DR SHIRLEY RADCLIFFE
ASSISTANT CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone [redacted] Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], National Medical Director, NHS England** **Sent via email: [redacted]** **2. [redacted], Chief Executive Office, Royal College of Paediatrics** **Sent via email: [redacted]** **3. [redacted], President of Royal College of Physicians** **Sent via email: [redacted]** **4. British Society for Allergy & Clinical Immunology** **Sent via email: [redacted]** **5. [redacted], Chief Executive Officer, General Dental Council** **Sent via email: [redacted]** **6. [redacted], Chief Executive & Registrar, Pharmaceutical Council** **Sent via email: [redacted]**
1	**CORONER** I am Dr Shirley Radcliffe assistant coroner, for the coroner area of East 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. 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 17th June 2023 I commenced an investigation into the death of Miss Hannah Eniola Angela Ayomipo Jacobs aged 13 years. The investigation concluded at the end of the inquest on 16th August 2024. The conclusion of the inquest was a narrative: On 8th February 2023 Hannah was served a dairy hot chocolate at Costa Coffee Barking despite her mother informing staff of a dairy allergy. Neither she nor her mother were carrying an Adrenaline Auto Injector which had been prescribed. Next, they went to the dentist where Hannah took some sips of her drink and developed symptoms of excessive saliva. During the brief time they were at the dental surgery it was not recognised that this was the beginning of an anaphylactic reaction. Hannah and her mother rushed to the Day Night Pharmacy where Hannah collapsed. LAS attended promptly, began resuscitation, and took her to Newham University Hospital where she was pronounced dead the same day.
4	**CIRCUMSTANCES OF THE DEATH** • Hannah was 13 with severe allergies to eggs, dairy and wheat. She was going to the dentist before school. Her mother was told she couldn't take her prescribed Epi-pen into school as she was to keep 2 at home and 2 at school. Hannah's mother was not carrying an Epi-pen either. They went into Costa Coffee on the way to the dentist where they were incorrectly served dairy hot chocolates. This was due to a failure of communication and a failure to follow the correct allergy process in Costa Coffee. They then went into the dentist and Hannah took a sip of her drink and felt unwell. She went into the dentist's room spitting out fluid which the dentist believed to be her drink combined with saliva. Hannah refused treatment and left the dentist with her mother to go to a local pharmacy for treatment. Her mother noticed Hannah's lips were swollen and asked for cetirizine from the pharmacist. Then she asked for an Epi-pen but due to a national shortage there was only one in stock, a 150micrgrams rather than the 500 Hannah had be prescribed. This was given but sadly Hannah went in to cardiac arrest and could not be resuscitated.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • The evidence at the inquest referred to allergy action plans discussed in the healthcare settings and given to parents and patients. Hannah displayed what appeared to be excessive salivation at the dentist which her paediatric consultant (who gave evidence) said, with the benefit of hindsight was actually a manifestation of her inability to swallow. This is a sign of anaphylaxis This was not recognised by dental staff as an inability to swallow and thus of anaphylaxis. • The other symptom Hannah demonstrated was swelling of her lips which is listed on allergy plans as a mild to moderate symptom and thus provided a false sense of reassurance to her mother that cetirizine was what she needed.

	• The risk of future deaths in the context of anaphylaxis remains in the absence of further consideration of what constitutes an anaphylactic reaction as opposed a mild reaction, and the education of parents and patients of the safety of using AAIs (adrenaline auto injectors) IF IN DOUBT. • I was made aware there had been a shortage of AAI at the time but a vial of adrenaline was available at the chemist. However, it takes time to draw up. I am not sure if (assuming no national shortage) all chemists have AAI in stock for emergencies.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **15th October 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Hannah's family, FSA, Costa Coffee, SBR Trading Royal Free NHS Trust, LBBD, to the Child Death Overview Panel (CDOP) (where the deceased was under 18). I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
	[DATE] 20th August 2024 [SIGNED BY CORONER]