*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], MP, Secretary of State for Health & Social Care.
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 February 2025, I concluded a four-day jury inquest into the death of Lachlan Charles Campbell who died on 1 November 2022 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 jury recorded the following: 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.
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) Delay in ambulance response attributable to delays in handover of patients at Royal Cornwall Hospital** 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, Professor Lyon, opined that had Lachlan been conveyed to hospital in a timely manner, his death would have been avoided.
At inquest, the jury heard from [redacted] who works in the patient safety team at South West Ambulance Service Trust. She told us: *On 31 October 2022, there were over 730 hours of ambulance time lost to handovers that were over the 15 minute target at RCHT, Derriford Hospital and North Devon District Hospital (NDDH). This is equivalent to approximately 66 DCA ambulance shifts lost to delays (based on a standard 11 hour shift). At RCHT, the average handover time per patient was one hour, 55 minutes and 57 seconds. At Derriford, the average handover was seven hours, five minutes and four seconds. At NDDH, the average handover was two hours, 12 minutes and 27 seconds.*
These events happened some time ago and I wanted to know if the situation had improved in the meantime. I was advised that in January 2025, the average handover time per patient at Royal Cornwall Hospital was just under 2 hours 15 minutes, in other words, the situation has worsened. This gives rise to an obvious concern and it is in these circumstances that I write to you.

May I also take the opportunity to bring to your attention that I have written Preventing Future Death (PFD) reports with the same concerns to two previous Ministers. I am aware some of my colleagues have additionally written with the same concerns.

Included in the Reply to my first PFD was a response from [redacted], the Chief Executive of the local ICB (to whom this is copied) which set out, most helpfully, a plan of action over the coming years to relieve the current pressures. It is entirely a matter for you how you choose to reply to this report but you may feel an update from Ms Shields would be informative.

2) **Information Sharing**
There is a concern also about how information was shared between the police and ambulance service. Both police officers said that, had they been aware of the extent of ambulance delays,

	they may have considered other options, notably, conveying Lachlan to hospital in a police car. I am writing separately to SWAST and Devon & Cornwall Police in this regard and your reply does not need to address this concern.
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 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], the two former police officers - The Chief Constable of Devon & Cornwall police. - SWAST. 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. I have sent copies of this letter to [redacted], Chief Executive Cornwall & Isles of Scilly ICB, [redacted], Chief Executive Cornwall Council and [redacted], Medical Director at Royal Cornwall Hospital. For the avoidance of any doubt, I do NOT require replies from them, but I felt they would find it helpful to be sighted on this exchange. 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**