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).

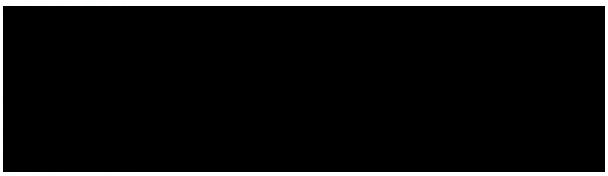
1.	**CORONER** I am Karen TAYLOR, Assistant Coroner, for the coroner area of West Sussex, Brighton and Hove.
2.	**DATE OF REPORT** 16 June 2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	**THIS REPORT IS BEING SENT TO** 1. South East Coast Ambulance Service NHS Foundation Trust 2. Association of Ambulance Chief Executives 3. NHS England 4. Appello Careline Operations Director 5. Telecare Services Association You are under a duty to respond to this report within 56 days of the date of this report, namely by August 11, 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.	**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.
7.	**INVESTIGATION AND INQUEST** On 04 September 2025 I commenced an investigation into the death of Derek Thomas BURT aged 81. The investigation concluded at the end of the inquest on 02 June 2026. The conclusion of the inquest was that: Derek Thomas Burt died on 15 May 2025 at his home address of 71 Fircroft Crescent, Rustington, Littlehampton in West Sussex as a result of a spontaneous rupture of an arterio-venous malformation at the back of his right ankle. He had an established medical history of varicose veins in both legs and suffered from monoclonal gammopathy. Although an ambulance was called via a Careline operator after 20 minutes of bleeding, sadly Mr Burt died due to a combination of exsanguination and ischaemic heart disease before potentially survivable treatment could be given.
8	**CIRCUMSTANCES OF DEATH** On 14 May 2025, Mr Burt got his wife into bed as part their usual night time routine. About 10 mins later he returned to his wife's room with his foot in a bowl that was half filled with blood. As Mrs Burt is immobile and bed bound, all she could do was sit on the edge of the bed and tell her husband to sit in a chair. She confirmed that she could not telephone for an ambulance as the phone was in the lounge, so she couldn't get to it. Sadly Mr Burt was deteriorating and becoming non responsive so Mrs Burt used her wrist alarm band to contact the Appello Careline call centre at 22:36. The call was not connected to an operator for a further five minutes and 49 seconds meaning the time was roughly 22:42. Mrs Burt told the careline operator the call was about her husband; she was bedbound; her husband had blood pouring out of his foot, about half a bowl of blood; that she didn't have a phone; her husband had not said what caused the bleeding; she thought it was coming from underneath his foot; he looked dreadful and was white plus he was groaning; although she asked him a direct question there was no response; and that he had been bleeding for 20 minutes. That part of the call lasted for 2 minutes then the careline operator contacted the emergency services. The call was logged at 22:44. All the information was passed on to the Emergency Medical Adviser (EMA) except in one important respect. No mention was made of the fact that Mrs Burt did not have access to a phone as it was in another room so she could not get to it. The EMA then confirmed that an ambulance was being arranged. It was

	categorised as C2 meaning the national target response time for the ambulance to arrive was 18 minutes (notionally 23:02). However, the careline operator was told it may arrive within the next two hours and 27 minutes, this being the longest waiting time for a category 2 call that day. The careline operator again spoke to Mrs Burt and reassured her that help was on the way but to call back if anything changed or got worse. Mrs Burt confirmed that Mr Burt was now non responsive and making funny breathing noises. The time was roughly 22:50 but the careline operator did not call the emergency services back with the new information. The call was then disconnected. Mrs Burt used her wrist alarm for the second time at 23:13 and the call was connected in 35 seconds. She confirmed her husband was no longer breathing and his mouth was open. The second careline operator called emergency services at 23:15 and as a result the call was upgraded to category 1. Two crews arrived at 23:23 followed by a critical care paramedic at 23:43 then HEMS at 00:04 plus an operational team leader. Sadly, recognition of life extinct was declared at 00:45. A post mortem examination took place on 21 May 2025. The pathologist gave cause of death as: 1a) Exsanguination and Ischaemic Heart Disease; 1b) Spontaneous Rupture of Arterio-Venous Malformation (Posterior Right Ankle); 2) Mono-Clonal Gammopathy. The pathologist indicated that the type of rupture from the back of Mr Burt's ankle was definitely survivable if a tourniquet has been applied and described this as a very basic action. When asked how quickly that treatment would have been needed, the pathologist indicated it was difficult to be precise but in his opinion treatment was needed within 15 to 30 minutes depending on whether the wound was spurting or dribbling.
9..	**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: 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. 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 the numerous calls made by the EMA and ambulance clinical safety navigator (CSN). 1) I heard evidence from the call centre manager of Appello Careline and the first careline operator that their system had 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 CSN with South East Coast Ambulance Service (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. 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. 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. 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.
10..	**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: [redacted] - Family [redacted] – Family [redacted], Appello Call Centre Manager [redacted] CSN, SECAMB 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.

11..	**SIGNATURE**  **Karen TAYLOR** **Assistant Coroner for** **West Sussex, Brighton and Hove**