GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Executive Headquarters / Pencadlys Gweithredol

Woodland House
Maes-y-Coed Road
Cardiff
CF14 4HH

Ty Coedtir
Ffordd Maes-y-Coed
Caerdydd
CF14 4HH

Eich cyf/Your ref: 9691348
Ein cyf/Our ref: SR-jb-1224-032
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol: 029 2183 6010

[redacted]
Chief Executive

6 December 2024

Private and Confidential
Ms G Kynaston
Assistant Coroner
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

By Email: [redacted]

Dear Ms Kynaston

Thank you for your letter received via email received 17 October 2024 in which you have shared the Regulation 28 with associated actions for improvement following the inquest into the sad death of Mr John Austin Follon.

I note that it is your view that some actions could be taken by the Health Board to minimise the risk of future deaths in similar circumstances. In addition, it is noted that the cause of the Cardiac arrest cannot be established and it is not possible to determine whether the lack of monitoring more than minimally contributed to this gentleman's death, the Health Board accepts that this is unsatisfactory for the family and did not assist the inquest process.

The matters of concerns raised are outlined:

(1) Changes to the alarm system have been made following Mr Follon's death such as making the alarm louder and ensuring a yellow ribbon appears and remains at the top of the monitoring screen until the alarm is reactivated. However, it is still possible for a member of staff to silence the alarm without checking on the patient and the alarm will remain silent until it is physically reactivated by a member of staff.

In the inquest it was acknowledged by the CVUHB (Cardiff and Vale University Health Board) representative that these measures taken would not in isolation prevent a reoccurrence of this event. It is hoped that the additional measures taken as outlined in this response will provide some further reassurance.

(2) Currently when the alarm is triggered, during the day shift, staff are required to check on the patient prior to the alarm being silenced, during a night shift staff are permitted to silence the alarm prior to checking the patient to reduce noise to a minimum while patients are sleeping. The latter was the position in the instant case when Mr Follon's lead became detached.

We would like to advise that there is no formal permission given to staff to silence the alarm before reviewing the patient at any time of day or night. Staff will often silence the alarm prior to reviewing the patient to reduce noise levels for the comfort of all patients however the issue that arose in this situation was that the alarm was silenced but the cause of the alarm was not clarified and Mr Follon was not reviewed as would have been expected in these circumstances.

(3) The monitors are not checked constantly or even every hour but are checked twice during each shift. During a busy night shift or during handover, if the person silencing the alarm does not attend to the patient at the time the alarm sounds and if the amber ribbon, which now appears on the monitor alerting staff to a "lead off' scenario, goes unnoticed, the risk that a patient will not be monitored for a significant period of time remains.

It may be helpful to clarify the monitors are observed regularly throughout the shifts but there is a checklist in place to review alarm settings and confirmation that alarms are on. The monitors are also checked outside of this process.

(4) During a night shift, the circumstances in which Mr Follon died remain the same notwithstanding changes to nursing practice and the alarm system have been made. The risk of a patient not being monitored for a significant period of time remains and could give rise to a death in similar circumstances in the future.

On review it was acknowledged that these circumstances could equally apply to a day shift and we fully acknowledge the above. However, following a number of meetings with our CVUHB clinical engineering department and the monitor manufacturer Phillips following receipt of the regulation 28 further amendments have been made to the system to mitigate the risk of this incident happening again.

These actions include:

There are two alarm reminder (re-alarm) settings; available for "All inop alarms"; and "Yellow + red alarms". Once set, this will cause a silenced alarm to reactivate after 2 mins should the alarm condition not be resolved. Yellow + red alarms already have the re-alarm setting on in CVUHB. Our immediate action after the incident was to make the ECG leads off / Lead set unplugged alarms a yellow alarm. This ensures staff can prioritise confirmed red alarm conditions, for example Cardiac arrest alarms. We have ensured that staff are reminded again to deal with a *lead off scenario* should the alarm be acknowledged but the issue persists.

The alarm configuration for telemetry units is managed by the central station. The changes to these have been completed within the Cardiothoracic areas on 22 November 2024 by Phillips and the CVUHB Clinical Engineering team.

Now that this work is complete, the next stage is to adjust the monitor configurations to match the central station and telemetry configuration; Clinical Engineering will visit the clinical areas to install these configurations onto the monitors. This will require a phased approach to maintain patient safety. All clinical wards in the Cardiothoracic Directorate will be complete by the assigned deadline of 8 December 2024.

The subsequent steps after resolving the immediate Regulation 28 actions is to assess and evaluate the configurations across all patient monitoring in CVUHB. In the first instance this will provide us with a more robust understanding of the current configurations. Secondly, we can decide if the changes implemented in the Cardiothoracic areas (yellow priority of leads off/unplugged, and re-alarm for the same) are applicable cross the Health Board. The Directors of Nursing have been asked by the Executive Nurse Director to scope and consider this regulation 28 in light of their own clinical areas and this work will be monitored via the Directors of Nursing forum.

It is also our intention to share this information through the Inquest and HOPE (Head of Patient Experience) networks as this could be beneficial across Wales.

I hope that this information is helpful and offers the assurance you are seeking regarding the improvements instigated to reduce the risk that patients in similar circumstances to Mr Follon will not have the alarm silenced without being checked and reviewed.

Yours sincerely

[redacted]

[redacted]
Chief Executive