**CORONER FOR INNER SOUTH DISTRICT**

**GREATER LONDON**

**Southwark Coroners' Court, 1 Tennis Street, Southwark, SE1 1YD**

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**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. [redacted], Chief Executive, Lewisham and Greenwich NHS Trust, University Hospital Lewisham, Lewisham High Street, London SE13 6LH<br>2. [redacted], Chief Executive NHS England, Trust Office, 4th Floor Gassiot House, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH<br>3. [redacted] Chief Executive Officer, Royal Pharmaceutical Society (RPS), 66-68 East Smithfield, London E1W 1AW<br>4. [redacted], Oracle and Cerner, Senior Client Accountable Executive-Oracle Health at Oracle, One South Place, London, EC2M 2RB<br>5. [redacted] Chief Executive Medicines and Healthcare Products Regulatory Agency (MHRA), 10 South Colonnade, Canary Wharf, London E14 4PU<br>5. [redacted] Chief Executive Officer, Royal College of Physicians, 11 St Andrews Place, Regents Park, London NW1 4LE |
| 1 | **CORONER**<br><br>I am Liliane Field for London Inner South |
| 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><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br><br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | INVESTIGATION and INQUEST<br><br>On 20 January 2022 I commenced an investigation into the death of Paula Doreen Hughes, aged 55 years.<br>The investigation concluded at the end of the inquest on 22 July 2025. The conclusion of the inquest was Paula Doreen Hughes died on 1 January 2022 at Queen Elizabeth Hospital, Woolwich, London. The medical cause of death was recorded as |

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| | 1a Acute (fulminant) hepatic failure<br><br>1b Paracetamol Overdose<br><br>2 Ischaemic heart disease, urinary tract infection, diabetes mellitus and excess alcohol consumption I concluded that the death with the following narrative:<br><br>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 |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Paula Hughes had been admitted to Queen Elizabeth Hospital on 6 January 2022 having suffered a fractured humerus following a fall the previous evening. Between 6 and 8 January 2022 she received paracetamol in excess of the recommended dose largely as a consequence of paracetamol being inadvertently prescribed addition to co-codamol, a paracetamol containing drug, on 7 January. Pharmacy review failed to pick up the concurrent prescription and both drugs were administered together on 3 or 4 occasions until the duplicate prescription was deleted at around 14.30 on 8 January. Despite a deterioration in her condition from around midday on 8 January, it was not recognised that Mrs Hughes had received an overdose of paracetamol until the morning of 9 January, by which time she had been admitted to intensive care in fulminating acute liver failure. As a consequence, she did not receive timely treatment with n-acetyl cysteine which would have mitigated the toxic effects of paracetamol on her liver. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report you.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>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)<br><br>(1) NHSE, RPS, Cerner, MHRA<br><br>I consider that the risk of concurrent prescriptions of paracetamol containing drugs is of wider national concern.<br><br>The Cerner prescribing system offers a duplicate checking functionality |

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| | 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.<br><br>(2) LGT<br><br>LGT's response to the incident was swift and commendable. A hard stop was introduced to the electronic prescribing system which eliminated concurrent prescriptions of paracetamol containing drugs. Further refinements of the system significantly reduced therapeutic excesses of paracetamol based on weight, which had been identified as an issue when investigating Mrs Hughes' death. However, it is my understanding that consideration is being given to changing the electronic record and prescribing system. My concern is that during any move to a new system, the safety nets introduced by the Trust will be diluted or lost<br><br>2. Management of therapeutic excess if it has not been prevented (LGT)<br><br>This issue has arisen from the finding that once the concurrent prescription had been identified, there had no attempt to consider whether there had been a therapeutic excess and whether Mrs Hughes had suffered harm. The Trust's response to the incident focused on prevention. It did not consider the adequacy of the clinical response once the overdose had been identified. The Trust relies on information sharing of learning from incidents and thereafter places reliance on individual clinical practice. I received no evidence of a robust process for ensuring a consistent clinical response to the management of therapeutic excess and the potential for toxicity.<br><br>3. The assessment of the ACVPU score (LGT, RCP, NHSE)<br><br>This concern has arisen out of the fact that Mrs Hughes was scored as alert when she was confused.<br>Confusion would have added a score of 3 to her NEWS2 score and would have resulted in an earlier escalation of her condition. I heard that confusion is not always easy to identify and that the signs can be subtle.<br><br>(1) LGT<br><br>The Trust provided training materials relating to detection and management of deteriorating patients. There was minimal guidance on how to accurately assess the ACVPU score and the confusion element in particular.<br>There remains a tangible risk that the ACVPU score will continue to be |

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| | assessed inconsistently, with new episodes of confusion continuing to be missed.<br><br>(2) NHSE, RCP<br><br>I consider that consistent and accurate assessment of the ACVPU element of the NEWS2 score is likely to a matter of wider concern. This concern is being brought to the attention of NHSE and the RCP as I consider that they have the power to support healthcare professionals to ensure consistent and accurate scoring of confusion.<br><br>4. Mechanism for recording over the counter medications taken prior to attendance at the Emergency Department (LGT)<br><br>This concern has arisen out of my finding that Mrs Hughes had taken an over the counter (OTC) drug containing paracetamol before her admission to hospital but that this had not been recorded as part of her medication history. The Trust's Medicines Reconciliation Policy requires that patients should be asked about OTCs. The Trust relies on individual clinical practice. There is no mechanism to ensure that pre-admission OTCs are consistently recorded such that the risk of therapeutic excess of paracetamol (or other drugs available OTC) in those circumstances continues to exist.<br><br>5. Trust approach to mitigating against confirmation bias and encouraging professional curiosity (LGT)<br><br>Confirmation bias and a lack of professional curiosity were significant features in Mrs Hughes' being administered two paracetamol containing drugs at the same time and in not investigating whether she had received a therapeutic excess and suffered consequential harm. I have found that the Trust does not have robust mechanism for mitigating against confirmation bias and encouraging professional curiosity.<br><br>6. Trust policy on managing virtual patient reviews (LGT)<br><br>This concern has arisen out of the fact that Mrs Hughes had been reviewed virtually rather than face to face a resident doctor on the morning before she became unwell. The Trust has no guidance or policy on virtual reviews. I was told that this is a matter of clinical judgment. The absence of any guidance to help a still relatively inexperienced resident doctor decide when they can dispense with a face-to-face review is a circumstance that creates a risk that future deaths may occur. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you, Lewisham and Greenwich NHS Trust, NHS England, The Royal Pharmaceutical Society. Cerner, The Medicines and Healthcare |

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| | products Regulatory Agency and The Royal College of Physicians have the power to take such action. |
| 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 Tuesday 9th December 2025. 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<br>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><br>1. Mrs Hughes' family<br>2. Lewisham and Greenwich NHS Trust<br><br>And to NHS England, The Royal Pharmaceutical Society. Cerner, The Medicines and Healthcare products Regulatory Agency and The Royal College of Physicians (who are not interested persons)<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he 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. |
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Liliane Field

Assistant Coroner for London Inner South