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], Secretary of State for Dept. Health & Social Care** **Sent via email: [redacted]** **2. [redacted] Secretary of State for Education** **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 February 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 19th August 2024. The conclusion of the inquest was a narrative conclusion: 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 Epi-pen 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 and 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 years old and had been diagnosed with severe allergies to eggs, wheat and dairy milk. She was prescribed an Epi-pen and antihistamines to manage her allergy. On 8th February 2023 she was going to school after a dental appointment. She was accompanied by her mother. Neither of them carried an EpiPen with them. The school kept 2 at the school and if Hannah went in with one it would be confiscated for the duration of the day. Hannah and her mother went into Costa Coffee Station Road Barking just before 11am on 8th February 2023. They had done this before with no problems. As usual her mother ordered 2 soya milk hot chocolate drinks. There was a lack of communication between the mother and the barista. The barista acknowledged that she heard that Hannah had an allergy but did not follow the correct procedure in place, which was to show them the allergy book kept at the till and clarify which drink they could safely have. Hannah and her mother were served dairy milk hot chocolates. They took them into the dental practice and at 10.59 Hannah took 3 sips and felt unwell. She went into the toilet and rang her mother by mobile phone and informed her she didn't think the drink was made with soya milk. When she came out of the toilet and went up to the dentist, she was spitting out what seemed excessive saliva. She then refused the treatment, left the dentist's room to go back to the toilet. Her mother followed shortly after and decided to go the pharmacy opposite to get some antihistamines. The entered the pharmacy at 11.11 am and as they did, Hannah collapsed to the floor. Her mother asked for cetirizine which had previously helped before. It was given to no effect. An EpiPen was requested but due to a national shortage of adrenaline auto injectors the pharmacist had only 1 paediatric injector which was of an insufficient dosage. However, it was given, and the LAS were called. They attempted to resuscitate Hannah but she died at Newham University Hospital as a result of anaphylaxis due to consumption of dairy.
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 to The **MATTERS OF CONCERN** are as follows. • Hannah was regularly prescribed Epi-pens (AAI) and had 2 at home and 2 at school. There was no consideration about how to contain the risk of anaphylaxis on the journey to and from school. • Her paediatrician gave evidence at the inquest and acknowledged it was a difficult issue as the pens can be misused, lost, forgotten, leaving an absence of pens at home at the weekend. However, the largest cause of mortality in anaphylaxis is the absence of a readily available adrenaline autoinjector.

	• The risk of future deaths in the context of anaphylaxis remain in the absence of an appropriate structure to educate the school, patients and the parents of the importance of carrying an AAI on their way to and from school.
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]