REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ian Thomas Trevor BEAN, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr R Henderson, Chief Executive, East Midlands Ambulance Service, Horizon Place, Mellors Way, Nottingham NG8 6PY**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall &The Isles of Scilly
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26 April 2018, an investigation was opened into the death of Ian Thomas Trevor Bean who died on 14/4/18 at Liskeard in Cornwall. The matter concluded with an inquest held on 9/10/19. Mr Bean was found to have died from: 1A) multidrug toxicity 2) chronic obstructive pulmonary disease. The conclusion recorded was that Mr Bean died by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bean had become agitated and distressed at his home address on the date of his death. He had telephoned his father who lived in Nottingham and to whom he had not spoken for two years. He told his father that he had failed him as a parent and that he was dying from an overdose of morphine (Oramorph) he had taken which was prescribed to him. His father rang East Midlands Ambulance Service to request an ambulance for his son in Cornwall. In error, the ambulance was directed to his father's address in Nottingham. It was accepted at inquest that this error was not causative of the death as paramedics and police were also called to the address in Cornwall. Nevertheless, it was felt that this was an error of such a fundamental nature that action should be taken to ensure deaths did not occur in the future from a similar oversight.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – An ambulance was wrongly dispatched to the address of Mr Bean's father in Nottingham rather than to Mr Bean in Cornwall.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. I am aware that your organisation has already reviewed the circumstances in which this error occurred. I would be pleased to learn the steps you have taken to prevent this sort of error from happening again. Could you also please confirm whether those steps have been audited and found to be sufficient?
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9/12/19. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Professor and [redacted] (GP.) I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** **[SIGNED BY CORONER]** **10.10.2019**