Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State

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[redacted]

HM Coroner Timothy Brennand
Coroner's Office Manchester West
First Floor Paderborn House
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[redacted]

29 January 2026

Dear Mr Brennand,

Thank you for the Regulation 28 report of 17/10/2025 sent to the Secretary of State about the death of Melanie Walker. I am replying as the Minister with responsibility for Medical Technology.

Firstly, I would like to say how saddened I was to read of the circumstances of Melanie Walker's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

The report raises concerns over the following areas:

- The heart monitor in use did not alert clinicians that a patient had experienced a cardiac event.
- The heart monitor became disconnected from the patient and was not identified by staff as it did not 're-alert' where staff had acknowledged an abnormal reading.
- The heart monitor in its current configuration may encourage the erroneous assumption by healthcare staff that a patient is being appropriately monitored when they are not.

In preparing this response, my officials have made enquiries with the Medical and Healthcare products Regulatory Agency (MHRA) to ensure we adequately address your concerns.

The setting of the patient monitor to not continuously alarm in the case of disconnection from the patient, combined with the staff expectation that it would do so, is the central event I wish to address. Philips has already stated that it is the factory default for these devices that the 'leads off' alert is set to 'alarm on'. Therefore, our response is based around ensuring users understand that these devices can be set to 'alarm off', and must be confirmed as being 'alarm on' when intended to be used in that manner.

In addition to its own response to your report in November 2025, Philips also issued a Field Safety Notice for users of their IntelliVue line of Patient Monitors. This highlights that alarm function is user reconfigurable, and should hence be confirmed in use to ensure it is not accidentally left in the ‘alarm off’ state. Following its standard practice, the MHRA has published the document on its gov.uk platform, ensuring users across the healthcare system have access to this information.

As next steps, MHRA is currently assessing this notice in line with its internal process flow, which includes an Extensive Review of the controls recommended by Philips and a Risk Assessment of the need for any further Field Safety Corrective Action and/or a Device Safety Information Alert. Should further action be found necessary to prevent future harms, I will ensure you are notified.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

Parliamentary Under-Secretary of State
for Health Innovation and Safety