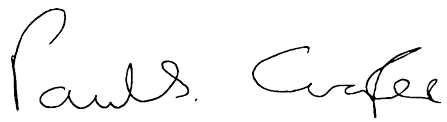
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Constable of Lincolnshire** **Chief Coroner**
1	**CORONER** I am Paul Cooper, Assistant Coroner for the Coroner area of Lincolnshire, Myle Cross, Macaulay Drive, Lincoln, Lincolnshire, LN2 1NN.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20 April 2021 I commenced an investigation into the death of Dainton Harley Hill Cressell GITTOS aged 11. The investigation concluded at the end of the inquest on 31 August 2022. The conclusion of the inquest was that: Dainton died as a result of the parent's neglect in not supervising Dainton, who was a vunerable child whilst he had a bath on 22nd January 2021 which contributed directly to the main cause of his death which from the Home Office pathologist's report was as follows The full medical cause of death being: 1a. Consistent with drowning 2. Cerebral Palsy due to congenital cytomegalovirus infection

4	**CIRCUMSTANCES OF THE DEATH** 1.Father gave child bath 2.Did not follow the manufacturer's guidance 3.Left the child unsupervised 4.Told mother he was in the bath, yet mother says he told her he was in bed. 5.The child was found unresponsive by mother sometime later still in the bath 6.The child had cerebral palsy 7.The child could not speak, bear his own body weight and was unable to call out for help. 8.Slid under the water and drowned. 9.Social services records indicate child protection conferences were held in 2010-2011and 2013 -2014 under category of neglect and emotional harm 10.In 2014,2015 and 2017 registered as a child in need. 11.The expert for the police Dr. [redacted] stated "All that can be stated with certainty is that if a carer were present and or the bath was filled in an unoccupied sate that this outcome would not have occurred" 12.CPS concede a) It is beyond doubt that Dainton was a child and lacked capacity b) [redacted] had responsibility for Dainton c)There was a failure by father to use the none-slip mattress in the bath d)There is no doubt the lack of supervision of Dainton when he was in the bath amounted to neglect e)Both suspects deny they were responsible for supervising Dainton when he was in the bath after father had left him 13.Extensive Class B drugs were found at the scene
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. The **MATTERS OF CONCERN** are as follows: I refer to all the evidence heard at the Inquest particularly, that of DC [redacted] and the Police's own expert Dr. [redacted], (recited above) and do not accept why any charges have not been brought against either or both parents focusing on s1(1) Children and Young Persons Act 1933 The police are asked to review their file again in view of the many concessions made by CPS and the findings as to cause of death now made in the Coroner's Court (admittedly on a different standard of proof but they are still findings after hearing evidence). Neglect runs right through this case and irrespective of the parent's allegations against each other like in the Coroner's Court the belief is that the evidence needs to be tested and if

	agreed charging criteria reconsidered as there are 3 other siblings. A vulnerable child aged 11 is dead.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 October 26, 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 Chief Coroner and to the following Interested Persons I have also sent it to The Chief Constable of Lincolnshire Police who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 31/08/2022**  **Paul COOPER** **HM Assistant Coroner for** **Lincolnshire**