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| | **Report to Prevent Future Deaths**<br><br>**Regulation 28 of**<br>**The Coroners (Investigations) Regulations 2013**<br><br>**Ismaeel ISLAM (died 07.03.25)** |
| 1 | **CORONER**<br><br>I am: Coroner ME Hassell<br>Senior Coroner<br>Inner North London<br>St Pancras Coroner's Court<br>Poplar Coroner's Court<br>Bow Coroner's Court |
| 2 | **DATE OF REPORT**<br><br>11 June 2026 |
| 3 | **CORONER'S LEGAL POWERS**<br><br>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and<br>The Coroners (Investigations) Regulations 2013, regulations 28 and 29. |
| 4 | **THIS REPORT IS BEING SENT TO:**<br><br>1. Chief Executive<br>Masimo UK<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 August 2026. I, the coroner, may extend the period if an appropriate application is made. |
| 5 | **YOUR RESPONSE**<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. |

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| | I have a duty to send a copy of your response to the Chief Coroner.<br><br>In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.<br><br>Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.<br><br>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that you have the power to take such action. |
| 7 | **INVESTIGATION AND INQUEST**<br><br>On 11 March 2025, I commenced an investigation into the death of Ismaeel Islam, aged almost six months old. I concluded the inquest on 3 June 2026.<br><br>Ismaeel died at the Royal London Hospital on 7 March 2025.<br>His medical cause of death was:<br><br>1a pulmonary heart disease<br>1b chronic pulmonary complications<br>(chronic lung disease, arterial pulmonary hypertension)<br>1b hypoxic ischaemic encephalopathy<br>following resuscitation from a cardiorespiratory arrest 03.11.24<br>1d trisomy 21 with congenital heart defects (atrial septal defect; ventricular septal defect) and lung growth disorder<br>2 ex prematurity (31/40), failure to thrive |
| 8 | **CIRCUMSTANCES OF DEATH**<br><br>Ismaeel Islam died from a natural cause, being a combination of Down's Syndrome, growth restriction and prematurity. |

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| | However, he was on a special care baby unit at the time of the collapse on 3 November 2024 that led to his death, and there was a failure to recognise his desaturation and respiratory arrest for approximately half an hour. This was because his monitor alarm had been turned down too low to be usefully audible, and his cot was not within the line of sight of the nurse caring for him who was at that point with another baby.<br><br>If Ismaeel's deterioration had been recognised immediately and treated appropriately, his life would have been saved. |
| 9 | **CORONER'S CONCERNS**<br><br>During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>I heard at inquest of several measures that have been implemented by the hospital trust to make this situation less likely to occur in the future, principally dealing with the audibility of alarms and nursing line of sight.<br><br>However, the trust told me that an approach has been made to you as manufacturer of the monitor alarms in question, to ask that the volume on these alarms be either locked or at least set to maximum as a default, but that you have not yet made a decision about this request.<br><br>I write now to urge you to consider as soon as possible the issue of how you can maximise patient safety in this respect. |
| 10 | **COPIES AND PUBLICATION OF THIS REPORT**<br><br>I have a duty to send a copy of my report to every interested person who in my opinion should receive it.<br><br>I also may send a copy of the report to any other person who I believe may find it useful or of interest. I have sent the report to:<br><br>• the parents of Ismaeel Islam<br>• Barts Health NHS Trust.<br><br>I also have a duty to send a copy of the report to the Chief Coroner.<br><br>You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). |

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| | Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 5 above for additional information relating to the publication of reports and responses. |
| | **SIGNATURE**<br><br>*ME Hassell* |