REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

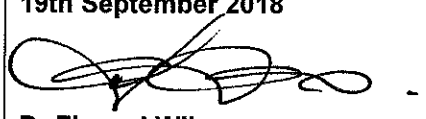
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr Simon Stevens, Chief Executive NHS England, Skipton House, 80, London Road, London. SE1 6LH.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
2	**CORONER'S LEGAL POWERS** 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	**Background.** Shortly before 01:00am on Wednesday 14 June 2017 a catastrophic fire broke out at Grenfell Tower, a 23 floor residential tower block on the Lancaster West Estate in London W1. Seventy people died as a direct result of the fire and one baby died in utero as result of his mother's smoke inhalation, bringing the total number of deceased to seventy one. **Names of the deceased:** Fatemah Afrasiabi Sakina Afrasiabi Fathia Ahmed Amal Ahmedin Mohammad Al Haj Ali Alexandra Atala Husna Begum Rabeya Begum Leena Belkadi Malak Belkadi Omar Belkadi Raymond Bernard Vincent Chiejina Fatima Choucair Nadia Choucair Sirria Choucair Bassem Choukair Mierna Choucair Zainab Choucair

	Joseph Daniels Jeremiah Deen Zainab Deen Anthony Disson Eslah Elgwahry Mariem Elgwahry Abdulaziz El-Wahabi Faouzia El-Wahabi Mehdi El-Wahabi Nur Huda El-Wahabi Yasin El-Wahabi Marco Gottardi Berkti Haftom Biruk Haftom Farah Hamdan Mohammed Hamid Mohammed Hanif Firdaws Hashim Yaqub Hashim Yahya Hashim Fethia Hassan Hania Hassan Abrufas Mohamed Ibrahim Isra Ibrahim Rania Ibrahim Amna Mahmud Idris Ali Yawar Jafari Nura Jemal Hamid Kani Hashim Kedir Khadija Khalloufi Victoria King Deborah Lamprell Gary Maunders Mary Mendy Kamru Miah Ligaya Moore Dennis Murphy Mohammed Amied Neda Isaac Paulos Steven Power Hesham Rahman Khadija Saye Abdeslam Sebbar Sheila Smith Gloria Trevisan Amaya Tuccu-Ahmedin Mohamednur Tuccu Jessica Urbano-Ramirez Marjorie Vital

	Ernie Vital and baby Logan Gomes Inquests have been opened and adjourned and suspended pending the Grenfell Public Inquiry and police investigation and any ensuing prosecutions for the seventy deceased who come under coronial jurisdiction. The death of baby Logan Gomes is also subject to police investigation and his death is highly relevant to inquest proceedings, despite being unable to have a separate inquest in his own name since he sadly died before he was born. For the limited purposes of this report I have deemed these investigations unsuspended. Further I understand that this report will not conflict nor compete with the terms of reference of the Grenfell Public Inquiry. As well as all those who died, a significant number of people escaped and survived, but many of these were exposed to smoke and dust inhalation. Significant numbers of first responders may also have been affected and those involved in working on site in the aftermath of the fire from body recovery and crime scene investigators, to the builders helping to shore up the building etc. Many people within the categories above and the community at large have suffered emotional trauma related to this disaster and many of these have suffered harm to their mental health as a result.
4	**Circumstances of the Deaths.** Evidence submitted as part of the investigations and issues that have been raised with me by the bereaved suggest that many of those who escaped were exposed to significant smoke inhalation. The smoke will have contained multiple toxic substances and it is of note that the building was known to contain asbestos. It is likely that almost all of those who died in the fire, died as a result of smoke inhalation, although this evidence has not yet been tested in court. It has also been brought to my attention that fire fighters involved in 9/11 have since suffered health problems related to fumes and dust that they inhaled in their response to the fire following that terror attack in New York. Asbestos is known to be associated with an increased risk of respiratory illness especially mesothelioma, which may present many years, not unusually decades, after the exposure. Real concern has been expressed to me by the bereaved in relation to the health of survivors, especially children and I have been informed that no physical health screening programme has been put in place to monitor the health of survivors on an on-going basis. There was extensive Health and Safety involvement on site following the fire and monitoring of the area by Environmental Health.

	This may have mitigated some if not all of the risks to onsite workers. I understand that fumes and dust from the site that passed to the surrounding environment is not thought to have significantly raised the risks of health damage to local residents compared to breathing the usual London air. Extensive support for mental health issues has been offered by Central and North West London NHS Trust in the aftermath of the fire to date, to bereaved, survivors and residents. I understand that funding remains in place for this until March 2019. The Metropolitan Police, The London Fire Brigade and Local Authorities each have occupational health provision for those employed by them and further the Metropolitan Police extended their services to those persons independently contracted but assisting with the police investigation.
5	**Concerns of the Coroner:** 1. That no structured health screening programme is in place for those who were exposed to risks of smoke and dust inhalation during the Grenfell Tower fire. 2. That those subject to smoke and dust inhalation are at risk of developing health conditions in particular respiratory illness after particulate and poison inhalation. 3. That there may have been exposure to asbestos during and after the fire that could possibly cause late onset health issues such as mesothelioma. 4. That without an appropriate system of health screening, there is a risk that illness may arise unnoticed or present later in survivors, first responders and site workers, and thus reduce their life expectancy. 5. That the NHS needs to undertake a risk evaluation and then consider an appropriate regular health screening programme for survivors of the fire and first responders and site workers. 6. That survivors and first responders and site workers, need to be given access to guidance and/ or information that would help them to understand what could be the health consequences of being exposed to the hazardous environment of the site of the fire. 7. That the NHS needs to oversee and co-ordinate and provide appropriate mental health support for all those affected by their involvement in the incident, be they survivors, bereaved, local residents or first responders or other workers involved in the aftermath. The potential impact of this disaster is very wide ranging. 8. It may be that the provision of some care services, for physical or psychological damage may be provided by occupational health services outside the NHS, however a scale and risk assessment of need and care provision needs to be undertaken to minimise persons affected slipping through the net and being lost from appropriate supportive services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 and organisations : 1. Next of kin of the deceased. 2. Grenfell United, 6th Floor, 17, Old Court Place, London. W8 4PL 3. Sir Martin Moore-Bick, Chair of the Grenfell Tower Public Inquiry, Holborn Bars, 138-141 Holborn, London. EC1N 2SW. 3. Cressida Dick, Commissioner of the Metropolitan Police, New Scotland Yard, Victoria Embankment, Westminster, London. SW1A 2JL. 4. Dany Cotton, Commissioner of the London Fire Brigade, 169, Union Street, London. SE1 0LL. 5. David Allen, Chief Executive Officer of Wates, Wates House, Station Approach, Leatherhead, Surrey. SE1 6LH. 6. Robert Jensen, Chief Executive Officer of Kenyon International, 1 The Western Centre, Western Road, Bracknell, Berkshire. RG 12 1 RW.

	7. Robyn Doran, Chief Operating Officer, Central and North West London NHS Foundation Trust, Stephenson House, 75, Hampstead Road, London. NW1 2PL. I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**19th September 2018**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**