Department of Health & Social Care

Minister of State for Care

39 Victoria Street
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SW1H 0EU

HM Coroner Emma Whitting
The Court House, Woburn Street, Ampthill, Bedfordshire MK45 2HX

06 May 2026

Dear Ms Whitting,

Thank you for the Regulation 28 report of 19 March 2026 sent to the Secretary of State / the Department of Health and Social Care about the death of Paul Nash. I am replying as the Minister with responsibility for primary care.

Firstly, I would like to say how saddened I was to read of the circumstances of Paul Nash's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The report raises concerns over the ability for epilepsy patients to obtain sufficient medication in a timely manner to ensure optimum seizure control. You have raised that delays in being able to access medicines is a risk that affects many epilepsy patients across the country.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

General practice is commissioned and performance-managed by NHS England, with responsibility delegated to Integrated Care Boards, who are expected to work with practices to provide support and agree improvement plans where performance concerns arise. Where issues persist, commissioners can intervene and use contractual levers, including remedial action, to ensure safe and appropriate patient care.

This Government is committed to improving care for people with neurological conditions, including those with epilepsy, and ensuring they receive the support they need. It is vital that we ensure that they, along with their families and carers, receive high-quality, compassionate care and access to the latest services and treatments. Sudden Unexpected Death in Epilepsy (SUDEP) is a rare but devastating outcome, and the Government recognises the profound impact it has on individuals, families, and the wider epilepsy community. We are committed to reducing the risks associated with epilepsy, improving understanding of SUDEP, and ensuring that people with epilepsy receive safe,

high-quality care. The Royal College of GPs aims to raise awareness of SUDEP amongst GPs and other primary care professionals, through its e-learning modules on SUDEP and seizure safety, which were developed in collaboration with SUDEP Action.

At a national level, there are a number of initiatives supporting service improvement and better care for patients with epilepsy, including the RightCare Epilepsy Toolkit, the Getting It Right First Time Programme for Neurology and the recently completed Neurology Transformation Programme.

One key focus of the RightCare Epilepsy Toolkit is reducing epilepsy-related deaths, including SUDEP. The toolkit includes several recommendations regarding identifying those who are most at risk of an epilepsy-related death and preventing SUDEP. The RightCare Epilepsy Toolkit emphasises structured risk assessment and the importance of routine, proactive conversations about SUDEP within care pathways. The toolkit signposts to practical resources such as the SUDEP & Seizure Safety Checklist, which assists clinicians in discussing and recording risk-reduction advice with patients and their families. This approach aligns with National Institute for Health and Care guidance, which advises that clinicians should discuss the individual risk of epilepsy-related death, including SUDEP, with people diagnosed with epilepsy at the time of diagnosis and revisit these discussions as part of ongoing care. Conversations should cover individual risk factors, such as uncontrolled seizures, missed medication, and nocturnal seizures, and provide practical advice on reducing these risks. This approach ensures patients and families are fully informed and able to take steps that improve safety and reduce the likelihood of SUDEP.

The Department recognises that delays in pharmacies processing repeat prescriptions can result in patients unexpectedly running out of vital medicines. That is why all community pharmacies providing dispensing services for NHS patients in England are required to dispense medicines for patients on demand with reasonable promptness. This is set out in regulations and within the terms of service for all pharmacies on the NHS Pharmaceutical list.

This recognises that a pharmacy might need to order a medicine in when they do not have is in stock. If this occurs, the pharmacy is required to inform the patient of this delay and when the pharmacy expects the prescription to be dispensed. This should enable the patient to make an informed decision whether they would be better off taking their prescription to a different pharmacy.

Prescriptions are generally written for a month's supply, with the onus on the patient to reorder their medicines in a timely way. Longer duration of supply (e.g. 56 and up to 84 days) is also possible, based on clinical decision making, balancing the risks of stock piling with the benefit of ensuring ongoing care.

The NHSApp is the preferred route to order repeat prescriptions and a variety of NHSApp champions (including some pharmacy staff) have been trained across primary care settings to promote its use. A community pharmacy can advise patients on how to make requests for prescriptions and there are options through the NHSApp to enable designated

carers to proxy-order prescriptions on a patient's behalf. A patient may agree with their GP to nominate a particular pharmacy to dispense their medicines using electronic repeat dispensing processes. This allows the pharmacy to supply a patient on a stable medication regimen in instalments over a 12-month period without the need to keep re-ordering via their GP. This should reduce the risk of missing to an order and the pharmacy can proactively work with the patient to ensure a regular supply in advance of running out based on their prescription and preferences, e.g. to help manage any holiday periods.

The Department recognises that delays in prescriptions being sent by GPs, such as in Paul Nash's tragic case, can result in patients being left without vital medication. Provisions are in place to prevent patients being left in this situation. If a patient needs to access an urgent supply of their medicines, then there are a range of options available, which can be found at Emergency prescriptions - NHS.

As set out in the Human Medicines Regulations 2012 pharmacists can make an emergency supply of medication without a prescription at the request of a patient or prescriber. Emergency supplies can be made if the pharmacist deems this to be clinically appropriate and the item is in stock, with some limited restrictions including some related to controlled drugs.

The Urgent Medicine Supply (UMS) element of the NHS Pharmacy First Service uses this legal route for patients who urgently need a medicine they are regularly prescribed through NHS111, both through the telephone service and online service. NHS 111 can work with carers or agencies as in the case of HEADWAY for Paul Nash to support requests for urgent prescriptions if the patient is unable to do this themselves. Following an initial rapid triage the patient will be referred to a pharmacy in a location nearest to them where they can obtain a supply that same day or in time before the next dose whichever is clinically appropriate.

Once referred, the patient will receive a consultation with the pharmacist. Where it is appropriate for the emergency supply to be made, and the medicine is in stock, the pharmacist will arrange for the patient to collect the item. If the medicine is not in stock, the pharmacist must proactively assist the patient by identifying another local pharmacy that has the medicine available and provides the service and forward the electronic referral. This may involve checking stock availability through local pharmacy networks or contacting nearby pharmacies directly. If all else fails and the situation is critical, patients should be directed to the nearest A&E department or most appropriate care setting to receive treatment.

The National Institute for Health and Care Excellence has also published guidance for pharmacists on making an emergency supply of medication, which reinforces the guidance of the Royal Pharmaceutical Society which states: "The pharmacist should consider the medical consequences of not supplying a medicine in an emergency" and "If the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care."

This guidance is further supported by the [service specification] for the NHS Pharmacy First service that was launched on 31 January 2024 ([NHS England » Launch of NHS Pharmacy First advanced service]). In cases where medication that is urgently required is not in stock at the pharmacy, the service specification states that, with the agreement of the patient, the pharmacist should identify another pharmacy that provides the service and forward the electronic referral to them (see 4.19). If the patient is unable to get to the premises, the pharmacist must ensure that the patient is able to obtain the supply in a timely manner by discussing all reasonable options for accessing their medicines (see 4.20).

A review in January this year of the Pharmacy First urgent medicines pathway has been undertaken in the context of time-critical medicines in response to a prevention of future deaths report for a patient who died from Sudden Unexpected Death in Epilepsy after he was unable to obtain an urgent prescription for his epilepsy medication. A time-critical medicine is one that must be given or taken at a specific time, where a delay in receiving the dose or an omission of the dose entirely may lead to a serious patient harm. As a result, a number of actions have been taken by NHS England:

- Issued a patient safety incident notification to all community pharmacy contractors and their pharmacy teams about the importance of supplying time-critical medicines.
- Reviewed the service specification that underpins the service and identified where text can be uplifted to emphasise the importance of time-critical medicines supply. The next steps are to consult with Community Pharmacy England on the proposed changes and work with the Department to publish a refreshed document later this year with wider contract changes for 26/27.
- Worked with regional pharmacy clinical leads to engage with Integrated Care Board pharmacy commissioning teams and Local Pharmaceutical Committees to share learning from the patient safety incident notification as well as engage with the Community Pharmacy Patient Safety Group that coordinates learning across the sector through Pharmacy Superintendents and the National Pharmaceutical Association.

The Department recognises that awareness of emergency supply provisions amongst both patients and pharmacy staff can be improved. The Department is committed to working with the pharmacy sector to improve awareness and ensure patients can access emergency supplies when necessary to prevent harm or death. We are currently in consultation with the sector representative body, Community Pharmacy England, on the 2026/27 Community Pharmacy Contractual Framework. As part of this consultation we will take into account learnings from Paul Nash’s death.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

MINISTER OF STATE FOR CARE