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Ambulance delays 'contributed' to County Durham man's death in case which saw 'gerrymandered' NHS investigation

Andrew Watson died 67 minutes after dialling 999

The ambulance service response to Andrew Watson was 'too slow'(Image: Handout / NEAS)

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By the time paramedics arrived to try to save the life of a County Durham man, “the cause was already lost” because of more than an hour of **delays in getting to him.** Andrew Edward Watson died due to a quinsy 67 minutes after calling 999 on October 10 2019, an inquest heard.

Senior assistant coroner Crispin Oliver told Crook Coroner’s Court that he had found “delays in the response of the ambulance service” had meant “emergency treatment [...] was not delivered in time”. The 32-year-old had been living in supported accommodation in Langley Moor.

The coroner also added that he had been “baffled” by the “perverse” situation which meant that because Andrew had called 999 himself, his choking symptoms could not generate a higher priority - category 1 - response. He is now to write to NHS England raising this concern.

On the morning of his death, he had reported to staff from Potens which runs the accommodation that he had experienced choking overnight and struggling to **breathe.** He attended his GP surgery and saw a nurse practitioner - Jacqueline Griffiths.

The court heard how she had not seen signs of quinsy, which is a complication of tonsilitis which sees a swelling of the tonsils block one’s airway.

In delivering his judgement, the coroner Mr Oliver’s said: “Had ambulances been more readily available, Andrew probably would have survived. In effect, service delays contributed to his death.”

He added: “Andrew was pronounced dead at 19.45pm on 10 October 2019 at Cecil Court, Langley Moor from a critical medical condition

requiring emergency treatment for survival. This was not delivered in time because of delays in the response of the ambulance service."

Mr Oliver also found that at the time of the arrival of paramedics William Parry and Catherine Wilson, "At that point Andrew's medical condition had ceased to be survivable."

The inquest's conclusion comes close to seven years after Andrew's death and follows his family fighting to re-open the formal investigation into what happened. This was necessary as the case is one to have figured in failings at the North East Ambulance Service with regard to the "covering-up" of safety investigations.

The coroner Mr Oliver said that while his role was not that of a public inquiry and he had not been tasked with examining "governance" at NEAS, that he had felt it necessary to adopt "permissible" attitude to questioning about how the aftermath of his death was handled.

The inquest heard how Andrew's case, like a number of others as disclosed by whistleblowers in 2022, saw the purported "harm level" downgraded by then-senior personnel.

It was only after media coverage of whistleblowing concerns around **"covering-up" of safety investigations**, which saw NEAS' then chief executive Helen Ray accept there had been "historical failings", that Andrew's family became aware of any investigation in his case at all.. In November 2024, **the family told ChronicleLive of their five year fight for justice.**

In his remarks, Mr Oliver said: "There is public interest in shedding light onto how a vital public service reports to the Coroner and also investigates itself in relation to a fatal incident concerning a member of

the public it was tasked to serve and strive to save. This is particularly so precisely because there is no Public Inquiry available.

“Secondly, it is reasonable for me to infer that that which NEAS have admitted in terms of ‘poor management and governance in [its] investigation’ has impacted directly on the coronial process.”

He added that some staff - notably the paramedics who attended Andrew and whose integrity he commended - had been “candid from the outset that the facts and implications of this case had to be taken seriously and investigated properly”.

But Mr Oliver said: “What can only be described as at best an ‘unhelpful’ element entered the process at an [root cause analysis] meeting and he referred to how the paramedics had suggested there was “jerrymandering” [sic] of evidence to “make the harm level settled upon fit the response timings”.

Mr Oliver said he is to write to NHS England under his duty to issue a prevention of future deaths notice where he feels is appropriate. He said he will highlight the issues which prevented Andrew’s death being given a higher priority response.

Mr Oliver said: “I remain baffled as to why choking due to intrusion of a foreign object generates a Category 1 response whereas choking due to a preventable but equally life-threatening natural cause generates only a category 2.

“It appears that because Andrew was, for the first two calls he made, making the calls himself and that they were not made by a third party that this was material to the **categorisation.** It seems somehow perverse that because he self-helped, this somehow reflected in a lower categorisation.”

Karen O’Brien, Deputy Chief Executive at North East Ambulance Service, said: “We are truly sorry for Andrew’s death and the distress caused to his family. We did not respond as quickly as we should have when he called us, and we have always acknowledged that this delay likely contributed to his death.

“We have taken significant steps since 2019 to reduce the delays to ambulance responses, which has included substantial investment in more paramedics and more ambulances. Today, our service is performing more strongly and reaching people faster.

“The coroner highlighted flaws in our investigation and governance processes at that time which was extensively reported upon in 2023 and have been addressed with oversight from NHS England.

“This has been a profoundly tragic case which has had an impact on everyone involved. We hope the inquest has provided answers for the family, although we know it does not ease the pain of their loss.”