




	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO</b></p> <p>The Local Authority – London Borough of Sutton The Sutton Local Safeguarding Children’s Board Cafcass The Children’s Guardian Services for Children Secretary of State for Housing, Communities and Local Government Sutton and Merton Community Services</p>
1	<p><b>CORONER</b></p> <p>I am Dame Linda Dobbs DBE, Assistant Coroner.</p>
2	<p><b>CORONER’S LEGAL POWERS</b></p> <p>I make this report under Paragraph 7, Schedule 5 of the Coroner’s and Justice Act 2009 and Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 29 October 2013, the death of Ellie May Butler was reported to the Coroner’s Office. On 14 November 2013, an inquest was opened. The inquest was adjourned pending the outcome of criminal proceedings against Ellie’s father and mother, [REDACTED].</p> <p>[REDACTED] The criminal proceedings concluded on 21 June 2016.</p> <p>On 11 August 2017, the inquest was resumed with a Pre-Inquest Review hearing. A further Pre-Inquest Review hearing was held on 15 December 2017. The inquest resumed on 12 March 2018. The evidence was completed on 23 March 2018. My conclusion was handed down on 10 April 2018. The conclusion of the inquest (attached) is one of unlawful killing. The cause of death was impact head injury, inflicted on Ellie by [REDACTED].</p> <p>[REDACTED]</p>

4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 28 October 2013, at her home address Ellie May Butler was assaulted by her father [REDACTED] resulting in fatal head injuries.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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 these concerns.</p> <p>The matters of concern are appended.</p>

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In the Assistant Coroner's opinion, action should be taken to prevent future deaths.</p> <p>The Assistant Coroner believes the following organisations have the power to take such actions:</p> <p>The Local Authority – London Borough of Sutton  The Sutton Local Safeguarding Children's Board  Cafcass  The Children's Guardian  Services for Children  Secretary of State for Housing, Communities and Local Government  Sutton and Merton Community Services</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 June 2018. I, the Assistant Coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>The Assistant Coroner has sent a copy of this report to the Chief Coroner and to all Interested Persons.</p> <p>I am also under a duty to send the Chief Coroner a copy of your responses. 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.</p>
9	<p>Dated 10 April 2018</p> <p>Signature </p>