Newcastle and North Tyneside
Ms Georgina Nolan
SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH

Date: 26 January 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG

Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU

1 **CORONER**

I am **Karen Dilks, Assistant Coroner** for **Newcastle and North Tyneside**

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 **INVESTIGATION and INQUEST**

On 16 July 2020 I commenced an investigation into the death of James ATKINSON. The investigation concluded on 15 January 2024 at the end of the inquest. The conclusion of the inquest was

(2) Anaphylaxis following peanut ingestion

(4) James Stuart Atkinson died on 10th July 2020 after eating a Chicken Tikka Masala pizza purchased from Dadyal Takeaway Restaurant in Newcastle upon Tyne via Deliveroo application. The pizza contained peanuts to which he was allergic.

The Dadyal menu did not contain specific information in respect of peanuts or other allergens.

James did not contact the takeaway to advise them of his allergy.

He ate the pizza, following which he suffered an anaphylactic reaction. No Epi-pen was located and delayed his access to adrenaline until Paramedics attended.

CIRCUMSTANCES OF THE DEATH

James was 23 years old with a history of Asthma. In 2010 he was confirmed to have an allergy to nuts and in particular peanuts.

He was prescribed an Epi-pen and antihistamines to manage his allergy. His Epi-pen was renewed only on his request, James last requested his Epi-pen in 2015. He attended 3 asthma reviews prior to his death. His allergy was not addressed during the reviews. There was no regular allergy review procedure provided locally or nationally.

4 On 10 July 2020 he ordered food for himself and flatmates from Dadyal Takeaway Restaurant. Their menu contained limited information as to the ingredients used in the dishes produced and no allergen information or allergen matrix. James ordered a Chicken Tikka Masala pizza. The presence of peanuts in both the dishes produced and in use in the kitchen was not referred to in the menu. James knew about his nut/peanut allergy. He did not contact Dadyal to advise of his allergy and was unaware that the Chicken Tikka Masala pizza ordered contained mixed nut powder comprising of up to 99 per cent peanuts. He suffered an allergic reaction shortly after consuming the pizza. He called an ambulance which arrived within four minutes of his call. His Epi-pen could not be located; missing an opportunity for an adrenaline injection prior to Paramedic arrival. Despite Paramedic and hospital care and treatment James died due to anaphylaxis resulting from peanut ingestion.

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.

5 The **MATTERS OF CONCERN** are as follows. –

The evidence in this case unequivocally established that James was not under regular review for his allergy, risk of anaphylaxis and the benefits of automatic adrenalin injectors.

The report of [redacted] (attached) identifies the need for wider consideration of a systematic approach to improving anaphylaxis awareness and management.

The risk of future deaths in the context of allergy/anaphylaxis remains in the absence of an appropriate structure to educate, review and manage those who are diagnosed allergies.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you [redacted] and The Rt Hon Victoria Atkins MP (Chair) have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 March 2024. 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: family of James Stuart Atkinson, Food Standards Agency, NHS England (North

East). I have also sent it to Deliveroo 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.
26 January 2024

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HM Assistant Coroner for Newcastle and North Tyneside