

[REDACTED]
Chief Medical Officer
Deputy Chief Executive
Medical Directorate
Jenner Building
Magdala Avenue
London N19 5NF
[REDACTED]
[REDACTED]

20/10/25

To:
Senior Coroner ME Hassell
Inner North London Coroner's Court

Response to Regulation 28: Prevention of Future Deaths Report

Re: Mary Anne Fitzpatrick (died 20 March 2025)

Dear Senior Coroner Hassell,

Thank you for your Regulation 28 report dated 20 August 2025 concerning the very sad death of Mrs Mary Fitzpatrick. On behalf of Whittington Health NHS Trust, I wish again to express our condolences to her family.

We take the concerns you have raised extremely seriously. This response sets out the actions we have already taken and those we are committed to undertaking to ensure learning, improvement, and prevention of similar future deaths.

1. Circumstances of Hospital Admission and Risk of Deconditioning

We recognise the risks associated with hospital admission for frail elderly patients, particularly where transfer occurs due to staffing limitations in community settings.

We accept that in this instance, the care of Mrs Fitzpatrick fell short in a number of ways.

Whittington Health NHS Trust

[REDACTED]

- **Missed leg ulcer management:** On the balance of probabilities, the deterioration of her leg ulcers was linked to the lack of treatment following the cancellations of scheduled appointments on 18, 20, 21, and 22 January 2025. As there was no evidence of mental impairment at that time, a mental capacity assessment was not carried out with regards to the decision to cancel visits, and she was presumed to have capacity.
- **Time in the Emergency Department:** Mrs Fitzpatrick spent 40 hours in the Emergency Department, due to the department being under extreme pressure. Some of this time in a temporary escalation space. We accept this falls short of the standard of care we would aspire to provide. Mrs Fitzpatrick arrived in Triage at 20:27. She was then transferred to a trolley and initially cared for in a temporary escalation space. While we work to avoid care in temporary escalation spaces, we have a standard operating procedure to set out the care which should carry on in non-clinical areas when necessary. At 23:45 Mrs Fitzpatrick was moved into a cubicle in the Majors area. She was transferred to a bed at 03:33 on 24/01/25. She was placed on a standard foam pressure relieving mattress at this time. When she was moved to the ward she was placed on a pneumatic pressure relieving mattress.
- **Pressure sore identification and management:** Her pressure areas were reviewed and documented within 2 hours of arrival and this identified her pressure sore. She was subsequently admitted and had further reviews, and the correct equipment and care plans were instituted.
- **Risk factors:** The risk of pressure sores was increased due to Mrs Fitzpatrick's frailty and incontinence. We regret that she developed additional grade 2 sores during her hospital admission.

Action Plan:

A Quality improvement Project is in progress in our ED to monitor adherence to Pressure Ulcer Prevention and Management Policy as ED acknowledge that elderly patients spend longer in ED due to the complexity of their care. The standard is that all at risk patients will have their pressure areas reviewed within one hour of admission, and that prevention management will be instituted within four hours. The project is carrying out spot check audits of a 10-point check list for 10 patients per week. The results will be presented to will be presented Emergency and Integrated Medicine Quality Committee on 20th November 2025.

Our Trust Policy governing care in temporary escalation spaces has been appended for reference.

Whittington Health NHS Trust

2. Frequency and Quality of District Nursing Visits

We acknowledge the coroner's concern regarding the frequency and appropriateness of district nursing visits and dressing changes. A review of Mrs Fitzpatrick's records has allowed us to reconstruct the chronology of community nursing input following her hospital discharge:

- There were 2 missed opportunities for dressing changes on 5 February (visit not allocated) and 10 February (Mrs Fitzpatrick declined to be moved by the two staff members attending so dressings were not completed).
- Despite these missed visits, there was regular documentation of wound progression, escalation to the GP, referral to Tissue Viability, and repeated advice regarding hospital admission.
- When the pressure ulcers were found to have deteriorated. A Safeguarding Alert was raised as the pressure relieving mattress had been found to be switched off with no explanation on 24 February 2025.
- Staffing during this period was affected by long-term sickness (1 staff member >4 months) and annual leave (2 staff members). However agency and bank nurses were used to maintain service cover, and a bank nurse undertook the joint visit on 8 February.
- Double-handed visits were provided where identified as necessary from 7 February onwards.
- We apologise that this information was not fully accessible to the coroner during the inquest

Action Plan:

- Ensure daily visits allocations are individualised to meet the patients' Pressure Ulcer (PU) management need by the duty manager, with monthly oversight from Service Lead.
- Timely referral to Tissue Viability Nurse (TVN), adherence with TVN recommendations, and progression of pressure ulcer management improvement plan are to be built into new quarterly audit cycle, and reviewed at divisional quality meeting.
- Shared learning from PU incidents will be ensured via weekly divisional pressure ulcer shared learning meetings.

Whittington Health NHS Trust

- A trial of visit allocation software (Docabode) is in progress in the Urgent response team and is intended to minimise travel time and maximise time for visits. If successful it will be trialled in District Nursing

3. Reflection, Learning, and Preparation for Inquests

We acknowledge the coroner's concern that there was insufficient reflection on the quality of district nursing care provided to Mrs Fitzpatrick, both during her deterioration and in preparation for the inquest. We accept that the deputy manager who attended court was not adequately prepared to give evidence, which fell below the expected standard.

We also recognise that our communication with Mrs Fitzpatrick's family—both in person and in writing—did not provide the clarity, explanation, or candour they deserved, and that this contributed to their distress.

Action Plan:

Mortality review process: Current mortality review processes are largely designed to cover inpatients. New procedures are being devised to ensure all patient deaths under our care in the community services we run are formally reviewed for learning.

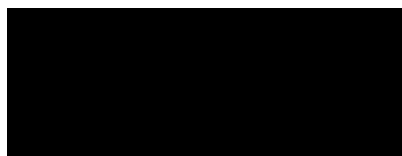
Learning from Death: incidents and feedback, inquest outcomes and PFD notices will continue to be shared with staff at meetings. In addition, they will also be cascaded to all staff working in community services.

Increase in support and training for staff involved in writing statements and attending the coroner's court: This will also include advice to ensure that staff will not only cover the care that was delivered by themselves, but provide an overarching statement covering the care delivered as a whole by the Trust. Support will be given by the legal services team. The Trust is reviewing the seniority of staff attending coroner's court to provide the court with the most useful and informative evidence. In addition to this, new guidance for staff preparing for inquests will be circulated by the Associate Medical Director for learning from deaths, in coordination with the legal department.

New proforma: A new Duty of Candour proforma has been developed to accurately capture both professional and written Duty of Candour, ensuring documentation is clear and complete. This will better enable tracking and audit of statutory duty of candour across the trust. We expect to have this completed by December 2025, with the results presented to the Quality Governance Committee.

Whittington Health NHS Trust

Duty of Candour audit and training: Ongoing audit and refresher training are being introduced to strengthen understanding of and compliance with Duty of Candour. Levels of completion of training will be monitored by the patient safety team, and the results presented to the Quality Governance Committee quarterly.




Chief Medical Officer

Whittington Health NHS Trust

