Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **President, Royal College of Midwives, 10-18 Union Street, London, SE1 1SZ** [redacted]**, Chief Executive, Institute of Health Visiting, John Snow House, 59 Mansell Street, London, E1 8AN** [redacted]**, President, Royal College of General Practitioners, 30 Euston Square, London, NW1 2FB**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner for the coroner area of Inner North London.
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 7 October 2025, Senior Coroner Hassell commenced an investigation into the death of Aylina Akhmadova aged 17 days. The investigation concluded at the end of the inquest on 27 May 2026.

	The conclusion of the inquest was that the medical cause of death was 1a Sudden unexplained death in infancy (SUDEP). I returned the following narrative conclusion: Aylina Akhmadova was born on 16 September 2025. Her parents require assistance from interpreters for medical appointments. Aylina was seen by midwives and health visitors following her birth who had no significant concerns regarding her health. On the night of 2 – 3 October, Ayline stopped feeding and kept crying. Her mother noted that she was less responsive and asked a friend to call the ambulance service on her behalf. A call was made at 8.47 am and classed as a 3rd party call as the friend was not with Aylina. The call handler requested contact details for Aylina's mother but was instead given details for her father who was at work. From the information that he provided the call was classed as a category 3 call which broadly requires a response within 2 hours. Aylina's father was wrongly told that a 111 call should be made or Aylina should be taken to an urgent treatment centre. No contact details were given for Aylina's mother at that time. Around 9.15 am, a paramedic made a number of attempts to follow up the call and obtain more information from Aylina's mother who was by that time travelling to hospital by taxi. Contact was made with Aylina's mother at 9.17 am but the paramedic was unable to obtain more information due to problems with lines being engaged, calls being dropped and the need to bring interpreters into the call. The taxi driver independently called the ambulance service at 9.28. He was advised to stop the taxi and await paramedics at a fixed location. Paramedics were dispatched and arrived at the location at 9.37 am but the taxi had continued travelling to the hospital. When Aylina arrived at hospital at 9.40 am she was in cardiac arrest. Attempts were made to resuscitate Aylina but her death was confirmed at 10.13 am. The precise cause of Aylina's death could not be determined at post-mortem. On the evidence available, it is not possible to say that Aylina would have survived if her mother had been spoken to earlier. However, the difficulties in contacting her mother meant that opportunities were missed to obtain information that may have led the Ambulance Service to give the call higher priority.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Aylina's death are set out in the above narrative conclusion. The evidence established that Aylina's parents did not know that the Ambulance Service is able to access telephone interpreter services for 999 calls. Similarly, the evidence established that Aylina's parents did not know that the Ambulance Service operates a triage system to determine the appropriate

	response to a 999 call and that a call should be made by someone who is with the patient.
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 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. – 1) Primary care professionals such as GP's, health visitors and midwives spend the most one-to-one time with families. They will be aware which patients and/or carers need assistance from interpreters for medical appointments. In primary care, professionals often give safety netting advice regarding the circumstances in which a person may need to call paramedics. For safety netting advice to be effective, patients and carers also need to know that a 999 call should be made by someone who is with the patient and that interpreters are available to help the ambulance service triage the call. 2) Using informal interpreters such as family and friends for primary care appointments can be a pragmatic solution when professional interpreters are not available. However, the practice carries a significant degree of risk as the informal interpreter may not convey information reliably. This can be mitigated in part if the healthcare professional is with the patient and able to form their own view of the patient's status based on the observations that can be made. 3) The use of informal interpreters in primary care settings can lead to patients and carers wrongly assuming that emergency assistance can only be accessed by someone who is able to speak English on their behalf. Where an informal interpreter is not with the patient, there is a substantial risk that they will not be able to give sufficiently accurate and/or up to date information to enable the Ambulance Service to reliably triage a call.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 31 August 2026. 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: Family of Aylina Akhmadova London Ambulance Service NHS Trust Whittington Health NHS Trust 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. 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 by the Chief Coroner.
9	**SARAH BOURKE** **HM Assistant Coroner** **Inner North London** **6 July 2026**