Royal Cornwall Hospitals
NHS Trust

Chief Medical Officer's Office
Royal Cornwall Hospital
Truro
Cornwall
TR1 3LJ

[redacted]

Date: 12 October 2026

Private and Confidential
Mr. Andrew Cox
H.M Senior Coroner for Cornwall and the Isles of Scilly
Pydar House
Pydar Street
Truro
Cornwall
TR1 1XU

Dear Mr Cox,

Re: The Late Ezrah Pollard – Regulation 28 PFD Report and Response

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated 09 September 2026 and received on the same day. This was issued following the inquest into the death of Ezrah Pollard which was heard over 7 – 8 September 2026.

I would like to take this opportunity to express my sincerest condolences to the family of Ezrah for their tragic loss.

During the inquest, the evidence revealed matters giving rise to concern. The first two concerns are for other organisations to address, and this response focuses on point 3 of the above report, namely:

- For 111, SWAST and RCHT – Ezrah's parents provided an initial history to 111 at the time of their first call. This was repeated when an ambulance was chased an hour later. Yet when Ezrah was admitted to hospital, the receiving clinicians were not aware of the history previously given requiring the parents to repeat the history and potentially delaying treatment. It was noted in evidence that this repetition of histories can result in an 'attrition of information.' It was felt there should be a facility for better information sharing between 111, SWAST and RCHT.

Please find below the response from the Trust and details of the actions taken in relation to the above concerns.

Response:

The Trust has discussed this matter with colleagues within the Emergency Department (ED) and the South Western Ambulance Service NHS Foundation Trust (SWAST). At present, there are no additional systems or mechanisms available that would facilitate more effective information sharing than those already in place. The ED routinely receives pre-alert information for patients being conveyed to the department; however, upon arrival, all patients must still undergo a formal triage assessment. This process is essential to confirm the patient's identity, assess their current clinical condition, and ensure that care is prioritised appropriately based on their presentation at that time. Reliance solely on pre-arrival information would not be appropriate, as a patient's clinical status may change significantly during transit. The Trust is not aware of any evidence to suggest that the triage process delays treatment or compromises patient safety. On the contrary, triage remains a key clinical safety measure that supports the timely identification and management of patients according to clinical need.

I hope that this response provides assurance to both you and Ezrah's family that the Trust has given careful consideration to the concern raised in your Prevention of Future Deaths Report and has undertaken a thorough review of the matter identified, and is satisfied that appropriate processes and safeguards are already in place.

Yours Sincerely

[redacted]

[redacted]
Chief Medical Officer
Royal Cornwall Hospitals NHS Trust