Regulation 28: Prevention of Future Deaths report

Maria Patricia Kelly (found deceased 15 May 2024)

	THIS REPORT IS BEING SENT TO: **1. Gray's Inn Road Medical Centre** **2. South Camden Rehabilitation of Recovery Team, North London Mental Health Partnership**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 6 June 2024 an investigation was commenced into the death of Maria Patricia Kelly age 54. The investigation concluded at the end of the inquest on 12 September 2024. I made a determination at inquest natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Maria Patricia Kelly was found deceased at her home address on 15 May 2024 by police following concerns raised by her neighbours and housing officer. Ms Kelly lived alone and was in poor health. She suffered from a significant number of medical and mental health problems and was prescribed a number of medications to treat these. Records show that there had been no contact with her GP since June 2023 and no contact with mental health services since August 2023. She had last been issued repeat medication on 1 August 2023. Numerous failed encounters were listed by both organisations. No welfare check was requested until 14 May 2024 when neighbours raised concerns. They reported that they may have seen her in January 2024 but could not

	been certain. Police initially declined to attend but forced entry the following day and discovered Ms Kelly deceased, and in a state of partial mumification.
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. Ms Kelly's medical records show that she suffered from a large number of medical conditions including steatosis of the liver, hydronephrosis, left anterior fascicular block, chronic kidney disease, iron deficiency anaemia, gastro-oesophageal reflux, hyperlipidaemia, simple schizophrenia, borderline personality disorder, recurrent depressive disorder and anorexia nervosa (possibly in remission). She had been also diagnosed with Non-Hodgkins Lymphoma in the past. She was prescribed repeat medications of Atorvastatin and Lansoprazole for her physical health problems, and Flupentixol (as directed by her consultant) and Mirtazapine for her mental health. A prescription appears to have been last issued by her GP on 1 August 2024. From 23 August 2023 until the practice was notified of her death, her GP summary showed 31 failed encounters for mental health reviews, as well as failed encounters for blood tests and bowel screening. Her last medical (mental health) review with South Camden Rehabilitation of Recovery Team (SCRRT) was on 7 March 2023. Ms Kelly's care coordinator went on leave in September 2021. Ms Kelly was placed onto the waiting list for allocation of a new care coordinator on 29 December 2023 after a review of the team's patient list found that there had been no contact with her since 11 August 2023. It was recorded that were "many attempts" (not quantified) to contact her. After a review on 29 December 2023 there were then 12 unsuccessful home visits and 6 failed telephone attempts. Despite this, no welfare check was undertaken, nor any request for a welfare made to her housing officer or police, until neighbours raised concerns on 14 May 2024.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 **22 November 2024**. 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] • HHJ Alexia Durran, the Chief Coroner of England & Wales 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.
9	**DATE** **SIGNED BY ASSISTANT CORONER** 27 September 2024