

Safety Action Notice

Reference: SAN2605

Issued: 07 September 2026

Ligature point found on reduced ligature door and alarm system.

RESTRICTED

This alert contains information which could lead to safety being compromised if misused. It should not be posted on public-facing websites or shared with a patient, carer or member of the public if they are unable to demonstrate an appropriate requirement for it.

Summary

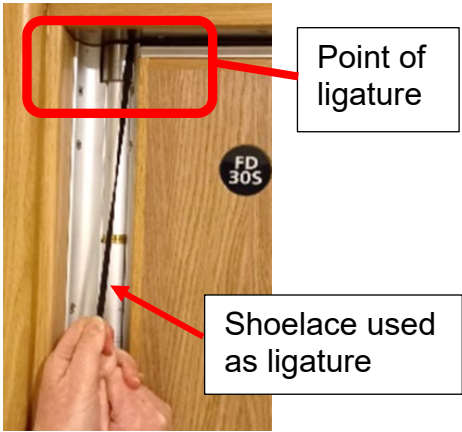
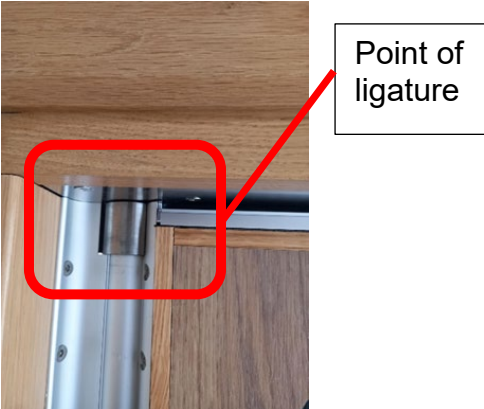
Following a reported incident in a mental health ward, a ligature has been detected on some Kingsway doorsets that have Door Top Monitors and/or Full Door Edge Alarms. Kingsway are aware of the reported incident and have rectified and are now undertaking a UK wide survey and rectification programme which includes direct engagement with NHS Scotland Boards.

Action

1. NHS Scotland Boards to check mental health wards for any installation of product types noted.
2. If any are found and Kingsway have not been engaged, contact should be made with Kingsway Group who can provide local resource. It is through contact with Kingsway that any survey needs can be determined along with any follow up rectification.

Equipment details

Model: SWING Anti-Barricade Door System with door top monitor. Catalogue Number: SWD02 (door) with KG500 TSP1149 DTM Adjustable End Cap (door top monitor)

 Point of ligature Shoelace used as ligature	 Point of ligature
Ligature point found	Adjustable end cap installed

Background Information

An incident was recorded where a patient had secured a ligature by slipping a shoelace into a gap between the door top alarm and the door hinge. A knot was then tied in the shoelace on the outside of the door. When pulled from inside the patient room, a point of ligature was created.

Kingsway as manufacturer were notified, attended site, initially provided a temporary solution and then undertook product development and testing to establish a permanent solution. The solution is a revised part of the door top alarm which can be retrofitted to existing installations.

Since the incident, Kingsway, with an awareness of where the affected products have been installed, have made direct contact with NHS Scotland Boards through their Regional Project Consultants and Project Managers. This has been with a view to arrange facility access and carry out compliance surveys, identifying any specific needs for rectification or upgrade works.

Upgrade and rectification works have been taking place across the UK since the incident was reported and a solution agreed.

Whilst Kingsway group have an awareness of where the affected products have been installed, it is possible NHS Scotland Boards may have an installation that is not recorded. This Safety Action Notice has been issued to advise NHS Scotland boards of the incident, of the affected products and the ability to check for any installation that may require survey and rectification by Kingsway.

Enquiries - manufacturer or supplier contact details

Kingsway Group UK & Europe:
Unit 1 Helix Logistics Park
Edgington Way
Sidcup
DA14 5BN

Tel: +44 (0) 2038 905 887

Email: concustomer.service@kingswaygroup.co.uk

Distribution of this alert

This alert has been distributed to Incidents and Alerts Safety Officers (IASOs) in all health boards and local authorities in Scotland. **If you wish to share the alert informally with colleagues**, please inform them that they may also receive it through the formal local distribution. The local distribution may include additional actions tailored to address local needs, agreed upon by the IASO in consultation with department heads and professional leads.

You can contact your local IASO to discuss this alert and who it should be distributed to. If you do not know who your IASO is, you can find their contact details here: [Find your Incidents and Alerts Safety Officer](#).

Suggested onward distribution (may not include all affected departments)

Capital Planning & Design
Health & Safety
Supplies / Procurement

Estates and Facilities Management
Mental Health Services
Persons undertaking ligature point risk assessments

Fire Safety Advisors
Risk Management

Information about IRIC

Incident Reporting & Investigation Centre (IRIC), Facilities Division, NHS Scotland Assure
Public Services Delivery Scotland, Tel: 0131 275 7575, email: nss.irc@nhs.scot

Accessibility: Please contact us using the above details if you are blind or have a sight impairment and would like to request this alert in a more suitable format.

IRIC remit: general information about adverse incidents, safety alerts and IRIC's role can be found in [DL\(2024\)32](#), *Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities*, issued 16 December 2024.

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