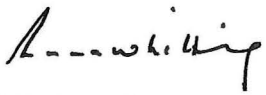
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT **DEATHS THIS REPORT IS BEING SENT TO:** **1 [redacted], COMMISSIONER FOR METROPOLITAN POLICE** **2 CEO COLLEGE OF POLICING** **3 CHAIR OF NATIONAL POLICE CHIEFS' COUNCIL** **4 SECRETARY OF STATE FOR DEPARTMENT OF HEALTH AND SOCIAL CARE** **5 SECRETARY OF STATE FOR HOME DEPARTMENT**
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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	**INVESTIGATION and INQUEST** On 30 October 2019 I commenced an investigation into the death of Harper DENTON aged 1 Month. The investigation concluded at the end of the inquest on 17 August 2022. The conclusion of the inquest was that: The Deceased was unlawfully killed by her father who had been previously convicted of violent offences against a two year old; failures by state agencies sufficiently to manage the continued high level of risk of his further offending contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** On 6 November 2019, [redacted] the Deceased's father, was sentenced to life imprisonment for her murder. It was not the first time that [redacted] had brutally attacked an infant; he had previously been convicted of violent offences against a 2 year old child in 2006. Despite being given a 9 year sentence, he was released on licence in July 2010 as dangerous as he had been in 2006; albeit his licence conditions required him not to have unsupervised contact with children under the age of 16 and to disclose details of any new relationships. Following his release in 2012, he came to the attention of the Metropolitan Police Service and was the subject of two CRIS reports involving allegations of Domestic Violence; both reports involved episodes of strangulation. However, there was a lack of information sharing with Probation at this time. He was subsequently recalled to prison for two 6 month periods for breaches of his licence conditions before finally being released for the last time, on 23 June 2014, to Approved Premises accommodation in London with continued restrictions regarding any unsupervised access to children and new relationships, particularly with women and children. At the beginning of December 2014, he moved into private accommodation and, within weeks, was the subject of a MARAC referral concerning further Domestic Violence; although this was co-chaired by the MPS a lack of proper investigation, co-ordination with Probation and serious information failures led to a missed opportunity not only to consider further criminal proceedings but also to identify him as a Potentially Dangerous Person and to manage the high risk he continued to pose accordingly. As a result, later that same year, he started a relationship with the Deceased's mother, moved into her accommodation in Bedfordshire, and the Deceased was conceived without either her mother, Bedfordshire Police, or local healthcare professionals, being aware of the continued risk he posed to her; however, a chance encounter by Bedfordshire

	Police on 30 November 2017 was a further missed opportunity for multi-agency safeguarding prior to her death.
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: **POLICE** 1.The MPS does not appear to have adopted ACPO Guidance on *Protecting the Public: Managing Sexual Offenders and Violent Offenders* 2010 and subsequent APP College of Policing *MOSOVO* Guidance, particularly with respect to PDPs. Because this concern maybe relevant to other police forces nationally, this concern is directed to the CEO College of Policing and the Chair of the NPCC as well as the Commissioner for the MPS. 2. There appears to be a lacuna in pro-active information sharing practices by Police (similar to those found under *Clare's Law* and *Sarah's Law*) in order to protect children from those who may present a threat to them as a result of having previous convictions for violence/cruelty offences against a child - this concern is directed to the CEO College of Policing and the Chair of the NPCC. **HO** 3. There is nothing today, such as form of Offender Register, to protect children from an individual who has already been convicted of a cruelty offence against a child and served their sentence. **DoHSS** 4.The need for a Health Visitor to carry out a full safeguarding assessment of a father's/co-parent's potential risks to a child is currently only 'best practice' and not mandatory.
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 30, 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 [redacted], **Chief Constable of Bedfordshire** [redacted] **Cambridge Community Services NHS Trust.** 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: 15/09/2022**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**