In the South London Coroner's Court

Inquest touching the death of Jeremiah Obaka

Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: [redacted] **Acting Director of Adults Services, London Borough of Sutton**
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South London
2	**CORONER'S LEGAL POWERS** 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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/
3	**INVESTIGATION and INQUEST** On 2nd July 2016 I commenced an investigation into the death of Jeremiah Obaka. The investigation concluded at the end of the inquest on 25th September 2016. The conclusion of the inquest was that Mr Obaka died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Obaka was 77 years old, with a number of medical conditions including chronic lymphoid leukaemia. He was provided with a package of care commissioned by the local authority whereby carers would visit him at least twice a day. Carers last visited Mr Obaka on 27th June 2016, but received no reply on subsequent visits. On 2nd July 2016 police broke into Mr Obaka's home and found him dead. There was a dispute as to the number and nature of communications between the local authority and the agency commissioned to carry out the visits.
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 **MATTER OF CONCERN** is as follows. – There was no agreed and consistent policy or guideline on what should happen in the event that a service user did not reply or could not be found. The local authority (now through a separate Limited company) and the care agency had separate and different guidelines, neither of which had been communicated to the other.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **8th December 2017** 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 Chief Coroner and to the following Interested Persons 1. Absolute Care Services 2. The family of Mr Obaka I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**DATE** 12th October 2017 **SIGNED BY CORONER**