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29th April 2026

Coroner: Mr Martin Lanchester, Assistant Coroner for Gwent

[redacted]

Dear Mr Lanchester

Thank you for your Regulation 28 Report of 6th March 2026, issued following the inquest into the death of Mr Alan Bevis Tomlinson. On behalf of Cardiff and Vale University Health Board, I wish to extend our sincere condolences to Mr Tomlinson's family for their loss. We recognise the purpose of your report is to prevent future deaths, and we welcome the opportunity to outline the actions we have taken and those we will be taking in direct response to the concerns you identified.

1. Summary of the Concerns Raised

We note and accept the concerns set out in your Report, including:

- Lack of clear guidance on thresholds or criteria for referring pacemaker data for cardiology review.
- Limited physiologist knowledge of infective endocarditis and its association with device infections.
- Inconsistent gathering of clinical information and examination/documentation of implant sites during clinic visits.
- Variability in communication and documentation practices, particularly regarding escalation to the Cardiology team.

We acknowledge the link you identified between the absence of timely referral and the delay in diagnosing Mr Tomlinson's evolving infective endocarditis.

Actions

The Health Board takes these findings extremely seriously. In response, the following actions have already been implemented:

Immediate Clinical Review and Strengthened Referral Criteria

- A revised escalation and referral protocol has been implemented within the Cardiac Device Clinic.
- A mandatory referral trigger is now in place if a device has lost a twofold safety margin. This has been clearly documented in the "Managing the Unwell Patient Standard Operating Procedure" (attached) which is stored on the departmental SharePoint.
- The Standard Operating Procedure has been shared with all Physiologists and will be presented at the departmental Quality and Safety meeting on the 13th of May.

Enhanced Clinical Assessment Standards

- A new history sheet has been developed for the documentation of all clinical findings during Device Check clinic appointments. This requires.
    - Documented assessment of the patient's general condition, including the Red Flag questions of any significant weight loss, any fevers, any changes to mobility, any difficulty with speech, and any breathing difficulties.
    - Mandatory inspection of the device implantation site and recording if presence of any redness, swelling, heat, or threatened erosion.
- Monthly notes audits will be conducted for the quarter following presentation of the SOP on the 13th of May.

Training and Education for Physiologists

- Training sessions have been arranged for delivery covering:
    - Recognition of infective endocarditis, including atypical presentations, will be delivered by a Consultant Cardiologist
    - Recognising the generally unwell patient and Red Flags which will be delivered by the Nursing Practice Educators
    - When and how to escalate to a cardiologist has been circulated via e-mail and will be delivered on the 13th of May Quality and Safety afternoon.

Strengthened Documentation and Communication Pathways

- All clinic entries now require explicit documentation of clinical findings, including implant site, any red flags and symptom information provided by the patient, as well as all device data and associated tests performed.
- The development of specific Cardiac Physiology inboxes in the existing e-Advice system.

Development of a Standard Operating Procedure (SOP)

We have finalised a comprehensive SOP for device the escalation of the unwell patient, covering.

Audit and Quality Assurance

- Audits of the following have been instigated:
    - Notes Standards compliance
    - E-Advice usage and response times

Digital Support

We are implementing the Fysicon system, which is an electronic patient record. This will incorporate all clinical notes and will provide trend data to further enhance the clinical decision making and improve patient outcomes.

Engagement With Staff and Wider Learning

The findings of the inquest and your Regulation 28 report have been:

- Shared with the Cardiology Directorate, Clinical Board leadership, and Quality & Safety Committee.

To develop these service improvements benchmarking exercises were conducted. The development of the Red Flag questions is a change to practice in Wales. On discussion with our colleagues in neighbouring health boards, it appears the undergraduate Cardiac Physiology teaching on recognition of systemic illness in patients is limited. The questions in device clinics remain focused on cardiology specific conditions, such as heart failure. As a Health Board, we recognise that this would be too limited for our patient cohort. We have, therefore, developed broader Red Flag questions and an associated training package.

We recognise the seriousness of the failings identified and are committed to ensuring that the lessons from this tragic case led to sustained, measurable improvement in our services. We

will continue to monitor compliance, strengthen training, and enhance our clinical pathways to prevent similar harm.

Please be assured of our full cooperation and our commitment to implementing the actions outlined. Should you require any further information or clarification, we would, of course, be happy to provide this.

Yours sincerely

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Chief Executive

Enc Managing the Unwell Patient SOP