	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Health and Care Professions Council**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 10 August 2016 I commenced an investigation into the death of Rex Brook Hall. The investigation concluded at the end of an inquest on 21 November 2016. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased passed away at the Solihull Hospital on the 28 July 2016 at 16:10. The Deceased had arrived at Solihull Hospital by ambulance at 14:39 with a reported history of right arm pain and atrial fibrillation, however, at 15:37 an ECG identified that he was experiencing a myocardial infarction and he was admitted to resuscitation but went into cardiac arrest at approximately 15:50 from which he could not be resuscitated. ECGs taken by paramedics at 13:59 and 14:03 showed ST elevation; this was not recognised by the paramedics nor were the ECGs reviewed on arrival at hospital. If ST elevation had been identified Mr Hall would have been transferred for assessment at the PCI unit at Birmingham Heartlands Hospital but although possible, it is unlikely that he would have survived. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1(a) ST ELEVATION MYOCARDIAL INFARCTION
5	**<u>CORONER'S CONCERNS</u>** 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: – That there may be deficiencies in the foundation training of paramedics: 1. one of the paramedics who qualified in 2015 after a 2 year foundation degree gave evidence that he had never had any formal testing on interpretation of 12 lead ECG; 2. the same paramedic gave evidence that he was not aware from his training that arm pain is a recognised, albeit, atypical sign of myocardial infarction; and 3. two paramedics did not identify obvious ST elevation (the other paramedic completed a diploma in paramedic science in August 2012).

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 January 2016. 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: West Midlands Ambulance Service, the Heart of England NHS Foundation Trust and the family of Mr. Hall. I have also sent it to Public Health England who may find it useful or of interest. 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	29/11/2016 Signature  Emma Brown Area Coroner **Birmingham and Solihull**