NHS England

Ms Karen Taylor
HM Assistant Coroner
West Sussex, Brighton and Hove
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

30 July 2026

Dear Ms Taylor,

Re: Regulation 28 Report to Prevent Future Deaths – Derek Thomas Burt who died on 15 May 2025

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16 June 2026 concerning the death of Derek Thomas Burt on 15 May 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Burt family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Burt's care have been listened to and reflected upon.

Your Report raises the following concerns:

1. Ambulance Trusts may not be aware that the careline system is able to set up three-way conversations or conference calls so that emergency services can be included in their conversation with the careline user.
2. There is no specific guidance for Apello Careline operators regarding emergency calls made to them by their service users.
3. The careline operator did not pass on key information to the Emergency Medical Adviser (EMA) relating to the caller's lack of access to a phone and the nature of the bleed. They also did not call them back when the patient became unresponsive.
4. Concerns were raised that the quality of the note taking by the EMA at South East Ambulance Service (SECAMB) had not been adequately checked nor actions taken to rectify the individual's note keeping deficiencies. This raised concerns with the quality of the call auditing system.
5. An opportunity was lost where the EMA could have obtained clinical advice at an earlier opportunity.
6. It was unclear whether careline companies are also exploring a trial of artificial intelligence equipment to improve accuracy of note taking.

Concerns 2,3. and 6 relate to the Apello Careline company, and as such are not within NHS England's remit to comment on. As your Report has also been addressed to the Apello Careline company they will be best placed to respond to these concerns.

NHS England's Ambulance Team have reviewed this Report and have advised that the concerns raised relate to operational matters, which are the responsibility of the local ambulance service; SECAMB NHS Foundation Trust, who will be best placed to respond to the concerns raised. We note that SECAMB have also been addressed in your Report and will respond directly to the concerns.

SEACAMB have advised the NHS England South East Regional team of improvements they have made as a result of your Report, which they will outline in their response.

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 Mr Burt 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 Medical Director
NHS England