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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Constable, Devon & Cornwall Police 2. [redacted], Head of Operations south-west, Probation Service 3. [redacted] Chief Executive, Cornwall Partnership Foundation Trust
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 3/7/26, I concluded the inquest into the death of Bernadette Rosario who was stabbed to death by her son, [redacted], on 28/3/23 at the age of 61. I recorded the cause of death as 1a) Stab wounds to face, head and upper limbs I recorded a conclusion that Bernadette was unlawfully killed. A number of serious failures on the part of various state agencies contributed to the outcome.
4	**CIRCUMSTANCES OF THE DEATH** On 28/3/23, Bernadette was stabbed to death at her home address of 2 Clayton Terrace, Carluddon, St. Austell in Cornwall. Her assailant had broken into her property and stolen knives approximately 18 months before her death and had made threats to kill her either himself or by encouraging another to do so. When her assailant was discharged from hospital in December 2022, there was a serious failure to discuss and reconcile conflicting clinical judgments as to the underlying nature of his diagnosis. There was no satisfactory assessment of risk or risk management planning that reflected the differing clinical opinions. Those responsible for managing Bernadette's assailant in the community failed properly to assess the risk of serious harm he posed to her. As a

	consequence, no or no adequate steps were taken to safeguard her or reduce the risk she faced. On the evidence, it is more likely than not that the serious failures to reconcile conflicting clinical judgments and to assess and decisively act upon the risk of serious harm Bernadette's assailant posed to her both contributed to her death more than minimally. While there was a serious failure to prepare in timely manner a file for potential prosecution following a break-in at Bernadette's home in March 2022, the evidence is insufficient and likely to be of such a speculative quality that it cannot be found it is either probable or possible this contributed to her death more than minimally. A copy of my full judgment is attached.
5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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. 1) The evidence revealed that the police, Carrick CMHT and the probation service were significantly under-resourced/under-staffed at the time of these events. The police had 50 CID vacancies with Officers carrying double a full workload. Carrick had 2/3 agency staff. Workloads within the probation service were at over 160%. I found the lack of resource/excessive workloads contributed to serious failures to work across agencies and manage [redacted]. As one witness put it, there was a collective failure properly to understand risk and then take steps to reduce it. Put another way by the same witness, everyone was in their lane but no one was looking across lanes. I draw to your attention my findings from paras 188 onwards of the attached judgment. I found this contributed to ineffective multidisciplinary team or cross-agency working and it prevented effective integrated offender management. I felt there would be real value in senior executives in the agencies concerned, and potentially other key state agencies, sitting down to review the lessons to be learned from this incident and taking steps to prevent similar deaths from occurring in the future.
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 1 September 2026. I, the coroner, may extend the period. I do not need to hear from all three Interested Persons if it is agreed that one of you will respond on behalf of all three – that is a matter I leave to you. 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: - Bernadette's family; Although not Interested Persons in the inquest, I am also sending a copy of my judgment to the Chief Executives of Royal Cornwall Hospital and Cornwall Council. 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]** **[SIGNED BY CORONER]** **3/7/26** [redacted]