REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of National Institute for Health and Care Excellence (NICE)** **2. Chief Executive of the Nursing and Midwifery Council (NMC)** **3. Chief Executive of the General Medical Council (GMC)** **4. Chief Executive of Dorset Healthcare University NHS Foundation Trust (DHUFT)**
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 23rd February 2024, I commenced an investigation into the death of James Fitzpatrick, born on the 5th June 1934, who was aged 89 years at the time of his death. The investigation concluded at the end of the Inquest on the 30th January 2026. The medical cause of death was: Ia Ischaemic Strokes Ib Severe Atherosclerosis II Airway obstruction from food material The conclusion of the Inquest was a narrative conclusion that James Fitzpatrick died as a consequence of naturally occurring disease, exacerbated by airway obstruction by food material.
4	**CIRCUMSTANCES OF THE DEATH** Jim was an 89-year-old gentleman with a history of decompensated heart failure and respiratory illness who at the time of his death was a patient on St Brelades Ward, Alderney Hospital, Poole, which is a mental health inpatient unit. At the time of his death, he was not detained under the Mental Health Act 1983 but was the subject of a Deprivation of Liberty Safeguards Authorisation.

	At some point between 2.30pm and 3pm on the 14th February 2024 Jim was in the lounge area on the ward when he was witnessed to eat a scone by a visitor to the ward. At approximately 3pm Jim was sitting in a chair in the lounge when he started to cough, was then witnessed to jerk as if having a fit and became unresponsive. Staff responded to his collapse, and he was transferred to his room for further care. Food material, which was thick, creamy and stringy was removed from his mouth. It is not possible to determine if this was regurgitated food material or food material Jim was eating at the time of his collapse. His condition did not improve, and his death was confirmed at 3.10pm.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (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. (2) 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. (3) 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. (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. (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.

	(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.
"6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th April 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: (1) Jim's Family (2) Dorset Healthcare University NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed**  **Rachael C Griffin** **HM Senior Coroner for Dorset** **12th February 2026**