South Western Ambulance Service
NHS Foundation Trust

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[redacted]

[redacted]

Mr Andrew Cox, Senior Coroner for Cornwall and the Isles of Scilly
Pyder House
Truro
TR1 1XU

Sent by email to [redacted]

12th November 2026

Dear Sir

Prevention of Future Deaths Report following the inquest touching upon the death of Master Ezrah Pollard

I am writing on behalf South Western Ambulance Service NHS Foundation Trust (hereafter referred to as the Trust) in response to a Regulation 28 report to prevent future deaths issued in relation to the death of Ezrah Pollard.

I would firstly like to extend my sincere condolences to the family of Ezrah Pollard and note their fantastic fundraising efforts for charities to help raise awareness of Group B Streptococcus (GBS).

In your Regulation 28 report, you set out three primary concerns which you identified during the course of the inquest. I will address these in turn:

Introduction of Category 1 disposition

Categorisation is set nationally by NHS England. I note that this element of the regulation 28 report is addressed to the Chair of the Advisory Group for NHS England. I will therefore not comment on this and allow them to respond to you directly.

Advice to self convey

It is important to highlight at the outset that calls are triaged by non-clinically trained EMDs (Emergency Medical Dispatchers). They use the MPDS triage system, an internationally

recognised tool, to assign call categorisation according to the answers they receive to scripted questions. They are not permitted to deviate from the questions contained within the protocol. Given they are not clinicians, it would not be appropriate for an EMD to provide self-conveyance advice outside of the approved Standard Operating Procedure (EOC58), which is used during periods of escalation where we are experiencing capacity pressures due to high demand. These measures are implemented temporarily for a short period of time to mitigate risk and improve overall patient safety. Depending on the level of escalation, there are different categories of call in which patients will be advised to make their own way to hospital.

EMDs undertake an intensive training programme before they commence call taking. The training focuses on the MPDS triage, along with familiarisation with the Trust's protocols and Standard Operating Procedures. The expectation is for the EMD to be able to identify and recognise a chief complaint from the information provided by the caller and select the most appropriate protocol. They are not expected to provide a diagnosis based on the symptoms described. The overall role of the EMD, allows for risk stratification across all calls received by the Trust and to ensure appropriate resource allocation.

EMDs do not have sufficient training or expertise to be able to identify a patient with Group B Streptococcus, nor definitively identify a patient with sepsis. During the course of the inquest, [redacted] explained the difficulties in differentiating a neonate suffering with sepsis versus a neonate with the common cold, particularly over telephone triage due to how their symptoms present. This would be challenging for any clinician without having eyes on the patient, and certainly beyond the scope of practice for an EMD.

If self-conveyance advice was given to callers, I anticipate that there would be variance in how that is interpreted by callers. Whilst I accept that some would dutifully accept this advice and promptly make their way to the nearest hospital, I am concerned that there would be a percentage of the population who would infer that because they are not receiving an ambulance, their condition must therefore be less serious and opt not to seek further medical attention because they feel their concerns have been dismissed. Similarly, it is also likely that some callers who follow the advice to attend hospital will view this as less urgent because they are not receiving an ambulance and may delay their journey to hospital.

I also acknowledge that the issue of whether parents of young neonates presenting with sepsis should be advised to self-convey arises from delays due to the demand on the ambulance service. The National Standard set by NHS England is for Category 2 disposition calls to be responded to within a mean response time of 18 minutes and a 90th percentile target of 40 minutes, and if the Trust had been able to meet this target, then the issue of self-conveyance advice would be a moot point. The Trust takes the issue of ambulance delays very seriously and significant work has been undertaken in conjunction with the system partners to try to improve response times and mitigate risk.

The work has included implementation of the Timely Handover Process to reduce handover delays at hospital, increasing the use of 'hear and treat' and consideration of

alternative treatment pathways, such as minor injury units or community-based care. The incident involving baby Ezrah took place in 2022, and I am pleased to report that there have been significant improvements in our response times since, as can be seen in the data from our corporate performance reports which are published publicly. However, I acknowledge that there is still more work to be done in order to consistently meet the national response time targets.

Providing callers with ETAs

The Trust does not currently provide ETA to callers, due to the large volume of calls that are received and the dynamic nature of service, which means that crews may need to be diverted to a higher acuity call and there can be peaks in demand which can significantly impact on response times, particularly if there has been a major incident. The risk in providing an ETA to a caller is that whilst correct at that specific moment in time, it could not be relied upon for long, as soon after there could be an influx of higher acuity calls making the information provided quickly inaccurate.

Several years ago, the Trust provided longest wait times to callers on Category 3 and 4 calls. Whilst there was initial success, unfortunately due to the unpredictable nature of the peaks in demand on the service the information given to callers became seriously inaccurate and misleading. As a result, this initiative was ceased.

The Trust is currently exploring whether we may be able to reintroduce sharing expected wait times with callers. Discussions have taken place internally with our data analytics team to consider the possibility of informing callers of the longest wait times in their areas. The barrier to implementation has been the technical capabilities of our system to ensure the accuracy of the information provided.

Our computer aided dispatch system (CAD) has recently been updated to Cleric. We are still in the early stages of the roll out of the new CAD system; however, it is hoped that this may provide additional functionality which may assist with keeping callers informed about wait times. However, the specific details are not currently known at the time of writing. The Trust acknowledges the importance of delivering this information to callers and aims to implement by April 2027.

The Trust proactively informs NHS England when we move into escalation as a result of extreme pressures on our service due to demand. It is the Trust's expectation that NHS England share escalation status information onwards with appropriate healthcare partners, including the 111 service. The Trust also has a live dashboard called 'OL334 Trust Status Report' which NHS England and the ICBs can access. This shows the Trust's current REAP level, CSP level, along with the number of calls awaiting an ambulance response for each area. The Trust would be happy to grant the 111 service access to the dashboard.

[redacted]

Information sharing

I acknowledge the concern raised regarding the 'attrition of information' when history taking is repeated. However, due to the nature of our service, there are limitations to the information gained by EMDs during telephone triage and this differs significantly from a triage conducted by a clinician who is attending a patient face to face. EMDs are reliant on the information provided by the caller. There is a risk that the information recorded may not be clinically accurate and on arrival at the Emergency Department there is potential for confirmation bias which could, in turn, skew the onward triage and assessment of the patient.

The Trust's expectation is that on arrival at the Emergency Department, a clinician would take their own full comprehensive history from the patient (or caregiver) and not rely on a history which has been obtained by a previous healthcare professional. If the Trust were to share information obtained with the Emergency Department this would be relying upon information obtained by a non-clinically trained EMD. Over reliance on this, would risk important information potentially being missed.

It is also important to acknowledge that the presentation of the patient may change en-route to hospital, and therefore it is essential for a fresh triage on arrival at the Emergency Department to ensure that they have the most up to date clinical picture. Whilst repeatedly providing a history of the complaint may be frustrating for the patient and/or family, it is an essential, and in many ways, unavoidable aspect of the triage process. A new triage also provides an additional opportunity to capture information which may have been previously missed or has newly developed.

During periods of escalation, we signpost a significant number of patients to self-convey and so it would not be practically possible to pass information for all this cohort of patients via electronic links. This would require additional time and resourcing which would take away from the primary purpose of triaging patients to allocate an appropriate resource, and would invariably have an impact on our call answering times.

It is possible that in some circumstances a clinician in the EOC will call ahead to the Emergency Department to alert them to a patient self-conveying, however, it is not mandated. This will be determined at the discretion and clinical judgment of the EOC clinician. At present, clinicians can send information in some cases via either PaCCS (Pathways Clinical Consultation Support) which facilitates booking into Emergency Departments, Urgent Treatment Centres or GP practices or the DoS (Directory of Services) which is a centralised real time database used in urgent and emergency care across NHS services. We do not have Interoperability Toolkit (ITK) links with Emergency Departments.

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I sincerely hope the above addresses the concerns raised.

Yours sincerely

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[redacted]
Executive Medical Director