REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **DUNCAN SELBIE, CHIEF EXECUTIVE OF PUBLIC HEALTH ENGLAND**
2. **SECRETARY OF STATE FOR HEALTH, DEPARTMENT OF HEALTH**
3. **NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD**
4. **NIALL DICKSON, CHIEF EXECUTIVE, GENERAL MEDICAL COUNCIL**
5. **NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP**

1	**CORONER** I am Maria Mulrennan, Assistant Coroner, for the coroner area of Nottinghamshire
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 (Investigation) Regulations 2013
3	**INVESTIGATION and INQUEST** On 17 November 2014 I commenced an investigation into the death of Harry George Mellor a child aged 8 years. The investigation concluded at the end of the inquest on 5th October 2015. The conclusion of the inquest was that Harry had died from pyelonephritis. I recorded a short form conclusion of natural causes.
4	**CIRCUMSTANCES OF DEATH** 1. At the age of 13 months Harry's parents expressed concern about Harry's lack of developmental progress and infrequent bowel movements. Despite extensive medical investigations between 2007 and 2010, it was not possible to identify the cause of Harry's hypotonia and hypermobility, and consequently the long term paediatric plan for Harry was to provide support via occupational therapy, physiotherapy, and on-going paediatric review and assessment. Harry made remarkable progress with his mobility but continued to experience problems with toileting and was prone to constipation. He was never continent of urine and faeces and wore nappies throughout life. 2. Although Harry had chronic health needs and remained open to the paediatric team, Harry was not subject to any further paediatric review after 10 March 2011. This was due to a combination of unfortunate circumstances. A partial booking system for paediatric appointments, which was in place in late 2011, required Harry's mother to contact the

	hospital to arrange an appointment date. The request was sent to the wrong address and Harry's mother was not aware of the need to arrange a further appointment. This failure went un-noticed until Harry's death in October 2014. 3. In December 2012, Harry's GP de-registered Harry, because his family had moved to a new home outside the practice area. Despite further house moves Harry's mother did not register Harry with a new GP after his de-registration in December 2012. This failure also went un-noticed until Harry's death in October 2014. 4. In the autumn of 2014 Harry began to complain of stomach pains. The mother believed that these symptoms were a recurrence of Harry's usual and long-standing problems with constipation and administered laxative medication. 5. On 28 October 2014 Harry collapsed unexpectedly at his child minder's home. Despite prompt emergency treatment it was not possible to revive Harry and he was pronounced dead shortly after his arrival at the emergency department.
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:- 1. There is no legal requirement to register or re-register a child with a General Practitioner 2. There is no reliable system in place to identify when a child has been de-registered from a General Practice 3. There are potential safeguarding concerns if a General Practitioner can de-register a child, particularly a child with chronic health needs, before a new General Practitioner has been identified and notified of the proposed de-registration 4. The paediatric team and physiotherapy services were not directly informed that Harry was going to be de-registered or had been de-registered
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. You should consider a

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	review of the procedures for the registration of children with General Practitioners
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 December 2015, I the assistant coroner, may extend the period. Your response must contain details of action taken or action 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, [redacted] (mother) [redacted] (father) and to Sherwood Forest Hospital Trust. 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** 22nd October 2015