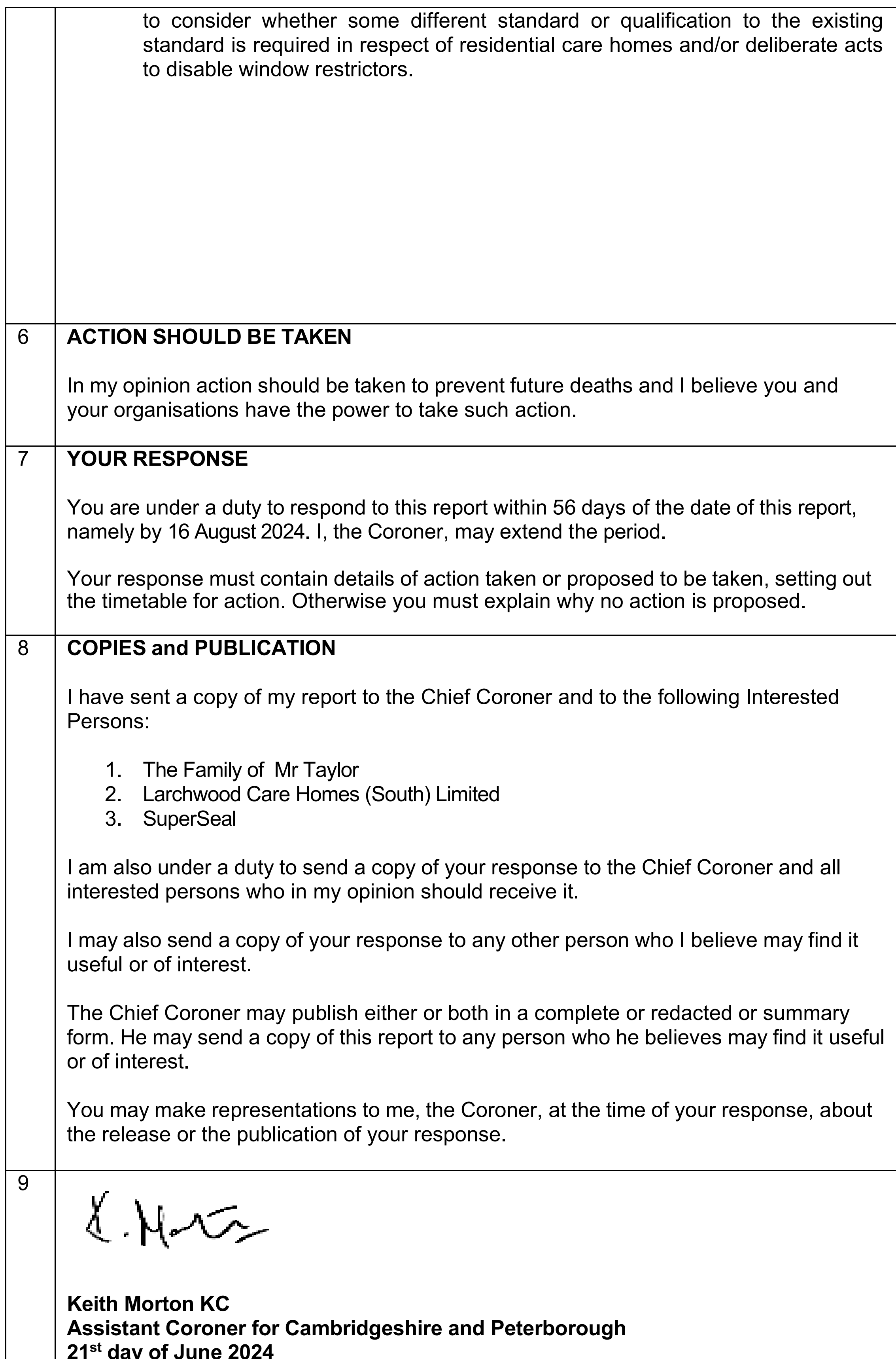
REPORT TO PREVENT FUTURE DEATHS
Pursuant to paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigation) Regulations 2013

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Secretary of State for Health and Social Care **2.** The Chief Executive, Care Quality Commission **3.** The Chief Executive, British Standards Institute
1	**CORONER** I am KEITH MORTON KC, an Assistant Coroner for the coroner area of Cambridgeshire and Peterborough
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 7 January 2021I commenced an investigation into the death of Terrence Roy Hubert Taylor, who died on 11 December 2020, aged 82. The investigation concluded at the end of the inquest before me and a jury on 20 June 2024.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Taylor was a short term resident at a residential care home. He suffered from confusion and memory loss following a stroke. He had absconded from a previous care home on a number of occasions via a fire exit. In order to ensure his safety he was moved to another care home which was reasonably considered to be secure. 2. He had a room on the first floor. The doors from the floor and to the outside were locked. The windows had window restrictors which complied with British Standard BS EN 14351-1 and BS EN 13126-5. These standards specify that window restrictors should be effective to withstand a static force of 350N for 60 seconds and restrict the window from opening more than 100mm. The window restrictors had been properly fitted and maintained. 3. The jury concluded, in summary and in so far as relevant, that during the early hours of 11th December 2020, while alone, Mr Taylor overcame a window restrictor, climbed out of a first floor window and fell to the ground, sustaining injuries from which he died. 4. The evidence was clear. An 82 year old man was able to apply sufficient force to detach the fixing which secured the window restrictor to the window frame. He was able to do so without the use of tools.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. The concern relates to the guidance provided to operators of residential care homes in respect of window restrictors and the standard they are required to meet. The current standards have been developed to prevent accidental falling from windows. They do not deal with deliberate attempts to defeat the restrictor, which may well be the situation encountered residential care homes, as in fact occurred in this case. This limitation is not known or understood by operators of residential care homes. 2. In December 2013 the Department of Health published Health Building Note 00-10 Part D: Windows and associated hardware. That guidance was not directed to residential care home provides. The Guidance was updated following an earlier Coroner's report to prevent future deaths addressed to the Chief Medical Officer. That Guidance Note provides that "… window restrictors tested to current British Standards may be inadequate in preventing a determined effort to force a window open beyond 100mm …". It also noted that: "… The relevant tests for restrictors cited in BS EN 14351-1 and BS EN 13126-5 have been developed to prevent accidental falling from windows … None of the British and European Standards deal with deliberate attempts to defeat the restrictor using impact forces, which may be the situation encountered un hospitals and care homes". 3. The evidence was that this Guidance was not generally known or understood by operators of residential care homes or manufactures or suppliers of window restrictors. 4. In 2019 the Health and Safety Executive published Research Report RR1150 Review of Window Restrictors use in Health and Social Care. The outcome of that research was that in order to protect vulnerable people in health and social care premises: "… it is suggested that window restrictors (and their fixings) are capable of withstanding push forces of at least 850N …". 5. Thus the HSE's research suggests that window restrictors in health and social care premises should be able to withstand forces very much greater than that of the British Standards. 6. The evidence was that this research was not generally known or understood by operators of residential care homes or manufactures or suppliers of window restrictors. 7. Operators of care homes are likely to consider they are taking reasonable steps to secure windows by fitting restrictors that meet the British Standards, whereas the 2013 Department of Health Guidance and the 2019 Health and Safety Executive research indicates that is not so. 8. Action is required to ensure operators of care homes are provided with reliable, up to date guidance and to ensure that the limitations of the British Standard are widely known and understood by operators of residential care homes. 9. Action is required to review the British Standard relating to window restrictors



	to consider whether some different standard or qualification to the existing standard is required in respect of residential care homes and/or deliberate acts to disable window restrictors.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 August 2024. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. The Family of Mr Taylor 2. Larchwood Care Homes (South) Limited 3. SuperSeal I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response.
9	**Keith Morton KC** **Assistant Coroner for Cambridgeshire and Peterborough** **21st day of June 2024**