**Mr Andrew Walker**
HM Senior Coroner
North London
Barnet Coroner's Court
29 Wood Street
Barnet
EN5 4BE

**National Medical Director**
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

**17th July 2026**

[redacted]

Dear Mr Walker,

**Re: Regulation 28 Report to Prevent Future Deaths – Prabhabai Cangi who died on 12 August 2025**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5 June 2026 concerning the death of Prabhabai Cangi on 12 August 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mrs Cangi's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mrs Cangi's care have been listened to and reflected upon.

Your Report raised concerns around the following:

1. The lack of a clear pathway for interpretation of ECG traces to a specialist doctor, when attending paramedics decide, when an ECG trace taken at the scene show abnormal automated interpretations, not to convey a patient to hospital.
2. The intermittent symptoms of chest pain, breathlessness, abnormal ECG with some ST elevation using one or more leads, did not result in the patient being taken to the nearest emergency hospital.
3. Where an ECG is abnormal, the patient was not advised to show the copy of the ECG to their GP.
4. That there is no guidance on photograph of the ECG uploaded to the record of attendance being clear and readable.

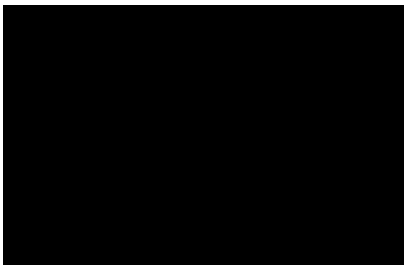
Having reviewed these concerns, and shared them with the ambulance team for comment, we consider that they relate to specific operational matters, which are the responsibility of the local ambulance service. We note that your report has also been addressed to London Ambulance Service, and so we have agreed that they are best placed to respond to your concerns.

We would also refer the Coroner to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) who develop clinical guidelines for UK NHS ambulance service paramedics on behalf of the Association of Ambulance Chief Executives and are working closely alongside National Ambulance Service Medical Directors.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mrs Cangi, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director
NHS England