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 Assistant Coroner for Gwent, for the Coroner Area of Gwent, in response to a Report to Prevent Future Deaths Regulation 28 following an investigation into the death of **Glyn Richard PRESSLEY**.

1.	**RESPONDENT** In line with the duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, the Chief Medical Officer for Welsh Government provides this response within 56 days of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** 27/08/2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The matters of concern identified in the report relate to communication between secondary and primary care, and in particular the understanding among secondary care clinicians of how correspondence sent to GP practices is handled on receipt. The report notes that secondary care clinicians believed correspondence sent to a GP practice would always be reviewed by a clinician. The report also records that, where correspondence does not contain a specific instruction for further action, it may be categorised by administrative staff and uploaded to the patient record without being reviewed by a clinician. The report identifies a concern that secondary care clinicians may not understand what needs to be included in correspondence to ensure it is reviewed by a clinician, and that this could create a risk of missed referrals, delayed diagnosis or delayed treatment. The Welsh Government acknowledges the concerns raised and has considered them carefully.

4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. The Welsh Government considers that the central issue raised by this report is the importance of clear communication and explicit responsibility for onward action at the interface between secondary and primary care and between secondary care specialities. It is important that, where a clinician identifies findings which require further investigation, referral, specialist review or follow-up, the required action is stated clearly and responsibility for that action is explicit. At the time of the events described in the report, the All Wales Clinical Communication Standards Protocol 2011 set out expectations for clinical communication between services. The Welsh Government has subsequently strengthened this framework through the publication of the All Wales Clinical Interface Standards, issued under WHC 2026/015. These standards reinforce the importance of clear communication between clinicians, explicit responsibility for follow-up action, and safe transfer of clinical information between services, specifically standards 2, 5,6 and 10. (WHC/2026/015: All Wales General Practice and Health Board Clinical Interface Standards). Following the death of Glyn Richard PRESSLEY, Aneurin Bevan University Health Board undertook a review of the care provided before surgery. The health board has advised Welsh Government that the review identified a number of recommendations and actions. These included exploring options to enable communications regarding patient consultations to be appropriately forwarded or copied to patients; work between the Pre-Assessment Clinic and Cardiology Directorate to agree criteria for direct onward referral; a formal discussion between those services on the management of incidental findings; interim referral arrangements for abnormal cardiac investigations identified through pre-assessment; a review of Pre-Assessment Clinic letter templates; and a review of delivery against the All Wales Clinical Interface Standards. The health board has also sought comments from the GP practice involved in the patient's care at the time. Those comments have helped inform consideration of the interface issue identified in the report. They indicate that the correspondence in question did not contain a clear request for action and that the key learning point concerns differing assumptions between primary and secondary care about responsibility for acting on investigation findings. The Welsh Government recognises that GP practices receive a high volume of correspondence and that administrative triage processes are used to support the safe and efficient management of that correspondence. The Welsh Government does not consider that the learning from this case should be framed as an expectation that every item of correspondence received by a GP practice must automatically be reviewed by a clinician. The key issue is that correspondence from secondary care should be clear where further action is required, including where referral, further investigation or specialist review is considered necessary. The local actions being taken by Aneurin Bevan University Health Board, together with the national expectations set out in the All Wales Clinical Interface Standards, are intended to address the concern that responsibility for onward action must be clear and understood across the interface between services.

5.	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Welsh Government will recirculate the All Wales Clinical Interface Standards to NHS Wales organisations in the context of this Regulation 28 report. This will be used to reinforce the importance of clear communication between clinicians and services; making any required action explicit in clinical correspondence; ensuring responsibility for follow-up, referral or further investigation is clear; avoiding reliance on assumptions about how correspondence will be processed by another service; and supporting safe transfer of clinical information across primary and secondary care. The Welsh Government will also ask Aneurin Bevan University Health Board to confirm progress against the local actions identified following its review, including the work between the Pre-Assessment Clinic and Cardiology Directorate, the interim referral arrangements for abnormal cardiac investigations, and the review of correspondence templates. The Welsh Government considers this to be a proportionate response to the matters raised. It recognises the concern identified by the Coroner, while also acknowledging that the circumstances of this case relate to the clarity of communication and responsibility at a specific clinical interface.
6.	[redacted] [redacted] **Chief Medical Officer, Welsh Government**