

1st July 2026

The Rt Hon James Murray MP
Secretary of State for Health and Social Care
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

Dear Mr Murray,

We are writing to you as GP co-leads of the Doctors' Association UK (DAUK) to express our profound concern following two recent coroners' investigations into the deaths of children who were referred by GPs to hospital with suspected appendicitis.

In both cases, the children had been appropriately treated in primary care and referred to an emergency department because their GP recognised the need for urgent hospital assessment. However, neither child was assessed by a doctor while in hospital.

In the case of nine-year-old Dylan Cope (1), he arrived with a written referral from his GP that, according to the coroner's findings, was not acted upon appropriately. Instead of being assessed by a doctor, he was seen by an advanced practitioner.

In the case of eight-year-old Ethan Hanson (2), despite being directed urgently to the emergency department by his GP, he too was assessed by an advanced practitioner rather than a doctor. Tragically, both children died.

These cases raise serious questions about the safety of current assessment systems in emergency departments and the roles of non-doctors. When a GP refers a patient to hospital, that referral represents a clinical judgment that is the equivalent of a medical consultant opinion in the community, and thus necessitates a further medical assessment.

It is deeply concerning that such referrals can result in decisions being made by non-doctors regarding their care or discharge before they are reviewed by a doctor. Patient safety must always be the priority, which is why DAUK is calling on the Government to introduce a new set of standards:

- Any patient referred by a community GP to hospital by a GP must be assessed by a doctor in the hospital.
- No patient presenting with undifferentiated (undiagnosed) symptoms should be allowed to be assessed or discharged without the approval of a doctor.
- We ask the Secretary of State to review the current status of assessments in emergency departments to ensure patient safety is the priority and that doctors are involved in all cases of undifferentiated care and GP referrals.

It is vital patients are kept safe and lessons are learnt before they become endemic. The Leng Review (3) recommended a similar approach for the use of physician assistants. The Ockenden Review of the failure of maternity services is a salutary warning of the harm caused when lessons are ignored. (4)

It's vital we ensure that the issues identified by the coroners in the cases of Dylan Cope and Ethan Hanson lead to improvements in clinical practice.

We welcome the opportunity to discuss these proposals with you and your officials.

Yours sincerely,



Dr Sarah Jacques and Dr Steve Taylor, GP co-leads, Doctors' Association UK (DAUK)

- 1) <https://www.leighday.co.uk/news/press-releases/2024-news/neglect-contributed-to-the-death-of-nine-year-old-dylan-cope-an-inquest-finds/>
- 2) <https://www.judiciary.uk/prevention-of-future-death-reports/ethan-hanson-prevention-of-future-deaths-report/>
- 3) <https://assets.publishing.service.gov.uk/media/6882346d9fab8e2e86161023/The-Leng-review-an-independent-review-into-physician-associate-and-anaesthesia-associate-professions-corrected.pdf>
- 4) <https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2026/06/ockenden-report-review-of-maternity-services-nottingham-university-hospitals-nhs-trust-web-accessible.pdf?>