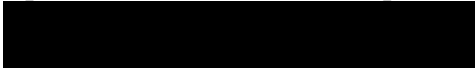
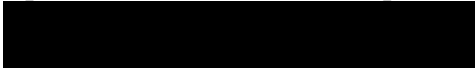


*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1.Cornwall Partnership (Foundation) Trust - CPFT 2.South West Ambulance Service Trust – SWAST 3.Lifestar Medical Limited - LML
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 8.10.25, I concluded the inquest into the death of Brian Ingram aged 85 who died in Royal Cornwall Hospital on 17/5/24. I recorded the cause of death as: 1a) Ischaemic heart disease with cardiomegaly; II) Diabetes, Chronic Kidney Disease, Dementia, Osteoporotic hip fracture. I recorded a conclusion of Accident.
4	CIRCUMSTANCES OF THE DEATH Brian was an 85-year-old man with a past medical history that included vascular Parkinsonism and dementia. On 11/5/24, he fell in his garden and suffered injury. The 111 service was called and an ambulance requested. After a delay of several hours, a private ambulance from LML conveyed Brian to Barncoose Minor Injuries Unit. A member of the family accompanied him but was asked to remain in the ambulance while Brian was clerked in. A Patient Clinical Record was not provided to staff. No physical assessment was conducted by the MIU staff who wrongly assumed Brian had been assessed by paramedics when the ambulance staff were Emergency Care Assistants. Brian had an x-ray of his knee but not his hip despite reporting groin pain and his family noting that one leg appeared shorter than the other. Brian was discharged. On 15/5/24, Brian was admitted into Royal Cornwall Hospital and had an x-ray that

	confirmed he had fractured his hip. He had an operation to fix the fracture but deteriorated and died in the hospital on 17/5/24.
5	<u>CORONER'S CONCERNS</u> During the course of this inquest, 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 family was under the impression that Brian was attended upon by paramedics rather than ECAs. It was accepted in evidence that proper introductions should be made when meeting a new family to include confirmation of a staff member's clinical grade. 2) Brian had dementia and so a family member accompanied him to the MIU. That family member was, however, asked to remain in the ambulance while Brian was clerked in. This caused or contributed to an omission to record groin pain as a presenting complaint. In evidence, it was suggested this was a hang over from COVID but it appears a practice that may need to be re-visited, especially where a patient presents with dementia and may not be able to provide a full or accurate history. 3) The inquest was told that it will ordinarily be a SWAST ambulance that attends the MIU and there is a process whereby an ACRF can be sent electronically with the relevant past medical history. On this occasion, an LML ambulance attended whose staff work from written Patient Clinical Records. There was a conflict in the evidence as to whether a PCR was provided to MIU staff. One had to be subsequently requested by CPFT to review what had happened on the day. It may be appropriate to review how information is shared between different organisations. 4) Brian was seen by a triage nurse who ordered a knee x-ray only. 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 RCHT which may have been appropriate if the complaint of groin pain had been noted. 6) The nurse clinician did not know the ambulance staff were ECAs and had wrongly assumed they were paramedics and had conducted their own assessment. 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.
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 CPFT and LML are under a duty to respond to this report within 56 days of the date of this report, namely by 6/12/25. I, the coroner, may extend the period. This correspondence is also sent to SWAST so that they may be involved in any discussions around information sharing. A formal response is not required from SWAST. 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: - Brian's family 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	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">[DATE]</td> <td style="width: 50%;">[SIGNED BY CORONER]</td> </tr> <tr> <td>8/10/25</td> <td></td> </tr> </table>	[DATE]	[SIGNED BY CORONER]	8/10/25	
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