FAO: Ms N J Mundy HM Coroner for South Yorkshire Coroner's Court Crown Court College Road	Your Ref: Date:	12 November 202	21
Doncaster			
DN1 3HS			

Dear Sirs

#### Inquest Touching the Death of Steve Paul Kirkham (the "Deceased") Date of Death: 30 April 2019 Inquest Date: 18 August 2021 Our Client: Intastop Limited

As you are aware, we are instructed to represent Intastop Limited.

Firstly, may we thank HM Coroner for her patience in awaiting our client's response to the Prevention of Future Deaths Report dated 18 August 2021. The extensions granted have enabled a response to be prepared which we hope HM Coroner finds detailed and comprehensive.

#### Circumstances of the Death & Concerns Raised

Our client understands that the Deceased was a resident in a private room (room 17) of Osprey Ward, Swallownest Court, Sheffield. The door to the en-suite in the room had been fitted with a device by our client in 2013 which was designed to sound an alarm should any weight be applied to the door, thereby altering staff.

## On 2 April 2019, the Deceased suggested that no alarm sounded albeit evidence is contradictory with suggested that no alarm sounded albeit evidence is contradictory with suggested that no alarm sounded by Yorkshire Ambulance Service NHS Trust, stating that he was informed by staff at Swallownest Court that they were alerted by a room alarm activated from the top of the toilet door. Our client attended on 3 April 2019 and confirmed the door alarm was in proper working order. However, it was identified and is accepted that there was a "blind spot" between the door, frame and domed cap near to the hinge area.

HM Coroner has identified the following matters of concern:

- 1. The presence of a "blind spot" on the door mechanism;
- 2. The potential for the door mechanism involved in this incident to be used in other places where vulnerable people are housed with the users unaware of the potential danger; and

3. The absence of information from our client in respect of action taken to rectify the "blind spot" area.

#### Response to Concerns

Firstly, our client wishes to express its apology for the absence of information available at the Inquest about action taken in response to this incident. Unfortunately, our client was not an Interested Person and had no knowledge of the Inquest proceedings.

HM Coroner may be assured that our client undertook a comprehensive investigation in response to this incident, the findings of which were shared with Rotherham, Doncaster and South Humber NHS Trust on 9 April 2019. A copy is enclosed for HM Coroner's attention.

By way of summary:

- Our client attended at Swallownest Court on 3 April 2019 in order to check the operation of the Intastop door top alarm on the en-suite of Bedroom 17 where the incident had occurred.
- Upon arrival, our client was also asked to check as many of the other door alarms as possible (excluding those in occupation) and produce a report on their operation, in particular looking at the installation and tamper delay.
- The Schedule of checks undertaken is detailed within the Door Top Alarm (Maintenance) Check Sheet which is again enclosed for HM Coroner's attention. All the alarms checked operated as intended, including that on door 17.

The Intastop door top alarm is designed to <u>reduce</u> the risk of **the reduce**. Unfortunately it is impossible to completely eliminate any chance of **the reduce** and this has been communicated to all users of the product. However, in response to this tragic event, and in an effort to prevent any future death, our client has undertaken the following actions:

- The alarm design was immediately amended to include a mechanical fixing between the hinge and the alarm so as to reduce the risk of turther. All NHS trusts have made aware of the re-designed door alarm that is available.
- All trusts were reminded that products installed by Intastop must be maintained as per Intastop's fitting instructions and/or the operation and maintenance manual. Trusts were also made aware of the planned preventative maintenance that was available through Intastop.
- As it was apparent from the post incident investigation that there was inconsistency when re-setting the door alarms, staff at Swallowdale were retrained on how and when to check the alarms as detailed in the operation and maintenance manual.
- The alarm has since been further re-designed to reduce the risk of even further and this is currently being live trialled at another NHS Trust.

HM Coroner can be confident that Intastop continuously looks to improve its existing product range and/or introduce new products to ensure it is meeting the needs of its customer and reducing **method** risk as much as possible. Intastop has always, and continues to work closely and actively with Trusts as regards communicating and trialling new product designs.

Intastop recognises that it is crucial the construction, design and health industries work together to create safer environments for patients and HM Coroner may be assured of Intastop's commitment to knowledge raising across the industry. In this regard, one of Intastop's employees, **Sector**, Director of Business Development, sits on the innovation and testing sub-committee of the Design in Mental Health Network (DIMHN). In conjunction with BRE, in May 2021, the DIMHN launched a world-fist testing scheme for products used in mental health care facilities. The scheme offers comprehensive testing guidance for materials, fixtures and hardware used within mental healthcare facilities, to include identifying "blind-spots" and how they are managed, thereby offering vulnerable patients more protection from **Sector** than ever before.

We trust the contents of this correspondence adequately satisfy HM Coroner's concerns, however, should any further information be required, please do not hesitate to contact our **equired** who will in turn liaise with our client who is happy to assist in any way.

Yours faithfully

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Keoghs LLP

Enclosures:

- Site Visit Report dated 05.04.2019
- Door Top Alarm Maintenance Check Sheet

### April 2019 Swallownest Osprey Ward Site Visit

# RDASH Content of the second se

Attendees Intastop

#### Summary of Visit

Intastop were called to site on 3<sup>rd</sup> April 2019 to check the operation of a door top alarm on room 17 Osprey ward, Swallownest, after an incident the night before. The alarm was checked and operational. The point was found to be between the door, frame and domed cap (see photo within appendices) this was referred to by the trust as a 'blind spot'. We have identified some recommendations at the end of this document.

14 of the 18 alarms on the site were also inspected (4 rooms had patients in them) and the maintenance report is attached within the report.

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#### Background

On 3<sup>rd</sup> April 2019 we received a call to the Intastop office which was taken by **Constitution** from , RDASH, at St Catherine's Hospital, Doncaster that a serious incident had occurred in room 17 Osprey Ward, at their Swallownest site and that we were required to attend site immediately to test the function of the door top alarm on the en-suite door of the room in question. This was reported to myself by **Constitution** immediately and **Constitution** and I went to the site with our testing kit just after midday.

The Door Top Alarms were supplied in 2013.

#### Site Survey Report

On reaching site and being introduced to the Maintenance Officer **Main**, we spoke to **Main**, Estates Manager for the trust who spoke to us on **Main** phone asking if we could check as many of the alarms as possible for operation and specifically produce a report on their operation by close of business and specifically room 17 where the incident happened. He also commented that **Main** had checked all the alarms and that most had intermittent faults i.e. they may work in one position, but not another for example bedroom 17. It was claimed it intermittently sounded in the centre middle and end and **Main** had checked all Osprey and Sandpiper Wards and that he had found the same issues on all the alarms and also that the time delay between triggering the alarm and the alarm sounding was 20 seconds not 10 as intended.

also said he would like to organise a full PPM inspection and that the incident had occurred by forming a with the patients cord out of their pyjamas between the door, frame and domed cap (see photo within appendices) this was referred to by the trust as a 'blind spot'.

See below the schedule issued to Intastop on site that we have replicated and typed up on the Door Top Alarm (Maintenance) Check Sheet attached.

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the Unit Director then escorted us to room 17 with two colleagues and the use of which I did not catch). Explained what had happened and that there had had been a fatality.

requested that we test the operation of the Intastop door top alarm on the en-suite of Bedroom 17 where the incident occurred the previous night and then asked us to check:

- 1) The installation and the tamper delay
- 2) The operation of the alarms it was thought they were not operating as they should
- 3) To check as many alarms as possible

The door top alarm alerted the staff attack system, sounded at the staff attack station and re-set as intended, we tested as per our procedures using a magnet to identify the operating cycle through the led lighting system i.e. green: working, amber: tamper loop delay, red: alarmed. The alarm sounded at 6.75 seconds.

The unit had power and sounded the alarm at 6.75 second. The LED went to red with no tamper delay LED light (amber), this could mean a loose or unconnected wire in the tamper loop or the alarm was not indicting it was following the tamper setting. This needs further investigation, but does not affect the alarm working as intended.

The point was found to be between the door, frame and domed cap (see photo within appendices) this was referred to by the trust as a 'blind spot'

After which she asked us to check as many as possible and then review the site visit with her at the end of those checks.

We then checked and recorded all of the alarms identified in the schedule as well as accessing the loft space and checking what setting the control box for room 17 was set at it was set at 5 seconds.



We then carried out checks on all the alarms and their operation and the intermittent fault identified by was proven to be incorrect and all the alarms operated as intended. During the earlier testing, was had not allowed the system to re-set and therefore they would not alarm again when they were depressed so soon.

The alarms in rooms 1, 2, 7, 15 could not be checked as they had patients in them. – we requested that we did not check alarms in front of patients, so these rooms were not checked.

On finishing our site check on Osprey Ward we sat down and reviewed with and her team and the trust director (whose name I did not get), we were asked some operational questions on the alarm which we answered and requested to produce a brief report, as well as organising a thorough check of all sites to be arranged with **and the set of** as ap.

concluded that she would have to put a nationwide alert to all trusts regarding the risk when used in conjunction with the alarms.

We sent a preliminary report as requested on Wednesday, 03-04-2019 (see appendices).

#### Conclusion

The 14 alarms were all functioning as required including door 17.

The door top alarm is designed to reduce the risk of **sector**, unfortunately it is impossible to eliminate completely any chance of **sector**.

#### Trust Recommendation

- Identify and rectify the problem found with tamper loop on alarm 17.
- Inspect all the sites at Scunthorpe, Swallownest and Doncaster and check the operations of the alarms.
- Offer more training for the staff on the operation and testing using the magnets.
- Inspect the 4 rooms we were unable to access on 3.4.19.

#### Appendices

Email to trust.

Wed 03/04/2019 18:18

Hi

Firstly, we wish the visit to site today had been under different circumstances, but hope we answered the questions you had today clearly.

This is a brief report on the operation of the Intastop door top alarms installed on the Osprey Ward at the Swallow Nest Site with specific detail on Bedroom 17 where an incident occurred the previous night. We were asked to check:

- 4) The installation and the tamper delay
- 5) The operation of the alarms it was thought they were not operating as they should
- 6) To check as many alarms as possible
- 1) The installation of the alarm

The installation of the alarm was correct, the hinge could have been slightly more elevated as per the image below and was slightly offset on the door.



#### 2) The operation of the alarms in the Osprey Ward

We tested the timing delay and it was between 5 and 6 seconds on all the alarms in the osprey ward. The timing setting on the control box in the loft space adjacent to bedroom 17 was set at 5 seconds. The operation discrepancy highlighted i.e. intermittent faults, was caused by not allowing the alarms to re-set before testing.

We checked the alarm functions at the centre and either end and they operated correctly i.e. followed the anti-tamper loop then set off. The only alarm that did not follow the tamper loop was bedroom 17 meaning it alarms immediately. This is probably a wiring fault in the hinge or control box.

We recommend we check thoroughly all the alarms and re-set the sensors as continuous use of the doors means they can fail, but they have not on Osprey. This I estimate will take 1-2 days, I think there are 40 alarms on this particular batch of installs that occurred in 2013. Also that you visit us here at Intastop to inspect our testing protocol prior to dispatch.

3) We checked all of Osprey.

Please contact me direct should you have any more questions and after the full site service inspection we can provide certificates of conformity.



Holly Street, Kelham Street Industrial Estate, Doncaster, DN1 3TR, United Kingdom



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Picture 1





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Custamer (Compa	ny Name)	RDASH
Site (Project):	Swallo	wnest Osprey Ward
Date of maintenanc	e check:	03/04/2019 77

#### Door Top Alarm | Maintenance | Check Sheet

	Manual Distantia		Visual Check		Operational Check		
DTA Serial #	Ward Details	Door #	Pass	Fail	Pass	Fail	Notes
NA	Osprey Ward, Door #1 En-suite Bedroom 1	1					COULD NOT ACCESS PATIENT PRESENT IN ROOMS
NA	Osprey Ward, Door #2 En-suite Bedroom 2	2					COULD NOT ACCESS PATIENT PRESENT IN ROOMS
NA	ditto	3	×		x		
NA	ditto	4	x		x		
NA	ditto	5	x		×		
NA	ditto	6	x		×		
NA	dītto	7					COULD NOT ACCESS PATIENT PRESENT IN ROOMS

Please sign to confirm that the maintenance work above has been agreed.

Customer

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Customer Signatur

Date: 03/04/2019

#### Door Top Alarm | Maintenance | Check Sheet

DTA Serial #	Ward Details	Door #	Visual Check		Operational Check		Notes
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NA	ditto	11	x		×		
NA	ditto	12	x	đ	×		
NA	ditto	13	x		x		
NA	ditto	14	x	Q	×		
NA	ditto	] 15					COULD NOT ACCESS PATIENT PRESENT IN ROOMS
NA	ditto	] 16	×	Ę	x		
NA	ditto	17	×		×		The alarm was operational but did not light the LED to follow the tamper delay is it alarmed immediately

Please sign to confirm that the maintenance work above has been agreed.

Customer

Customer

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#### Door Top Alarm | Maintenance | Check Sheet

DTA Serial #	Ward Details	Door #	Visual Check		Operational Check		Notes
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Please sign to confirm that the maintenance work above has been agreed.

Customer

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