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## Inquiry into ambulance service failings ruled out



Image caption,  
David and Tracey Beadle said they would keep campaigning for a public inquiry

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**The bereaved family of a teenage girl have hit out at the government for not telling them a public inquiry into an ambulance service had been ruled out.** A previous review into the North East Ambulance Service (NEAS) found multiple failings, including that reports detailing how a paramedic gave inappropriate life support to 17-year-old Quinn Milburn-Beadle were **removed and amended**.

In a letter sent to a Teesside MP in May, health minister Karin Smyth ruled out a statutory inquiry which she did not believe would "bring any new lessons... that would improve patient safety".

Quinn's family, who only discovered the inquiry decision this week, said the issue had been "brushed under the carpet".

Dame Marianne Griffiths' independent review in 2023 found NEAS had provided inaccurate information to the coroner and had a culture where staff were "fearful of speaking up", **for which the service apologised**.

A number of affected families have since called for a public inquiry.



Image caption,

Alicia Watson's son Andrew died in 2019

The letter from the Department of Health and Social Care (DHSC) to MP Luke Myer was shared with the family of Andrew Watson earlier this year.

Mr Watson had died at his home in Langley Moor in County Durham **after waiting for more than an hour for paramedics in 2019.**

His death was not investigated as part of Dame Marianne Griffiths' review but Myer had raised the family's call for a public inquiry.

In response, Smyth offered the family her "deepest sympathies", but added: "Based on the information you have provided, I do not believe that a statutory inquiry will bring any new lessons or information that would improve patient safety at NEAS beyond those identified by Dame Marianne in her report."

Mr Watson's mother Alicia told the BBC: "I fully back a public inquiry because until there's accountability and people held responsible we are never going to get the truth."



**IMAGE SOURCE, FAMILY HANDOUT**

Image caption,

Quinn Milburn-Beadle was not given appropriate life support  
Whistleblower Paul Calvert, an NEAS coroner's officer who **claimed the organisation was covering up important details relating to fatalities**, said the decision had also been confirmed to him, but via a freedom of information (FOI) request.

In response to his FOI, Mr Calvert was told that the secretary of state for health and social care, via Smyth, had "decided in May 2025 that there will be no public inquiry into the NEAS deaths scandal".

He was similarly told of the view that it would not uncover new details that could inform improvements.

Quinn's mother Tracey Beadle said they only found out this week, through Mr Calvert, that a public inquiry had been ruled out.

She asked: "Why were we not told?"

Quinn's father David Beadle added: "It just feels like it's been brushed under the carpet and it's nothing to see here, move on."

They vowed to keep campaigning for a public inquiry.

When asked to confirm if it had ruled out a public inquiry, and if it had told the families, the DHSC said the 2023 review was "highly critical of the trust and outlined how it should have responded to these incidents".

"The trust accepted these findings and ministers have been assured the trust is implementing all of its recommendations."

Kevin Scollay, chief executive of NEAS, said: "The families and relatives in these cases remain at the forefront of our minds and I offer again the apologies previously made by the trust for the distress we have caused them."

"The trust has fully co-operated with the independent review into its services, accepted wholly the recommendations made and acted upon them to improve our services."