[redacted]
[redacted]
Date: 22 November 2021

Mr Kevin McLoughlin
HM Senior Coroner
West Yorkshire (Eastern District)
HM Coroner's Service
71 Northgate
Wakefield
WF1 3BS

Dr [redacted]
Medical Director
Trust Headquarters and Medical Education Centre
Aberford Road
Wakefield
WF1 4DG

[redacted]

Dear Mr McLoughlin

Re Inquest of Mary LAND (dcd) – 21.11.1944 to 05.02.2021 – [redacted]

I am responding on behalf of the Trust to the Regulation 28 Report to Prevent Future Deaths that you issued on 29 September 2021 jointly to Philips Respironics, The Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care, and The Mid Yorkshire Hospitals NHS Trust (MYHT).

The Matter of Concern raised in your report was:

> *The Philips Respironics AF541 mask connects to the tubing, linking it to the BiPAP ventilator by means of a 'push on' connection (rather than a fitting involving positive engagement). Evidence taken at the Inquest indicates this connection has come undone on other occasions as well. The introduction of a filter at the site of this union increases the potential for the joint to come apart. Consideration should be given to installing a more robust docking mechanism which is less vulnerable to working loose, or being inadvertently pulled apart, for example, by a patient suffering from delirium.*

As you acknowledged during the Inquest, the Trust conducted a very open and candid significant event RCA investigation into this tragic incident and identified four actions in response to recommendations arising from the investigation.

We subsequently undertook these actions and I am able to confirm that all four actions were completed by 4 August 2021 (refer **Attachment 1**).

The following recommendation and its corresponding action are of specific relevance to the Matter of Concern.

Recommendation 2: ***Scope and discuss with regional units if there can be an improvement on securing tubing circuit connections***

Action 2: ***To understand if manufacturer or other solution [is available] to provide greater tubing circuit connection stability*.**

The inclusion of a filter to manage COVID-19 patients was recommended as part of the British Thoracic Society (BTS) Guidance issued in Wave 1 of the Pandemic (refer **Attachment 2**). At date, this advice remains current and is considered best practice for infection prevention and control purposes of COVID-19 patients on non-invasive ventilation.

Unfortunately, the additional filter component inserted between the facemask and the ventilator tubing *may* have contributed to destabilisation of the circuit, although this cannot be clinically proven, and there is no current research/evidence to confirm or reject the theory that the additional filter caused/causes destabilisation of the circuit.

Following the Inquest, the Trust has had further internal discussions with our Respiratory Team, including our lead for Non-invasive Ventilation (NIV), regarding the use of the filter. The presence of the filter is still considered beneficial in preventing the transmission of COVID-19 and as such, the Trust continues to use the filter in accordance with the BTS guidance.

Of note, at the time when the incident was investigated and design solutions were researched, there was no all-in-one circuit available, i.e. where the filter was an integral constituent of the mask, rather than an optional add-on component. As such, the Trust thanks you for raising this issue directly with the manufacturer, Philips Respironics.

I trust this advice is helpful and thank you again for raising this important matter with us.

In closing, on behalf of The Mid Yorkshire Hospitals NHS Trust, I would also like to take this opportunity to once again offer our sincere condolences to Mrs Land's family in relation to her sad death.

Yours sincerely

[redacted]

Dr [redacted]

Medical Director