Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] Service Director Creative Support Ltd Wellington House 131 Wellington Road South Stockport SK1 3TS
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 30 January 2019, Senior Coroner Mary Hassell commenced an investigation into the death of Christina Lawal aged 63 years. The investigation concluded at the end of the inquest which was conducted by me on 7 November 2019. The conclusion of the inquest was that Miss Lawal's death was due to natural causes. The medical cause of death was: 1a acute myocardial infarction

	1b coronary artery atherosclerosis 2 Type 2 diabetes mellitus My short form conclusion was that "Miss Lawal had a myocardial infarction at her home on 23 January 2019. The infarction atypically presented as abdominal pain in the period before she went into cardiac arrest".
4	**CIRCUMSTANCES OF THE DEATH** Christina Lawal had type 2 diabetes with serious complications. She lived in Duncan Court which is an extra care sheltered housing scheme. She was a wheelchair user. She attended hospital for dialysis 3 times per week. On 23 January 2019, Ms Lawal attended dialysis and returned home around 6.30 pm. She informed staff that she was tired and that she was going to bed. At 7.20 pm she complained of stomach pain. Staff offered to call her an ambulance, Miss Lawal said that she would speak to the out of hours doctor. Miss Lawal spoke to the out of hours GP service and was advised to take Gaviscon. She was then left alone. At around 9.15 pm, Miss Lawal pulled the alarm cord in her flat. 2 staff members attended to find that she was vomiting and complaining of severe abdominal pain. One staff member returned to the office in order to make a 999 call to paramedics whilst the other remained with Miss Lawal. Miss Lawal's pain increased which led to a further call being made to the ambulance service. Paramedics arrived shortly before 10 pm. Miss Lawal went into cardiac arrest shortly after their arrival. Attempts were made to resuscitate Miss Lawal using advanced life support measures. She was taken to the Royal London Hospital where her death was confirmed at 23.05.
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 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) The care worker had to return to the main office at Duncan Court in order to make a 999 call as there was no cordless telephone available for her use. 2) The emergency triage system used by the London Ambulance Service often involves the caller being asked to give information regarding the patient's appearance (e.g. do they feel hot, are they sweating or clammy etc). Similarly callers may be asked to put questions to the patient regarding the nature and location pain. A caller may not give the correct information if they are not with the patient at the time of the call. 3) Callers to the ambulance service may not be aware of further deterioration in a patient's condition if they are calling from a different location.

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 23 January 2020. 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 [redacted] (niece) 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.
	Sarah Bourke **Assistant Coroner** **28 November 2019**