Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Minister for Health** **[redacted], House of Commons, London, SW1A 0AA**
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner area of Norfolk
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 12 June 2024, I commenced an investigation into the death of Susan Elizabeth CLISSOLD, aged 72. The investigation concluded at the end of the inquest on 23 June 2025. **The medical cause of death was:** 1a) Sepsis Secondary to Infected Burn and Pressure Sore 1b) Multiple Sclerosis 1c) 2) **The conclusion of the inquest was:** Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Mrs Clissold had multiple sclerosis and was registered blind. She had carers four times per day. Mrs Clissold had a pressure sore on her sacrum which district nurses came in to dress. On 29 April 2024, Mrs Clissold scalded her leg with hot coffee and suffered a burn. This too required regular dressing. On 15 May 2024, Mrs Clissold was admitted to Norfolk and Norwich University Hospital with a temperature and low blood pressure and symptoms of infection. She was treated with IV antibiotics and fluids. Mrs Clissold's condition at times improved but then deteriorated. On the morning of 31 May 2024, Mrs Clissold's condition deteriorated and shortly thereafter a referral was made for palliative care. Mrs Clissold died on 9 June 2024.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. District nurses were required to attend to Mrs Clissold on a weekly basis. On several occasions they did not attend because they did not have sufficient members of the team available. 2. Evidence was heard that individual cases are becoming more complex involving greater input from the community nursing team and there are an increasing number of patients requiring support. 3. Norfolk Community Health and Care NHS Trust has taken steps to try to ensure there are sufficient staff to attend to patients in the community as required, such as by relocating staff on a temporary basis and prioritising patients. 4. However, evidence was heard they are not able to attend to every appointment as required
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 August 19, 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 **Family of the deceased** **Legal for Norfolk Community Health and Care** I have also sent it to **Care Quality Commission (CQC)** **Healthwatch Norfolk** who may find it useful or of interest. 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 person who I believe may find it useful or of interest. 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	**Dated: 27/06/2025** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH