Regulation 28: Prevention of Future Deaths report

Billie Diane WICKS (died 15.09.24)

	THIS REPORT IS BEING SENT TO: **1. Medical Director** **Royal Free Hospital** **Pond Street** **London NW3 2QG** **2. President** **Royal College of Paediatrics and Child Health** **5-11 Theobalds Road** **London WC1X 8SH** **3. President** **Royal College of Emergency Medicine** **Octavia House** **54 Ayres Street** **London SE1 1EU**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 17 September 2024 one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Billie Wicks aged 16 years. The investigation concluded at the end of the inquest on 6 March 2025. I made a narrative determination having found that Billie died from infective exacerbation of asthma.

4	**CIRCUMSTANCES OF THE DEATH** Billie had been brought to the Royal Free Hospital just before midnight the night before her death with an asthma attack. A first presentation of asthma at the age of 16 years without any family history is unusual, and it was a busy night in the accident and emergency department. Billie was inappropriately discharged at approximately 3.30am without adequate repeat observations or senior clinical review, and so her asthma was not diagnosed or treated. If it had been, she probably would have survived.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. A PSII (patient safety incident investigation) was conducted and learning identified, but some areas of concern do remain. The **MATTERS OF CONCERN** are as follows. 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. 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.

	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. 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. 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).
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 May 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • Billie's parents • HHJ Alexia Durran, the Chief Coroner of England & Wales

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.	
9	**DATE** 13.03.25	**SIGNED BY SENIOR CORONER** *ME Hassell*