IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Jake Brian BAKER
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Executive - Surrey County Council 2. [redacted], Chief Executive – Care and Quality Commission
2	**CORONER** Miss Caroline Topping, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into the death of Jake Baker was opened on the 13th August 2020 and resumed on the 23rd January 2021. The resumed inquest was adjourned on 2 occasions for further evidence to be provided and suspended to await the result of a prosecution under regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The inquest was concluded on the 14th December 2023. Evidence in respect of matters pertaining to this report was heard on the 1st February 2024. Jake Baker died on the 31st December 2019 at home at Queen Elizabeth Way, Woking and the medical cause of his death was: 1a Diabetic Ketoacidosis The narrative conclusion found that:

	Jake Baker had twin diagnoses of learning disability and type 1 diabetes. He was not capable of, and had not been trained to, manage diabetes independently if he developed hyperglycemia and became unwell. His family had not been given any training to recognise a deterioration in Jake's condition and when to seek emergency medical assistance. Those involved in making decisions for Jake from the Surrey Care Leavers team and Childrens Services failed to ensure Jake's safety when he went home for overnight contact from March 2019 by : a.) Failing to obtain information about the risks posed by type 1 diabetes from specialist diabetic services. b.) Failing to obtain information about Jake's cognitive ability and how it impacted on his ability to manage his diabetes independently. c.) Failing to undertake a risk assessment in relation to his ability to manage diabetes independently. d.) Failing to create an adequate pathway plan which included a proper evaluation of what support Jake needed to have contact with his family e.) Failing to co-ordinate the agencies providing support for Jake to inform the pathway plan. f.) Failing properly to plan for Jake's care leaving by failing to hold properly minuted and informed meetings prior to making a decision that Jake could have unsupported contact with his family. g.) Failing to ensure that Ruskin Mill Trust were aware that the local authority had not risk assessed Jake having unsupported contact with his family. h.) Failing to inform Jake of the risks of going home unsupported and to suggest ways to mitigate the risks i.) Failing to correctly identify that, had Jake been made aware of the risks and despite that insisted on going home unsupported without any mitigation in place, a capacity assessment would be required. Had such a capacity assessment been undertaken he would have lacked capacity to make that decision and safeguarding measures would have had to be taken. There was a systemic failing on the part of Surrey County Council adequately to train and oversee personal advisers in relation to their legal obligations in preparing pathway plans. Ruskin Mill Trust failed to ensure Jake's safety when he went home for contact by:

	a.) Failing to ensure that any employees involved with pathway planning meetings for Jake were fully informed about the extent of the risks posed by type 1 diabetes. b.) Failing to risk assess the risk posed to Jake by his diabetic condition when he went home for contact. c.) Failing to put in place a care plan informed by his diabetic specialist team, Jake, his family and staff. d.) Failing to ensure that they were aware on a daily basis when he was away from the college what his blood sugar readings were. Had they done so they could have ensured admission to hospital at the latest by the morning of December 29th 2019. e.) Failing to establish the nature of his condition when notified that he was unwell on the 30th December 2019 and to give appropriate advice that he needed immediate hospital admission. The death was contributed to by neglect.
5	**CIRCUMSTANCES OF THE DEATH** Jake Baker was made subject to a care order in 2009 and remained in the care of Surrey County Council until he turned 18 on the 29th March 2019. He was diagnosed with type 1 diabetes in 2014. He was diagnosed as learning disabled and in 2015 was assessed to have an overall IQ of 42 with working memory and processing scale of 50 placing him below the 0.1 centile in these domains. Once subject to a care order he retained contact with his family in Woking during thrice yearly supervised contact visits. Following being diagnosed with type 1 diabetes he was cared for both at school and in his residential care home by staff who were given training by St Peter's Hospital in relation to diabetes management. In September 2018 he was placed in a full-time residential placement at Ruskin Mill College. Whilst at the college the management of his diabetic condition was overseen by members of staff who supervised Jake whilst he took blood readings and calculated the insulin dose required. Secondary diabetic care transferred to Gloucester Royal Hospital. Jake continued to have a social worker until he reached 18 years old when he became a care leaver and came under the auspices of the Surrey Care Leavers team. He was entitled to a personal adviser once he left care. There was a statutory duty on the personal adviser to write a pathway plan for Jake which would include consideration of what support he

	required to sustain appropriate family relationships and how his health needs were to be met. The personal adviser was required to coordinate support and ensure that agencies providing services that contributed to the pathway plan were engaged in information sharing and pathway planning. No advice was sought from specialist diabetes services to inform the pathway plan and no risk assessment was undertaken in relation to the risks of Jake having unsupported contact with his family in so far as management of diabetes was concerned. A referral was made to the Surrey County Council Transitions Team for an assessment of Jake's care needs. The entry requirement for that team required an evidenced diagnosis of learning disability. The report containing the original diagnosis had been lost. Childrens Services were unable to obtain an up to date diagnosis of learning disabilities. Jake was assessed not to meet the threshold for the transitions team. He did not have the support of an adult social work team. This outcome was being challenged when he died. Two professional meetings took place, attended only by local authority employees, prior to Jake's 18th birthday and agreed that Jake should have unsupported staying contact with his family on the 29th March 2019. The meetings were unminuted and the emails which refer to the decisions made at the meetings make no reference to any consideration of the dangers inherent in Jake's diabetic condition nor his ability to manage it unsupported. 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. Jake lacked the ability to be wholly independent in managing his diabetes. He was not given any information about the dangers inherent in him having unsupported contact if his blood sugars became deranged and he became acidotic. No capacity assessment was undertaken in relation to Jake's ability to make a decision to go home unsupported. His final looked after child and pathway planning meeting took place on the 27th March 2019 at Ruskin Mill College attended by his social worker, independent reviewing officer and 2 members of staff from the college. There are no minutes of the meeting. The pathway plan was deficient in that the domain relating to contact with family was not filled in. The only reference to what would take place in relation to contact was that he would be supported with travel warrants by the local authority and

	would stay in touch with college staff so they know he was safe and when he was returning. Jake had two overnights stays with his family in March and November 2019 of one and two nights respectively. He then asked his personal adviser for travel warrants to travel for contact from the 24th December to the 30th December 2019. No risk assessment was undertaken in relation to him having unsupported contact for this length of time by either his personal adviser or the college. In November 2019 he transferred to Glasshouse College in Stourbridge which was an internal transfer within the Ruskin Mill Trust Group. On the 24th December 2019 Jake was dropped at his family home at Queen Elizabeth Way, Woking. He was provided with sufficient insulin for the stay. The family were not given any advice at any stage on how to keep Jake safe if he became unwell nor any emergency contact numbers. They were not given any training in diabetes management nor the symptoms which might suggest he needed immediate medical attention. Overnight from the 28th to the 29th December 2019 he developed diabetic ketoacidosis as a result of being hyperglycaemic in the preceding days. He began to vomit. He required immediate hospitalisation. On the 30th 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 the 31st December 2019. If Jake had been admitted to hospital at any time prior to 5 pm on the 30th December 2019 he would have been successfully treated. The death was avoidable.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. Jake died more than 4 years ago. Evidence was provided as to what steps have been taken by both Ruskin Mill Trust and Surrey County Council to address the concerns enumerated in the narrative conclusion. I am satisfied that Ruskin Mill Trust have undertaken an extensive review of their practices since the death to address the concerns. 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 **MATTERS OF CONCERN** are as follows: a.) 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 in relation to it so as to be assured of the adequacy of the training and its implementation. b.) The process by which diagnoses of learning disabilities can be obtained remains opaque. There is no protocol in relation to this. The current situation leaves those making decisions in relation to young people struggling to obtain this vital information. c.) The issue of how the numerous adult social care teams are accessed to obtain adult social care assessments for care leavers leads to confusion and delays. Vulnerable care leavers are at risk of being denied necessary support. d.) How internal meetings and formal review meetings with other interested parties are informed and recorded is not subject to a protocol and the risk remains that decisions will be taken without adequate information and inquiry as to the risks inherent in those decisions. e.) Practice standards have not been put in place in relation to risk assessments of care leavers to inform their needs.

	f.) Mental Capacity Act training is not mandatory in children's services and the adult services have no audit of the effectiveness of the mandatory training provided and how it is being used in practice. There is therefore a risk that erroneous assumptions as to capacity will continue to be made.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
9	**COPIES** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] [redacted] Ruskin Mill Trust Gloucester Royal Hospital The Care Quality Commission 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.
10	**Signed:** **Caroline Topping** **H.M Assistant Coroner for Surrey** **Dated this 8th day of February 2024**