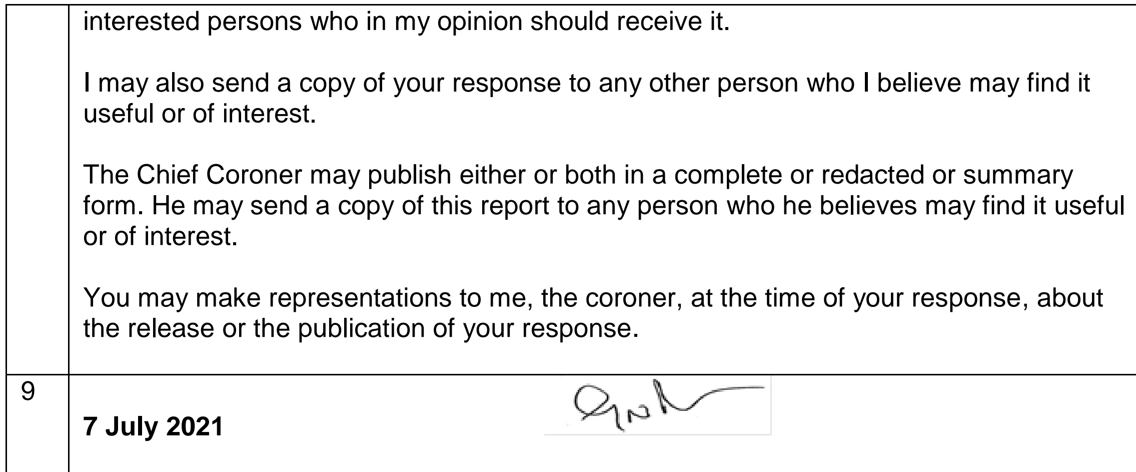
MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) [redacted], Royal College of Anaesthetists, Head of Clinical Quality Standards. (2) [redacted], Associate Director of Faculties, Faculty of Intensive Care Medicine
1	**CORONER** I am Nadia Persaud, Her Majesty's Coroner for the Coroner Area of East London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 6 May 2020, I commenced an investigation into the deaths of Mr Kishorkumar Patel and Mr Kofi Aning. The investigation is ongoing and the inquest hearings are listed to be heard in October 2021. It is my view that the concern that has been brought to my attention, is a concern that requires addressing at the earliest possible stage. I do not consider that it is appropriate to await the conclusion of the Inquest hearings.
4	**CIRCUMSTANCES OF THE DEATH** Mr Patel and Mr Aning were both treated at the Nightingale Hospital in London in April 2021. In both cases there was a serious incident in which the wrong filter was found to have been used within the breathing systems of their intensive care ventilator. It is understood that these two cases came within a cluster of similar incidents. No conclusion has been reached as to whether the incident with the filter contributed to the

	deaths. The question of causation will be considered at the Inquest hearings. The question of causation is not determinative of the making of a Preventing Future Deaths Report.
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation the evidence revealed matters 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. The **MATTERS OF CONCERN** are as follows: An independent expert has advised: *In my opinion, the non-standardised colour coding used by manufacturers of these filters, the number of different types of filters with different names, the variable optimal position of the filters, and whether a wet or a dry breathing system is being used, results in an extremely confusing situation. One of the leading manufacturers of these filters (Intersurgical) produces HMEs that are blue, which is the same colour as the non-HME filters supplied to NHL by another company. A photograph of the non-HME blue filter is inconsistent with the photograph of the green HME and yellow non HMEs shown on page 6 of the guidance for use of anaesthetic machines for the ventilation of adult critical care patients. In my experience, few doctors and nurses working in ICU are knowledgeable about all these different filters and which ones should be used for any given breathing system.* *In my opinion, the confusion over breathing system filters and HMEs is widespread among ICU staff (doctors and nurses) and the classification and colour coding of these filters/HMEs is worthy of review, simplification, and standardisation.* The concerns raised by the independent expert are not confined to the Nightingale, emergency provision hospitals, but relate equally to all intensive care settings, particularly when the intensive care provision has to be extended to other areas of the hospital. As there are still pressures within the ITU settings and in light of the imminent, planned reduction in COVID-19 safeguards, I consider that action should be taken to address this concern at the earliest possible stage.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **1 September 2021**. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: the families of Mr Patel and Mr Aning, Barts Health NHS Trust. the CQC and to the local Director of Public Health. I am also under a duty to send a copy of your response to the Chief Coroner and all



	interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**7 July 2021**