



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 [REDACTED] Minister of State for Care sent via Department of Health and Social Care</p>
1	<p>CORONER</p> <p>I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>INVESTIGATION and INQUEST</p> <p>On 5th March 2025 I commenced an investigation into the tragic death of-</p> <p>Janette Margaret PALMER</p> <p>The investigation concluded at the end of the inquest on 10th March 2026. The conclusion of the inquest was that Janette Palmer died as the result of:-</p> <p>Accidental death, contributed to by frailty of old age and underlying poor health.</p> <p>The medical cause of death was confirmed as:</p> <p>1a Bronchopneumonia 2 Frailty of Old Age and Left Hip Fracture.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Janette Palmer's death was verified at 15:15 on the 24th February 2025, at the St Nicholas Hospice, Bury St Edmunds, in Suffolk.</p> <p>Janette had been admitted to the St Nicholas Hospice on 21st February 2025 from the West Suffolk Hospital, Bury St Edmunds.</p> <p>Janette was admitted to the West Suffolk Hospital on 15th February 2025 following an unwitnessed fall she had suffered at her home address in which she suffered a fracture to her left hip.</p> <p>Upon admission it was identified that Janette had also had a heart attack (myocardial infarction), although whether or not this occurred before or after her fall could not be established.</p> <p>Janette also suffered from a number of significant co-morbidities, and a surgical procedure to repair her hip could not be attempted.</p> <p>Janette went onto develop a serious chest infection (bronchopneumonia) and her</p>



	<p>condition continued to deteriorate until her sad death.</p> <p>At the time of her fall on the 14th February 2025, an electrical power cut at her independent living housing for elderly individuals (Chestnut Court run by Havebury Homes Partnership) had occurred, meaning that none of the lights were on in Janette’s flat when she was found.</p> <p>Whether or not the lights were out at the time of Janette’s fall, and whether or not the lights being out contributed to her fall, could not be established on the available evidence.</p>
<p>5</p>	<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 could 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>In evidence it was heard from UK Power Networks (Operations) Ltd that a power outage in the area of Janette’s supported living accommodation had occurred on the 14th February 2025.</p> <p>The UK Power Networks (Operations) Ltd confirmed that Chestnut Court was not on their Priority Services Register and therefore did not qualify for additional support during the electrical outage.</p> <p>The additional support offered to properties on the Priority Services Register includes regular call backs with updates, SMS messaging updates, torches, battery back-up packs, the supply of hot food and drink, and if needed hotel accommodation.</p> <p>In their evidence Havebury Housing Partnership (the Housing Association which runs Chestnut Court) stated that it had no knowledge that a Priority Services Register existed, or knowledge of the enhanced response available if their properties were on that register.</p> <p>Given the circumstances of Janette’s case, it is not suggested that had Chestnut Court been on the Priority Service Register her tragic death would not have occurred.</p> <p>However, I am concerned that the lack of knowledge that the UK Power Networks Priority Services Register actually exists, may just not relate to the Havebury Housing Partnership but also to the many other providers of care home and sheltered housing facilities.</p> <p>I am concerned that in different circumstances, such as an extreme weather event, residents of other care homes and sheltered housing will not benefit from the enhanced response available and deaths may occur, due to a lack of knowledge of the UK Power Networks Priority Services Register by the individuals or businesses running those facilities.</p>
<p>6</p>	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
<p>7</p>	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report,</p>



	<p>namely by May 06, 2026. 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 Chief Coroner and to the following Interested Persons;-</p> <ol style="list-style-type: none">1. Janette's next of kin.2. Havebury Housing Partnership <p>I am under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> <p>You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Dated: 11/03/2026</p> <p></p> <p>Nigel PARSLEY HM Senior Coroner for Suffolk</p>