusion. Dr Zaidman indicated that the pleural effusion needed to be drained quickly and safely.
- 439 A/Professor Carmo confirmed in her statement that the overnight NETS team were due to finish their shift at 7am. The NETS team scheduled to commence their shift at 7am were provided with a briefing to attend Orange Hospital.
- 440 A/Professor Carmo said that prior to 2017, the NETS service was co-located at Westmead with helicopters and fixed wing aircraft. Since 2017, helicopters used by

NETS were relocated to Bankstown airport, and fixed wing craft were relocated to Mascot.

441 A/Professor Carmo noted that there is effectively now only one helicopter available to NETS, noting:

“Changes to the system now mean that NETS is required to telephone NSW Ambulance’s Aircraft Control desk to request use of an aircraft to fly a NETS’ team. NSW Ambulance then determines whether to allocate a helicopter or fixed wing aeroplane, depending on availability, calls the pilot with the request, awaits a response from the pilot and, if the task is accepted, finally telephones NETS back with their plan”.

442 On 13 June 2022, NSW Ambulance advised NETS that a helicopter could not launch due to poor weather and a fixed wing aircraft was available to take off from Sydney Airport in Mascot at 09.00 hours.

443 A/Professor Carmo confirmed that a further NETS call occurred at 8.01am, with Dr Buckmaster indicating to the new duty NETS retrieval consultant, Dr Seigel, that “it was thought that she may have paediatric inflammatory multi-syndrome toxic shock (PIMS TS), which is a complication or consequence of COVID-19,” owing to Pippa’s recent COVID-19 infection. Dr Seigel arranged for Dr Cavazzoni, PICU consultant to join the call. Dr Cavazzoni indicated that the team should drain the pleural effusion after establishing an airway.

444 At 9.50am, the NETS retrieval team landed at Orange airport and arrived at the hospital at 10.20am.

445 A/Professor Carmo detailed the two further NETS telephone calls between Dr Cavazzoni and Dr McGillivray, the NETS consultant retrievalist, and a further call involving all three practitioners.

446 In her oral evidence, A/Professor Carmo confirmed that in 2022, the health system was experiencing a rise in the number of patients presenting with RSV.

447 A/Professor Carmo opined that Pippa was the “first case in a series of cases that we had to deal with over the ensuing 18 months” which appeared to be due to a Group A Streptococcus, or Streptococcus pyogenes infection.

448 A/Professor Carmo noted that:

“Prior to that we’d seen nine cases in five years, and over that 18 month we saw 72 cases, with four more children who unfortunately succumbed to the illness. The five cases that occurred - the 9 cases that occurred in the previous five years was a much more indolent or slower onset, gave more time for clinicians to be able to treat the patient successfully. Whereas the type of

illness that we saw over that. Was a sort of crashing, devastating, catastrophic sepsis scenario that, you know, everyone had to get their wits together and manage really quickly to get ahead of”.

- 449 A/Professor Carmo confirmed that the changed nature of the Group A Streptococcus infections affected the nature and timing of the advice the NETS team were giving to clinicians, noting:

“NETS is often seen as the fulcrum or the sense in the system because we see all the critically ill children coming through our phone line and so we get a sense of what's going on every season...so we often see trends before they're actually a trend. So our advice, particularly for putting in pleural drains, was much more clear going forward than even our intensive care colleagues because we knew we had to get that source control by draining the bug out of the chest to be able to manage the children as best we could”.

- 450 A/Professor Carmo confirmed that blood tests are required to diagnose Group A Streptococcus, together with a chest x-ray. A/Professor Carmo indicated that:

“young doctors are trained to try and be judicious with the use of x-ray and to certainly have good antibiotics stewardship and that they don't give antibiotics to every child who presents with a virus. That creates a lot of tension for young doctors actually”.

- 451 A/Professor Carmo confirmed that with the aggressive nature of the Group A Streptococcus in 2022, it was important to put in a chest drain, despite clinicians raising concerns that that procedure was 'risky', as the risks of not putting it in were much more serious and “we became far more clear that they actually absolutely needed to put it in and they needed to put it in now and we're coming. Yes, we did get a much clearer about our advice”.

The evidence of Mr Adrian Fahy

- 452 Mr Adrian Fahy is the Executive Director, Quality, Clinical Safety and Nursing for WNSWLHD.
- 453 Mr Fahy prepared three statements dated 11 April 2024, 21 May 2025 and 23 May 2025. He also gave oral evidence during these proceedings on 27 May 2025. He confirmed that he was not personally involved in the events surrounding Pippa's treatment at either Cowra or Orange Hospitals.
- 454 Mr Fahy agreed that locum doctors were contracted to work for the WNSWLHD in 2022 (and continue to be), with an expectation that they are available 'on call', both on and off site. He confirmed that Dr Buckmaster provided paediatric services at Orange Hospital, in addition to providing advice across the WNSWLHD.

455 Mr Fahy confirmed that Dr Buckmaster had indicated to Orange Hospital at around 10.45 am on 12 June 2022 that he did not have remote access to the critical care camera network, known as the Critical Care Advisory Service, which allows a remote doctor to review a patient via an over-bed camera.

456 Mr Fahy confirmed his understanding that Dr Buckmaster could access the camera system while he was inside the hospital by accessing the facility's laptop, but not outside the hospital. Essentially, Dr Buckmaster could not access the camera network if he was using his own computer or laptop.

457 Mr Fahy confirmed that the current over bed fixed camera at Cowra Hospital is the same camera and technology which was available in 2022.

458 Mr Fahy confirmed that at times doctors have used their mobile phones to transmit information, however, the LHD "certainly wouldn't advocate that, and there are risks in doing so," including the quality of the transmission and confidentiality.

459 Mr Fahy indicated that efforts have been made to ensure access to the Critical Care camera for locum doctors, which included preparing a:

"checklist, revising it, and ensuring that that access is provided....there's also been updates to the orientation process, and there's a detailed document that has been provided for locum doctors, particularly in paediatrics in this instance so that they understand the access being provided and how to use all of the devices that they would be accessing".

460 Mr Fahy was unable to confirm whether locum doctors are provided with information about local operating procedures, such as the local CERS policy, as he is "not operationally responsible for service delivery".

461 Mr Fahy was questioned as to his understanding of the availability of the Paediatric Sepsis Pathway at the WNSWLHD in 2022. He said that the Paediatric Sepsis Pathway record was a paper-based system in 2022. He was unable to assist with where the Paediatric Sepsis Pathway paperwork was physically located at Cowra Hospital in June 2022, however he speculated that it may have been in the staff station area, which was quite a small area in the ED.

462 In June 2022, the Australian Commission on Safety and Quality in Health Care, published the "Sepsis Clinical Care Standard" policy, to assist local LHDs to develop policy guidelines relating to sepsis.

463 Mr Fahy confirmed that there didn't appear to be any reference to the pathway in the clinical notes at Cowra or Orange until 4am on 13 June 2022. He commented:

"it is, indeed, quite remarkable that sepsis training had been really quite prevalent across NSW health for a number of years. I was concerned to see

that sepsis had not been referred to and, indeed, sepsis pathway hadn't been utilised and we undertook to try and understand what needed to occur so that we could give more prominence to the sepsis pathway and, indeed, the sepsis training that relates to the pathway, and also that's at a local level, and then at a system level as well. Though there were a number of activities that were undertaken at a local level and then, indeed, at a systems level which I've made comment of in my statement and I've annexed some relevant documents that relate to those as well".

464 Mr Fahy agreed that the first Sepsis Identification and Management Procedure published by the WNSWLHD was dated, or endorsed, in May 2023. He confirmed that it is a document that sought to centralise all relevant guidelines from the Australian and NSW guidelines, including the Clinical Excellence Commission (CEC).

465 Mr Fahy agreed that the 2023 Sepsis Identification Management Plan was designed to encourage clinicians to approach sepsis management, not only where there has been a confirmed diagnosis of sepsis, but also where it is being considered in terms of a differential diagnosis. He stated:

"It actually step through all of the different actions you should take as a clinician to rule out possible sepsis or, indeed, if you have sepsis by a blood test, a lactate or a C-reactive protein, it steps out the processes you should take in resuscitating and treating that patient".

466 Mr Fahy indicated that prior to June 2022, there were education programs at the LHD which alerted clinicians to the sepsis pathway. He confirmed that the adult and paediatric sepsis training was not mandatory at the time but now is.

467 In addition, the LHD has undertaken:

"some auditing through a system call QARS to consider patients who are treated with sepsis and did they have the pathway included, and that gives us some values that are monitored at that site and service level. I think it's making obvious that no matter what level of skill that you are, you need to undertake sepsis training...we've tried not to make it too onerous. For example, the SEPSIS KILLS training, we've mandated that, that you redo that every five years, so we've tried not to make it too onerous. Yet we've been quite explicit in that we need you, when you're working in these clinical areas, to have undertaken that training as a minimum standard".

468 He indicated that the auditing system considers the notes on discharge of a patient "to check that there was a pathway included in the clinical record and the treatment

had occurred as per the pathway,” and the audit considers ten sepsis cases every six months at a minimum.

469 The audit results also reflect the proportion of cases where a lactate measurement was obtained, which is an important diagnostic indicator in identifying and confirming the presence of an infection.

470 Mr Fahy conceded that the audits do not necessarily confirm that the sepsis pathway is being used as intended by the LHD. In addition, he agreed that between January to May 2024, the audit suggested that fewer clinicians were utilising the pathway. He was asked how those numbers could be improved and responded:

“we’ve drawn out for health service managers, facility directors of nursing and others, their accountability. What I think needs to happen is that there needs to be a much stronger emphasis at a site and a service level so that it's seen that this is something that we're constantly looking at, observing, providing feedback around, and indeed, where needed, having some difficult conversations around why wasn't a pathway included in that particular case note file, for example”.

471 Mr Fahy confirmed that clinical notes are recorded using an electronic medical record (**eMR**) system, however the sepsis pathway document does not form part of that record. The sepsis pathway document is still in a paper form and once completed, is scanned into the electronic record.

472 Mr Fahy stated that he was unaware that the Sydney Children's Hospital Network (**SCHN**) had developed a system where an alert is activated when a clinician enters information into the eMR which indicates that sepsis may be developing or is a potential diagnosis. Mr Fahy noted that

*“Certainly we’re moving towards replacing the electronic medical record with a record called single digital patient record (**SDPR**) which will have an electronic tool in it. That’s still being worked up at the moment”.*

473 Mr Fahy confirmed that a new paediatric observation chart was to be released across the LHD in June 2025, which would include a question directed to parental concerns relating to their child, specifically, “Do you feel that your child is improving or deteriorating?” If the response indicates a parent is concerned about their child deteriorating, that response will trigger an additional yellow zone criteria.

474 Mr Fahy accepted that in Pippa’s case, despite having several yellow and red zone readings no immediate clinical review or CERS response was called. He stated that that was not consistent with LHD policy in place at the time.

475 He further confirmed that in June 2022, a single yellow zone observation should have resulted in a clinical review within 30 minutes and a single red zone observation should have resulted in a rapid response being called.

476 He also agreed that a rapid response criteria (red zone) is met if the “patient’s clinical observation falls in the “RED Zone” on the NSW Health General Observation Charts (as above) or if a clinical review has not been responded to in the 30 minute timeframe, or clinical staff/family or carers express serious concern”.

477 Mr Fahy also agreed that it was “very clear” from the CERS protocol that “The Paediatric Registrar and Consultant – are to be called after hours (1600-0800) to come in and attend any paediatric or neonatal rapid response”.

478 Mr Fahy confirmed that no rapid response was called prior to, nor when a single red zone reading was recorded for Pippa at 2.35am.

479 Mr Fahy responded to RN Sadler’s expressed reticence to contact a senior doctor on the morning of 13 June 2022, even when she thought it may be warranted, by stating that RN Sadler could have activated the red button alarm or called the paediatrician directly. He continued, stating that the LHD has undertaken assertiveness training where nursing staff perceive there is some type of power differential:

“I tell them that they need to be incredibly clear in seeing a yellow zone or seeing a red zone observation and being quite clear that they are escalating for a rapid response, they're escalating for a clinical review, documenting that in the clinical record, and taking the necessary steps to do so”.

480 Mr Fahy confirmed that acronym REACH, “refers to a system that enables patients, carers, families to raise their concerns about a worrying change in condition while in hospital”.

481 The letter ‘C’ in the acronym refers to “Call: provide patients and families with an independent avenue to call for a rapid response if still concerned and other avenues are exhausted”. Mr Fahy said that a parent’s concern can be the basis for a clinical review and ultimately a rapid response.

482 Mr Fahy stated that if a REACH call was placed regarding a Cowra Hospital doctor, the call:

“goes outside to our virtual care services and it’s responded to initially by the nurse educator and often the – either the intensive care specialist or emergency specialist that’s on-call and so they’re the ones that talk to the family; hear their concern and then reference that concern back to the treating clinician on the ground. At Orange, the call goes to a campus nurse manager and the campus nurse manager then attends the department and has the conversation with the

family and then considers the resourcing issues and the concerns. So it operates differently at both of those two facilities”.

- 483 Mr Fahy was asked whether any consideration had been given to permitting parents or carers to upload photographs or videos through the REACH protocol to allow families to better articulate their concerns. He indicated, “Look, not particularly at this point. But I wouldn’t say anything isn’t a consideration when we’re considering quality care of a patient”. He then indicated that it may be in breach of NSW Health policy.
- 484 REACH is now known as “Raise It”. “Raise It” was designed “in collaboration with key stakeholders, including families who have experienced the worst possible outcomes and have advocated to strengthen NSW Health’s patient, family and carer escalation processes”. The NSW Health site acknowledges Pippa’s family “for their advocacy and courage in the face of their tragic losses”.
- 485 Mr Fahy indicated that he was aware of concerns raised in Pippa’s case that the clinicians had become anchored to a working diagnosis of a viral illness to the exclusion of other possible diagnoses. Mr Fahy confirmed that the LHD had “developed a set of tools around cognitive bias,” including a fact sheet addressing issues associated with cognitive bias. He further indicated that they had promoted the “Take 2 – think, Do” resource, which encourages clinicians to take “several minutes to think: Has the diagnosis that I’ve arrived at, is that the only logical diagnosis? Are there other things that I should rule out? Are there other things that I should do”.
- 486 Mr Fahy was asked about the issue of workplace fatigue. He said that he had become aware that Dr Morris had worked about 25 hours straight by the conclusion of his shift. He accepted that “that’s a risk and a tenable risk in my mind”. He confirmed that staff changes were made after Pippa’s death where two clinicians are now rostered for two 12 hour alternating shifts, meaning that one clinician was rostered for the day shift and one for the night shift, rather than a clinician working a shift and then being ‘on call’ for the next shift.
- 487 Mr Fahy was asked about his understanding of the issue of surge capacity at Cowra Hospital. He clarified that there are several NSW Health codes, including code black and code yellow. Mr Fahy explained:

“So, code yellow also does apply, which is a major internal emergency situation. Code black is when the resources of the organisation are working outside of their operational scope, or there’s some other type of major emergency or the facility needs to be placed into lockdown. So, either of those for unprecedented clinical activity or the facility going into a code black situation both require that the health service manager and the nurse manager were called.... they’re called in the out

of hours and they'd make a determination around additional resources that may be required or if the facility is able to remain open or needs to go in ambulance bypass, etcetera. And if they're in a situation where they feel the facility isn't coping effectively, they can log a call to a number called the HSFAC, the Health Service Functional Area Coordinator, for emergency or for disaster essentially, and that person can actually provide further advice around how they should move forward in that particular instance”.

488 Mr Fahy indicated that he had made enquiries regarding 12 June 2022 and was advised that an additional nurse (an AIN) was provided to assist with the paediatric cardiac patient, and that no other staff were deployed that day to assist with the additional patients waiting in the Cowra Hospital ED.

489 Mr Fahy was questioned about Pippa's allocated triage scale 3 (ATS 3) at 2.06pm on 12 June 2022, which required an assessment within 30 minutes. The following exchange took place:

Q. In a situation of a health service such as Cowra, I triaging patients it knows it cannot meet that demand, it knows it cannot see the patients according to how quickly they're supposed to be seen? What's the escalation process, how is that supposed to be dealt with?

A. So, that would fit in the code yellow activation, which has been in operation for some years now, and that's major internal clinical acuity, and it would mean that there'd be some type of determination made that there are a number of critical cases that are still waiting to be seen that haven't been seen within the agreed ATS timeframe. And so that would be indicative of needing additional resources, more people, more doctors, more nurses to actually physically see patients.

Q. Are you saying that is already spelled out in policy that the inability of the health service to meet the triage times of all the allocated for patients should result in somebody raising a code yellow alert in the pathways you've described?

A. Not exactly, I'm sorry if I wasn't clear there. If you're getting a cluster of a number of people who have high urgency categories who aren't able to be seen based on volume and complexity, then that should trigger a call rather than a singular case.

Q. When you say, “high urgency”, are we talking about triage category one or two?

A. Yeah, ATS 1, 2, 3, in my mind, is what I'm making reference to.

490 Mr Fahy then confirmed that Cowra Hospital is undergoing renovations which will expand the facility from a three-bed hospital with a mental health examination room to a facility which is double the size. However, even after the renovations have been completed, Cowra Hospital will not be able to admit paediatric patients.

Determination of factual disputes

Hindsight and grunting

491 Legal representatives for numerous parties have urged the Court to exercise caution when assessing evidence retrospectively. It is acknowledged that during these proceedings the Court has had the benefit of accessing and assessing evidence that was not available to clinicians at the time of their involvement in Pippa's treatment, such as complete medical records, videos, photographs, text messages and the opinions of eight highly qualified experts.

492 The benefit of hindsight permits an investigation, such as an inquest, to fully explore, analyse and review the circumstances associated with the death of a person.

493 In that context, each of the clinician's conduct should be considered and analysed in terms of what they knew and appreciated, as well as what they ought to have known or discovered.

494 I have considered the circumstances of Pippa's presentation, the expertise and training of the relevant clinicians and the wave of Group-A Streptococcus infections.

495 An analysis of Pippa's care and treatment at both Cowra and Orange Hospitals is informed by the primary source material contained in Annah's videos, photographs, texts messages and social media posts. They represent real time concerns and Pippa's deterioration over several hours.

496 A significant matter that arose during the inquest and in written submissions on behalf of some parties, focused on the issue of Pippa's grunting, observed in at least four videos. Those videos also elicited other obvious and concerning symptoms which were observed and addressed by the conclave of experts.

497 Similarly, the experts commented in both conclaves that Annah was clearly concerned and alert to Pippa's deterioration over several hours.

498 Without this objective evidence, it is likely that Annah's assertions would have been disputed, discounted and denied.

499 The videos were provided to the Officer in Charge (**OIC**) of the investigation in 2022. The OIC produced the videos to Armidale Local Court. These videos were later identified as "sensitive" material and were not provided with the brief of evidence. During the first tranche of the inquest, the legal representatives for the family indicated that they would seek to play four videos. Those videos were played during

the first tranche and after the experts had provided their initial reports. Dr Morris, Dr Buckmaster, Dr Mir, RN Potter-Bancroft and RN Sadler were shown the videos while giving oral evidence and were asked to comment on their contents without having previously viewed the videos. Similarly, the experts were first shown the videos during their initial conclave.

- 500 Each of the experts immediately identified the sounds Pippa was making in the four videos as “grunting”.
- 501 The experts considered the contents of the videos to be very significant and that “sort of breathing in that manner is often thought to be related to potentially pneumonia and other chest infection and possibly sepsis and just becoming more unwell due to an infection”. The experts noted that “It can be louder and softer at different times” and may not have been appreciated by junior doctors.
- 502 The experts noted that in addition to the grunting sound, Pippa appeared very unwell. A/Professor Irwin noted that the “video at 5.14 which also revealed Pippa was flushed, which is another somewhat subtle but a discriminatory finding that indicates bacterial infection” and that she had “serious bacterial infection plus or minus sepsis”.
- 503 Professor Craig agreed that the sound of grunting may be less obvious in a busy ED, however, during a one-on-one assessment “it can probably be picked up by the doctor facing the patient”. Professor Craig made the very telling comment that “it’s sort of a visible as well as audible thing going on”.
- 504 Of note, even when the videos were played to the various clinicians involved in Pippa’s treatment at Cowra and Orange Hospitals, they either could not identify the grunting sounds or described the sounds in different terms.
- 505 The content of the videos highlights the benefits of videoconferencing, particularly if it had been available at the time of the call between Dr Mir and Dr Buckmaster.

The finding that can be made is that the “grunting” sounds identified in the videos were present at the time of Pippa’s presentations at Cowra and Orange Hospitals albeit possibly louder and softer at different times.

Findings on key issues

Issue 1(a) - Was Pippa appropriately triaged?

- 506 In their joint expert report, the experts considered that either an ATS category 2 or an ATS category 3 rating would have been appropriate.
- 507 They agreed that an ATS 2 rating would require Pippa to be assessed within 10 minutes and that an ATS 3 rating would require an assessment within 30 minutes.
- 508 The practicalities and challenges confronted by Cowra Hospital on 12 June 2022 meant that neither time frame for an assessment would have been achieved due to the arrival of another critically ill child.
- 509 The experts opined that the allocation of a ATS 2 rating would have emphasised and recognised that Pippa was a seriously ill child as well, and that this may have changed the whole trajectory of her treatment.

The following findings can be made:

- (i) An ATS 2 rating would have been an appropriate triage category; and**
- (ii) The triage category had no impact on the outcome given competing patient loads.**

Issue 1(b): Did Pippa have clinical signs and symptoms indicative of sepsis at the time of her admission to the emergency department at Cowra Hospital?

- 510 Pippa presented to Cowra Hospital with a 4-day history of high temperature, a runny nose and a moist cough, lethargy, reduced oral intake and urine output and diarrhoea. Those symptoms were consistent with sepsis but likewise were consistent with other common childhood illnesses.
- 511 Significantly, Pippa also had a high heart rate attracting a red zone observation, signs of a secondary deterioration and a high level of parental concern.
- 512 Leaving to one side whether Pippa was grunting, Pippa had symptoms which were indicative of sepsis at the time of her presentation to Cowra Hospital.

The following finding can be made:

- (i) Pippa had clinical signs and symptoms of sepsis at the time of her admission to the emergency department at Cowra Hospital.**

Issue 1(c): Was the sepsis pathway followed? If not, should it have been, and how would this have affected the care provided to Pippa?

- 513 All the experts “emphatically” agreed that Pippa met the criteria for initiation of the Paediatric Sepsis Pathway which ought to have triggered a senior clinician review per the pathway after her presentation to Cowra Hospital.
- 514 The basis of the expert conclusions was due to Pippa displaying a single red zone observation, being her heart rate of 171 bpm at triage.
- 515 Although Pippa met the criteria for inclusion on the Pathway, this did not mean that she had a diagnosis of sepsis. It is recognised that the Pathway is a screening tool which seeks to identify all children who may have sepsis, to ensure that they are assessed and treated (if necessary) promptly.
- 516 The experts agreed that a senior clinician should have assessed Pippa within either 10 or 30 minutes (depending on the ATS rating) but did not all agree that blood tests and imaging should have been obtained at that time.
- 517 The experts agreed that even though a senior clinician was unlikely to be available within that time frame, the activation of the Pathway would have flagged the possibility that Pippa had sepsis, possibly encouraging consideration of a differential diagnosis and mitigating against diagnostic anchoring. A/Professor Braslins opined that Dr Mir was not a “senior clinician from my perspective” and concluded that Pippa should have been transferred to a facility that was staffed with paediatric clinicians.
- 518 The experts agreed that if blood tests had been ordered while Pippa was at Cowra Hospital, or alternatively when she arrived at Orange Hospital, they would have indicated abnormalities suggesting a serious bacterial infection or sepsis.
- 519 A separate consideration related to whether a Rapid Response should have been initiated in accordance with the relevant CERS policy due to Pippa’s red zone observation recorded at triage.
- 520 RN Potter-Bancroft indicated that Cowra ED did not have a separate rapid response team, given that the same staff that were already performing triage or care and treatment would constitute the team. In any event, RN Potter-Bancroft was not of the opinion that Pippa required a Rapid Response on 12 June 2022.

The following findings can be made:

- (i) RN Potter-Bancroft should have initiated the Paediatric Sepsis Pathway at the time of Pippa's triage;**
- (ii) Due to the presence of a red zone observation, the Paediatric Sepsis Pathway required a Rapid Response to be called and an initiation of treatment within 60 minutes;**
- (iii) A Rapid Response was also required in accordance with CERS policy;**
- (iv) It is unlikely that a faster response could have been achieved, due to the other paediatric emergency; and**
- (v) Had the Pathway been initiated, there would have been evidence of a documented consideration of sepsis at an early stage, which had the potential to affect the course of Pippa's treatment, at both Cowra and Orange Hospitals.**

Issue 1(d): Was Pippa reviewed in an appropriate timeframe? If not, what were the reasons for the delay?

- 521 Following RN Potter-Bancroft's triage at 2.06pm, Pippa was not seen by any other clinician or nurse until Dr Mir commenced his assessment at about 5.30pm.
- 522 RN Potter-Bancroft agreed that a second set of observations should have been taken within 15 minutes of the first set of observations at 2.06pm, however she was "extremely busy".
- 523 Cowra Hospital medical records contain an entry made by RN Potter-Bancroft at 2.48pm, which states "2mg Ondansetron". In her statement, RN Potter-Bancroft said, "This medication was administered during triage however was not documented until 1448 as I was very busy trying to get everyone waiting triaged prior to the Category 1 arriving".
- 524 RN Potter-Bancroft's statement indicated that she explained to Annah that they were expecting an emergency presentation shortly, which would delay the doctor assessing Pippa. RN Potter-Bancroft stated:

"Pippa's mum asked me if she could wait at home with Pippa instead of in a full waiting room as she only lived a couple of houses away and would bring her back once the doctor was available. I agreed and said that that would be okay. I took down Pippa's mother's phone number and placed it into the comments section on FirstNet with a note saying call mum. I informed her mum that if there were any concerns or she thought Pippa was getting worse to please bring her back to ED sooner and notify staff".

- 525 Annah recalled being told by RN Potter-Bancroft to go home at about 2.45pm as there was going to be a long delay. Annah recalled asking, “Should we go somewhere else” and being told, “No, just go home and we will call when we can see her”. Annah returned home with Pippa until about 3.30pm, following which she re-presented to the hospital due to her concerns that Pippa was very unwell. Annah recalled being told by the nurse at the ED door that Pippa “wasn’t that bad” and “to go home”.
- 526 Relevantly, Annah sent text messages confirming that she had been told to go home at this time. At about 4.40pm, Annah recalled that a doctor and nurse came into the waiting room, stating “Please go home if your medical needs can wait, it’s going to be a long wait”.
- 527 Dr Mir stated that during this time he was looking at the waiting room via a CCTV monitor and could see Pippa sitting on Annah’s lap. He was of the view that Pippa was not well.
- 528 At about 5.15pm, Dr Mir went to the waiting room and informed those waiting that they were treating a very unwell child and that there would be a delay in treating patients. He recalled speaking to Annah and indicating that he would see Pippa as soon as he was free.
- 529 At 6.20pm, Pippa was assessed by Dr Mir.
- 530 There is an obvious factual dispute between the recollections of Annah and RN Potter-Bancroft. A resolution of those disputed facts is not directly determinative of the issue of the appropriate timeframe for Pippa’s review given the delay occasioned by the need to treat another critical patient.

The following findings can be made:

- (i) According to the expert evidence, it would have been appropriate to allocate Pippa an ATS 2 rating, requiring her to be clinically reviewed within 10 minutes. Even if her case attracted an ATS 3 rating, a review was required to be undertaken within 30 minutes.**
- (ii) The three-hour delay which occurred was not an appropriate timeframe for a patient who required a review to occur within 10 minutes.**
- (iii) The reason for the delay stemmed from the arrival of a critically ill patient, who was treated by Dr Mir. There was no other doctor available at Cowra Hospital.**

Issue 1(e): Was Dr Mir's assessment adequate? Did he undertake appropriate investigations?

- 531 Dr Mir began his assessment of Pippa at 5.30pm and completed his progress note about one hour later after speaking with Dr Buckmaster.
- 532 He reviewed the earlier triage notes and took a history from Annah. He was aware from the triage notes that Pippa's peripheral pulse rate was recorded at 171 bpm just after 2pm, which he accepted was abnormal.
- 533 At the time of his review, Pippa's heart rate was 89 bpm, her oxygen saturation was 92% on room air (yellow zone), she had a respiratory rate of 22, was in mild respiratory distress and her blood pressure was 108/62. Dr Mir recorded Pippa's heart rate and oxygen saturations in his notes, with the other observations being recorded by nurse "April".
- 534 Dr Mir indicated that he performed a capillary refill test which he recalled was normal, although he did not record that result in his notes. He further recalled that Pippa was not pale, nor did she have mottled skin. He denied she had a rash.
- 535 He recalled that Pippa had a slightly increased work of breathing. He accepted that this was concerning. He confirmed that he listened to Pippa's chest with a stethoscope and heard diffuse bilateral crepitations.
- 536 Dr Mir's impression was that Pippa had an acute viral illness. He perceived she was dehydrated, which was secondary to her experiencing vomiting and diarrhoea.
- 537 He opined that the change in Pippa's heart rate from 171 to 90 bpm was consistent with his impression that she was dehydrated due to her earlier vomiting and diarrhoea, and he understood that she had been given an ice block which she had tolerated whilst in the waiting room.
- 538 Dr Mir indicated that he had considered "things like pneumonia, sepsis, appendicitis, even urinary tract infections". He did not think that Pippa met the criteria for the Paediatric Sepsis Pathway and decided to keep her under observation and seek a second opinion from Dr Buckmaster. He accepted that Pippa was displaying at least two yellow zone observations, including low oxygen saturation and a high level of parental concern.
- 539 He accepted that a patient with possible sepsis should have repeat observations to ascertain if a pattern was emerging and it was not satisfactory that there was a delay in obtaining these.
- 540 Dr Mir contacted Dr Buckmaster through the vCare service at around 6.10pm as he had formed the view that Pippa was too unwell to be sent home and could not be admitted to Cowra Hospital.

- 541 At the time of the call, Dr Mir recalled that he asked a staff member to turn on the overbed camera at Cowra Hospital which was equipped with a microphone. As it happens, Dr Buckmaster was having dinner in town (Orange) and was unable to gain access to the Critical Care Advisory Service, which would have provided him with access to the Critical Care Overbed Network. This would have allowed him access to the patient overbed camera, as well as the ability to view patient medical records. Access by Dr Buckmaster to real time video of Pippa at this time may have provided him with a crucial diagnostic consideration regarding Pippa's grunting, which will be discussed below.
- 542 Dr Mir stated that he provided an iSoBAR handover to Dr Buckmaster, including details of Pippa's previous high heart rate.
- 543 Dr Mir recalled that Dr Buckmaster informed him that a cannula should be inserted if there was a spike in Pippa's temperature so that intravenous hydration and blood testing could be performed and antibiotics administered.
- 544 Dr Buckmaster and Dr Mir agreed that their impression was that Pippa had a viral illness, that they should "encourage oral hydration" and that Pippa should be admitted to Orange Hospital within a 3-hour timeframe. The travel time by road between the two centres was estimated to be just over one hour.
- 545 After the phone consultation with Dr Buckmaster, Dr Mir requested that the nursing staff arrange for Pippa to be transported by ambulance to Orange. Dr Mir also asked that the nursing staff inform him if Pippa's observations deteriorated.
- 546 Dr Mir did not see Pippa after this consultation and was unaware that prior to her transportation to Orange Hospital her temperature had risen to 38 degrees and her heart rate had increased to 169 bpm at 7.20pm, as measured by the attending paramedics.
- 547 A/Professor Irwin stated:

"If Dr Mir had concluded that Pippa had probable or likely sepsis, he ought to have initiated a bundle of care, including antibiotics and intravenous fluids. If on the other hand he made an assessment as he appears to have done that this was a self-limiting viral infection, transfer to a paediatric ward may have been appropriate. That's at the core of whether or not Pippa received appropriate care. I felt that what was being documented appeared consistent with a viral lower respiratory tract infection. But the videos are striking, and in the context of the red flags (re-presentation, unexplained pain), sepsis ought to have been suspected...it's obvious that people anchored to Dr Mir's diagnosis and held onto the diagnosis of viral lower respiratory tract infection, but I don't know that Dr Mir can be held responsible for that".

548 Professor Curtis opined that:

“Pippa is clearly a septic child. There were enough signs that sepsis should have been considered. One has to conclude therefore that the assessment was inadequate. I was also going to raise the incongruent HR and the auscultatory findings not fitting with the later x-ray. It’s clear that sepsis was not considered”.

549 A/Professor Irwin continued, stating that:

“I thought the documented heart rate of 90 seemed incongruous and discordant with the other observations, and I wondered whether that was erroneously measured. Secondly, the clinical assessment of the auscultation of the chest which found bilateral crackles, given the later assessment of unilateral signs on the ultrasound and Dr Buckmaster’s examination, I wondered whether that clinical assessment was erroneous”.

550 In his oral evidence, A/Professor Irwin commented that:

“The heart rate of 90 just seems to me a little implausible. There’s not a single observation that’s documented that’s similar to that through the 18 or more hours that we’re recording Pippa’s heart rate. The auscultation findings, they fit the diagnosis that Dr Mir had concluded, a lower respiratory infection, but they seem somewhat unlikely, one can’t be sure but somewhat unlikely, given the examination findings at 4.00am where there’s dense consolidation and a significant effusion. And if those findings had been elicited, or indeed the finding of grunting and severe respiratory distress that we saw on the video, Dr Mir’s had said, then I think that Dr Mir’s assessment and differential diagnosis would have been much less credible”.

551 Professor Craig considered that Dr Mir’s assessment was adequate and that he had contacted the senior paediatrician for advice and had formulated an appropriate plan for Pippa’s transfer to Orange. Professor Craig indicated that in his view, it was not required of Dr Mir to document his consideration of sepsis at this time. However, Professor Craig continued:

“The striking thing about the videos is the grunting...The grunting had been appreciated, there definitely should have been an IV. Should the grunting have been appreciated is the crux of it. Junior doctors don’t get everything right. The videos are striking. Pippa was pretty sick”.

552 Professor Butt opined:

“Dr Mir made many mistakes. He was the most senior clinician there and tries to do his best, but he is clearly not a senior clinician and lacking senior support. I believe his approach impacted the perception of Pippa’s severity of illness at Orange Hospital.... Dr Mir did ring and speak to a paediatrician, so he did seek

some advice. More questions could have been asked of him by that person. But at the end of the day, he performed to his level and wasn't able to get advice to help him".

553 Dr Morton perceived that Dr Mir's assessment was adequate. He commented that if Pippa's grunting had been present (and accepting Professor Craig's impression that it was probable that it was present most of the time), then it would have been appropriate to notice and comment on it to Dr Buckmaster.

554 A/Professor Raftos perceived that Dr Mir's assessment was reasonably thorough and he had made appropriate contact with Dr Buckmaster. He did raise concerns that given Pippa's initial high heart rate, low saturations and bilateral crepitations, he should have considered the possibility of bacterial infection and commenced investigations and treatment according to the Paediatric Sepsis Pathway.

555 A/Professor Starr commented that:

"The very first video does not show a child who is septic. The second one is more concerning. If the timing is correct, the second video is around the time Dr Mir assessed the child. That child is sleeping though, and the only thing to say is that it's not a static thing. The child might not have been grunting when Dr Mir assessed her. I can't say that Dr Mir's assessment was inappropriate. He seems to have taken an adequate history and examined the child and he says this could be a viral illness. What he's gone on to do is speak to a paediatrician, and that was appropriate too. I agree in part with what Prof Craig said, but we can't assume that what is seen in the video is what Dr Mir saw".

556 All experts were very clear and concise in their appreciation of the grunting sounds that they elicited from the two videos time stamped 2.19pm and 5.14pm. There was no prevarication.

557 During his sworn evidence, Dr Mir listened to the two video recordings taped by Annah. He indicated that he had not heard Pippa making a similar sound at the time he assessed her.

558 Dr Mir had not had an opportunity prior to giving evidence on 2 July 2024 to hear either recording due to the circumstance set out above. He was the only witness of the six clinicians to accept without hesitation that the sound depicted on the recording was consistent with grunting.

559 On his behalf, it has been submitted that not hearing the grunting noise is not evidence that it was present nor that it was missed as:

- a. Grunting is not static, it can be intermittent, softer and louder at different times;

- b. Grunting is a rarity in normal medical training, and it is not something you see a lot;
- c. Whether the grunting was present the whole time Pippa was at Cowra was something Professor Craig could not comment upon;
- d. The video recording depicts that it was recorded on a phone, with Annah videoing very close to Pippa, with her either sitting on her lap and the phone close to Pippa's face;
- e. The noise of an ED might have made it difficult to hear the grunt; and
- f. Dr Mir, together with other witnesses of fact, did not hear it.

The following findings can be made:

- (i) Dr Mir's assessment was not adequate, given the issues surrounding incongruous heart rate of 90 and the auscultation findings. In addition, the experts' comments that the videos depict a child that "is clearly a septic child";**
- (ii) In addition, he ought to have been able to identify Pippa's grunt, which on balance was present during his interview, some 16 minutes later than the second video recording, taking the abovementioned factors into account; and**
- (iii) Dr Mir should have specifically documented his consideration of sepsis.**

Issue 2(a): Was it reasonable in the circumstances to transfer Pippa to Orange Hospital? Would it have been appropriate and practicable to treat Pippa at Cowra Hospital instead? Did Cowra Hospital's emergency department have the resources and capacity to treat Pippa?

- 560 After Dr Mir's assessment of Pippa at 5.30pm, no further observations were undertaken prior to the arrival of the ambulance that had been organised to transport Pippa and Annah to Orange Hospital.
- 561 The ambulance arrived at 7.18pm and Pippa's observations were taken by the paramedics at 7.20 pm and 7.55pm. Pippa's readings included a temperature of 38 degrees, which was slightly elevated but still within normal parameters, a heart rate of 169, placing her in the yellow zone and an oxygen saturation of 92% which placed her in a second yellow zone. The paramedics administered Panadol to treat her temperature, which was administered at 7.35pm, prior to transportation.
- 562 The two yellow zone observations should have mandated a review of Pippa by a senior clinician under the Paediatric Sepsis Pathway. There is no evidence that Dr Mir was contacted and made aware of the two yellow zone observations, nor that the paramedics had administered the Panadol.

- 563 Dr Mir indicated that had he been advised that Pippa had become tachycardic or had a temperature, he would have taken bloods, started fluids and called Dr Buckmaster.
- 564 The evidence does not indicate why the change in observations made by the paramedics was not brought to Dr Mir's attention. This evidence represents a missed opportunity to identify that Pippa's condition had deteriorated and to commence treatment at Cowra Hospital.
- 565 The ambulance left Cowra Hospital at 7.55pm and arrived at Orange Hospital at 8.55pm which comfortably fit within the three hour medically agreed timeframe.
- 566 All experts agreed that it was reasonable to transfer Pippa to Orange Hospital and that she met the criteria for transfer under the relevant policy.
- 567 The relevant policy for an interfacility transfer permits such transfers when the treatment that the patient requires cannot be provided or is beyond the capacity of the transferring hospital. In addition, it is permitted when a child requires ongoing inpatient management and there is no appropriate inpatient care at the transferring hospital, or the child cannot be cared for in a paediatric safe bed.
- 568 It was apparent that Cowra Hospital did not have the capacity to admit children.

The following findings can be made:

(i) it was reasonable to transfer Pippa to Orange Hospital; and

(ii) It was not appropriate or practicable to treat Pippa at Cowra Hospital, which did not have the capacity nor the resources to do so.

Issue 2(b): Was Pippa transferred to Orange Hospital in a timely manner?

- 569 During the phone conversation between Dr Mir and Dr Buckmaster it was agreed that Pippa should be transferred to Orange within a medically agreed timeframe of 3 hours. Pippa's transfer did not commence for about 6 hours after her initial presentation.
- 570 A/Professor Braslins commented that consideration should have been given to "bypassing" a hospital if it does not have the capacity to review a patient in a timely manner. He accepted that transferring an undifferentiated patient carried the risk that the patient may deteriorate without access to medical support.
- 571 Professor Craig stated that while systems ought to be in place for a hospital bypass, doing this in an ad hoc fashion is risky, however this does not prevent patients from simply turning up at another hospital.

- 572 Dr Morton indicated that there is a risk associated with bypassing and the need to assess the patient's condition prior to doing so. He did not think that Annah should have been directed to another hospital at the outset.
- 573 A/Professor Raftos opined that if Cowra was unable to treat Pippa in a timely manner, she should have been sent elsewhere. He acknowledged that this carried a risk, however, he perceived that doing nothing also carried a risk.
- 574 The WNSWLHD had a process in place for obtaining additional resources where a hospital's capacity to respond to patients' needs is challenged. According to Mr Fahy, this process has been enhanced since Pippa's death.

The finding that can be made is that Pippa was transferred to Orange in an appropriate timeframe in the circumstances.

Issue 2(c): Was adequate information conveyed between the two hospitals?

- 575 Cowra and Orange Hospitals are within the WNSWLHD and share the same electronic record system. Dr Morris was able to access the earlier notes made at Cowra Hospital by medical staff, including Dr Mir's clinical notes.
- 576 Dr Morris stated that he had not seen the ambulance triage notes, although they were accessed shortly before his first assessment of Pippa. He suggested that they may have been printed and placed with other documentation in a basket at the end of Pippa's bed. NSW Ambulance is not a party to these proceedings, so no recommendation can be made regarding the issue of electronic clinical note sharing between NSW Ambulance and LHDs.
- 577 The issue of videoconferencing was referred to above, including the advantages of such a resource.

The following findings can be made:

- (i) adequate information was conveyed between the two hospitals; and**
- (ii) The transfer of information would have been enhanced by the availability of effective videoconferencing.**

Issue 3(a): Was Pippa appropriately triaged at Orange Hospital?

- 578 Pippa arrived at Orange Hospital at 8.55pm and was triaged by RN Mason Reyes at 8.58pm. He recorded a heart rate of 161 and oxygen saturations of 93%, both being in the yellow observation zone. RN Reyes allocated Pippa an ATS 4 score, which required her to be seen within 60 minutes.
- 579 Pippa was placed in a bed where she could be closely observed in the ED.

580 Professor Craig indicated that an ATS 3 or 4 score would have been reasonable, however given that Pippa was seen promptly by Dr Morris, the decision had no real consequence. There was some disagreement between the experts regarding the appropriate triage scale, although all agreed that it would not have made a difference given that she was seen by Dr Morris within 15 or 20 minutes.

The findings that can be made are:

(i) ATS 3 or 4 would have been reasonable; and

(ii) Pippa's triage category did not make a difference to the care she received.

Issue 3(b): Was the sepsis pathway followed at Orange Hospital? If not, should it have been, and how would this have affected the care provided to Pippa?

581 Dr Morris reviewed Pippa at around 9.15pm. He reviewed the electronic medical records, including Dr Mir's earlier assessment. He took a history from Annah and noted that Pippa looked miserable and upset. He denied that she looked "floppy."

582 He noted that Pippa had two abnormal observations, being an elevated heart rate of 152 bpm (yellow zone) and a low oxygen saturation of 92% (yellow zone). She also had some work of breathing. He performed a capillary refill test, which at 3-3.5 seconds, was borderline normal to abnormal. He stated that he had listened to Pippa's chest and heard bilateral crackles. He denied that he had not auscultated Pippa's chest. Dr Morris concluded that Pippa had a viral illness.

583 Dr Morris appeared initially reluctant to accept that Annah was exhibiting significant parental concern, although eventually conceded that she was concerned that that this constituted a further yellow zone observation.

584 According to the Paediatric Sepsis Pathway, Pippa's three yellow zone observations recorded by Dr Morris required a review by a senior clinician within 30 minutes and that blood be obtained for testing.

585 The experts generally agreed that the Paediatric Sepsis Pathway should have been implemented, although A/Professor Starr did not consider that blood tests were necessary at that time.

586 Professor Craig indicated that Dr Morris' decision not to follow the pathway resulted in a diagnostic anchoring to the conclusion that Pippa was suffering from a respiratory virus, rather than a consideration of the possibility that she had sepsis.

The following findings can be made:

(i) the Paediatric Sepsis Pathway was not followed and (ii) Pippa's three yellow zone observations should have resulted in a review by the senior clinician within 30 minutes and blood tests.

Issue 3(c): Was Dr Morris's assessment adequate?

- 587 Dr Morris appeared to have obtained a detailed history and conducted a thorough examination. He prepared a detailed progress note and communicated his findings to Dr Buckmaster.
- 588 Dr Morris was shown the two videos of Pippa recorded at 1.46pm and 5.14pm. In response to the first recording, he said that he could hear her making a “grunting sound in association with her breathing”. In relation to the second recording, he said that “that’s an abnormal sound. That’s less of a typical grunt, but yes, I think you could probably use that term. Yes”. Dr Morris said that he did not detect any similar sounds when he assessed Pippa at 9.15pm and indicated that he first recalled hearing her making a grunting sound at 2.40am the following morning.
- 589 Professor Craig concluded that Dr Morris made a thorough and detailed assessment and elicited most signs and symptoms correctly. He did not, however, identify the grunting sounds, which on balance were present. He concluded that Dr Morris did not appreciate the significance of the grunting, as well as the fine blanching rash and poor capillary refill.
- 590 Professor Butt stated that Dr Morris failed to appreciate the progression of Pippa’s disease, her reduction in oxygen saturation, her raised heart rate and her increased work of breathing. He further concluded that it was likely that Pippa had a developing pleural effusion at the time of his review, which was missed.
- 591 A/Professor Irwin considered that Dr Morris’ assessment was detailed but agreed that the features of serious infection were missed, which he attributed to “diagnostic anchoring”.
- 592 A/Professor Braslins and Professor Curtis both perceived that significant signs were missed during the review.
- 593 A/Professor Raftos considered that Dr Morris’ assessment was thorough, but inadequate conclusions were made.
- 594 Conversely, A/Professor Starr indicated that Dr Morris’ assessment was “very good” and that he performed a thorough examination. A/Professor Starr stated that Dr Morris’ impression of a viral illness was consistent with Pippa’s presentation at that time and the management plan was appropriate in the circumstances.

The following findings can be made:

(i) Dr Morris performed a thorough examination and assessment;

(ii) Dr Morris missed the significance of Pippa's grunting which, on balance, was present at the time of his review; and

(iii) This resulted in incomplete information being given to Dr Buckmaster, which anchored the diagnostic thinking of both doctors to a viral illness and the development of the management plan.

Issues 3(d) and (e): Why was no blood test or X-ray undertaken initially? Should this have occurred? Was the initial management plan appropriate, in light of information known at the time?

595 The initial management plan reflected the impression that both Dr Morris and Dr Buckmaster shared – that Pippa was suffering from a viral illness. In that context, the decision to hydrate Pippa for a period and then re-assess her could be considered reasonable.

596 The serious shortcomings associated with the management plan included not activating the Paediatric Sepsis Pathway given the yellow zone observations, the likelihood of Pippa grunting and the progression of her symptoms.

597 The experts generally agreed that Pippa ought to have had a senior clinician review and blood should have been taken for testing at the time of her admission to Orange Hospital in accordance with the Pathway. Activating the CERS protocol would have led to a similar result.

598 The experts that gave oral evidence agreed that Dr Buckmaster should have attended the hospital and examined Pippa given her symptoms at that time.

599 Professor Butt commented, "She had lung disease shown by grunting, and she was dehydrated. If you're thinking her tachycardia was partially a result of dehydration, then I wouldn't be filling that stomach up with liquid, I'd be running it through an IV."

600 Professor Craig stated that it would have been "very reasonable" to obtain blood tests at this time and the failure to order them as Pippa deteriorated became more unreasonable.

601 The experts agreed that had blood tests been ordered at this time, they would have indicated abnormalities consistent with a serious bacterial infection or sepsis.

602 There was no consensus between the experts regarding the need for imaging or the commencement of antibiotics at that time.

The following findings can be made:

(i) the initial management plan was reasonable, but only as it related to the shared impression that Pippa had a viral illness;

(ii) The initial management plan was not appropriate given Pippa's yellow zone observations and the “grunting”; and

(iii) The three yellow zone observations, together with Pippa's other symptoms, should have resulted in a clinical review by Dr Buckmaster and blood testing.

Issue 3(f): Why was rehydration delayed?

- 603 Pippa’s rehydration did not commence until 11.30pm, a delay of about 90 minutes. This was despite the importance of rehydration to the management plan agreed to by Dr Morris and Dr Buckmaster.
- 604 The documentary evidence tendered in these proceedings provided an explanation for the delay.
- 605 Pippa remained in the ED for about 1.5 hours after her assessment.
- 606 RN Hill observed that Pippa’s oxygen saturation levels had fallen to 91% after Dr Morris’ review. RN Hill contacted Dr Morris, who suggested that she should sit Pippa up to see if her levels improved. Pippa did not improve and RN Hill again contacted Dr Morris enquiring whether she should start Pippa on oxygen, to which Dr Morris agreed. Oxygen was commenced via nasal prongs at a rate of 0.5L/min at 9.55pm. Pippa’s oxygen saturation improved to 95%.
- 607 Dr Morris also requested RN Hill insert a nasogastric tube. RN Hill attempted to introduce the NGT at 10.35pm, however, Pippa could not tolerate it and brought up mucus and vomitus. RN Hill again contacted Dr Morris who prescribed Ondansetron.
- 608 At 10.42pm, Dr Morris altered the calling criteria in relation to Pippa’s oxygen saturation. Generally, a “normal” calling criteria would have been above 95%, with yellow zone criteria between 90 and 95%. Dr Morris reduced Pippa’s calling criteria to reflect a normal reading above 92% with a yellow zone above 88%. Observations taken at this time, showed Pippa had an elevated heart rate of 157, being in the yellow zone.
- 609 A bed became available for Pippa in the paediatric ward at around this time. Usually, a patient would not be transferred from the ED to a ward if the patient’s observations were not stable. RN Hill contacted Dr Morris. Dr Morris indicated that he believed Pippa needed rehydration on the ward. RN Hill then contacted RN Sadler on the

ward who agreed to accept Pippa's transfer. Pippa was transferred at around 11pm and her rehydration commenced at 11.30pm.

The finding that can be made is that rehydration was delayed due to the time taken to transfer Pippa to the paediatric ward.

Issue 3(g): Should a clinical escalation have occurred (A) when Pippa began to show signs of respiratory distress (B) when a red zone heart rate was recorded; and/or (C) when blood test results were first returned?

- 610 RN Sadler was the nurse-in-charge of the paediatric ward. She had over 45 years' experience as a nurse, including as a paediatric nurse.
- 611 RN Sadler had been given a handover by RN Hill and understood that rehydration had not commenced, but that an NGT was in situ.
- 612 At 11.21pm, RN Sadler took Pippa's observations, noting that she had an elevated heart rate of 157 bpm, an oxygen saturation of 95% and mild work of breathing, with a note stating, "use of accessory muscles". RN Sadler increased Pippa's oxygen to 1.0L/min via nasal prongs.
- 613 Dr Morris reviewed Pippa in the ward at around midnight. He was not called to attend but wanted to see how Pippa was progressing. RN Sadler recalled speaking with Dr Morris at around this time.
- 614 No observations were recorded during this review, although Dr Morris recalled that Pippa's heart rate was in the "low 150s" when she was settled and that her work of breathing was mild-to-moderate.
- 615 Dr Morris indicated that he was "very strongly guided" by RN Sadler's experience. RN Sadler noted that Pippa had just commenced rehydration and she wanted to see how Pippa responded.
- 616 Dr Morris had read Pippa's medical records for an earlier admission to Canowindra Hospital in relation to a viral induced wheeze and considered it appropriate to administer Ventolin if her mild-to-moderate WOB continued. He charted that medication at 11.30pm.
- 617 In his review progress note, Dr Morris considered that the management plan, including rehydration, should be continued. This would appear to be at odds with the management plan devised with Dr Buckmaster, which stated that if Pippa's condition did not improve, Dr Morris should escalate her care back to Dr Buckmaster.
- 618 Dr Morris indicated that he did not escalate the matter at this time, as it was not a detailed review, Pippa was asleep and her rehydration had only just started.

- 619 Dr Buckmaster had an expectation that Dr Morris would contact him if Pippa's presentation did not improve. Dr Buckmaster did not have an expectation that the delay in commencing rehydration should have been brought to his attention. He also did not think it unreasonable for Dr Morris to administer Ventolin without reference to him, although it represented a change in the management plan.
- 620 At 1am, RN Sadler increased Pippa's oxygen to 1.5L/min as her oxygen saturation had fallen to 92%. Her note stated that Pippa was "unsettled [with] increased WOB" and had a "tracheal tug, [with] use of accessory muscles."
- 621 Although Pippa's condition was deteriorating, RN Sadler did not increase the frequency of observations. The next set of observations were recorded at 2.35am.
- 622 Dr Buckmaster indicated in his evidence that if he had been contacted at this time, he would have taken blood and commenced antibiotics.
- 623 Ventolin was administered at 1.15am and 1.35am. At 2.10am, RN Sadler noted that Pippa had started "grunting" and had an abdominal distention. She called Dr Morris who was dealing with two patients in ED and attended at 2.40pm.
- 624 Annah recorded two videos with time stamps 2.19am and 2.25am. These videos show Pippa in bed with an audible breathing sound and some movement in the muscles in her neck.
- 625 At 2.35am, RN Sadler took Pippa's observations. Pippa had a heart rate of 196 bpm, placing her in the red zone, a respiration rate of 34 and her oxygen saturation had fallen again to 90%, placing her in the yellow zone. RN Sadler again increased Pippa's oxygen to 2.0L/min. RN Sadler recorded a note stating, "tracheal tug, use of accessory muscles". RN Sadler called Dr Morris again.
- 626 At 2.40am, Dr Morris attended the ward and assessed Pippa. He noted that her appearance had clearly changed. Her heart rate was high and her oxygen saturation levels were between 86 and 90%. She was "grunting" and had abdominal breathing and intercostal recession. He used a stethoscope to listen to her chest and noted that her breathing had changed, with sharper breathing sounds evident on the right side and duller sounds on the left.
- 627 Dr Morris was shown the two videos taken at 2.19am and 2.25am and agreed that they depicted Pippa's breathing when he conducted his review at 2.40am.
- 628 Dr Morris did not contact Dr Buckmaster. He accepted in retrospect that he should have. He indicated that he believed that a senior doctor would require blood test results and he arranged for blood to be taken.
- 629 Dr Buckmaster indicated that both the red zone heart rate of 196 bpm and signs that Pippa was "grunting" were both very significant developments. He stated that he

had an expectation that Pippa's care would be escalated to him promptly. He agreed that the video timed 2.25am showed Pippa "grunting". He confirmed that if he had been called at 2.40am he would have commenced antibiotics.

- 630 Dr Morris accepted that the red zone heart rate at 2.40am suggested that Pippa was in septic shock. He indicated that at that time his diagnosis was sepsis, although he did not document that, nor did he contact Dr Buckmaster about this most significant development.
- 631 Dr Morris accepted that the red zone heart rate required a Rapid Response to be called in line with the CERS policy. He agreed that he did not believe that RN Sadler had called him to attend as part of a Rapid Response.
- 632 Dr Morris could not explain why he failed to call a Rapid Response at this time.
- 633 Dr Morris did not agree that RN Sadler had suggested calling a Rapid Response, because if she had, he would have "wholeheartedly agreed".
- 634 RN Sadler could not explain why she did not initiate a Rapid Response. She could not recall pointing to the "emergency button" and indicating if Dr Morris did not call a Rapid Response, she would, as contended by Annah.
- 635 RN Sadler's oral evidence was peppered with poor recall, inconsistencies and improbabilities. Her evidence was not reliable.
- 636 The factual dispute regarding the "emergency button" is difficult to resolve on the evidence, however, given the inadequacy of RN Sadler's evidence, it is more likely than not that Annah's version is accurate, however a positive finding in that regard cannot be made.
- 637 Dr Morris arranged for blood to be taken from Pippa. Emla cream was applied to Pippa's hand and she was taken to a procedure room at 3.10am. Dr Morris attempted to introduce a cannula but could not advance it into a vein. A small amount of blood was extracted; however, it later coagulated and was unsuitable for testing. Dr Morris was advised that the first sample was unsuitable at 3.50am and a further sample was obtained at 4.01am.
- 638 The blood results became available at 4.15am and showed a high lactate level of 4.4, which was a marker of serious infection. The results also showed a low white cell count of 2.8 and a CRP of 258.
- 639 At 3.59am, a further set of observations was taken by RN Sadler, showing Pippa's heart rate at 191bpm, with an elevated respiration rate and an oxygen saturation of 90%.

640 A/Professor Braslins stated:

“At 9.30pm there was a plan to escalate if Pippa deteriorated, and at 12.15am there was a plan to escalate if Pippa deteriorated. At 0100 hours, she deteriorated and the plan wasn’t followed. The plan would have led to taking blood which would have led to diagnosis of serious bacterial infection and initiation of antibiotics”.

641 The experts agreed that Pippa’s condition had clearly deteriorated by 1am, with Pippa appearing “unsettled with increased work of breathing and a rapid heart rate”.

642 Pippa had not improved since the commencement of rehydration at 11.30pm. In addition, RN Sadler had resorted to increasing Pippa’s oxygen more than once, to maintain saturation with her increased work of breathing.

643 Professor Butt was concerned that the clinicians failed to follow the management plan, which required the administration of fluids, blood tests and consideration of antibiotics if Pippa did not improve. He noted that if Pippa did not improve, her case should have been escalated back to Dr Buckmaster.

644 The experts agreed that at 2.35-2.40am a Rapid Response should have been initiated given Pippa’s high heart rate of 196 bpm, being a red zone reading. They agreed that Dr Buckmaster should have been contacted, that he should have attended in person and that IV fluids and antibiotics should have been commenced. Such a decision would have been consistent with the Paediatric Sepsis Pathway and the CERS protocol developed by the WNSWLHD.

645 Dr Morris’ decision not to call a Rapid Response was a significant error and policy breach. Calling a Rapid Response would have ensured that several senior critical care clinicians attended on Pippa and developed a plan for her urgent treatment.

646 The experts all agreed that administering stacked Ventolin was not reasonable or appropriate. It was noted that there was no “evidence of hyperinflation, expiratory wheeze, or airflow obstruction”. In addition, it diverted from the agreed management plan and again highlighted that Dr Morris was anchored to the original diagnosis of a viral illness.

The following findings can be made:

(i) At 1am, when Pippa had failed to improve with rehydration and was showing signs of deterioration, Dr Buckmaster should have been contacted, blood tests should have been ordered, and antibiotics should have been administered.

Those steps were consistent with the plan which had been formulated earlier between Dr Buckmaster and Dr Morris;

(ii) The plan to administer Ventolin was neither reasonable nor appropriate given Pippa's symptoms and the agreed plan;

(iii) At 2.35am, Pippa's condition required a Rapid Response, regardless of the diagnosis or the agreed plan;

(iv) Either Dr Morris or RN Sadler should have called a Rapid Response; and

(v) It was not appropriate to delay calling Dr Buckmaster while waiting for the blood test results. It is accepted that Dr Morris was attempting to be diligent, however his decision showed a misunderstanding of the seriousness of Pippa's condition and significantly contributed to her need for an urgent intervention.

Issue 3(h): Was there an adequate, appropriate and timely escalation of care, after the working diagnosis of sepsis was made at about 4.15am on 13 June 2022?

647 Dr Morris contacted Dr Buckmaster at around 4.15am when he received the blood test results. This was the first discussion to take place between the two doctors since their earlier conversation at around 9.45-10pm the evening before, some six hours earlier.

648 Dr Morris told Dr Buckmaster that he was critically concerned that Pippa may have sepsis, or be in septic shock, due to her lactate result. He also provided Dr Buckmaster with Pippa's observations and the CRP result. They discussed a plan which included providing empirical antibiotics, disconnecting the NGT, administering a fluid bolus, increasing her oxygen to 14L, organising a chest x-ray, as well as repeating blood tests in one hour.

649 Dr Morris noted the plan in the medical records and recorded for the first time, "Now considering Pippa as being unwell with sepsis."

650 Dr Buckmaster recalled asking Dr Morris if he would like him to come into the hospital and Dr Morris responding that he had a "clear plan."

651 Dr Buckmaster conceded that he should have attended the hospital at this time. He stated however, that the management plan would have been the same.

- 652 Antibiotics were commenced at 4.42am and oxygen was increased to 14L at 4.55am. A further lactate test was obtained at 5.32am, which returned an elevated reading of 3.8.
- 653 A chest x-ray was performed at 5am. Dr Morris had been previously advised not to rely on the small image on the radiographer's machine and to wait for the formal image before acting. The formal image became available at 5.30am. It showed a "complete opacification left hemithorax" with a "possible mass effect suspicious for a large left pleural effusion."
- 654 Dr Morris immediately called Dr Buckmaster and advised that the x-ray showed pneumonia and a probable effusion. Dr Buckmaster advised him to add a further antibiotic, further fluids and to commence oxygen via High Flow Nasal Prongs. He indicated that he would attend hospital. Dr Buckmaster arrived at about 5.45am.
- 655 There was delay in the escalation of Pippa's care, occasioned by the need to seek advice from NETS as the hospital did not have the resources readily available to respond to Pippa's needs. Had a Rapid Response been called earlier, it is likely that NETS would have responded earlier.
- 656 Professors Butt and Craig considered that even at 6.30am, when the seriousness of Pippa's condition was recognised, organised and timely treatment could have saved her life.

The following findings can be made:

- (i) the actions taken by staff to escalate Pippa's care were appropriate; and**
- (ii) the lapse of over 4 hours between Dr Buckmaster's attendance and Pippa's admission to the ICU did not represent a timely escalation of care.**

Issues 4(a), (b), (c) and (d): Was it appropriate to seek NETS medical retrieval of Pippa in the circumstances? Was an appropriately skilled and qualified NETS team assembled? Did NETS attend Orange Hospital as soon as reasonably practicable? Was adequate care provided by NETS during efforts to resuscitate Pippa?

- 657 NETS is the state-wide service for clinical advice, triage and retrieval of newborns, infants and children. It is a state-wide service of NSW Health, managed for the last 10 years by the Sydney Children's Hospital Network. The service provides 24/7 telephone advice to doctors (and in cases where there is no doctor, to nurses) where the needs of the patient exceed the skills, facilities and capabilities of the local hospital.
- 658 Dr Buckmaster contacted NETS at 6.10am. Dr Zaidman told Dr Buckmaster to arrange an ultrasound of Pippa's lungs. The ultrasound was performed during the call which confirmed that Pippa had dense consolidations in her left lung. Dr

Zaidman advised Dr Buckmaster that Pippa needed the effusion drained as soon as possible. Dr Buckmaster indicated that he did not have the skillset to perform the drain and went to enquire with his colleagues if they could do so.

659 When provided with the ultrasound results, Dr Zaidman recognised that a NETS retrieval team needed to be deployed and that the hospital may not have a clinician with the appropriate level of skill to insert a chest drain.

660 Pippa's transfer was allocated a priority 1 (**P1**) category, which is the most urgent clinical triage category and requires the immediate dispatch of a retrieval team by air.

661 The process for arranging either a helicopter or a fixed wing aircraft to attend an emergency required the nurse co-ordinator to contact NSW Ambulance aeromedical desk to request a P1 retrieval team. NSW Ambulance conveyed this information to the aviation team who performed a risk assessment of the available resources and identified the fastest and safest method of transportation. The risk assessment concluded that a helicopter could not launch due to adverse weather conditions and a fixed wing aircraft was arranged for 9am, which was the earliest available flight.

662 A second phone call was made by Dr Buckmaster to the duty NETS retrieval consultation, Dr Seigel at 8.01am. Dr Buckmaster said that he thought that Pippa may have paediatric inflammatory multi-syndrome toxic shock, which is a complication or consequence of COVID-19.

663 Dr Buckmaster advised Dr Seigel that there was an emergency medical specialist at Orange Hospital who was prepared to drain Pippa's lung. Dr Cavazzoni joined the phone call and agreed with the plan to intubate, ventilate and gain a central line access in theatre. The doctors agreed that the pleural effusion could be drained after establishing an airway.

664 The NETS team departed Sydney airport at 9.20am and arrived at Orange Hospital at 10.40am.

665 At 11.08am, Dr Angela McGillivray contacted her NETS colleague, Dr Cavazzoni, regarding hypotension and cardiovascular support immediately post intubation and high ventilation requirements.

666 Two further calls were made by Dr McGillivray to Dr Cavazzoni after Pippa's first and second cardiac arrests.

667 Dr Andrew Berry prepared a statement for these proceedings dated 6 December 2024. He was not required to give oral evidence during the inquest.

668 Dr Berry's statement was prepared in response to criticisms raised by Professor Butt. The first criticism was raised in Professor Butt's supplementary statement dated 23 June 2024, where he said:

"The advice (from NETS provided to the treating team prior to the arrival of the retrieval team) included drainage of the effusion, the need for vascular access, fluid resuscitation, possible inotropes/vasoconstrictors and respiratory support. All appropriate but with a lack of emphasis about the need for rapid treatment and likely ongoing deterioration of Pippa. Dr Zaidman who provided advice stated the possibility of admission to Westmead to a normal ward and not PICU reflecting the "attitude" of the advice".

669 In his Further Supplementary Report dated 23 September 2024, Professor Butt said:

"Pippa had what we call in Victoria 'go now' criteria...namely pneumonia with effusion, progressive deterioration in clinical state and an elevated blood lactate. Pippa needed intubation, vascular access and drainage of effusion. These were urgent – that is done now. The entire language and actions used do not reflect a do it now attitude. The fact that transfer to ICU took 3 hours and the effusion had not been drained, that NETS waited to leave etc are all part of that "attitude" which to me has all the correct words but not an emphasis of severe urgency".

670 Dr Berry indicated that "there is no suggestion by hospital staff that NETS did not adequately convey its recommended treatment for Pippa. There is also no suggestion from Hospital staff that once NETS was involved, the Hospital did not appreciate Pippa's critical condition". Dr Berry also noted that:

"Dr Zaidman's comment regarding Pippa's potential bed allocation is not Dr Zaidman expressing a view about Pippa's acuity. Rather, the transcript captures an internal discussion about the 2 possible pathways available for Pippa at the Children's Hospital Westmead (CHW) being ICU or a bed on the ward."

671 Dr Berry also noted that Pippa was triaged as a P1 priority, which is the highest priority. It meant that the NETS team left as soon as possible, which is similar to the Victorian Go Now criteria.

The findings that can be made are:

(i) it was appropriate to seek a medical retrieval of Pippa in the circumstances;

(ii) the NETS team were appropriately skilled and qualified.

**(iii) the NETS team attended Orange Hospital as soon as reasonably practicable;
and**

(iv) NETS provided adequate advice and care.

Proposed Recommendations

- 672 At the conclusion of the evidence, Counsel Assisting proposed four recommendations be directed to the Chief Executive of the WNSWLHD, as follows:
- a. Consider amendment of policy WN_PD2020_004 “vCare – Referral of Children and Adolescents for Specialist Care and/or Transfer” to require that:
 - ii. prior to transport, a patient’s observations should be taken, and
 - iii. any deterioration in the patient’s condition should be brought to the attention of both the referring clinician and receiving clinician.
 - b. Consider the introduction of a practice where, whenever a child’s observations are taken, the child’s parent or carer must be asked “Are you concerned your child is getting worse?”, and where a positive response will lead to a clinical review.
 - c. Consider whether alternative technologies, including mobile phones, could be used by a specialist to review a patient remotely by video, and, if considered appropriate, develop guidelines for their use.
 - d. Develop training for junior doctors working in emergency departments or paediatric wards, based on the facts of Pippa’s death, and incorporating the videos of Pippa that were taken at Cowra and Orange Hospitals.

Proposed Recommendation 1

- 673 The evidence confirmed that Pippa’s observations deteriorated after Dr Mir’s review and prior to her being transported by ambulance to Orange Hospital. These observations were not relayed to Dr Mir, and according to Dr Morris, he was not advised of this development.
- 674 This was a significant matter which should have been brought to the attention of Dr Mir so that he could have reviewed Pippa observations prior to transport. This information should also have been brought to the attention of Dr Buckmaster. It may well have affected Dr Buckmaster’s impression of the seriousness of Pippa’s illness.
- 675 A review of the policy which governs the transfer of children between hospitals does not require any obligation to re-check a patient’s observations prior to transportation, nor to escalate care in the event of a deterioration. Given the real likelihood that there could be a significant lapse of time prior to transportation, the recommendation has merit.
- 676 Dr Mir and Pippa’s family have submitted that the recommendation should be amended by requiring medical staff to ask parents if they have recorded video of the

patient's condition and whether they consent to it being viewed by others. This amendment is not supported by the LHD.

677 The LHD supports the original recommendation and contends that the issue of enquiring about video footage is case-specific and unnecessary. A separate concern was raised that the use of mobile phone videos may not be as reliable as other forms of technology, and that these would be preferred where available.

678 The second submission is not accepted, and this is a case in point. The obligation to require staff to make the request in each case is probably not necessary.

Proposed Recommendation 2

679 The second recommendation is no longer sought by counsel assisting as the proposal has been overtaken by events, specifically the incorporation of the question, "Are you worried your child is getting worse" into the SPOC on 29 July 2025.

680 The WNSWLHD confirmed that:

"a positive answer to that question constitutes a yellow zone observation. Further, the WNSWLHD has updated both PD2021_003: Recognition and Management of Deteriorating Patients and PD2021_017: ED Minimum Vital Sign Observations to reflect the incorporation of the family/carer concern proactive escalation tool: annexed and marked A and B respectively. Finally, the WNSWLHD has developed implementation audits for the use of the family/carer concern proactive escalation tool, with these audits having been added to the 2026 routine clinical audit schedule."

Proposed Recommendation 3

681 This recommendation is not supported by the WNSWLHD due to the clinical risks associated with mobile phones and other technology.

682 In 2025, the Health Direct Video Call platform was rolled out in NSW. The platform can be used on mobile phones and there is no prohibition to do so. The WNSWLHD however discourages the use of mobile phones for video, particularly due to concerns about data and/or video quality, as well as patient confidentiality, and expresses a preference for the existing vCare network of bedside cameras.

683 Dr Buckmaster appeared to be unaware of the orientation manual for paediatricians which states that the on-call paediatrician should carry a laptop when they are outside the hospital to ensure access to medical technology.

684 There does not appear to be any current policy which provides guidance to practitioners on the circumstances where mobile phone videos may be appropriate,

or conversely, warning them about the specific dangers associated with the use of that technology.

- 685 The mobile phone videos of Pippa were highly relevant to the assessment of her condition, particularly by the expert panel. Although it is accepted that there may be risks associated with the use of mobile phones, and a preference for other technologies, it is imperative that medical staff are provided with guidance on the topic.

Proposed Recommendation 4

- 686 This recommendation is supported by the WNSWLHD, although it is submitted by the LHD that the videos of Pippa should be provided to the Clinical Excellence Commission with the consent of Pippa's family.
- 687 If Pippa's family are forthcoming with their consent, it is proposed that the Clinical Excellence Committee should be advised of the recommendation and invited to provide a response.

Recommendation proposed by Pippa's family

- 688 The family have sought to have RN Potter-Bancroft, RN Mason Reyes and RN Alicia Stephens referred to their professional association or employer for counselling. I have formed the view, for differing reasons that such referrals should not be made.

Conclusions

- 689 Pippa was a very unwell child at the time of her presentation to Cowra Hospital on 12 June 2022. At the initial triage, RN Potter-Bancroft should have considered the Paediatric Sepsis Pathway given Pippa's high heart rate. An appropriate course of management would have resulted if RN Potter-Bancroft had followed that pathway.
- 690 A request for additional clinicians during 12 June 2022 resulted in AIN Williams assisting with Pippa's triage, however, she then assisted the other critically unwell patient rather than ED patients. It is unclear whether a further additional staffing request was made or not. The evidence suggests that the Cowra Hospital ED was significantly understaffed on the afternoon of 12 June 2022.
- 691 RN Potter-Bancroft said that if she had decided to call a Rapid Response due to Pippa's raised heart rate just after 2pm, there would be no additional staff to assist Dr Mir and the nursing staff. Pippa should also have been observed at regular intervals or alternatively should have been transported to another hospital with capacity at an earlier time.
- 692 The experts generally agreed that Dr Mir's assessment notes were appropriate, although A/Professor Irwin raised concerns regarding Pippa's documented heart rate of 90 which "seemed incongruous and discordant with the other observations, and I wondered if it was erroneously measured. Secondly, the clinical assessment of the auscultation of the chest which found bilateral crackles, given the later assessment of unilateral signs on the ultrasound and Dr Buckmaster's examination, I wondered whether that clinical assessment was erroneous".
- 693 Dr Mir gave oral evidence that he used a stethoscope during his assessment of Pippa, whilst Annah refuted this claim.
- 694 The experts reviewed the video recorded at 5.15pm which was taken in close proximity to Dr Mir's assessment. The experts noted that the "grunting is clear" and that Pippa looked "toxic" and appeared "flushed". They also noted that these "signs ought to have been given greater weight" and "that sepsis should have been considered".
- 695 Dr Mir did contact Dr Buckmaster which was appropriate. The fact that Dr Buckmaster was unable to access the overhead camera at Cowra Hospital due to IT issues was a lost opportunity.
- 696 Pippa's heart rate increased again into the red zone while waiting to be transported to Orange Hospital, resulting in the paramedics administering Panadol. This red zone reading does not appear to have been relayed to Dr Mir and Dr Morris stated that he did not read the NSW Ambulance notes which were printed at Orange Hospital just prior to his assessment of Pippa.

- 697 The experts agreed that Dr Morris documented a detailed assessment but “there were omissions and probably errors”. The experts generally agreed that he should have placed Pippa on the Paediatric Sepsis Pathway given the yellow zone readings. Some of the experts believed blood tests should have been initiated at that time, while others considered that further observation and rehydration was appropriate.
- 698 The experts did express concern regarding the videos depicting Pippa “grunting” and that this appeared to have been missed by Dr Morris. The experts also agreed that Dr Morris appeared to be anchored to the diagnosis of a viral infection as discussed with Dr Buckmaster and did not consider a differential diagnosis (including the possibility of sepsis) until Pippa’s significant deterioration at 2.40am on 13 June 2022.
- 699 The experts agreed that at that time Dr Morris should have called a Rapid Response and antibiotics should have been administered. The experts were critical of Dr Morris for his failure to accept at an earlier time that Pippa’s condition was not improving which should have prompted a review of the management plan agreed to earlier with Dr Buckmaster.
- 700 The experts were also critical of Dr Buckmaster’s failure to attend the hospital when he was contacted by Dr Morris at 4.15am, rather than waiting until after Dr Morris’ second call. Indeed, some of the experts expressed a view that Dr Buckmaster should have attended the hospital after Dr Morris’ first call to him at around 9.45pm on 12 June 2022.
- 701 The experts were critical of the failure to drain the pleural effusion at Orange Hospital as recommended by the NETS clinicians.
- 702 It should be noted that Dr Morris was a junior doctor who worked a near 26-hour shift, which is clearly unacceptable and cannot be condoned. The WNSWLHD has now changed its rostering system to lessen the likelihood that this will occur in the future.
- 703 The WNSWLHD maintained through Mr Fahy that the Paediatric Sepsis Pathway was known to staff at Cowra and Orange Hospitals in June 2022. The evidence in this inquest suggests otherwise.
- 704 It is accepted that the nature and aggressiveness of the likely Group-A Streptococcus infection was not known at the time of Pippa’s presentation, however it appears that protocols were ignored and/or not followed at both hospitals. The evidence suggests that there were significant errors relating to Pippa’s care and treatment at both hospitals.
- 705 Pippa’s death was wholly preventable.

Family reflections

- 706 Pippa's parents, Annah and Brock speak of a child who was unique, loving and very much loved. Annah recalled that:

"We were blessed to spend so many special memories with Pip. She loved dancing, reading books, yoga, playing with dolls, going on holidays, arts, crafts, painting nails, going to Ma and Poppy's farm to feed the animals and eating way too many ice-creams".

- 707 Annah continued, stating:

"One of Brock's favourite daily traditions with Pip was when she would run up to him, hold his head and give him a kiss on each cheek and forehead. All Pip ever knew in her life was love and happiness. Pip fitted so perfectly into our family and our home. We never once took it for granted. I can vividly remember pinching myself daily that this was our family and our life".

- 708 Both Annah and Brock talked of the enormous loss and grief that persists each day. Annah told the inquest that:

"We are shells of our former selves and spend our days constantly triggered and anxious. Every small bit of happiness we experience is now overshadowed by a sadness that our Pippa isn't here to live them with us".

- 709 Brock said:

"No more kisses on the cheek or cuddles. We as a family had lost part of us. A daughter, a sister, a granddaughter, a friend, and a sparkle from the air. With every bit of happiness we try to have with our babies, it is also great sadness, as we are missing Pippa. I took up drinking first thing in the morning to numb the pain, finishing bottles. Nothing helped. So, I went back to playing rugby league and union, so I could hurt somebody and get hurt. As the feeling of emotions I couldn't understand, the pain which I was feeling – a hidden pain inside – I needed to be hurt physically. I also had to show my kids that there was a positive way to deal with emotions through sport".

- 710 Annah commented, "Pip fought hard, she fought hard for her own life, trying to save herself. She fought so hard that her little heart just couldn't take it any longer.

- 711 Pippa's parents have advocated for change through this process, and some important changes have already been implemented, such as the Raise It campaign. Further changes are proposed in terms of training, education and other recommendations.

- 712 Her family held themselves with great dignity and grace during these proceedings, despite the extraordinary circumstances that consumed them all.

Closing Observations

- 713 Before turning to the findings that I am required to make, I would like to acknowledge my gratitude to Mr Jake Harris, counsel assisting and Ms Leanne Kohler, Principal Solicitor for their support, commitment and their extraordinary preparation of such a complex matter.
- 714 I would also like to acknowledge and thank the Officer in Charge of this investigation, Detective Senior Constable Mark Harris for his thorough investigation and his commitment to Pippa's family.
- 715 Finally, I would like to again record my most sincere condolences to Pippa's family.

Findings

I make the following findings pursuant to section 81(1) of the *Coroners Act 2009* (NSW):

The identity of the deceased

The person who died was Pippa Mae White.

Date of Death

Pippa died on 13 June 2022.

Place of Death

Pippa died at Orange Health Service in Orange, NSW, 2800.

Cause of death

The cause of Pippa's death was sepsis, caused by an aggressive bacterial infection on a background of Group-A Streptococcus infection.

Manner of Death

Pippa died after several clinicians failed to recognise the seriousness of her condition. By the time it was recognised, Pippa was gravely unwell and she did not then receive the organised, timely and urgent care that she required.

Recommendations

I make the following recommendations pursuant to section 82 of the *Coroners Act 2009* (NSW).

To the Chief Executive, Western New South Wales Local Health District

1. Consider amending policy WN_PD2020_004 “vCare – Referral of Children and Adolescents for Specialist Care and/or Transfer” to require that:
 - a. Prior to transport, a patient’s observations should be taken, and
 - b. Any deterioration in the patient's condition should be brought to the attention of both the referring clinician and receiving clinician.
2. Consider whether alternative technologies, including mobile phones, could be used by a specialist to review a patient remotely by video, and, if considered appropriate, develop guidelines for their use.
3. Develop training for junior doctors working in emergency departments or paediatric wards, based on the facts of Pippa’s death, incorporating the videos of Pippa that were taken at Cowra and Orange Hospitals.

I now close this inquest

A handwritten signature in black ink, appearing to read 'Joan Baptie', with a long horizontal stroke extending to the right.

Judge Joan Baptie
Deputy State Coroner
29 September 2026