IN THE WEST LONDON CORONERS COURT

BEFORE DR SEAN CUMMINGS

HM ASSISTANT CORONER LONDON (WESTERN AREA)

THE INQUEST TOUCHING THE DEATH OF NATASHA EDNAN-LAPEROUSE

DATE OF DEATH: 17th JULY 2016

HM ASSISTANT CORONER DR SÉAN CUMMINGS

Summing up of evidence presented and heard; Conclusion

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1. This inquest concerns the death of Natasha Ednan-Laperouse who was born on the 16th December 2000 and who died in Nice on the 17th July 2016.

2. I received very helpful assistance from Mr Hyam for the Laperouse family, Mr Campbell for Pret-á-Manger, Mr Saxby for British Airways, Mr Renteurs for Dr Pearson-Jones and I was very grateful to Mr Fortune who attended and represented Hillingdon Council and assisted Mrs Saunders.

3. I will deal firstly with the evidence and then submissions and finally my conclusion.

The journey and the emergency

1. I heard that over the course of her life, Natasha had developed a number of allergies, asthma and also experienced eczema. She is first recorded as experiencing a possible allergic reaction to sesame seeds at around the age of 2. There are extensive medical

notes including from her GP, The Royal Brompton Hospital and also the Chelsea and Westminster Hospital. I admitted all of these under Coroners Rule 23.

2. I heard from her father that the family as a whole adapted to accommodating Natasha's allergies. Notably, they carried and used medications when needed and they sought, scrupulously Mr Ednan-Laperouse told me, to detect and avoid allergens in foodstuffs so as to avoid the prospect of an allergic reaction.

3. Natasha carried with her two epipens which are spring loaded auto injector devices containing 300mcg of adrenaline and they have a 16 mm needle. Dr Croom told me this is important because in the UK Resuscitation Guidelines the ideal length needle is given as 25mm to ensure access to muscle so the adrenaline is effective. An epipen has a needle length which the same guidance suggests is for use in preterm or very small infants. Dr Croom told me that there is another device called the Emeraid with a longer needle and higher dose of adrenaline.

4. On the 17th July 2016 Natasha, her friend Bethany and her father were travelling to Nice to stay in Natasha's grandparents apartment. It was the start of the summer holidays and a number of trips and events were planned for the summer. Natasha was excited by what she was hoping was to be "her best summer ever".

5. They got up early, did not eat breakfast and were driven to Heathrow Terminal 5 by Natasha's mother, Tanya.

6. They arrived early and decided to eat breakfast there. They went to Pret for breakfast. Nadim Ednan-Laperouse encouraged the girls to choose what they wanted. Natasha chose an artichoke and olive tapenade baguette. She inspected it for details of contents and then handed it to her father who also checked it.

7. Natasha ate the baguette. She developed an itchy throat some three minutes later. She used her piriton – chlorphenamine – medication. The group then moved to the gate and boarded the plane.

8. Mr Laperouse says that around 25 minutes into the flight Natasha said her throat was still itchy and so she took a further dose of piriton. The situation deteriorated, initially

slowly thereafter. She became concerned her neck was red and went to the toilet to look. When she returned from the toilet her midriff was covered in hives under her clothing.

9. They proceeded to the toilet where the first of Natasha's epipen's was administered into her right thigh. The effect was not as hoped and Natasha asked for the second epipen to be given. Mr Ednan-Laperouse gave the second epipen dose into the right thigh, near to the first. This important because my expert, Dr Alex Croom, Consultant Allergist told me that the effect of adrenaline is to constrict the blood supply and for this reason ideally adrenaline doses should be placed in the other limb to ensure maximum absorption.

10. Accounts as to timings vary but I accept that these events actually happened towards the latter part of the flight and after food and drinks had been served in the cabin.

11. Despite the use of the second epipen Natasha deteriorated further. She said "daddy, help me, I can't breathe". Oxygen was called for and provided on maximum flow. There were seven oxygen cylinders on board and I was told that on maximum flow they should each last approximately 30 minutes. Natasha had been moved to the fold down crew seat. Mr Laperouse says that approximately 5 minutes after giving the second epipen, Natasha lost consciousness.

12. A doctor was requested. Dr Pearson Jones attended. Dr Pearson Jones had gained his degree the day before. He was not registered at that point but he had qualified. He had been required by his first employing NHS Trust to undertake an ALS course before taking up his first role and he had completed this.

13. Dr Pearson Jones was confronted by a rapidly evolving catastrophe. He instructed that Natasha be laid on the floor. He made attempts using a jaw thrust technique to ensure her airway was patent. He was provided with a medical kit. He drew up and gave chlorphenamine injection. He saw a glass ampoule with 1 in 10000 adrenaline but was not confident at calculating the dose. He did not see that there was a further epipen in the kit. He knew that Natasha had had two injections of epipen already.

14. Some time after and as the plane came into land Natasha experienced a cardiac arrest and he commenced full cardiopulmonary resuscitation using chest compressions and rescue breaths.

15. Dr Pearson Jones was not told that there was a defibrillator on board. Whilst I consider this to be an omission on the part of the BA crew, I do not believe this made a material difference to the outcome. The reason for my saying this is that (1) my expert Dr Croom told me that it is unlikely that there would have been a shockable rhythm which the defibrillator could have treated, the position in these circumstances being typically one of a pulseless electrical arrest where the heart is generating normal rhythm but the heart muscle does not respond (2) the cardiac arrest happened in the very final part of the descent and (3) when the French paramedics applied a defibrillator the rhythm was not shockable.

16. Both Dr Pearson Jones and crew member Mr Ballestri are to be commended for their actions. They were faced with a dire situation at the worst part of the flight in terms of being able to offer assistance but they performed admirably and I am grateful for their efforts.

Pret

17. I heard extensive evidence from Mr Perkins, Director of Risk and Compliance for Pret-á-Manger and he gave evidence over a number of hours.

18. He told me that Pret operates partly under regulation 5 of the Food Information Regulations. Pret outlets have kitchens adjacent to individual outlets preparing fresh food which is then packed and displayed for sale. The term used is "pre-packed for direct sale". The ingredients are sourced externally but the items are "assembled" if I can use that term, in the kitchen. The outlet at Terminal 5 where the Laperouse party bought their items has such an arrangement.

19. One of the effects of the regulation 5 is that it allows for incomplete labelling of food products. It allows for a general description eg in this case Artichoke and Olive Tapenade Baguette which indicates the main flavours and items, but does not require identification of allergens in bold lettering on the packet.

20. Mr Perkins told me at the time Pret relied on signposting. This means that stickers were meant to be placed on the food display units, known as langars, highlighting that allergy information was available on questioning staff or by referral to the Pret website.

21. The langars are well lit, refrigerated storage units made largely of stainless steel. Mr Perkins estimated they were approximately 1.2 metres wide and 2metres high. Each outlet has a number of them. The signposting sticker is 13 cm by 13 cm and is placed in the top right hand corner of the langar. The sticker is made of transparent plastic with white lettering. This is then stuck on the stainless steel background.

22. Photographs were produced and it is I believe fair to say that the stickers were difficult to see. It was pointed out to me by Mr Perkins that the various regulators had assessed them as being within the law. Whilst I accept that, I am of the view that they were inadequate in terms of visibility.

23. There was evidence that there were occasions when the signposting stickers were absent.

24. As mentioned in 18 above, the food is mixed and packed in the outlet kitchen. The materials are sourced externally. This includes the bread baguettes. In response to questions from Mr Hyam, Mr Perkins told him that they were prepared to Pret specifications and were delivered part baked. As part of the Pret specification sesame was included in the bread mix at a ratio of 2.41 %. Sesame is an Annex II allergen. By virtue of Regulation 5 referred to above, Pret did not declare or display the presence of this or other allergens on the packets which were "prepacked for direct sale".

25. I heard from Mr Perkins that at the time of Natasha's death there was an inconsistent and indeed incoherent system for receiving and monitoring reports of problems with foods or items purchased at Pret. It seems that some complaints were dealt with by customer services and some by Safety. Some were dealt with by a "gesture of goodwill". Overall I was left with the impression that Pret had not addressed the fact that monitoring food allergy in a business selling more than 200 million items a year

was something to be taken very seriously indeed. Knowledge of complaints and reports of allergy will inform safety developments within the company.

26. I also heard from Mr Perkins that unlike in other large organisations where an unexpected death occurs eg NHS Trusts, no formal investigation or report was commissioned but rather shareholders and the board were informed. No formal documentation of that appears to exist.

British Airways

27. I heard from Captain Hunter of British Airways. Captain Hunter gave me a clear and logical explanation as to why he proceeded to Nice airport for his emergency landing rather than diverting to Lyon or Grenoble or Marseilles.

28. I heard from Ms Durrant about the training of crew members on board, their duties in emergency and about materials and medicines carried on board.

Submissions

I received helpful written submissions from Mr Hyam and also Mr Campbell in relation to conclusions, relevant law and also the prospect of reports to prevent future deaths. I also received comprehensive oral submissions from Mr Saxby for British Airways.

I find that:-

1. Natasha Ednan-Laperouse was allergic to sesame from an early age.

2. That Natasha chose an Artichoke and Olive Tapenade baguette at Pret at T5 LHR on the 17th July 2016.

3. That she checked the packaging and her father checked the packaging to look for allergens.

4. That Natasha was reassured by the absence of allergens identified on the packaging.

5. That as a result of eating a baguette containing an allergen, namely sesame seeds which Pret had explicitly commissioned into their dough recipe, Natasha suffered a catastrophic anaphylactic reaction from which she could not be saved.

My conclusion is a narrative one.

Natasha Ednan-Laperouse died of anaphylaxis in Nice on the 17th July 2016 after eating a baguette, purchased from Pret-a-Manger at LHR T5. The baguette was manufactured to Pret specifications and contained sesame to which she was allergic. There was no specific allergen information on the baguette packaging or on the langar barker and Natasha was reassured by that.

That concludes the Inquest into the death of Natasha Ednan-Laperouse

Other matters

Report to prevent Future Deaths – Regulation 28

I will be making the following reports:

1. To Pret-a-Manger in relation to collecting information on allergic reactions and responding to serious concerns. (I am grateful to Mr Campbell for his submissions on this point but feel that the measures taken are insufficient)
2. To the MHRA and to the manufacturers of the Epipen in relation to the apparently inadequate length of the needle and the dosage of adrenaline within the device.
3. To Mr Michael Gove Secretary of State Department for the Environment, Food and Rural Affairs in relation to considering whether large food business operators should benefit from Regulation 5 Food Information Regulations.

Dr Séan Cummings

Her Majesty's Assistant Coroner London (Western Area)

28th September 2018