ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department for Environment, Food and Rural Affairs, Defra** **2. Department for Transport** **3. Department of Health and Social Care** **4. Mayor of London** **5. Transport for London** **6. London Borough of Lewisham** **7. General Medical Council** **8. Health Education England** **9. Nursing and Midwifery Council** **10. Royal College of Physicians** **11. Royal College of Paediatrics and Child Health** **12. Royal College of General Practitioners** **13. NICE** **14. British Thoracic Society**
1	**CORONER** I am Philip Barlow, assistant coroner for the coroner area of Inner South London
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 17 December 2019 I re-opened an investigation into the death of Ella Adoo Kissi-Debrah. The investigation concluded at the end of the inquest on 16 December 2020. The conclusion of the inquest was: Medical cause of death: 1a) Acute respiratory failure 1b) Severe asthma 1c) Air pollution exposure Narrative conclusion: Died of asthma contributed to by exposure to excessive air pollution.
4	**CIRCUMSTANCES OF THE DEATH** Ella died at the age of 9. She had severe, hypersecretory asthma causing episodes of respiratory and cardiac arrest and requiring frequent emergency hospital admissions. On 15 February 2013 she had a further asthmatic episode at home and was taken to hospital where she suffered a cardiac arrest from which she could not be resuscitated. Air pollution was a significant contributory factor to both the induction and exacerbations of her asthma. During the course of her illness between 2010 and 2013 she was exposed to levels of nitrogen dioxide and particulate matter in excess of World Health

	Organization Guidelines. The principal source of her exposure was traffic emissions. During this period there was a recognized failure to reduce the level of nitrogen dioxide to within the limits set by EU and domestic law which possibly contributed to her death. Ella's mother was not given information by health professionals about the health risks of air pollution and its potential to exacerbate asthma. If she had been given this information she would have taken steps which might have prevented Ella's death. There was no dispute at the inquest that atmospheric air pollution is the cause of many thousand premature deaths every year in the UK. Delay in reducing the levels of atmospheric air pollution is the cause of avoidable deaths.
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 national limits for Particulate Matter are set at a level far higher than the WHO guidelines. The evidence at the inquest was that there is no safe level for Particulate Matter and that the WHO guidelines should be seen as minimum requirements. Legally binding targets based on WHO guidelines would reduce the number of deaths from air pollution in the UK. (2) There is a low public awareness of the sources of information (such as UK-Air website) about national and local pollution levels. Greater awareness would help individuals reduce their personal exposure to air pollution. It was clear from the evidence at the inquest that publicising this information is an issue that needs to be addressed by national as well as local government. The information must be sufficiently detailed and this is likely to require enlargement of the capacity to monitor air quality, for example by increasing the number of air quality sensors. (3) The adverse effects of air pollution on health are not being sufficiently communicated to patients and their carers by medical and nursing professionals. The evidence at the inquest was that this needs to be addressed at three levels: a. Undergraduate. I am informed that undergraduate teaching is the responsibility of the GMC, Health Education England and the NMC. b. Postgraduate. I am informed that postgraduate education is the responsibility of the Royal Colleges, in this case the Royal College of Physicians, the Royal College of Paediatrics and Child Health, the Royal College of General Practitioners, and the NMC. c. Professional guidance. In this case relevant organisations are NICE and the British Thoracic Society.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. Concern 1 above should be addressed by the Central Government Departments (Defra, DfT and DHSC). Concern 2 above should be addressed by the Central Government Departments, the Mayor of London and the London Borough of Lewisham.

	Concern 3 above should be addressed by the named professional organisations. They may wish to collaborate in issuing their response. In addition, it will be sent to the DHSC and Faculty of Public Health for information.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 June 2021. 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 all Interested Persons and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). 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	**20 April 2021** **Philip Barlow**