Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Vice President of Oracle Corporation UK Limited** **2 National Medical Director, NHS England & NHS Improvement**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 23 September 2022 I commenced an investigation into the death of William Richard STOCKIL aged 74. The investigation concluded at the end of the inquest on 25 April 2024. The conclusion of the inquest was that: William Richard Stockil died on 6 September 2022 at Royal Surrey County Hospital, Egerton Road, Guildford, Surrey from a pneumonia. This developed following his admission for treatment of conditions caused by a long lie at his home where he had been on the floor for more than 8 hours on 31 August 2022.
4	**CIRCUMSTANCES OF THE DEATH** On 31 August 2022 Mr Stockil was admitted to hospital having been found on the floor at home that day by his family. He was reportedly walking when his legs gave way and he was unable to get himself up. He had evidence of rhabdomyolysis and dehydration on admission. I heard evidence that there was a suspicion Mr Stockil may have an infection due to infection markers, but I also heard that this could have been a result of inflammation following being on the floor. In any event he was prescribed broad spectrum antibiotics to cover an infection having been seen by a Dr at 1am on 1 September 2022. Mr Stockil's prescription was completed using the Trust's electronic prescription system. It was intended by the Dr that he would receive IV 1.2grams of Co-amoxiclav once every 8 hours. When inputting the prescription, the Dr inadvertently selected 18 rather than 8 hourly administration using the drop-down menu. The Dr prescribed the medication for 72 hours on the basis that Mr Stockil was awaiting blood results and that once those were received, likely within 72 hours, there would be a review of his medications. On 3 September 2022 Mr Stockil received the last dose of the prescription made on 1 September 2022. It had not been extended. The electronic prescription system sent out alerts to any member of staff who accessed his medical records on the system to make them aware that his prescription was due to end. It is not clear who received these but I heard evidence that they may have been received by a number of staff who would not consider that this was relevant to their role in the care of Mr Stockil and as such "clicked" off the alerts to them on the system. It was not the case that the alerts were only sent to

	prescribers but instead anyone who accessed his medical records for whatever reason. The alerts were not picked up or actioned by any clinician. The system sent out the pre-agreed number of alerts and then stopped sending the alerts. Mr Stockil received no further antibiotics until 5 September 2022 when he developed signs of infection and clinicians prescribed further antibiotics. The Court found that the cessation of medication was not on the balance of probabilities causative or contributory to Mr Stockil's death.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) I heard evidence that the electronic prescription system at the Royal Surrey Hospitals NHS Foundation Trust is provided by Cerner. The system has been changed since the death of Mr Stockil in that alerts of medication ending are now only sent to clinicians who have the right to prescribe in order that alerts are seen by the correct staff. It is no longer the case that the alerts can be used up in sending alerts to clinicians who do not have the ability to address prescriptions. The current version of the system generates alerts when anyone with a prescribing right accesses the patient's records. This means that an alert will only be shown to a prescriber and only if they access the patient's records. Therefore, it was accepted that there was a risk that the alerting system would not operate to draw attention to the need for prescription review before the medication ceases if no prescribing clinician accesses a patient's record. This creates a risk that medications will cease when they should be continued and creates a risk of future deaths.
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 June 2024 2024. 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 [redacted] [redacted] [redacted] **Royal Surrey NHS Foundation Trust** I am also under a duty to send a copy of your response to the Chief Coroner and all

	interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 18/06/2024** J. Andrews **Joanne ANDREWS** **Area Coroner for** **West Sussex, Brighton and Hove**