

Case 1001818

Mr J. Pollard Senior Coroner Coroner's Court 1 Mount Tabor Street Stockport SK1 3AG Richmond House 79 Whitehall London SW1A 2NS

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Thank you for your letter of 4 November 2015, following the inquest into the death of Hilda Haughton. I was sorry to hear of Mrs Haughton's death and wish to extend my condolences to her family.

I was concerned to read of the injuries sustained by Mrs Haughton whilst she was a patient at Tameside Hospital. I note that you have requested a direct response from the hospital in relation to the improper use of cot rails on Mrs Haughton's bed and a lack of candour shown by hospital staff to the family. I expect Tameside Hospital to fully address these concerns, and I have asked to see a copy of its response to you.

The issue you raise for the Department concerns the speed of closing for fire doors held open by electromagnetic devices, in hospitals in England. The system means that hospitals can programme the speed at which their fire doors automatically close in the event of a fire or other emergency. However, the faster the closing time, the greater the force with which the doors close.

You report that Tameside Hospital has, in the wake of Mrs Haughton's death, increased the closing time of their fire doors from three seconds to six seconds to reduce the speed and force with which the doors close. However you question whether this is an adequate response and suggest that the potential dangers of fire doors, held open with similar types of door fastener, need to be raised with all hospitals.

The relevant British Standard covering the requirements for such devices is BS EN 1154: 1997 Building hardware – Controlled door closing devices – Requirements and test methods. This British Standard allows a degree of flexibility in the speed at which doors should close of between 3 and 20 seconds.

It is not therefore in the Department's power to control how long it should take for fire doors to close in NHS premises. Such matters are for local management to decide in light of legislation, advice from relevant professional bodies and in line with recognised safety standards.

Having considered the circumstances of this particular tragic incident and made reference to the British Standard, the Department has issued an Estates and Facilities Safety Alert to the NHS in England.

The Alert reference is EFA/2015/006 and was published via the Department's Central Alerting System on Thursday, 3rd December 2015. The alert will also be published by the devolved health administrations in Wales, Scotland and Northern Ireland (who have been consulted on the content of the alert) on the same day.

The purpose of the alert is to raise awareness of the circumstances of the incident you have reported and to set out necessary action to be taken, within defined timescales, to reduce the risk of similar incidents in the future. The actions set out in the alert are not restricted to fire doors held open by electromagnetic devices, and are intended to cover all self-closing fire doors.

This alert follows an earlier safety alert issued to the NHS in 2004, which stated that: "Any remote or unsupervised release of self-closing fire doors may injure occupants. The responsible person should only carry out fire alarm tests and/or remotely release self-closing fire doors if arrangements (so far as is reasonably practicable) are in place to safeguard the occupants from injury, e.g. by a door striking the occupant."

A copy of the Estates and Facilities Safety Alert is attached for your information.

I am grateful to you for bringing the circumstances of Mrs Haughton's death to my attention and hope that her family can take some comfort from the actions the Department is taking to reduce the risk of a similar occurrence in the future.

DAVID PRIOR