Regulation 28: Prevention of Future Deaths report

Gabriella Omolabake Torisheju JAIYESIMI (died 20.02.25)

	THIS REPORT IS BEING SENT TO: **1. The Chief Executive** **Tesco PLC** **2. The Chief Executive** **Total Security Services Limited (TSS)** **3. The Chief Executive** **Security Industry Authority (SIA)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 25 February 2025, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Gabriella Jaiyesimi. The investigation concluded at the end of the inquest on 22 August 2025. I made a narrative determination at inquest. I recorded the medical cause of death as: 1a hypoxic ischaemic brain injury 1b out of hospital cardiac arrest of uncertain aetiology
4	**CIRCUMSTANCES OF THE DEATH**

	Gabriella Jaiyesimi suffered seizures and a cardiac arrest on 24 January 2025 while at the supermarket Tesco in Colney Hatch. She died a month later as a consequence of the hypoxic brain injury she sustained during that cardiac arrest. Before the arrival of an ambulance, she received no cardiopulmonary resuscitation (CPR) and no effective first aid at scene. Staff did call an ambulance.
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. At the point Gabriella Jaiyesimi began fitting while she was in the store, it was coincidence that one Tesco employee had personal experience of seizures, recognised these in Ms Jaiyesimi and was able to describe them to ambulance control. That individual then did as she was trained to do and left the management of the situation to the duty manager. When Ms Jaiyesimi was on the floor having suffered several fits, no person put her in the recovery position. They were apparently unaware that her present position could be causing an airway obstruction preventing her breathing. Then when Ms Jaiyesimi stopped breathing, nobody recognised this, though they were looking at her and made one inadequate attempt to feel for breathing (by placing a single finger somewhere near her nose). No person ever attempted to check Ms Jaiyesimi's pulse to see if her heart was still beating. Even if they had identified her cardiac arrest, there was nobody present who would have started CPR. Nobody thought of fetching one of the store defibrillators. Lack of CPR notwithstanding, the failure to understand the situation properly meant that nobody relayed the crucial information of the arrest to the ambulance service. It is impossible to say whether, if effective first aid and CPR had been administered, Ms Jaiyesimi's life could have been saved. However, it is surely in the public interest that at least basic first aid can be offered to shoppers as well as to staff, and I heard that Tesco is committed to looking after its shoppers.

When Gabriella Jaiyesimi suffered a cardiac arrest –

Tesco

1. There was no Tesco first aider working at Colney Hatch.

2. The TSS security officer was first aid trained, but none of the Tesco staff knew that.

3. All staff, including the TSS security officer, properly understood the Tesco policy of calling the duty manager to assess such an emergency and decide upon the correct course of action, but the duty manager charged with this responsibility had no CPR or first aid training. She told me that most of the Tesco duty managers were not CPR or first aid trained.

   She did call the ambulance service, but she was not in a position to make a properly informed decision as to how to proceed at scene. She tried to follow the instructions of ambulance control, but she had no context for this and was not able to follow these instructions fully.

   I heard that it was the duty manager's choice not to be first aid trained. She said that she did not like blood and was afraid of the responsibility of a paramedic. However, on further exploration she said that she would like to be able to recognise a person not breathing and she would like to be able to administer basic first aid.

TSS

4. The TSS security officer was first aid trained, but did not tell anyone that he was first aid trained.

   He told me repeatedly that his job was simply to do whatever the duty manager told him to do. Despite being the only first aider present, he took no responsibility at scene. He failed to offer Ms Jaiyesimi or the duty manager any meaningful support at all.

The SIA

The security officer had undergone SIA compliant first aid training in order to renew his licence. His first aid at work qualification was in date. He told me that his role as a security officer was to ensure the safety and security of people and merchandise in the store.

5. However, he did not display any understanding of basic first aid procedures. He told me that the first aid training he had received was simply a tick box exercise to enable him to renew his SIA licence.

	• When the duty manager specifically asked him to check for breathing, his one attempt to do this was wholly ineffective. • He never considered checking for a pulse. He told me that he had never been trained to check for a pulse. • He said that he had not been trained in how to use a defibrillator and so he would not consider fetching one. • When the staff member on the phone to the ambulance service relayed the instruction to place Ms Jaiyesimi in the recovery position, he did not. He told me that he did not remember being asked to do this. He also told me that he did not remember ever being taught the recovery position. • Finally, the security officer said that if he did ever see anyone not breathing in the future, he would wait for the arrival of paramedics to attempt to do anything about that.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 21 October 2025. 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 following. • The mother of Gabriella Jaiyesimi • HHJ Alexia Durran, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.	
9	**DATE** 26.08.25	**SIGNED BY SENIOR CORONER** *ME Hassell*