	 Southwark Coroner's Court, 1 Tennis Street, SE1 1YD **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** 1. The Rt. Hon Matt Hancock, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London, SW1A 2NS 2. [redacted], Chief Executive, Foods Standard Agency, Floors 6 and 7, Clive House, 70 Petty France, London, SW1H 9EX 3. The Rt. Hon Robert Jenrick, Secretary of State for Housing, Communities and Local Government, 2 Marsham Street, London, SW1P 4DF
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest into the death of Master Ruben Bousquet (case ref [redacted]) who died aged 14 on 18.04.19 in Evelina Children's Hospital. The inquest was concluded on 5th August 2020. The conclusion as to how he came by his death was given as: Acute anaphylaxis to cows milk allergen from cross contamination of popcorn.
4	**CIRCUMSTANCES OF THE DEATH** Master Ruben Bousquet was exquisitely sensitive to certain food allergens, principally milk protein food, which had led to 3 hospital admissions. On 17.04.19, he ate some sweet unpackaged popcorn, purchased from a cinema in Greenwich, and began to feel unwell. He was driven home to access his emergency

	treatment for anaphylaxis, and became distressed about 15 minutes after consumption, about 3 minutes from home. He collapsed and was given Adrenaline injections twice and effective CPR. Ambulance crews arrived after about 5 minutes, found severe bronchospasm, which delayed endotracheal intubation, released a tension pneumothorax and gave advanced cardiopulmonary resuscitation. He remained unconscious and was taken to Evelina Hospital where he was found to have developed irretrievable brain damage inconsistent with life and died at 19.25 on 18.04.19. The popcorn was manufactured and supplied free from milk protein, but had become cross contaminated at some stage in the food chain, which could not be determined, partly because appropriate food testing was not conducted in a timely manner, and partly because the level of allergen likely to trigger his response was thought to be close to the limit of detection.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence was heard from the FSA and Royal London Borough of Greenwich that the reporting process and sharing of information on fatalities was not strong enough to ensure timely investigation and for lessons to be learnt to prevent future deaths. The **MATTERS OF CONCERN** are as follows: 1. Reporting and Registering The Head of Incidents at the FSA informed the court that the FSA has started work on a reporting platform for allergic reactions, but needs access to information on all fatalities if it is to have effective oversight of food safety. It would welcome improved appropriate sharing of information on fatalities as they are not routinely notified in a timely manner when there is a report of a fatality by the local authority or coroner. The Team Leader of Environmental Health in Royal Borough of Greenwich gave evidence that in 2019 the national Work Related Deaths Committee accepted a recommendation that the practical guide of the WDRP should be updated to address concerns surrounding food allergy deaths and the HSE is considering an amendment, but it has not yet been possible to take this forward. The Head of Trading Standards at the Royal London Borough of Greenwich confirmed that there was no national register (the subject of a PFD report from this jurisdiction in November 2019), but stressed that it is not the HSE who investigates these deaths and that a national process was needed that involved the local authorities coroners and FSA.

	2. Availability of emergency Adrenaline Auto-injector devices (AAIs) in the Retail food sector Ruben's parents have asked that the feasibility of food businesses being issued with AAIs. An Environmental Health officer has advised that this would need a change in the law and that such a change would potentially create new risks to lives, as well as the potential to save others. The court has heard no substantive evidence on whether the matter has been officially investigated and it is unclear whether its benefits outweigh its disadvantages, but it clearly has the potential to save lives.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to consider establishing a national reporting system which includes timely reporting to local authority and FSA and maintenance of a register of fatalities and their investigations, and consideration be given to investigating the feasibility of wider access to AAIs. I believe that the organizations would wish to learn of the circumstances of this death and are in a position to facilitate a collaborative process to mitigate or prevent future deaths.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday, February 11th 2021. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons and /or witnesses: [redacted], Incidents Adviser for Food Standards Agency, [redacted], Head of Trading Standards & Commercial Environmental Health at Royal London Borough of Greenwich, [redacted], Government Chemist, [redacted] Next of Kin, [redacted] Director of Thomas Tuck Limited, [redacted] Senior Associates of Gowling WLG for Odeon Cinemas, [redacted] Associate for Frutarom, [redacted] Barrister for London Ambulance Service.

	I am also sending this report to the following, who may have an interest: Royal College of Paediatrics and Child Health, ROSPA and Health and Safety Executive. 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	**[DATE]** **18th December 2020**	**[SIGNED BY CORONER]** **Andrew Harris, Senior Coroner**