REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 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).

1.	CORONER I am Frazer STUART, Assistant Coroner, for the coroner area of Gwent.
2.	DATE OF REPORT 17 July 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. Chief Medical Officer for Welsh Government You are under a duty to respond to this report within 56 days of the date of this report, namely by September 11, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. 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. 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. 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.
6.	SUMMARY OF CORONER'S CONCERN SUMMARY OF CORONER S CONCERN

	1am concerned that clinicians in secondary care are not aware of how their correspondence to primary care is handled upon receipt. If correspondence from secondary to primary care does not contain a specific instruction for further action, it is not viewed by a clinician but categorised by administrative staff, and uploaded to a patients file with no action being taken. It became apparent during the course of the inquest hearing that secondary care clinicians are not aware of this process and believed that every letter sent to a GP surgery would be passed to a GP or other medically qualified person for review. The inquest heard how this is the position across Wales, and was not limited to the ABUHB area. 1am concerned that these circumstances create a risk that the need for a referral to a specialist could be missed, resulting in a risk of death following delayed or missed diagnosis and treatment.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and 1believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 03 September 2024, the Senior Coroner for Gwent commenced an investigation into the death Glyn Richard Pressley aged 55 years. The medical cause of death was: 1A Hypertensive Heart Disease 2 Coronary artery atherosclerosis & obesity The investigation concluded at the end of the inquest on 16 July 2026. The conclusion of the inquest was that: Mr Pressley died on the 20 August 2024, at 11B Turner Street, Newport, as a result of heart failure My conclusion was one of Natural Causes.
9.	CIRCUMSTANCES OF DEATH In November 2021, Mr Pressley underwent a hip replacement. As part of the pre-operative procedure, he underwent an ECG and echo cardiogram examination which revealed he was suffering from a Left Bundle Branch Block, an ejection fraction of 48% alongside a grade 1 diastolic dysfunction. This was not an impediment to having his hip operation, but the anaesthetist wrote to Mr Pressley's GP to inform him of the findings with a view to exploring the issues in more detail.

	These circumstances give rise to a risk of future deaths due to missed opportunities for referral to specialists for diagnosis and treatment.
11.	**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: • Family members and NOK of deceased • Chief Executive of ANEURIN BEVAN UNIVERSITY HEALTH BOARD 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.
12.	**SIGNATURE**  **Frazer STUART** **Assistant Coroner for** **Gwent**