Regulation 28: Prevention of Future Deaths report

Max TURBUTT (died 25.04.22)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Kent County Council**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 May 2022, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Max Turbutt, aged 21 years. The investigation concluded at the end of the inquest earlier today. I made a determination of death by suicide. The medical cause of death was hanging.
4	**CIRCUMSTANCES OF THE DEATH** Max had suffered mental ill health for a number of years. He had been accommodated under Section 20 of the Children Act and supported by Kent County Council as a Child in Care, then as a Care Leaver by the 18 Plus Service under Section 23c of the Children Act.
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. Max's father told me at inquest that in March and April 2022, Max tried to contact his personal advisor at the 18+ Service at Thistley Hill in Dover on several occasions over a number of weeks, but found her phone always to be switched off. There was no redirect and no out of office on her email. Max's father also tried to call her, with the same result. Just over a week after Max's death, his family received a letter addressed to him from Kent Social Services, explaining that his social worker was off sick. A crisis number was given and Mr Turbutt called it, but it was simply an answerphone. This arrangement does not seem adequate for a vulnerable person in need.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 19 December 2022. 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 following. • [redacted], Max's parents • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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.	
9	**DATE** 18.10.22	**SIGNED BY SENIOR CORONER** *ME Hassell*