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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Registered Manager, Bowden Derra Park Ltd, Launceston**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 13/3/23, I concluded an inquest into the death of Lugh Baker . The medical cause of death was recorded as: 1a) Unascertained 1b) 1c) II) I recorded an Open Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Lugh was a 24-year-old man with a diagnosis of Angelman's syndrome. He suffered with epileptic seizures for which he was prescribed medication, and he had difficulty swallowing. At the time of his death, he was a resident at Rosewood House in Launceston which provided supported living for individuals with physical and/or mental disadvantages. On 21/4/21, he was given prescribed medication with a chocolate milkshake at about 20:00. He was checked upon subsequently before being found unresponsive at about 23:30. CPR was initiated during the course of which an unsealed, partly-consumed chocolate bar was seen under or near his bed. Lugh had a care plan that mandated he should not eat unsupervised and should eat sitting up. It is not known how the chocolate bar came to be found where it was. It is further not known if Lugh had been eating it immediately prior to his death. Lugh could not be resuscitated. A post-mortem examination did not reveal evidence of airway obstruction. The evidence did not further or fully explain the means whereby the cause of death arose.
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. – i) I heard evidence at inquest that all residents were constantly monitored yet I found as fact that there were times when this did not happen for Lugh. I was informed that a new system has been put in place requiring staff to sign a form indicating the periods in time when they were responsible for monitoring residents. I asked for evidence to demonstrate this (a completed form) and for confirmation that, where there were any gaps in monitoring, these were explained on the form. ii) Concern was raised that Care Plans for new residents were not reviewed sufficiently promptly. I asked to see a policy document setting out the expectation for healthcare professionals for how long it should take for a new resident's Care Plan to be reviewed after admission. iii) Concern was also raised about what steps will be taken, and when, where a new resident with an unusual presentation is admitted. In this case, Lugh had a diagnosis of Angelman's syndrome with which staff were unfamiliar. Again, I asked to see a policy document setting out what training or other steps will now be taken in such circumstances and by when.
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 10 May 2023. 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: - Family of Lugh Baker 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE] 13.3.23** **[SIGNED BY CORONER]**