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Coroner catalogues care failures in diabetic death

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Surrey County Council (SCC) has been accused of not taking its responsibilities seriously after an eighteen-year-old tragically died from diabetes.

Jake Baker, an 18-year-old with a learning disability and type 1 diabetes, died at home following Diabetic Ketoacidosis. He required residential care since the age of eight, under the guardianship of the council. An inquest concluded a catalogue of failures by Surrey County Council and other bodies contributed to Jake's death.

The coroner found Surrey Care Leavers team and Children Services had failed to obtain information about Jake's cognitive ability and his capability of managing his diabetes independently, a Prevention of Future Deaths report published this month reads.

Coroner **Caroline Topping** said: "I am not satisfied that Surrey County Council have undertaken a rigorous review of the circumstances of the death, nor that the risk of future deaths has been averted. The issues surrounding the inadequacy of Jake's pathway plan have not been addressed comprehensively in the last 4 years. Training for personal advisers is not mandatory and is only now being rolled out."

The court was not provided with copies of the training or any protocol to be assured of the adequacy of the training and its implementation.

The coroner said that Jake's death was "avoidable" and was "contributed to by neglect". In September 2018 Jake (then 17) was placed in a full-time residential placement at **Ruskin Mill College**.

At the time of his death, Jake was staying with family for a few days when he became seriously ill from uncontrolled diabetes. Jake's mother and stepfather found him unresponsive. His family previously said "there is nothing that can take away the pain" of losing their son.

The days before his death were 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 Surrey County Council when eight years old, his family's lawyers said.

He was entitled to a personal adviser who had a statutory duty to write a pathway plan for Jake, including consideration of how his health needs were to be met. However, when away from home, no advice was sought from specialist diabetes services to inform the pathway plan and no risk assessment was made for Jake having unsupported contact with his family and managing his diabetes, the coroner's report concludes.

Meetings discussing Jake staying over at his family's house without support were unminuted. The emails which refer to meeting decisions made no reference to any of the dangers inherent in Jake's diabetic condition nor his ability to manage it unsupported. The family were also not given any advice or training on how to keep Jake safe if he became unwell nor any emergency contact numbers.

The coroner added: "The local authority employees held the mistaken belief that if Jake wanted to go home unsupervised once he turned 18 there was nothing they could do to stop him. No capacity assessment was undertaken in relation to Jake's ability to make a decision to go home unsupported. In my opinion there is a risk that future deaths could occur unless action is taken"

Four years on from Jake's death, the coroner found the process of obtaining learning disabilities diagnoses remains opaque and difficult as there is no protocol in relation to this. Vulnerable care leavers are at risk of being denied necessary support due to the confusion and delay teams accessing adult social care assessments.

Jake was assessed not to meet the threshold for SCC Transitions Team because a report containing his original disability diagnosis was lost. Children's Services were unable to obtain an up to date diagnosis. He did not have the support of an adult social work team and this outcome was being challenged when he died.

Overnight from the 28 to the 29 December 2019, Jake developed diabetic ketoacidosis as a result of being hyperglycaemic in the preceding days. He began to vomit and required immediate hospitalisation. On 30 December 2019 the college was notified by his family that he was too ill to travel. The staff who were travelling to collect him were told to return to the college. His family was not told to take him to hospital.

He was last seen alive at 11pm and found dead at 3am on 31 December 2019. If Jake had been admitted to hospital at any time prior to 5pm on the 30 December 2019 he would have been successfully treated."

The family claim that Jake's death was avoidable if he had been admitted to hospital any time before 5pm on December 29. 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

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by them in the worst possible way.

“Jake was an enthusiastic and determined young man who always put his mind to things. 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”

Clare Curran, SCC Cabinet Member for Children, Families and Lifelong Learning, said: “Our deepest sympathies remain with Jake’s family and friends. 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 and we will be responding to the Coroner outlining our action plan to prevent future deaths. While we have already made changes, we know there is still further to go and we will carefully consider the Coroner’s concerns as we take our next steps.”

Published on 14 February 2024, SCC have up to 56 days to formally respond to the coroner’s report and outline the service’s action plan.