ANDREW BARKLEY
LL.B, Hon DUniv
HER MAJESTY'S CORONER

for the
Stoke-on-Trent and North Staffordshire
Coroner's Area

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, University Hospital of North Midlands** **Chief Executive's Office** **Trust Headquarters** **City General Site** **Newcastle Road** **Stoke-on-Trent** **ST4 6QG**
1	**CORONER** I am Sarah Murphy HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 3rd may 2018 an investigation into the death of Gladys Margaret Borgogno was commenced. The investigation concluded at the end of the inquest on 29th July 2019. The conclusion of the inquest was that the deceased died due to a recognised complication of a surgical procedure. The cause of death was: 1a Acute pancreatitis. 1b Gallstones and endoscopic retrograde cholangiopancreatography (ERCP). - II Hypertensive heart disease.
4	**CIRCUMSTANCES OF THE DEATH** 1)On the 24th April 2018, Mrs Borgogno underwent an ERCP procedure due to symptomatic bile duct stones. The procedure was uneventful but some stones remained. 2) Mrs Bogogno's post procedure observations were normal but prior to discharge, she was noted to vomit bile. This was not regarded as being indicative of a diagnosis of pancreatitis following a medical review as there were no other clinical symptoms. 3) Mrs Borgogno was discharged home after the standard four hour post procedure hospital observations and provided with written discharge instructions which warned of seeking further medical advice if severe symptoms developed which included vomiting. 4) Mrs Borgogno continued to vomit in the car on the way home and at home, but did not seek further medical attention. 5) Mrs Borgogno was found the following morning lifeless on her living room floor with vomit in close proximity and was confirmed dead by paramedics at 10am on the 25th April 2018.

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) The length of the post procedure observation period where there has been an episode of vomiting in the absence of any other symptoms and normal observations. (2) The pre and post procedure written documentation in respect of the advice to seek further medical attention if vomiting developed post procedure upon discharge from hospital. In evidence at inquest, the treating Consultant Pancreatico-biliary Surgeon advised that he understood the family's confusion surrounding the symptom of vomiting given the fact that Mrs Borgogno had vomited after the procedure but had been discharged from hospital. He advised that he would recommend that the hospital review its pre and post procedure ERCP documentation provided to patients.

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 Friday 27th September 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: 1. [redacted] (son of the deceased) 2. [redacted] Deputy Legal Services Manager, UHNM 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	31/07/2019 Signature_____ Sarah Murphy HM Assistant Coroner **Stoke-on-Trent & North Staffordshire**