Mr David Donald William Ried
HM Senior Coroner
Worcestershire Coroner's Court
The Civic
Martins Way
Stourport-on-Severn
Worcestershire
DY13 8UN

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

2nd June 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lucy Jane Phelan who died on 14 May 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 1 April 2026 concerning the death of Lucy Jane Phelan on 14 May 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lucy's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Lucy's care have been listened to and reflected upon.

Your Report raises concerns around:

- 'Alarm fatigue' in a busy environment like a hospital's Emergency Department, particularly when patient numbers are high, staff find it increasingly difficult to react and respond to the many different types of alarm in use.
- The use of 'latching' facilities on monitoring equipment is likely to contribute to the phenomenon of 'alarm fatigue'. This has been recognised by the equipment manufacturer which no longer recommends its use on Emergency Department monitors, and by Worcestershire Acute Hospitals NHS Trust who have switched it off on monitors in its Emergency Departments.
- It is not known whether, and to what extent, the 'latching facility' remains in use in Emergency Departments in other hospitals in England and Wales.

NHS England's National Patient Safety Team have advised that 'alarm fatigue' is a recognised phenomenon and the function 'alarm latching' is a setting that requires any triggered alarm to be manually acknowledged and resolved by a member of staff. There are however, other limitations relating to any secondary triggered alarm that may tailor use of this function. The suggestion that 'the equipment manufacturer no longer recommends the use of alarm latching functionality on the Emergency Department monitors' is currently subject to further investigation as such information would need to be officially communicated to all users and be part of the medical device manual and Instructions for Use (IfU) documents.

The NHS England National Patient Safety Team are engaging with the regulator of medical devices, the Medicines and Healthcare products Regulatory Agency (MHRA),

to explore whether this is the manufacturer position and whether these requirements have been met.

The MHRA are the correct authority to advise on concerns regarding medical devices with alarm latching capabilities healthcare organisations. The NHS England National Patient Safety team will continue to engage with the MHRA to understand how latching functionality is best managed in the clinical environment. The MHRA will be coming back to us once they have gathered further information from the manufacturer regarding this specific case.

Midlands regional colleagues have advised that this case will be shared with the relevant Integrated Care Board and with regional nursing colleagues for information and will suggest the possibility of sharing the learning with Trust Patient Safety Specialists. We have also been advised that learning will also be shared at the Mortality Forum due to be held in June 2026.

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 Lucy, 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,

National Director of Patient Safety

NHS England