Kernow Health CIC
1st Floor, Cudmore House
Oak Lane
Truro
Cornwall
TR1 3LP
[redacted]

Date: Wednesday 28th October 2026

[redacted]

Dear Mr Cox,

Re: Regulation 28 Prevention of Future Deaths letter
Ezrah Pollard, deceased

In response to your letter our organisation Kernow Health CIC has carefully reviewed your report, and I can provide the following information for you.

Matters of Concern

1) We are unaware of a restriction in requesting a Category 1 ambulance. A Category 2 ambulance is what we would request as an emergency response unless the individual was requiring immediate life support (i.e. resuscitation due to cardiac or respiratory arrest), which would be the criteria for a Category 1. I expect this will be clarified by the SWAST reply to these concerns raised. We do not have a tangible action to deliver in response to this concern.

2) It is not currently usual practice to advise on waiting times for ambulance arrival. I would expect SWAST to explain their processes as a current time is subject to constant change due to amongst other things fluctuating prioritisation requests, geographic conditions and nearest availability. This is frustrating for families, but guaranteed dispatch/arrival times are complex to predict. In this case where it was apparently known by SWAST to be 4 hours delay then I agree that a warning and management of expectation would have been useful. However, as you suggest, the script for the 111 Pathways system in 2022, and currently, does not allow for any variation in advice. The call handler goes through life threatening and emergency response questions and if these are triggered then a disposition of an ambulance is actioned immediately, as in this case. This curtails any further script and time on the call, but worsening advice/safety netting is given. Even if the non-medical call handler knew of the delay, it is still seen as best practice to have an ambulance attend rather than advise going to the Emergency Department (ED) themselves. If a clinical advisor was brought into the call, there would be concern over the delay in assessing further and still the clinician would be trained not to offer anything other

than an emergency response ambulance. This is because if emergency or life-threatening interventions are required then it is seen as safer to deliver interventions and conveyance by ambulance than to transfer at risk with family/friends in a car. Unfortunately, it was not safer for Ezrah in this situation.

If the Pathways system had deemed this to not trigger an emergency response, then the call script questions would have proceeded further and after assessment an option to self-present at ED may have been a disposition then as a safe non-emergency response. Pathways is a Class 2 approved medical device, it is a nationally mandated and designed process, and it may be worth a further approach to them to explore this matter of concern.

At any point from us requesting an ambulance SWAST can re-triage and upgrade or downgrade a response accordingly. The safety netting advice in the event of any deterioration is also to call 999 and at that point SWAST would triage the need and response urgency again. I do not know if SWAST mandate a re-triage or comfort call if they know of significant delays in the ambulance service.

Any action to improve these processes is unfortunately outside of our influence or control. It would require national influence as well as an agreed clinical guideline as to if and when a divergence from the script would be clinically recommended.

3) We send the consultation information to the ambulance service electronically when we request a disposition so no action to alter this process is required. This information can be passed on further by SWAST to help collate information. This is hard for the individual or families and if SWAST can add to that record and pass to ED (if they do not do so already) then it could avoid some repetition and information loss, but a real time clinical re-assessment would still be done.

Yours Sincerely

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Chair Kernow Health CIC