ROYAL PHARMACEUTICAL SOCIETY

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Ms Liliane Field
Coroner for London Inner South
Ref: Prevention of future deaths Report Reg 28 Paula Doreen Hughes [redacted]

[redacted]

1st December 2025

Dear Ms Liliane Field,

**RE: Regulation 28 Prevention of Future Deaths Report for Ms Paula Doreen Hughes, deceased.**

We are writing to you regarding the report into the death of Ms Paula Doreen Hughes dated 1st January 2022. We would like to express our sincere condolences to the family of Ms Paula Hughes.

The Royal Pharmaceutical Society (RPS) is the professional leadership body for pharmacists and pharmacy in Great Britain, representing all sectors of pharmacy. Our role is to lead and support development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. We transferred our regulatory role to the General Pharmaceutical Council ('GPhC') in 2010, and they now regulate pharmacy and pharmacy professionals in Great Britain.

We acknowledge the conclusion from the inquest on 22nd July 2025 that the medical cause of death of Paula Doreen Hughes was recorded as *acute (fulminant) hepatic failure; paracetamol overdose; and ischaemic heart disease, urinary tract infection, diabetes mellitus and excess alcohol consumption*.

We also acknowledge your conclusion narrative that it was *'a medication error resulting in an unintended therapeutic excess of paracetamol contributed to by failure to recognise it and administer timely treatment to mitigate the risk of liver toxicity'.*

[redacted]

[redacted]

We note the matters of concern in the report with respect to the Royal Pharmaceutical Society (RPS):

1. ***In respect of preventing concurrent prescriptions of paracetamol containing drugs and otherwise preventing prescribing errors resulting in therapeutic excess of paracetamol (NHSE, RPS, Cerner, MHRA, LGT)***

***(1) NHSE, RPS, Cerner, MHRA***

***I consider that the risk of concurrent prescriptions of paracetamol containing drugs is of wider national concern. The Cerner prescribing system offers a duplicate checking functionality that is not a standard feature. It is hard stop and can be overridden and was not adopted by the LGT when the system was introduced. All the healthcare professionals were aware that co-codamol contained paracetamol and should not be prescribed with paracetamol. However, the 2 prescribing doctors failed to recognise that Mrs Hughes was already prescribed a paracetamol containing drug. 2 nurses failed to recognise they were administering 2 paracetamol containing drugs. A pharmacist failed to identify the concurrent prescriptions during reconciliation. '***

In considering our response we have sought input from our Expert Advisory Groups (RPS Hospital and Digital Expert Advisory Groups) and colleagues in the NHS England Patient Safety Team. We have also informally discussed and shared the learning from this case with relevant stakeholders at our meetings as appropriate to raise awareness.

In our response, we have focused on what we believe to be the two key system learning areas: (1) the people issues and (2) the technology issues.

In relation to the *people issues*, there were opportunities for healthcare professionals (without the need for any digital intervention) to identify the medication error. Electronic prescribing and medicines administration systems (EPMA) and clinical decision support (CDS) tools have been widely adopted in healthcare settings to support clinicians in making prescribing decisions and reduce the number of prescribing errors.[1] They, however, do not replace the personal responsibility and accountability for prescribing and clinical decision making for healthcare professionals. The coroner accurately highlights in the report the importance of professional curiosity in delivering person-centred care. The PFD report does also highlight the need to remind clinicians of the risks around the prescribing of paracetamol containing products and the issue of duplication. Professional leadership bodies can highlight this particular safety concern and raise awareness of national resources such as the BNF which have a particular reference to safe paracetamol prescribing.

In relation to the *technology issues*, detecting and managing safety risks with electronic prescribing can be difficult due to the complex nature of potential errors relating to not only the system itself, but also the behaviours of users and characteristics specific to organisations. The systems may face a range of problems in practice, including alert fatigue, increased prescriber error and issues with partial or inconsistent implementation[2,3].


1. Kit Lo, M., Bourne, K., Besharat, I., 2025. Designing an electronic prescribing and medicines administration system in a paediatric setting. *The Pharmaceutical Journal* [Online]. Available from: https://pharmaceutical-journal.com/article/ld/designing-an-electronic-prescribing-and-medicines-administration-system-in-a-paediatric-setting [Accessed 17 November 2025]
2. Lorenc, T., Khouja, C., Sowden, A., 2022. Electronic prescribing and Clinical Decision Support Underpinning theories and future directions [Online]. Available from: https://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3966 [Accessed 17 November 2025]
3. HSIB, 2019. Investigation report: Electronic prescribing and medicines administration systems and safe discharge [Online]. Available from: https://www.hssib.org.uk/patient-safety-investigations/electronic-prescribing-and-medicines-administration-systems-and-safe-discharge/investigation-report/ [Accessed 17 November 2025]

We understand from RPS Digital and Hospital Expert Advisors that most EPMA software in acute trusts have some form of decision support system as part of their package. Most would have a therapeutic duplication alert or a 'pop up' enabled that would alert the prescriber when they are prescribing paracetamol and another medicine that contains a paracetamol containing medicine. The system functionality can be set not to alert when prescribing, as there may be legitimate circumstances when a prescriber may want to prescribe the same or a similar medicine. For example, the acceptable duplication of insulin dosing where a patient may need a long-acting insulin prescribed as part of their regime in conjunction with a short acting insulin, or where regular morphine and PRN/as required morphine is co-prescribed for breakthrough pain.

We believe that steps could be taken to try and build alerts and warnings for the *unacceptable* duplication of medicines into these electronic prescribing systems to make them safer. This would require national oversight to coordinate work with secondary care system suppliers.

We understand that NHS England commission the 'Electronic Prescribing & Safety Evaluation' (ePRaSE) project, an online NHS-sponsored self-assessment tool developed to help trusts learn about how well their electronic prescribing systems have been configured and maintained to mitigate against known prescribing risks to keep patients safe.

Thank you for highlighting your concerns in this prevention of future death report. We will consider how we can raise awareness of these important issues through our future communications and engagement with the wider pharmacy sector.

Yours sincerely,

[redacted]

[redacted]
Patient Safety Manager
Royal Pharmaceutical Society


1. Kit Lo, M., Bourne, K., Besharat, I., 2025. Designing an electronic prescribing and medicines administration system in a paediatric setting. *The Pharmaceutical Journal* [Online]. Available from: https://pharmaceutical-journal.com/article/ld/designing-an-electronic-prescribing-and-medicines-administration-system-in-a-paediatric-setting [Accessed 17 November 2025]
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3. HSIB, 2019. Investigation report: Electronic prescribing and medicines administration systems and safe discharge [Online]. Available from: https://www.hssib.org.uk/patient-safety-investigations/electronic-prescribing-and-medicines-administration-systems-and-safe-discharge/investigation-report/ [Accessed 17 November 2025]