John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 the 3rd of May 2022 I commenced an investigation into the death of Ann Margaret Cotgrove (DOB 10.08.51 DOD 03.05.22). The investigation concluded at the end of the inquest on the 20th of February 2025. The cause of death was recorded as being due to 1(a) Peritonitis , Acute Liver Failure and Bronchopneumonia 1b Gall Bladder Perforation 1c Endoscopic retrograde cholangiopancreatography due to obstructive jaundice and the conclusion of the inquest was that the death was due to medical misadventure.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that Miss Cotgrave had been admitted to Glan Clwyd Hospital on the 31st of March 2022 and was being investigated to establish the cause of her jaundice. She did not undergo a required ERCP until the 19th of April and on the 22nd of April was found to have sustained a perforation which is likely to have occurred in the course of that procedure. By that time she was too unwell to undergo reparative surgery and she passed away on the 3rd of May 2022. The delay in her undergoing the ERCP was due (inter alia) to the consultant gastroenterologist requesting that advice from tertiary centre in Liverpool be obtained prior to the procedure due to a suspicion of malignancy. He was subsequently informed that advice had been received indicating the ERCP should be undertaken at Glan Clwyd and he therefore proceeded. Whilst there is no reason to doubt the veracity of the consultant's evidence, that advice from the tertiary centre had been sought, there is no documented evidence in relation this.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter 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 **MATTER OF CONCERN** is as follows. – That there was no record of any discussions which took place been Glan Clwyd and the tertiary centre and no formal documented process in relation to such referrals and the subsequent advice which was provided and thereafter acted upon.

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 by 18th April 2025 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 Family of the Deceased and to the Chief Coroner. 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 21st February 2025  Signature Senior Coroner for North Wales (East and Central)