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**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the coroners (Investigations) Regulations 2013, **TEC QUALITY on behalf of the TSA** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**7TH August 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** **We have been asked to respond to this matter:** **About TSA** TSA is the industry body for Technology Enabled Care (TEC), working to support the transformation of the sector through stronger partnerships, data, and workforce development, while responding to the growing opportunities and challenges within TEC. A key part of our role is promoting the quality and safety of TEC services through the development of standards and the provision of independent audit and certification. This work is delivered by our wholly owned subsidiary, **TEC Quality Ltd**, the only UK Accreditation Service (UKAS) accredited certification body in the TEC Sector. We also support our members through guidance, training, and knowledge sharing to improve service delivery, particularly in relation to analogue-to-digital transformation, business growth, and sector-wide improvement.

About TEC Quality and the Quality Standards Framework

TEC Quality operates the **Quality Standards Framework (QSF)**, an outcomes-based auditing scheme designed to drive quality, consistency, and safety across the TEC sector.

The standards are reviewed annually through a formal scheme change process to ensure they remain robust and relevant within an evolving operational and technological environment.

In addition, TEC Quality provides CPD-accredited e-learning programmes, particularly aimed at frontline operational staff, to support the development of knowledge, skills, and nationally benchmarked best practice.

Although TEC remains an unregulated sector, the QSF represents the closest equivalent to an independently audited quality assurance framework aligned to recognised British and European standards. The framework provides Commissioners, procurement bodies, Local Authorities, housing providers, and care organisations with assurance that appropriate safeguards and quality processes are in place to protect Service Users.

Neither TSA nor TEC Quality were part of the coroner's hearing for this case.

The **MATTERS OF CONCERN** identified by the Coroner in the report are as follows:

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.

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.

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 has suggested it but she did not do so in this case as she took her lead from the EMA.

	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. 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. **TEC Quality response to point 1:** A review of this incident highlights several key areas for consideration and potential improvement: • Communication of critical information between agencies in particular ensuring that communication pathways for triage of the Service User by the ambulance service and clinical teams are available • Clarity and effectiveness of communication pathways. • Availability and utilisation of conference calling functionality within the Appello TEC monitoring platforms. • The ability to facilitate conference calling functionality on a wider, national scale during emergency response situations. In this case, it is difficult to determine whether a different outcome would have resulted had information been communicated more effectively between the parties involved. However, it is reasonable to consider whether further questioning or alternative actions may have been taken had it been clearly communicated that the Service User could not be contacted via either their landline or mobile telephone. For example, if the Emergency Medical Advisor (EMA) had been advised at the outset that direct telephone contact with the Service User was not possible, consideration may have been given to establishing an alternative communication route, such as a conference call involving the monitoring centre and ambulance service. Or whether localised on-site contact could be found from the Service User's records and contact list. It should be noted that conference calling functionality is not universally available across TEC monitoring platforms nor is it appropriate in every call to the ambulance service. Current intelligence suggests that only a limited number of systems offer this capability. Nevertheless, where such functionality exists, monitoring centre operators should proactively consider its use when it becomes apparent that a Service User

	cannot be contacted through conventional telephone channels. In this particular case, it could be argued that a more proactive approach to facilitating a three-way conversation may have supported information sharing between the parties involved. While TEC Quality has no authority to influence or amend national ambulance service triage systems, there may be opportunities to strengthen communication processes where referrals are made between TEC monitoring centres and ambulance services. In particular, where contact details are passed for onward communication, TEC operators and EMA's should ensure that the telephone number provided is active, accessible and represents a viable means of communication. Consideration could also be given to incorporating additional questions within ambulance triage processes, such as: • Is the Service User able to answer or access a telephone? • If not, does the telecare system have conference calling capability that could facilitate communication between relevant parties? More broadly, the incident demonstrates that there were multiple communication challenges throughout the response process. Given the severity of the call, it may have been beneficial for the ambulance service to re-establish contact with the monitoring centre when attempts to contact the Service User proved unsuccessful. This would have enabled the sharing of updated information, reassessment of available options, and a more coordinated response between agencies. 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. 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. 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. **TEC Quality response to points 2 and 3:** A review of this incident has identified several key areas for consideration and potential improvement: • Service User records, including the accuracy, completeness and ongoing maintenance of contact information. • Recording details of additional household members and their potential role as responders. • The capability of TEC Monitoring Centres to respond appropriately and their responsibility to follow established procedures and escalation pathways. At the point of installation, and as part of routine reviews and updates, typically undertaken at least annually, TEC providers are expected to maintain accurate and up-to-date information for each Service User. This information would normally include the Service User's name, address, date of birth, relevant medical conditions, GP details, contact and responder information, known risk factors (for example, living alone or hoarding concerns), and details of any third parties involved in their care, such as domiciliary care agencies. Where additional household members reside at the property, it would be expected that, as a minimum, their name and relationship to the Service User are recorded within the Service User record, as they may represent an important source of information, contact point, or as a potential responder during a TEC incident. From a TEC Monitoring Centre perspective, operators are responsible for assessing incoming calls, following established protocols and arranging the most appropriate response based on the information available. To support this, TEC Quality provides certified organisations with a Decision Support Toolkit (DST) designed to assist non medically trained frontline monitoring centre operators in identifying relevant symptoms, by asking appropriate incident-specific questions and determining suitable escalation pathways. The DST was established through stakeholder collaboration and consultation including Central Ambulance Service, NHSE and AACE. The DST describes a major bleed may result in death or is life threatening from a sudden new injury or from a previous disease or injury and will need an emergency clinical response and breathing difficulty information, which includes a comprehensive list of descriptors, information prompts and example questions. A review of the call recordings suggests that opportunities may have been missed to provide the Emergency Medical Advisor (EMA) with information that could have informed the triage assessment and potentially supported a higher-priority emergency response. Whilst it is not possible to determine whether the outcome would have been different, the timely communication of all relevant information remains a critical

component of effective emergency response management.

It should also be recognised that TEC Monitoring Centre operators manage a diverse range of incidents and are not solely responsible for responding to health-related emergencies. Their role frequently involves liaising with ambulance, fire and police services, alongside managing welfare and reassurance calls. As such, TEC operators are expected to possess the skills, knowledge and professional judgement required to assess situations effectively and coordinate the most appropriate response in accordance with established procedures and best practice and this may not be limited to the Service User alone.

This incident highlights the importance of:

- Maintaining comprehensive and regularly updated Service User records.
- Recording details of all household members including those who could potentially become the service user themselves and thus requiring a response or who may act as contacts or responders.
- Ensuring that all relevant information is communicated promptly and accurately to emergency service partners.
- Not making any assumptions but refer back to the Service User for clarity.
- Consistently applying established call-handling protocols and decision-support tools.
- Providing operators with the knowledge, confidence and competence required to manage complex incidents and support effective response prioritisation.

QSF certified organisations should ensure that all TEC Operators complete both in-house training and the Continuing Professional Development (CPD) learning modules provided by TEC Quality as part of the Quality Standards Framework (QSF). TEC Quality recommends that the coroner endorses the TSA Quality Standards Framework certification for all TEC Providers.

This will help ensure that TEC operators are equipped to gather, assess and communicate critical information effectively to EMA's and other emergency service professionals.

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 bedbound therefore could not assist Mr Burt. None of this information was therefore available to the CSN who carried out the clinical review.

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 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. 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 5) I heard that an EMA can 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. **TEC Quality response to points 4 and 5:** These are internal ambulance processes and TEC Quality are not able to influence nor make comment in these areas. 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. **TEC Quality response to points 6:** Ambulance services, including SECAMB and other NHS ambulance trusts, and Technology Enabled Care (TEC) providers operate as separate organisations, with a variety of service delivery models in use across the country. While TEC organisations are encouraged to establish data-sharing agreements with local ambulance services where possible, this can be challenging for national providers operating across multiple ambulance trust regions. As a result, the primary route for requesting an emergency response remains through the standard 999 telephone service. In the vast majority of cases, this process is effective and appropriate. At present, there are no nationally established pathways that enable information captured through TEC systems, including AI-assisted note-taking, to be transmitted directly to ambulance services via email or other electronic means as part of an emergency referral process. The use of AI technology within TEC services to capture and document live call information is an emerging area and is not currently embedded as standard practice across the sector. All inbound and outbound TEC calls are recorded and retained,

	enabling review for quality assurance, training purposes, and investigation of incidents or events by authorised senior personnel. Under the TEC Quality Standards Framework (QSF), a minimum of two calls per operator are subject to quality assurance review each month, including at least one emergency-related call. This process supports ongoing performance monitoring, compliance with procedures, and the identification of learning opportunities.
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.* TEC Quality were provided with the call recordings and further information to support the response to the PFD notice. Further actions are outlined below.
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.* **Key Learning to point 1:** Effective communication, timely information sharing, and the proactive use of available technology are critical factors in supporting collaborative decision-making between TEC monitoring centres and emergency service partners. Opportunities exist to strengthen guidance and operational procedures in these areas to help reduce the risk of similar issues occurring in the future and these will be addressed through future TEC Quality CPD e-learning programme and through strengthened QSF criteria for all certified TEC Monitoring Auditees to ensure the quality of TEC call monitoring and response. **Key Learning to points 2 and 3.** The review identified significant missed opportunities in information gathering, communication, monitoring, escalation and adherence to procedure. In response to the learning arising from this incident, TEC Quality will strengthen future learning and development programmes, which is a mandatory requirement for

	all QSF-certified organisations, with a particular focus on: • The importance of maintaining accurate and up-to-date Service User records, including details of additional household members. • Ensuring that appropriately skilled, knowledgeable and competent operators are available to manage incoming calls. • Implementing robust training, competency assessment and continuing professional development programmes. • Reinforcing the use of the TEC Quality Decision Support Toolkit, or an equivalent approved in-house system, to ensure operators ask relevant incident-specific questions and follow appropriate escalation pathways. • Strengthening operators' understanding of the information required by emergency service partners to support informed triage and response decisions. These actions will support continuous improvement across the sector and help maximise the effectiveness of TEC services in responding to emergency situations. **Key Learning Points for point 6** TEC Quality and AACE (the Association of Ambulance Chief Executives) have a well-established partnership and a proven track record of working collaboratively to address issues such as this. This close working relationship will continue, ensuring that the interests of both the TEC and ambulance sectors are effectively represented.
6.	**SIGNATURE** [redacted] [redacted] Head of Quality and Improvement TEC Quality