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[redacted]

National Medical Director
NHS England
Wellington House
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5th December 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Paula Doreen Hughes who died on 1st January 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12th October 2025 concerning the death of Paula Doreen Hughes on 1st January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Paula's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Paula's care have been listened to and reflected upon.

Your Report raises concerns with prescribing errors, leading to concurrent prescriptions of paracetamol containing drugs being administered. You were concerned that the Cerner prescribing system offers a duplicate checking function but that this is not a standard feature. You also raised concerns with the assessment of Paula's Alert, Confusion, Voice, Pain, and Unresponsive (ACVPU) score, in particular that she was scored as alert when she was confused. You noted that the consistent and accurate assessment of the ACVPU element of the National Early Warning Score (NEWS) 2 is likely to be a matter of wider concern.

The risk of concurrent prescriptions of paracetamol containing drugs

Currently, it is possible to have more than one paracetamol containing drug on a patient's list of prescribable drugs and for both drugs to be issued concurrently. Electronic prescribing allows for the prescriber to be alerted if they attempt to prescribe two paracetamol containing drugs concurrently. In this case, although this safety feature was available in Cerner, it was not a 'standard feature' and it is assumed that it was not 'switched on'. Had this feature been enabled, there is a reasonable likelihood that the error would have been prevented.

A significant proportion of NHS Trusts (92% of acute providers) have implemented Electronic Prescribing and Medicines Administration (EPMA) systems, though the functionality and configuration of clinical decision support (CDS) and alerts vary widely. While these alerts are an important safety feature, they are designed to

support, not replace clinical judgement and responsibility. In particular, there is a risk that frequent alerts can lead to “alert fatigue” and desensitisation, increasing the risk of overlooking critical warnings. This reinforces the need for careful consideration of which alerts remain active, even for common contraindications, as repeated exposure can normalise risk and condition users not to pay attention to alerts. Additionally, some NHS Trusts do not yet have EPMA systems, making vigilance through multidisciplinary review essential to mitigate these risks.

There are some cases where it may be intentional to have more than one paracetamol item prescribed concurrently, such as for prescribing both oral and intravenous paracetamol. In this scenario, multiple prescriptions would have to be written to give these options. There are some systems that provide decision support at the point of administration – for example, if the patient had received a dose of paracetamol in the last 4 hours or they had reached their limit for the day, then there would be an alert if the user attempts to give the patient more. However, this type of alert is not universal to all systems.

If an electronic prescribing system has safety-critical features, then a strong argument can be made that these should be a ‘standard feature’ rather than an optional feature (as appears to be the case with Cerner).

NHS England commissioned the ‘ePrescribing Risk and Safety Evaluation’ (ePRaSE) toolkit, which is an online self-assessment tool that NHS secondary care providers are able to register to use with annual releases. It is intended to test how effectively e-prescribing systems respond to high-risk prescribing scenarios. The 2025 release is now finalised and therapeutic duplication as a theme is included. This incident will be considered as part of the review of the scenarios for the next release in 2026 as a priority area.

NHS England also understands that Lewisham and Greenwich NHS Trust (LGT) are looking into available electronic prescribing systems that assist in preventing concurrent prescriptions of paracetamol containing drugs. They are currently liaising with neighbouring Trusts to consider the other barriers they can put in place to reduce the risk of this happening again.

Assessment of the ACVPU (Alert, Confusion, Voice, Pain, Unresponsive) element of the National Early Warning Score (NEWS) 2

NEWS2 is a scoring system in which a score is allocated to various physiological measurements when a patient presents to, or is being monitored in, hospital. It asks clinicians to distinguish between a patient being 'alert' or otherwise experiencing 'confusion' and/or 'unresponsiveness'. The existence of ‘confusion’ is sometimes subtle and hard to recognise. The subtle signs of mental alteration might be better picked up by family or friends, and the work NHS England is undertaking on implementing Patient Wellness Questionnaires and patient safety initiatives such as Martha's Rule will support this. However, the Royal College of Physicians, to whom your Report is also addressed, would be best placed to address how to support training

of healthcare professionals to ensure consistent and accurate assessment of the ACVPU element from a national perspective.

From a local perspective, NHS England is aware that, in 2022, LGT provided additional training on 'The Deteriorating Patient' to the ward where Paula was cared for. Since September 2023, the Trust has introduced additional recommended courses including the 'Simulation Study Day', which focuses on the recognition and management of the deteriorating patient, the Airway, Breathing, Circulation, Disability, and Exposure (ABCDE) assessment, escalation and NEWS2. In June 2024, the ward Paula was on received a month-long series of informal teaching sessions about NEWS2 and response.

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 Paula, 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