REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Michael Gove, Minister for Housing, Department for Levelling Up, Housing and Communities 2. Mr Steve Barclay, Secretary of State for Health
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 27th December 2020, I commenced an investigation into the death of Awaab Ishak Awaab died on the 21st December 2020 at the Royal Oldham Hospital. He was 2 years old. The investigation concluded on the 15th November 2022. The medical cause of death was confirmed as 1a) Acute Airway oedema with severe granulomatous tracheobronchitis due to 1b) Environmental mould exposure. I recorded a narrative conclusion: Awaab Ishak died as a result of a severe respiratory condition due to prolonged exposure to mould in his home environment. Action to treat and prevent the mould, was not taken. His respiratory condition led to a respiratory arrest. The medical advice given to his parents led to Awaab receiving sub-optimal airway ventilation which was unable to prevent his cardiac arrest.
4	**CIRCUMSTANCES OF DEATH** Awaab lived with his parents at [redacted], Rochdale. This property is owned by Rochdale Boroughwide housing association ("RBH"). In 2017 the presence of mould in the flat was notified to RBH. The advice given to [redacted] (Awaab's father) was to, "paint over it." [redacted] had recently arrived in the UK from Sudan. The fact this needed to be with specialist paint was not made clear to him. In 2018 Awaab was born. I am satisfied from the evidence that the mould remained a continuing and recurrent issue whilst the family were in the property, albeit no further complaint was made to RBH until July 2020. In 2019 the family made an application to be re-housed. In July 2020 the family showed a Health visitor the mould and a letter was sent dated 9th July 2020 to RBH by the health visitor explaining their concerns about the mould and potential impact on Awaabs health. Throughout his life Awaab had recurring cold symptoms such as runny nose, cough, and respiratory tract infections. His GP confirmed that he attended at their surgery more than most children. In June 2020 the family instructed solicitors to make a disrepair claim due to the mould. An inspection carried out by RBH on the 14th July 2020 confirmed the presence of mould in the kitchen and bathroom. The policy at the time was not to progress to repair and treatment until the agreement of the solicitors had been obtained.

No action had been taken to treat the mould by the time Awaab died.

At the time of his death significant mould was present in all the rooms in the flat.

During the course of the Inquest the court heard evidence from the Housing Ombudsman regarding their October 2021 report SPOTLIGHT on damp and mould. Many of the themes they had noted from the increased number of complaints to them were found in Awaab's case, namely:

- Professionals placing too much emphasis on the cause of the mould being due to "family lifestyle." In fact as [redacted] indicated, homes need to be habitable for modern living. There is no evidence the family lived an "excessive" lifestyle and the daily activities of living which contributed to the damp and condensation were normal activities such as cooking, washing, bathing and drying clothes.
- There was a lack of proactive action to consider wider potential sources of damp such as structural. However I did not find that there were any structural issues such as leaks etc.
- There was a lack of proactive treatment of the mould and a lack of consideration of the ineffective ventilation within this ageing property. In this case there was a fan in the bathroom which did not work effectively, there was no mechanical ventilation in the kitchen at all. There was no window in the bathroom and the window in the kitchen opened onto the communal walkway.

The court heard evidence that the impact on health from damp and mould is a widespread national issue. Of particular importance is the fact this is not simply a social housing issue. The same concerns apply as much to the private landlords, where evidence suggests the problem is worse. The October 2021 Spotlight report by the Housing Ombudsman makes this clear.

[redacted] Consultant Mycologist sampled the mould from within the home following Awaab's death. He gave evidence to the court on the illnesses and harm, including death, which can arise from the inhalation of fungi from mould. It was apparent that updated information regarding the current health risks relating to damp and mould are not widely available or known to the housing sector.

[redacted] compared the information sharing, campaigns and primary legislation which surround gas safety and legionnaires which have been hugely beneficial. In comparison there is a lack of the same information or legislation in respect of damp and mould.

The court heard from the housing association regarding the challenges they face due to the reliance on ageing housing stock, the lack of new builds to create increased property numbers, lengthier waiting lists for people who are requesting social housing and the impact of mandatory changes such as the need to be carbon neutral. It was clear that RBH have learnt many lessons following Awaab's death.

Following Awaab's death the local authority carried out a Housing Health and Safety Rating System ("HHSRS") report. The HHSRS is used to assess the suitability of properties under the Housing Act 2004. This is the local authority tool used with a view to engaging landlords and enforcing any remedial action required. This rating sheet is outdated for damp and mould.

Post mortem examination of Awaab and subsequent testing confirmed the presence of granulomas. The Forensic pathologist was able to rule out all other causes of these and directly concluded that prolonged exposure to mould led to Awaab's respiratory arrest.

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 will 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 2006 document, "A Decent Home: Definition and Guidance for Implementation" does not give any consideration to the issue of damp and mould. Nor does it provide any guidance as to the need for a property to be adequately ventilated.

2. The HHSRS data sheet relating to damp and mould, is used to calculate risks of the incident and the spread of harm is not reflective of the current known risks of damp and mould and harm to health.

	3. There was no evidence that up to date relevant health information pertaining to the risks of damp and mould was easily accessible to the housing sector. 4. The evidence highlighted a "policy" amongst the housing associations, in cases where a disrepair claim has been brought of waiting for agreement from the claimant (or their legal representative) before rectifying any recognised disrepair. 5. The private landlord sector does not have access to the Housing Ombudsman for their complaints to be investigated independently.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 13th January 2023. 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 namely:- Family of Awaab Ishak Rochdale Boroughwide Housing Association Rochdale Borough Council Northern Care Alliance 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 from. 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	Date: 16-11-2022. Signed: J Kearsley