FAO: Ms N J Mundy
HM Coroner for South Yorkshire
Coroner's Court
Crown Court
College Road
Doncaster
DN1 3HS

[redacted]
Your Ref: [redacted]
Date: 12 November 2021
[redacted]
[redacted]
[redacted]

[redacted]

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 [redacted]. It is suggested that no alarm sounded albeit evidence is contradictory with [redacted], Clinical Supervisor employed 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 reduce the risk of [redacted]. Unfortunately it is impossible to completely eliminate any chance of [redacted] 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 [redacted] further. 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 re-trained 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 [redacted] 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 [redacted] 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, [redacted], 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 [redacted] 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 [redacted] who will in turn liaise with our client who is happy to assist in any way.

Yours faithfully

Keoghs LLP

Enclosures:

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