

GRAEME HUGHES
HIS MAJESTY'S
SENIOR CORONER
SOUTH WALES CENTRAL
CORONER AREA



CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW



ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p style="text-align: center;">REPORT TO PREVENT FUTURE DEATHS</p> <p style="text-align: center;">REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013</p> <p>Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).</p>
1	<p>CORONER</p> <p>I am Patricia Morgan Area Coroner, for the coroner area of South Wales Central.</p>
2	<p>DATE OF REPORT 6th May 2026</p>
3	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>



4	<p>THIS REPORT IS BEING SENT TO</p> <ol style="list-style-type: none"> 1. Cwm Taf Morgannwg University Health Board 2. Cardiff and Vale University Health Board 3. Cabinet Secretary for Health and Social Care in Wales, Welsh Government. <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st July 2026. I, the coroner, may extend the period if an appropriate application is made.</p>
5	<p>YOUR RESPONSE</p> <p>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.</p> <p>I have a duty to send a copy of your response to the Chief Coroner.</p> <p>In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.</p> <p>Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.</p> <p>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.</p>
6	<p><u>SUMMARY OF CORONER'S CONCERN</u></p> <p>During the inquest touching the death of Lisa Jayne Townsend, the Coroner heard evidence in respect of the absence of clear guidance and protocol for when a referral should be made by the local hospital (Princess of Wales, Bridgend) to the tertiary centre (University Hospital of Wales) in respect of Hepato-Pancreato-Biliary (HPB) related matters. There was a delay in advice being sought from and transfer to the tertiary centre taking place. There remains no established protocol to assist Clinicians with when they should escalate and seek further specialist advice from their tertiary centre to ensure timely consideration of the patient's issue.</p>



ACTION SHOULD BE TAKEN

7 In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

INVESTIGATION AND INQUEST

On 26/09/2025 I commenced an investigation into the death of Lisa Jayne Townsend. The investigation concluded at the end of the inquest on 17/04/2026.

The medical cause of death was:

1a Sepsis

1b Cholecystitis (operated 01/10/2024)

1c

1d

II

The circumstances were :-

8 Mrs Lisa Jayne Townsend had been unwell since early August 2024 with abdominal pain. It was identified in late September 2024 that she was suffering with cholecystitis and pancreatitis, necessitating surgical intervention to remove her gall bladder. This surgery was delayed but took place on 1 October 2024, during which an injury was sustained to the bile duct. Multiple attempts to rectify the injury via an ERCP took place over the coming weeks which were unsuccessful. Mrs Townsend was transferred to University Hospital of Wales, Cardiff on 20 November 2024. There, further surgical intervention took place. Ultimately, Mrs Townsend was unable to overcome chronic sepsis and she was overwhelmed by infection. She died on 20 March 2025 at University Hospital of Wales, Cardiff.

There were multiple delays and issues in Mrs Townsend's care, along with the injury sustained in the surgery of 1st October 2024 which more than minimally contributed to her death.

Conclusion:



	Mrs Townsend died as a result of bile duct injury and complications arising from delayed surgery.
9	CIRCUMSTANCES OF DEATH See box 8 above
10	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: See box 6 above

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

[please do not use individual's names, but instead roles/titles]

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1. Cwm Taf Morganwg University Health Board
2. Cardiff and Vale University Health Board
3. Cabinet Secretary for Health and Social Care in Wales, Welsh Government.

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

6 May 2026

SIGNED:



Patricia Morgan Area Coroner for South Wales Central Coroner Area



**Chief
Coroner**

