Timothy William Brennand
HM Senior Coroner
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National Medical Director
NHS England
Wellington House
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[redacted]

17 December 2025

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Melanie Jayne Walker who died on 26 December 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17th October 2025 concerning the death of Melanie Jayne Walker on 26th December 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Melanie's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Melanie's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Melanie's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raised concerns about the heart monitoring machine used for Melanie on 17 December 2024. You were concerned that the electrical monitoring equipment did not trigger any alarm from Melanie's heart monitor, when it should have done. You raised the risk that where a blue 'in op' alert is triggered by an event such as an abnormal reading or a monitor lead becoming disconnected, staff are not re-alerted once the original alert has been acknowledged through pressing a button, even if an issue such as disconnection remains. You considered this risk remains an issue for all Hospital Trusts nationally.

NHS England would advise that the Medicines and Healthcare products Regulatory Agency (MHRA) would be best placed to respond to these concerns. The MHRA would also be in a position to issue a Device Safety Information bulletin, if required, to advise NHS organisations of the current risk and to update on the steps taken by the manufacturer (Philips) to implement the monitor reconfiguration and the new 'yellow alert' system.

NHS England's North West regional colleagues have engaged with Greater Manchester Integrated Care Board (ICB), who have advised that the learning from the Patient Safety Incident Investigation has been shared via the Speciality and Divisional Governance structures and via Trust Governance structures, which include the Medical Devices Committee, Quality Assurance Committee and Patient Safety Group.

The ICB has advised that in an area such as resuscitation, monitoring is continuous, as the patients are on telemetry monitoring. It would be normal practice for patients not to be directly observed over short periods, depending on their individual clinical trajectory. Melanie's clinical trajectory was that of improvement, as she had been stable for over 3 hours with overall improvement. It was felt that the key safety action was the reconfiguration of the alarm system, which would then alert staff if any leads had become dislodged or removed.

Greater Manchester ICB has also advised that, regarding the reconfiguration of alarms, the monitors have since been reconfigured. Now, when an 'ECG leads off' alarm is generated, the monitor will give the visual yellow flashing banner. If the alarm is acknowledged, the yellow banner will remain and the audio will re-alarm after three minutes if the ECG leads are still not connected, whereas previously the monitor would 'blink' only and would not alarm.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Melanie, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

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

Yours sincerely,

[redacted]

[redacted]
National Medical Director
NHS England