REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **General Medical Council Regent's Place, 350 Euston Road, London NW1 3JN**
1	**CORONER** I am JOHN GITTINS, senior coroner for the coroner area of North wales (East and Central)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION** On the 9th of May 2013 I commenced an investigation into the death of KATE LOUISE PIERCE, Aged 7. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** The deceased is Kate Louise PIERCE (d.o.b. 29/06/2005). Although the matters in question took place on or around the 29th March 2006, Kate eventually died on the 14/03/2013 aged 7 years. No post-mortem examination has been held and Kate's body has been cremated. The cause of death as per Kate's death certificate is; Acquired Cerebral Palsy, epilepsy and chronic lung disease complications following Meningitis'
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. The **MATTERS OF CONCERN** are as follows. – On the 29th of March 2006 Kate was taken into the Wrexham Maelor Hospital where she was examined by a Dr [redacted]. It appears from the evidence available that he failed to deal correctly with the diagnosis of Kate's condition and furthermore there is a belief that he may have misled the parents of Kate by indicating that he had sought a second opinion from a colleague before discharging her when this was not in fact the case. I understand that enquiries were made previously by the GMC following a complaint against Dr [redacted] but that no action has been taken due to legal action by the Dr

	in view of the elapse of a relevant time limit. In the course of my current investigation following Kate's death, a statement has been obtained from a witness namely Dr [redacted] and a copy of this is annexed hereto. My view is that this statement casts doubt on Dr [redacted] fitness to practice and this is of grave concern as my understanding is that he currently continues to practice as a GP within my Coroner Area. In view of this I consider that there is a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 14th of February 2014. 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 Chief Coroner and to the following Interested Persons, the parents of Kate Pierce and to the LOCAL SAFEGUARDING BOARD. I have also sent it to DCI [redacted] of Cheshire Police who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he 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 by the Chief Coroner.
9	**[DATE]** 20.12.13 **[SIGNED BY CORONER]**