REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr Simon Wilkinson, CEO of Byron Hamburgers Limited;** 2. **The Rt Hon Theresa Villiers MP, Secretary of State for Environment, Food and Rural Affairs;** 3. **Rt Hon. Matt Hancock MP, Secretary of State for Health and Social Care;** 4. **Emily Miles, CEO of the Food Standards Agency;** 5. **Lord Toby Harris, Chair of the National Trading Standards Board; and** 6. [redacted] **President of the British Society for Allergy and Clinical Immunology.**
1	**CORONER** I am Briony Ballard, 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 28 April 2017 I commenced an investigation into the death of Owen Carey, 18 years old. The investigation concluded at the end of the inquest on 13 September 2019.The conclusion of the inquest was: (2) (*medical cause of death*) severe food induced anaphylaxis and (4) (*conclusion*) On 22 April 2017, Mr Carey died from a severe food induced anaphylactic reaction from food eaten and ordered at a restaurant despite making serving staff aware of his allergies.
4	**CIRCUMSTANCES OF THE DEATH** Mr Carey suffered from a number of allergies, including to dairy. On 22 April 2017 he went to Byron restaurant at the O2 centre, Greenwich, and selected a grilled chicken breast and fries, believing them to be free of dairy. The chicken was in fact marinated in buttermilk. The deceased made the serving staff aware of his allergies. The menu was reassuring in that it made no reference to any marinade or any potential allergenic ingredient in the food selected. Mr Carey was not informed that there were allergens in the order. The food served to and consumed by Mr Carey contained dairy which caused him to suffer a severe anaphylactic reaction from which he died.
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 adequacy and effectiveness of allergen training at Byron O2: My findings included that there must have been a human error by a member of Byron O2 serving staff at the point of ordering. The training provided to serving staff regarding allergens at Byron O2 was limited to a combination of staff members simply attesting to the fact that they had *read* the company's training on allergen

	information and no more, coupled with an "on the job" induction in respect of which no records or details existed. It was accepted in evidence that Byron O2 had a high turnover of serving staff. This, I was told and accept, is common for the restaurant industry overall, who often rely, for example on seasonal workers. I was not confident that the current approach to allergen training about which I heard evidence was effective and / or would engage the less diligent employee, which any organisation will have, and which are potentially in a greater proportion where there is high staff turnover. (2) The effectiveness of the current placement and appearance of allergen notices on restaurant menus to trigger an allergen discussion between a customer and serving staff: I was told, and accept, that it was more important to trigger a discussion between a customer and member of serving staff about allergens than to have a menu which included complete allergen information on its face. However, the prompt for this discussion on the Byron O2 menu at the time was: (i) on the side of the menu which appeared to focus solely on a 'special', namely a Kim Cheese burger, (ii) at the very bottom and distant from all the main food options, (iii) in very small font and (iv) on a royal blue background in black ink. I was told that this placement and appearance was not outwith the general approach of the restaurant industry as a whole and that the current Food Information Regulations did not, unlike with prepacked food, specify the location and / or font size and / or prominence of such an allergen notice. It concerns me that such little prominence appears to be given industry wide to a notice which is intended to trigger what could potentially be a lifesaving discussion between a customer and member of serving staff. It further concerns me that there are no **statutory requirements** regarding the appearance of such an allergy notice. (3) The lack of key allergen information on the face of restaurant menus and therefore their potential to be falsely reassuring: In my findings I concluded that Owen (and his brother) would have been falsely reassured with the menu description of Owen's order because on its face the Byron O2 menu in place at the time did not readily identify that the chicken would have been marinated in buttermilk or at all. I was shown a more up to date menu from Byron O2 and note that where buttermilk is now used to marinate chicken it is identified. However, the prompt for this change was one of 'food fashion' I was told rather than a move to make the menu more allergen friendly. Although I accept that triggering a discussion between a customer and member of serving staff about allergens is of key importance (as indicated above), the absence of any simple allergen words or symbols on the face of a restaurant menu is of concern, particularly when one takes into account (i) what I was told about the latest figures demonstrating how a significant proportion of customers may be naturally shy/ reluctant about sharing their allergies with serving staff and (ii) that restaurants, like Byron O2, tend to attract young diners dinning alone (i.e. school age children without their parents). It also concerns me that at the time there were symbols on the menu depicting the use of peanuts, but no other allergen, which in my view could also have potentially falsely reassured dinners that allergens were being identified on the face of the menu when *in fact* they were not. (4) The lack of a national register recording severe food anaphylactic reactions: I was told in evidence that despite: faster ambulance response times, a greater awareness of allergies and a greater distribution of epi-pens that the death rate for severe food anaphylaxis remains static and that this is attributed in part to the fact that little is known about these deaths because thus far there has been a failure to collect together any learning from these tragedies. It concerns me that there is therefore no national register recording the circumstances of these deaths which could then be analysed and learnt from by allergy specialists.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr Simon Wilkinson, CEO of Byron, and your organisation, and the following: The Food Standards Agency, National Trading Standards Board, Department for Environment,

	Food and Rural Affairs, the Department of Health and Social Care and the British Society for Allergy and Clinical Immunology 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 25 November 2019, 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 (1) the Carey family (2) Mr Simon Wilkinson, CEO of Byron Hamburgers Limited (3) [redacted]echnical Manager of Byron Hamburgers Limited. I have also sent it to [redacted]CEO of Anaphylaxis Campaign and Carla Jones, CEO of Allergy UK and [redacted]of Allergy Action who may find it useful or of interest. 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	30 September 2019 *Briony Ballard* **[DATE]** **[SIGNED BY CORONER]**