	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Constable, Devon & Cornwall Constabulary**
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 2 December, I concluded a four-day jury inquest into the death of Daniel Lee Tilley who died in Newquay on 7 July 2019. . The medical cause of death was recorded as: 1a) Hanging 1b) 1c) II) The jury recorded a Narrative Conclusion in the following terms: *Open conclusion: The evidence is not sufficient to conclude that it is more likely than not, that Daniel intended to take his own life. It is possible that a significant delay in responding to an emergency call, caused by a lack of resource deployment officers, and/or a lack of police officers on the ground contributed to the outcome.*
4	**CIRCUMSTANCES OF THE DEATH** The jury found the following as fact: *Daniel Lee Tilley was found hanging [redacted] 18:50 on 07/07/2019, later being pronounced dead by paramedics at 19:30.* *Daniel had suffered with his mental health for a number of years and had been known to have expressed suicidal thoughts and had made previous attempts to take his own life. The evidence shows that alcohol was a factor in the previous suicide attempts, during bouts of heavy drinking. It has been noted that when not intoxicated Daniel expressed regret at previous suicide attempts and had a positive outlook. He was looking forward to starting a new job and was engaging well with his GP.* *On the 07/07/2019 at 14:28 a call was made to 999 to seek police assistance as a result of Daniel's behaviour, threats of suicide and threats to harm others. The call was received, log completed and graded as 'prompt' at 14:39. The log included a range of relevant information but did not include the fact that threats to others had also been made, but it was mentioned in the call.* *The view of the jury is that given the information available, and the circumstances at the time, an allocation of either 'prompt' or 'immediate' would have been understandable.* *All witnesses agreed that there were insufficient staff in the CMCU and police officers on the ground in Newquay, due to previous reductions in resources. There was also extraordinarily high levels of demand during the summer and on 07/07/2019 in particular.* *It is possible that the shortfall in staffing levels had a significant impact on the ability of the police to respond to this incident in a timely way.* *The jury strongly agree with all of the witnesses, that 4 hours response time is an unacceptable delay.*
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. The funding of the force is insufficient to allow it to meet the increase in demand that occurs every summer when tourists come to Devon & Cornwall. I have written separately to the Home Secretary in this regard and a copy of my letter is enclosed for your information. No response is required from you. ii. a) Staffing levels in the CMCUs (both call handlers and Resource Deployment Officers) in Plymouth and Exeter are insufficient for the workloads experienced. b) There are an inadequate number of uniformed Officers available to respond in a timely fashion to the demand seen over the summer months. Let me acknowledge that I recognise these two issues are intertwined. The amount of budget the force receives will dictate what it can afford in terms of police staff and police officers. As Chief Inspector [redacted] accepted during the course of this inquest, the police did the best they could with what they had; they simply did not have enough. My concern in relation to the CMCUs is that this problem has existed – on the evidence I heard at inquest – for a decade or so, and it is unresolved today. Indeed, I am bound to note the recent decision of HMICFRS to move the force into an enhanced level of monitoring with one of the stipulated grounds being: 'the force does not answer, or respond to, emergency or non-emergency calls within adequate timeframes, and too many calls are abandoned…' The jury heard from Chief Supt [redacted] and ACC Leaper at inquest. They were told that staffing levels for both call handlers and RDOs were still not at the 'design' brief advised by BT but that recruitment processes were in hand which, it was hoped, would achieve this. They were told that three separate pieces of software were to be introduced in the New Year which, once fully operational, ought to permit greater efficiencies and speedier call management. In writing to you, I wanted to bring these matters to your attention so that you can ensure the intended improvements are realised. I understand once you start in your new role you will require a little time to bring yourself up to speed with what will inevitably be a raft of pressing issues, that budgets for 2022/3 are yet to be finalised and, finally, that the recruitment drive and IT upgrades still need to be completed. For those reasons, I have extended the time below for the formal Reply from you.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report. As coroner, I may extend the usual 56-day period and I think it appropriate to do so in this case. I will be pleased to receive your Reply by no later than 6 April 2023. 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: - the family of Daniel Tilley; - [redacted], the Police and Crime Commissioner

	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] 6.12.22** **[SIGNED BY CORONER]**