Extract of relevant content about NEAS handling of Quinn Beadle's death, from the Interim AuditOne report

The full report can be found at this link: Interim AuditOne report March 2020

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

to

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.

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.

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.

> *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.

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*

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.

to

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.

---

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.