East Kent Hospitals University NHS Foundation Trust

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30 March 2022

[redacted], Chief Executive

Dear Madam

Mr Christopher George Osland – PFD Response

Thank you for your Prevention of Future Death Report dated 22nd February 2022 sent pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 concerning the death of Mr Christopher George Osland on 12th May 2021.

I understand that during the course of the inquest you heard evidence that revealed matters giving rise to various concerns that need to be addressed to prevent a future death. I will address your concerns in chronological order:

1. **Nursing staff are unaware that the room monitor volume could be reduced to the point where it was not audible outside the room, as a result, the volume of the room alarm was not part of handover equipment check**

and

2. **The circumstances in which the room monitor alerts were reduced were not documented, and accordingly subsequent staff would not be aware that they had been so reduced.**

The volumes on the monitors have now been defaulted to 8-10 (which is the highest volume on the machine) and cannot be reduced by the ICU (Intensive Care Unit) staff. ICU staff are now not able to reduce and set the alarms on these machines themselves and this can only be carried out by the Trust's Electrical and Mechanical Engineering Department (EME) on request. As a result of this change, volumes of the alarms will not routinely be required to be discussed at handover.

We care

However, if EME have been requested to change the volumes, this will be documented along with an individualised risk assessment in the patient record. In future, a review of alarm levels will take place as part of our configuration of current ICU monitors but I can assure you that volumes will be set at a level which will be agreed by the configuration working group which comprises of critical care, medical devices, EME and GE Healthcare (manufacturer of the monitors).

3. **After silencing the 'OFF COMS' alert on the central monitor, no steps were taken to ensure it was reconnected to the room monitor**

and

4. **No steps had been taken to respond to the 'OFF COMS' notification on the central monitor screen which had persisted for the 5 days prior to the 26th April 2021.**

Since this incident, EME have carried out an inspection of the ICU Department's electrical supply system. As a result, they identified faults with the cabling which could have affected the connection of monitors to the central monitor. The entirety of the cabling in ICU at Kent & Canterbury Hospital has been replaced to improve connectivity and since this has been carried out there have been no issues with connectivity. If the 'OFF COMS' alert appears, the process is to inform the Nurse in Charge and report this to EME as soon as the staff are made aware of the issue. The process of reporting issues to EME is now more robust with logging and receipt of calls and the Trust now uses a dedicated IT system (EQUIP) which allows for a review of any issues that are outstanding or recurring themes that need to be acted upon. Additionally, we have implemented twice daily audit checks on the central monitoring system to ensure that it is connected with every monitor in ICU - these checks are recorded in the unit diary.

5. **Specifically, in respect of point 3 & 4, it is unclear as to when the 'OFF COMS' disconnection between the room and central monitor would have been rectified had it not come to light after Mr Osland's cardiac arrest.**

As outlined in the GE Healthcare log report which was adduced in evidence at the inquest, the central monitoring system disconnected from the monitor in Mr Osland's room on 19th April 2021 and re-connected itself on 26th April 2021, around 20 minutes after his cardiac arrest. It is accepted that had Mr Osland not suffered a cardiac arrest we would have been unable to tell you with any confidence when the fault would have come to light. This has now been rectified and I refer you to our responses above.

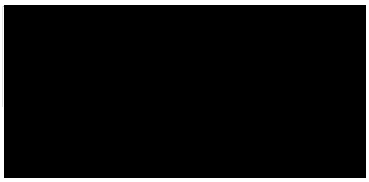
6. **It was unclear what steps nurses were supposed to take when confronted with an 'OFF COMS' alert or screen notification**.

Before Mr Osland's death the process for ICU staff confronted with an 'OFF COMS' alert or screen notification was to report the matter to EME. However, it is accepted that this was not widely known by nursing staff and I refer to the above response in paragraph 4 which details how the Trust has improved the reporting process.

I can confirm that as a result of this incident, the inquest and your PFD Report the Critical Care Steering Group considered all matters associated with Mr Osland's care and will ensure all recommendations are addressed and continue to be monitored.

Lastly, I hope I have provided you with the relevant assurance that the Trust has taken the incident and your concerns seriously and we will continue to strive to offer high standards of clinical care to our patients in the ICU setting.

Yours sincerely



Chief Executive