ROYAL PHARMACEUTICAL SOCIETY

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Ms Elizabeth WHEELER,
Assistant Coroner for the coroner area of Cheshire
Ref: 2025-0295

By email via:
[redacted] cc: [redacted]

30th July 2025

Dear Ms Elizabeth Wheeler,

RE: Regulation 28 Prevention of Future Deaths (PFD) Report for Mr Simon Hockenhull, deceased.

We are writing to you regarding the report into the death of Mr Simon Hockenhull dated 12th June 2025. We would like to express our sincere condolences to the family of Mr Hockenhull.

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.

In considering our response, we have sought input from the RPS Expert Advisory Groups.

We acknowledge the conclusion from the inquest on 10th June 2025 that the death of Mr. Hockenhull was as a result of contracting lobar pneumonia, contributed to by his underlying diabetes and diabetic gastro enteropathy which materially reduced his resilience.

We also note the brief summary of matters of concern in the PFD Report:

'In the course of this inquest, I have heard that some diabetic medications and devices have a life span of 14 days. When two are prescribed, they therefore amount to a 28 day supply.

I have heard that this can cause problems as there are some pharmacists who interpret a 28-day supply as a "month", and that it can therefore be challenging to obtain a further prescription within the same calendar month. For patients who already have a complex relationship with their medication and monitoring regime, the challenges this causes can mean that they then do not take their medication as consistently as they need to. For patients with a diagnosis of diabetes, this can have rapid and significant impacts on their health, including developing the life-threatening condition of diabetic ketoacidosis.

At the heart of the issue seems to be that a "month" is being inconsistently defined. Sometimes it means 28 days, sometimes it is a calendar month.

The RCGP RPS "Repeat Prescription Toolkit" (October 2024) does not seem to address this issue, so it may be that prescribers and dispensers are unaware of this issue.'

It is challenging to comment as fully as we would wish as we are not in possession of the full details of the case and there are still a number of unknown elements from the Report (for example we do not yet know what diabetic medication had been prescribed for the deceased, or if it was the case that the medication couldn't be ordered?). We would like however to address your general concerns around the RCGP RPS Repeat Prescribing Toolkit and the issue of prescription duration.

The NHS prescribes and dispenses over 1 billion items per year and the vast majority of patients in England receive their medicines safely and on time. However, in 2021, the Department of Health and Social Care published its report into overprescribing - *Good for you, good for us, good for everybody: a plan to reduce overprescribing to make patient care better and safer, support the NHS,*

and reduce carbon emissions. This made 20 cross-sector recommendations to address the concerns around over prescribing of medicines that may not be appropriate. One of the recommendations was to develop a repeat prescribing toolkit.

The RCGP RPS Repeat Prescribing Toolkit was commissioned by NHS England to help practices improve the consistency of repeat prescribing processes and support this with training resource.

At the time of drafting the RCGP RPS Repeat Prescribing Toolkit, the Toolkit working group (made up of practicing GPs, Clinical Pharmacists, Patients, GP practice staff, NHS England policy leads and regulators), had been informed that NHS England may be exploring work on prescription duration and so it was agreed that specific guidance on prescription duration was out of scope for the toolkit. The toolkit was never intended to be a clinical guideline and so would not have addressed the specific issues that you have highlighted in this case. Annex A of the Toolkit (page 87) details what was within and outside of the scope of the Repeat Prescribing Toolkit.

You are correct, in highlighting that there is a variation between the understanding of a length of a ‘month’.

Most medications are prescribed as (calculations of) 28-day supplies (e.g. 28 days/56 days/84 days). This often aligns with the standard pack sizes of the majority of medications. This allows quantities of different medications to be synchronised so that a patient prescribed multiple medications should be able to order once per supply and receive an equal amount of all medications to manage their medications. To avoid any gaps in medication provision, prescribers will often need to issue 13 x 28-day prescriptions over the course of the year.

Patients are *usually* advised to order their prescription medications 7-14 days in advance of running out, depending on the GP practice and community pharmacy workload. So, a patient's request for medication within 14 days of the due date would usually be accepted and issued despite being an 'early' request, as it allows the community pharmacy time to order and dispense the medications, then the patient to collect the medication before their dose is due. Most GP practices set deadlines for medication requests to be processed by their prescribers (an example of this may be within a 48-hour period), and then community pharmacies usually mirror this. This should allow medication to be available at the pharmacy for the patient to collect before their dose is due. Some practices / pharmacies may ask for a longer lead time depending on their workload.

Whilst it is a risk that patients may forget to order their medication or order late or or there is a delay in the prescription being issued from the GP practice or community pharmacy, it is not usually linked to the medication duration of 28 vs 30 days. It is worth noting that legislation permits the community pharmacist to issue an emergency supply of a patient's regular medication following appropriate clinical checks.

Calendar months in the year would be 28, 29 (leap year), 30 and 31 days, but this would be unworkable as previously mentioned, medication pack sizes are determined by the manufacturer and the licensing is based on the pack size submitted. Splitting some packs means the pharmacy would be supplying 'off label' which can bring separate issues around that. Again, these will vary depending on whether they are a "calendar" pack or a standard pack.

It is also worth noting that guidance on the supply of medication "Original Pack Dispensing (OPD)" was published in 2023 following a public consultation, and the Human Medicines Regulations 2012 (HMRs) were amended to allow Original Pack Dispensing (OPD). The integrity of medication packaging is also an important safety feature, and not all medication packs can and should be split.

In general, clinicians should consider the individual needs of each patient and their ability to manage their medication. Vulnerable patients and for those patients whose ability to self-manage their medication is an issue, should form part of any risk assessment, care plan and structured medication review.

Thank you for highlighting your concerns in this prevention of future death report. We will raise awareness of the report through our communications and engagement with other key medicines and patient safety stakeholders who play an important role in providing advice and support to the profession. It would also help if you and the family of Mr. Hockenhull were happy to give permission for us to see the full details of the case, in order to understand the details of what happened and if there is any further learning that could be shared with members of both the Royal Pharmaceutical Society and Royal College of General Practitioners.

Kind regards

[redacted]
Patient Safety Manager
Royal Pharmaceutical Society