	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Dr Matthew Patrick, Chief Executive, South London and Maudsley Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX** And copied to: • The Family of the deceased • Chief Coroner for England and Wales • London Borough of Southwark (Housing Assessment and Support Service) • King's College Hospital NHS Foundation Trust • [redacted] General Practitioner, Aylesbury Partnership, Taplow, SE17 With copies for interest to: • HM Senior Coroner, Dr Andrew Harris, Inner South London • INQUEST • Coroners Society of England and Wales
1	**CORONER** <u>Coroner</u> I am Miss Sarah Ormond-Walshe, Assistant Coroner, Inner 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.
3	**INQUEST** **CHRISTOPHER TOKE AJAYI (deceased)** On 27th September 2012 the court was referred the death of Christopher Ajayi, aged 45

	year old. The investigation and inquest concluded at the end of the inquest on 30th September 2014. The cause of death was found to be: *1(a) Hyperosmolar non-ketotic coma (HONK)* *1(b) Diabetes Mellitis types II (Insulin dependent), Schizo-affective disorder* *Part 4 (Conclusion)* *Natural causes to which Neglect contributed.*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were recorded as: *The deceased was aged 45 years old, with a long history of schizo-affective disorder and, at times, type II Diabetes Mellitis. He had a long history of not complying with his treatment. He was admitted to the Maudsley Hospital on 9th May 2012 initially using an alias name and then put under s3 MHA 1983. During this admission he became severely ill, with HONK (Hyperosmolar non-Ketotic coma), and had a brief spell at King's College Hospital ITU (4th-7th August 2012) to treat that. This left him, for the first time, insulin dependent, requiring him to give himself insulin injections twice a day. Upon transfer back to the Maudsley plans were to have him put under a Community Treatment Order, upon discharge. He clearly required supported accommodation, especially in light of his newly diagnosed insulin dependent diabetes Mellitis Type II. He was discharged, however, into unsupported housing and no action was taken to check on him before he died. This was all despite the fact that he was only dispensed with only two weeks' supply of medication upon discharge and it must have been known he had missed his depot anti-psychotic injection, his follow up appointments and tribunal hearing.* *He was found decomposed in his unsupported accommodation on 17th September 2012, approximately a month after his discharge, having been seen by no professional or carer during that month. The deceased was a vulnerable person, and a challenging patient too. There were many failures in relation to his care in relation to his discharge planning, and his discharge follow up.* *These include:* 1. *There was a failure to check his GP status after it became clear what his*

real name was.

2. *There was a failure to appoint a GP to look after the deceased once he was discharged into the community.* ***This was a gross failure.***

3. *There was a failure to properly, or adequately prepare for the deceased's discharge e.g. failing to ensure he returned to KCH for further education 4-5 days before discharge.*

4. *There was a failure in communication in relation to ensuring that the deceased's psychiatrist who assessed him when finally discharging him on a CTO, knew of his new diagnosis of HONK.*

5. *There was a failure to discharge him into supported accommodation of at least low – medium support.* ***This was a gross failure.***

6. *There was a failure to send a discharge notification to a new GP who should have been appointed to care for the deceased.* ***This was a gross failure.***

7. *There was a failure to send a discharge summary to a GP who should have been appointed to care for the deceased.* ***This was a gross failure.***

After his discharge from hospital:

8. *There was a failure to ensure he was checked in relation to taking his insulin and his psychiatric medication, which it appears he had stopped after a while.* ***This was a gross failure.***

9. *There was a failure to arrange a police welfare check, or otherwise ensure the deceased was checked on,*
   when:
   (a) He failed to attend his Tribunal meeting in relation to his CTO on the ward on 31st August 2012.
   (b) He did not attend his 3rd September 2012 base meeting
   (c) He missed his depot injection on 10th September 2012
   (d) He missed his base appointment on 12th September 2012

   These were gross failures, individually, and cumulatively.

	But for one or more of these gross failures, on the balance of probabilities, the deceased would not have died when he did. *I probably find that he died of uncontrolled diabetes, linked to one or more of the gross failures.*
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. – Mr Ajayi was aged 45 when he died. He had a long history of mental illness and a forensic history. He suffered with severe mental illness with a diagnosis of paranoid schizophrenia in 1989 which was amended to schizo-affective disorder in 2002. He was a wanderer and also not always compliant with medication. He was single and had little or no contact with his family in the time leading up to his death. In the last hospital admission before his death he was diagnosed with HONK – Hyperosmolar non-Ketotic coma. This means his blood sugar was high. He now required insulin to control his diabetes and he was, when discharged, to administer this to himself twice a day. On the 9th August 2012 there was a discharge planning meeting at the Maudsley (his last hospital admission). His Care Coordinator attended. It was known by then, because of his poor history of being non-compliant, that he would be being discharged with a Community Treatment Order in place. His named Care Coordinator does not seem to recall much about this meeting but has acknowledged that he would have been told that Mr Ajayi was now insulin dependent. From thereon, it appears that nothing of value was done in relation to Mr Ajayi's discharge planning. He was eventually discharged, wrongly, into unsupported accommodation with no care package, where no GP was caring for him and no Diabetic nurse aware of his discharge. Whilst his named Care Coordinator was on leave his colleague, another Care Coordinator, equally did not ensure everything was in place. Both argued that as Mr Ajayi was placed by Southwark Council, after discharge, into accommodation out of the borough, that militated, practically, in relation to them visiting post discharge. No one

was to visit him.

To use the words that Counsel for the family used, this group of staff (Care Coordinators) carry an enormous responsibility. The job must be carried out with great diligence and care. Staff must be of the right calibre, and have the right training, and support, to carry out their tasks well. The evidence revealed that these members of staff have a high degree of delegation imposed upon them. They are dealing with probably the most vulnerable people in society.

It cannot be uncommon for a mentally unwell person to be discharged from hospital whilst suffering from a physical condition. One impinges on the other when that person is required to administer life-saving treatment to themselves. Therefore, they are particularly vulnerable. I acknowledge that patients such as Mr Ajayi, who frequently disengage with treatment, can only have their risk of harm/death reduced, not eliminated. However, this case highlighted so very many missed opportunities, mainly within the department of Care Coordinators.

I have heard some evidence about resources impinging upon matters. Certainly, in this case, the accommodation which would be available for an individual such as Mr Ajayi (who was on the Sexual Offender's list as well as having the problems cited above), is, and was, limited. However, this report is not concerning that issue. It concerns the ability of this group of staff to carry out their jobs ensuring the lowest possible risk to their users as can be achieved. If necessary, Mr Ajayi should have (as would have been likely), stayed in hospital until the right discharge arrangement was in place (supported accommodation or unsupported with an intensive package of care). The caring element of the Care Coordinator role was missing.

I am assured that the team that was responsible for Mr Ajayi's community care have developed a more structured multi-disciplinary approach including monitoring of 7 day follow up and I am told is robustly monitored in respect of compliance with the seven day follow up), and the identification of high risk patients such as Mr Ajayi. I am further assured that discharge planning is expected to be comprehensively and carefully planned before discharge. Sadly, I did not find this evidence reflected in the Care Coordinators' evidence. I have not been shown any audit figures to prove that changes have been checked as in action comprehensively, and the evidence was not impressive in relation to changes within this particular department. No re-training was evident. Both Care Coordinators were experienced and both also knew Mr Ajayi and his history, albeit not acting upon his new diagnosis. The evidence as a whole came across as still a service dealing with extremely vulnerable members of the public, where crucial decisions and follow up impinge directly on those individual's well-being,

	as well as others in the community. There appears to have been no root and branch overhaul of the department. Further, there was inconsistent evidence as to supervision, which in itself, would only account for supervisory control over some users of the service, at that particular time. I have concerns that the named Care Coordinator told me that his supervision was two weekly, where his manager told me it was monthly. Other than more supervision, I am struggling to find any other tangible changes that I am sure have been made, to prevent this group of staff from allowing the same circumstances to occur again.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Trust has 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 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. If you require any further information or assistance about the case, please contact the Corner's Officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • The Family of the deceased • London Borough of Southwark (Housing Assessment and Support Service) • King's College Hospital NHS Foundation Trust • [redacted] General Practitioner, Aylesbury Partnership, Taplow, SE17 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**[DATE]** **31st October 2014**	**[SIGNED BY CORONER]**