Department of Health & Social Care

From [redacted]
Minister of State for Care

39 Victoria Street
London
SW1H 0EU

Our ref: [redacted]

Keith Morton KC
Assistant Coroner
Cambridgeshire and Peterborough Coroner's Office
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

By email: [redacted]

16 August 2024

Dear Mr Morton,

Thank you for the Regulation 28 report of 21st June 2024, sent to the Department of Health and Social Care (DHSC), about the death of Mr Terrence Roy Hubert Taylor. I am replying as the Minister with responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Taylor's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning, and I am grateful to you for bringing these matters to my attention.

The report raises concerns over:

1. Current guidance for residential care homes on the British Standard for window restrictors. The guidance does not factor in situations where a resident deliberately attempts to defeat the restrictor.

2. DHSC and NHSE's best practice guidance, *Health Building Note 00-10 Part D: Windows and associated hardware*. This guidance does highlight that the British Standard for window restrictors does not factor in deliberate attempts to defeat the restrictor using impact forces. However, Health Building Notes are written for the design and planning of new healthcare buildings and/or the adaptation or extension of existing facilities. As such, this guidance, though relevant, has not been directed to residential care home providers and was not known or understood by care home operators, manufacturers, or suppliers of window restrictors.

3. Research by the Health and Safety Executive (HSE) in 2019, which is not known by care home operators or window restrictor manufacturers and suppliers, advises that window restrictors should withstand forces greater than the British Standard.

Regarding these concerns, you had two requests for action. The first related to raising awareness of the latest guidance regarding window restrictors, including the limitations of the British Standard, amongst residential care home operators. Your second request was to review the British Standard to consider whether changes were required.

In preparing this response, Departmental officials have made enquiries with the Care Quality Commission (CQC).

In response to your first request, CQC are a named responder to this case. CQC's separate response will address concerns related to raising awareness amongst residential care home operators of the latest guidance on window restrictors.

CQC expect providers and registered managers to be aware of, and follow, best practice guidance. In 2022, CQC published a '*Learning From Safety Incidents*' webpage on window restrictors. This can be found, alongside relevant, up to date guidance on complying with the relevant health and safety precautions, here: www.cqc.org.uk/guidance-providers/learning-safety-incidents/issue-7-falls-windows. The webpage also links to the latest HSE guidance on risks to vulnerable members of the public from falling from height from windows. It can be found here: www.hse.gov.uk/safetybulletins/windowrestrictors.htm.

Having discussed the case of Mr Taylor with CQC, they have updated their '*Learning From Safety Incidents'* webpage with a link directing providers to the *Health Building Note 00-10 Part D: Windows and associated hardware*. CQC have also committed to publish a note in their bulletin to providers in August 2024 to remind providers of the CQC's '*Learning From Safety Incidents'* webpage.

In response to your second request for action, reviewing the British Standard is not within the scope of my Department's responsibilities. However, my officials have contacted HSE on this matter and await their reply.

I hope this response is helpful. Thank you again for bringing these concerns to my attention.

Yours sincerely,