Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive of Cardiff and Vale University Health Board**
1	**CORONER** I am Martin LANCHESTER, Assistant Coroner for the coroner area of Gwent
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 14 May 2024 I commenced an investigation into the death of Alan Bevis TOMLINSON aged 55. The investigation concluded at the end of the inquest on 24 February 2026. Alan Tomlinson died on the 18 April 2024 at his home, from the effects of untreated infective endocarditis likely caused by a longstanding soft tissue infection at the site of a pacemaker implant which was implanted in May 2023. Mr Tomlinson's developing Infective Endocarditis was not identified by his treating general practitioners and this was likely to have contributed to his death. Mr Tomlinson's pacemaker had been noted to be defective in January 2024 but he was not referred to the Cardiology department at University of Wales Hospital and this also was likely to have contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** On 16th April 2024 Alan Bevis TOMLINSON attended at the University Hospital (UHW) Cardiff as he felt unwell and had swelling around the site of his pacemaker. Alan had been unwell for several months and had suffered significant weight loss and was anaemic. Alan had a new pacemaker fitted in May 2023 and he had not been well since this was changed. On arrival at the UHW Alan was told that he had swelling around the site of his pacemaker and needed to be admitted to a cardiac ward for further investigation and treatment. Alan was advised to return to his home address as there was no cardiac bed available. Alan died at his home address on the 18th April 2024.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) Mr Tomlinson had a history of heart valve surgery and was fitted with a new pacemaker in May 2023. The device was reviewed periodically at the Cardiac Device Clinic at the

	University Hospital of Wales. In the months after implantation, the pacemaker showed progressively increasing ventricular thresholds. At his review on 8 January 2024, the threshold was 5.0 V @ 2 ms and the predicted battery life had fallen to 10 months. Although he was well known to the physiologists and was visibly unwell, with marked weight loss, no record was made of his clinical condition. Evidence from a consultant cardiologist confirmed that the elevated threshold required referral to the Cardiology Department, but no referral was made. I found that the pacemaker itself did not cause Mr Tomlinson's death from untreated infective endocarditis. However, a timely referral to cardiology would probably have led to earlier diagnosis, and the delay was likely to have contributed to his death. Evidence from the Chief Physiologist identified wider concerns within the service, including: 1. Lack of guidance on when pacemaker data should trigger cardiology review; 2. Limited physiologist knowledge of infective endocarditis; 3. Inconsistent gathering of clinical information and implant site checks during clinic visits; 4. How clinical findings were documented and communicated, particularly to the Cardiology team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 01, 2026. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Family Members And Next Of Kin** I have also sent it to **Not Applicable** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 06/03/2026**

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Martin LANCHESTER
Assistant Coroner for
Gwent