NHS England

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20th January 2026

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Paolino Amico who died on 12 June 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 November 2025 concerning the death of Paolino Amico on 12 June 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Paolino's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Paolino's care have been listened to and reflected upon.

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

Your Report raises concerns around morphine administration involving multiple nurses, who had all completed their original training outside of the UK and had undertaken a Trust's medicines administration training. Such training should have enabled the nurses to recognise that the prescription of morphine sulphate (MST) was inappropriate, and that there had been a prescription error leading to multiple overdoses of MST. You also raised that medicines administration refresher training for nurses is not mandatory.

Inaccurate or incomplete recording of medication in the patient's records

Nurses, as key members of the healthcare team, play a vital role in the administration, monitoring and documentation of medication. It is difficult to ascertain from this specific case and the information available what specific systems and other contributory factors may have hindered the nurse in the Emergency Department (ED) from documenting or scrutinising the administration of MST, noting the fast paced and busy ED environment.

Evidence and published research highlights that distractions and interruptions cause memory lapses and task omissions, and are recognised factors leading to nurses forgetting to document care and potentially leading to omissions of care. Documentation is guided by the rights of medication administration and regulatory standards set by bodies like the Nursing and Midwifery Council (NMC) and Care Quality Commission (CQC).

Contemporaneous patient medical records must be completed at the time of administration to avoid errors, and the practitioner administering the medication is accountable for their actions. To ensure high standards of care, the NMC has established comprehensive guidelines and standards for medicines management.

Inappropriate escalation to the junior doctor for prescribing pain relief

Your Report raises concerns around the ED nurse approaching a foundation year 1 doctor to prescribe pain relief, rather than escalating to the nurse in charge or a senior doctor. Evidence and published literature recognises that human factors such as workload, fatigue and competing priorities can contribute to errors in clinical practice; therefore supporting our workforce in these and other settings is essential to improving patient safety.

Year 1 foundation doctors can prescribe medication, under supervision. It may be that the nurse was not aware of this and assumed that the doctor would have asked a more senior doctor to check and sign off on the medication prescription.

Medication error and scrutinising the prescription

Your Report also raises concerns around the prescription error and lack of scrutiny, despite multiple nurses being involved in checking and administering a controlled drug. Administering medicines is a high risk task in healthcare and medication checks are critical to prevent errors (defined as any mistake in the prescribing, dispensing, administering or monitoring of medicines).

Annually, an estimated 237 million medication errors occur with administration and prescribing being the most common. Of this 66 million are potentially clinically significant errors.. In line with the National Patient Safety strategy, healthcare providers must be committed to minimising risk and harm to patients and, to ensure safety, the NHS is using a Just and Learning Culture approach which involves identifying the causes of errors and learning from them.

Registered nurses are expected to scrutinise prescriptions, ensuring that they are legible, valid and appropriate for the patient before administration. This includes checking the patient's identity, the medicine name, dose, route and timing as well as confirming that the prescription complies with legal requirements, particularly for controlled drugs. However, as stated above, based on the information available it is difficult to ascertain what system factors may have contributed to the medication errors in Paolino's case.

Controlled drugs must be administered in strict accordance with policy, usually requiring a second registered nurse to witness preparation and administration, with

both signatures recorded in the controlled drugs register. National Institute for Health and Care Excellence (NICE) medicines optimisation guidance (NG 5, 2015) emphasises the need for robust systems to verify prescriptions and prevent avoidable harm. When multiple nurses check a controlled drug but fail to identify an error, this highlights a breakdown in the safety system such as clinical oversight of prescribing by pharmacists. The Royal College of Emergency Medicines and UK Clinical Pharmacy Association have issued a joint statement on the benefits of pharmacy support to emergency departments.

NHS England offers support to providers to improve the safe use of controlled drugs. NHS Trusts must appoint a Controlled Drugs Accountable Officer and a Medication Safety Officer. Their remits differ however both have a duty to ensure the safe use of opioids in their organisations. NHS England operates networks for both groups to receive and spread the learning from errors. We also offer guidance and tools to enable NHS Trusts to effectively learn from patient safety incidents through the Patient Safety Incident Response Framework. We note that the Patient Safety Incident Response Plan for the Princess Alexandra Hospital includes workstreams to improve safety in ED, in Medicines management, controlled drugs and medicines reconciliation

Failure to escalate National Early Warning Score (NEWS)

When a patient's NEWS score reaches 10, this represents a critical level of physiological deterioration requiring an urgent medical response. Providers will have local policies and Standard Operating Procedures (SOP) in place for the safe and effective management of this. This information would be important to ensure lessons are learnt and the risks of reoccurrence are mitigated.

NEWS was developed by the Royal College of Physicians in 2012, aimed at standardising the process for recording, scoring and responding to changes in routinely measured physiological parameters in acutely unwell patients, and to support the reliable recognition and response to acute deterioration. The guidance is clear that scores as high as 10 mandate an immediate urgent call to a senior doctor or the rapid response team. Registered nurses are professionally accountable under the NMC Code to 'Raise concerns immediately if you believe a person is at risk.' It is recognised that a failure to escalate promptly in these circumstances places the patient at significant risk of harm.

Documentation must also reflect the NEWS score, the actions taken and the time of escalation, ensuring transparency and accountability.

Overdosing medication

It is disappointing that, despite multiple nurses checking and administering a controlled drug on 5 separate occasions between 10 and 11 June 2024, it did not raise concerns about the potential for a prescription error, nor was it noted that Paolino had already received 1 dose of MST that morning. As above, when multiple nurses check a controlled drug but fail to identify an error, this highlights a breakdown in the safety system such as a lack of an independent double checking process. Registered nurses are expected to exercise vigilance when scrutinising prescriptions and preparing medicines, ensuring that doses are correct and appropriate for the patient. The NMC

Code requires nurses to ‘preserve safety’ and ‘practise effectively’, which includes preventing harm through careful checking and adherence to local medicines management policies.

Lack of mandatory refresher training

Registered nurses are expected to maintain up-to-date knowledge and competence in medicines management through initial training and regular refresher programmes. The NMC Code requires nurses to ‘keep your knowledge and skills up to date’ and to practise safely by recognising the limits of their competence.

The NICE medicines optimisation guidance NG 5 (2015) referenced above recommends that organisations support healthcare professionals through training and education to ensure safe prescribing, dispensing and administration. In this specific case, education and training alone would not prevent these types of safety system issues and would not be sufficient to mitigate the risk of reoccurrence. Systems improvements and mechanisms will need to be implemented to ensure lessons are learnt and that the current organisational and systems factors and processes highlighted in this case are addressed, to ensure the safe and effective checking and administration of medications. This has been substantiated by safety research and incident analysis.

The Royal College of Nursing guidance emphasises that medicines administration training should be refreshed periodically to ensure familiarity with current legislation, local policies and best practice in areas such as controlled drugs, high risk medicines, and safe prescribing. Refresher training also reinforces the importance of double checking, accurate documentation and escalation procedures when errors or adverse reactions occur.

Local Actions

The Princess Alexandra Hospital NHS Trust will be providing their own response to this Report, however, the Hertfordshire & West Essex ICB have advised NHS England of the Trust’s governance arrangements and actions being taken to address the concerns raised. It is understood that the Trust’s Patient Safety Group (PSG) has active oversight of several of the areas highlighted in the Report, particularly medicines safety, recognition of deterioration, and incident learning.

Medicines safety is a standing agenda item at their PSG, supported by the Medicines Optimisation Group and Medication Safety Officer, with regular review of prescribing and administration incidents, controlled drugs governance, and training compliance. The PSG has recognised gaps in training uptake and has been sighted on system-level behaviours through its routine oversight of medicines safety and incident learning. Themes PSG have been sighted on include:

- Variable engagement with medicines safety processes, such as inconsistent uptake of medicines management training and variation in adherence to medicines administration standards.

- Inconsistent escalation behaviours, for example delays in escalating concerns or delays in closing incidents and embedding learning.
- Operational pressures influencing practice, such as missed opportunities to scrutinise prescriptions or incomplete discharge processes.
- Variation in response to clinical or governance challenge, where concerns about documentation or compliance have not always been acted on promptly.

PSG has strengthened leadership challenge, required divisional action plans where compliance is low, and continues to monitor medicines safety, controlled drugs governance and deterioration as standing agenda items."

Recognition and escalation of deteriorating patients is overseen through the Deteriorating Patient Group, with additional mitigation introduced via 12-hour harm reviews in urgent care settings to examine escalation, observations and clinical response.

The PSG has also strengthened its focus on timely incident closure and learning, with senior leadership challenges and actions in place to ensure serious incidents are reviewed, learning is embedded, and assurance is provided through the Quality & Safety Committee and Trust Board.

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 Paolino, 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
NHS England