REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
2.	**DATE OF REPORT** 24th June 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. Minister of State for Health 2. Chief Executive of NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th August 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** 1. Depending on the methods adopted by hospitals in England and Wales when disposing of unused liquids in sharps bin, there is a risk that the liquids could be used and lead to fatal consequences. 2. There is no legal requirement for doctors to notify NHS Trusts of their private work patterns or notify private providers of their NHS work patterns which can result in continuous periods of working without rest which could put both patient and doctors' lives at risk.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 24th June 2025, I commenced an investigation into the death of Naeem Ahmed, aged 50 years, born on 1st October 1974. The Inquest concluded on the 19th June 2026. The medical cause of death was: Ia Combined [redacted] and alcohol toxicity How when and where Naeem came by his death was recorded as: At around 11am on the 21st June 2025, the deceased was found in a collapsed and unresponsive condition, slumped forward in the chair, in the anaesthetic registrar room, which is a doctor's mess room, at Poole Hospital, Poole. On the floor next to him, on a bloodstained towel, was a used needle with a syringe attached which was subsequently found to contain [redacted] and an alcohol wipe. In his bag, in the room, was also located a half empty bottle of whiskey. The conclusion recorded was misadventure.
8.	**CIRCUMSTANCES OF DEATH** Naeem was a Consultant Anaesthetist who was working at Poole Hospital, Poole at the time of his death. He began a run of 9 nights work on the 12th June 2025 as the anaesthetist working in the hospital overnight, and due to staff illness agreed to cover a further 2 night shifts. He was working overnight from the 20th to the 21st June 2025. He had last been seen alive at around 06.17am on the 21st June when he made his way to a room allocated for rest for doctors working overnight in the hospital. He did not attend for the handover meeting at 8am and as he had not responded to attempts to contact him by 11am, staff entered his locked room and found him collapsed and unresponsive in the room. He was found to have died from use of alcohol and [redacted] however it could not be ascertained where the drugs had come from.

9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: Following Naeem's death the Trust, University Hospital Dorset NHS Foundation Trust (UHD) instructed an independent review of the circumstances of his death and the processes in place within the Trust. This led to the Trust taking action to amend their practice around disposal of drugs and working patterns of doctors at the Trust. I am concerned that the practices in place at the time of Naeem's death at Poole Hospital, which have now been changed, will be operating in other Trusts nationally. Evidence at the Inquest revealed that at the time of Naeem's death a process in place at Poole Hospital that if there were small volumes of medicines to be disposed of by representatives of the Trust which were less than 50ml in volume, such as after surgery had taken place, these would be squirted into the sharps bins and then the needles would also be disposed of in the sharps bin too. This was identified in the independent review which concluded that this practice posed a risk that fatal medicines could be accessed from the sharps bin. As a result, UHD now use gels in the sharps bins which immediately denature and destroy the liquids squirted into the sharps bins. I am concerned that what was happening at the time of Naeem's death continues to happen at other Trusts across England and Wales and could lead to future deaths. The review and the coronial investigation also revealed that Naeem died whilst working the 9th shift in a run of 11 night shifts for UHD which began on 12th June 2025 and that in June 2025 he undertook clinical work for more than one provider on the same calendar day on different occasions, and on one occasion he undertook daytime work for an external provider before commencing a resident overnight shift for the Trust later the same day. The review also identified that trust systems for job planning, rostering, appraisal, and secondary employment operated independently and were not designed to provide an integrated view of timing, sequencing, or cumulative workload across employers, whether over short periods or across an annual cycle. Whilst UHD have undertaken work to resolve this issue, I am concerned that this practice exists at other Trusts in England and Wales and could lead to fatigue and fatal outcomes to patients and doctors. w
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest.

	I can confirm I have sent the report to: 1. Naeem's family 2. University Hospital Dorset NHS Foundation Trust 3. General Medical Council I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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