RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.

It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026),any representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision.

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

[redacted]

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, H.M. Patricia Morgna for the Coroner Area South Wales Central in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of Lisa Jayne Townsend that concluded on 6 May 2026.

RESPONDENT

1. In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **NAME** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.

2. DATE OF RESPONSE 17 June 2026

CONFIRMATION OF CORONER'S MATTERS OF CONCERN

The Health Board understands the Coroner's concern to be that there was an absence of clear guidance and protocol as to when referral should be made from the local hospital to the tertiary HPB (Hepato Biliary) centre in relation to HPB conditions, that there was delay in specialist advice being sought and in transfer taking place, and that there remains no sufficiently established protocol to assist clinicians in identifying when escalation to tertiary HPB advice and transfer should occur.

Position of the Health Board in response to that concern

The Health Board accepts that, in this case, there was delay in escalation from the treating Health Board ensuring referral for specialist HPB input, and it acknowledges the importance of ensuring greater clarity and consistency in regional referral arrangements for patients with suspected bile duct injury and other complex benign HPB pathology. At the same time, the Health Board considers it important to distinguish between a lack of clinical principles and a lack of formal commissioning arrangements. The management of suspected bile duct injury is guided by established national and international clinical standards which support early recognition, prompt discussion with a specialist HPB centre at the point of suspicion, and transfer where required for definitive expert management. These principles are embedded in surgical training and are recognised as standard practice. This is consistent with the position already set out in the current draft response.

The Health Board also wishes to clarify the current service context. The HPB team at University Hospital of Wales provides a highly specialised tertiary HPB service; however, that service is not formally commissioned or funded as a regional emergency HPB on-call service for conditions such as bile duct injuries and complex benign HPB pathology. Notwithstanding that absence of formal commissioning, the service is routinely approached by other Health Boards for specialist HPB advice and management. The Health Board's position is therefore that specialist expertise is available and is accessed, but the absence of a commissioned regional on-call model can result in over-reliance on informal pathways rather than a single formally defined regional referral route. This reflects

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and develops the commissioning point already included in your current draft. The Health Board further notes that there have been prior occasions on which patients with suspected bile duct injury have been referred to the HPB service in a timely way from the same Health Board, including from the same clinical source. The Health Board therefore considers that the principal issue arising from this case was not the absence of specialist knowledge or the impossibility of access to specialist advice, but rather the failure to apply established escalation principles promptly and consistently in this specific instance.

DETAILS OF ACTION TAKEN, how has the concern been addressed.

Action already taken

In response to the concern identified, the Health Board has reviewed the issues raised in relation to regional escalation to specialist HPB services. Immediate work has been undertaken to reinforce the existing expectation that suspected bile duct injury and comparable complex benign HPB cases should trigger early consultant-level discussion with the tertiary HPB centre at the point of suspicion, including where concern arises intra-operatively or in the post-operative period. This aligns with the emphasis in your current draft on early identification, timely specialist consultation and appropriate transfer.

The Health Board has also taken steps to remind relevant partners of the existing escalation framework for HPB complications, including the need for urgent advice to be sought promptly and for transfer to be considered without avoidable delay where specialist tertiary management is indicated. As reflected in the current draft, this includes reinforcing designated contact avenues, urgent advice procedures and the importance of timely escalation.

In addition, focused communication and educational activity is being used to reinforce the existing clinical principles underpinning referral and escalation for suspected bile duct injury. The purpose of this action is to reduce unwarranted variation in practice, strengthen clinician awareness of when specialist input should be sought, and support more reliable application of recognised standards across organisational boundaries.

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DETAILS OF FURTHER ACTION PROPOSED

To address the Coroner's concern more explicitly and transparently, the Health Board proposes further work to move from reliance on recognised but partly informal arrangements to a more clearly documented regional framework. This will include the development and dissemination of a formalised escalation and referral framework for suspected bile duct injury and other relevant complex benign HPB pathology, setting out referral triggers, expected timescales for consultant-to-consultant discussion, contact arrangements, and expectations regarding transfer where tertiary management is required. This builds directly on the current draft's commitment to improve clarity and consistency through more formal frameworks. The Health Board also intends to continue engagement with regional partners, Welsh Government and relevant commissioning bodies regarding the current service model. As already acknowledged in your draft, the absence of a commissioned regional HPB on-call rota creates avoidable ambiguity in identifying a single point of referral. The commissioning of a defined regional emergency HPB on-call function would provide greater clarity, strengthen accountability, reduce reliance on informal routes, and support more consistent and timely access to specialist expertise. The current draft expressly notes that commissioning the on-call rota would be welcomed to address and mitigate related risks.

The Health Board will additionally ensure that the learning from this case is embedded through governance processes, with oversight of implementation through the appropriate clinical governance structure, including confirmation that the revised escalation arrangements have been communicated and that compliance can be tested through audit or case review. This expands the assurance language already present in your draft that the Health Board remains committed to enhancing educational initiatives and reinforcing assurance processes

Conclusion

The Health Board recognises the seriousness of the issues identified by the Coroner and is committed to taking proportionate action to reduce the risk of recurrence. In summary, the Health Board's position is that the clinical principles governing early referral of suspected bile duct injury are established and understood, but that this case has highlighted the need to strengthen the consistency, formality and assurance of regional escalation arrangements. The actions already taken and the further actions proposed are intended to improve clarity of access to specialist HPB advice, reduce variation in referral practice, and support safer and more timely escalation for future patients.

SIGNATURE

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