

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: Blackpool Teaching Hospitals NHS Foundation Trust
1	CORONER I am Tim Holloway, Assistant Coroner, for the area of Blackpool & Fylde
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 <i>Conclusion of Investigation (Section 4)</i> Narrative Conclusion. On 26 th November 2020, Mrs Maureen Christy fell in the hallway of her home at 12 Toronto Avenue, Fleetwood, Lancashire, FY7 8HB. The cause of her fall was muscle wasting and consequential poor balance which was a natural expression of her frailty. Mrs Christy was transferred to Blackpool Victoria Hospital, and presented at the Accident and Emergency Department at 13.19 hours on the same date. An intracapsular fracture of the neck of the left femur was confirmed on plain x-rays. On 27 th November 2020, Mrs Christy underwent a hemiarthroplasty under spinal analgesia. In the course of her admission, Mrs Christy presented with delirium, the causes of which were multifactorial. The delirium, low weight and cognitive impairment would have made Mrs Christy more vulnerable to Covid-19 and would have affected her ability to cope with it. On 8 th December 2020 and/or shortly prior thereto, Mrs Christy was exposed to, and contracted, the SARS-CoV-2 virus on Bay 2 of Ward 35 of the Hospital, on which she was resident at the time. In consequence of the known exposure, she was identified as a "Covid contact" within the meaning of the Hospital's internal guidance but was not tested for Covid-19 under the Hospital's internal guidance at that time. The absence of such further testing in the Hospital did not contribute to Mrs Christy contracting the SARS-CoV-2 virus, or to her death. Mrs Christy was discharged home on 11 th December 2020 and developed symptomatic Covid-19 on or around 14 th to 16 th December 2020, by reason of having been exposed to the SARS-CoV-2 virus in Bay 2 of Ward 35 of the Hospital, the Covid-19 being hospital-acquired. Mrs Christy's presentation deteriorated and, on 4 th January 2021 she died at home. Her death was verified at 00:15 hours on 5 th January 2021. Frailty of old age had increased Mrs Christy's vulnerability and was contributory to her death. Cause of death: 1a Hospital-acquired Covid-19 infection b Hip fracture (operated) c II Frailty of old age
4	CIRCUMSTANCES OF THE DEATH Box 3 of the Record of Inquest recorded as follows:

	See Box 4.
5	<u>CORONER'S CONCERNS</u> 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. The MATTERS OF CONCERN are as follows: (1) The central policy or practice change with which this inquest was concerned was that pertaining to the testing of those designated as "Covid contacts". (2) The adoption and understanding of good policy and practice, serves to protect patients and to provide clinicians with an overarching framework within which to work. It provides clinicians with the security of knowing what is expected of them in their clinical practice. (3) The policy change concerned was not acted upon in the case of the Deceased at the time of her being identified as a "Covid contact". Notwithstanding the Trust's recognition of the need to strengthen the dissemination of policy and practice changes, confusion around the dissemination of that policy or practice change, persisted to the time of evidence being given in this inquest. (4) Whereas steps are already being taken to address the issue of the dissemination of policy and practice changes, this investigation has revealed matters giving rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, by reason of shortcomings in the dissemination of policy and practice changes pertaining to clinical care.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe Blackpool Teaching Hospitals NHS Foundation Trust has 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 31st December 2025. 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, through their legal representatives were applicable: (1) [REDACTED] son of Mrs Maureen Christy (2) The Mount View Practice (3) Lancashire County Council 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.

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**Assistant Coroner for Blackpool & The Fylde
(Signed electronically)**

Dated: 4th November 2025