

From the Chief Executive and Registrar



Rachael Clare Griffin  
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[REDACTED]

2 April 2026

Dear Rachael

**Regulation 28 Prevention of Future Deaths report dated 12 February 2026 in relation to James (Jim) Fitzpatrick**

I would like to begin by offering my heartfelt condolences to Jim's family for their tragic loss.

Your report identifies areas of concern relating to different aspects of handovers between doctors, nurses and support staff. Our vision is for safe and effective nursing practice across the four countries of the UK and as Chief Executive and Registrar of the Nursing and Midwifery Council (NMC) I take these matters very seriously.

I set out below details of the action we have taken following receipt of your report and further steps we are considering.

**Concerns arising from your report**

Your concerns relate to the evidence you heard in respect of communication, handover, record keeping, escalation of risk, and the safe transfer of responsibility for care. You highlight 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. You point to the lack of generic national guidance to assist in ensuring relevant, pertinent and critical information is passed on to those who will be caring for the patient.

We recognise that this 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.

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We're the independent regulator for nurses and midwives in the UK, and nursing associates in England. Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing.

Registered charity in England and Wales (1091434) and in Scotland (SC038362)

## Our response

While we recognise the concerns raised, we consider that communication, handover, record keeping, escalation of risk, and the safe transfer of responsibility for care are already addressed adequately within the Nursing and Midwifery Council's professional standards, including ***The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates and the Standards of proficiency for registered nurses.***

We do believe national guidance would be helpful to support a consistent and collaborative approach to handovers across the wide range of organisations responsible for delivering and regulating care.

The [Code](#) sets clear expectations for the professionals on our register in relation to communication, teamwork, record keeping and patient safety. In particular:

- Section 7 requires registrants to *communicate clearly*, including taking reasonable steps to meet people's communication needs and checking understanding
- Section 8 requires registrants to *work co-operatively*, maintain effective communication with colleagues, keep colleagues informed when sharing care, and share information to identify and reduce risk
- Section 10 requires registrants to *keep clear and accurate records*, including recording risks, problems and actions taken so that colleagues have the information they need
- Section 16 requires registrants to *act without delay if there is a risk to patient safety*, including raising and escalating concerns where care or public protection may be compromised
- Section 17 requires registrants to take reasonable steps to protect people who are vulnerable or at risk from harm.

These standards apply in all settings and when responsibility for care is transferred between professionals or teams.

Our [Standards of proficiency for registered nurses \(2018\)](#) also set requirements relevant to safe handover, coordination of care and information sharing. In particular:

- Platform 1: Being an accountable professional requires nurses to understand and apply legal, regulatory and governance requirements (1.2), communicate effectively (1.11), keep clear and accurate records (1.16), and act to minimise risks to health and safety (1.5)
- Platform 5: Leading and managing nursing care and working in teams requires nurses to work effectively within teams (5.4), communicate with colleagues, supervise and coordinate care (5.5), and provide constructive feedback and challenge where care may be unsafe (5.9)

- Platform 6: Improving safety and quality of care requires nurses to recognise risks to safety (6.2), comply with frameworks for reporting and managing risk (6.3), identify hazards and take action (6.6), and learn from incidents and near misses (6.8)
- Platform 7: Coordinating care requires nurses to work in partnership across services (7.1), understand policy and organisational processes (7.2), and coordinate care safely across settings, including during transitions and transfers (7.10).

These proficiencies apply to all registered nurses at the point of registration and underpin practice across all care environments, including mental health inpatient settings.

Taken together, the Code and the standards of proficiency establish clear professional expectations that information relevant to a person's safety must be accurately recorded, communicated and handed over when responsibility for care changes, and that nurses must act where failures in communication may place people at risk.

Where we identify concerns that a professional on our register may not have met these standards, we will investigate this. Where concerns relating to patient safety are made out, we will take such action as is appropriate to protect the public and uphold trust in the professions in line with our fitness to practise process.

Where we receive evidence of any concerns that may be relevant to public safety but which fall outside of our regulatory remit, we may decide to refer matters to the police or other appropriate authorities for further investigation, particularly where there is evidence of a poor outcome.

### **Actions we have taken in response to your report**

In respect of the concerns arising in your report, we have:

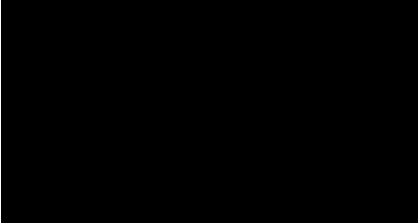
- Met with the General Medical Council to discuss whether there are any areas where we can align to strengthen our joint position on handovers and to explore opportunities for future collaborative working to develop some joint messaging highlighting the expected standards for communication within and across the multi-disciplinary team
- Taken steps to ensure that the concerns raised in your report have been shared with relevant teams within the NMC to assess whether we need to take any further steps in line with our usual processes
- We have shared your report with our Intelligence Sharing Hub (ISH) to assess and share emerging concerns or risks identified across other regulators and patient safety organisations. The report will be discussed at its next meeting.

## **Conclusion**

Thank you for sharing the areas of concern with us, identified during your investigations. We will continue to reflect on these issues.

Once again, I would like to offer my condolences to Jim's family for their tragic loss.

Yours sincerely



Chief Executive and Registrar