Cornwall Partnership
NHS Foundation Trust

Suite 6, Carew House
Beacon Technology Park
Dunmere Road
Bodmin
Cornwall
PL31 2QN
[redacted]

HM Senior Coroner Mr Andrew Cox
[redacted]

29 January 2026

[redacted]

Dear Mr Cox

Thank you for your letter and report dated 8 October 2025.

We are grateful for the opportunity to address your concerns, which have arisen concerning Mr Ingram's care. A meeting of all recipients of your report took place following the inquest. The following represents the joint response of Cornwall Partnership Foundation Trust (**CFT**), South Western Ambulance Service Foundation Trust (**SWAST**) and Lifestar Medical Limited (**LML**). All parties wish to express their sincere condolences to Mr Ingram's family for their loss.

Your letter sets out seven areas of concern, upon which the parties have had the opportunity to reflect individually and collectively, following the inquest. We have summarised below; the issues you have asked the parties to consider and address and have responded to each in turn.

1. **The importance of proper introductions between ambulance crews and family members, to include confirmation of a staff member's clinical grade.**

1.1 Since the inquest, LML has issued an organisation-wide memorandum concerning the mandatory requirement for all staff to clearly identify themselves to all patients, families and partner agencies. This information must include

their first name and clinical role, for example, for an Emergency Care Assistant (**ECA**), what this entails and its distinction from the role of a paramedic. The scope of their practice must also be clarified and outlined at the beginning of every patient encounter and during interactions with other organisations. The memorandum issued to staff includes practical examples of how each role, and its limitations, should be explained. Staff have also been reminded of the strict requirement to adhere to uniform policy, which includes always wearing the correct epaulettes.

1.2 LML delivers three mandatory, annual face-to-face training days for staff, to ensure their competence and alignment to organisational standards. On each day of this training, the importance of clear introductions is reiterated to staff, and put in practice through group discussions and acting out scenarios.

2. **The practice of asking a family member to remain in the ambulance while Mr Ingram was clerked in.**

2.1 All parties recognise the importance of involving and consulting with family members or carers, when assessing a patient and taking their history. As you identified, had Mr Ingram's daughter been with him when he was taken into Camborne & Redruth Community Hospital Minor Injuries Unit (**MIU**), she may have been able to provide additional information or context concerning his injury, including the fact that he was experiencing groin pain. This in turn may have prompted further investigation of Mr Ingram's injury and/or escalation to the acute hospital (Royal Cornwall Hospital Emergency Department (**ED**)). The involvement of family members in Mr Ingram's case was of greater importance due to his dementia, and the impact this had on his ability to provide an accurate history to the ambulance crew or clinician.

2.2 It was suggested in evidence at the inquest, that the practice of asking a family member to remain in the ambulance, may have been a remnant of procedure adopted during the COVID-19 pandemic. LML has reflected upon the decision of the ECA ambulance crew in this case, which was not in line with their policy. Following the inquest, LML has:

2.2.1 Issued an organisation-wide memorandum to remind all staff:

a. Of the important role that patients' relatives and carers play in supporting safe and effective patient care.

b. Of the mandatory requirement to ensure that relatives and/or carers are not excluded from any stage of the assessment or care process. The only exception to this is where a patient with capacity, declines

to be accompanied by or share information with a person, and/or where there is a clear safety issue or safeguarding concern.

c. That the presence of relatives/carers is often vital to obtain an accurate history, to understand the patient's 'baseline' and to recognise subtle changes or nuances that the patient may not be able to express themselves. This is especially important when patients lack capacity in relation to their care and treatment, have memory impairment, cognitive difficulties or communication challenges. Relatives and carers often hold key information that supports clinical decision-making and safeguards the patient's best interests.

d. Where any concerns arise about a relative's presence, the decision to exclude them must be clearly justified, documented and proportionate, with the patient's safety and wellbeing as the primary consideration.

2.3 Whilst CFT was not aware that Mr Ingram's daughter was waiting in the ambulance in this case, we appreciate that had our Minor Injuries Unit (MIU) staff come to the ambulance to carry out an initial assessment of Mr Ingram and consider his suitability for review and/or treatment in the MIU, they would have discovered her waiting there, and had the opportunity to take any relevant history. It is established MIU practice to assess patients in the ambulance, prior to checking them in. This is expressly stated in the MIU Operational Policy, which sets out the procedure for patients being brought into the MIU by ambulance, as follows:

"In the event of a patient arriving by ambulance it is the responsibility of the MIU to assess the patient in the ambulance with the paramedics prior to offloading. If the patient has a minor injury / illness, which is suitable for treatment within guidelines, and there is every expectation that the patient will be discharged independently from the MIU directly home, the Practitioner will accept the patient from the ambulance crew. This process is supported by Southwestern Ambulance Service Foundation Trust. A copy of the ambulance documentation must accompany the patient and be left with the MIU receiving team."

2.4 Assessing the patient in the ambulance enables the assessing practitioner to establish whether the MIU is the correct setting for their treatment, or whether they require assessment and care by clinicians working in an emergency department (**ED**), for example. It has become clear following the inquest, that LML (who do not routinely transport patients to the MIU), were not familiar with this procedure. Learning has been discussed between the parties, and the

Operational Policy has been shared by CFT with LML, to ensure that its crews are made aware of this.

2.5 The facts relating to Mr Ingram's inquest have also been used as a case study and presented at the Learning from Experience (**LFE**) Forum, a meeting attended by all MIU clinical leads, to discuss any collective issues to be addressed, and to share learning and best practice across CFT. It was reiterated at the LFE Forum, that in accordance with policy, all patient arrivals via ambulance should be initially assessed in the ambulance, and a full assessment of the patient should be carried out by an MIU clinician (discussed further below).

2.6 There has been a team-wide communication to all MIU staff, reiterating the requirement for all patients arriving by ambulance (SWAST or otherwise), to be physically assessed and have a handover and history taken in the back of the ambulance, before the patient is accepted into the MIU. It has been clarified that the patient should only be booked in to the MIU, once the clinician has confirmed their acceptance with the admin team. Patients arriving by ambulance are not to be booked in until they have been assessed as suitable for treatment at the MIU.

2.7 Teams have also been reminded to trust their clinical judgement when a patient arrives, and not to be afraid to decline a patient based on their own assessment if they do not feel the patient is appropriate for the MIU. This is expanded upon below.

2.8 Key themes and learning arising from the inquest, have also been shared with the service's Clinical Quality and Governance Group (**CQaGG**), attended by service leads, and other patient safety-related forums. These include reminding MIU staff that ambulance patients must be assessed in the vehicle to establish whether the MIU is the appropriate setting and ensuring that the patient record is shared with the MIU before ambulance crews leave. The importance of input from patients' relatives and carers has also been highlighted with teams, to ensure in particular that patients with dementia or learning needs are accompanied. CFT's Standard Operating Procedure for our Specialist Dementia Care inpatient ward, reminds staff of the importance of person-centred care, which includes allowing patients' families and carers to be actively involved and consulted throughout. These principles apply throughout all care settings. All MIU and Urgent Treatment Centre (**UTC**) teams have been reminded of and directed to this policy, which has formed part of several LFE forums, shared with all relevant staff.

3. **The sharing of information between different organisations when transferring a patient to a new care setting. In this case, the concern related to discrepancies around the provision of the Patient Care Record (PCR) by the ambulance crew to the MIU.**

3.1 It will ordinarily be a SWAST ambulance that attends the MIU with patients. There is an established process whereby SWAST is able to send details of the incoming patient and medical history electronically. The usual process followed by ambulance crews when transferring patients to the MIU has been summarised by SWAST as follows:

3.1.1 Crews will usually ring ahead prior to arriving at the door of a MIU or UTC.

3.1.2 Once the crew has arrived with the patient, a Healthcare Professional (**HCP**) will come out to the ambulance to see the patient, physically assess their suitability for treatment at the MIU or UTC, and receive the verbal handover. The MIU Operational Policy on receiving patients from ambulance crews has been sent to SWAST as a reminder that patients are not to be brought in to the unit before being assessed for suitability.

3.1.3 If the receiving HCP is happy to accept the patient, then the crew will assist the patient into the department. The electronic PCR is then emailed over to the MIU/UTC. This email is undertaken via the 'MobiMed' (a mobile app containing an electronic patient record management system), from a list of possible email addresses that are easy to select.

3.2 In Mr Ingram's case, the ambulance which attended the call was a private ambulance provided by LML, whose staff work from written Patient Clinical Records (PCR). The possibility of LML adopting a similar electronic system of recording PCRs was discussed, however the associated set-up and maintenance costs were not considered financially viable for a medium sized ambulance provider. There was a conflict in the evidence at the inquest as to whether a PCR was provided to MIU staff. During discussions between the parties following the inquest, it was considered that the ECAs who brought Mr Ingram into the MIU may have retained his PCR, rather than left it with the MIU, because they were intending to wait for him to be x-rayed and then take him back home.

3.3 LML has issued a company-wide communication to all staff, to ensure that appropriate handover of PCRs takes place. Staff have been reminded of their legal and professional duty to ensure that documentation is completed for every patient journey, without exception. Accurate documentation is

fundamental to safe, high-quality care and provides an essential audit trail for all clinical activity.

3.4 LML has also implemented a policy which applies to all cases where crews transport a patient to an alternative provider (i.e. the MIU instead of the ED) and all parties agree that the same crew will transport the patient back to their point of origin. This is in recognition of two distinct episodes of care, each requiring independent clinical documentation. In these circumstances, two separate PCRs must be completed. A full PCR is to be completed for the initial journey to the MIU, with a signed carbon copy to be left with the MIU. Another separate PCR is to be completed for the return journey and again, a carbon copy left with the patient when they arrive home and the crew departs.

3.5 LML crews have also been reminded to ensure that PCRs are shared with the receiving destination in a timely manner and used alongside a structured verbal handover at every transfer of care. Documentation should never replace verbal communication; both are essential for continuity, safety, and clarity. This has been codified in a new policy, which has communicated to staff and reinforced by:

3.5.1 Emailing to individuals directly.
3.5.2 Uploading to the electronic staff record system, which requires staff acknowledgement to confirm that it has been read.
3.5.3 Including this in staff training days; and
3.5.4 Continuing LML's practice of a monthly audit of PCRs, in which 10% of all PCRs are reviewed by experienced clinical consultants, against national standards. Any sub-standard practice in completing/sharing PCRs is addressed with the relevant staff member(s), with any repeat issues generating a review at a clinical governance meeting and disciplinary procedures, where appropriate.

3.6 As stated above, most ambulance transfers will be via SWAST ambulances and the process set out above will ensure that timely transfer of patient data takes place. LML has implemented policies and procedures to ensure that its own records are handed over to the HCP and patient for each episode of care. We recognise that there may however be ambulance calls attended by other private providers. In this case, Mr Ingram's call was responded to by NHS 111, when it was allocated to them by SWAST. It was clarified by SWAST during discussions following the inquest, that SWAST categorised the initial 999 call from Mr Ingram's family, and passed it to NHS 111 for further clinical input. At that point, the call was closed to SWAST.

3.7 LML was therefore instructed by NHS 111 to attend to Mr Ingram. On the basis that future calls could be categorised and dealt with by NHS 111 rather than

SWAST, the parties considered it prudent (with your consent) to inform Kernow Health CIC (**KHCIC**) (which delivers the NHS 111 integrated care service) of this Regulation 28 Report. This was done with a view to ensuring that learning is disseminated to all other relevant parties, including any other private ambulance firms who may be instructed to respond to such calls. The response from KHCIC is set out at paragraphs 5.1-5.2 below.

3.8 From the perspective of CFT, all MIU staff have been reminded that the PCR, whether this is in paper form or any electronic PCR, should be received from the ambulance crew before the patient is booked in. Learning has been identified following the inquest in relation to patient handover at the MIU. It is acknowledged by CFT that there was an over-reliance on a verbal handover from the ambulance crew (believed by MIU staff to be paramedics), which had an impact on the initial assessment by the MIU practitioner. All staff have been reminded of the importance of taking a full patient history and all available patient documentation, prior to accepting the patient on to the MIU. This learning and required actions have been shared with staff via email and have featured on the agenda of MIU staff meetings over the last 12 months.

4. **Mr Ingram was seen by a triage nurse who ordered a knee x-ray only.**

4.1 A number of contributory factors led to this outcome, including the lack of a PCR and any detailed handover concerning Mr Ingram's symptoms and medical history; Mr Ingram's own inability to give a full and accurate history; his family waiting in the ambulance on the crew's instruction and therefore not being with him when he was being triaged; and the lack of any full, physical examination.

4.2 Had the MIU procedure been followed as regards the examination of patients in the ambulance prior to booking them in, and ensuring handover by ambulance crews of the PCR, then adequate clinical history should have been available from the PCR and/or Mr Ingram's daughter. It is likely this would have resulted in Mr Ingram being transferred to the ED at Royal Cornwall Hospital for further examination and treatment.

4.3 We have set out above, the measures taken by LML and CFT to ensure that MIU patient transfer protocols are followed, patient medical history is handed over promptly and family members are involved in this process. Additional learning has been identified in relation to practitioners' reliance on previous assessments of patients. This is detailed further in response to the concerns below.

5. **The nurse clinician was asked to review the x-ray only. There did not appear to have been any check as to whether Brian needed to be conveyed to RCH.**

5.1 Concerning the initial decision to transfer Mr Ingram to the MIU, KHCIC has reviewed your report and checked their records in relation to the role of NHS 111 in Mr Ingram's care. They have stated in response, that KHCIC provided no clinical assessment or judgement in this case. Their involvement was limited to that of transport dispatch for Mr Ingram's conveyance to Royal Cornwall Hospital ED, via LML. They acknowledge that the crew called NHS 111, and the decision was to convey Mr Ingram to the MIU instead.

5.2 The dispatch function came under the umbrella of the Inter Facility Transport Contract (IFT). KHCIC's function for this was a control and dispatch function for private ambulance services. KHCIC states that it acted as transport dispatch and did not otherwise manage Mr Ingram's case and pathway options. The IFT contract has now ceased and KHCIC therefore no longer dispatches ambulances under this system.

5.3 As noted above, it is acknowledged that upon arriving at the MIU, Mr Ingram should have been assessed and his history taken in the ambulance, to identify whether the MIU was an appropriate setting for treatment. Had this been done, groin pain may have been noted from the PCR and/or from consulting with Mr Ingram's daughter and may have prompted escalation of Mr Ingram's care to an acute care setting. One of the reasons this was not explored further by MIU staff, appears to have been an overreliance upon the assessment carried out by the LML ambulance crew, who were believed to be trained paramedics rather than ECAs (learning and actions identified in relation to this point are addressed further at paragraph 6 below).

5.4 As patients are usually transferred to the MIU by SWAST ambulances, HCPs have some expectation that the 'Neck of Femur' pathway for clinical checks would be followed by ambulance crews. SWAST has outlined this process as follows:

5.4.1 The ambulance crew attends an incident with a patient that has hip pain, suspecting a hip fracture, which they cannot completely rule out.

5.4.2 The crew call the Single Point of Access and discuss this with either the acute GP or a clinician within KHCIC. In Mr Ingram's case, the ECAs from LML were dispatched at the instruction of NHS 111 (provided by KHCIC).

5.4.3 If it is deemed necessary for the patient to have an x-ray, this can be arranged by the crew taking the patient to a community hospital with Same Day Emergency Care (**SDEC**), which in this case, would include the MIU. Once there, the crew are requested to take the patient to the MIU for the x-ray and wait with the patient. If the x-ray comes back with a fracture showing, the crew would transfer the patient to the ED. If there is no fracture, then the crew can hand over the patient to the MIU and leave (although note that whilst this process applies to the MIU, it can vary slightly across different SDEC sites).

5.5 CFT has also reflected on the missed opportunities to identify the extent of Mr Ingram's injuries when he was brought into the MIU by the ambulance crew. Learning has been highlighted and communicated to all MIU teams concerning the importance of professional curiosity, both in terms of the information handed over by other HCPs, and the practitioner's own assessment of the patient. The key lessons and themes emerging following the inquest have been captured and discussed at MIU meetings and on a wider basis across CFT through CQaGG (as described above) and other patient safety forums. Staff have been reminded that the responsible clinician receiving the patient at the MIU is accountable for the entire period of patient care, which includes carrying out a full assessment of the patient in each case.

6. **The nurse clinician at MIU did not know the ambulance staff were ECAs and had wrongly assumed they were paramedics and had conducted their own assessment**

6.1 As the majority of patients brought to the MIU arrive with SWAST ambulance crews, this led to an incorrect assumption that the crew were paramedics, and a certain pathway would have been followed as regards Mr Ingram's assessment following a fall (details of which are set out at paragraph 5.4 above). SWAST sets out the following guidance to ambulance crews on identifying themselves (taken from their 'Accessing Telephone Advice' policy):

"6.5 ***Identifying your Clinical Grade***
6.5.1 When seeking advice, staff and volunteers must inform the clinician of their clinical grade. It is important that the clinician providing the advice is aware of this, as their advice may vary between an ECA, Technician, and a Paramedic."

There is an expectation that the crew communicate their role and grade to the HCP that is taking the handover.

6.2 LML has taken steps to inform and train all its staff on the requirement to provide clear and consistent introductions to other HCPs. This includes an explanation of their role, any limitations in the service they can provide/the extent of their training, and the fact that they are not paramedics.

6.3 As highlighted above, CFT has also reiterated to its staff, the importance of each clinician maintaining independent, clinical judgement when carrying out their own assessment of a patient, and to query/challenge the extent of any previous assessment carried out, where necessary. This has taken place through the training and communications to all MIU staff described above, and the wider dissemination of learning across CFT, through its quality and governance, and patient safety forums.

7. **The nurse clinician did not conduct his own physical assessment or speak to the available family member to confirm the relevant history and presenting complaints.**

7.1 We recognise that this was an important missed opportunity. CFT has taken clear and decisive steps to ensure that all staff are aware of the requirement to carry out a full physical assessment when patients are brought to the MIU (assuming they are initially deemed to be suitable following an ambulance-based triage). This has been communicated in MIU team meetings, LFE Forums, clinical supervision meetings, and across CQaGG and other patient safety forums attended by team leads across the spectrum of community services. CFT will continue to monitor the implementation of this learning, when carrying out documentation audits and observations of care, as part of our ASPIRE accreditation requirements.

The concerns raised in your report have given all parties the opportunity to reflect on Mr Ingram's care. The various connected factors described above, led to a series of missed opportunities to escalate his care to the correct setting in the ED.

We hope that following Mr Ingram's sad death, this response provides some insight into the detailed discussions which have taken place across all recipient organisations, to ensure that learning is embedded and reflected in daily practice, and that this offers some reassurance that your concerns have been addressed.

Yours sincerely

Chief Improvement Officer

Cc: South Western Ambulance Service
Lifestar Medical Limited