REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health, Richmond House, 79 Whitehall, London, SW1A 2NS** **2. Food Standards Agency, Aviation House, 125 Kingsway, London, WC2B 6NH**
1	**CORONER** Tanyka Rawden, Assistant Coroner for South Yorkshire (West)
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** On 28 July 2015 an investigation was commenced into the death of Dylan Paul Hill aged 18 years. Following a post-mortem examination, the investigation concluded with an inquest on 19 and 20 December 2017. The inquest was assisted with evidence from the partner of Dylan Hill who was at the restaurant with him, representatives from Trading Standards and Environmental Heath, the owner of the restaurant and an expert, [redacted]. The conclusion of the inquest was that Dylan Paul Hill died at Barnsley General Hospital of an anaphylactic reaction after eating a korma meal at a restaurant in Barnsley on 17.05.15. Dylan was served a korma containing almond powder. That powder contained almonds and peanuts. The restaurant was not aware the almond powder contained peanuts as it was not labelled and had been decanted into another container. Importantly, no steps had been taken by the restaurant to ascertain the ingredients of the almond powder. There was no allergen information on the menus or displayed in the restaurant Dylan didn't have his EpiPen with him but it cannot be said this would have brought about a different outcome.

4	**CIRCUMSTANCES OF THE DEATH** Dylan Paul Hill was diagnosed with a peanut allergy at the age of ten. In consequence he had been issued with an adrenaline auto-injector (in this case an EpiPen). Mr Hill also suffered from asthma. On 17.05.17 Mr Hill and his partner went to a restaurant in Barnsley. Mr Hill ordered a Korma meal and became unwell after eating one or two mouthfuls. He asked the waiter whether the meal contained nuts and was told it did. After returning home a short time later Mr Hill collapsed and was confirmed dead on arrival at the local A&E Department. Pathology examination showed that Mr Hill had died of an anaphylactic reaction. Examination of the contents of the ingredients of the korma showed that the 'almond powder' contained 94% almonds and 6% peanuts. In evidence it was clear the restaurant did not know the 'almond powder' contained peanuts as the ingredients had not been checked on purchase, the powder had been decanted into an unlabeled container, and the packaging disposed of.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries 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 **MATTER OF CONCERN** is as follows. – Evidence was given before the Court of an incident within the same premises in September 2014 where a curry containing nuts was given to a customer who had requested a nut free curry. That customer had an anaphylactic reaction and was taken to hospital where he made a full recovery. Evidence was also given that the Trading Standards department of the local council had not been told of this incident prior to the death of Mr Hill. Had they known, they would have arranged a priority visit. After Mr Hill's death the restaurant were issued a prohibition notice that they were not permitted to offer allergen free meals. Evidence was given that there are no procedures in place for such communications between the health services and Trading Standards in cases of non fatal anaphylactic reactions. In my opinion there is a risk that future deaths may occur unless cases of non fatal anaphylactic reactions caused by the ingestion of purchases from food business operatives are reported to those regulatory authorities responsible for the supervision and monitoring of food safety and hygiene. The question therefore arises as to whether the emergency services and health services within the area can work together to ensure that Trading Standards Departments are made aware of all anaphylaxis incidents relating to commercial premises so that the appropriate action can be taken as regards those premises.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you 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 1 March 2018. I may extend this period upon your application. 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 Person: [redacted], family representative. Others sent copies for information: 1. Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust 2. Chief Executive, Sheffield Children's hospital, Sheffield, Western Bank, Sheffield, S10 2TH 3. Chief Executive, Barnsley District Hospital, Gawber Road, Barnsley, S75 2EP 4. Chief Executive, Clinical Commissioning Group, Sheffield, 722 Prince of Wales Road, Sheffield, S9 4EU 5. Chief Executive, Clinical Commissioning Group, Barnsley, 49/51 Gawber Road, Barnsley S75 2PY 6. Chief Executive, Yorkshire Ambulance Service, Springhill 2, Wakefield 41 Business Park, Brindley Way, Wakefield, WF2 0XQ 7. Chief Executive, Trading Standards, Sheffield City Council, 5th Floor, Howden House, Sheffield, S1 2SH 8. Chief Executive, Trading Standards, PO Box 602, Barnsley, S70 9FB 9. Environmental Health, Sheffield City Council, Staniforth Road, Sheffield, S9 3HD 10. Environmental Health, Barnsley Metropolitan Borough Council, Common Road, Brierley, Barnsley, S72 9EP 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.

Mrs Tanyka Rawden

4 January 2018