*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 Constabulary 2. [redacted], Medical Director, SWAST
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 27/2/25, I concluded a four-day jury inquest into the death of Lachlan Charles Campbell who died on 1/11/22 at the age of 51. The jury recorded the cause of death as 1a Bronchopneumonia, hypothermia and Combined Drug Intoxication II Fatty Liver Disease The jury recorded a narrative conclusion of a *Drug-related death contributed to by neglect. Responding police officers missed opportunities to provide sufficient care to Mr Campbell as they did not provide shelter, warmth or appropriate medical attention. Delays in responding services resulted in a failure to provide Mr Campbell with timely care which contributed to his death.*
4	**CIRCUMSTANCES OF THE DEATH** The relevant background circumstances are that: Mr Campbell had a history of recreational drug misuse with previous non-intentional overdoses. On 31/10/22, he travelled by train from St Austell to St Erth to visit a friend. While with his friend, it is understood he took drugs as he then became unconscious/fell asleep. His friend took him back to the railway station to catch the last train back to St Austell. At approximately 00:15 on 1/11/22, a bus driver saw Lachlan outside the

	train station. He was on his knees, bent forwards with his head on the ground in what was described as a 'prayer position.' A concern for welfare call was made to the emergency services. A police response was delayed, understandably, owing to a higher priority call being received in relation to an incident of potential domestic violence to which the Officers were diverted. The Officers arrived with Lachlan shortly after 01:00. At 01:42, a request was made for an ambulance. This resulted in a Category 2 disposal requiring an attendance within an average of 18 minutes with 90% of incidents to be attended upon within 40 minutes. The Officers left Lachlan at the scene understanding that an ambulance would arrive shortly. They had initially wondered if Lachlan was the male involved in the incident of Domestic Violence but once it was recognised he was not and that the suspect was still at large, there was a concern to apprehend the suspect to safeguard the female victim. After a downpour, Officers returned to the scene shortly before 05:00 to find Lachlan in much the same position but now soaked through. They discussed their options and the risk of hypothermia. A chasing call was made to the ambulance service and it was identified there were still 13 Category 2 or higher cases ahead of them. No ETA was provided. The Officers decided to watch Lachlan from their car. At approximately 06:00, his breathing became agonal. The outstanding call was upgraded to Category 1. An ambulance crew arrived on scene at 06:15 just over 4.5 hours after the first call against a target time of 18 minutes. The situation could not be retrieved and resuscitation efforts were abandoned as futile at 07:45. An expert, [redacted], opined that had Lachlan been conveyed to hospital in a timely manner, his death would have been avoided. The jury found: Despite appropriate treatment by paramedics and medical professionals, Mr Campbell died in hospital due to cardiac arrest detailed in section 2 at 7:45am in Royal Cornwall Hospital, Truro. a) How is it that an ambulance has not attended Mr Campbell until 6:15am after one had been requested by police at 01:42? Operational requirements on South West Ambulance Service Trust (SWAST). Handover delays at Royal Cornwall Hospital and poor communication between police and ambulance services. b) Were the actions taken by police officers at the scene appropriate? If not, what should have been done and by when? Actions by police officers were not appropriate. The primary survey by police officers was inadequate at first attendance. At second attendance, patient should have been conveyed to hospital. Advice should have been taken from supervisory officer. To what extent have other duties been a factor? Other duties delayed initial response but were not a factor in relation to second response. c) Are any failings gross failing? Yes, as police officers didn't provide shelter, warmth or appropriate medical attention to Mr Campbell and this amounted to serious failings.

	d) On a balance of probabilities had different actions been taken at a timely manner would Mr Campbell's death have been avoided? Yes, if actions had taken place such as conveying Mr Campbell to hospital at an appropriate time or more care had been taken to provide shelter and warmth as hypothermia could have been avoided. While it was not explored at inquest, I am aware that one Officer has resigned and one had been dismissed by reason of gross misconduct before the inquest was heard.
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) Delays in ambulance attendance. I have written to the Secretary of State separately in this regard and you do not need to address this in your reply. 2) Information sharing between SWAST and D&CP. A number of issues were revealed during the course of the evidence. a) A concern for welfare call was received by police at circa 00:15. Officers attended on scene at circa 01:00 and chased an ambulance at 01:42 only to find one had not been previously called resulting in an initial delay of nearly 1.5 hours. b) The initial caller had been a bus driver. His mobile details were not taken and so SWAST was unable to call him back for further information they required. When police officers were asked for their numbers, they provided their shoulder numbers, not their mobile numbers. SWAST thus had incomplete information when considering what disposition was appropriate. c) Police Officers were advised the call had resulted in a Category 2 disposition but were not provided with an ETA. The target time was 18 minutes but an ambulance did not arrive until 06:15, some 4.5 hours later. Had Officers been aware of the likely delays, their evidence was that they would have considered other options (such as conveying Lachlan to hospital in their car.) d) In reaching a Category 2 disposition, SWAST understood the Officers were remaining with Lachlan. In the event, they left him to deal with an unresolved domestic violence incident. At inquest, evidence was given that, had this been known to SWAST, a Category 1/2 disposition may have been reached. e) In the event Officers had concluded there was a need to convey Lachlan to hospital, it would have meant there were no available Officers in the Penzance area. While this is a matter for police to reflect upon, it was notable the Officers' supervisor

	was not contacted to discuss options. f) The inquest heard that in other countries (USA) there are arrangements in place for police to drop victims in need of urgent treatment at hospital (eg stabbings) without being detained for extended periods (current handover for ambulance crews in excess of 2 hours.) If ambulance delays are set to continue and police may need increasingly to convey patients to hospital, is there value in considering whether arrangements of this nature would be beneficial?
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 26 April. 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: - The family of Mr Campbell - [redacted] and [redacted], former police officers 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]** **28.2.25**