REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

HM Area Coroner, Darren Stewart OBE for the Coroner Area Suffolk in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Saffron Hannabel Wednesday Cole-Nottage**, and an inquest that concluded on **15 May 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Neil Moloney (Chief Executive, East of England Ambulance Service NHS Trust)** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE** 12 August 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: <u>East of England Ambulance Service NHS Trust (EEAST)</u> a. The time taken to identify the scenario as a rescue and to call Fire Service, particularly given the use of the phrases 'fell down headfirst in the rocks at the seafront' and 'caught head down in the rock' within the first 60 seconds of the call. There was a further failure to promptly call the fire service when reaching an 'accessible entrapment' solution following the entrapment script. b. Lack of understanding of other emergency services capabilities e.g. Fire and Rescue Service, HMCG. c. Poor situational awareness by the Call Handling Team which then informed how the response by the emergency services was managed. Had Suffolk Fire and Rescue Service (SFRS) been called when Police were, Saffron would have been extricated when there was a possibility of successful resuscitation. d. Passage of information to Fire Control Room was inadequate and

	confusing. The tone and language of the call used by the EEAST caller alerting the Fire Control Room suggested at best confusion and at worst an inadequate appreciation of the situation, including the requirement for the situation to be treated as a rescue and the need for timely action. Information passed during the call was inaccurate and did not reflect the information held by EEAST at the time of the call. Had this information been passed the Fire Service would have responded without the need for further clarification with HMCG as to the requirement for Fire Service involvement. e. Inaccurate and poor recording of information on the CAD notes by the EEAST Call Handler and others involved in the management of the response, which resulted in partial and inaccurate information being communicated both internally within EEAST and to other emergency services. This included: 1. No ETHANE message recorded in the CAD to transfer information e.g. the failure to promptly identify Saffron's location and communicate this to other emergency services; 2. No time of submersion expected to be recorded in the CAD for drownings, particularly from the caller in order to inform decision making around when to cease resuscitation attempts. I recognise that this is not a script question, but when a caller provides this information anyway, it is valuable clinical information for those making resuscitation decisions; 3. No entry in the CAD to remind responders of the JRCALC timings; 4. Incomplete/unintelligible CAD notes entries (e.g. 20.00.38 hours "the water is now"). f. There was a failure to apply the JRCALC guidelines on submerged persons through: 1. Failure to record the time Saffron was seen to be submerged so as to create an accurate start point to focus resuscitation efforts; 2. Having failed to do this, the JRCALC guidelines were not applied in that the submersion start point was not set at the time the first responder attended the scene to focus rescue efforts; 3. The assessment that the rescue had changed to a recovery operation without the examination of the patient (other than viewing from a distance) and within 30 minutes from the time of the call (as the earliest start point) was a failure to consider JRCALC timescales and a failure to apply JRCALC guidelines; 4. The effect of these failures was to create the impression for each emergency response unit subsequently attending after the EEAST RRV that the activity was not a rescue but a recovery when the guidelines

	clearly stated otherwise. g. The failure to apply JESIP principles either in the management of the call by EEAST call handling staff or at the scene of the incident, examples of which are: 1. Inadequate communication from EEAST to other emergency services (EEAST, SFRS & HMCG). This created a confused picture of what was happening at the scene and created an impression of inertia by emergency services prior to the Fire Service arrival; 2. Inadequate effort to share situational awareness and enable a jointly managed response to the incident.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here. If you feel that the response should not have been sent to you, please state this]. *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* **a. The time taken to identify the scenario as a rescue and to call Fire Service, particularly given the use of the phrases 'fell down headfirst in the rocks at the seafront' and 'caught head down in the rock' within the first 60 seconds of the call. There was a further failure to promptly call the fire service when reaching an 'accessible entrapment' solution following the entrapment script.** **b. Lack of understanding of other emergency services capabilities e.g. Fire and Rescue Service, HMCG.** Following this incident, a protocol has been approved in relation to engagement with the Fire and Rescue Service (FRS). This was co-designed by a regional group established by EEAST with the fire services across the region (EOC Standard Operating Procedure (ESOP)146). The procedure sets out the capabilities of the FRS; identifies the categories of calls for which EOC staff are expected to contact the FRS to request support at an incident; and specifies the appropriate and effective method for the EOC to communicate relevant information to the FRS when requesting their attendance. This procedure is currently being embedded within EOC policies and procedures to ensure consistency and parity of practice across the various operational areas within EEAST. It has been complemented by a range of videos shared with all Senior Call Handlers and Call Handler Team Leaders demonstrating the FRS capabilities. In respect of HM Coastguard and liaison with them to understand activation

	criteria, response remits and capabilities, a commander training session took place on 10 July 2026. With effect from 3 November 2025, all call handling staff have been allocated one hour of protected time per month. This protected time is designated for the review of emails and newly issued or amended policies and procedures, the completion of mandatory training, participation in additional training delivered by the International Academy of Emergency Dispatch and engagement in one-to-one meetings. There are plans to increase this allocation to two hours of protected time per month over the course of the coming year, which will allow EOC staff the time to ensure new policies/procedure are read and understood, with the ability to raise concerns with a supervisor during their protected time. The provision of an equivalent level of protected time for dispatch staff has presented greater operational challenges. However, it is acknowledged that the dispatch role affords a greater degree of flexibility within the working day, including periods of reduced activity, during which staff are able to review procedures and complete training requirements. It is anticipated that protected time arrangements for dispatch staff will be fully implemented by 30 September 2026. The protected time referred to above will include dedicated provision for the review of the ESOP and for consideration of guidance relating to the appropriate activation of HM Coastguard. **c. Poor situational awareness by the Call Handling Team which then informed how the response by the emergency services was managed. Had Suffolk Fire and Rescue Service (SFRS) been called when Police were, Saffron would have been extricated when there was a possibility of successful resuscitation.** See updates in respect of a). Furthermore, the reconfiguration of EEAST's Emergency Operation Centres will involve a review of the Call Handler Team Leader role, including consideration of revised team structures and a reduced number of direct reports. The new EOC being developed in Chelmsford is set for completion in November 2026 and the wider restructure and review is likely to be completed in early 2027. **d. Passage of information to Fire Control Room was inadequate and confusing. The tone and language of the call used by the EEAST caller alerting the Fire Control Room suggested at best confusion and at worst an inadequate appreciation of the situation, including the requirement for the situation to be treated as a rescue and the need for timely action. Information passed during the call was inaccurate and did not reflect the information held by EEAST at the time of the call. Had this information been passed the Fire Service would have responded without the need for further clarification with HMCG as to the requirement for Fire Service involvement.**

	The ESOP146 referred to in a) above explicitly outlines how information should be shared with FRS, in line with the ETHANE messaging concept stipulated through the JESIP guidelines. This is further supported by the training provided to both EOC and frontline staff outlined in more detail in g) below. IT messaging, via the desktop display when initially logging in, is utilised to ensure staff are regularly reminded of their responsibilities in line with the JESIP guidelines. For example, in July the M/ETHANE messaging principles were displayed on all EOC staff desktops. **e. Inaccurate and poor recording of information on the CAD notes by the EEAST Call Handler and others involved in the management of the response, which resulted in partial and inaccurate information being communicated both internally within EEAST and to other emergency services. This included:** **1. No ETHANE message recorded in the CAD to transfer information e.g. the failure to promptly identify Saffron's location and communicate this to other emergency services;** **2. No time of submersion expected to be recorded in the CAD for drownings, particularly from the caller in order to inform decision making around when to cease resuscitation attempts. I recognise that this is not a script question, but when a caller provides this information anyway, it is valuable clinical information for those making resuscitation decisions;** **3. No entry in the CAD to remind responders of the JRCALC timings;** **4. Incomplete/unintelligible CAD notes entries (e.g. 20.00.38 hours "the water is now").** Accuracy and appropriateness of CAD entries are principles that EEAST seeks to embed consistently across all EOC teams, including call handling, dispatch and CAS (Clinical Assessment Service) staff. However, it is recognised that this is not a matter that can be addressed through a simple or immediate solution and that determining what information is, or is not, relevant requires professional judgement which can be challenging to teach and standardise. Recording appropriate CAD entries is included in the training the call handling staff receive and can also be identified through the local auditing processes in place. Following the evidence given by EEAST witnesses, the EOC management team are committed to reviewing this further and identifying a standardised approach, where possible. The attendance to Saffron will be used as an anonymised case study to assist with this and will be picked up within the

	protected time and 1:1s as outlined above. Furthermore, a reminder will go into the EOC Patient Safety newsletter by 31 October 2026 in respect of the important of recording accurate and appropriate CAD notes. In relation to the issue of recording the time of submersion, EEAST does not have the authority to amend the scripts within AMPDS due to the applicable licensing arrangements. However, EEAST has engaged with the AMPDS provider (International Academy of Emergency Dispatch) to request the introduction of a specific 'time of submersion' field within Protocol 14. Information relating to EEAST's attendance at the incident involving Saffron has been provided to contextualise and support the need for this additional field. EEAST will continue to work with the AMPDS provider to progress this. Non-clinical EOC staff (including call handlers, call handler team leaders and members of the dispatch and incident command teams) do not have access to JRCALC. Accordingly, they are not expected to be aware of, or have any knowledge of, the contents of these documents. Non-clinical EOC staff are required to comply with a range of procedures specific to their respective roles and areas of responsibility. **f. There was a failure to apply the JRCALC guidelines on submerged persons through:** **1. Failure to record the time Saffron was seen to be submerged so as to create an accurate start point to focus resuscitation efforts;** **2. Having failed to do this, the JRCALC guidelines were not applied in that the submersion start point was not set at the time the first responder attended the scene to focus rescue efforts;** **3. The assessment that the rescue had changed to a recovery operation without the examination of the patient (other than viewing from a distance) and within 30 minutes from the time of the call (as the earliest start point) was a failure to consider JRCALC timescales and a failure to apply JRCALC guidelines;** **4. The effect of these failures was to create the impression for each emergency response unit subsequently attending after the EEAST RRV that the activity was not a rescue but a recovery when the guidelines clearly stated otherwise.** The JESIP updated Drowning - G0660 guideline was published on the JRCALC (Joint Royal College Ambulance Liaison Committee) app on the 21st October 2024. Prior to this, the guideline was titled 'Immersion and Drowning

	– G0660', but the guideline was revisited and renamed as part of the bundle updates. This app is accessed by clinicians via the Trust-issued iPads and contains both updated JRCALC and EEAST clinical guidelines. We have made efforts to ensure the tool is accessible and signposts staff to help learning and navigating the tool. [redacted] (Deputy Medical Director, EEAST) met with the staff who hold responsibility for the content of JRCALC guidelines on 4th March 2026. As a direct result of this meeting, the JRCALC guideline group agreed to move the submerged person tool out of the subsection part of the drowning page and ensure that search terms 'drowning' or 'submersion' would display the tool near the top of the search results to ensure ease of rapid access. The issue with regards to confusion of the term 'start clock' was raised, specifically as to whether this meant from a bystander account pre-ambulance arrival or whether it meant from the first patient contact with a responder. It was decided not to change or add to the wording of the tool at this time implying that it should be a responder at scene making this decision. EEAST recognises that we have a responsibility to ensure staff are aware of and use the tool in cases such as these in the future. From 1 July 2026 – 28 July 2026, a new operating mode within the JRCALC application was piloted by three other ambulance services, referred to as *"Emergency Mode"*. This functionality enables users to configure the application so that emergency-specific guideline updates are prioritised and displayed. By way of example, in the context of a drowning or submersion incident, the relevant emergency guidance will be prominently visible to support timely clinical decision-making. EEAST are awaiting the evaluation and feedback from the pilot before considering whether to adopt this mode. EEAST are able to monitor which members of staff have reviewed any local clinical guidelines and JRCALC updates within the app. For registered clinicians, maintaining up-to-date clinical knowledge and understanding forms part of their professional obligations, including familiarisation with and review of JRCALC updates. Key updates are also communicated via EAST24, EEAST's internal intranet platform. All EEAST frontline clinical staff have access to the Clinical Advice Line for the provision of further clinical advice or support during a 999 call. The Clinical Advice Line is a dedicated service established to provide remote clinical guidance to operational staff. It is delivered by the Clinical Co-ordination Team and staffed by experienced paramedics and nurses, with additional support available from advanced practitioners, general practitioners, emergency department consultants, and mental health nurses. The Critical Care Desk (CCD) can be reached via channel 202 on an individual crew member's handheld radio for specific advice from a paramedic with experience in critical care (CCD clinician). The CCD clinician is a senior paramedic who will have received recent training on High Acuity, Low Occurrence (HALO) events such as drowning and thus will have a more recent working knowledge of the submerged person tool. A new instruction

	has been sent to all CCD clinicians that for all drowning incidents they are now required to contact ambulance crews via radio on route to scene to give instructions to find the submerged person tool via the JRCALC app. They will also be requested to make early contact with other rescue agents in line with JESIP principles. Crews will be encouraged to contact CCD for immediate advice with decision-making and application of the tool. CCD clinicians have also been instructed to check if fire and rescue have been called. They will document the time of the submersion and who witnessed the submersion on the CAD notes, communicating this to ambulance crews and critical care assets. **g. The failure to apply JESIP principles either in the management of the call by EEAST call handling staff or at the scene of the incident, examples of which are:** **1. Inadequate communication from EEAST to other emergency services (EEAST, SFRS & HMCG). This created a confused picture of what was happening at the scene and created an impression of inertia by emergency services prior to the Fire Service arrival;** **2. Inadequate effort to share situational awareness and enable a jointly managed response to the incident**. In 2024, EEAST established an Incident Co-ordination Centre (ICC) in accordance with its obligations under the *Emergency Preparedness, Resilience and Response: Core Standards (Standard 26)*. To support this implementation, EEAST developed a bespoke training package incorporating the JESIP in May 2024, with the ICC becoming operational in August 2024. Delivery of this training is restricted to accredited JESIP Train-the-Trainer instructors. The ICC training module was made available to EOC staff at dispatcher level and above, including senior call handlers. An annual mandatory e-learning package on ICC and JESIP guidelines for all EOC staff was introduced in 2025. All frontline clinical staff receive bi-annual training in relation to the Joint Emergency Services Interoperability Principles (JESIP) guidelines, including specific training on the use of the METHANE and ETHANE frameworks for the structured sharing and communication of information with partner agencies. Additionally, there are stickers on the dashboard of every frontline vehicle with information in respect of providing METHANE/ETHANE updates. An article has been published in *Safety Matters*, EEAST's internal patient safety newsletter, addressing the application of JESIP principles and Joint Decision-Making in circumstances where a clinician attends as the first resource on scene, in the absence of an Operational Commander and prior to a declaration of a Major Incident. In addition, the JESIP application is available on all Trust-issued iPads for use by frontline clinical staff.

	Multi-agency incidents (such as this one) are now focussed onto one Talk Group using open speech, which facilitates swifter communication between the different EOC functions and frontline staff.
5.	**DETAILS OF FURTHER ACTION PROPOSED** *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Command and Control Policy is currently under review to ensure alignment with recent changes within the EOC, including developments relating to EOC staff roles and Operational Commander and Team Leader training. The revised policy will include an amendment to confirm that the EOC commander will retain ownership of any multi-agency call prior to the operational commander arriving on scene. This should provide clarity as to who is responsible for the call from an EOC setting until handed over to the frontline operational commander on scene.
6.	**SIGNATURE**   **Chief People Officer & Deputy CEO** **Signed for and behalf of Neill Moloney, CEO**