From Rt Hon Norman Lamb MP
Minister of State for Care and Support

Department of Health

Department of Health
Richmond House
79 Whitehall
London SW1A 2NA

Christopher Dorries
HM Coroner South Yorkshire (West)
The Medico-Legal Centre
Watery Street
Sheffield
SS3 7ET

02 SEP 2014

Dear Mr Dorries,

Thank you for your letter to Jeremy Hunt about the death of Lucy Moffatt. I am responding on his behalf.

I am sorry to hear about the tragic circumstances in this case.

Your report advised that Ms Moffatt had been diagnosed with mental health issues and, while suffering a reoccurrence of her paranoid schizophrenia, she jumped (or fell) from a second floor window.

The inquest found that there were issues with the restrictors used on the windows at the facility and you subsequently raised several concerns about the windows at the crisis house, which include the following:

- The type of window restraint can appear secure when it is not actually locked.
- The lock can be 'defeated' by a pair of scissors – and this may be the case with similar windows.
- Care Quality Commission (CQC) inspectors had not been made properly aware of the DH alert on this issue.

The DH alert noted in your report regarding 'window restrictors that may be inadequate in preventing a determined effort to force a window open' was a Health Technical Memoranda (HTM). HTMs give up-to-date established best practice advice and guidance to the NHS about specialised building and engineering technology used in the delivery of healthcare.

When an issue is brought to light and flagged by the Department of Health in an HTM, I expect appropriate action to be taken by healthcare providers as soon as possible. The fixtures and fittings used must be fit for purpose and healthcare providers must ensure that this is the case in all of their buildings. I note that you

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have written to the Trust concerned and would be grateful to have sight of the response received.

I also note your concerns about communication between the Department of Health and the CQC. Officials at my Department have discussed your report with the CQC and considered how the CQC can ensure that these alerts are reaching the appropriate teams.

The CQC have confirmed that neither the registration assessor nor the inspector in this case were specifically aware of the Department of Health alert concerning the strength of window restraints. However, under the current statutory and regulatory framework the primary responsibility for managing patient safety and ensuring that such alerts are actioned lies with the provider.

Regulation 16 of the Regulated Activities Regulations states that the registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of carrying out the regulated activity is properly maintained and suitable for its purpose, and used correctly.

The CQC takes into account how this regulation is met during registration and subsequent inspection. Currently, however, the CQC does not mandate exactly what systems or equipment should be in place – the responsibility falls on the provider to ensure that they take account of alerts, such as deciding on the particular window restrictor to be used.

The CQC is committed to continuous improvement and takes the concerns raised in your report extremely seriously. As your concerns touch upon the broader question of the implementation and inspection of Safety Alerts, the CQC will take steps to improve the implementation of Safety Alerts, including the Department of Health Alerts.

I hope that this information is useful and I thank you for bringing the circumstances of Lucy Moffatt's death to our attention.

Yours sincerely,

[redacted]

NORMAN LAMB