

National Medical Director NHS England & NHS Improvement and Interim Chief Executive, NHS Improvement Skipton House 80 London Road London SE1 6LH

9th September 2021

Coroner M E Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP

Dear Ms Hassell,

Re: Regulation 28 Report to Prevent Future Deaths – Chimezie DANIELS who sadly died 26 January 2021

Thank you for your Regulation 28 Report dated 16 August 2021 concerning the death of Chimezie Daniels on 26 January 2021. Firstly, I would like to express my deep condolences to Chimezie Daniel's family.

The regulation 28 report concludes Chimezie's death was a result of SARS CoV-2 infection and pulmonary sarcoidosis.

Following the inquest you raised concerns in your Regulation 28 Report to NHS England regarding

- At inquest, I heard that on most CPAP machines, the alarm that sounds for a very small leak from the mask is no different from the alarm that sounds for total cessation in oxygen supply.
- Clinicians told me that it would be much more helpful if very serious matters were denoted by an urgent alarm, and less serious matters in another way.
- When the alarm on Mr Daniels' machine sounded, there were four other alarms sounding simultaneously for the four other patients in the bay where he was being nursed. This gave the determination of the cause of his low oxygen saturations an added complexity, particularly at a time in the pandemic when there was so much pressure on beds that CPAP patients were being nursed on medical wards rather than in the high dependency unit.
- I appreciate that there will not always be an intention to connect to an oxygen supply. Nevertheless, I am sure that further consideration can be given to the issue that the inquest touching Mr Daniels' death has highlighted.

The national patient safety team at NHSEI have provided me with a response below.

NHS England and NHS Improvement

The main area of concern that you raised within the Preventing Future Deaths report relates to the alarm sound and whether there should be a different sound for 'serious matters'. This will require a change in the design of the associated medical devices which would fall into the remit of the Medicines and Healthcare products Regulatory Agency (MHRA).

The national patient safety team have worked with two national professional organisations on general safety concerns relating to non-invasive ventilation/CPAP.

- The national patient safety team worked closely with the British Thoracic Society during the development of their recently published guidance on <u>Respiratory Support Units</u> to ensure that several key safety issues were addressed in the guidance. This included recommendations that 'local protocols should be in place to detect disconnection from CPAP and NIV and will include disconnection alarms on machines and defining the protocols for the frequency of nursing review especially for patient nursed in side rooms' and 'all machines should, at a minimum, have a disconnection alarm ... where patients are nursed in side rooms, the alarm should be audible from outside the room.' The BTS guidance also includes a checklist which provides an additional safety intervention and includes checking alarms and that the device is actually attached to oxygen.
- The national patient safety team continues to work with the Faculty for Intensive Care Medicine to develop guidance on the setting up of breathing circuits and we will engage with them to include guidance on disconnection alarms to ensure staff are aware of what each alarm may be indicating and the relative urgency to respond to an alarm.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director NHS England & NHS Improvement and Interim Chief Executive, NHS Improvement