



Corporate Office

Sentinel House
Nuffield Industrial Estate
2 Nuffield Road
Poole, Dorset
BH17 0RB

1st April 2026

Dear Mrs Griffin,

Re: Regulation 28 Report following the inquest touching on the death of James Fitzpatrick

I acknowledge receipt of the Regulation 28 Report issued to Dorset HealthCare University NHS Foundation Trust on 12th February 2026, following the inquest touching on the death of James Fitzpatrick.

Firstly, I want to express my sorrow about the death of Mr Fitzpatrick and to reiterate our condolences to his family and loved ones.

In your regulation 28 letter you identified six areas of concerns that were associated with handover processes and you highlighted there was no written local and national guidance on the handover of a patient's care. In response to your six identified areas of concern highlighted, please see our responses below.

- 1. There is a lack of written national guidance on how handovers between Doctors, Nurses and support staff should be undertaken either when a patient is moved between wards or hospitals, or when there is the handover to staff starting a shift who will be taking over the care of the person. Whilst it is acknowledged that each Trust has different policies and procedures in place, there is no generic national guidance to assist in ensuring relevant, pertinent and critical information is passed on to those who will be caring for the patient.*

Trust Response:

Following the concerns raised, we undertook a further review to determine whether any national guidance was in development. At present, we are not aware of any proposed updates or new guidance documents regarding community and mental health handover processes. We await the response from the National Bodies identified in your Regulation 28 report (NICE, GMC,



NMC), and any guidance that is issued in this area. However, in the meantime we have reviewed our own local arrangements and our additional action in relation to this is set out in section 3 below.

- Evidence was provided that national guidance currently exists in England and Wales for handovers relating to emergency care in acute hospitals, however there is no other guidance for other healthcare settings as to what a handover should include or how it should be undertaken.*

Trust Response:

A further review was undertaken and the NICE guidance reviewed again, which confirmed that there remains no current guidance specifically regarding community and mental health inpatient areas. We await the response from the National Bodies identified in your Regulation 28 report (NICE, GMC, NMC), and any guidance that is issued in this area. However, in the meantime we have reviewed our own local arrangements and our additional action in relation to this is set out in section 3 below.

- Within DHUFT there is a lack of written guidance or policy as to how handovers should be undertaken and recorded by those working within the Trust.*

Trust Response:

The Trust acknowledges there is no specific policy/guidance around handovers currently in place. Discussions have taken place with senior leads across both physical and mental health inpatient services in respect of this following the inquest.

The current position is that:

- our community hospitals use SystemOne, which generates an electronic handover document based on core principles of good handover practice
- Mental health services use RiO, which does not currently support electronic handover document extraction, leading to continued reliance on paper processes

We are committed to ensuring that the development and implementation of the new pan-Dorset electronic health record in 2028 prioritises a robust, accurate, and live handover function to support safe and consistent practice across all services.

In the interim, we have commenced development of guidance for staff regarding the format of handovers on inpatient units. This is based on SBAR (Situation, Background, Assessment, Recommendation) principles. This is currently being taken through our internal governance process. If national guidance becomes available, we will review and align our local guidance accordingly.



Alongside this immediate action to develop this guidance we have adopted a focus on handovers as a Trust Quality Priority for 2026/27. As part of this work, the first action is to scope the handover processes across all mental health inpatient units by June 2026. This will allow us to understand current approaches, the reasoning behind them, and what changes are required in light of the learning from this inquest whilst we await the new electronic health record. Establishing the Quality Priority for “Improving Inpatient and Transfer of Care Handovers”, means that audits of any incidents relating to concerns regarding handover processes will be reviewed and reported through the Directorate Management Groups for oversight and assurance. The auditing processes will be undertaken between June 2026 and March 2027.

- 4. Two weeks prior to his death, Jim was moved to another ward within Alderney Hospital. There was a verbal handover undertaken which was recorded in the electronic patient records. No written handover was provided. The patient records referred to him being a “high risk of choking” and “on an unofficial soft diet”. This information was not true and was not recorded anywhere else in his records or risk assessments.*

Trust Response:

We recognise that handover practices vary across mental health inpatient areas, with some relying on verbal handover or a combination of verbal and paper processes. These variations often reflect the nature of the patient group, some of whom may remain in services for extended periods.

However, the actions noted in section 3 above will introduce consistent guidance across the trust, and the work described as part of our Trust Quality Priorities for 2026/27 will support audit of this specifically in our mental health inpatient settings. This will allow us to understand current approaches, the reasoning behind them, and whether changes are required in light of the learning from this inquest whilst we await the new electronic health record.

- 5. Further evidence was given that at the time of Jim’s death there were a number of agency workers at Alderney Hospital, and they would rely on information provided to them at the start of their shift during the handover as they would not have time to go through each patient’s records to appraise themselves of the patient’s history and risks. A daily written handover sheet was provided at the beginning of each shift which would be updated during the day, however from the daily handover sheet provided to the Court for the day of Jim’s death, pertinent general information about Jim was missing from that handover sheet.*

Trust Response:

As noted above under points 3 and 4, and as part of the wider review described, we are taking action to support greater consistency and reduce the



risk of omissions, through developing a guidance document based on SBAR (Situation, Background, Assessment, Recommendation) principles. If national guidance becomes available, we will review and align our local guidance accordingly.

Progress will be monitored quarterly through Dorset HealthCare's Quality Governance Group. This will ensure there is appropriate governance and oversight at a senior level within the Trust.

- 6. The lack of written local and national guidance on the handover of a patient's care creates a risk that incorrect or incomplete information can be passed to those caring for an individual which may impact upon the patient's care and may lead to a future death.*

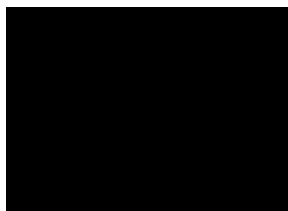
Trust Response:

The actions identified above that are now underway seek to address the concerns identified and will strengthen local handover processes. Oversight will continue through the Quality Governance Group, supported by quarterly audits reviewing incidents across all inpatient wards where handover may have been a contributing factor.

I hope that this response, and the actions and improvements we have commenced, provide assurance that the Trust is committed to learning from this inquest and to strengthening the safety and reliability of handover processes across our services. We will continue to monitor any developments in national guidance and ensure our Trust Board remains fully sighted on progress, including the role of the future electronic health record in reducing gaps, inaccuracies and omissions.

Our thoughts remain with Mr Fitzpatrick's family following their loss. We hope that the steps we are taking demonstrate our commitment to learning, improvement and the overall safety and care of our patients.

Yours sincerely



Chief Executive