**David Place**
**Senior Coroner for the City of Sunderland**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Riverview Surgery, Riverview Health Centre, Sunderland**<br><br>**The Royal College of General Practitioners (RCGP)** |
| 1 | **CORONER**<br><br>I am David Place, His Majesty's Senior Coroner for the City of Sunderland |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 14th November 2024 I commenced an Investigation into the death of Master Avery Jake Hall, who died in Sunderland on 13th November 2024 aged 4 days. The Investigation concluded at the end of the Inquest on 23rd January 2026.<br><br>The medical cause of death was confirmed as: -<br>Ia Hypoxia Ischaemia and diffuse alveolar damage<br>Ib Olygo/anhydramnios and foetal distress<br>Ic Premature rupture of membranes, small placenta with distal villous maldevelopment and low grade foetal vascular malperfusion<br><br>I gave a narrative conclusion 'Avery Jake Hall died from complications known to arise when candesartan is used throughout pregnancy particularly in the second and third trimester and his mother had continued to use this medication which had been prescribed to her since 2022 being unaware of the risks it posed due to a combination of unclear and indecisive advice at the outset and no additional advice about the safety of the medication from clinicians involved in her antenatal care.' |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Avery Jake Hall died at Sunderland Royal Hospital on 13th November 2024 having developed global hypoxia and diffuse alveolar damage with hyaline membranes in the lung following his birth as his development in pregnancy had been compromised by reduced amniotic fluid leading to poor lung development and impairment of urine production by the kidneys. During pregnancy Avery's mother had continued to take Candesartan which had previously been prescribed to her to treat |

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| | migraines. She did not receive definitive advice from clinicians to stop taking it despite various opportunities to do so and this is a medication contraindicated in pregnancy due to risks including foetal renal failure and pulmonary hypoplasia. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are: –<br><br>Avery's mother suffered from migraines which were increasing in severity, so she sought advice from her GP when aged 21 years old. She was prescribed Candesartan 4mg by her GP shortly before her 22nd birthday. This was to be taken daily and was placed on a repeat prescription of 28 tablets. The dose was increased to 8mg after 3 months and following a referral, the treatment was endorsed by a Consultant Neurologist at a consultation 4 months after the initial prescription. The evidence revealed that no advice was provided as to the risks of this medication should she be considering having a child.<br><br>Following a positive pregnancy test in April 2024, Avery's mother sought advice from her GP about which of her prescribed medications were safe to use during pregnancy.<br><br>During the telephone consultation with her GP on 11th April 2024 she was given specific advice to avoid using 3 of 6 prescriptions. I am concerned that the evidence highlighted that Avery's mother was given only generic advice that it was best to avoid all medication during pregnancy but was not given specific advice to stop using Candesartan, and the risk of continuing to take this medication in pregnancy was not identified during this consultation.<br><br>Although Avery's mother had a number of attendances with clinicians throughout her antenatal care, the evidence revealed that she was given no additional advice regarding the safety of her medication and, whilst she was advised to seek advice from her GP as the prescriber, she did not feel it was necessary to do so having already had such a consultation in April 2024.<br><br>Avery's mother continued to suffer from migraines during her pregnancy and was unaware of the risk posed by taking Candesartan in pregnancy due to a lack of clear and definitive advice about the risk. I am concerned that she was able to resume taking Candesartan approximately 14 days after her initial GP consultation as the medication remained on a repeat prescription which she was able to continue to request during her pregnancy, and each request was approved without a detailed review. The last repeat prescription being approved only 12 days prior to Avery's birth.<br><br>I am concerned that despite advice from the GP that it was best to stop all medication during pregnancy, Candesartan remained as a repeat prescription and, in addition to that, there were no warnings placed on the system which would have alerted the clinician approving the request for the repeat prescription that the patient was pregnant thus necessitating a review.<br><br>I shall be glad to be told of any learning arising from this death and timescales and results of your review. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st March 2026. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -<br>• Family and their Solicitors and Counsel<br>• South Tyneside and Sunderland NHS Foundation Trust and their Solicitors<br>• Solicitors and Counsel for Riverview Surgery<br>• Care Quality Commission<br><br>I am also under a duty to send the Chief Coroner and all interested persons, who in my opinion should receive it, a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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 this 2nd day of February 2026<br><br>Signature: [redacted]<br>HM Senior Coroner for the City of Sunderland |