

## **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 \(2026\)](#).

THIS RESPONSE IS BEING SENT TO:

**The Senior Coroner, H.M. Patricia Morgan 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, **Cwm Taf Morgannwg University Health Board** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.

2. **DATE OF RESPONSE 2 July 2026**

**CONFIRMATION OF CORONER'S MATTERS OF CONCERN**

The **MATTERS OF CONCERN** were identified in the report are as follows:

- injury to the patient's bile duct during the procedure, and delay in transfer to a tertiary centre.

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

4. **DETAILS OF FURTHER ACTION PROPOSED**

We have now changed our pathway and follow up for patients with this complication. Please see the new guidelines of clinicians as set out below.

**Clinical Guidance**

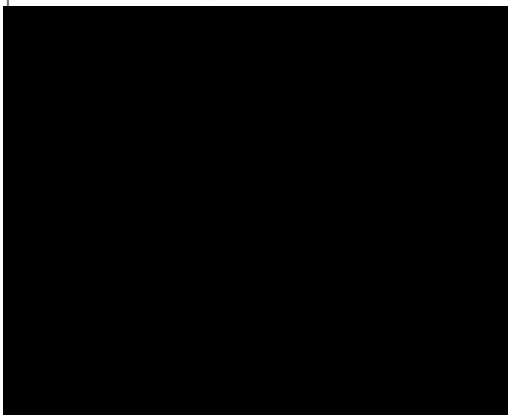
All patients presenting with a suspected or confirmed bile duct injury following an operation or procedure must be managed in accordance with the following principles:

1. Early Senior Review and Internal Discussion
  - The responsible clinician must seek a second opinion within their department at consultant level at the earliest opportunity.
2. Mandatory Early Tertiary Referral
  - Specialist advice must be sought at the earliest opportunity from the Hepato-Pancreato-Biliary surgical team at the University Hospital of Wales. (Currently, there is no 24/7 Hepato-biliary service provided by UHW.)
  - This discussion must occur as soon as bile duct injury is suspected or confirmed to discuss further management or determine the need for transfer to UHW.
3. Consultant-to-Consultant Communication
  - All referrals must be conducted consultant-to-consultant
  - All discussions must be clearly documented within the Welsh Clinical Portal (WCP) and the patient's case notes.
4. Transfer to Tertiary Centre
  - CTM UHB does not provide a 24/7 ERCP service, which is frequently required in the management of bile duct injuries.

- Where indicated and after discussing with HPB team at UHW, patients must be transferred promptly to UHW under the care of the HPB surgical team.
  - Both Health Boards will work collaboratively to ensure:
    - Timely acceptance
    - Efficient coordination of transfer
    - Avoidance of unnecessary delays
5. Feedback and Learning
- The tertiary centre will provide structured feedback to the referring clinician and team, including:
    - Management undertaken
    - Learning points
  - This feedback will be shared with the wider surgical team to support organisational learning.
6. Clinical Governance
- All cases of bile duct injury will be mandatorily reviewed at the monthly Morbidity and Mortality (M&M) meeting within the Health Board.
  - These cases will form part of ongoing clinical governance and quality improvement processes.
  - All future cases of bile duct injury within the Health Board will be reviewed against this guidance to assess compliance.

I hope that this assures you that there has been learning from this case and we have taken steps to ensure that our processes have been modified accordingly. Should you require any further information then please let me know.

**SIGNATURE**



**Prif Weithredwr/Chief Executive**

