



نتقدم بثقة  
Moving Forward  
with Confidence

رؤية عُمان  
2040  
Vision

To:

**THE DIRECTOR GENERAL OF HEALTH SERVICES IN ALL GOVERNORATES**  
**Commanding Officer, Armed Forces Hospital (Al Khoudh & Salalah)**  
**Director General of Engineering Affairs, MOH**  
**Director General of Royal Hospital**  
**Director General of Khoula Hospital**  
**Director General of Medical Supplies (MOH)**  
**Director General of Pvt. Health Est. Affairs (to kindly arrange distribution to all Pvt. Hospitals)**  
**Hospital Director (Al Nahda Hospital)**  
**Hospital Director (Al Massara Hospital)**  
**The Head of Medical Services in SQU Hospital**  
**The Head of Medical Services in Royal Oman Police**  
**The Head of Medical Services in Ministry of Defence**  
**The Head of Medical Services in The Diwan**  
**The Head of Medical Services in The Sultan's Special Force**  
**The Head of Medical Services in Internal Security Services**  
**The Head of Medical Services in Petroleum Development of Oman**  
**The Head of Medical Services in LNG Oman**  
**ALL PRIVATE PHARMACIES & DRUG STORES**

After Compliments,

Please find attached our Circular No 129 dated 21/6/2023 Regarding NCMDR Field Safety Corrective Action of Oxylog 3000 plus from (mfr: Draeger Medical Systems Inc).

Copy to:

- Director, Office of H.E. The Undersecretary for Health Affairs
- Director of Medical Device Control, DGPA&DC
- Director of Pharmacovigilance & Drug Information Dept, DGPA&DC
- Director of Drug Control Department, DGPA&DC
- Director of Pharmaceutical Licensing Department, DGPA&DC
- Director of Central Quality Control Lab., DGPA&DC
- Supdt. of Central Drug Information



**PADC**  
المديرية العامة للصيدلة والرقابة الدوائية  
Directorate General of Pharmaceutical  
Affairs & Drug Control



ص.ب: ٣٩٣ مسقط - الرمز البريدي: ١٠٠ - هاتف: ٢٢٣٥٧١١١ - فاكس: ٢٢٣٥٨٤٨٩

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Circular No. 129 / 2023

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Moving Forward  
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رؤية عمان  
2040  
Oman Vision

03 -12-1444 H

21 -06-2023

**Field Safety Corrective Action of Oxylog 3000 plus from Draeger Medical Systems Inc.**

Source	NCMDR - National Center Medical Device Reporting- SFDA. <a href="https://ncmdr.sfda.gov.sa/Secure/CA/CAViewRecall.aspx?caid=6&amp;rid=19578">https://ncmdr.sfda.gov.sa/Secure/CA/CAViewRecall.aspx?caid=6&amp;rid=19578</a>
Product	Oxylog 3000 plus.
Description	Surgical equipment/ Anaesthesia - anaesthesia and medical gas supply.
Manufacturer	Draeger Medical Systems Inc.
Local agent	Waleed Pharmacy & Stores LLC.
The affected products	All Oxylog 3000 plus devices Part No 5704811 and 5704813.
Reason	Potential of above devices stopped ventilation due to a discharged battery. This could be happened despite the fact they are connected to a mains supply after prior battery operation.
Action	1. You will contacted to arrange a date for a firmware update of the Printed Board Assembly Charger. 2. The devices can continue to be used safely by following precautions and actions in the attachment. 3. Contact the local agent for remedial action.
comments	Healthcare professionals are encouraged to report any adverse events Suspected to be associated with the above device or any other medical device to Department of Medical Device Control through the E-mail: <a href="mailto:Med-device@moh.gov.om">Med-device@moh.gov.om</a>

Dr. Mohammed Hamdan Al Rubaie

Director General



To our customers of the  
Emergency and Transport Ventilator  
Oxylog 3000 *plus*

May 2023

## Important Safety Notice

Oxylog 3000 *plus* may not switch to mains supply following battery operation.

All Oxylog 3000 *plus* devices Part No 5704811 and 5704813,  
Basic UDI DI 040486751304015FK19Z000XW, may be affected.

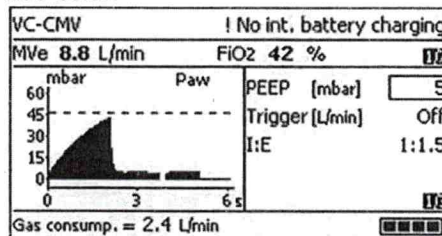
Dear Sir, Madam,

During the course of our global market surveillance activities, we have become aware of instances where emergency and transport ventilator Oxylog 3000 *plus* devices stopped ventilation due to a discharged battery. This happened despite the fact they were connected to a mains supply after prior battery operation.

In those cases, the battery status indication was correct at all times and the specified battery alarms ("Charge int. battery" and "Int. battery discharged") were brought to the user's attention correctly. No serious injuries to patients have been reported as a result of this issue.

The root cause of the inability to switch to mains supply could be identified as a problem of the charging circuit which can occur in the following sequence of situations:

1. a prior battery issue indicated by the alarm "No int. battery charging" occurred during use on mains supply – see below



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Swift-Code: COBA DE FF 230  
Sparkasse zu Lübeck  
IBAN: DE15 2305 0101 0001 0711 17  
Swift-Code: NOLADE21SPL

Sitz der Gesellschaft: Lübeck  
Handelsregister:  
Amtsgericht Lübeck HRB 7903 HL  
Komplementär: Drägerwerk Verwaltungs AG  
Sitz der Gesellschaft: Lübeck  
Handelsregister:  
Amtsgericht Lübeck HRB 7395 HL

Vorsitzender des Aufsichtsrats der  
Drägerwerk AG & Co. KGaA und  
Drägerwerk Verwaltungs AG:  
Stefan Lauer  
Vorstand:  
Stefan Dräger (Vorsitzender)  
Rainer Klug  
Gert-Hartwig Lescow  
Dr. Reiner Piske  
Anton Schrofner

and

2. the internal battery is NOT removed and reinserted or replaced as recommended as remedy for this alarm message according to the Instructions For Use (IFU) and
3. the device is disconnected from mains supply (e.g., for patient transport) and
4. the device is reconnected to mains supply.

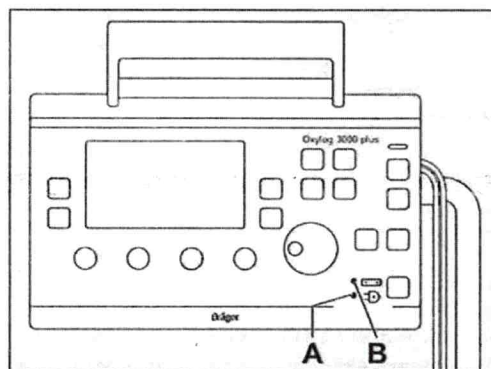
Only if all the conditions are fulfilled and after the aforementioned alarms were given, ventilation could stop as soon as the battery charge was depleted.

Ventilation can be maintained using the manual resuscitator which needs to be ready according to the IFU.

#### Actions to be taken:

Please make sure that the battery is always removed and reinserted or replaced after occurrence of the "No int. battery charging" alarm message, without removing the device from mains supply.

Prior to a device being used on a battery supply, ensure the correct switchover by disconnecting from and reconnecting the device to a mains supply. Please verify the colors of indicators A and B as per the diagram below:



A should display a green light, and B should display a green or yellow light. If B displays a red light, you should disconnect and reconnect or replace the battery.

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Your local Dräger Service representative or our service partner will contact you to arrange a date for a firmware update of the Printed Board Assembly Charger to be performed free of charge.

The devices can continue to be used safely as long as the aforementioned precautions and actions are taken.

Please ensure that all users and maintenance personnel of the above-mentioned products are made aware of this Important Safety Notice within your organization. If you have provided the products to third parties, please forward a copy of this information.

Please keep this information available until the indicated update measures have been completed.

The responsible authorities have been notified of this action.

**Identification of the affected medical devices:**

According to our records, you have received at least one Oxylog 3000 *plus*. All devices may be affected by this issue.

**Contact:**

If you have any questions, please do not hesitate to contact your local Dräger representative.

We apologize for any inconvenience caused by this measure.

With kind regards



Head of Product Management  
Care Area Intensive Care  
Business Unit Therapy  
Medical Division



Director Post Market Surveillance  
Quality & Regulatory Affairs  
Medical Division

European Single Registration Number: DE-MF-000005329