Lewisham and Greenwich
NHS Trust

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HM Assistant Coroner Lillian Field
London Inner South Coroners Court
1 Tennis Street
Southwark
London
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5 December 2025

Dear HM Assistant Coroner Dr Lillian Field

RESPONSE TO PREVENTION OF FUTURE DEATH REPORT
Paula Doreen Hughes

We are writing in response to your prevention of future death report dated 10th October 2025, concerning the care provided to Ms Paula Doreen Hughes. The Trust continue to extend our condolences to the family of Ms Hughes.

Your report highlighted in total six matters of concern that the Trust will endeavour to address, and we provide further information as to these concerns below.

1. **Preventing concurrent prescriptions of paracetamol containing drugs and otherwise preventing prescribing errors resulting in therapeutic excess of paracetamol**

There are several safety elements incorporated into the Lewisham and Greenwich NHS Trust (LGT) electronic prescribing and medicines administration (EPMA) system, iCare. This includes a 'hard stop' on prescribing concomitant paracetamol containing products and a number of 'soft stops' as listed below:

(i) For prescribers:

- Hard stop alert if the patient is already prescribed a paracetamol containing product, or if multiple paracetamol-containing products are prescribed concurrently (except for a single stat IV dose prescribed with regular oral paracetamol, which is often done post-surgery as part of Enhanced Recovery After Surgery (ERAS))

- Dose range checking for IV paracetamol exceeding 15 mg/kg or oral doses exceeding 1 g (the oral paracetamol dose range checking will soon be updated to also oral doses exceeding 15 mg/kg for patients weighing less than 50 kg following updated guidelines)

(ii) For nurses:

- Soft stop alert for nurses at point of administration if giving 5 doses given in 22 hours or 6 doses given in 24 hours - the alert itself makes it clear how many doses and when the doses were given
- Soft stop alert for nurses at point of administration if intravenous dose is greater than 15 mg/kg (i.e., it is possible for the prescriber to prescribe paracetamol with only an estimated weight, if an actual weight is recorded and the dose is found to be too high it will alert the nurse) - currently only for IV doses but will include oral doses following updated guidelines
- "Dose too close" alert for when paracetamol is being given within 4 hours of a previous dose

In May 2027, the Trust will be joining Epic, an electronic records and prescribing system shared by our neighbouring Trusts, Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH).

There is not currently a hard stop in place for duplicate paracetamol prescriptions within the instance of Epic. However, this functionality is available, and the working understanding is that all safety features on iCare that are not present on Epic will be implemented. This will require agreement from all three Trusts (LGT, GSTT and KCH) and we will seek assurance of this as part implementation.

2. Management of therapeutic excess if it has not been prevented

The iCare system has an approved protocol available for paracetamol overdose (screenshots attached). This is the Scottish and Newcastle Anti-emetic Pre-treatment (SNAP) protocol. We recognise that a clinical guideline would help clinicians to identify whether this is required or not, and this is not something that currently exists at LGT. We will develop a clinical guideline for the management of paracetamol overdose in due course, that will be available to all Trust staff, to include a robust clinical response to the management of therapeutic excess and the potential for toxicity.

3. The assessment of the ACVPU score

The Trust acknowledges the concerns raised by the Coroner regarding the inaccurate assessment of ACVPU in this case, the associated impact on NEWS scoring, and the risk this poses to timely escalation of a deteriorating patient. We recognise that assessment of confusion can be subtle and subjective, and that training and policy must clearly support staff to identify even early or mild indicators of altered cognition. In direct response to the Coroner's concerns, the following actions have been agreed by the Senior Nursing leadership team:

(i) Strengthening of Deteriorating Patient Training

The Lead Practice Development Nurse will review and update the Trust's Deteriorating Patient Training Programme to incorporate clearer guidance, case-based scenarios, and explicit teaching on the assessment of ACVPU, including recognition of subtle confusion.

(ii) Refresher Training for Ward Staff

All clinical staff on the ward where the patient was admitted will complete refresher training on recognising and escalating the deteriorating patient, with a specific focus on accurate ACVPU assessment. This will help ensure consistent and reliable NEWS scoring across the team.

(iii) Improvement in Training Compliance Trust-wide

The Trust will increase the number of staff completing deteriorating patient training across all relevant clinical areas during 2026/27, compared with the 2025 baseline. This will support a broader uplift in staff knowledge and skills relating to the identification of patient deterioration, including cognitive change.

(iv) Review of the Adult Deteriorating Patient Policy

The Lead Practice Development Nurse, the Trust Resuscitation Lead and Consultant Lead for Deteriorating Patients will review and revise the Trust's Adult Deteriorating Patient Policy to ensure the inclusion of relevant Royal College of Physicians guidance and clear instructions for assessing ACVPU, including how to identify subtle confusion.

These actions have already been shared with the relevant clinical leadership teams to ensure full alignment and implementation across nursing and medical services. The Trust is committed to improving the accuracy of ACVPU assessment and the reliability of NEWS scoring to support early identification of deterioration, in line with the Coroner's concerns.

4. Mechanism for recording over the counter medications taken prior to attendance at the Emergency Department

The London Care Record (a secure digital system which provides access for healthcare staff to review health and care information such as GP records), information obtained from patients and their carers, and information brought in London Ambulance Service (LAS) are regularly used sources of information. The Emergency Department can be a challenging environment in which to initiate the medicines reconciliation process.

Handover documentation from LAS includes a section for Medication History, but does not prompt specifically for over-the-counter (OTC) medication. In Mrs Hughes' case however, this information had been included in the 'Event History' section. The LAS handover document is uploaded to iCare as a PDF. Depending upon the screen size of the device being used, the PDF may need to be magnified to clearly read information included.

Some actions identified through discussion with senior pharmacy staff to address some of the challenges of completing a medicines reconciliation in the Emergency Department (ED) are as follows:

- Explore options for amending ED clerking proforma to include prompt 'Any medications – including over the counter – taken in the last 96 hours'
- Explore options for LAS handover proforma to include OTC medicines as a separate prompt
- Review the Medicines Reconciliation Policy
- Add a specific section for OTC products
- Review checklist to improve clarity around discussing OTC products
- Add a specific reference to looking at the LAS handover document as a source of information
- Review checklist for different staff groups/settings
- A Medicines Reconciliation Quick Reference Guide for ED staff highlighting sources of information and including prompt for OTC products
- There are some options for reviewing pharmacy specific processes on iCare in relation to documenting the use of OTC products that the Trust will explore. The feasibility of these options and an appraisal of these would be required, including:
    - Introduce a question: *'The patient has been asked about OTC products'* and a yes/no button as part of Pharmacy Medication History. This would act as a prompt for those completing medication histories to specifically ask about OTC products
    - Include the field, '*OTC medication – yes/no/NA'* as part of 'Document Medication by History' form. This would allow the documentation of regularly used OTC items to be included as part of the medication history.

Implementation will require collaboration with wider clinical teams and this will be achieved through taking the plans through clinical governance forums.

5. Trust approach to mitigating against confirmation bias and encouraging professional curiosity

Regarding the care of Ms Hughes, it is evident that members of staff did not demonstrate the necessary rigour, attention to detail and professional curiosity which may have contributed to her deterioration.

The initial duplicate paracetamol prescription was a simple error, but the ongoing continued behaviours of the individuals involved in facilitating excess paracetamol being given could be attributed due to confirmation bias and lack of professional curiosity.

Doctors are taught from the earliest stages in their education and training to think independently, use safety systems to prevent error and to raise their concerns where appropriate. Staff, including nurses, are taught to raise concerns and challenge unsafe practise. Staff are taught to follow standards as set out in the trust medicines policy however this is part of a wider framework of professional behaviour and standard setting, relating to both GMC and NMC training and guidelines. There are multiple ways any health care professional could raise concerns about a prescription, both formally and informally at LGT and challenge is welcomed. Nurses are taught to be able to flag concerns at multiple levels – with resident doctors, consultants, pharmacy and with their nursing counterparts. In this scenario, it is more likely that a lack of attention to detail was the problem vs an unwillingness to challenge. None of the staff interviewed expressed concerns about communication. Additionally, there is also a ‘Speak up Guardian’ who’s contact details can be found on the Trust’s intranet.

Learning from patient safety incidents is embedded at LGT at a local (weekly incident teaching) and at an organisational level. The October 2025 Patient Safety Group has presented this case for discussion and learning specifically regarding whether confirmation bias played a role in Ms Hughes’ care. This case will also be shared in Grand Round and with medical students in 2025/26.

6. Trust policy on managing virtual patient reviews

The Trust is developing guidance on virtual reviews using the NHS guidance (https://www.england.nhs.uk/long-read/remote-consulting/) [updated by NHSE in March 2025]. This guidance relates to full patient reviews as part of clinic appointments/virtual wards, however the guidance can also be transposed to telephone referrals/reviews.

Additionally, most reviews are expected to be done face to face, however, it is also accepted that a colleague may ask for advice without face-to-face review and there are professional standards around this. There are multiple situations where a virtual review is acceptable, and it would be unsustainable and impossible for every review to be done face to face. This would be the same process between all health care professionals.

Staff are encouraged to escalate if there is disagreement on the need for a face-to-face review. The organisation is currently reviewing escalation processes around advice giving, recognising that it is key for staff to be able to escalate if they feel a patient requires more senior input or a face-to-face assessment for example.

Internal professional standards (IPS) are a key part of the review process. The Trust have reviewed their IPS very recently and are participating in a leadership exercise on this topic with dissemination to all staff on any learning/changes required. This is being done in conjunction with Getting It Right First Time (GIRFT) as part of a wider exercise on efficiency and safety and led by the medical directorate. There are now many systems within the NHS (as part of the wider NHS desire for streamlined pathways and community interface) that support virtual review (e.g. virtual ward) and whilst they are not directly relevant to this case, it is accepted that we do not need to always review face to face as long as adequate information is shared and there is an escalation process. This will no doubt become more important and there is ongoing work with an intention to edit the IPS locally, and work with the Virtual Ward providers to maximise safety around virtual review.

The Trust will disseminate the above by way of patient safety bulletins, the need for vigilance around virtual review and advise staff of the dangers of it and the clear routes for escalation if they are not satisfied with the response.

Ensuring compliance and the effectiveness of new processes will be overseen and monitored by the Trust via its governance structures for quality. We would like to assure you that Lewisham and Greenwich NHS Trust have taken the concerns raised seriously and learning from this incident will be shared and overseen by the Quality and Patient Safety Committee.

Should you have any further questions regarding any of the information provided in this letter or require any further information please do not hesitate to contact us.

Yours sincerely

[redacted]

Chief Medical Officer
Lewisham & Greenwich NHS Trust

Enc: screenshots of SNAP protocol on iCare