Royal College of General Practitioners

[redacted]
Vice Chair Member Standards

Mr David Place
His Majesty's Senior Coroner for the City of Sunderland

[redacted]

19 March 2026

Dear Mr Place

Regulation 28 Report to Prevent Future Deaths - regarding the death of Master Avery Jake Hall

Thank you for asking us to comment on the matters of concern following the sad death of Avery Jake Hall who died on the 13th of November 2024.

Our sincere condolences go to his family given the difficult circumstances and the ongoing questions on how this could have been prevented. We will address the issues raised as requested in the hope that the response can help answer the concerns of the Coroner and Avery's loved ones.

You have numerous matters of concern relating to this deeply upsetting death.

- Continuation of repeat prescribing of Candesartan throughout the pregnancy in spite of the GP's clinical advice to stop the medication on 11th April 2024.
- The lack of specific advice regarding Candesartan in pregnancy and the risks involved.
- Missed opportunities to highlight the risks with clinicians through her multiple attendances through her antenatal care.

To give context to the family, The Royal College of General Practitioners works to improve patient care by encouraging the highest possible standards in general medical practice by supporting members, setting standards, providing education and training, promoting research and advocating and representing the College and its 56,000 members.

Training
General Practitioners have a broad curriculum, and the College is responsible for the definitive educational framework for all doctors undertaking GP speciality training. Within GP

Training there is now a mandatory Prescribing Assessment, introduced in 2019, to examine prescribing decisions, assessing against current evidence, considering prescribing in special groups including children, the elderly or in pregnancy.

Within the RCGP Womens Health toolkit, the breadth of information resources on prescribing in pregnancy are provided with links, including the Specialist Pharmacy Service, (SPS) https://www.sps.nhs.uk/articles/the-risks-and-principles-of-prescribing-in-pregnancy/

Prescribing in Pregnancy is a specific section within the British National Formulary, (BNF), available online, listing specific concerns for each drug reflecting known evidence from trials and continuing monitoring. Clear advice is given as to whether the medication should be avoided, may have harmful effects or when it is not known to be harmful, with the current advice that Candesartan should be avoided.
https://bnf.nice.org.uk/drugs/candesartan-cilexetil/#pregnancy

Information resources are readily available to both clinicians via UKTIS and their patient-facing resource BUMPs (Best Use of Medicines in Pregnancy) websites, summarising the current known evidence for medications prescribed for pre-existing conditions prior to pregnancy, as in Candesartan for the indication of migraines. Full monographs are available to healthcare professionals when we register with the site using our nhs.net email address.

These pages are updated when new evidence evolves and from my own viewing the current information was last updated https://uktis.org/monographs/use-of-angiotensin-ii-receptor-antagonists-in-pregnancy/ in July 2025 and https://www.medicinesinpregnancy.org/leaflets-a-z/angiotensin-receptor-blockers/ January 2026 on UKTIS and BUMPs respectively.

A phone number allows healthcare professionals to contact UKTIS for help and advice if required: 0344 892 0909.

Systems

GP Information Technology Systems give prescribing alerts at the point of issuing the prescription. There is no single GP IT System and each supplier will have their own prescribing advice software, for example EMIS, SystmOne and Medicus. Communication with these suppliers would be valuable to clarify a system-wide safety net in the event of human error leaving a harmful prescription within repeat medications for a patient coded as being pregnant.

The manufacturers DCB0129 hazard log will have a specific hazard identifying medication causing harm, one cause of which is a change in clinical circumstances rendering an existing repeat prescription unsafe. The hazard "controls" (things that reduce the risk) include presenting information to the users at the relevant moments e.g.

- When a new codable condition is added which can computably surface a warning,
- When a digital prescribing safety check is activated by a user,
- When a repeat prescription request is being reviewed prior to being issued,
- What systems are in place to identify and manage Alert Fatigue in users

Systems do seem to highlight the risks at the point of initiation as a new prescription. It is unclear whether an Alert is raised across all systems for existing repeat prescriptions, such as Candesartan in this case. Exploration of this issue with the suppliers would be valuable to avoid further events.

The next layer of safety in prescribing is the dispensing pharmacist, who may refer the prescription back to the prescriber if they identify a risk or concern. This area of the process is beyond the remit of the RCGP.

A development that has subsequently become available is the contractual obligation to report such incidents to the Learning From Patient Safety Exercise (LFPSE) established in October 2025, following on from the National Reporting and Learning System, which was utilised predominantly by secondary care health services.

Once again, our condolences go to Avery's parents and family. I hope the comments provide a full picture of where the RCGP can influence the prevention of future deaths within training and continuing professional development.

Yours faithfully

Vice Chair Member Standards