REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Darren STEWART OBE, HM Area Coroner, for the coroner area of Suffolk.
2.	**DATE OF REPORT** 17 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. [redacted] Chief Executive Officer, East of England Ambulance Service NHS Trust (EEAST) 2. [redacted], Chief Executive Officer, NHS England 3. Chief Constable [redacted], JESIP National Police Strategic Lead and Senior Responsible Officer, JESIP Interoperability Board, Chair You are under a duty to respond to this report within 56 days of the date of this report, namely by August 12th, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note 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 names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of

	Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** The management of the emergency response to the circumstances of Saffron COLE-NOTTAGE's death, including the information recorded in the CAD, communication between emergency services and the application of the Joint Emergency Services Interoperability Principles (JESIP). Several concerns have national implications. These are; the application of JESIP to single casualty events and the inclusion of Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and JESIP considerations in the scripts used by ambulance service call handlers.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 03 February 2025 I commenced an investigation into the death of Saffron Hannabel Wednesday COLE-NOTTAGE aged 32. The investigation concluded at the end of the inquest on 15 May 2026. The conclusion of the inquest was that: Narrative Conclusion - Saffron Hannabel Wednesday Cole-Nottage was walking along the concrete apron on the lower beach at Lowestoft on the evening of 2nd February 2025 when she fell and became wedged between two rocks that were part of sea defences. This area of the seafront was closed to the public, it was wet and slippery with algae, visibility was poor and Saffron had been drinking. Although bystanders tried to free her, they were unsuccessful. A call to the ambulance Service was made around 19:52 hours which provided an account that she was caught between rocks at the sea front and at risk of drowning. Although an ambulance was quickly dispatched, the East of England Ambulance Service NHS Trust Emergency Control Room did not immediately contact the fire service. During the 999 call, at around 20:00 hours it was conveyed that Saffron had become submerged under the water. The first paramedic arrived at Saffron's side at 20:13 hours and rapidly made the determination that Saffron was deceased and that this was not a rescue but a recovery situation. This determination, which was conveyed to the attending police and HM Coastguard was contrary to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance which advises that rescue attempts should continue for at least 30 minutes after the arrival of the first professional rescuer and confirmation of submersion.

	A team from Suffolk Fire and Rescue Service (SFRS) arrived at around 20:22 hours and having assessed the scene considered rescue attempts should proceed and immediately sought to rescue Saffron. From when first hands were placed on Saffron, she was removed from the water in less than half a minute. However, resuscitation attempts were sadly unsuccessful. Had the SFRS been immediately alerted to the incident, by 20:03.30 hours, it is possible that Saffron would have been extricated from the rocks sooner and survived. However, it is not probable that she would have done so. A postmortem examination of Saffron's body established that her medical cause of death was due to drowning. Saffron Hannabel Wednesday Cole-Nottage died from drowning following her becoming trapped in rocks on the Lowestoft seafront due to accidental causes. The medical cause of death was confirmed as: 1a. Drowning
9.	**CIRCUMSTANCES OF DEATH** Narrative conclusion see above.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** 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. <u>NHS England</u> a. Noting the concerns articulated above, consideration of how JESIP working and JRCALC considerations can be incorporated within call handler scripts used by NHS Ambulance Services, whether this be NHS Pathways or MPDS. <u>JESIP Interoperability Board</u> a. Evidence of interoperability working in relation to the use of ETHANE message format and the application of JESIP for single casualty incidents involving a multi agency response, indicated that insufficient or no consideration (with the exception of the Fire Service) was given to apply JESIP in such circumstances.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • **Chief Constable Suffolk Constabulary** • **Chief Officer Suffolk Fire and Rescue Service** • **Chief Executive HM Coastguard** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**