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Family's five year fight for justice over brother's death at just 32 after waiting more than hour for ambulance

Andrew Watson died in 2019 - his family are still fighting for justice.

Sam Volpe Health Reporter
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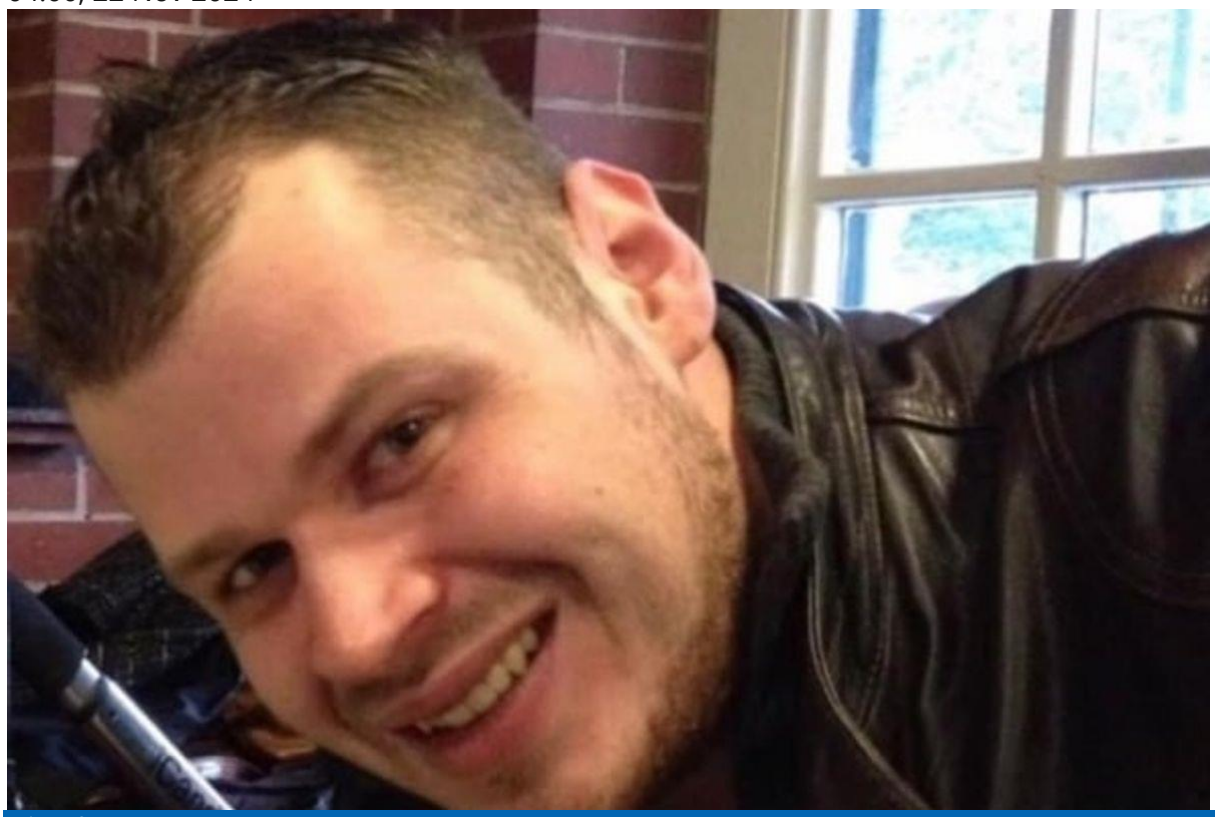

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Andrew Edward Watson, who died after waiting more than an hour for an ambulance(Image: Watson family)

More than five years on from his death, the family of a County Durham man who suffocated while waiting for an ambulance are

determined to continue to fight for justice in the face of alleged "cover-ups".

Andrew Watson, 32, died on October 10 2019. after waiting more than an hour for an ambulance. He had quinsy - an infection in his tonsils which the NHS website describes as a "complication of tonsillitis". The NHS's advice is to do as Andrew did, and call an ambulance or head for accident and emergency.

His case is among those where the **North East Ambulance Service** has come under fire for either withholding or altering documents which ought to have been submitted to a presiding coroner. Others include those of **Quinn Evie Milburn-Beadle** and **Peter Coates**, which were among those examined in a review commissioned by **NHS** England and led by Dame Marianne Griffiths.

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That review found "leadership dysfunction" led to **NEAS** not being as candid as it should have been with the coroner. However, Dame Marianne's review did not consider Andrew's case - and that too is something his family say they are angry about. They have not been involved in subsequent engagement following the scandal - and did not

even know how it touched on Andrew's case until approached by the press in 2023.

Inquest proceedings in Andrew's case were initially discontinued in 2020, but last week were formally re-opened. But Andrew's family fear that their trust in the organisations who should keep us safe has been "broken". The ambulance service has called this a "complex and tragic case" - and said it would be inappropriate to comment further ahead of the planned inquest.

And more recently, Andrew's family were angered to receive a letter in June - via solicitors - in which they were told that Andrew's case did not feature in the "interim Audit One report". Andrew's family said this was "another lie". Andrew's case is in fact examined by that report, which ChronicleLive has seen - **and this has previously been reported in the public domain**.

What happened to Andrew?

On the morning of October 10, 2019, Andrew, who lived in Langley Moor, visited his GP complaining of a sore throat. He was prescribed antibiotics. At 5.43pm that day, he called 999 as he was struggling to breathe. He rang again at 6.23pm. And then, when his condition had worsened to the point he was unresponsive, at 6.35pm, a worker at his supported living facility called again.

At this point Andrew's case was upgraded to the most serious category - 1 - and an ambulance arrived in ten minutes. National target response time for a category 1 call is seven minutes, while for a category 2 call is 18 minutes.

Before the final call, Andrew's case had been graded a category 2 call - Andrew's family believe this should have been treated as a category 1 incident from his first call.

By the time the ambulance arrived at 6.45pm, ten minutes on from the final call, it was too late. Andrew died shortly before 8pm. On returning from the scene, the paramedics involved flagged concerns about the delays Andrew had faced - and this triggered a range of investigations.. Crucially though, neither that these investigations were taking place, nor their findings, were shared with the coroner for months.

Investigations and whistleblowing

After Andrew's death and concerns being flagged internally by one of the paramedics who was concerned that an "opportunity was missed" to get a "quicker response", a number of investigations took place. These included a "root cause analysis" and reviews of the 999 calls made.

In the review of the calls, an investigator said during the first call that: "Although the correct category of response was reached, the correct disposition was not."

And during the third call, the review found there were issues and "a delay" in getting to the correct disposition - which means a decision on whether an ambulance should be sent, with what urgency, and for what reason.

The review of calls - which took place a week after Andrew's death - also found the third call handler should have "coaching" including over not "talking over" callers, given that in the call in question a support worker was trying to explain Andrew was turning blue but was spoken over.

Following that, a "root cause analysis" carried out on December 11, 2019, found that this was a "moderate harm" incident, stating: "The patient died as a result of an un-diagnosed acute medical condition.

Potentially this was a treatable condition if the patient had received treatment earlier."

That report found: "Insufficient resources were available to respond to the demand for that shift compound by delays to hand patients over at hospitals. The patient's condition deteriorated during this delay and was not identified or escalated."

A week later at a meeting it was agreed "that the harm level should be reduced to a low harm incident".

However, none of these documents, or others related to Andrew's case, were shared with the coroner - and in February 2020 whistleblower Paul Calvert, who worked in the trust's coroners and claims team, raised concerns about this.

Paul went public with these concerns - that had also been shared with agencies including NHS England, the Care Quality Commission and **Northumbria Police**. His concerns related to what he said were "cover-ups", where coroners were not being given an accurate picture of investigations into incidents.

Those concerns led to some cases being examined by independent assurance firm AuditOne. The firm's report highlighted how one investigation report shared with a coroner was altered and in "direct contrast" to what had initially been written.

Referring to Andrew's case, the authors of the Audit One report highlighted how there were "several reports [...] completed some considerable time ago yet there does not appear to be any final reports. These reports are relevant to the death and should be disclosed."

In fact, nothing other than an electronic patient record was sent to the coroner until a letter dated May 20 2020 - when call records and reports including the "root cause analysis" report were forwarded along with the following comment: "During the process of reviewing the disclosure to your office it was identified that some information was not correctly shared with the Trust's Coroners and Claims team and therefore not disclosed to your office as a consequence."

What do Andrew's family want?

Andrew's family have said they are furious at the way the death of their loved one has been treated - and they want justice and accountability. Speaking on behalf of the family, his younger sister Rachel Turnbull told ChronicleLive: "It was extremely heartbreaking to get my head around losing him, and what we believed at the time about how he died - only to then find out three years later it was a cover-up.

Rachel said the family continued to grieve and added: "But we still feel we continue to be lied to. We do not know what to believe is the truth, because the trust had been broken."

For herself, Rachel said, there had been serious mental health consequences. "It has utterly destroyed any trust I once had for professionals - and the anxiety, panic attacks and depression I have suffered since still continue," she said. "Especially as every time someone in the family takes ill or has a sore throat it affects us all with anxiety and sadness.

"We as a family want justice for Andrew, he should still be with us and we are still being lied to. No family should have to go through what we have, and I'm sure that every person involved in the cover up would be just like us - wanting justice if it happened to their family."

The family described Andrew, who was originally from Teesside, as a caring and bright man. Rachel added: "He had a very large group of

friends who now only have memories of him. He had a great sense of humour and he was a very kind, caring person who was loved by so many."

Andrew left siblings, his mum and dad, a nephew and nieces, including one who was just 10 days old when he died and was named Grace-Andie in his honour.

Additionally, the family feel that recent public discussions, including an August board meeting where the chair of an independent oversight group referred to other families as "most affected" - and omitted Andrew's family - had been "upsetting". Rachel said this caused them to wonder if Andrew's life was seen as worthless.

What has the ambulance service said?

A spokesperson for the North East Ambulance Service said: "This was a complex and tragic case. As it is subject to an ongoing review by the Coroner, it would not be appropriate for us to comment upon it further until the conclusion of that process. The Trust will fully assist the Coroner with his investigation."

The trust said it would also not able to comment on why Andrew's family and their lawyers had been told he did not feature in Interim Audit One report.

However, when whistleblowers first made the Interim Audit One report public - including in it the review of Andrew's case, NEAS said it had learned from all of these cases but the trust's chief executive Helen Ray accepted "historical failings" and added: "Utmost in our mind are the families and we unreservedly apologise for the distress we have caused to them."

After Dame Marianne's review made 15 recommendations for NEAS and three recommendations for the wider NHS, Mrs Ray said her "door is always open, at any time" to the families involved in these cases, and she also said she was thankful for Paul Calvert's whistleblowing - who she said did "absolutely the right thing", adding: "At the time I do not think we acted quickly enough."

Referring to how this lack of candour happened, she said issues had occurred when processes had not been followed.

"Where unfortunately we have stepped outside of these processes, that's where we have encountered problems," she said. Mrs Ray added that she knew the families affected by this had "deserved better".

The re-opened inquest proceedings into Andrew's death continue and there will be a formal Pre-Inquest Review at the Durham and Darlington Coroner's Court in February 2025.