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 **Indy Storm Mason-Kidd**, and an inquest that concluded on **19 June 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted] **(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** 25 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> The persistent delays in relation to EEAST meeting target response timings across all categories of calls. In Indy's case his call was categorised as a category 2 call with a target of an 8-minute response. In fact, an ambulance was not dispatched until 53 minutes after the call, some three times the target response time. The evidence before the Court is that such delays are chronic, with few effective measures capable of addressing the problem.
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.* **The persistent delays in relation to EEAST meeting target response timings across all categories of calls. In Indy's case his call was**

categorised as a category 2 call with a target of an 8-minute response. In fact, an ambulance was not dispatched until 53 minutes after the call, some three times the target response time. The evidence before the Court is that such delays are chronic, with few effective measures capable of addressing the problem.

1. The court was previously provided with the EEAST Action Plan Feb 2025-26 (Appendix A) and this response should be read in conjunction with this action plan to demonstrate the progress made to date.

2. EEAST Action Plan April 2026-27 is the latest action plan EEAST is working towards in respect of managing delays and will be reviewed in early 2027 to establish what further action is required.

3. For clarity, Category 2 coded calls are for patients whose condition is potentially serious and require rapid assessment, urgent on scene intervention or urgent transport to hospital. We aim to respond to nine out of ten patients with the appropriate emergency resource within 40 minutes and with an average time of 18 minutes.

A&E Operations

4. Operational Productivity is measured and monitored by EEAST both internally and externally. It is managed through the Productivity forums, local performance cells, the Trust Performance Board and the Change Portfolio Board. Reports on compliance are also shared with the Trust Board sub-committees and through external meetings.

   - **Improve Category 1 mean performance to a 7 minute response time**

5. EEAST remains focused on prioritising emergency responses for the most critically unwell patients. Performance against the Category 1 (C1) mean response time has improved with April 2026 recording an average of 8 minutes 4 seconds. This represents a 5-second improvement in March 2026 and a 41-second improvement compared with February 2026. This continues to be a key priority and is subject to regular oversight.

   - **Improve Category 2 mean performance response times to 31 minutes and 15 seconds**

6. Category 2 (C2) incidents continue to represent most of the Trust's operational activity. Performance has shown improvement, with the average C2 response time in April recorded at 27 minutes 21 seconds. This reflects an improvement of nearly one minute compared with March 2026, and a more substantial improvement of almost ten minutes when compared with February 2026. This continues to be a key priority and is

subject to regular oversight.

- **Reduce the number of patients conveyed to hospital to 62%**

7. Performance against this measure remains consistent with expected operational practice, reflecting a greater emphasis on thorough on-scene assessment and the appropriate use of alternative care pathways. The overall conveyance rate for April 2026 achieved the 62% target, at 59.36%.

- **Reduce the average on scene time for patients that are not conveyed to hospital to 70 minutes**

8. For non-conveyed patients, the average on-scene time in April 2026 was recorded at 1 hour 8 minutes 6 seconds, continuing to remain within target.

- **Reduce the average on scene times for patients that are conveyed to hospital to 42 minutes**

9. For conveyed patients, the average on-scene time remained consistent with previous months but continued to exceed the target, which in April 2026 was recorded at 44 minutes 45 seconds.

- **Aim to achieve an arrival to handover at A&E time of 30 minutes**

10. Average Arrival to Handover (A2H) time showed improvement in April 2026, meeting the target at 29 minutes 58 seconds.

- **Aim to achieve a handover to clear time of 15 minutes**

11. Handover to Clear performance remained within the 15-minute target for April 2026, recorded at 12 minutes 10 seconds which is consistent with previous months.

- **Reduce the out of service shift hours to less than 6%**

12. EEAST continues to report Out of Service (OOS) performance using both measures that include and exclude cohorting. Cohorting is an operational approach whereby a double-crewed ambulance awaiting handover at a hospital assumes responsibility for an additional patient. This enables the other ambulance crew to become available more

quickly and respond to further 999 calls, thereby improving resource utilisation and operational capacity.

13. This approach recognises that cohorting is a system-level intervention beyond the Trust's direct operational control and allows for a clearer distinction between internal performance and wider system pressures. Overall, OOS performance improved to 4.91% in April 2026, achieving the 6% target. When cohorting is excluded, OOS performance further improves to 4.14%.

Telephone triage via Clinical Assessment Service (CAS)

14. The Unscheduled Care Co-ordination Hubs (UCCH) have all been successfully implemented across EEAST, these allow clinicians to access alternative pathways or clinical support other than attendance at an Emergency Department. EEAST monitor the Hear and Treat metric on a monthly basis, which is showing an increasing trajectory.

15. Calls are now passed via technology links to our 111 providers in 5 out of the 6 areas of the region.

16. In terms of the number of Category 2 calls receiving a clinical call back, this was 62,000 over the last year. EEAST has recently implemented a larger nationally approved code set of C2 calls that can be navigated, which means a further clinical assessment before the correct pathway is confirmed.

17. The number of calls being passed to other healthcare providers via Access to the Stack has also been increasing with an acceptance rate increase compared to last year.

18. There is an improving trend of Hear & Treat across the region and EEAST is managing more patients than ever in this manner, circa 1000 patients more each week compared to last year.

19. The number of Clinical Assessment Service clinicians has increased and the current establishment is 112 WTE work force effective of the anticipated148 WTE in post. The addition of these clinicians to the team will continue to support the work outlined above.

Community Response

20. EEAST has continued to increase our ongoing recruitment of volunteers within the community response and blue light collaboration portfolio. This includes the development of the Emergency Responder scheme with our Basics partners in Norfolk and Beds and Herts, our Emergency Responder partnership with St John in Norfolk along with the increased development of our fire service relationships across the region to

develop the response model. Our Community First Responder recruitment has continued and will continue to support the development of the existing CFR groups, the locality cars with appropriate plans for sustainability of volunteers. The hours provided by the Community Response and Blue light teams has continued to consistently deliver a level of hours around 20,000 per month.

Urgent Care

EEAST has twelve teams of Advanced Clinical Paramedics and Advanced Paramedics across the Trust targeted to suitable low acuity calls with the aim of safe and effective admission avoidance. They're coordinated by the EOC-based Urgent Care Desk (UCD).

Patient Safety

21. EEAST are committed to engage with system partners to effectively review delay incidents across the region. The patient safety team continue to review delay incidents reported via EEAST's incident reporting system, Datix.

22. Any delay which is deemed to have harmed a patient will be discussed at the EEAST's Incident Review Panel (IRP). Those meeting the moderate, severe or fatal harm are reviewed by the patient safety team, this includes a Duty of Candour (DOC) call with the patient or family involved and ensures our statutory obligations in terms of Duty of Candour are completed in full.

23. Throughout the 2025/26 financial year, the Head of Patient Safety and patient safety lead from the Suffolk and North East Essex Integrated Care Board (SNEE ICB – this was EEAST's lead ICB at the time) conducted a trial to improve the review of system delays. With delays being multifactorial, our aim was to better include the acute hospitals or community services involved in the delay to ensure we were not reviewing incidents in isolation.

24. Due to ICB reconfiguration the reviews of delays that are deemed to have caused harm to patients are now reported directly to the acute hospitals involved, this is completed by the EEAST patient safety team. Patients and families are made aware of the report we make to the acute hospitals so that they are aware the acute hospital trust may well be in contact directly with them during their external review processes.

25. EEAST are also providing a monthly report to all ICB's to outline the number of delays discussed at the IRP regardless of the harm decision made by IRP, this is to demonstrate that delays are not an issue during months we do not report any delays that have caused moderate or above harm. This continues to be monitored with the current lead Norfolk and Suffolk ICB.

	Summary 26. Category 2 performance remains heavily influenced by system-wide demand, with pressures across the urgent and emergency care pathway having a direct effect on operational delivery. Recognising this, we have developed more comprehensive and resilient seasonal plans for both winter and summer, designed to improve demand management, enhance system responsiveness and maintain the positive trajectory of performance improvements achieved at the start of the financial year.
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.* HM Coroner also identified a further concern during the inquest, which was addressed to NHS England: *The ability of NHS Ambulance Services to identify the location of patients within high density residential locations. This includes the effectiveness of call handler scripts used by NHS Ambulance Services, whether this be NHS Pathways or MPDS to provide precise locations and whether the incorporation of systems such as 'what three words' may afford greater accuracy.* In order to assist with this, EEAST is writing to all university campuses in the region to provide advice to students on how to call 999 and, specifically, the best method of providing their location and address.
6.	**SIGNATURE**