

[REDACTED]
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care



Llywodraeth Cymru
Welsh Government

[REDACTED]
Rachel Knight
HM Coroner for South Wales Central

4 February 2026

Dear Rachel Knight,

Regulation 28 Report – Milos Jankovic

Please accept my apologies for the delay in responding to your Regulation 28 report into the death of Milos Jankovic.

I was sorry to read about the circumstances which led to Mr Jankovic's death and would like to take this opportunity to offer my condolences to Mr Jankovic's family and friends.

I was concerned to read about the issues highlighted in your Regulation 28 report. Health boards in Wales are responsible for delivering healthcare, in line with recommended clinical practice, which includes the provision of surveillance procedures for conditions such as Barrett's Oesophagus.

Health boards should offer people with Barrett's Oesophagus surveillance endoscopy every two to three years and more frequently if they develop pre-cancerous cells. A small proportion of people with Barrett's Oesophagus will go on to develop oesophageal cancer.

In terms of recalling people with Barrett's Oesophagus for surveillance procedures, it is the secondary care team which manages this process. The need for surveillance is added to a patient's record by the patient administration system used by the health board. Health boards operate standardised recall procedures and follow-up procedures for non-responders to invite people for their surveillance appointments.

I am not of the view that GPs should be engaged in recalling individuals or that their clinical record systems should be amended to include prompts to recommend surveillance. This would lead to a confusion of responsibilities and duplication in terms of booking procedures. GP systems should in general not use digital flags to prompt recommended clinical practice, as GPs should apply their training, clinical guidelines and locally-agreed clinical pathways for the management of any condition. Digital flags in GP systems should be reserved to highlight serious patient safety risks, such as allergies or safeguarding issues.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

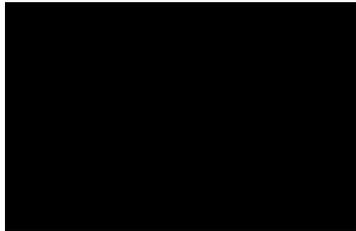
We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

With regard to the secondary care management of surveillance lists, unfortunately, there is a risk that process or administrative errors can occur. This may happen if, for example, clinical teams do not act on pathology results; if records are inaccurate or are misplaced; if validation or booking procedures are not completed accurately, or if there are breakdowns in communication with independent sector providers.

It is with regret that I am unable to comment on whether such factors may have played a role in the death of Mr Jankovic. The responsibility for the operational delivery of the surveillance list rests with the health board concerned for his treatment – the Welsh Government has no access to health board records or digital systems and processes. The power and expertise to investigate the circumstances of Mr Jankovic's death – and that of the other case you refer to – and the processes involved in managing the surveillance, lie with the health board.

Could I therefore suggest, in this case, that you ask the health board concerned how it manages the surveillance waiting list for Barrett's Oesophagus and ask it to identify any administrative failings involved, and how it can strengthen its records and processes to avoid future deaths.

Yours sincerely,



Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care