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Coroner highlights 'knock-on effect' after inquest takes almost 7 years following ambulance service delays

Senior assistant coroner Crispin Oliver spoke in his final judgement in the case of Andrew Edward Watson about the impact of delayed justice.

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Sam Volpe Health Reporter
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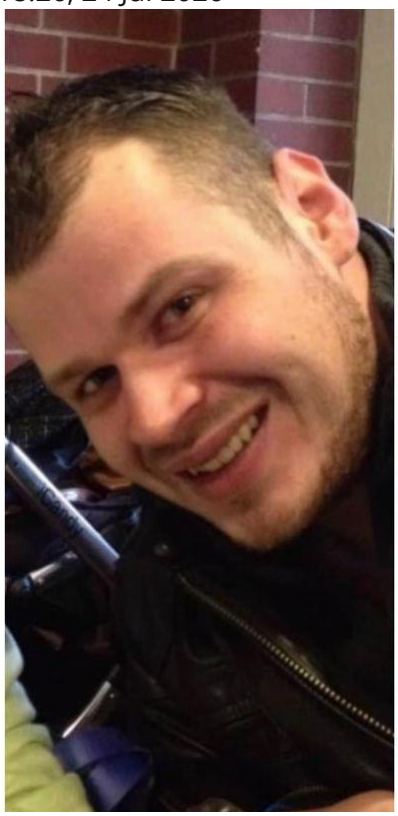

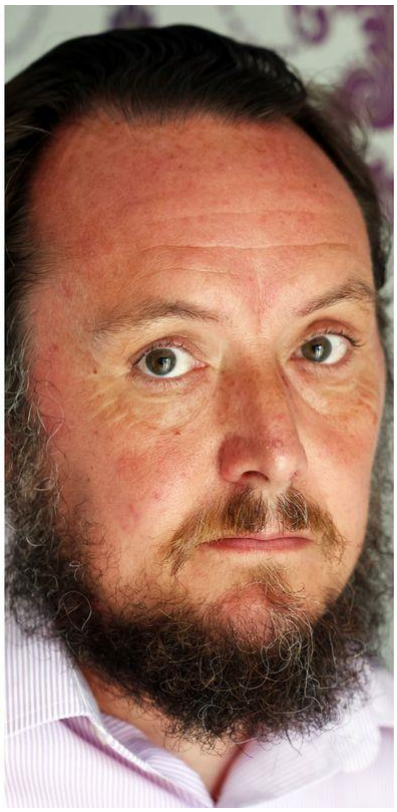

Andrew Edward Watson (left) died after ambulance delays getting to him. Paul Calvert (right) whistleblew about failings in what coroners were told.(Image: Handout / ChronicleLive / NEAS)

During 2021 and 2022, **North East Ambulance Service whistleblower Paul Calvert** approached the media with a story. He told us how there were cases where NEAS personnel were n**ot being candid** with coroners about a number of cases where care had gone wrong in some way - and resulted in someone's death.

That saw some reports not shared at all, or others shared in an amended form. NEAS says these governance issues have been "addressed with oversight from NHS England".

The names of some of those affected may be, by now, known to readers: Quinn Evie Milburn Beadle, Peter Coates, Andrew Watson. 2026 has seen inquests highlight the failings that led to the latter two deaths, but only after delays of more than five years in each case. This week following Andrew's inquest, a coroner has highlighted how this issue led to delays in justice for his family.

Andrew died after there was a 67-minute delay between his first 999 call and an ambulance arriving at his Langley Moor flat. He was just 32. **The inquest's conclusion was that the delay had "contributed" to his death - and that by the time paramedics had arrived, "the cause was lost".**

While clear that his role was not to examine governance issues or replicate a public inquiry, senior assistant coroner Crispin Oliver's judgement included that, in the case before him:

- "What had happened is that NEAS staff had not shared relevant information with the Senior Coroner at the time of his Investigation."
- Mr Oliver also highlighted that staff - and especially the paramedics who attended the scene and tried to save Andrew's life - had been clear at the time "that the facts and implications of this case had to be taken seriously and investigated properly".
- But that this candour was overruled at meetings which were held in an "autocratic" style by NEAS' then head of patient safety Shelley Dyson.
- Mr Oliver's remarks also made clear that on the evidence in his courtroom, other staff had not agreed with a decision to downgrade the stated level of "harm" attached to Andrew's case. It had previously been deemed "severe".
- Mr Oliver added that the evidence of Donna Hay, who had written a "route cause analysis" of what had happened in Andrew's case was that Ms Dyson had run the meeting “autocratically”, that “individuals’ views were dismissed” and seemed to have a “conclusion in mind that she wanted to reach that the rest in the room did not agree with”.
- The court heard evidence from one paramedic that they believes the evidence was "jerrymandered" [sic] to meet such a conclusion. In the end, the case was deemed to have had "moderate" harm - but then the reports author Ms Hay was not invited to a follow-up meeting.
- At that further meeting, in January 2020, of a group set up to review serious incidents, this case was again considered. It was reported that Andrew's case had been one of "moderate harm". The same meeting heard NEAS had been told to report cases of moderate harm to the relevant coroner. In Andrew's case, a coroner was not told about this until May.

- This delay saw the coroner close the previously opened investigation. The inquest proceedings were not re-opened until late 2024.
- Mr Oliver has also discussed the consequences caused by a near-seven-year interval between Andrew's death and the inquest taking place. He said: "This has inevitably had a knock-on effect on the quality of the evidence provided to the Inquest. It is now closing on seven years since the events surrounding Andrew's death. Passage of time has inevitably impacted on all the witnesses, notably in my view, those from Potens."

NEAS has previously made public apologies about what happened in Andrew's case, and others including those of Peter Coates and Quinn Evie Milburn Beadle. In 2022, Paul Calvert publicly disclosed how an external report by firm AuditOne had found that correct process with regard to what was being shared with the coroner was not being followed as of Spring 2020. Mr Calvert had raised concerns internally prior to this on numerous occasions.

The AuditOne report produced at that time, so when Andrew's case was months old, rather than years, highlighted: "The coroner is not being made aware of concerns and / or investigations being carried out by the trust in a timely fashion."

Dame Marianne Griffiths then, in 2023, **completed a review of some of the cases** - though not Andrew's. She found the lack of disclosure had been contributed to by "leadership dysfunction". Again, at this time, NEAS bosses reiterated apologies.

Senior figures at the time including former chief executive Helen Ray accepted that staff had made "grave errors". Mrs Ray also told **ChronicleLive** she had been thankful for Paul Calvert's

whistleblowing - she said he did "absolutely the right thing". She added: "At the time I do not think we acted quickly enough."

Mrs Ray continued: "Firstly, I would like to say how sorry I am for any distress caused to the families for mistakes made in the past. Each family has received an unreserved apology from me on behalf of the trust. There were flaws in our processes and these have now either been addressed or are being resolved at pace."

Ms Dyson - and her former direct superior ex-NEAS director Joanne Baxter continue to be subject to **a fitness to practice tribunal** brought by the Nursing and Midwifery Council - though this was adjourned earlier this year until January 2027. In the tribunal thus far, they were accused of "directing" attempts to conceal documents from coroners. They deny the charges against them.

Following Andrew's inquest, 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."