Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1 Royal College of Pathologists** **2 Cambridgeshire Constabulary**
1	**CORONER** I am Elizabeth GRAY, Area Coroner for the coroner area of Cambridgeshire and Peterborough
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	On 09 December 2021 an investigation was commenced into the death of Benedict Edward Falcon Blythe aged 5 years old. The investigation concluded at the end of the inquest on 09 July 2025. The conclusion of the Inquest Jury was that: "Accidental exposure to an allergen, cows milk protein, causing fatal anaphylaxis."
4	**CIRCUMSTANCES OF THE DEATH** Benedict died at Peterborough City Hospital (PCH) on 1/12/21 as a result of food induced anaphylaxis; he was 5 years old at the time of his death. Benedict suffered from asthma and a number of allergies including a milk and egg allergy. He was under the care of the paediatric allergy team at PCH. Benedict had started in reception year at [redacted] PS in September 2021. On 29 November 2021 Benedict was unwell overnight, he vomited twice, which was observed by his mother to consist of phlegm and was kept off school on 30 November 2021. He attended school as normal on 1 December 2021. At morning break time on 1 December 2021Benedict went outside with a group of other children to have his snack – a snack of biscuits which he had brought into school from home. He then returned to the classroom where he was offered a drink of which ought to have been of the oat milk provided to the school by his parents.

	Benedict's oat milk was kept in a fridge in the school staff room separate from the individual cartons of cow's milk provided to non-allergic children and together with a carton of lactose free milk provided to a child in Benedict's class who was lactose intolerant. Benedict was reported to have decided not to drink the milk handed to him in his own cup/receptacle and poured it away. The Class Teacher accepted that she could not be certain whether Benedict had taken a sip of the drink when she wasn't looking. Typically, the Class Teacher or a Teaching Assistant would collect the milk from the staff room at break time, pour oat milk into Benedict's designated cup/receptacle, pour the lactose free milk into a school provided cup/receptacle for the lactose free child, and distribute the individual cow's milks cartons to the remaining children. Shortly later Benedict was seen to have vomited. Benedict's parents were contacted to come into school and collect him; he was cleaned by a Teaching Assistant and sat reading a book with the Teaching Assistant when he vomited again. Benedict was then escorted outside by the Class Teacher to get some fresh air and his parents were contacted to take him home. Shortly after Benedict went outside with his Class Teacher, he collapsed was carried back into the classroom. His Adrenaline Auto Injector (AAI) was administered by a first aid trained Teaching Assistant; a 2nd AAI was subsequently administered. Benedict was not responding and he was not breathing and CPR was started. Benedict's father attended school and carried out CPR as did other teaching staff. The emergency ambulance crews and emergency helicopter medical crew also attended. Benedict was taken to PCH where he was declared deceased. Police attended the school and carried out an investigation within the classroom and school environment and took witness statements. Benedict's vomitus was not seized as part of the Police investigation and no other investigatory authority requested the collection of data samples or preservation of evidence at the scene. At PCH the paediatric consultant requested that mast cell tryptase tests were done during the resuscitation efforts, to identify whether Benedict had suffered an anaphylactic reaction, and which confirmed that he had. Initial investigations into Benedict's death focused on his consumption of a McVitie's biscuit which he had brought in from home, and which he ate at the break time in school before he vomited and subsequently collapsed. During

	the course of the investigation, it became evident that the Mcvitie's biscuit did not cause Benedict's anaphylactic reaction and that it was more likely than not that Benedict's anaphylactic reaction was caused by exposure to cow's milk protein. The retention of samples and testing by pathologists would have assisted in identifying the cause of Benedict's anaphylactic reaction at an earlier stage and may prevent future deaths.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: 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: 1) **<u>In relation to Pathology</u>** That Kennedy samples collected during a post-mortem examination, should be revised to include the following in cases of suspected anaphylaxis: a. blood samples for mast cell tryptase and sp IgE serology 2 suspected allergens b. stomach contents to be immediately stored (and/or frozen) by the pathologist for the analysis of the presence of the triggering allergen c. blood samples if taken at hospital should not be destroyed but retained for testing d. that an early blood sample is taken after death and stored for later analysis e. that the possibility that the death is due to anaphylaxis is raised with the senior coroner for the area where the death occurred at the earliest opportunity f. tissue samples are taken and retained. g. Consideration given to the development of a standard protocol to ensure appropriate samples are taken at the correct time to assist later investigation.

	2.) **<u>The police investigation</u>**: In the circumstances where there is an unexplained death of a child or the person and where that are data samples and evidence available at the scene including by way of example vomitus, that the police should include as part of their investigation, the seizure and retention of any such material for the purposes of later investigation either by the Police the Pathologist or the Coroner.
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 **January 20, 2026**. 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 **Family of Benedict BLYTHE –** [redacted] **(Parents)** [redacted] **Primary School** **Peterborough City Council** [redacted] [redacted] **Pladis** **North West Anglia NHS Foundation Trust** **Department of Education** **East of England Ambulance Service**

	and to the Child Death Overview Panel. I have also sent it to [redacted] **– Consultant in Allery and Asthma** 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 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 by the Chief Coroner.
9	**Dated: 25/11/2025** [redacted] **Elizabeth GRAY** **Area Coroner for** **Cambridgeshire and Peterborough**