Kate Robertson
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, HM Senior Coroner for North West Wales
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 3 March 2022 I commenced an investigation into the death of Jennifer Lydia Campbell (DOB 612/6/48) who died on 24 February 2022. The investigation concluded at the end of the inquest on 24 October 2023. A narrative conclusion was recorded with the cause of death as:- 1a Slower lobe pneumonia, biliary sepsis 1b Obstructing gallstones Jennifer Lydia Campbell had an ultrasound scan of her abdomen on 25 October 2021 at the request of her GP following abnormal liver function tests, which showed gallstones. The GP referred her to gastroenterology on 28 October 2021. Following review, a referral was made by the gastroenterologist for Endoscopic retrograde cholangiopancreatography (ERCP) and this was sent to the endoscopy department on 3 November 2021. The referral form was not received by the endoscopy department and the Endoscopic retrograde cholangiopancreatography (ERCP) did not occur. Jennifer Lydia Campbell became unwell on 22 February 2022 and was subsequently admitted into Ysbyty Gwynedd on 23 February 2022 where she was treated for severe infection due to obstructing gallstones and died on 24 February 2022.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Jennifer Lydia Campbell was aged 73 years of age at the time of her death on 24 February 2022. She had a recent past medical history of gallstones and previous kidney cancer. She underwent blood tests via her GP in October 2021 and in an appointment

	on 11 October discussed her abnormal liver function test. On 25 October 2021 she underwent ultra sound of the abdomen which showed large gallstones. She was advised she needed a procedure. On 28 October 2022 a referral was sent by her GP to gastroenterology department, marked as routine. On 2 November 2021 the gastroneterologist referred Mrs Campbell directly for ERCP procedure and dictated a letter to her to explain this. A paper referral was completed as per procedure and sent to the endoscopy dept on 03 November 2021. There is no record of the referral form being received by endoscopy and it is not clear why it was not received or what had occurred to it. Jennifer Lydia Campbell received a copy of the letter from the Gastroenterology department dated 3 November 2021 confirming that ECRP was needed, and she had been put on the waiting list. On 21 February 2022 Mrs Campbell started to become unwell, she was in pain and suffering. On 23 February 2022 she attended the Emergency Department due to vomiting for 2 days and not being able to get out of bed. She was admitted but deteriorated and died on 24 February 2022 at Ysbyty Gwynedd from infection and pneumonia due to the obstructing gallstones.
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 – a. There was no evidence of any formal investigation having been undertaken into how the referral for ERCP became lost. It appears that only during the course of Inquest proceedings did the issue relating to the lost referral become known to the Health Board. Even once it became known to them in 2022 there was still no investigation undertaken. It is not understood at all which incidents that occur are to be investigated. I have issued a number of Prevention of Future Death Reports relating to investigations and governance and yet these concerns continue. I am not in any way satisfied that improvements have occurred. b. Given that no investigation was conducted to understand how the issue may have occurred there has been no learning, change or improvement to ensure it is not repeated. I have been provided with no assurances in this regard. c. There was no evidence that any audits had taken place to review whether any other patients' referrals had become 'lost'. d. Matters relating to the ERCP which did not take place were identified by the Medical Examiners in their report dated 4 days after the deceased's death. There was no evidence as to whether the Health Board had been made aware of the concerns therein and if so, what action they had undertaken as a result.

	e. Evidence was heard relating to electronic notes and referrals. Such referrals remain paper based and there is no indication as yet when these will be fully electronic. I am aware that this national strategy is ongoing but the time it is taking is putting patients' lives at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 19 December 2023. I, Kate Robertson, 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 Family of the Deceased and to the Chief Coroner. I have also sent a copy of this Report to [redacted], Health Minister, for her information. 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	Dated 24 October 2023  Signature Kate Robertson HM Senior Coroner for North West Wales