Regulation 28: Prevention of Future Deaths report

Claire Elizabeth HOMER (died 05.05.23)

	THIS REPORT IS BEING SENT TO: The Medical Director, CEO and Legal Department of: Camden and Islington NHS Foundation Trust St Pancras Hospital 4 St Pancras Way London NW1 0PE
1	**CORONER** I am: Harry Lambert Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 23 My 2023 an investigation was commenced into the death of Claire Homer aged 46 years. The investigation concluded at the end of the inquest held on 2nd and 11th November 2023. The Inquest found that Claire Elizabeth Homer suffered from a debilitating constellation of physical, psychiatric and somatic illnesses, with a complex interplay between them. She was found dead in her home on 5 May 2023. Despite Post Mortem examination and toxicology, no cause of death was identified. The medical cause of death was Unascertained.

	I returned an Open Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Please see attached Findings of Fact.
5	**CORONER'S CONCERNS** 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. On the 27 April 2023 Claire's GP, [redacted], wrote an email to [redacted] sharing concerns around her worsening, querying the CDAT referral and suggesting family involvement in the formulation of a management plan. Unfortunately there was no reply to this email until 5th May 2023, by which time it was too late. I do not criticise [redacted] for this, as she was on holiday and thereafter catching up with what was no doubt an avalanche of emails. This does raise the question, however, of whether more robust protocols need to be in place to address the scenarios of (a) patients who are not initially deemed to require handover care but deteriorate during a member of staff's leave and (b) both key points of contact being on leave at the same time.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 xxx. 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 following. • [redacted], brother of the Deceased • [redacted], father of the Deceased • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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. 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.
9	**DATE** 10.11.23 **SIGNED BY ASSISTANT CORONER**