

10 April 2026

Rachel Griffin
HM Coroner
The Coroner's Office for the County of Dorset,
Civic Centre,
Bourne Avenue,
Bournemouth
BH2 6DY

Dear Ms Griffin

Re: Regulation 28 Prevention of Future Deaths Report (James Fitzpatrick)

I write in response to your regulation 28 report dated 12 February 2026, regarding the very sad death of James Fitzpatrick. I would like to express my sincere condolences to James's family.

The patient safety leads at NICE have discussed the report and understand that your request is that we develop 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 a handover to staff starting a shift, who will be taking over the care of the person.

We have carefully considered this request, and our conclusion is that further NICE guidance in this area would not add to the guidance already available from other organisations such as the Nursing and Midwifery Council (NMC) the General Medical Council (GMC) and NHS England and overseen by the Care Quality Commission (CQC). I have explained our reasoning for this below

The report has highlighted a number of areas for concern which the patient safety leads have addressed.

- 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.*

2. *There is no national guidance for non-acute healthcare settings as to what a handover should include or how it should be undertaken*

NICE has published limited guidance in this area. NICE guideline [Emergency and acute medical care in over 16s: service delivery and organisation \(NG94\)](#) covers organising and delivering emergency and acute medical care for people aged over 16 in the community and in hospital, and recommends the use of structured handovers during transitions of care. The NICE quality standard [Emergency and acute medical care in over 16s \(QS174\)](#) states in quality statement 4 that 'Adults admitted with a medical emergency have a structured patient handover during transitions of care'. However, these recommendations do not quite apply to the circumstances of this report

Other organisations however do have broad guidance on handover that is not setting specific. Both the NMC and the GMC place emphasis on good communication between practitioners and with patients, particularly at the time of patient transfer or handover. [The NMC Code of Conduct](#) states that practitioners should 'Keep clear and accurate records relevant to your practice'; 'complete records at the time or as soon as possible after an event'; and 'Work in partnership with people to make sure you deliver care effectively'.

These records include accurate handover, both oral and written. Standard 8.2 of the NMC code states that practitioners must 'maintain effective communication with colleagues' and 8.6 'share information to identify and reduce risk'.

In '[Good Medical Practice](#)' the GMC has detailed guidance on continuity of care (paragraph 65) and on delegating safely and appropriately (paragraphs 66-68); the GMC outlines what medical staff must do to work safely in the interest of patients during patient handover.

In addition, NHS England has published [Safe Communication: A guide to improving transfers of care and handover \(NHS England, 2015\)](#), which sets out what good handover must achieve and how organisations should design it.

These resources, and others, recommend the use of structured communication tools, standardisation of the format of handover and the minimum information required, the use of documentation to support verbal handover and the roles and responsibilities of practitioners during handover.

We believe that detailed specific guidance for every individual healthcare facility on patient handover would be very challenging for a central organisation to produce and would not be well adapted to the local setting and context. Instead, each organisation should produce local, relevant guidance based on the resources outlined above.

3. *Within DHUFT there is a lack of written guidance or policy as to how handovers should be undertaken and recorded*

This area of concern is for DHUFT to respond to.

4. *In a previous transfer, incorrect information was handed over about the person concerned*

This area of concern is for the NMC to respond to.

5. *Staff relied on information provided to them at the start of their shift during the handover and a daily written handover sheet, provided at the beginning of each shift and updated during the day*

I have addressed this point above in explaining the various guidelines that exist for healthcare practitioners. We do not feel that an additional general recommendation to 'ensure all pertinent information is included in written handover sheets' is likely to prove effective.

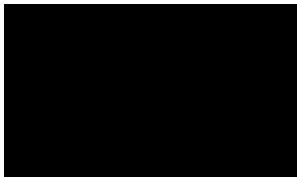
6. *The lack of written local and national guidance on the handover of a patient's care creates a risk that incorrect or incomplete information can be passed.*

As noted above, there is general guidance on this from the NMC, GMC and NHS England. In addition, the CQC sets out clear expectations for safe, effective clinical handover within its fundamental standards and regulatory framework. Therefore, it is unlikely that further NICE guidance would improve on this current guidance.

I hope that the information above is helpful in explaining the guidance that exists and my rationale relating to further guidance in this area.

I would like to reiterate my sincere condolences to James's family.

Yours sincerely,



Chief Executive

