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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chair of the Emergency Call Prioritisation Advisory Group, NHS England, Wellington House, 133 – 155 Waterloo Road, London, SE1 8UG 2. [redacted] Medical Director, South West Ambulance Service Trust 3. [redacted] Chair, 111 service, Cornwall, 4. [redacted] Chief Medical Officer, Royal Cornwall Hospital
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 8/9/26, I concluded the inquest into the death of Ezrah Pollard who died at Bristol Royal Hospital on 25/3/22 at the age of 18 days. I recorded the cause of death as 1a) Group B Streptococcal (GBS) sepsis and meningitis. I recorded a conclusion that Ezrah died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Ezrah was born at Royal Cornwall Hospital on 7 March 2022. On 23 March, he became unwell presenting initially as grizzly, not feeding and having a foul nappy. Subsequently, he developed a fever. A call was made to the 111 service at approximately 20: 25 hours. This call was transferred to South West Ambulance Service Trust and a category 2 disposition was reached requiring an ambulance response within 18 minutes. At 21:30 hours, an ambulance was chased but owing to significant operational pressures an ambulance was not dispatched. Ezrah was taken to Royal Cornwall Hospital by his parents where it was recognised that he was profoundly unwell. He was treated overnight and on 24 March 2022, he was transferred to hospital in Bristol. A CT head scan revealed a devastating brain injury. Ezrah deteriorated and died in

	the hospital on 25 March 2022.
5	**CORONER'S CONCERNS** During the course of the 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) For Chair of Advisory Group – The inquest understood there is currently no pathway that provides for an infant up to the age of 3 months (the end date for the development of late on-set Group B Streptococcus sepsis) to have a Category 1 ambulance disposition. On the facts of this case, a Category 2 disposition was reached notwithstanding the fact that it was identified Ezrah was presenting with fever, grunting, breathlessness, "deathly colour" and drowsiness, all 'red-flag' markers. The expert to the inquest, [redacted], advised that the particular vulnerability of this cohort of patients (under the age of 3 months ie infants without a developed immune system) appeared not to be recognised within the current ambulance pathways. A copy of [redacted] report can be made available upon request. 2) For Chair of Advisory Group, 111 and SWAST - Neither the 111 service nor SWAST were able to provide Ezrah's parents with guidance about the likely delay in ambulance arrival. At the time of this incident, ambulances were taking four hours on average to respond to a Category 2 disposition. Ezrah required immediate antibiotics, yet their administration was avoidably delayed. If, after consideration of this PFD, a Category 1 disposition is still not considered appropriate for infants under the age of 3 months presenting with infection/sepsis/GBS notwithstanding the matters raised above, the evidence heard at inquest was that it was important for parents in these circumstances (with an infant with suspected infection/sepsis/GBS where there will be a delay in ambulance attendance) to be advised to take a child to hospital immediately. It is understood the scripts currently followed by telephone dispatchers/non-medically qualified health advisors do not mandate this. It was also suggested during the inquest that, alternatively, the parents could speak to someone medically qualified ie a doctor, nurse or midwife, who, on the facts of this case, were felt likely to advise an immediate attendance at hospital. 3) 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 that there should be a facility for better information sharing between 111, SWAST and RCHT.
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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6/11/26. I, the coroner, may extend the period. 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: - Ezrah's parents - 111 service - SWAST 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. She may send a copy of this report to any person who she 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	**[DATE]** **[SIGNED BY CORONER]** **9/9/26** [redacted]