

Regulation 28: Prevention of Future Deaths report

Mary Anne FITZPATRICK (died 20.03.25)

	<p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Executive Whittington Health NHS Trust Whittington Hospital Magdala Avenue London N19 5NF</p>
1	<p>CORONER</p> <p>I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 26 March 2025, one of my assistant coroners, Harry Lambert, commenced an investigation into the death of Mary Fitzpatrick aged 86 years. The investigation concluded at the end of the inquest yesterday. I made a narrative determination at inquest, which I attach.</p> <p>Mrs Fitzpatrick's medical cause of death was:</p> <p>1a aspiration pneumonia 1b dysphagia 1c frailty 2 sacral pressure sore</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p>

	<p>Mrs Fitzpatrick was discharged from the Whittington Hospital on 29 January 2025 and was then treated by the Islington Central district nursing team from Whittington Health.</p> <p>Her sacral pressure sore was assessed as a category 2 on 1 February. By 24 February it was a category 4 – a gaping, open wound. It forced her readmission to hospital on 27 February, at which point she deconditioned and then died.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows.</p> <p>As you will see from the Record of Inquest attached, I made a finding that death would not have occurred when it did, had it not been for the 23 January admission to hospital, the development of the pressure sore, and the failure properly to treat that pressure sore.</p> <ol style="list-style-type: none"> 1. It is well recognised that the admission of an elderly person to hospital can be risky and should only be undertaken if really necessary. These days, a long wait on a hospital trolley is predictable. Even without that, the elderly are known often to decondition quickly. <p>At inquest I accepted the evidence of Mrs Fitzpatrick's family that the reality of her admission to the Whittington on 23 January 2025 was that it was undertaken because there was only one nurse attending her on that day and this nurse felt she could not transfer this small, elderly lady alone with the aids that were available.</p> <ol style="list-style-type: none"> 2. The district nurses did not visit to dress the sacral wound with appropriate frequency. Sometimes they attended as planned, but sometimes they did not attend and sometimes they attended but did not change the sacral dressing. It remains unclear to me why that was so. The only explanation I was given was that they were probably "thin on the ground". 3. When I took evidence from the deputy manager of the Islington Central district nursing team, I was very forcibly struck by the lack of reflection undertaken since Mrs Fitzpatrick's death, about the district nursing care, even when preparing to give evidence at inquest.

	<p>The deputy manager was poorly prepared for inquest, appeared to have an inadequate understanding of what was required of her giving evidence, had not acquainted herself with some basic elements of the medical records and, whilst in the witness box, changed her mind about what home visits had been undertaken depending upon who asked her the question.</p> <p>She steadfastly refused to acknowledge gaps in care despite glaring evidence to the contrary, and when this was brought to her attention she simply stopped answering.</p> <p>It is difficult to see how a trust can learn and improve care if there is no serious consideration of why there was a poor outcome.</p> <p>Even the letter of apology sent to Mrs Fitzpatrick's family was offered to her daughter in an offhand way during a very short telephone call. When giving evidence, the deputy manager seemed to be in difficulty understanding what an apology is, naming this a letter of apology but in essence describing a letter of sympathy, emphasising that it was not an admission that the trust had done anything wrong. I still do not have a proper understanding of what such a letter was meant to achieve. Much more importantly, it seemed to me that Mrs Fitzpatrick's family do not have a proper understanding of what this letter was meant to achieve. They did not seem comforted by it.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 October 2025. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following.</p>

	<ul style="list-style-type: none"> • The daughter of Mary Fitzpatrick • Care Quality Commission for England • HHJ Alexia Durran, the Chief Coroner of England & Wales <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p>				
9	<table> <tr> <td>DATE</td><td>SIGNED BY SENIOR CORONER</td></tr> <tr> <td>20.08.25</td><td><i>ME Hassell</i></td></tr> </table>	DATE	SIGNED BY SENIOR CORONER	20.08.25	<i>ME Hassell</i>
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