**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:

**The Senior Coroner, [X] for the Coroner Area West Sussex, Brighton and Hove** in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Derek Thomas BURT**, and an inquest that concluded on **02 June 2026**.

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| 1. | **RESPONDENT**<br><br>In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **NAME** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted. |
| 2. | **DATE OF RESPONSE** |
| 3. | **CONFIRMATION OF CORONER'S MATTERS OF CONCERN**<br><br>The **MATTERS OF CONCERN** were identified in the report are as follows:<br><br>The MATTERS OF CONCERN are as follows:<br>Overall, I accept this was an unusual set of circumstances in that the call to emergency services was made by a careline operator who was relaying information from the patient's wife who was herself the careline user and she was bedbound so not in a position to assist her husband who was bleeding heavily and non responsive, nor could she get to a phone to answer (as it was in another room) the numerous calls made by the EMA and ambulance clinical safety navigator.<br><br>That said, no one appears to have thought that the Appello careline system could have been used to speak to Mrs Burt via a third party conference call as that is the very method used to call for help and she used it successfully, not once, but twice. I am concerned that this system and technology is utilised fully to potentially give vital clinical advice that may save future lives.<br><br>1) I heard evidence from the call centre manager of Appello Careline and the first careline operator that their system has the capability to speak directly to Mrs Burt without her pressing her wrist alarm button as this could have been done via the digital base unit that was in her bedroom. The system can also set up a 3 way conversation or conference call to include any of the emergency services. Indeed the operator told me she has done this in the past if asked to do so by the emergency services or she |

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| | has suggested it but she did not do so in this case as she took her lead from the EMA.<br><br>Conversely, I heard from a clinical safety navigator (CSN) with SECAMB that she did not know careline companies could set up 3 way conference calls for a CSN to speak to the patient or helper directly. She knew that Police and Fire Services used 3 way conference calls using careline systems but not Ambulance Trusts.<br><br>This case had moved from the dispatch to the clinical stack and from the timeline of calls supplied it seems 15 calls were made between 22:52 and 23:23 to the landline and mobile numbers supplied but of course, it was impossible for Mrs Burt to answer them. No one thought to go back through the digital base unit to offer the basic clinical advice that was needed. I am concerned that both Ambulance Trusts generally as well as Careline companies may not be aware of the potential to save lives using available technology.<br><br>2) I also heard from the careline centre manager that Appello does not have any specific documentation, training material or guidance that considers calls for assistance made by the service user for people other than themselves. It was good to learn that both careline operators did respond positively to the cry for help from Mrs Burt. I remained concerned however that there is no policy or guidance available for operators to cover this type of emergency or life threatening situation and no training has yet been devised to learn from the unusual circumstances that occurred here.<br><br>3) I also remain concerned that the first careline operator did not pass on a key piece of information to the EMA, namely that the caller did not have access to a phone. Nor did she ask if the blood was spurting or dribbling. Although, it was relayed that Mrs Burt was bedbound, the EMA would not have realised that Mrs Burt couldn't get to the phone as it was in another room.<br><br>In addition the first careline operator did not call the EMA back when she learned Mr Burt was non responsive and had developed breathing problems. The CSN confirmed to me that if a second call had been made at that point then the call would have been upgraded to category 1. This would have been at approx 22:50. In other words around the same time the EMA was trying to call Mrs Burt back. The clinical review was allocated at 22:55 and the second 999 call was logged at 23:15 so approximately 20-25 mins had elapsed.<br><br>4) Likewise, I heard from the SECAMB CSN that she had carried out an audit of the EMA notes added to their system when speaking to the first careline operator. She did so from a clinical perspective and she discovered missing information that was given but not recorded at all namely: that there had already been 20 minutes of bleeding at the time of the first call (approx. 22:43); Mr Burt was not responding normally/groaning; and Mrs Burt was<br>bedbound therefore could not assist Mr Burt. None of this information was therefore available to the CSN who carried out the clinical review.<br><br>In addition, I heard that the end to end review carried out by SECAMB and focused on the dispatch difficulties that existed on 14 May 2025. I appreciate that the dispatch and clinical review systems were different at that time and have now been changed but I remain concerned that the quality of note taking has not been properly checked and |

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| | action taken to rectify then make improvements with any individual concerned as well as capturing learning points for others. Here vital information was missing and was needed to ensure an effective clinical review could take place and thereby ensure that the category of call response is accurate.<br><br>I was told this call had been audited and was found to be 95% compliant. This also calls into question the quality of the call auditing system<br><br>5) I heard that an EMA could hold a call and speak to a CSN to get basic first aid advice or join the CSN into the call. Given the volume of blood that had already been lost in this case, I am concerned that this opportunity to give clinical advice was lost especially as the call had come in via a careline operator.<br><br>6) I was told that SECAMB is taking part in a pilot called Tortoise looking at using AI to improve the accuracy of note taking. It was unclear whether a similar scheme is being explored by careline companies or if there is effective liaison between careline companies and ambulance trusts. |
| 4. | **DETAILS OF ACTION TAKEN,** how has the concern been addressed.<br>[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].<br>*Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*<br><br>Concern 1<br><br>SECAMB acknowledges the Coroner's concern (1) regarding awareness and utilisation of Careline technology, including the ability to facilitate direct communication with service users and establish three-way conference calls involving ambulance service clinicians.<br><br>The Trust has reviewed the learning arising from this inquest and has amended its local operating procedure relating to failed callback processes. This guidance now specifically includes circumstances where calls originate from Careline providers.<br><br>The revised procedure requires clinicians, where direct contact with the patient or caller cannot be established, to contact the Careline provider to determine whether there have been any updates or changes to the patient's condition. The guidance also directs staff to explore whether the Careline provider can facilitate a three-way conference call, enabling direct communication between the clinician and the patient where this functionality is available.<br><br>The Trust recognises the potential benefits of utilising Careline technology to support clinical assessment and the provision of appropriate advice in circumstances where conventional telephone contact is not possible. In addition to the changes already implemented within the clinical callback process, SECAMB is currently reviewing how similar functionality may be utilised by Emergency Medical Advisors at the point of the initial 999 call. This work remains ongoing and no final solution has yet been agreed; |

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| | however, the Trust is committed to identifying opportunities to improve communication pathways and maximise the effective use of available technology.<br><br>Concern 3<br><br>SECAMB also acknowledges the Coroner's concern (3) regarding the impact that incomplete information sharing and the inability to establish direct contact with the caller may have had on the subsequent clinical assessment of this incident.<br><br>Following review of the learning arising from this case, the Trust has amended its failed callback procedure to ensure that where information is available indicating that a caller or patient cannot access a telephone, clinicians are required to consider alternative routes of communication, including re-contact with the originating careline provider where appropriate.<br><br>The Trust will reinforce the importance of reassessing incidents whenever additional information indicating deterioration in a patient's condition becomes available, whether this information is received directly from the patient, a relative, a careline provider or another third party. This learning will be incorporated into staff communications and ongoing operational training.<br><br>Concern 4<br><br>SECAMB acknowledges the Coroner's concern (4) regarding the completeness of information recorded within the emergency call record, the impact this may have had on subsequent clinical review, and the effectiveness of the audit process in identifying deficiencies in documentation.<br><br>The Trust has also reviewed the audit findings associated with this case. During that review it was identified that documentation quality forms a relatively small component of the current NHS Pathways audit framework. SECAMB has discussed this concern with NHS Pathways, recognising the Coroner's observations regarding the significance of missing or inaccurate information within call records. As the national audit framework is owned and maintained by NHS Pathways, any review of the weighting applied to documentation standards sits within their remit. SECAMB will continue to contribute to discussions and share learning where opportunities for improvement are identified.<br><br>The learning arising from this case has also informed local discussions regarding the assessment of documentation quality within assurance and audit processes, with a view to ensuring that significant omissions within call records are identified, escalated and addressed through appropriate learning and improvement activity.<br><br>In addition, the circumstances of this case and the learning identified during the inquest have been reviewed through the Trust's governance processes and shared with relevant operational and educational leads. |

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| | Concern 5<br><br>SECAMB acknowledges the Coroner's concern (5) that opportunities may exist to utilise available clinical support during complex or unusual calls to ensure that appropriate clinical advice is provided at the earliest opportunity.<br><br>The Trust's operating model enables Emergency Medical Advisors (EMAs) to access real-time clinical support from clinicians, including Clinical Safety Navigators, when additional advice, guidance or decision-making support is required. This includes circumstances where calls present with complex clinical needs, unusual circumstances or communication challenges.<br><br>Following the learning identified through this inquest, SECAMB has commenced a review of how access to clinical inline support is utilised within the Emergency Operations Centre. As part of this work, the Trust will be relaunching communications and guidance to remind staff of the availability of clinical support and to reinforce expectations that clinicians should be engaged where calls present with complexity, uncertainty or circumstances that would benefit from additional clinical input. This process has now been formally added to the Emergency Operations Centre Call Handling Procedure which is currently going through the final steps of Trust governance ahead of publication, where it will reinforce with our call handlers the need to seek clinical support whenever they feel the need to or the call is outside their scope of practice. It is anticipated this will be concluded by the end of Quarter 2.<br><br>This work aims to strengthen awareness and utilisation of existing escalation pathways, ensuring staff are supported to access clinical expertise whenever required and helping to maximise opportunities for timely clinical advice to patients and callers. |
| 5. | DETAILS OF FURTHER ACTION PROPOSED<br><br>Concern 4<br><br>SECAMB acknowledges the Coroner's concern (4) regarding the completeness of information recorded within the emergency call record, the impact this may have had on subsequent clinical review, and the effectiveness of the audit process in identifying deficiencies in documentation.<br><br>The Trust fully recognises that accurate and comprehensive documentation is essential to support effective clinical assessment, review and decision-making throughout a patient's journey. Whilst emerging technology may offer future opportunities to improve the capture of information, SECAMB does not consider that current solutions are sufficiently developed for implementation within Emergency Medical Advisor (EMA) call handling processes at this time.<br><br>The Trust is currently participating in trials of Tortus AI technology to support clinical |

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| | note taking. However, this technology is presently focused on clinical applications and is not yet at a stage where its use within the emergency call handling environment is considered practicable. Separately, work is ongoing across the sector to explore automated call auditing and transcription solutions. Cleric CAD, amongst other providers, is investigating the potential for live transcription functionality across all calls, which may support the completeness and accuracy of information available to clinicians and operational teams in the future.<br><br>Whilst these longer-term technological developments continue to be explored, the Trust has taken immediate action by raising the learning identified through this inquest with the Training Department. A review is underway to determine what enhancements can be made to training, guidance and development processes to further support Emergency Medical Advisors in accurately documenting information obtained during emergency calls. This will be in place by the close of the financial year.<br><br>The Trust is reviewing how documentation quality is considered within local assurance processes to ensure that significant omissions within call records can be more readily identified, escalated and addressed through learning and improvement activity.<br><br>SECAMB acknowledges the Coroner's concern (6) regarding the role that emerging technologies and partnership working may play in improving communication, information sharing and patient outcomes.<br><br>As outlined elsewhere within this response, the Trust has identified opportunities to strengthen its understanding of the capabilities available through Careline providers and to improve how these capabilities can be utilised within ambulance service operations. This learning has informed broader discussions regarding collaborative working with Careline providers operating within the Trust's footprint.<br><br>The Trust is currently progressing work through its Falls and Frailty Pathways of Care, within which closer engagement and partnership working with Careline providers has been identified as a key area of development. This work will provide opportunities to improve mutual understanding of organisational processes, escalation pathways, communication methods and technological capabilities, ensuring that available resources can be utilised more effectively in support of patients requiring urgent care.<br><br>The Trust will also seek to use these partnership arrangements to share learning arising from this case, including consideration of circumstances where telecare users seek assistance for another person and the communication challenges that may arise in such situations.<br><br>SECAMB recognises the value of fostering strong relationships with Careline providers and believes that the ongoing work within the Falls and Frailty Pathways of Care will further strengthen these partnerships, support shared learning and help identify opportunities for service improvement across organisational boundaries. |

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| | The Trust remains committed to exploring both technological and operational solutions that enhance communication, improve patient assessment and support safe and effective care for patients accessing emergency services through Careline systems.<br><br>SECAMB is grateful for the opportunity to consider the concerns raised by HM Coroner and the learning identified through the inquest into the death of Mr Burt. The Trust has carefully reviewed those matters falling within its area of responsibility and has taken steps to implement improvements whilst also identifying further opportunities for development. SECAMB remains committed to continuous learning, strengthening partnership working, enhancing communication and ensuring that its policies, processes and systems support the delivery of safe, effective and patient-centred care. The Trust will continue to monitor the progress of the actions outlined within this response and incorporate learning as part of its ongoing quality improvement and governance arrangements. |
| 6. | **SIGNATURE**<br><br>  |