Royal Free London
NHS Foundation Trust

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Private and Confidential
His Majesty's Senior Coroner Mary Hassell
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Via Email

12 May 2025

Dear Madam,

Re: Regulation 28: Prevention of Future Deaths report – Billie Wicks (date of death: 15 September 2024)

We write to you in response to the Regulation 28: Prevention of Future Deaths report following the inquest into the death of Billie Wicks

We would like to reiterate our sincere condolences to the family of Billie for their loss.

The Royal Free London NHS Foundation Trust has carefully considered the matters of concern raised in the Regulation 28 Report.

We are grateful for the opportunity to respond to the matters you have raised and would like to start by assuring you that this safety event has been reviewed as part of our routine governance process, prior to the inquest. The Trust reviewed this safety event at the Patient Safety Event Review Panel (PSERP) on 25 September, where it was agreed that a Patient Safety Incident Investigation (PSII) would be undertaken. The PSII was completed and the findings shared with Billie's family in advance of the inquest.

The inquest took place on 6 March 2025 and raised several matters of concern which have been responded to below:

1. ***At inquest, I heard repeatedly that on the night Billie attended, the Royal Free emergency department was understaffed, and that it remains understaffed of doctors, nurses, and even a healthcare assistant who could take basic observations. Billie should have had observations every hour. If she had had these observations, the emergency registrar who discharged her would have recognised that she was not as well as he thought and would have sought senior medical review. That senior medical review would have changed the course of her management and saved her life. Following the inquest touching the death of Daniel Klosi, I wrote to you on 16 August***

2024 about a lack of observations in the emergency department of the Royal Free. Although the circumstances were different, there is a theme.

It is acknowledged that on the night Billie attended the Royal Free Hospital Emergency Department, there was a failure to recognise the significance of her abnormal observations, resulting in Billie being discharged inappropriately. The lack of repeat observations is also recognised as an ongoing theme which has been extensively addressed and a number of measures, already in place, have been detailed in this response. It is noted that patients in the emergency department are required to have hourly observations whilst they remain abnormal. In Billie's case her observations remained abnormal, therefore a further set of observations would have prevented her discharge from the department. To further address these concerns, the following actions have been taken:

- Emergency department paediatric consultant cover has been augmented since this incident and is now consistently scheduled every day between 09:00 - 23:00 hrs Monday to Friday, providing senior supervision during these hours to the middle grade doctors working in this area, maintaining robust training and guidance during these hours to enable improved decision making and increased confidence overnight.

- Following this safety event, all paediatric patients with abnormal vital signs must be referred to Paediatrics prior to discharge, the guideline has been updated and shared to reflect this requirement.

- Access to an onsite Paediatric consultant is available 24/7 and an emergency medicine consultant is available 24/7 through the on-call system if needed to support the above action.

- All new doctors starting in the Emergency Department, now receive a mandatory teaching session at induction focusing on paediatrics and paediatric deterioration and escalation with regular sessions timetabled ongoing to maintain this education.

- In addition to these measures, this case has been shared on multiple occasions during Paediatric and ED Mortality and Morbidity (M&M) meetings, hospital wide safety briefings across all divisions as shared learning.

- Nurse staffing on the night of Billie's first attendance on 14th September 2024 was in line with the nursing establishment levels of safe staffing except for one Registered Nurse (RN) rota gap during the day shift prior to Billie's attendance. In the interim the trust has approved additional staffing to medical and nursing shifts, filled by bank and agency staff to mitigate staffing to the levels described in the business case based on safe staffing skill mix assessment and the level of acuity / complexity of patients attending in the Royal Free Hospital emergency department.

- Long-term mitigation of the current establishment is anticipated and is associated with the trusts process of business case approval. However, in the interim we are achieving the augmented staffing levels with bank and agency shift cover until we have the reconfigured and augmented establishment approved. This will increase the number of senior staff on shift as well as supplement the paediatric team with an Emergency Department Assistant (EDA) 24/7. This is a non-registered clinical member of staff who can take on duties similar to a Health Care Assistant/Support Worker including performing and recording observations on paediatric patients.

2. ***The registrar who saw Billie the night before her death prescribed an antibiotic, but he was not in the habit of giving the first dose in the department and he did not on this occasion. This meant that Billie's infection was not tackled as quickly as it could have been. This seems to indicate a training and potentially a guideline need.***

The addition of an ED pharmacist would support reliable stocking of medications, provide access to critical medications out of hours, education throughout the department and provide continuous and vital expertise. The lack of pharmacy resource within the Emergency Department is noted to be an area of concern. It is recognised and is continually monitored, risk mitigations have been identified, and actions are currently being driven to try to resolve this in the form of a business case. The business case is currently progressing through an approval process with a comprehensive action plan in place whilst this gap remains.

Whilst this work is being undertaken steps have been put in place to reinforce that when indicated medications should be started in the department and given as 'To Take Away' (TTA) medications. This education has already commenced in the doctor's induction programme and will continue going forwards.

This pharmacy resource has also been explored in greater detail in the Patient Safety Incident Investigation (PSII) and appropriate actions have been added to monitor progress of the business case previously referred to. An additional action to ensure there is sufficient supply of medication in the adult TTA stock cupboard in the Emergency Department and to include medication stock responsibilities in job planning has been agreed to further support the ED team in this area, this is being led by the Divisional Clinical Director for this area.

After a thorough review by the multidisciplinary team (MDT) panel, it was determined that antibiotics were unlikely to have altered the outcome, as the infection was likely to be viral in nature. The panel agreed that while initiating antibiotics at an earlier stage was unlikely to have altered the outcome for Billie, it may well alter the course of other patients in similar circumstances.

3. ***At the time of Billie's presentation, the registrar was unaware of the possibility of adult-onset asthma. This seems to indicate a training and potentially a guideline need.***

It is acknowledged in Billie's case, the registrar reviewing Billie did not consider a diagnosis of adult-onset asthma. Paediatric Asthma Wheeze Guidelines and a case study of the incident has been used to exemplify learning from this incident. The learning and reflections have been delivered at the ED Mortality and Morbidity meeting, paediatric teaching sessions to middle grades and junior doctors, and is included within the Junior Doctors induction plan. The intended effect is to enhance awareness of the guideline and drive the knowledge and application of treatments for asthma. Improving awareness of the Paediatric Wheeze pathway has already commenced including the implementation of standardised assessments for patients presenting with asthma or wheeze.

4. ***I heard that Billie was safety netted when she was discharged. Her parents were told to bring her back if they had any concerns. I have heard this safety netting advice being described many, many times in different inquests. What worries me about it in this context is that Billie's parents had brought her to hospital because they were concerned. They were then reassured by hospital staff. It is therefore difficult to see***

how this particular advice could be a meaningful instruction. In reality, her parents' initial concern was well placed, and they had responded to it appropriately by bringing Billie to hospital. When Billie began to deteriorate again, her parents' natural instinct had been blunted by their first visit to the hospital.

It is acknowledged that all parents attending the paediatric Emergency Department are concerned for their children and the team rely on good history and information gathering along with thorough assessments to identify the most appropriate course of action to be taken. In this case, the primary concern was that Billie was discharged on her first attendance without ensuring her vital signs were within normal parameters. More specific safety netting advice should have been given around the increase in difficulty breathing, failure to respond to treatment provided either by RFH or the GP and had Billie been discharged with more specific advice, she may have re-presented earlier. To note, safety netting is a well-recognised tool and ensures patients do return if a patient deteriorates and are reviewed by a senior ED clinician. This is successfully employed in many cases and there are Royal College of Emergency Medicine (RCEM) guidelines that describe the process if a patient returns to an emergency department.
At the Royal Free the Royal College of Paediatrics and Child Health (RCPCH) AND Healthier Together QR codes are available for common presentations to support safety netting advice given.

5. **Whilst I doubt that it would have made a difference in this case, I understand that blood pressure is not, yet an observation included in the national paediatric early warning score (PEWS)**

NHS England is rolling out a new national standardised approach of tracking the deterioration of children in hospital, which is scheduled for full completion, nationally by 30 September 2025. The Royal Free London (RFL) is currently working through the implementation of this into our Electronic Patient Record (EPR) system and aims will be in line with this guidance. It is expected to be implemented at the Royal Free Hospital (RFH) by the national deadline.

Previously there has not been published national guidance on vital signs. National PEWS is a new national guideline and will include blood pressures. Whilst in Billie's case the blood pressure was not taken, it was likely to have been normal and would not have changed the outcome in this case.

In response to this case a cross-site working group has been established to unify the recognition and actions to be taken in a deteriorating child. This includes all Royal Free London (RFL) hospital sites and has multi-disciplinary membership. Meetings are held on a 2-weekly basis and the group oversees the progress of the implementation of the national PEWS, education, staffing, guidelines and risk evaluation.

The action plan outlined in the Patient Safety Investigation (PSII) has been provided below.

The Trust is committed to learning from Billie's tragic death and continuously improving patient safety. We will actively monitor adherence to the ongoing improvement plans and the Trust's action plan is set out below. This will be monitored by the Acute Medicine, Emergency Department and Elderly Care (AMEDEC) Divisional Quality & Safety Board and the Clinical Performance and Patient Safety Committee.

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Action Plan

Safety action description		Responsibility for monitoring/ oversight	Action Deadline	Evidence
Relevant Recommendation - Staffing/ Education				
1.	For the senior matron for the Emergency Department to continue to review the business case for recruitment of a Clinical Practice Educator (CPE), Emergency Department Assistant (EDA) and overall nursing staffing in the Paediatric Emergency Department.	Senior matron, Emergency Department	30/05/2025	Copy of the business plan
2.	Senior matron for Emergency Department to review staffing skill mix for day and night shifts.	Senior matron, Emergency Department	30/05/2025	Copy of the business plan
3.	For the senior matron for the Emergency Department to organise future team days with a focus on PEWS, escalation of abnormal observations and observations on discharge	Senior matron, Emergency Department	30/05/2025	Copy of the training plan
5.	For the senior matron and ED consultants for the Emergency Department to ensure all staff carry out robust communication and timely documentation.	Senior matron, Emergency Department	30/05/2025	Copy of the training plan
6.	For the Senior Matron for the Emergency Department to discuss a plan for ensuring huddles take place overnight in the Emergency Department with Paediatric Emergency to ensure robust communication between the nursing and medical teams	Senior matron, Emergency Department	30/05/2025	Copy of the training plan

7.	To discuss the Paediatric Asthma Wheeze Guidelines during team days .	Senior matron, Emergency Department	30/05/2025	Copy of the training plan
8.	Education in the doctor's induction program on TTA medications	Emergency Department Governance Lead	Completed/ Ongoing	Copy of the training plan
9.	All new doctors starting in the Emergency Department, there is now a teaching session during induction focusing on Paediatrics and regular sessions ongoing to maintain this education to include individualised specific safety netting depending on clinical symptoms.	Emergency Department Governance Lead	Completed	Copy of the training plan
Relevant Recommendation – Pharmacy Provision				
10	To ensure pharmacy provision in the Emergency Department through the implementation of plans for a dedicated ED Pharmacist.	Divisional clinical director for acute medicine, emergency and elderly care	30/05/2025	Copy of the business case
11.	To ensure sufficient supply of medication in the adult TTA stock cupboard in the Emergency Department and to include medication stock responsibilities in job planning.	Divisional clinical director for acute medicine, emergency and elderly care	30/05/2025	Copy of the training plan
Relevant Recommendation – Pharmacy Digital Solutions				
12.	As part of the working group there will be discussions about how deteriorating young people (between aged 16–18-year-old) can be captured by using PEWS or NEWS	The PEWS Implementation Working Group	30/05/2025	Copy of the meeting minutes
Relevant Recommendation – Shared Learning				
13.	To formalise the process of shared learning of emergency department safety events between Royal Free, Barnet and North Middlesex Hospital sites through the regular meetings of the	Divisional clinical director for acute medicine, emergency and elderly care	30/05/2025	

	Leadership of the ED services (senior matrons and governance leads).			
14.	In addition to these measures, this case has been shared on multiple occasions during Paediatric and ED Mortality and Morbidity (M&M) meetings for ongoing and shared learning	Divisional clinical director for acute medicine, emergency and elderly care	Completed	
Relevant Recommendation – other				
15.	Following this safety event, all paediatric patients with persistent abnormal vital signs at the point of discharge, must be referred to Paediatrics prior to discharge, the guideline has been updated and shared to reflect this requirement	Clinical Director for Childrens' Services Royal Free London (Barnet, Chase Farm & Royal Free North MIddlesex)	Completed	
16.	Paediatric consultants cover in place consistently from 09:00 to 23:00 (Monday to Friday)	Clinical Director for Childrens' Services Royal Free London (Barnet, Chase Farm & Royal Free)	Completed/ Ongoing	

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We will be sending a copy of this letter to North Central London Integrated Care Board.

If you would like any further information about any part of this letter, please do not hesitate to contact us.

Yours sincerely,

[redacted]

[redacted]

Director of Nursing,
Royal Free Hospital
London Group NHS Trust

[redacted]

Medical Director
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Royal Free London Group NHS Trust