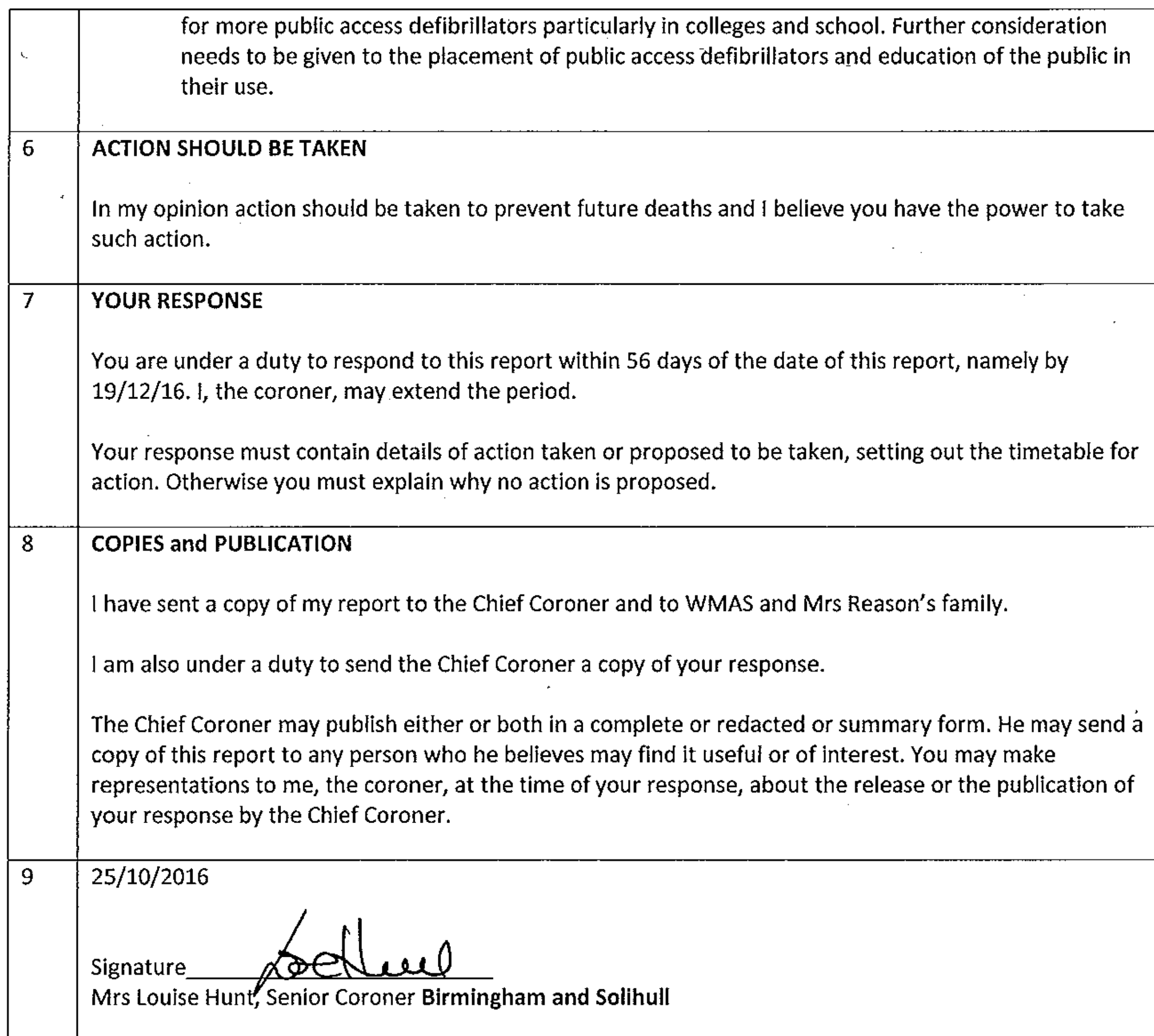
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Department of Health 2. Department of Education 3. NHS England 4. Resuscitation Council 5. British Heart Foundation 6. Public Health England.
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**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 29/06/2016 I commenced an investigation into the death of Jane Louise Reason aged 57. The investigation concluded at the end of an inquest on 13th October 2016. The conclusion of the inquest was Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a lecturer at King Edward VI College in Stourbridge. She was found collapsed at her place of work at 12.50 on 28/04/16. Staff commenced CPR until a first responder arrived at 12.59 followed by an ambulance crew at 13.12 who then continued CPR. On arrival of the ambulance crew a technician applied defibrillator pads but did not deliver a shock despite one being indicated. When further ambulance staff attended they were able to deliver a first shock however when they attempted to deliver a second shock the defibrillator battery failed. Another battery was obtained from the ambulance. There was a delay of 13 minutes in delivering the shock. The deceased was taken to Queen Elizabeth Hospital in Birmingham where she arrived at 13.55. She was declared deceased at 14.03. The evidence provided confirms the delay in providing a shock did not contribute to her death. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a. HYPERTENSIVE HEART DISEASE
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. – 1. Evidence at the inquest confirmed that the greatest chance of survival following an arrhythmic out of cardiac arrest is with early defibrillation and CPR. I heard evidence that there was a need



	for more public access defibrillators particularly in colleges and school. Further consideration needs to be given to the placement of public access defibrillators and education of the public in their use.
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 19/12/16. 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 WMAS and Mrs Reason's family. 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	25/10/2016 Signature____________________ Mrs Louise Hunt, Senior Coroner **Birmingham and Solihull**