ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Calderdale and Huddersfield NHS Foundation Trust** **2. [redacted]** **3. The Chief Coroner** **4. Thelma Walker MP**
1	**CORONER** I am Angela Carol Brocklehurst Assistant Coroner, for the Coroner Area of West Yorkshire (Western) Division
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 21st November 2017 an investigation into the death of Tae'jelle Kaliyah Francois was commenced:- The investigation concluded at the end of the inquest on 4th September 2019. The conclusion of the inquest was a Narrative Conclusion as set out below. 1a - The Medical Cause of Death was Acute Asthma
4	**CIRCUMSTANCES OF THE DEATH** On the 3rd June 2017, Tae'jelle Kaliyah Francois continued to suffer symptoms of an acute Asthma Attack which had begun several days previously. Despite the use of prescribed medicine her ill health continued and a decision was taken to seek hospital care by her family. During the journey to hospital and whilst waiting for admission Tae'jelle's condition deteriorated critically and she collapsed. Despite receiving appropriate resuscitation treatment she failed to respond and tragically passed away at Huddersfield Royal Infirmary at 22.45 hours that day.
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. – (1) At the point of admission into the Accident and Emergency Department, Tae'jelle was taken into the waiting area without either the Receptionist or the Triage nurse having the opportunity to visually assess her, despite Tae'jelle being in a medically critical state. Tae'jelle was taken into the waiting area of reception, where she stopped breathing.

	It was only as a result of the intervention of a member of the public that this condition was discovered, and as a result of that involvement Tae'jelle was taken into the Resus Department, where further treatment failed to revive her. (2) Evidence was given at the Inquest as to a Guidance recommended by The Royal College of Emergency Medicine upon dealing with the Emergency Assessment of Emergency patients. Such a Protocol provides for Reception to inform the Triage nurse of suspected seriously unwell patient, with the opportunity of then escalating the treatment of that patient. (3) Evidence was given at the Inquest that this opportunity was missed as neither the receptionist nor the Triage Nurse were provided with the opportunity to make the necessary assessment, despite the fact that the Department was not busy at the time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 11th November 2019. 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] and to Thelma Walker MP and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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.
9	**16th September 2019** **SIGNED BY ASSISTANT CORONER** Angela Brocklehurst