Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: The Royal Pharmaceutical Society**
1	**CORONER** I am Elizabeth WHEELER, Assistant Coroner for the coroner area of Cheshire
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 06 December 2024 I commenced an investigation into the death of Simon HOCKENHULL aged 56. The investigation concluded at the end of the inquest on 10 June 2025. The conclusion of the inquest was that: Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Hockenhull died at his home address on 5 December 2024. He had been diagnosed with diabetes in 2017. Since diagnosis, he had struggled to control this. His diabetes, and the poor management of the same, led to gastro-intestinal issues. The underlying diabetes and the associated gastro-intestinal issues made him more prone to contracting infections and more vulnerable when he did contract them. In 2024, his diabetic control significantly worsened. He was admitted to the ICU multiple times over that year as a result of diabetic ketoacidosis. From 2 December 2024, Mr Hockenhull's brother and community healthcare professionals became concerned about Mr Hockenhull's health. On 5 December, he was found collapsed but breathing at his home. His brother called emergency services, but by the time paramedics arrived, Mr Hockenhull had died. Mr Hockenhull died as a result of contracting lobar pneumonia, contributed to by his underlying diabetes and diabetic gastro enteropathy which materially reduced his resilience
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 06, 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - Mr Hockenhull's family I have also sent it to - Countess of Chester Hospital NHS FT who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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.
9	**Dated: 12/06/2025**

Elizabeth WHEELER
Assistant Coroner for
Cheshire