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NHS ambulance service doctored documents to cover up truth about deaths

Grieving families were not told full facts

David Collins, Hannah Al-Othman and Shaun Lintern Saturday May 21 2022, 6.00pm, The Sunday Times

The parents of Quinn Evie Beadle must have thought life could not get any worse when their daughter died in 2018.

They later found out, however, that the "kind, caring" 17-year-old had been failed by a paramedic at the scene of her death — and that the ambulance service altered documents to try to stop them finding out the truth.

The teenager, who dreamt of becoming a medic but suffered poor mental health, was found after she hanged herself near her home in Shildon, Co Durham, on the evening of December 9, 2018. The paramedic who attended the scene made basic mistakes, and made no effort to clear her airway or continue with basic life support — despite the fact her heart was still active.

But instead of attempting to learn lessons, bosses at the North East Ambulance Trust (NEAS) set out to prevent the family learning what happened.

They changed a key witness statement given to the coroner at her first inquest, removing references to mistakes the paramedic had made and inserting the claim that any life support offered would "not have had a positive outcome". They also withheld from the coroner a key piece of evidence — a reading from a heart monitor — which demonstrated Quinn's heart activity.

It is thought Quinn's death could be one of more than 90 cases in the past three years in which the NEAS failed to provide families with the whole truth about how their relatives died.

Senior managers repeatedly withheld key evidence from coroners about deaths linked to service failures, an internal report shows. In some cases, bosses doctored or suppressed evidence to cover up failures by staff.

An independent report into a small number of the cases, including Quinn's, raised by whistleblowers found that, as in her case, statements were changed or suppressed and pieces of key evidence not disclosed.

Despite the findings of the 2020 report — which was shared with the chief executive of the ambulance trust and other senior staff but not made public — whistleblowers say the NEAS has failed to tackle the problem.

They say they have concerns about dozens more deaths that have emerged since the report. "The trust has been so concerned about protecting their own image,

about making sure the reputation of the ambulance service is not damaged in the region," a source in the NEAS said. "They have put that ahead of everything else — even ahead of the bereaved families."

The NEAS last week acknowledged some past issues in reporting to the coroner but said it had made "significant improvements" since a "task-and-finish group" was concluded in January 2021.

Despite this, the whistleblowers claim they are being driven out of the organisation for raising the problems. This year, in return for taxpayer-funded payments of more than £40,000, two staff members were asked to sign gagging agreements that seek to limit them from making further reports about their concerns to the authorities — including the Care Quality Commission regulator and the police.

Last week the NEAS refused to "confirm or deny" the existence of such non-disclosure agreements (NDAs).

Gagging clauses were supposed to have been banned in the NHS by Jeremy Hunt, then the health secretary, in 2014. In The Sunday Times last week, in an extract from his new book, Hunt branded the NHS a "rogue organisation" with an ingrained culture of cover-ups.

Hunt, a Tory MP and chairman of the Commons health select committee, said: "This case is deeply concerning and appears to be another example of the toxic blame culture in the NHS which incentivises cover-ups and means the same mistakes are repeated time and again. These types of gagging clauses have no place in a system where learning from mistakes is a matter of life and death."

Ambulance 'meltdown'

The NEAS, which covers a large area from Berwick-upon-Tweed, the most northernly town in England, to Teesside, has been dogged by concerns about poor performance.

In 2019, bosses came under pressure over a series of deaths following failures by paramedics.

These included a 15-year-old girl who died of anaphylactic shock after "unqualified" paramedics failed to give her the correct medication; a former RAF serviceman who died after waiting 12 hours for an ambulance; and Norman Thompson, 62, who died in his niece's arms after she had battled to save him for more than an hour, performing CPR as he deteriorated. He bled to death after 999 calls were not prioritised.

In 2015, MPs from the region described the service as being "in meltdown", with constituents "losing faith in the service". It was time, they said, for urgent action. A recurring problem was staff shortages and poor training.

It was against this backdrop that, in 2019, some of the NEAS coroners' officers — the officials responsible for ensuring coroners in the area were alerted to, and

supplied with evidence on, deaths linked to the ambulance service — began to raise concerns.

NEAS bosses, they claimed, were holding back key information about deaths linked to the ambulance service. As a result, coroners were being kept in the dark about internal investigations into deaths, including those that appeared to be linked to failures by paramedics and other NEAS staff.

Some of the complaints centred on an internal patient safety committee formed by the NEAS in September 2019.

The stated purpose of this group — known as Seacare — was to review information meant for disclosure to coroners to ensure its "quality, accuracy and objectivity".

However, the whistleblowers claimed that in reality the committee was screening the information and in some cases ensuring that evidence that could be damaging to the ambulance service was changed or withheld.

The whistleblowers were concerned that statements and internal investigation reports were being sent to the Seacare group for "review" before they were submitted to the coroner — and were only being sent once that had taken place.

By 2019, the whistleblowers believed evidence had been withheld from dozens of families.

In response to the allegations, a company called AuditOne — made up of former NHS finance directors and former police officers — was brought in by the NEAS to review the claims. Its conclusions, some of which have never been shared with the families involved, can be revealed for the first time today. They make for grim reading.

Report doctored

The internal report into the circumstances of Quinn's death — compiled by an experienced clinician three months after her death — exposed the serious mistakes made by the paramedic at the scene.

The clinician concluded that the electrocardiogram heart monitor, or ECG, had shown "no evidence of an asystolic reading" — in other words, no evidence of a "flatline" reading, which would have suggested Quinn's heart had stopped.

Despite this, however, proper resuscitation methods and procedures were not carried out. The clinician noted that "no effort was made to clear the patient's airway ... basic life support was not continued, and advanced life support was not attempted".

Two days after the report was submitted to NEAS managers, the coroner emailed requesting to see it and asked why the coroner's office had not been told such an investigation was taking place. Shortly afterwards, a meeting was held by managers. They decided to change the report before it was given to the coroner and to withhold the damning ECG evidence.

“A decision was reached that findings in relation to the ECG activity should be removed and the conclusions amended,” the AuditOne report found.

“No minutes were taken of this meeting, and nothing was documented as to the rationale behind the decision.”

The clinician’s observations about the lack of effort to clear Quinn’s airway or provide life support were removed. Also removed was a section from the paramedic at the scene saying that: “On reflection he should have provided advanced life support at this incident.”

A paragraph was added to the report to say that: “The decision not to start advanced life support upon reflection was the correct decision.”

It was a remarkable turnaround from the clinician’s original findings. The new version added that resuscitation “would not have had a positive outcome”.

The amendments, AuditOne found, had “removed a critical fact and changed the conclusions so dramatically that it did not reflect the findings within the report, nor the original conclusions drawn by [the clinician]. The most crucial part of the new conclusions was in direct contrast to the original conclusions.”

When asked about the changes, the clinician said he had not felt he could raise concerns because those responsible for changing his statement were “very senior members of the trust who outranked him”.

After reviewing the doctored report, the coroner was unimpressed. She adjourned the first inquest into Quinn’s death in 2019, saying there was not enough information to determine exactly how she died.

Only at a second inquest in 2020 were the family told by the coroner how the ambulance service had tried to turn “black into white”.

The coroner ruled there was “sufficient doubt” that Quinn intended to take her own life. “I also cannot say it was an accident. Either way, the evidence is insufficient for a formal conclusion to be reached,” she said.

The family’s heartbreak did not end with Quinn’s death. Her mother, Tracey, said the tragedy led to their 21-year-old son Dyllon — their only other child — taking his own life while at university in Manchester.

Three years later, the family have yet to receive a proper apology. The NEAS has not accepted liability for Quinn’s death.

“They donated £3,000 to the Quinn’s Retreat charity,” Tracey said. “That’s what my daughter’s life was worth to them. The coroner said that they’d changed it from black to white. They just covered it up and covered it up.

“You just can’t believe that a service that’s supposed to look after people could lie to you like that.”

The NEAS said it made a “full disclosure” to the coroner in advance of the adjourned inquest, and commissioned an independent investigation into the

circumstances. It admitted the coroner was “critical” of its governance processes, but said “he was satisfied the systems we put in place would prevent a repetition”.

Crew stopped to refuel

In a second case identified by the auditors, managers withheld evidence of a fatal decision by paramedics to stop and refuel on their way to a man who was struggling to breathe, even though they had enough fuel to reach him.

Peter Coates — who was bedbound and reliant on an oxygen machine — called for an ambulance early on March 14, 2019. There had been a power cut in his village and the 62-year-old’s electric-powered oxygen machine had stopped working.

The first ambulance crew were less than two minutes away. However, they were unable to get out of the ambulance station because the electronic gates had failed in the same power cut. They were not aware there was a manual override.

The call was transferred to a second crew, which was given permission to stop at a garage to refuel. Once at Coates’s home, they struggled to gain entry.

By the time they arrived — 34 minutes after the 999 call — Coates was dead.

Although an investigation began the same day, the coroner was not made aware of this at the time, or of the fact that there had been any delay in getting help.

Despite the mistakes and delays, a decision was made by bosses to downgrade the incident to “low harm”, on the basis that the primary reason for Coates’s death had been the oxygen equipment malfunction.

The coroner, in fact, “should have been notified” straight away about the death and about the delays, the AuditOne investigation found.

The NEAS internal investigation soon found that the second ambulance had in fact had sufficient fuel to complete the journey. This raised questions as to why the stop occurred. A statement made by one of the paramedics involved, explaining the decision to refuel, was never disclosed to the coroner.

Instead, the paramedic was asked by bosses to produce a new statement, which made no reference to the decision to refuel. The coroner was “only supplied with the [later] statement, which does not include any reference to the refuelling”, AuditOne found.

The withholding of the original statement and the NEAS investigation report into the electric gates appears to be a breach of the legal obligation to disclose material to the coroner.

The original statement “was relevant to the death and should have been disclosed”, AuditOne found.

The NEAS never produced any “investigation report in relation to the delay concern”, nor did it inform the coroner that it had investigated it, the auditors added.

As a result, Coates’s family were kept in the dark about many details of his case. They knew nothing about a first crew and the electronic gates until contacted by The Sunday Times. “This is information that should have been made public, and should have been known to us, to the family,” Peter’s daughter, Kellie Coates, 46, said last week. “I’m quite angry that it was hidden.”

Coates’s 31-year-old son, Aidan, said it was clear that bosses were trying to hide a “failing system”. He added: “They’re trying to bury it, and dispose of things to try to manipulate the story, to try and make themselves look better.”

In a letter to the coroner in May 2020, the NEAS said: “We made a full disclosure of information that had not previously been shared.” This included a statement from the crew and an incident report log.

Fatal delays

A number of the cases raised by whistleblowers involved patients who died after ambulance delays.

In November 2019, Sandra Currington, 52, from Gateshead, telephoned for an ambulance complaining of pain in her arm and shoulder, along with difficulty breathing. The ambulance took an hour and 27 minutes to arrive. By the time paramedics entered the property, Currington was dead.

It later emerged that despite her breathing problems, the call had not been graded as a “category 1” incident, which would have required an ambulance to attend within seven minutes, but a “category 2”. Even then, the ambulance crew should have been on the scene within 18 minutes.

During an internal inquiry, an email was sent by a NEAS manager stating that she would “pull a report together and strip out anything unnecessary”. It is not known “whether anything has been stripped out” that should have been sent to a coroner, AuditOne said in its report.

However, it noted that the coroner was made aware of the delay in the ambulance attendance by police, rather than by the NEAS. Last week the NEAS said it had apologised to the coroner in May 2020 for not disclosing all the relevant information. The NEAS said it then “provided full disclosure”.

Another case identified by the report was that of Andrew Wilson.

Wilson, 32, lived in a specialist supported living facility in Langley Moor, Co Durham. He made a 999 call at 5.38pm on October 10, 2019, saying he was having difficulty breathing, his throat was swelling and he was vomiting blood.

A second call was made at 6.23pm, saying his condition was getting worse. At 6.35pm, staff at the facility rang the NEAS to say Wilson was unresponsive.

The crew arrived at 6.45pm, 67 minutes after the first call. Shortly afterwards, Wilson died.

The next day, paramedics raised concerns about the delay and the "potential missed opportunity" to recognise the extent of his illness. But bosses decided the 67-minute delay should be categorised as having caused only moderate harm.

This was despite the fact that an internal report found an earlier response would have increased Wilson's chances of survival, and that "a delay in receiving an ambulance response is likely to have contributed to this outcome [his death]".

Wilson's case was "not raised" with the team charged with liaising with the coroner, so the death was not disclosed to the coroner, the AuditOne report found. Months after Wilson's death, the coroner requested a report from the paramedic and still "did not appear to be aware" that the NEAS had carried out an internal investigation into the death.

The NEAS wrote to the coroner in May 2020 to apologise about not disclosing the full information about the case and subsequently submitted shift reports, a dispatch report, staffing reports and audio records.

Bullied and gagged

AuditOne's investigators took a sample size of 30 cases of concern, dated from 2019 to February 2020, and looked at a six in close detail.

Based on those cases, the report concluded that it was clear the NEAS was failing in its duty to disclose material about deaths to coroners in a proper and timely fashion. "The coroner is not being made aware of concerns and/or investigations being carried out by the trust in a timely fashion ... in some cases, documents relevant to the death and disclosable are not being disclosed to the coroner," said the report.

"It is not for the trust to determine whether to disclose a document. If it is relevant to the death it must be disclosed."

After receiving the AuditOne report, Helen Ray, the NEAS's chief executive, set up a "root-cause review" in 2020, putting Dr Mathew Beattie, its medical director, in charge of disclosure problems.

Beattie and Derek Winter, the lead coroner for the northeast of England, were said to have had "discussions" about the findings of the AuditOne report. However, whistleblowers said changes made by Ray did not fix the problems.

Coroner's officers raised concerns about disclosure over 57 cases between July 31, 2020 and July 5 last year, according to NEAS sources. In total, concerns about disclosure are understood to have been raised in more than 90 cases. "The recording of cases of concern only really began in 2019," said the source. "The numbers are staggering."

The NEAS said last week that most of the cases after July 31, 2020 raised "minor issues" that did not affect the families concerned.

By 2020, some of those raising concerns started to feel bullied. Some reported being "shouted down" by managers who were supposed to be releasing the relevant documents for disclosure.

As a result, NEAS staff alerted external organisations to what was happening, including the Care Quality Commission, the Nursing and Midwifery Council, the General Medical Council and even Northumbria police.

In June 2020, Northumbria police received information from NEAS staff relating to allegations of cover-ups of mistakes and delays by paramedics, and vital information being withheld from families. They were also told that documents were being altered, concealed and even destroyed. Detectives interviewed the whistleblowers.

Police also approached Winter, the senior coroner for Sunderland, who took over the handling of the case that year.

Earlier this year, bosses at the service asked some members of staff to sign non-disclosure agreements in return for payments of more than £40,000. These agreements would have prevented the staff members from repeating their concerns — even to police — unless there was "a significant change in the nature of the concern".

Adam Convisser, an employment partner at Quastels law firm, said: "There is existing guidance and regulation concerning NDAs that prevents them from blocking whistleblowing disclosures."

Ray, who earns a £150,000 salary, will be in parliament this week to answer concerns about the service. The revelations in the report would "undoubtedly" be on the agenda, said Labour's Ian Mearns, Currington's MP. Cover-ups like the one exposed at the NEAS "completely undermine public trust" in the NHS, Mearns said.

The Conservative MP Dehenna Davison, who is the Beadles' MP, said she had contacted Sajid Javid, the health secretary, to raise concerns and to ask that he "personally intervene and look into how NEAS can make urgent improvements". Grahame Morris, the Labour MP for Easington, in the northeast of England, called the culture of cover-ups "outrageous" and a "systemic failure", adding: "We need some urgent corrective action."

Ann Ford, of the Care Quality Commission, said that in May 2020 the CQC had received concerns from an NEAS employee about the safety of patients and attempts by the trust to withhold information required by the coroner.

Ford said: "A thorough review of this information found no evidence that the trust had tried to withhold information from the coroner and also found that they had taken action to improve governance processes and ensure an effective coronial process."

Northumbria police confirmed concerns had been raised by NEAS staff in June 2020. “After officers reviewed the information provided, it was agreed the matters raised should in the first instance be referred to the coroner’s office,” said a spokesman. “There has since been no further police involvement.”

Beattie said in 2019 that concerns were raised by staff relating to the “quality and timeliness of documents disclosed to coroners”.

He said a “task-and-finish group” was established to address the concerns. “The task-and-finish group was concluded in January 2021 with these actions completed and assurances provided to our board of directors that significant improvement had been achieved,” Beattie added.

Cases of concern raised after that date concerned “minor issues” about procedures and policy being followed, with no impact on the families, he said.

The NEAS said that “any suggestion we have not taken action to address these historical issues is wrong”.
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