REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

- Mr Niall Dickson, Chief Executive, GMC, 3, Hardman street, Manchester. M3 3AW.
- Mr Simon Kayel, Chief Executive, Medical Protection Society, 33, Cavendish Square, London. W1G 0PS.
- 3.

President,
Royal College of Physicians,
11 St Andrews Place
Regent's Park
London
NW1 4LE

1 CORONER

I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London

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 and INQUEST

On 14th June 2013 I commenced an investigation into the death of **Professor John Elfed Davies, aged 71yrs.** The investigation concluded at the end of the inquest on 31st October 2013.

The conclusions of the inquest were as follows:

Injury or disease causing death:

I(a) Incised wounds to neck and multiple stab wounds to the chest.

How, when and where Professor Davies came by his death:

On Monday 10th June 2013, a 71 year old male was found deceased lying on the floor of his hotel room. He had self inflicted incised wounds to his neck and multiple stab wounds to his chest. A note was found in the room confirmed to be in his handwriting. His death was deemed non suspicious by police. He was concerned about his health, finances and a complaint that had been made about his practice to the GMC.

Conclusion of the coroner as to the death:

He took his own life.

4 CIRCUMSTANCES OF THE DEATH

A note found at the scene clearly indicated that the proceedings against him by the GMC were very much playing on his mind at the time he took his own life.

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.

The MATTERS OF CONCERN are as follows. -

This is the second death of a doctor that has come before me over the last 2 years where a GMC investigation into the doctor's practice has been found to play a part.

I am concerned that clinicians who are subject to such investigative processes are suffering adverse psychological effects which may be unrecognised and unsupported.

Consideration should be given to the language and tone of written communications, the provision of information about relevant support agencies, and the assessment and identification of suicidal or other self harming behaviour by the relevant body and the facilitation of appropriate on-ward referral.

It is for each organisation to which this report is addressed to consider any appropriate and specific actions for them to take.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.

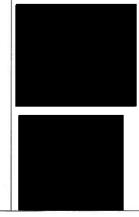
7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th April 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:



I have also sent it to:

Raglan Surgery, Chepstow Road, Raglan, Usk, Monmouthshire. NP15 2EN.

Consultant Surgeon
54 Hanover Gate Mansions
Park Road
London
NW1 4SN

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 13th February 2014

Dr Fiona Wilcox

HM Senior Coroner Inner West London.