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Tribunal hears ambulance evidence 'not disclosed' to coroner

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By **Kayleigh Fraser** Senior Reporter

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NEAS (Image: NEAS)

A senior North East Ambulance Service (NEAS) boss has said that crucial information relating to patient deaths was “not disclosed” to coroners, as key legislation was challenged.

Alan Gallagher, head of regulatory services at NEAS, spoke of “full evidence” including call logs and dispatch reports previously being withheld after deaths during a Nursing and Midwifery Council (NMC) hearing that continued today (Monday, March 23).

His former colleagues Shelley Dyson, formerly head of patient safety, and Joanne Baxter, ex-director of quality and safety, face allegations of “bullying colleagues” and covering up crucial information sent to coroners on patient deaths.

If the claims are proven, the pair, who are both no longer employed by the trust, could be handed a caution, conditions of practice, suspended, or even struck off from nursing altogether. The hearing is expected to wrap up on March 26.

The panel heard evidence from Mr Gallagher regarding a Rapid Process Improvement Workshop (RPIW) held in 2019, which centred around the coronial process.

According to a witness statement by Mr Gallagher, the meeting “quickly turned sour” as Ms Dyson began to question experts and suggested that legislation on what information is shared to coroners, including dispatch reports and call logs, be changed.

He said: “The experts were saying that we had a legal requirement to share relevant information with coroners that included information of staff involvement, and not to redact this was one of the points.

“At one stage, Ms Dyson stated that the legislation needed to change and stated that we should request changes to the law. Ms Dyson wasn’t happy with information being shared to the coroner.

“I had to explain that this was what was required by law.”

Mr Gallagher went on to discuss patient safety incidents, which he said were “not managed well” by the service and impacted what information was given to coroners.

He added that Ms Baxter had “very different views on NEAS processes”, and wanted to write a simpler, summary report to coroners instead of providing all details, saying NEAS had “changed processes” when it came to disclosure.

However, according to Mr Gallagher, this meant that full evidence on cases was not being given to coroners, and despite raising concerns, the ‘summaries’ were still sent.

He said: “We were not sharing full, relevant information with senior coroners.

“We were not disclosing full evidence to the coroner, which would result in the coroner not having full access to all relevant documentation and evidence to consider the case.”

The hearing comes four years after NEAS faced repeated claims it misled coroners before 2020 in a bid to cover up medical mistakes after patients died, prompting families of loved ones affected to call for a public inquiry.

During the first day of the hearing (March 5), Carol Anne McLachlan, safer care manager at NEAS, had spoken of a “toxic” work environment she felt she was working under, adding it was “driven” by Ms Baxter from 2018 onwards.

A witness statement read by case presenter Rowena Wisniewska said: “I felt that the work environment was toxic and it was driven and created by Ms Baxter.

“The toxicity created made it a very difficult to come in to work.”

Ms McLachlan added: “Staff morale was very low. Some people weren’t talking to other people.

“It was just a very challenging time to work in. Nobody knew what they were coming into the next day.

“It wasn’t a pleasant environment to work in. The trust values weren’t being adhered to.”

Whistleblower Paul Calvert first alleged in 2022 that NEAS had misled families and coroners at inquests to cover up medical errors dating back to 2018 and 2019.

He raised the alarm on at least 90 cases where he believes medical reports were changed, meaning crucial details of what happened to people in their final moments, including potential negligence, may have been kept from grieving families.

MPs previously heard Paul was “bullied, harassed and blackmailed” after raising concerns about evidence being allegedly covered up within NEAS, where he worked as a coroners' officer.

NEAS apologised to families affected after a 2023 review and has repeatedly stressed it has improved and enacted 15 recommendations including around its internal culture and communication.

The trust said it has and will continue to support the NMC in its investigation.