REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Andrew Walker, HM Senior Coroner for the Coroner area of North London.
2.	DATE OF REPORT 5th June 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. NHS England 2. London Ambulance Service 3. You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st **July 2026**. I, the Coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** There is no escalation pathway to a specialist doctor when London Ambulance Service paramedics need to review ECG traces taken at the scene when they attend. A patient with coronary syndrome was not recognised resulting is a late presentation myocardial infarction.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 15th August 2025, I commenced an investigation into the death of Prabhabai Cangi aged 78 years. The medical cause of death was 1a. Cardiac Arrest 1b. Pericardial tamponade (pericardiocentesis and drain insertion 12/03/2025) 1c. Late presentation myocardial infarction 1d. II. Hypertension, Hypothyroidism **How, when and where** Prabhabai Cangi died in Harefield Hospital, Uxbridge on the 12th August 2025. **Conclusion** Prabhabai Cangi died as a consequence of delayed hospital treatment.
8.	**CIRCUMSTANCES OF DEATH** On the 12th of August 2025 Prabhabai Cangi died in Harefield Hospital having had an ST elevation myocardial infarction at home. An ambulance attended at her home on the 7 August 2025 where she presented with, amongst other symptoms, burning chest pain within the last 3 days associated with breathless on exertion especially on climbing stairs. An ECG taken by the LAS showed an abnormal ECG with some ST elevation. Mrs Cangi was taken to hospital where despite expert care she died the same day. Had Mrs Cangi been taken to hospital, rather than being discharged to see her own doctor, it is likely that Mrs Cangi would not have died when she did.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could 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 is no clear pathway for interpretation of ECG traces to a specialist doctor, when attending paramedics decide, where an ECG trace taken at the scene show abnormal automated interpretations, not to convey a patient to hospital. That 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. That where the ECG is abnormal, the patient was not advised should show the copy of the ECG to their GP (unless the patient is taken to hospital). That there is no guidance on photograph of the ECG uploaded to the record of attendance being clear and readable.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. NHS England 2. The family 3. London Ambulance 4. 5. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

	SIGNATURE **HM Senior Coroner Mr Andrew Walker**