Mr Darren Stewart OBE
HM Area Coroner for Suffolk
The Coroner's Court and Offices
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National Medical Director
NHS England
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28th August 2026

Dear Mr Stewart,

Re: Regulation 28 Report to Prevent Future Deaths – Saffron Hannabel Wednesday Cole- Nottage who died on 2nd February 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17th June 2026 concerning the death of Saffron Hannabel Wednesday Cole- Nottage on 2nd February 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Saffron's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Saffron's care have been listened to and reflected upon.

Your Report asked for consideration as to consideration of how the Joint Emergency Services Interoperability Principles (JESIP) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) considerations can be incorporated within call handler scripts used by NHS Ambulance Services, whether this be NHS Pathways or Medical Priority Dispatch System (MPDS).

NHS Pathways

NHS Pathways has a pathways called scene safety which is accessed after the health advisors reaches an ambulance outcome. Within this pathways the health advisor will be presented the following questions to support the crew and health advisors in managing the incident. Other scripts that are used in managing these incidents that are outside of the triage are managed and owned by the ambulance service

- Is there any further information that will help with ambulance dispatch? - This includes:
  - Building access codes
  - special access routes
  - remote or hard to find locations
  - Mechanism of injury (if appropriate)
  - Any DECLARED information about the patient, for example, infectious illnesses or weight concerns that may require specialist equipment.
- The scene is safe BUT the patients is trapped - This means there are no hazards for the ambulance crew/public, but the patient is trapped. For example:
  - Caught in machinery

    - Pinned by a heavy object
    - Trapped inside a vehicle, room or building.
- The scene is unsafe BUT the patients is trapped - Hazards include: Being near to road traffic, railway lines or water, Fire, toxic or electrical hazards or potential violence, Suspected Individual Chemical Exposure (I.C.E) incidents, also known as chemical suicide, AND The patient is caught in machinery or pinned by a heavy object. This includes being trapped inside a vehicle, room or building.
- Does the situation now require the dispatch of other emergency services?

The system aligns with the latest medical guidelines from respected bodies, including NICE (National Institute for Health and Care Excellence), the UK Resuscitation Council, JRCALC and the UK Sepsis Trust. This is undertaken through a formal process where an Evidence and Referencing Group (ERG) review new and updated evidence and guidance that may impact clinical triage or prehospital care in England to proactively identify any clinical updates or system changes that may be required. This would also include review of JESIP guidance.

Medical Priority Dispatch System

MPDS is a long-established triage system launched in 1979, published by the Priority Dispatch Corporation (PDC), and its ongoing development is supported by the International Academies of Emergency Dispatch (IAED), at which the English ambulance services which use the MPDS have significant clinical and operational representation and are therefore able to influence its development. NHS England does not manage or oversee the MPDS and we are therefore unable to provide comment on their system.

NHS Resilience Emergency Capabilities Unit (ECU)

We have been in contact with the Emergency Capability Unit who have undertaken an SBAR (Situation-Background-Assessment-Recommendations) review relating to this Report.

Within their assessment they have highlighted an absence of specific training, guidance and other supportive measures (e.g., via call handling and dispatch software) for Ambulance Emergency Operational Centre(EOC) staff relating to water incidents. The relevant Casualty Management Models are being generated to support, among others, EOC staff as part of the Immediate Care section. It highlights the need for greater engagement with, and training for, EOC staff in the context of major and complex incidents. They have advised that this is within the ECU's workplan for this year.

The other area this Report has highlighted a need for focus on is the alignment of Emergency responder interoperability: lexicon with other responding agencies, to ensure uniform terminology is used across agencies. The Emergency Capability Unit is taking forward this piece of work with the College of Policing in response to a recommendation from the Southport Inquiry.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Saffron, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Director of Patient Safety
NHS England