COUNTER FRAUD

WORKFORCE INVESTIGATION: INTERIM REPORT

North East Ambulance Service NHS Foundation Trust

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INTRODUCTION

As a result of concerns raised in relation to the coronial process adopted by North East Ambulance Service NHS Foundation Trust (NEAS), an independent review was carried out by legal firm, Ward Hadaway. Ward Hadaway were requested to review 4 Coroner's cases that had caused particular concern and a report of the findings was produced in August 2019.

The purpose of this investigation is to establish whether the Trust's coronial process meets legislative and policy requirements, particularly in respect of the accuracy and completeness of information disclosed.

The investigation is to include consideration of the review by Ward Hadaway and whether the specific concerns raised have been addressed by the Trust and recommendations implemented.

The investigation will also review the relevance and robustness of the Trust's policies and processes in place in relation to the preparation and submission of information for coronial investigations and will include a review of a sample of cases to support the findings. The sample will include the case of QM which is due to be heard in the Coroner's court on 30 March 2020.

The scope of this investigation had already been drafted by the Trust at the point the investigation was commissioned.

AIMS

To establish:

- all relevant legislation, policies and guidance for the purposes of the Trust's coronial process.
- whether the Trust's coronial process adheres to the relevant legislation, guidance and policies.
- whether the Trust's coronial process is fit for purpose.
- whether the concerns raised by Ward Hadaway's review have been addressed.
- whether recommendations made by Ward Hadaway have been implemented.

FINDINGS

This interim report details the initial findings however, the investigation remains ongoing. The final report will address all areas under review including any necessary recommendations to improve the Trust's coronial process. It may be necessary to submit a further interim report(s) as the investigation progresses.

Legislation

Coroners and Justice Act 2009

It is the duty of the Coroner to inquire into the causes and circumstances of a death under the Coroner's and Justice Act 2009.

Part 1 Chapter 1 – Investigations into deaths

Section 1 - Duty to investigate certain deaths

A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if the coroner has reason to suspect that

- the deceased died a violent or unnatural death,
- the cause of death is unknown, or
- the deceased died while in custody or otherwise in state detention.

In addition, although not specified within the Act, the Coroner will also investigate where the deceased has not been seen by the doctor issuing the medical certificate, or during the 14 days before the death (CPS legal guidance – Coroners – updated 3 December 2019).

Section 5 – Matters to be ascertained

The purpose of an investigation into a person's death is to ascertain:

- Who the deceased was;
- How, when and where the deceased came by his or her death; and,
- The particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.

Section 6 – Duty to hold an inquest

A Senior Coroner who conducts an investigation into a person's death must (as part of the investigation) hold an inquest into the death if he has reason to suspect

- the deceased has died a violent or unnatural death,
- the cause of death is unknown, or
- the deceased died while in custody or state detention

Schedules

Schedule 5

Schedule 5 provides a Senior Coroner power to require a person

- to produce any documents in the custody or under the control of the person which relate to a matter that is relevant to an inquest and/or an investigation, or
- to produce for inspection, examination or testing any other thing in the custody or under the control of the person which relates to a matter that is relevant to the investigation.

A document or thing is under a person's control if it is in the person's possession or if he or she has a right to possession of it.

A person may not be required to give, produce or provide any evidence or document if he or she could not be required to do so in civil proceedings in a court in England and Wales.

Schedule 6

Schedule 6 defines that it is an offence for a person to do anything that is intended to have the effect of

- distorting or otherwise altering any evidence, document or other thing that is given, produced or provided for the purposes of an investigation under this Part of this Act, or
- preventing any evidence, document or other thing from being given, produced or provided for the purposes of such an investigation,
- or to do anything that the person knows or believes is likely to have that effect.

The schedule also defines that it is an offence for a person

- intentionally to suppress or conceal a document that is, and that the person knows or believes to be, a relevant document, or
- intentionally to alter or destroy such a document.

A document is a “relevant document” if it is likely that a person conducting an investigation under this Part of this Act would (if aware of its existence) wish to be provided with it.

A person guilty of an offence is liable on summary conviction to a fine not exceeding level 3 on the standard scale, or to imprisonment for a term not exceeding 51 weeks, or to both.

Coroners (Inquest) Rules 2013

Rule 8

Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable.

Coroners (Investigations) Rules 2013

Paragraphs 28 and 29

Following an inquest, the Coroner can make recommendations to prevent future deaths from occurring, previously known as a 'Rule 43 Report' but now known as a 'Preventing Future Deaths Report' or 'PFD Report'.

The respondent is given 56 days to reply in writing, giving details of actions that have been taken or proposed to be taken, or an explanation as to why no action will be taken to prevent future similar deaths.

Legal Advice

Email dated 15/07/2019

[redacted], Ward Hadaway, provided Joanne Baxter with legal advice given to the Trust recently on several topics in relation to the coronial process. This advice is summarised below:

Disclosure of draft and final documentation

Coroners are entitled to all relevant documentation relating to an Inquest. The final report will normally suffice along with supporting standalone reports however the Coroner has the power to request working drafts.

Staff involved in investigations should only comment within the scope of their practice and knowledge.

If further evidence comes to light following finalisation of a report, the final report should be disclosed together with a clarification report or statement.

Communication between the Trust's teams

The Coroner's team is the conduit between the Trust and the Coroner and as such should be aware of all documentation and investigations relating to a patient who is the subject of an inquest, in order to ensure that all relevant material is disclosed. If the team are not aware of reports and other documents, there is a very real risk that information which should be given to the Coroner by the Trust is missed.

Trust "committee" review of disclosure before the same is sent to a Coroner

Patient care records, audios, call logs and items such as Recognition of Life Extinct forms are primary source material akin to medical records which must be disclosed in their original format and should be actioned as soon as possible. The Trust should review material before disclosure in order to ensure it relates to the correct patient, there is no third party non-relevant confidential information which should be redacted and to ascertain whether the Trust needs to commence an investigation. Reviews should be regular and frequent.

Redaction of information from Coronial disclosure

Coroners legislation does not specify circumstances in which material can be redacted, however this does not mean that a party is strictly prohibited against redaction of information in circumstances when such redaction is appropriate i.e. information relating to third parties, sensitive material relating to criminality, which may be unsubstantiated and of no relevance to the Coroner's Inquest.

Email dated 04/12/2019

On 4 December 2019, [redacted] was asked to provide legal advice on whether the Trust should be reporting deaths to the Coroner where there has been a delay in ambulance attendance. [redacted] emailed the advice to Joanne Baxter that same day.

The advice given is that the Trust should report such deaths to the Coroner. The Coroner will want to be made aware of the delay irrespective of whether there were any missed opportunities and notwithstanding the Trust's view that the patient would have died in any event.

If the Trust's preliminary investigations suggest that there were no missed opportunities and/or that the patient would likely have died in any event, the Trust can put these views (properly evidenced) to the Coroner. The Coroner should take this evidence on board however, the Coroner will likely wish to undertake his or her own investigations and will need to weigh the Trust's evidence against that of other parties, such as the family, police, hospitals, the pathologist etc. A Coroner could also decide to obtain his or her own independent medical evidence from a doctor with respect to causation and whether, in fact, the delay caused or contributed to the death. This is ultimately a question to be answered by the Coroner (potentially assisted by an expert) and not the Trust.

A Coroner's investigation and Inquest is purely a fact-finding inquiry. If there has been a delayed ambulance attendance, this is a pertinent fact that the Coroner should be made aware of.

Furthermore, even if the evidence indicates that the delay did not cause or contribute to the particular patient's death in question, Coroners have wider powers pursuant to Coronial legislation to write Regulation 28 Reports for the Prevention of Future Deaths where they feel that unsafe systems and processes are at play which place the public at risk. Coroners are duty bound to write such reports where they perceive such a risk to exist.

SEACARE Process

SEACARE group

SEACARE was introduced following a Rapid Process Improvement Workshop (RPIW) in May 2019. The SEACARE group meet to share and review information disclosure to ensure its quality, accuracy and objectivity.

SEACARE group is chaired by Head of Patient Safety & Experience, Shelley Dyson with Vice Chair being Head of Risk and Regulatory Services, Alan Gallagher. Meetings are held every Tuesday and can be deferred for one week only in exceptional cases.

The group consists of

- Safety (Patient Safety)
- Experience (Complaints)
- Adult (Safeguarding)

- Children (Safeguarding)
- Audit (Learning from Deaths)
- Risk (Coroners and Claims)
- External (Subject Access requests)

A representative from each team is required to be present at the weekly meetings.

Each team is required to submit a weekly report to the Patient Safety Team (PST) members for discussion the day prior to the meeting. The Patient Safety team members are

- Shelley Dyson (SD)
- [redacted]
- [redacted]

The meeting administrator will maintain an action log during each meeting.

Classification of documents

2 types of documents subject to disclosure have been identified

- Those that may be "locked down" at the end of the episode of care and contain no subjective opinion in their content or may be generated by individuals during inquiries and investigations. These include:
    - Electronic Patient Report Form (EPRF)
    - Control logs
    - Recognition of Life Extinct forms (ROLE)
    - Audio files for call recordings
- Documents generated by individuals after an episode of care which include:
    - Review reports e.g. call reviews, delay reports
    - Records of case discussions e.g. Clinical Review Group discussions (CRG)
    - Complaint investigations, reports and final letters
    - Staff statements
    - RCA documents

These lists are not exhaustive.

Watermarked templates (working copy) have been produced by SEACARE for the various reports/statements that may be requested.

Requests for reports/statements are emailed to the relevant team and copied into the PST.

The receiving team are required to inform PST of the allocated author and expected date of completion of the report/statement.

Any junior member of staff is required to have their report/statement checked by supervision prior to submission. The checked working copy must then be emailed direct to PST for review at the next SEACARE meeting. Once cleared for disclosure the watermark will be removed and forwarded to the Coroners and Claims Team (C&C) for disclosure.

C&C have direct access for disclosure purposes, to "locked down" (primary source) documents which can be disclosed without delay. All other documents must go through SEACARE for checking and authorisation prior to disclosure.

HMC07 Procedure for management of Coroners

This document provides guidance on the management of Coroner's requests for disclosure.

The document outlines 8 different procedures to be followed, dependant on what is being requested. The document does not provide easy to follow instructions which could cause unnecessary delays.

IN SUMMARY

It is the duty of the Coroner to establish the causes and circumstances surrounding a person's death. This is not the duty of the Trust. The duty of the Trust is to disclose to the Coroner any information (document or thing) relevant to an inquest and/or investigation into the death of that person. The Coroner has the power to require this disclosure.

Any concerns raised and investigated by the Trust such as delays in attendance/clinical assistance are relevant to the death and should be disclosed. The Trust should be aware at the point of these concerns being raised, that the Coroner would want to be told so that this information can be considered as part

of the Coroner's investigation/inquest. The Coroner cannot consider any information that they are not or have not been made aware of.

There should be no unnecessary delay in disclosure and the Trust should not wait for the Coroner to request the information. The disclosure should not be limited to only that which the Coroner specifically requests but should include all information relevant to the death. The Coroner is required to complete an inquest within 6 months of the date on which they become aware of the death. The delay of disclosure of information may result in an inquest being re-opened, an exhumation of a body and/or a cause/circumstance of death not being established.

The Coroner is also required to produce a Preventing Future Deaths Report (PFDR) when risks have been identified during the course of the investigation/inquest. Delays in attendance/clinical assistance may be relevant to such reports and not disclosing the same may result in a PFDR not being completed.

The Trust have received legal advice from Ward Hadaway which reiterates the requirement for the Trust to pro-actively disclose information to the Coroner and to review documents prior to disclosure to ensure they relate to the correct patient and to redact any sensitive/third party information. The advice also outlines the importance of the C&C team being made aware of all relevant information as they are the conduit between the Trust and the Coroner.

The SEACARE process was introduced by the Trust in May 2019 to ensure quality assurance and quality control in the delivery of disclosure to the Coroner.

Case Reviews

The following cases have been reviewed and support the initial overall conclusions reached within this investigation. Only dates from the individual timelines relevant to the conclusions are included in this report.

The case of QM (HMC 2011) will be reviewed end to end, however initial findings only are described within this interim report.

HMC 2011

Background

On 9 December 2019 QM, 17 years old, was found by police hanging from a tree a short walk from her home. The officers cut her down from the tree and commenced CPR. A rapid response vehicle (RRV) was the first to arrive on scene and the paramedic declared Recognition of Life Extinct (ROLE). Following this declaration, a [redacted] also arrived on scene followed by a double crewed ambulance (DCA).

09/12/2018

Concerns were raised by the crew of the DCA that full advanced life support (ALS) procedure was not followed prior to ROLE being declared despite QM being warm to touch and cardiopulmonary resuscitation (CPR) having been performed by police. A NEAS07 was completed.

10/12/2019

Similar concerns were reported by clinical audit team regarding the lack of detail in relation to symptoms recorded on EPRF and ALS procedure not being followed and a further NEAS07 completed. This NEAS07 expresses opinion that CPR should have been given.

An internal investigation was commenced by the Trust and [redacted] assigned as Investigating Officer.

18/03/2019

The investigation report was completed by [redacted] and emailed to Shelley Dyson (SD), Alan Gallagher and [redacted]. The report concluded that guidelines with regards to ROLE had not been applied correctly and that ALS should have been commenced.

20/03/2019

The Coroner emailed C&C informing [redacted] had been made aware that NEAS were carrying out an investigation in relation to CPR at scene. The Coroner requested the report and queried why the Trust had not informed of their investigation. An inquest was to be held on 23/04/2019.

26/03/2019

A strategy meeting took place to discuss the contents of [redacted] report and a decision was reached that findings in relation to the ECG activity should be removed and the conclusions amended. No minutes were taken of this meeting and nothing was documented as to the rationale behind the

decision. [redacted] amended the report and the following paragraph was removed from the report in its entirety.

The only recorded ECG activity lasts for a total of 16 seconds (19:36:05 - 19:36:21) and on review does not indicate a reading of Asystole. It does indicate significant disturbance throughout with no rhythm recognition (APPENDIX 6 & 7).

The conclusions were also amended from

In conclusion, in relation to this Incident, the Investigating Officer has established that local procedures and JRCALC Guidelines with regards to Recognition of Life Extinct have not been applied correctly. Equally, the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard. Given the circumstances, recorded and explained by all who attended, Advanced Life Support could and should have been provided.

It is the Investigating Officer's recommendation that separate consideration as to all contributory factors involved in the decision-making at this Incident is taken into account in order to address the concerns.

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In conclusion, in relation to this Incident, the Investigating Officer has established that local procedures and JRCALC Guidelines with regards to Recognition of Life Extinct have not been applied correctly. However the decision not to start ALS upon reflection was the correct decision, the patient had fixed and dilated pupils, had absent pulses and purple ligature markings around the neck and CPR with ALS would not have had a positive outcome. It was found however during the investigation that the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard and further training is required to ensure these issues are addressed.

Other amendments were made including the removal of the following sentences:

The attending paramedic has stated asystole was witnessed on the ZOLL monitor. *Retrieval of this activity on the ZOLL does not confirm this.*

Subsequently GW has confirmed that on reflection he should have provided Advanced Life Support at this incident.

Concerns remain in relation to the ECG with no evidence of an asystolic reading. There are additional concerns that no effort was made to clear the patient's airway, that Basic Life Support was not continued, and Advanced Life Support was not attempted.

28/03/2019

[redacted] sent an email to [redacted] and Darren Green (DG) requesting advice from [redacted] whether [redacted] was able to accept the changes suggested by [redacted] and as an independent IO side entirely with the paramedic's decision making despite the lack of supporting evidence. I have not had sight of the reply.

29/03/2019

The amended report was disclosed to the Coroner minus the appendices, one of which was the ECG activity strip.

01/04/2019

[redacted] being the author of the investigation report was requested to represent NEAS at the inquest, however the inquest was subsequently adjourned as the Coroner was unable to conclude.

24/04/2019

Coroner requests statement from clinical manager who signed off report to explain the investigation report conclusions.

07/11/2019

A final response letter was sent by Chief Executive Officer Helen Ray, to the family addressing complaints/concerns raised by them in relation to the handling of the case by NEAS. Within this letter the following statements were made to the family:

> *Scrutiny on incidents and their management - We have established a group adjacent to the Clinical Review Group to triangulate all INCIDENTs rated moderate or higher, patient deaths, Coroner cases, deaths known to safeguarding, and complaints. This group – known as SEACARE- has a robust tracking and monitoring system to ensure RCAs are managed appropriately and within*

agreed timeframes, as well as ensuring duty of candour is enacted and sufficient information is escalated to the Clinical Review Group.

Information Sharing with Coroner - We now notify the Coroner pro-actively if there is any investigation into an incident involving a patient death, even if the incident is not moderate, severe, or catastrophic in severity.

Conclusions for HMC 2011

The Trust commenced an investigation into the failure to follow ALS procedure on 10/09/2018, the day after QM's death. This was not disclosed to the Coroner.

The Coroner should have been made aware of the concerns under investigation by the Trust on or soon after 10/12/2018 as the Trust would have been aware that this information would be required by the Coroner.

The Coroner requested the investigation report on 23/03/2019 having learned of the NEAS investigation from an external source.

The investigation report was reviewed at a strategy meeting on 26/03/2019 and amended by someone other than the author. The amendments removed a critical fact and changed the conclusions so dramatically that it did not reflect the findings within the report, nor the original conclusions drawn by [redacted] The most crucial part of the new conclusions was in direct contrast to the original conclusions so much so that the Coroner subsequently requested a statement from the [redacted] who signed off the report.

Although [redacted] accepted the amendments this was with reluctance as [redacted] sends an email seeking advice whether [redacted] should change [redacted] conclusions despite the lack of supporting evidence.

[redacted] has subsequently provided a statement confirming [redacted] did not feel [redacted] could raise [redacted] concerns as the strategy meeting was very high level with very senior members of the Trust who outranked [redacted]

The original report of [redacted] should not have been amended by someone else to reflect conclusions which were in total contrast to [redacted] own conclusions. [redacted] is a [redacted] and [redacted] findings and conclusions were within the scope of [redacted] practice and knowledge.

Any conflicting/different professional opinion should have been submitted by way of a separate statement or report from the [redacted] including the rationale for their conclusion. This would have provided openness and candour to all and would allow the coroner to properly assess and reach a conclusion or seek independent opinion.

[redacted] was requested to attend the inquest to provide evidence in relation to the findings of [redacted] investigation. The conclusions documented within the report that was disclosed was in direct contrast to the original conclusions drawn by [redacted] This would in essence mean that if [redacted] gave evidence to reflect the report which had been disclosed, [redacted] would commit a criminal offence of perjury and if [redacted] gave [redacted] evidence truthfully this would be in direct conflict to the report. [redacted] should never have been placed in this detrimental position.

HMC 2193

Background

At 17:38 on 10 October 2019 32 years old male, AW, contacted NEAS complaining of breathing difficulties, swelling of his throat and vomiting blood. A further call was received from AW at 1823 reporting deteriorating conditions. AW resided in a specialist community supported living facility and at 18:35 staff contacted NEAS to report AW unresponsive and the incident was re-graded to C1. Crew arrived on scene at 18:45 [redacted] ALS was performed however AW passed away.

11/10/2019

Attending [redacted] raised concerns the following day, around the delay in clinical assistance and potential missed opportunity in recognising the extent of AW's illness. An incident report was created, and statements requested from both [redacted]

15/10/2019

Discussed at SEACARE and decision made that case is to go to the Clinical Review Group (CRG) on 22/10/2019.

17/10/2019

A working copy of the Call Review Report is completed and concludes that grading C2 is appropriate, but some learning is identified for the Health Advisors.

22/10/2019

Case taken to CRG who agreed the incident did not fit the criteria for a Serious Incident (SI) but confirmed harm as moderate due to concerns that AW had seen his GP earlier that day and the delay in ambulance arrival. Decision made that a Root Cause Analysis (RCA) investigation should be completed.

29/10/2019

Dispatch review requested.

A working copy Dispatch Investigation Report has been already been completed but is undated. This report concludes the response time as 63 minutes but no missed opportunities to dispatch earlier.

11/12/2019

A working copy RCA report is completed which documents that the final report will be disclosed to the Coroner and NOK, should contact be established.

The report findings note:

> *it is likely the patient would have benefited from earlier treatment and intervention which would have included advanced airway management. It is possible that if treatment had of been started earlier then the chance of survival would have been increased. A delay in receiving an ambulance response is likely to have contributed to this outcome.*

20/12/2019

RCA panel agreed to reduce harm classification to low. Rationale being although harm may have been caused, calls handled correctly and no missed dispatch opportunities. It was agreed however the SD should still present at SIRG as there was still a feeling it could have been a moderate harm incident.

27/02/2020

Request from Coroner for report from [redacted] to assist pathologist in determining cause of death and to include explanation regarding a lump on deceased's throat.

EPRF supplied to the coroner that same day.

C&C note there are no concerns raised by the Coroner at this point however a delay in clinical assistance investigation is linked to the deceased and SEACARE is contacted to establish whether the report should be disclosed and if so what and how much. No response has been received from SEACARE to date.

Conclusions for HMC 2193

The attending [redacted] raised concerns regarding delay in clinical assistance the day following AW's death and an investigation commenced. This investigation was not raised with the C&C Team and has therefore not been disclosed to the Coroner.

On 11/10/2019 it is noted that statements had been requested from both attending paramedics. There is no record of these statements having been obtained however if they exist these would be relevant to the death and disclosable.

There are working copies of a Call Review Report, Dispatch Investigation Report and RCA report. All 3 reports were 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 to the Coroner.

Coroner requested a report from [redacted] on 27/02/2020 to assist the pathologist in determining death and does not appear to be aware of the NEAS investigation to date._

HMC 2164

Background

At 10:15 19 December 2019 [redacted] contacted NEAS reporting [redacted] 62 years old, had fallen onto a washing basket and pierced his side with significant blood loss. [redacted] is conscious and breathing and the incident is graded as C2.

A further 4 ETA calls were received describing a deteriorating condition with the last being at 11:04. [redacted] rings back at 11:14 and incident re-graded to C1 at 11:20 as [redacted] was now described as unconscious. Crew arrive on scene at 11:22 some 1 hour 7 minutes after initial call. [redacted] was declared deceased on scene.

29/12/2020

Working copy of EOC Clinician Call report is prepared which identifies several areas of concern and requests an investigation into whether there was a missed opportunity to allocate a resource from the first call (after the dispatcher reviewed the case at 10:38) given that it would have been appropriate to allocate a specialist trauma resource.

The timeline within the report documents the arrival on scene as 11:22:10, a delay of 1 hour 6 minutes and 40 (34) seconds from the initial call at 10:15:36

A working copy of a Dispatch Report is also prepared but is undated. This report concludes there were no missed opportunities to allocate a resource earlier.

31/12/2020

Case discussed at SEACARE and decision made to take full case to CRG on 07/01/2020.

07/01/2020

CRG meeting held and incident declared as a Serious Incident (SI) based on the 1 hour 7 minutes delay. Patient Safety Team to arrange RCA.

09/01/2020

Coroner informed death has been declared a SI and the STEIS (Strategic Executive Information System) report is disclosed which highlights the concerns as delay in C2 response and deteriorating patient.

Information within the STEIS report appears to be misleading regarding the time of arrival on scene however this may be unintentional.

The report states:

> *Call was received on the 19th December 2019 to the 999 Service at 10:15 am from the patient's* [redacted] *The patient was reported to have fallen onto a washing basket and pierced his side. Blood loss was described as significant; however the patient was conscious and breathing and the call*

was triaged to a C2 disposition. A further 4 calls were received up to 11.04 describing a deteriorating condition. The last call described the patient as now unconscious, and the patient was re triaged to a C1 disposition and a response arrived within 6 minutes. HEMS were also dispatched and assisted with resuscitation efforts. Patient was sadly declared deceased on scene.

This suggests the last call was made at 1104 and the incident is re-graded to C1 with the crew arriving within 6 minutes which would be 1110.

The EOC Clinician Report documents the last call being [redacted] ringing back at 11:14:06, the re-grading at 11:19:56 and the arrival on scene at 11:22:10.

On the same date C&C highlight 2 NEAS07 reports linked with deceased to SD.

667614 – Incorrect End Disposition

667689 – Delay in Clinical Assistance

These reports have not been viewed.

13/01/2020

72-hour report completed which documents an incident investigation meeting is to be held early February and the investigation report will then be presented at Serious Incident Review Group (SIRG) in February 2020.

12/02/2020

SD clarifies with C&C that there have been no more communications with the Coroner since 09/01/2020.

Conclusions for HMC 2164

The Coroner was correctly informed that the incident had been declared as SI on 09/01/2020

The 2 draft reports which were available on 09/01/2020 are relevant to the death and require finalisation for disclosure to the Coroner. There is nothing recorded to explain the lengthy delay in a final report being authorised.

HMC 2112

Background

At 04:01 14 March 2019 bed bound 62 year old male, PC, contacted NEAS reporting due to power cut he is having difficulty in breathing as his oxygen machine has stopped working.

1st crew dispatched were unable to leave the station due to failure of electronic gates and being unaware of manual override.

2nd crew dispatched requested to refuel prior to attendance and upon arrival at address could not initially locate safe keys to secure entry.

Upon entry male found deceased in bed.

2nd crew arrived within 14 minutes however total of 34 minutes elapsed from 1st crew dispatched.

14/03/2019

Investigation commenced.

NEAS07 651873 created by EOC Dispatch in relation to Patient Safety for difficulty in obtaining clinical assistance.

15/03/2019

Estates notified to comment on manual override of gates in the event of this happening again.

24/03/2019

Statements to be obtained from crew regarding the need to refuel.

25/03/2019

Request for NOK details for Duty of Candour.

28/03/2019

NOK details supplied.

28/03/2019

Emails are added regarding gate manual override.

28/03/2019

Statement provided by [redacted] regarding the circumstances of requesting to refuel and the difficulty in locating the patient's safe key upon arrival at the address. The statement also provides brief details regarding the patient's oxygen supply.

This statement is relevant to the death and disclosable.

03/04/2019

Following consultation with SD the consensus is to downgrade the incident to low harm as the root of causing patient harm was due to lack of/battery malfunction in the CPAP equipment. This suggests the patient harm was recorded higher than low initially.

04/04/2019

Audio confirms the request to refuel was due to only 1 bar of fuel showing. Statement to be obtained from requesting [redacted]

08/04/2019

Statement provided by [redacted], regarding the circumstances of requesting to refuel and the difficulty in locating the patient's safe key upon arrival at the address. The statement also provides brief details regarding the patient's oxygen supply. [redacted] explains [redacted] used the phrase "we only have one bar" not realising that they had enough fuel to attend the incident as [redacted] was not corrected by [redacted]

This statement is relevant to the death and disclosable.

Feedback form documents advice given to [redacted] re misinterpretation of terminology which lead to an avoidable delay in response.

12/04/2019

Investigation closed and learning regarding the override process to be cascaded.

17/10/2019

Email from Coroner requesting statements from attending paramedics detailing how PC was found and which oxygen supply system he was attached to and whether it was the CPAP system referred to.

The Coroner also requested to be supplied with details of the time of the call to NEAS, how it was graded and the dispatch and arrival time.

21/10/2019

C&C email SEACARE requesting authority to disclose the original statement of [redacted] or whether a further statement should be requested. Reply received stating statement would be reviewed by SEACARE.

Control log and EPRF sent to Coroner by C&C.

22/10/2019

SD notes in SEACARE meeting, a new statement should be requested from [redacted] to address specific questions as the original statement is not suitable as it was written in relation to the incident and not for the Coroner. New statement requested. No consideration given to the statement provided by [redacted]

23/10/2019

Second statement provided by [redacted] makes no reference to the original statement nor does it make any reference to the refuelling. The statement outlines the events upon arrival at the address and the situation regarding the oxygen supply.

24/10/2019

Email from SEACARE confirming receipt of statement (dated 23/10/2019) which is to be reviewed the following week.

31/10/2019

Statement (dated 23/10/2019) cleared by SEACARE and forwarded to Coroner by C&C.

17/11/2019

Having received the statement dated 23/10/2019 the Coroner requests further clarification from [redacted] regarding the oxygen supply.

18/11/2019

Further statement requested. C&C update SEACARE and informs of family and coroner raising safeguarding concerns.

21/11/2019

[redacted] emails response to request for a further statement notifying they are unable to clarify points raised by coroner. [redacted] email forwarded to coroner by [redacted]

Conclusions regarding HMC 2112

The Coroner requested information relevant to the death of PC on 17/10/2019, some 7 months after the incident. Coroner is clearly not aware of the NEAS delay investigation at the time of this request. Had the Coroner been informed of the delay investigation on or around 14/03/2019 when the incident was raised at NEAS disclosure of documents would have been timely.

The statement provided by [redacted] on 28/03/2019 was relevant to the death and should have been disclosed along with all other relevant documentation providing the Coroner with the full circumstances surrounding the death of PC and any clarification could have been sought by the Coroner at that early stage.

When the Coroner requested a statement from attending paramedics in October 2019, the original statement of [redacted] was deemed unnecessary to disclose, despite the statement covering the circumstances in which the delay had occurred and details of the situation regarding the oxygen supply, albeit brief. Had the Coroner been supplied with this statement they could have sought further information and/or

clarification at that time. By not informing the Coroner of the delay investigation a request for a new statement from [redacted] was made 7 months after the event when memory would not be fresh.

The statement of the [redacted], [redacted] which is also relevant, particularly in relation to the necessity to refuel, does not appear to have been considered nor has it been disclosed.

There does not appear to have been any investigation report produced in relation to the delay concern and the Coroner does not appear to have been informed of any investigation or been supplied the NEAS07 or audio calls. The Coroner has only been supplied with the statement dated 23/10/2019, which does not include any reference to the refuelling together with the email in relation to the queries raised about the CPAP machine. The control log which has been disclosed does note both the power cut and refuelling however the delay is not obvious. The Coroner should have been notified at the time.

HMC 2135

Background

[redacted]

19/11/2019

Email from Coroner providing details of family concerns and PM report. Coroner requests_statement from driver, investigation report and call triage.

25/11/2019

Driver identified, and statement requested.

26/11/2019

Confirmation that SEACARE have received call review and report which will be reviewed at meeting today.

02/12/2019

2 statements (the first encompassing the full circumstances and the supplementary statement addressing the specific concerns raised by the deceased's [redacted] completed and delivered by hand to C&C which were then forwarded to SEACARE. SEACARE reminded that reports still not received despite being reviewed 26/11/2019.

11/12/2019

Report cleared for disclosure.

12/12/2019

2 identical reports supplied to C&C except one without an author and no title recorded.

13/12/2019

Titled report emailed to coroner.

21/01/2020

Both statements cleared for disclosure. It is noted that there is no requirement for supplementary statement following discussion with [redacted] 2 x statements to Coroner.

Conclusions for HMC 2135

2 x statements provided by the driver were sent to SEACARE on 02/12/2019 but were not cleared for disclosure until 21/01/2020. It appears SEACARE perceived the statements to be of insufficient quality despite the statements containing all the relevant information required by the Coroner. If SEACARE considered there were points that needed clarification or additional information, then a further statement should be requested. The statements should have been disclosed to the coroner without the substantial delay with a note to the coroner that a supplementary statement has been requested to cover… abc. The Coroner waited unnecessarily for these statements for over 7 weeks.

HMC 2143

Background

52 years old female contacted NEAS on 30/11/2019 complaining of pain in shoulder and arm and difficulty in breathing. Incident graded as C2. Ambulance arrived 1 hour 27 mins later and patient was found deceased, 53 minutes after incident graded.

03/12/2019

Police informed Coroner that patient had requested ambulance and when it arrived an hour later patient was deceased. Coroner requesting report re call triage and dispatch by 15/01/2020.

03/12/2019

C&C email to SEACARE informing of Coroner's request and noting there is already a NEAS07 and EOC Dispatch Report attached to the deceased. C&C requests authority to disclose.

04/12/2019

Report has not been cleared by SEACARE.

05/12/2019

Email from [redacted] to SD stating [redacted] would pull a report together and strip out anything unnecessary not requested from the coroner.

18/12/2019

Report documents and statements cleared.

03/01/2020

Report returned to SEACARE as no author and title included.

08/01/2020

Report received by C&C and disclosed to Coroner.

15/01/2020

Coroner queries any response from family re the report.

27/01/2020

Response. NOK contacted, and agreement made to share report.

Conclusions for HMC 2143

The Coroner was made aware of the delay in ambulance attendance by police.

It appears a delay investigation had already been completed prior to 03/12/2019 but the Coroner had not been notified by NEAS. This report had not been cleared by SEACARE.

On 05/12/2019 [redacted] informs SD that [redacted] will pull a report together and strip out anything unnecessary. It is unclear why a report would be needed to be pulled together as records show a report was already in existence on 03/12/2019. This may suggest that there is an original report in addition to the one disclosed to the Coroner. It is unknown at this point whether anything has been stripped out that may be relevant for disclosure.

There are 2 reports on file however they are duplicates except one does not have a title and author. This does not appear to be the original report.

Documents and statements are also referred to as being cleared on 18/12/2019. This appears to be an error however if they do exist, they are relevant to the death and therefore disclosable.

CONCLUSION

The review is ongoing however initial conclusions are:

It is the duty of the Coroner to establish the causes and circumstances surrounding a person's death. This is not the duty of the Trust. The duty of the Trust is to disclose to the Coroner any information (document or thing) relevant to an inquest and/or investigation into the death of that person. The Coroner has the power to require this disclosure.

SEACARE process was implemented in May 2019 to ensure quality assurance and quality control in the delivery of disclosure to the Coroner. This process is not fulfilling its expectations and is causing lengthy delays in some circumstances. The Coroner is not being made aware of concerns and/or investigations being carried out by the Trust in a timely fashion. The Coroner only becomes aware when they request information from the Trust, in the main as a result of external agencies. In some cases, documents

relevant to the death and disclosable are not being disclosed to the Coroner. It is not for the Trust to determine whether to disclose a document. **If it is relevant to the death it must be disclosed.**

The Trust has received legal advice in relation to the Coroners and Justice Act 2009 and requirements placed upon the trust to disclose information (documents/things) to the Coroner.

In July 2019 Ward Hadaway advised that the Coroner's team being the conduit between the Trust and the Coroner should be aware of all documentation and investigations relating to a patient who is the subject of an inquest, in order to ensure that all relevant material is disclosed. They warned that If the team are not aware of reports and other documents, there is a very real risk that information which should be given to the Coroner by the Trust is missed. This advice has not been followed and C&C are still not being made aware of all incidents where concerns have been raised and/or investigations commenced.

In December 2019 Ward Hadaway advised that the Trust should pro-actively advise the Coroner of delay investigations. Again, this advice is not being followed.

On 7 November a letter was issued to the family informing that SEACARE had a robust tracking and monitoring system and the Trust pro-actively informs the Coroner of any investigation into a patient's death. This cannot be shown to be the case.

The cases reviewed as part of this initial review reveal the following to support these conclusions.

HMC 2193 – Despite the death occurring on 10 October 2019 and the Coroner requesting a report from [redacted] on 27 February 2020 to assist the pathologist in determining death, the Coroner does not appear to been made aware of the NEAS investigation._

HMC 2164 – Despite the death occurring on 19 December 2019 2 draft reports which are relevant to the death still require finalisation for disclosure to the Coroner. There is nothing recorded to explain the lengthy delay in a final report being authorised.

HMC 2112 - The death occurred in March 2019 which is prior to SEACARE however the Coroner requested information relevant to the death on 17 October 2019. The Coroner does not appear to have been made aware of the investigation.

A statement has been disclosed to the Coroner that makes no reference to the delay. 2 statements which are relevant and refer to refuelling prior to attendance have not been disclosed. It is documented that one of these undisclosed statements was considered and deemed not relevant for disclosure. It is unknown whether the second statement has been considered at all.

HMC 2135 – An unnecessary and unjustified delay of 7 weeks in the disclosure of statements to the Coroner.

HMC 2143 – Despite the Trust commencing an investigation following the death on 30 November 2019 The Coroner was made aware of the delay in ambulance attendance by police.

RECOMMENDATIONS

Full recommendations will be provided in the final report however it is imperative that the Trust consider the following in the meantime.

Recommendation 1 – The Trust to flag all deaths to the Coroner where concerns have been raised and/or an investigation commenced. It is for the Coroner to consider whether this information will form part of the Coroner's investigation/inquest.

Recommendation 2 - Explore the possibility of introducing a system whereby C&C carry out a daily check of system(s) over the previous 24 hours (72 hours on a Monday) to identify any deaths where a NEAS07 has been completed. This would ensure C&C are aware of any cases which the Coroner may need to be informed of.

Recommendation 3 – Explore the possibility of an IT solution that sends an automatic flag to C&C whenever a NEAS07 is completed in relation to the death of a patient or a step within the NEAS07 completion which prompts the author to flag the case to C&C.

Recommendation 4 – Ensure training is provided to SEACARE Patient Safety Team in relation to the duty of the Coroner and the duty of the Trust. SEACARE to be instructed that if a document is relevant to the death it is required to be disclosed despite views of the Trust.

Recommendation 5 – Consider the necessity of all documents other than primary documents being reviewed by SEACARE. C&C staff deal with disclosure daily and should be capable of reviewing simple statements providing they have adequate training. This would prevent unnecessary delays in disclosure.