

25 March 2026

Rachael C Griffin

HM Senior Coroner for Dorset

The Coroner's Office for the County of Dorset

Civic Centre

Bourne Avenue

Bournemouth

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Dear Rachael

I am writing in response to your letter of 12 February 2026 enclosing your report into the death of James Fitzpatrick. I am sorry to hear of the circumstances surrounding Mr Fitzpatrick's death, and I extend my condolences to his family and friends.

I appreciate the opportunity to review your report and respond to the concerns that you raise. I am responding as the Medical Director and Director of Education and Standards at the General Medical Council, and I have engaged with the matters of concern raised that are within our remit as the professional regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK.

I have noted your concerns around a lack of national written 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 patient.

We set a number of professional standards that are relevant to the concerns you've raised in your report and we regularly work with others across the system to raise awareness of the standards and support the professionals on our register to implement them.

In preparing our response, we met with the Nursing and Midwifery Council (NMC) to discuss alignment across our respective pieces of guidance and to explore opportunities for future collaborative working to develop some joint messaging highlighting the expected standards for communication within and across the multi-disciplinary team.

Our role and the role of our guidance

Our role

We work with doctors, PAs, AAs, patients and other stakeholders to support good, safe patient care across the UK. We set the standards that our registrants and their educators need to meet, and help them achieve them. If there are concerns these standards may not be met, or that public confidence in doctors, PAs or AAs may be at risk, we can investigate and take action if needed.

Our professional standards

We set the values, knowledge, skills and behaviours expected of all doctors, PAs, and AAs registered with us when caring for patients and working with colleagues. Our core guidance on professional standards, [Good medical practice](#), and the more detailed guidance which supports it, form the [professional standards](#) we expect all doctors, PAs and AAs to follow.

We do not set clinical standards or give clinical advice to our registrants. This is the role of a wide range of other bodies, such as the National Institute for Health and Care Excellence (NICE), government health departments and the medical royal colleges. I can see that you have sent your report to NICE.

The development of *Good medical practice* (2024) and continuity of patient care

We recently completed a review of *Good medical practice* and the latest version (effective from 30 January 2024) was developed following an extensive public consultation process, involving members of the professions, the public, patients and other stakeholders. Analysis of the responses revealed that team working and continuity of care were priority themes and we strengthened the guidance in several areas to reflect this.

We added an introductory paragraph to the standards around contributing to the continuity of care for all patients. [Paragraph 65](#) says;

Continuity of care is important for all patients, but especially those who may struggle to navigate their healthcare journey or advocate for themselves. Continuity is particularly important when care is shared between teams, between different members of the same team, or when patients are transferred between care providers.

Paragraph 65 expressly refers to patients who may struggle to navigate their journey, such as the elderly, the vulnerable, those with multiple illnesses and those who lack capacity. We also refer to sharing reasonable adjustments and communication support preferences with others involved in their care, within and across teams as required. We make clear that registrants must be confident that information necessary for ongoing care of the patient has been shared, for example, before a registrant goes off duty, delegates care or refers the patient to another health or social care provider.

We also strengthened the wording of our expectations around delegating safely and appropriately at paragraphs [66 and 67](#). We expect the professional delegating care of the patient to be confident that the person they are delegating to has the necessary knowledge, skills and training to carry out the task. Clear instructions must be given, as well as encouragement to ask questions and seek support or supervision if it's needed. And the professional receiving a delegated task must be confident that they have the necessary knowledge, skills and training to undertake it; if they are unsure, they must prioritise patient safety and seek help.

Our guidance on record keeping

Good medical practice sets out our expectations of registrants regarding recording their work clearly, accurately, and legibly at [paragraphs 69 and 70](#).

More detailed guidance on handover

Our [Leadership and management](#) guidance expands on what we say in *Good medical practice*, and goes into further detail regarding communication and team working. Within this guidance we set standards which relate to all medical professionals registered with us, and we also set standards for those medical professionals with extra responsibilities.

[Paragraph 12](#) of the guidance refers to all medical professionals. It says that medical professionals should not assume that another team member will pass on the information needed for patient care. They should check if they are unclear about the responsibility for communicating information, including during handover, to members of the healthcare team, other services involved in providing care and patients and those close to them.

Our review of our guidance on *Leadership and management* and *Raising concerns*

We have recently conducted a public consultation on these two pieces of guidance, and we are in the process of analysing the results. We intend to publish a report on the findings of the consultation later this year and will go on to develop an updated version of the guidance. We will consider the concerns raised in your report as part of this review process.

As mentioned above, paragraph 12 of *Leadership and management* already makes explicit reference to handover. However, we received feedback during the consultation process that there a common misperception that the standards we set in this guidance apply only to those in specific management or leadership roles. One of our key objectives when we launch the updated guidance, therefore, will be to emphasise the importance and relevance of the standards in the guidance to all registrants, not just those in management or leadership roles.

Also of note, [paragraph 15](#) currently sets the expectation that registrants with extra responsibilities must be satisfied that systems are in place to communicate information about patient care. When we look at redrafting this duty, we will aim to be more explicit that the duty extends to ensuring that

all relevant, pertinent and critical information about a patient is shared between all the healthcare professionals involved in their care, especially when care is passing from one team to another.

I have included an annex to this response which sets out the full wording of the all the standards I have referred to, and also some additional standards from the current version of *Leadership and management* around communication with and between teams ([paragraphs 10, 11, 13 and 14](#)).

The work we do to support implementation of the professional standards

Our [Outreach](#) teams across the UK regularly give talks and run workshops on the implementation of our guidance to our registrants. These workshops will often highlight the importance of communication, teamwork, ensuring effective information sharing and prioritising patient safety.

Implicitly, within most workshops we deliver we include the messaging that doctors should communicate well, work collaboratively with colleagues, contribute to a team, reflect on their own performance and document their actions/notes clearly and accurately.

Whilst we do not deliver a workshop which specifically focuses on handovers and continuity of patient care, we have a case study we use that covers themes within *Good medical practice* which support continuity of care and safe delegation.

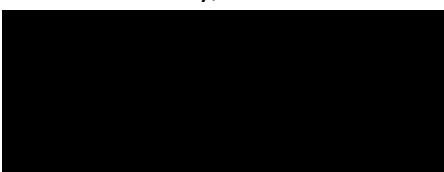
Next steps

We will continue to liaise with the NMC to identify any areas where we can work in partnership to raise awareness of the expected standards regarding communication and collaboration across the professions we regulate. One of the areas in which we have already done this is in maternity care, where we have worked with the NMC to develop resources to support professionals working in this area.

We will explore opportunities to promote our expectations regarding handovers, continuity of care, team working and communication with our Outreach team as we look to promote and implement our updated guidance on *Leadership and management* and *Raising concerns*.

I hope that my response has provided you with reassurance that we set professional standards which speak to the concerns you have raised, and that we will continue to emphasise the importance of communication and teamwork around patient safety in our messaging as we progress with our future work in developing our professional standards.

Yours sincerely,



Medical Director and Director of Education and Standards

Annex

Paragraph 65 of Good medical practice

- a. You must promptly share all relevant information about patients (including any reasonable adjustments and communication support preferences) with others involved in their care, within and across teams, as required.
- b. You must share information with patients about:
 - i. the progress of their care
 - ii. who is responsible for which aspect of their care
 - iii. the name of the lead clinician or team with overall responsibility for their care
- c. You must be confident that information necessary for ongoing care has been shared:
 - i. before you go off duty
 - ii. before you delegate care, or
 - iii. before you refer the patient to another health or social care provider.
- d. You must check, where practical, that a named clinician or team has taken over responsibility when your role in a patient's care has ended.

Paragraph 10 of Leadership and Management

Communication within and between teams

Multidisciplinary teams can bring benefits to patient care when communication is timely and relevant, but problems can arise when communication is poor or responsibilities are unclear.

Paragraph 11 of Leadership and Management

All medical professionals

You must make sure that you communicate relevant information clearly to:

- a. colleagues in your team
- b. colleagues in other services with which you work
- c. patients and those close to them in a way that they can understand, including who to contact if they have questions or concerns.

This is particularly important when patient care is shared between teams

Paragraph 13 of Leadership and Management

All medical professionals

You should encourage team members to cooperate and communicate effectively with each other and other teams or colleagues with whom they work. If you identify problems arising from poor communication or unclear responsibilities within or between teams, you should take action to deal with them

Paragraph 14 of Leadership and Management

Medical professionals with extra responsibilities

You must provide necessary and timely information to those you manage so they can carry out their roles effectively. You should also pass on any relevant information to senior managers and make sure that arrangements are in place for relevant information to be passed on to the team promptly.

Paragraph 15 of Leadership and Management

Medical professionals with extra responsibilities

You must be satisfied that systems are in place to communicate information about patient care.

Paragraph 69 of Good medical practice

You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.

Paragraph 70 of Good medical practice

You should take a proportionate approach to the level of detail but patients' records should usually include:

a relevant clinical findings

b drugs, investigations or treatments proposed, provided or prescribed

c the information shared with patients

d concerns or preferences expressed by the patient that might be relevant to their ongoing care, and whether these were addressed

e information about any reasonable adjustments and communication support preferences

f decisions made, actions agreed (including decisions to take no action) and when/whether decisions should be reviewed

g who is creating the record and when.

Paragraph 20 of Good medical practice

You must give priority to patients based on their clinical need if these decisions are within your power. If inadequate resources, policies, or systems prevent you from doing this – and patient safety or dignity may be seriously compromised as a result – you must follow the guidance in paragraph 75

Paragraph 45 of Good medical practice

You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must follow our guidance on Openness and honesty when things go wrong: the professional duty of candour, and you should:

a put matters right, if possible

b apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)

c explain fully and promptly what has happened and the likely short-term and long-term effects

d report the incident in line with your organisation's policy so it can be reviewed or investigated as appropriate – and lessons can be learnt and patients protected from harm in the future.

Paragraph 72 of Good medical practice

You should be familiar with, and use, the clinical governance and risk management structures and processes in any organisation that you work for or are contracted to.

Paragraph 73 of Good medical practice

To help keep patients safe you must:

a contribute to confidential inquiries

b contribute to adverse event recognition

c report adverse incidents involving medical devices (including software, diagnostic tests, and digital tools) that put the safety of a patient or another person at risk, or have the potential to do so

d contribute to incident reviews and/or investigations

e report suspected adverse drug reactions

f respond to requests from organisations monitoring public health.

When providing information for these purposes you must follow our guidance on Confidentiality: good practice in handling patient information.

Paragraph 75 of Good medical practice

You must act promptly if you think that patient safety or dignity is, or may be, seriously compromised.

a If a patient is not receiving basic care to meet their needs, you must act to make sure the patient is cared for as soon as possible, for example by asking someone who delivers basic care to attend to the patient straight away.

b If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should first protect patients and put the matter right if that's possible. Then you must raise your concern in line with your workplace policy and our more detailed guidance on Raising and acting on concerns about patient safety.

c If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body, or us. If you are still concerned, you must report this, in line with your workplace policy and our more detailed guidance on Raising and acting on concerns about patient safety.

Paragraph 76 of Good medical practice

If you have a formal leadership or management role, you must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making sure that any concerns raised with you are dealt with promptly and adequately, in line with your workplace policy and our more detailed guidance on Raising and acting on concerns about patient safety.