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Catalogue of errors – death inquest

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A Woking family has spoken of their “incredibly difficult time” after losing their son saying “there is nothing that can take away the pain”. Their comments came after an inquest concluded a catalogue of failures by Surrey County Council and other bodies contributed to the death of 18-year-old diabetic Jake Baker.

Jake, who also had learning disabilities, died on December 31, 2019, while visiting his family home.
It was the first time he had stayed away from his care facilities for more than two nights in a row, since being placed in the care of the Surrey County Council when eight years old, his family lawyers said.

The teenager arrived home on Christmas Eve, became unwell on December 28 and was found unresponsive on New Year’s Eve by his mother and stepfather, neither of whom had been trained to recognise or seek medical advice for a deterioration in Jake’s diabetes.

According to the family’s lawyers, Coroner Carolyn Topping said Jake’s death was avoidable and, if he had been admitted to hospital any time before 5pm on December 29, he would have been successfully treated.

They added that the coroner said there had been “a systemic failing on the part of Surrey County Council to adequately train and oversee personal advisers about their legal obligations in preparing pathway plans for children leaving care”.

In a statement, the family said: “Losing Jake has been incredibly difficult for our family, especially as he died in our home at what should have been a happy time. We trusted Ruskin Mill Trust with Jake’s care, and we have been let down by them in the worst possible way. Jake was an enthusiastic and determined young man who always put his mind to things. He was happy to help out in the garden or with DIY.

“He had a kind soul and would get very excited when meeting new people. He loved dogs and playing pranks on his brothers and sisters. Jake wanted to be more independent and was keen to learn but to anyone who met him it was clear that he needed help, particularly in handling his diabetes.

“Before Jake turned 18, he had a key worker that we trusted and who he had a great relationship with. We were able to spend time together as a family safely, knowing that Jake was well supported by the staff at Burbank children’s home. This changed when Jake moved from Burbank to Ruskin Mill College. We were told it would be his road to independence and from this point on we didn’t have much contact with the people who were supposed to be supporting Jake. We were never made fully aware of how severely his diabetes could affect him, or how he should be managing it.

“As a family we did all we could to make sure that Jake was looking after himself and was well taken care of, but those that were put in charge of his care didn’t give us the information necessary to ensure Jake’s safety. There is nothing that can take away the pain of losing Jake, but it is our hope that lessons will be learned from his death so that another tragedy is prevented.”

The cause of death was given as diabetic ketoacidosis.

Jake had been living at a residential college run by Ruskin Mill Trust in Stroud, for 15 months.
The trust is a charity that provides specialist education for young people with learning difficulties and special educational needs.

The coroner also said the trust failed to ensure Jake’s safety when he went home for contact with his family. Following his death Transform Residential Limited, the body responsible for providing care services to Ruskin Mill Trust, was ordered to pay a total of £22,721.04 at Staines Magistrates’ Court, after pleading guilty to causing a resident avoidable harm, the Care Quality Commission said.

Jake had been a resident at Glasshouse College since November 18 2019. Previously he lived at Ruskin Mill College, run by the same provider.

According to the family’s lawyers, the coroner said Jake lacked the ability to be wholly independent in managing his diabetes and was not given any information about the dangers for him to have unsupported contact if his blood sugars became imbalanced.

They added that Ms Topping said those involved in making decisions for Jake, from the Surrey Care Leavers team and Children’s Services, failed to ensure Jake’s safety when he went home for overnight contact from March 2019 and that Ruskin Mill Trust failed to ensure Jake’s safety.

Anna Moore, who represented Jake’s family, said: “The coroner’s detailed investigation and critical findings illustrate a

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catalogue of failings that led to Jake's death. Jake's family welcome these conclusions and hope that lessons will be learned from his death. What is particularly important is that those authorities entrusted to look after children and support them through their transition to adulthood are doing so properly.

"The evidence heard at the inquest showed that no one with current responsibility for Jake had a clear picture of needs and what support he required. Very worryingly, those at Surrey County Council who were meant to be supporting Jake into his transition to adulthood were not aware of the scope and extent of this important role. This needs to be urgently addressed so that children and young adults, and particularly people like Jake with additional needs, are given the support they need when they turn 18 and beyond."

Clare Curran, Cabinet Member for Children, Families and Lifelong Learning at Surrey County Council, said: "Our deepest sympathies remain with Jake's family and friends at this difficult time. The services provided to Jake fell short of what he and his family needed to keep him safe, and we are very sorry for our part in that. We have taken a number of actions over the past four years to improve our support for young adults leaving care. While we have already made changes, we know there is still further to go and we will carefully consider the coroner's findings as we take our next steps."

Ruskin Mill Trust took over responsibility for residential care from Transform Residential Limited in August 2020. A spokesperson said: "Jake's death was heart-breaking and our thoughts remain with his family. He was well known to our staff and his loss came as a profound shock to everyone here. We deeply regret that in this instance some key measures that should have been in place for his visit home were overlooked. We aim to provide the highest standards of care.

"Since this tragedy occurred, the overnight risk assessment protocol has been fully reviewed and we have taken steps to strengthen practice, policies and procedures to ensure this kind of incident never happens again."

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