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All-Wales Medical Equipment Managers Group
NHS Wales Local Health Boards and Velindre University NHS Trust

Dear colleagues,

**Regulation 28 Prevention of Future Deaths Report – Assurance on alarm
“latching” functionality in acute monitored environments**

A [Regulation 28 Prevention of Future Deaths Report](#) has raised concern about the use of “latching” alarms on physiological monitoring equipment in England and Wales.

The aim of this communication is to ensure that current practice does not introduce avoidable patient safety risks and to support a consistent, all-Wales approach to alarm management.

The Regulation 28 Report relates to a death in an emergency department in England and highlights that latching functionality may:

- contribute to alarm fatigue
- make it difficult to distinguish new alarms
- affect the reliability of alarm audit logs

The equipment manufacturer no longer recommends use of the latching function on Emergency Department monitors. Although this case related to an Emergency Department, similar risks may arise in all clinical areas using continuous patient monitoring, particularly in high-acuity environments.

Required Actions

You are requested to work with the relevant medical equipment teams to undertake local assurance assessments as follows:

1. Review current practice

- Identify whether “latching” alarm functionality is enabled or disabled on physiological monitoring equipment across all relevant clinical areas.
- Review historical incident data (e.g., Datix) for alarm-related events, near misses, or trends

2. **Assess risk and safety**

- Review local risk assessments, policies and standard operating procedures relating to alarm management.
- Ensure arrangements are in place to minimise alarm fatigue and support timely and appropriate clinical response.
- Ensure clinical engagement and ownership, with appropriate input and sign-off from senior nursing and medical leads.

3. **Take appropriate action**

- Where latching is currently enabled, assess whether continued use is safe and clinically justified. Implement changes where required with clear timescales for review, removal or further risk assessment.
- Ensure staff are:
 - Competent in the use of physiological monitoring equipment
 - Aware of alarm management principles and risks associated with alarm fatigue
 - Appropriately trained in the use of physiological monitoring equipment
- Identify and reduce unwarranted variation in alarm configuration across sites and departments.

4. **Coordinate and share findings**

- Discuss findings through the All-Wales Medical Equipment Managers Group to be compiled into a summary report of current practice, risks, and recommended actions.
- The report will be submitted by **September 2026** to the soon to be established Healthcare Quality & Improvement Board.

Monitoring and compliance

Compliance with this WHC will be monitored through the All-Wales Medical Equipment Managers Group and reported to the Healthcare Quality & Improvement Board.

Thank you for your continued leadership in patient safety.

Yours sincerely

A handwritten signature in black ink that reads "Isabel Oliver". The letters are cursive and connected, with a prominent initial "I".

PROFESSOR ISABEL OLIVER

A handwritten signature in black ink that reads "Sue Tranka". The letters are cursive and connected, with a prominent initial "S".

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