RCEM
Royal College of Emergency Medicine

Patron: HRH Princess Royal
Octavia House,
54 Ayres Street,
London, SE1 1EU

Tel: +44 (0)20 7404 1999
Fax: +44 (0)20 7067 1267
www.rcem.ac.uk

Coroner ME Hassell

Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

02 May 2025

Dear M. E Hassell.

Firstly, may we pass on my condolences to the family and friends of Billie Wicks. We appreciate the opportunity to comment on the issues raised by HM Coroner.

Staffing

We are unable to comment about the staffing model, numbers, or skill mix, at The Royal Free Hospital's emergency department. The Royal College of Emergency Medicine (RCEM) has guidance regarding the level of staffing for doctors [1], nurses, and healthcare staff [2]. In December 2024, the RCEM also published standards around staffing [3]. Each ED should have a senior decision-making (tier 4) doctor in the department at all times [3, 7]. A tier 4 doctor may be referred to as a registrar. Adequate staffing is required to deliver safe care.

Physiological Observations

Each emergency department (ED) should have a track and trigger tool for children (of all ages) [3] and adults. There are several different scores that are referred to as PEWS. The national paediatric early warning system (nPEWS) was designed for inpatient use, and a new ED version is currently being developed and tested. NEWS2 and nPEWS both include blood pressure monitoring. RCEM and the Royal College of Paediatrics and Child Heath, do not currently support the use of nPEWS in the ED [5,6]. It is acceptable to use the adult national early warning score (NEWS2) in children aged 16 and above [4]. Both nPEWS and NEWS2 have suggested frequency of repeat observations depending on the initial set of observations performed.

Listening to parents & carers

The nPEWS and the EDnPEWS that is being developed both contain a section to record parental/carer concern and this is included in the escalation advice. RCEM is supportive of the testing of Martha's Rule in the ED setting.

Antibiotic administration

It is good practice for the prescribing and administration of medicines to be performed by different practitioners [8]. There is current guidance on the management of sepsis. This would suggest that for sepsis without shock, antibiotics should be administered within three hours [9]. It is unclear whether Billie had sepsis. Guidance for the time to administer the first dose of antibiotics in people with infection without sepsis are less proscriptive. RCEM notes that Billie was discharged after about three and a half hours. It is assumed that she was given antibiotics at discharge, to self-administer. Antibiotics are only part of the management for an exacerbation of asthma thought to be secondary to a bacterial

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infection. Exacerbations of asthma in childhood are often secondary to viral infection; if this was the case, the timing of the first dose of antibiotics is irrelevant. It is unclear if Billie was given any steroids or received any other acute management for asthma. RCEM are not aware of any national guidance or clear rationale which would support a directive that, in the absence of suspected allergy, the first dose of an antibiotic needs to be administered by a clinician.

Recognition of Adult-onset Asthma

Billie was 16 years old, whilst legally a child, for the purposes of assessment and treatment of asthma it may have been appropriate to have managed her as an adult [10]. There are national guidelines around the management of acute exacerbations of asthma, as well as the diagnosis of asthma [11,12]. RCEM has learning resources regarding asthma diagnosis and treatment. This highlights that one in four patients are not diagnosed with asthma until an adult [13,14], and asthma is part of the curriculum for post-graduate doctors in training [15].

Safety Netting

ED clinicians will often see patients and discharge them home knowing that there is a possibility (however small) that their condition might deteriorate.

RCEM shares your concerns regarding the use of the term 'safety netting' in medical notes. This term is only of value if the components of the 'safety net' have been documented. RCEM considers the components which relate to safety netting (as opposed to other information which might be provided to the patient) to include: [18]

- What symptoms to look out for which suggest condition is not getting better
- What symptoms should necessitate review in the community (GP)
- What symptoms should necessitate review back in the emergency department or the need to telephone 999
- What, if any, follow-up is required

This is in keeping with the information contained in many patient information leaflets produced by the NHS [16] relating to conditions which may present to an emergency department and be suitable for discharge, including asthma [17]. The provision of standard written advice or access to online material via a QR code is ideal [18]. RCEM will update its existing guidance on the provision of information to patients to specifically address the issue of 'safety netting', we are grateful to you for bringing this issue to our attention.

Yours sincerely,

[redacted]

Chair, Quality in Emergency Care Committee
Royal College of Emergency Medicine

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