Riverview Surgery

[redacted]

Riverview Health Centre
Borough Road
Sunderland SR1 2HJ

[redacted]

Mr David Place
Senior Coroner for the City of Sunderland
HM Coroner's Courts
City Hall
Plater Way
Sunderland
SR1 3AA

[redacted]

Dear Mr Place

Avery Jake Hall: Prevention of Future Deaths Report

I am writing on behalf of the Riverview Surgery in response to your Prevention of Future Deaths Report (PFDR) dated 2 February 2026 in order to provide you with information regarding the further steps we are taking in addition to those set out in the SEA to ensure that there is no recurrence of these devastating events.

For completeness, I attach the SEA detailing the steps taken previously. Following receipt of your PFDR, I have considered carefully your concerns and conclusion and revisited the SEA in order to further develop the systems currently in place, to address your concerns. These additional changes are as follows:

1. An SOP has been implemented in relation to prescribing medication to women of child bearing age (15-55 years old). I attach the SOP. A clinical practice meeting has been arranged for 26 February 2026 at which the SOP will be discussed and laminated copies distributed.
2. The SOP goes further than the previous SEA in the following respects:

a. It relates to any new medication at the point of initiation.
b. If there is a concern as to a medication's safety in pregnancy, the medication is to be stopped and removed from the repeat and acute list of medications and the patient advised of safe alternative medication.
3. As set out in the SEA, a review of all female patients of child bearing age who are prescribed ARB medication was to be undertaken every 6 months and an alert added to their prescription to stop taking this medication if they become pregnant and to speak to their GP. The frequency of this review has now been increased to 3-monthly in light of the risks of this medication in later pregnancy. In addition, as most prescriptions are now electronic rather than paper copies, the alert will be added to the prescribing instructions section so that it is clearly shown on the label printed for the patient's medication by the pharmacy when they collect their medication.

I wish to make clear that had I known of the BNF warning for candesartan in 2024, I would have given definitive advice that it must be stopped and I would have removed it from the repeat prescription list. The SOP will ensure that patients receive an early alert and counselling in relation to any concerns about their current medications should they become pregnant. Once the patient informs the practice of their pregnancy, an urgent review will take place with a doctor to address their current medication risks, stop medications which are contraindicated or for which there is concern about their safety in pregnancy and advise upon safe alternatives.
Had the SOP been in existence in April 2024, it would have led me to stop the 3 medications which the BNF advised avoiding or were contraindicated in pregnancy, namely candesartan, melatonin and lansoprazole, and to remove them from the acute and repeat prescription lists.

I have also considered further whether it is possible to identify or flag a pregnant patient when they request repeat medication. This would be an important safeguard for doctors reviewing the two hundred or so repeat medication requests received on a daily basis. Due to their volume and the other priorities for clinicians' time, it is not practical for the doctor to review each patient's records when authorising every request. We do not have the technical IT skills at the practice to make changes to the computerised records system and I have therefore contacted our system provider EMIS to ask for their advice and input on whether it is possible, and if so how, to introduce a flag which would identify the pregnancy coding on the patient's record and link it to the repeat prescriptions for the patient (and ideally include the BNF advice for that medication as well). I hope that this is a proportionate and practical way to address the

issue you have raised, which will further strengthen the safeguards in place with the 3 monthly review of all female patients of child bearing age prescribed ARB medication.

I wish to make clear how seriously I and the practice take the issues you have raised and hope you are reassured by the steps already undertaken and the further steps which are being undertaken following your PFDR.

Yours sincerely,

[redacted]

cc CQC

Significant Event

Start date 3-3-25

Brief summary

Patient contacted the surgery via e-consultation on 10-4-24 since she had just found out that she was pregnant and was unsure whether her current medications were safe to continue with during her pregnancy. She had a GP telephone consultation on 11-4-24 where all her medications were checked against the paper version of the BNF number 86 September 2023 – March 2024. She was advised to stop all medications and provided with suggestions as to over the counter alternatives. The practice was informed of a neonatal death at 13-11-24. A Teams meeting with [redacted] (Quality and Safety Matron, Obstetrics and Gynaecology SRH) and an Obstetrics and Gynaecology Consultant was held at 1430 on 24-3-25. This Teams meeting implicated that the Candesartan which had been taken throughout pregnancy had led to the neonatal death.

The date a discussion about the event occurred

Practice clinical meeting 6-5-25

Further Practice meeting 8-9-25 @ 1200 – Community Midwife has been invited to attend.

A description of the actual event

I shared and discussed all the concerns, notably what I had done since learning of the neonatal death and Candesartan (Angiotensin 2 receptor blocking medication/ARB), and what further safeguards can primary care put in place to prevent any reoccurrence.

A description of the actual event

1. I shared a summary of events with my Surgery's clinical team.
2. I shared what I had done since becoming aware of the issue with regards to Candesartan.

What went well or not

The team was deeply upset to learn of this event and were saddened on behalf of the lady and her family. We had an open and very frank discussion as to how it had happened and what safeguards were needed to prevent it from happening ever again.

What could have been done differently

At the point of initiating the Candesartan medication, adding an alert to the medication and advising the patient to stop if becoming pregnant.

Any other colleagues present at the time of the significant event

6-5-25 @ 1200; Practice Nurses ([redacted] & [redacted]), [redacted], Nurse Practitioner ([redacted]) and [redacted] on 6-5-25.

8-9-25 @ 1200; Practice Nurse ([redacted]), Nurse Practitioner ([redacted]), Salaried GPs ([redacted] and [redacted]), Community Midwife ([redacted]), GP partner ([redacted]), Practice Manager ([redacted]).

Reflections on the event in terms of knowledge skills and performance; safety and quality; Communication, partnership and teamwork; maintaining trust;

All information was discussed candidly – everyone agreed that the implemented safeguarding changes were appropriate with no further amendments.

What changes have been agreed for me personally and for the team

1. Any patient who advises that they have become pregnant will be alerted to myself via a task from reception so that I can; a. Code that they are currently pregnant, b. Request referral to our Community Midwife and c. Conduct a medication review. If I am unavailable the task will be sent to the on/call GP, all clinicians have been briefed as to the dangers of Candesartan.
2. All clinical staff are now fully aware as to the dangers of Candesartan and since it is a class effect around all ARB medication.
3. All clinical prescribing staff will add a patient alert/warning to the patient's prescription warning all women of childbearing age that Candesartan must be stopped if the patient becomes pregnant.

Changes carried out and their effect;

1. I reviewed all women of childbearing age taking Candesartan and indeed taking any ARB medication.
2. All those of childbearing age have had an alert added to their prescription warning them to stop immediately if they become pregnant and to see their GP.
3. Opportunistically all women taking Candesartan or any ARB of childbearing age are verbally warned as to the medication dangers and are advised to stop immediately if they become pregnant.
4. I am now alerted by a task sent from reception upon them being advised by a woman that she has become pregnant, a. I check that they have been coded as being pregnant, b. I check that they have been referred to the Community Midwife, and c. I perform a medication review such that if the patient takes any medication they are asked to book a telephone consultation with myself and if they take no medication then no further action is required. This is fully documented in the patient consultative record. If I am unavailable, then the task is sent to our duty/on-call GP. All our clinical staff are now fully aware as to the dangers of Candesartan, ARBs in general and pregnancy.
5. As a practice we no longer use the paper BNF for medication reviews and now use the electronic version.

6. I have written a letter to the BNF to alert them as to this egregious omission in respect of Candesartan and pregnancy usage.
7. I have highlighted this issue and case within the East Sunderland PCN amongst partnered GPs to disseminate learning points.
8. I have highlighted this concern to our East Sunderland PCN prescribing lead, Sunderland's LMC chair and the Sunderland ICB prescribing lead both for wider learning and safeguarding. The Sunderland ICB prescribing lead will arrange an educational session for all Sunderland GPs in respect of drugs in pregnancy, highlighting ARB medication.
9. I have discussed the issue with our local pharmacist/[redacted] who is also a member of the Sunderland's LPC (Local Pharmacy Committee). I was surprised to learn that when a patient claims an NHS exemption from prescription charges, the IT system does not alert the pharmacist as to the reason why. So currently there is no system to alert the pharmacist as to a patient being pregnant. [redacted] will raise these issues at the next LPC and see if they can organise further training for Sunderland's pharmacists.

Reflections:

Learning need addressed

I am now aware as to the dangers of Candesartan and any ARB in pregnancy. I will now rely solely on the electronic BNF.

Method used:

Audit of those women taking Candesartan and any ARB medication of childbearing age.

Outcome of Activity

To put in place robust safeguarding procedures such that this event can never happen again.

Outline any further learning or development needs highlighted by the activity

Shared both at practice clinical level and wider to PCN/LMC/ICB/LPC. I have alerted the BNF by letter.

Audit fully completed 2-10-25

Riverview Surgery

Standard Operating Protocol

Prescribing to women of childbearing age 15-55yo

1. At the point of initiating any new medication, the medication is checked using the electronic version of the BNF as to its safety if the woman was to become pregnant.

2. If there is concern as to the medication's safety in pregnancy, the patient is both to be counselled and an alert is added to the prescribing instructions. The alert is to state that the medication is to be stopped if the patient becomes pregnant, and to speak to her GP.

3. Upon the patient informing the Practice that she is pregnant a task is sent by the reception team to the on/call GP that day.

4. The on/call GP will code the patient as being pregnant and task reception to refer her to the midwife providing the date of the patient's LMP (last menstrual period).

5. The on/call GP will immediately review the patient medical record; if the patient is taking no medication, then no further action is required. However, if the patient is taking medication, then a task is to be sent to reception requesting an urgent medication review with the patient and a GP.

6. At the point of the urgent medication review with the patient, the GP will establish all taken medications and their dosage. The electronic BNF will be reviewed as to the identified medications and their safety in pregnancy. All contraindicated medications and those where there is concern as to the medication’s safety in pregnancy will be stopped and removed from the repeat and acute list of medications.

Dated 5-2-2026

Review date of this SOP is every 2 years