Ms Joanne Andrews
Area Coroner for West Sussex,
Brighton and Hove
Record Office
Orchard Street
Chichester
PO19 1DD

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

8 July 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – William Richard Stockil who died on 6 September 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 April 2024 concerning the death of William Richard Stockil on 6 September 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to William's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about William's care have been listened to and reflected upon.

I am grateful for the further time granted to response to your Report, and I apologise for any anguish this delay may have caused to William's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Your Report raised concerns over the electronic prescription system (EPS) provided by Oracle Corporation UK Limited (formerly Cerner Limited), and raised that there was a risk that the set-up of the alerting system now used by the Royal Surrey NHS Foundation Trust (RSFT) (following the circumstances of William's death) will not operate to draw attention to the need for a prescription review before the medication ceases if no prescribing clinician accesses a patient's record.

Health IT System Suppliers, such as Oracle Corporation UK Limited, should ensure that their system defaults are configured accurately and appropriately to meet the needs of their users in most clinical situations. The circumstances of your report relate to the local configuration of clinical decision support / alert functionality within the EPS.

NHS England will be engaging with Oracle Corporation UK Limited on the issues raised. I note that you have also addressed your Report to Oracle Corporation UK Limited, and we have been sighted on their response to you dated 27 June 2024. We note that they state they have not found any defect or fault with their software, and that they are open to exploring with RSFT whether any configuration changes, alterations to working practices and additional training may assist to further mitigate any clinical risks. Any identified learnings could be facilitated through their dedicated User Groups and/or general guidance could also be provided on how to best design

and implement prescribing clinical decision support for clinical systems. NHS England will also ensure that the concerns raised in your Report are shared with systems by our Regulation 28 Working Group regional representatives.

The NHS Digital Medicines Programme commissions a system called the e-Prescribing Risk and Safety Evaluation (ePRaSE), which is a tool that supports NHS Trusts in configuring their Electronic Prescribing and Medicines Administration (ePMA) systems, to mitigate prescribing risks and improve safety. There could be scope to incorporate a test script to explore this issue in future iterations of ePRaSE, and this will be considered by the team.

NHS England has also engaged with the Royal Surrey NHS Foundation Trust on the concerns raised in your Report and note that there has also been escalation of the issues raised in your Report across regional and national digital teams. We would refer you to the Trust for further information on their system configurations and agreed processes.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of William, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director