East Midlands
Ambulance Service
NHS Trust

Confidential

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Mr A J Cox
Acting Senior Coroner for
Cornwall and the Isles of Scilly
The New Lodge
Newquay Road
Penmount
Truro TR4 9AA

4 December 2019

Dear Mr Cox

Regulation 28 – Prevention of Future Deaths report regarding the case of Mr Ian Thomas Trevor Bean deceased

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 10 October 2019, bringing to my attention HM Coroner's concerns arising from the Inquest into the death of Mr Ian Bean.

I would like to assure you that the Trust takes all matters relating to patient safety extremely seriously. In particular, matters arising from Coroners' Inquests, from which lessons can be learnt, including Prevention of Future Deaths Reports, are discussed by the Incident Review Group and Lessons Learned Group.

Matters of Concern:

You have raised concern that an ambulance was wrongly dispatched to the address of Mr Bean's father in Nottingham, rather than to Mr Ian Bean's address in Cornwall.

Sequence of Events

On 14 April 2018, Mr Bean's father rang East Midlands Ambulance Service (EMAS) at 1940 hours to request an ambulance for his son. Mr Bean provided the Emergency Medical Dispatcher (EMD) with details of his son's address in Cornwall.

In April 2018, when a caller dialled 999 from a landline, the Computer Aided Dispatch (CAD) system, which is used by EMDs, automatically imported the caller's address into the CAD. On this occasion therefore, the CAD system contained details of both Mr Bean Senior's and his son's address.

The EMD acted appropriately by promptly telephoning South West Ambulance Service Trust (SWAST) at 1943 hours and the details of Mr Bean's call were passed to them, including information regarding Mr Ian Bean's overdose and self-harm. The call ended at 1949 hours.

However, a Dispatch Officer incorrectly allocated a resource to Mr Bean's address in Nottingham. Unfortunately, they did not notice the Cornwall address, or the notes that the EMD had entered in the incident log that that call had been passed to another Ambulance Trust.

Whilst there was no delay in an ambulance being requested to be dispatched to Mr Ian Bean, a mistake occurred in an ambulance also being dispatched to Mr Bean Senior's address in Nottingham.

Current system

We continually review our systems and processes to ensure that we are delivering the best possible service to our patients. We have worked with other Ambulance Trusts to develop call-passing technology. Since 13 December 2018, calls are passed through an electronic gateway, which negates the need for verbal handover.

The new system will only permit one address to be added onto the electronic gateway and the process followed now is that Mr Bean Senior's address would be added to a notepad on the file, which is not immediately visible on the screen.

This is a more efficient method of passing calls and will avoid a similar situation occurring in the future.

I can only apologise to Mr Bean's father that an ambulance arrived at his address and for any additional distress caused to him. I hope that this response provides the necessary assurance that no delay occurred in us transferring his request for an ambulance to attend his son to the SWAST.

I hope that this response provides you with the appropriate level of assurance in relation to our commitment to continuous improvement of services.

Please do not hesitate to contact me should you require any additional information, or any clarification, in connection with the above.

Yours sincerely

Richard Henderson
Chief Executive