Preventing deaths from anaphylaxis

Harnessing information from coroners to save lives

21 October 2025



This research is dedicated to all those who have tragically lost their lives to anaphylaxis, and to their families and friends who continue to carry the weight of their loss.

The content of this report may be distressing for some readers.

Natasha Allergy Research Foundation
The UK's Food Allergy Charity

Sponsored by

LEIGH DAY

Preventable Deaths Tracker



"Behind every statistic is a name, a face, a story.

There's our daughter Natasha, who died aged 15 from anaphylaxis to sesame, and too many others like her. Different stories, the same heartbreak.

To lose a loved one to anaphylaxis is devastating. To fail to learn from the mistakes made, to help keep others safe and prevent future deaths, is unthinkable.

We hope this study will help to shine a light on the need for action so that no more parents have to go through the terrible loss that we will always endure."

Nadim and Tanya Ednan-Laperouse OBEs
Founders, The Natasha Allergy Research Foundation.



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Acknowledgments

We thank The Natasha Allergy Research Foundation and Leigh Day Solicitors for supporting this report and the launch event. We acknowledge the work of coroners who write Prevention of Future Deaths reports and the Chief Coroner's Office who publish this information.

We recognise the people behind each of these deaths and the profound impact it has on bereaved families, friends and professionals, as well as those deaths not reported in this report. We note the content of this report may be distressing for some readers.

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Foreword by Natasha's Foundation

Why we need urgent change to prevent food allergy deaths

By Nadim and Tanya Ednan Laperouse OBEs, founders of The Natasha Allergy Research Foundation

"It's been nine years since we lost our daughter, Natasha. Nine years since she went into anaphylactic shock after eating a baguette that didn't list sesame on the label.

Natasha's death was entirely preventable. It should never have happened. And what breaks our hearts even more is knowing that others have died since in a similar way, due to similar failings.

We are determined that other families never have to bear the terrible grief we will always carry. That's why we funded this research into inquests involving anaphylaxis, to make sure lessons aren't just learned but are acted upon to prevent future deaths."



The system that's failing to learn from loss

Coroners have an essential role in investigating sudden or unexplained deaths, to ensure mistakes are not repeated.

When someone dies suddenly or unexpectedly, coroners are meant to investigate to help prevent future deaths. It's supposed to be one of the most important safety nets we have. It is a chance to make sure action is taken to save lives.

But this research has revealed what we, as bereaved parents, already knew: the system isn't working.

Even though deaths from anaphylaxis are often sudden and unexplained, not all are investigated by coroners. There are no national statistics showing how many inquests involve deaths from anaphylaxis. On average, just two Prevention of Future Deaths reports a year are issued for anaphylaxis cases.

Almost half of organisations fail to respond within the legal 56 days, and more than half take no action at all.

We are literally watching the same mistakes being repeated. We are failing to turn lessons from tragedy into lasting change.

5 steps to help save lives

We have five clear recommendations to ensure lessons are not just learned but acted upon to prevent future deaths.

1. **A national database** of all deaths investigated by coroners.
2. **Mandatory investigation** of all anaphylaxis deaths by coroners.
3. **Parliamentary oversight** for ensuring responses to Prevention of Future Deaths reports.
4. **Appoint an Allergy Tsar** - a national allergy champion to drive change.
5. **Mandatory national reporting** of all anaphylactic events, including near-fatal ones.

These aren't complicated ideas. They're simple, sensible, and long overdue.

The statistics: and the people behind them that matter

The research analysed over 6,000 Prevention of Future Deaths reports since the system began and identified 32 involving anaphylaxis.

Children **aged 10 to 17** were at greatest risk.

Every food-related anaphylaxis death was **preventable.**

Over **1,368** years of life were lost - an estimated **£96 million** cost to the UK.

189 safety concerns were raised - and many were repeated again and again: **lack of training, poor communication, and no national safety systems.**

Yet only **45%** of organisations even responded.

And still, no one can with confidence say how many people die each year from anaphylaxis in the UK. Estimates range from 20 to over 8,600.

Meanwhile, hospital admissions for severe food allergic reactions have tripled in the last 20 years - and it is young people who are most at risk.



Seven years after Shanté Turay-Thomas' death from anaphylaxis, her mum Emma said something that has stayed with us:

"After reading this report, I feel lucky that an inquest was carried out into Shanté's death and a Prevention of Future Deaths report issued. Yet five years on from the inquest, the coroner's concerns about the lack of a national allergy lead, an Allergy Tsar, to act as a champion for people living with allergies and drive forward change, have still not been acted upon. We need to learn lessons from our mistakes to prevent future deaths. How many more lives must be lost before we learn? That's why this research matters and why we are urging the Government to consider these findings with the urgency and seriousness they deserve."

Executive summary

Exactly how many people in the UK die from anaphylaxis, a severe allergic reaction triggered by food, drugs and venom among other things, is unclear. Estimates vary widely, with reports ranging from 20 deaths per year to over 8,600 a year[1,2].

Despite anaphylaxis being sudden and unexpected, not all anaphylaxis deaths result in an inquest. Furthermore, using the **Preventable Deaths Tracker** - the first surveillance tool of coroners' Prevention of Future Deaths reports (PFDs) in England and Wales - we have uncovered that only two anaphylaxis deaths per year were reported in PFDs between July 2013 and August 2025 – the tip of the iceberg. However, PFDs have an important role in raising concerns to organisations that have the power to act to prevent future deaths. Anaphylaxis is preventable and learning the lessons from these deaths is vital for keeping people safe and saving lives.

Key findings

- Children aged 10 to 17 were at greatest risk among the 32 deaths due to anaphylaxis reported by coroners in PFDs.
- Over 1,368 years of life were lost across the 32 deaths, equating to a median of 72 years lost for every anaphylaxis death in school-aged children, costing the UK almost £96 million.
- Drugs (50%) and food (41%) were the most common allergens resulting in fatal anaphylaxis in PFDs. While all food allergies were known prior to deaths, three-quarters of drug allergies were previously known.
- After analysing the 32 PFDs, 189 concerns were identified that had been raised by 27 coroners. Most related to communication, the limitations of existing systems/lack of systems, need for education, training, and national oversight. These concerns were repeated time and time again by coroners in the PFD reports, with coroners often referring to similar PFDs as part of their concerns.
- Despite the repeated concerns and legal requirement to respond to the coroner within 56 days, just 45% of the 68 organisations that were sent PFDs responded, and even fewer reported taking action following deaths.
- 62% of the PFDs were sent to local organisations, further limiting the prospect for national action to prevent future deaths.
- Only 13 PFDs (40.6%) had all responses published and there is no real-time statutory system to track this, except the ongoing and unfunded work of the **Preventable Deaths Tracker (PDT).**
- The PDT has created a national surveillance tool for fatal anaphylaxis reported in PFDs to enable the real-time identification and analysis of new reports[3]:

Scan to go to PFD Tracker



Recommendations

The findings of this research identified critical areas for action to prevent future deaths and non-fatal anaphylaxis. The recommendations are:

1. A national database of all deaths investigated by coroners.

A statutory, national database of all deaths investigated by coroners in England and Wales should be established by The Ministry of Justice, working with the Chief Coroner's Office. In addition, there should be sustainably funded, independent research to routinely analyse and report findings from the database using live dashboards and surveillance tools that enable real-time learning. **The Preventable Death Tracker** used in this report can do this and a campaign has been launched to gather support for its use.
To support the campaign scan this QR code >>

2. Mandatory investigation of all anaphylaxis deaths by coroners.

All suspected deaths from anaphylaxis should be referred to the coroner and immediate investigation started, in the same way that work-related accidents and deaths in state custody are investigated. The Ministry of Justice, working with the Chief Coroner's Office and key stakeholders, should also ensure timely reporting of such deaths to support evidence-based public health responses. Guidance should be developed to improve how these deaths are investigated, including improving the collection of samples, timeliness and quality of autopsies. This guidance should be developed with key stakeholders so that it's relevant for all organisations involved, including coroners, pathologists and police.

"Guidance should be developed to improve how these deaths are investigated."

3. Parliamentary oversight for ensuring responses to Prevention of Future Deaths reports

The Ministry of Justice, working with the Chief Coroner's Office should enable Parliamentary oversight for Prevention of Future Deaths reports, similar to that of the Freedom of Information Act 2000, which requires public, private and third sector organisations to respond to coroners within 56 days, and sustainably support the digital infrastructure that allows the public to track responses to ensure transparency, accountability, and open justice.

4. Appoint an Allergy Tsar - a national allergy champion to drive change.

A national leadership role, an **Allergy Tsar,** should be appointed by The Department for Health and Social Care, to be a champion for people living with allergies as well as coordinate existing systems involved in anaphylaxis. This would include leading public education campaigns, training for organisations, staff, patients and carers, investigations of fatal and non-fatal anaphylaxis, including monitoring coroners PFDs, and following up on recommendations and policies that involve and impact people with allergies.

5. Mandatory national reporting of all anaphylactic events, including near-fatal ones.

A mandatory national reporting system for all anaphylactic events, including near-fatal reactions, should be set up by The Department of Health and Social Care, working with the UK Health Security Agency, the Food Standards Agency, and devolved administrations. This system should mirror the statutory notification process for infectious diseases, requiring registered medical practitioners, emergency departments and food service outlets to report all suspected anaphylaxis cases. Reports should be shared with relevant public health and food safety authorities to enable rapid investigation, traceability, and identify emerging allergen risks.

Introduction

Anaphylaxis is the most severe allergic reaction and can be fatal. It is estimated that 1 in 300 of the European population may be affected by anaphylaxis in their lifetime[4]. Hospital admissions due to anaphylaxis increased by 615% in England and Wales between 1992 and 2012[5]. While deaths from anaphylaxis are preventable, fatality data on anaphylaxis is limited.

Fatality data

Exactly how many people die from anaphylaxis in the UK is currently unclear, as accurate mortality statistics are not routinely published. Freedom of Information requests to the Office for National Statistics (ONS) reported a 15% increase in deaths in England between 2001 and 2018[6,7]. The Government reported ONS figures in Parliament, stating 1,665 deaths were registered in 2023, where fatal anaphylactic reactions were reported as the underlying cause of death, and 8,645 deaths where fatal anaphylactic reactions were mentioned on the death certificate[1].

However, the ONS uses broad International Classification of Diseases (ICD) codes that mostly do not involve anaphylaxis. The UK Fatal Anaphylaxis Registry (UKFAR) has received voluntary submissions on deaths since 1992, which have been used to study food anaphylaxis and hospital admissions[5,8,9]. In 2000, the UKFAR reported approximately 20 deaths per year, but noted that this is likely to be an underestimate[2]; nonetheless, this is the figure used in National Institute for Health and Care Excellence (NICE) guidance[10].

"There is no single data source that establishes the full extent of fatal anaphylaxis in England and Wales"



Between 2006 and 2022, the UKFAR catalogued 570 deaths, but due to resource limitations and data protection regulations, this information was reported to be incomplete[11]. In April 2019, the National Child Mortality Database (NCMD) began collecting data on all deaths in those aged under 18 in England, which was used to assess deaths due to asthma and anaphylaxis[12]. The NCMD investigation identified 19 child deaths due to anaphylaxis between April 2019 and March 2023, an average of five fatal anaphylaxis deaths in children each year.

Overall, there is no single data source that establishes the full extent of fatal anaphylaxis in England and Wales, which prevents real-time analysis that could inform practice and policy to save lives.

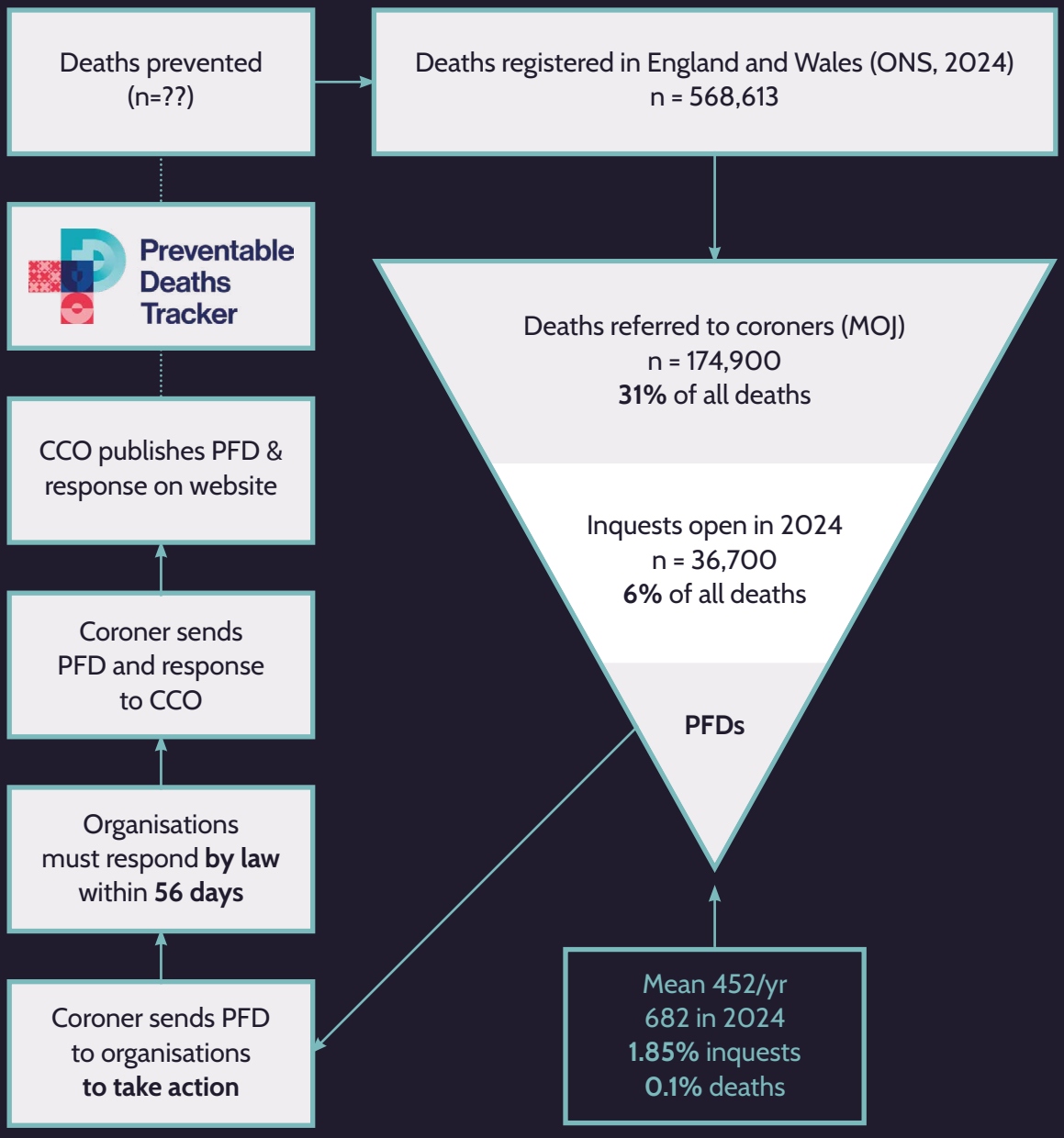
The Coroner Service

Sudden or unexpected deaths must be referred to coroners in England and Wales, who have a statutory requirement to write Prevention of Future Deaths reports (PFDs) to organisations that they deem have the power to take action to prevent similar fatalities[13-15], **(Figure 1).**

However, we know that not all anaphylaxis deaths are the subject of an inquest. Using the Preventable Deaths Tracker[16], PFDs have been systematically collated and analysed to identify concerns raised by coroners for national learning[17]. However, until now, this had not been conducted for fatal anaphylaxis.

Therefore, this study aimed to conduct the first analysis of trends and concerns raised by coroners in PFDs following fatal anaphylaxis, examine organisational responses, and create a national surveillance tool that tracks PFDs in real-time.

Figure 1: Death investigations in England and Wales, with statistics for 2024. CCO: Chief Coroner's Office; MOJ: Ministry of Justice; ONS: Office for National Statistics; PFD: Prevention of Future Deaths reports.





“Cases were brought to a review panel of clinical and coronial experts when there was any uncertainty to reach consensus”

Methods

A national observational study was designed using established research methods[18,19], and the study protocol was pre-registered on an open repository[20].

PFDs were identified using keyword searches (see **Annex A**) in the Preventable Deaths Tracker's (PDT's) searchable repository[16,21]. Identified PFDs were independently screened in duplicate and included if anaphylaxis caused or contributed to the death, or coroners raised concerns relating to anaphylaxis. Cases were brought to a review panel of clinical and coronial experts when there was any uncertainty to reach consensus. Deaths due to other allergic reactions (e.g. allergic asthma) and adverse drug reactions were not included.

Once screened, data was extracted into the PDT, including demographics (age and sex), date of death, coroners' conclusion and investigation information, causes of death, place of death, location of anaphylactic reactions, implicated allergen, medical history, medical interventions, coroners' concerns, and details of report addressees and whether they responded. This was verified in duplicate for each death. If any data was missing the relevant coroners' offices were contacted directly.

Descriptive statistics were used to synthesise the quantitative data, including median and interquartile ranges (IQR) for continuous variables and frequencies for categorical variables. The years of life lost (YLL) were calculated using the ONS Projected Expectations of Life Tables[22], from which we calculated the monetary impact of these deaths, using the Value of a Statistical Life (VSL) from HM Treasury's guidance of £70,000 per year for 2020-21[23]. International Classification of Diseases Eleventh Revision (ICD-11) codes were assigned to each PFD using the medical causes of death[24].

Content analysis was used to categorise concerns raised by coroners and actions reported in responses to identify repeated themes from the qualitative data. The organisations to whom PFDs were sent were categorised as 'completed' if all requested responses were published, 'partial' if some but not all responses were published, or 'overdue' if no response was published as per Regulation 29 of the Coroners (Investigations) Regulations 2013[13].





Findings

Coroners reported on 32 deaths from anaphylaxis in PFDs in England and Wales between July 2013 and August 2025.

This equates to an average of only 2 anaphylaxis deaths reported by coroners in PFDs each year, which underestimates the extent of fatal anaphylaxis in England and Wales.

Most of these deaths were reported by coroners in 2014 and 2019, with most deaths occurring in 2017 **(Figure 2).**

Although anaphylaxis is sudden and unexpected, it is not possible to determine how many deaths due to anaphylaxis were referred to and investigated by coroners in England and Wales as there is no national coronial database.

Using the **Preventable Deaths Tracker,** a national surveillance tool, fatal anaphylaxis reported in PFDs can be tracked **(Figure 3)** and these PFDs can continue to be identified[3]:

Scan to go to PFD Tracker

Figure 2: Trends over time of 32 coroners' Prevention of Future Deaths reports (dark blue) published in England and Wales between July 2013 and August 2025 and deaths (teal) from anaphylaxis reported by coroners.

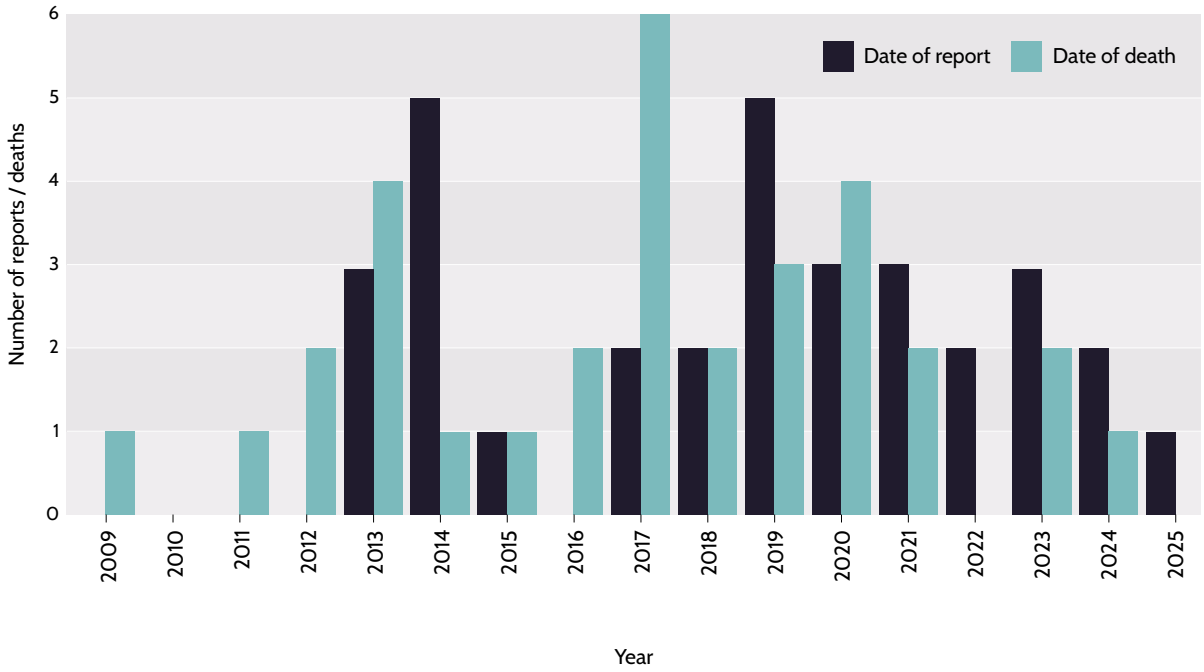


Figure 3: National surveillance tool created using the Preventable Deaths Tracker for fatal anaphylaxis reported by coroners in Prevention of Future Deaths reports.

Preventable Deaths Tracker

Anaphylaxis

Fatal anaphylaxis reported by coroners in England and Wales since July 2013.

The Preventable Deaths Tracker (PDT) enables bespoke analysis of coroners' Prevention of Future Deaths reports (PFDs) using our searchable database and analytical tools.

Commissioned by the Natasha Allergy Research Foundation, this live surveillance tool tracks deaths from anaphylaxis when the coroner writes to organisations to take action to prvent future deaths. It automatically updates in real time.

Reports
From July 2013 to present
32

Deaths
From July 2013 to present
32

DOWNLOAD

> Download Sample

Published coroners' Prevention of Future Deaths reports in England & Wales.

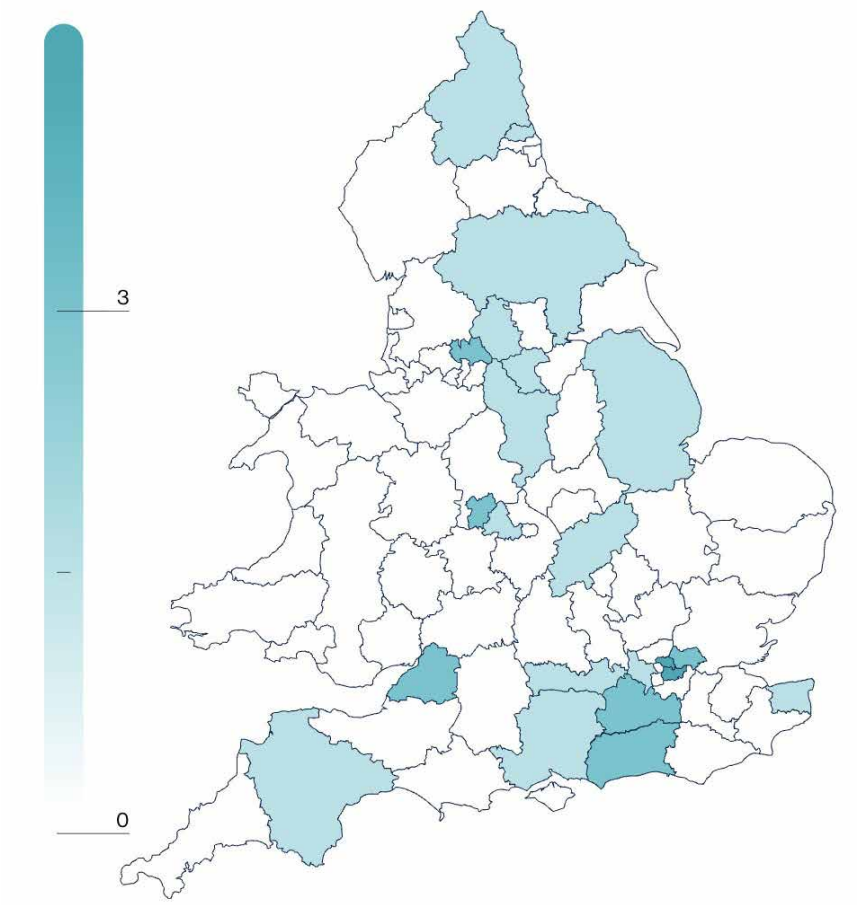
Completed
From July 2013 to present
40.6%
Reports with all published responses

Overdue
From July 2013 to present
28.1%
Reports without any published responses

Partial
From July 2013 to present
31.3%
Reports with some, but not all, required responses published

Pending
Due within 56 days of report date
0.0%
Responses due for reports published in last 56 days

Geography



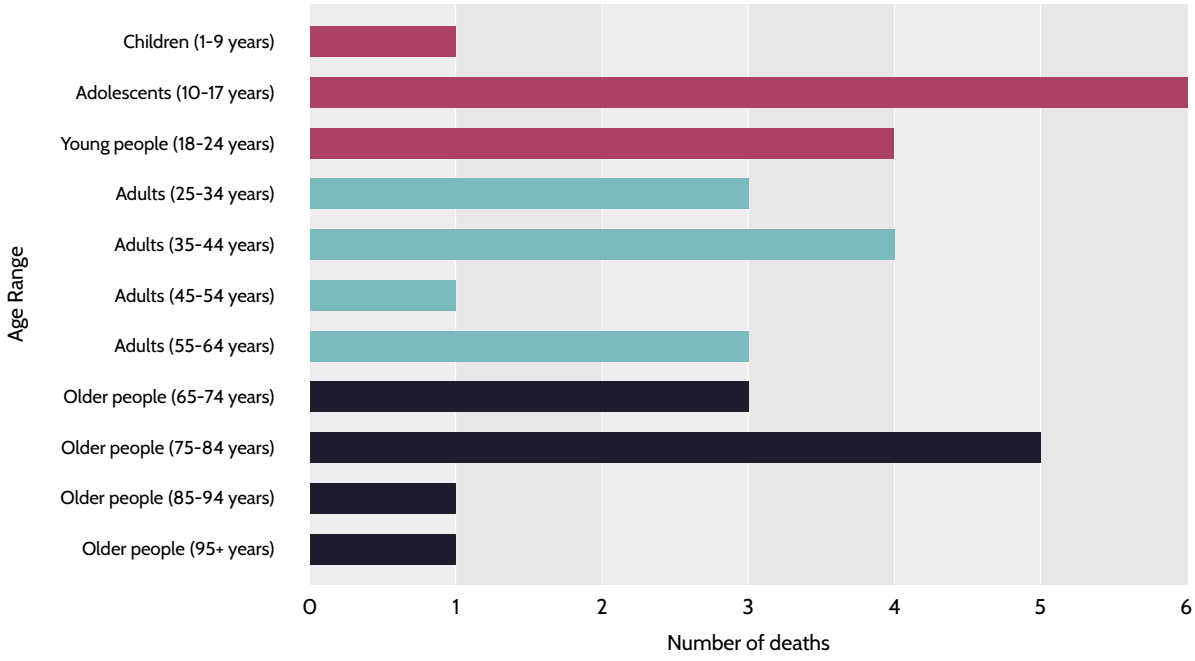


Demographics and characteristics

Half (53%) of deaths were in females, and deaths occurred across all age groups from 9 to 97 years old **(Table 1).**

The median age at death was 38 years (IQR: 18-66 years), with the most at-risk age group for fatal anaphylaxis being 10-17 years **(Figure 4).**

Figure 4: Age ranges of fatal anaphylaxis reported by coroners in PFDs between July 2013 and August 2025.



Almost one-third (31%) of deaths occurred in school-aged individuals (18 years and younger), all of which involved food allergens except the death of 17-year-old Alexandra Briess that occurred during anaesthesia.

Impact of loss

In total, 1,368 years of life were lost following the 32 fatal anaphylactic events. Over half of these life years lost - 721 years - were for school-aged children **(Table 1).**

This amounts to a median of 48 years lost for every death from anaphylaxis, and 72 years lost for school-aged individuals, costing the UK almost £96 million **(Table 1).**

Table 1: Summary of the demographics and impact of fatal anaphylaxis reported by coroners in PFDs in England and Wales between July 2013 and August 2025.

	All deaths (n=32)	School-aged (n=10)	Food allergens (n=13)
Age (years)			
Median (IQR)	38 (18-66)	14.5 (13-18)	18 (14-23)
Range	9-97	9-18	9-44
Female (%)	17 (53%)	4 (40%)	5 (38%)
Years of life lost			
Total	1368	721	864
Median (IQR)	48 (19-68)	72 (71-74)	71 (31-73)
Value of Statistical Life (VSL)			
Total	£95.76 mil	£50.47 mil	£60.48 mil
Median	£3.36 mil	£4.99 mil	£4.97 mil

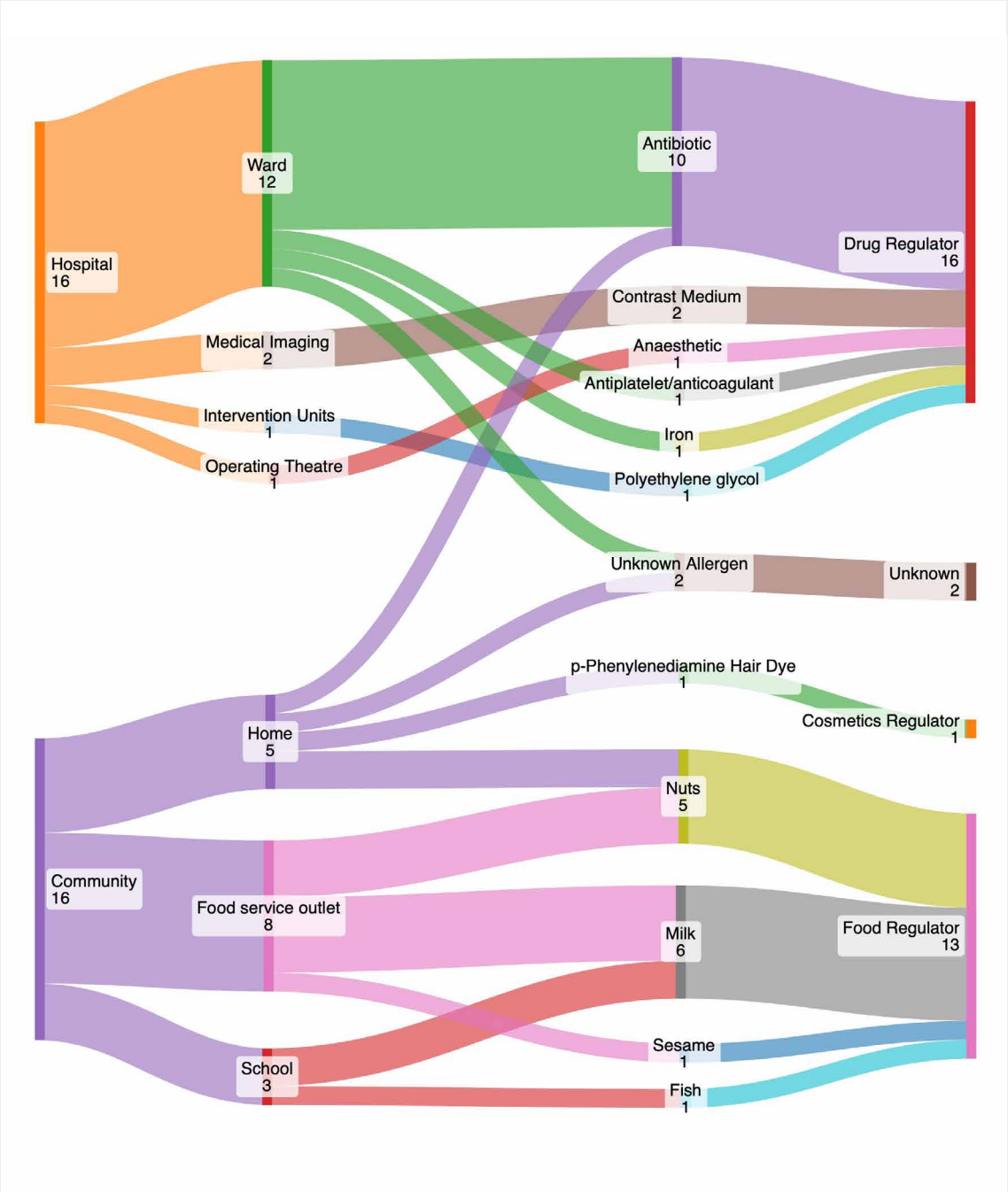


Allergens

The most common groups of allergens resulting in fatal anaphylaxis were drugs (50%) and food (41%), with one death from the chemical **paraphenylenediamine (PPD)** following recurrent use of hair dye against a background of long-standing allergies and previous adverse reactions.

Half of all anaphylactic events occurred in the community, with most occurring following the purchase of food from a service outlet, five in the home, and three at school **(Figure 5).** The remaining anaphylactic events occurred in hospitals, triggered by drug allergies. The details of the allergens following two deaths were unknown.

Figure 5: Anaphylactic pathway from location of exposure to type of allergen and regulator responsible for oversight.





All deaths from food-related anaphylaxis occurred in people with known food allergies, they were aged between 9 and 44 years, with a median age of 18 years (IQR:14-23 years).

The most commonly reported food allergies prior to death were milk (46%) and nuts (39%). In those with reported medical histories, asthma was the most common, occurring in 38% of those with food allergies.

"The most commonly reported food allergies prior to death were milk and nuts."

Three-quarters of drug anaphylaxis deaths occurred in people with known drug allergies, with most involving penicillin-based antibiotics, where medical records were not accessed prior to administration.

Causes of deaths

Anaphylaxis was reported as a medical cause of death in 94% of PFDs with almost three quarters (73%, n=22) reporting anaphylaxis as cause Ia, 10% (n=3) as cause Ib, 17% (n=5) as cause Ic and 3% (n=1) as cause II. One medical cause of death mentioned anaphylaxis twice.

After anaphylaxis, the other most common medical causes of death were arrests (25%), infection (22%), and ischaemia (22%), followed by adverse drug reactions and food allergies **(Table 2).**

The verification of all deaths occurred in hospitals, except for one food-related death that was confirmed in their own place of residence.

Table 2: Medical causes of death in the 32 Prevention of Future Deaths reports published in England and Wales between July 2013 and August 2025.

Medical causes of death	Frequency
Anaphylaxis	**31 (97%)**
Unspecified (4A84.Z)	16 (50%)
Drug-induced anaphylaxis (4A84.1)	8 (25%)
Anaphylaxis due to allergic reaction to food (4A84.0)	5 (16%)
Anaphylaxis due to radiocontrast media (EL80)	2 (6%)
Arrests	**8 (25%)**
Cardiac arrest, unspecified (MC82.Z)	4 (13%)
Cardiopulmonary arrest (MC82.4)	4 (13%)
Infection	**7 (22%)**
Bacteraemia (MA15.0)	1 (3%)
Bronchopneumonia (CA40.Z)	1 (3%)
Chest infection NOS (CA2Z)	1 (3%)
Infective exacerbation of chronic obstructive pulmonary disease (CA22.1)	1 (3%)
Surgical site infection (NE81.2)	1 (3%)
Tonsilitis (CA03.Z)	1 (3%)
Urinary tract infection NOS (GC08.Z)	1 (3%)
Ischaemia	**7 (22%)**
Anoxic-ischaemic encephalopathy (8B24.0)	3 (9%)
Ischaemic heart diseases, unspecified (BA6Z)	3 (9%)
Hypoxic brain injury (8B24.Z)	1 (3%)
Adverse drug reaction	**4 (13%)**
Harmful effects of drugs, medicaments or biological substances, not elsewhere classified (NE60)	4 (13%)
Food allergy	**4 (13%)**
Food hypersensitivity, unspecified (4A85.2Z)	4 (13%)
Asthma	**3 (9%)**
Bronchial asthma NOS (CA23.32)	2 (6%)
Status asthmaticus NOS (CA23.31)	1 (3%)
Bleeding	**3 (9%)**
Abdominal haematoma (NB9Y)	1 (3%)
Intracranial haemorrhage, unspecified (8B0Z)	1 (3%)
Post-operative bleeding (NE81.0Z)	1 (3%)
Injury	**3 (9%)**
Fracture of neck (NA22)	1 (3%)
Pressure sore (EH90.Z)	1 (3%)
Tendency to fall (MB47.C)	1 (3%)
Coronary artery disease	**2 (6%)**
Coronary atherosclerosis, unspecified site (BA52.Z)	1 (3%)
Diseases of coronary artery, unspecified (BA8Z)	1 (3%)
Diabetes Type 2	**2 (6%)**
Type 2 diabetes mellitus (5A11)	2 (6%)

Medical causes of death	Frequency
Kidney disease	**2 (6%)**
Chronic kidney disease (GB61.Z)	1 (3%)
Glomerular disease with focal and segmental sclerosis (MF8Y)	1 (3%)
Organ failure	**2 (6%)**
Multi organ failure (MG4A)	1 (3%)
Respiratory Failure (CB41)	1 (3%)
Thromboembolic event	**2 (6%)**
Acute myocardial infarction (BA41.Z)	1 (3%)
Deep vein thrombosis (BD71)	1 (3%)
Aneurysm	**1 (3%)**
Abdominal aortic aneurysm, unspecified (BD50.4Z)	1 (3%)
Arrhythmias	**1 (3%)**
Atrial fibrillation, unspecified (BC81.3Z)	1 (3%)
Biliary disease	**1 (3%)**
Calculus of gallbladder or cystic duct with acute cholecystitis (DC11.0)	1 (3%)
Bone disease	**1 (3%)**
Osteoporosis (FB83.1)	1 (3%)
Chronic heart disease	**1 (3%)**
Adhesive pericarditis (BB2Y)	1 (3%)
Clotting disorder	**1 (3%)**
Haemophilia A (3B10.0)	1 (3%)
Frailty	**1 (3%)**
Ageing associated decline in intrinsic capacity (MG2A)	1 (3%)
Hypertension	**1 (3%)**
Other specified secondary hypertension (BA04.Y)	1 (3%)

Medical interventions

When anaphylaxis occurred in the community, 81% of PFDs included information regarding medical interventions; six reported the use of adrenaline auto injectors (AAIs) and only one reported the use of two AAIs.

When anaphylactic events occurred in hospital, information regarding medical interventions was also included in 81% of PFDs; three-quarters reported resuscitation attempts, and one did not provide details of the intervention. Adrenaline was not specifically reported as an intervention in any PFD following hospital-related anaphylaxis.

Coroners' conclusions of the inquest

The majority of inquests (81%) were concluded as narrative, followed by accidental conclusion (10%), misadventure (6%) and natural causes (3%).

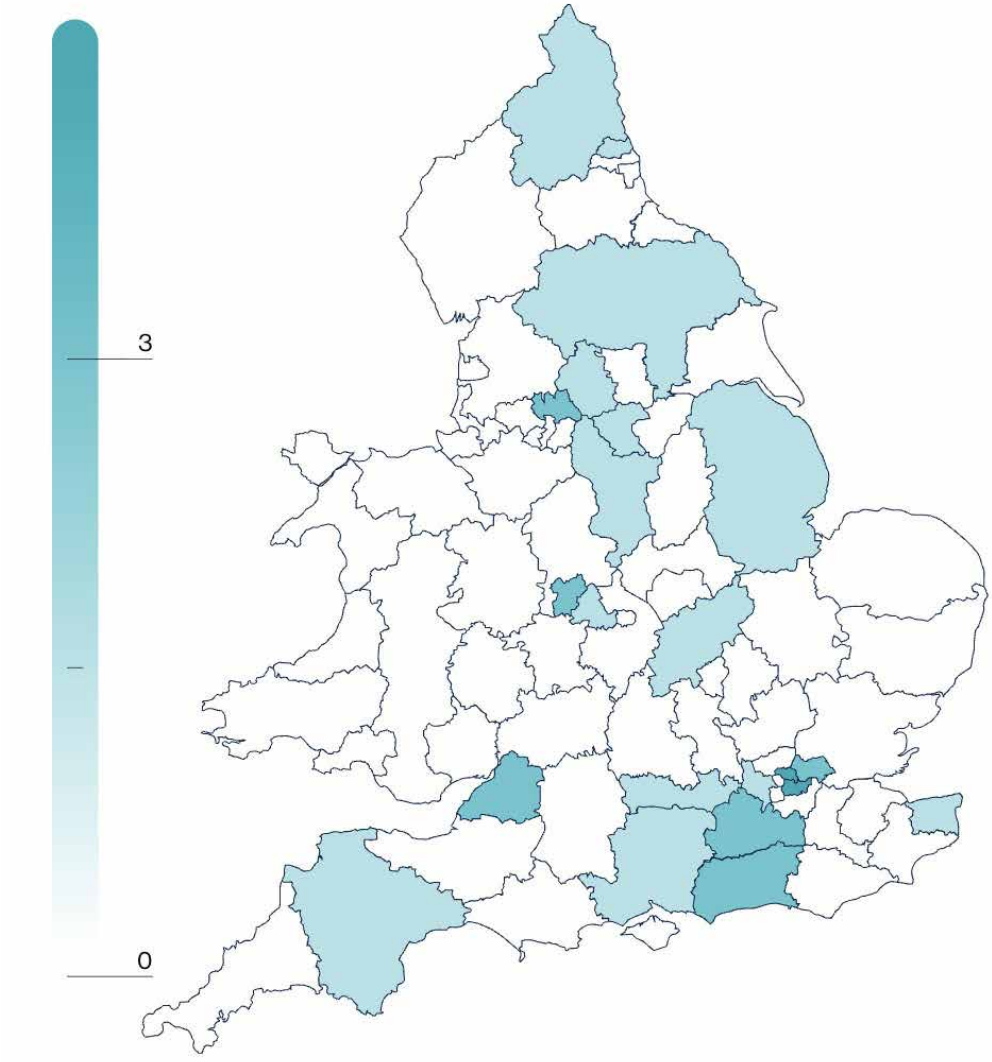


Coroners

The 32 PFDs were written by 27 coroners based in 22 areas **(Figure 6).**

There was wide variation in reporting, with most reported by coroners in London (28%) and none reported by coroners in Wales.

Figure 6: Geographical variation of the 32 Prevention of Future Deaths reports by coroner areas in England and Wales.



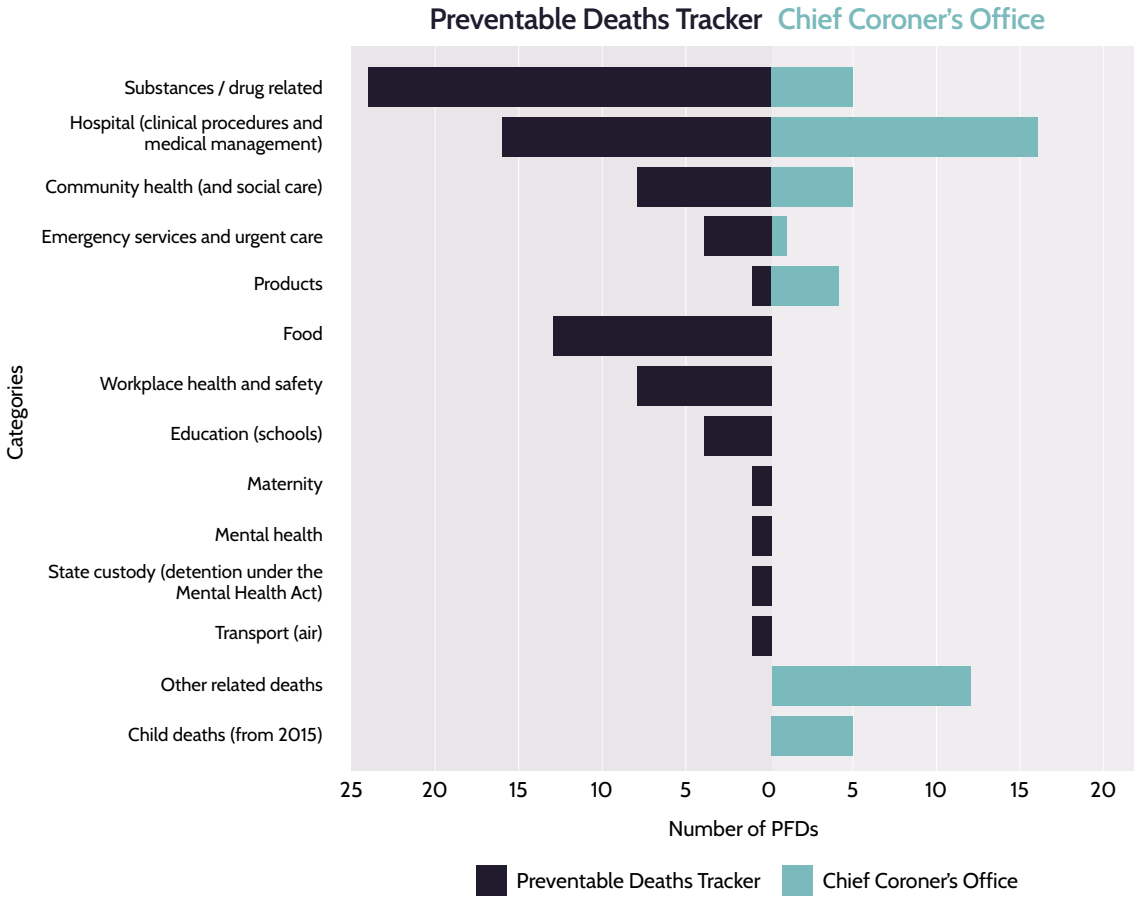
Categorisation of PFDs

When publishing PFDs, the Chief Coroner's Office assign reports to a "PFD Report type". For the 32 fatal anaphylaxis PFDs, these were most often classified as 'hospital deaths' or 'other related deaths' **(Figure 7),** which limits learning and the ability to identify reports.

The Preventable Deaths Tracker (PDT) has created a formal taxonomy for categorising PFDs that accounts for all types of deaths, including adding categories for food, education, and maternity, among others, so that 'other related deaths' is obsolete. The PDT's extraction of age and assigning age ranges means that the 'child death' category is also obsolete, and the more granular data allows for better insights into at risk and vulnerable groups.

Furthermore, we found that the Chief Coroner's Office 'Child deaths' category misses several PFDs as there were 10 school-aged individuals and seven under the age of 18, compared to the five assigned as 'child deaths' by the Chief Coroner's Office. Finally, the PDT assigns these categorising using a team of experts that take into consideration all information reported by the coroners, including concerns, to ensure all relevant categories are assigned **(Figure 7).**

Figure 7: Categorisation of PFDs using the Preventable Deaths Tracker taxonomy (dark blue) compared with the PFD report type assigned by the Chief Coroner's Office on the Judiciary website (teal).

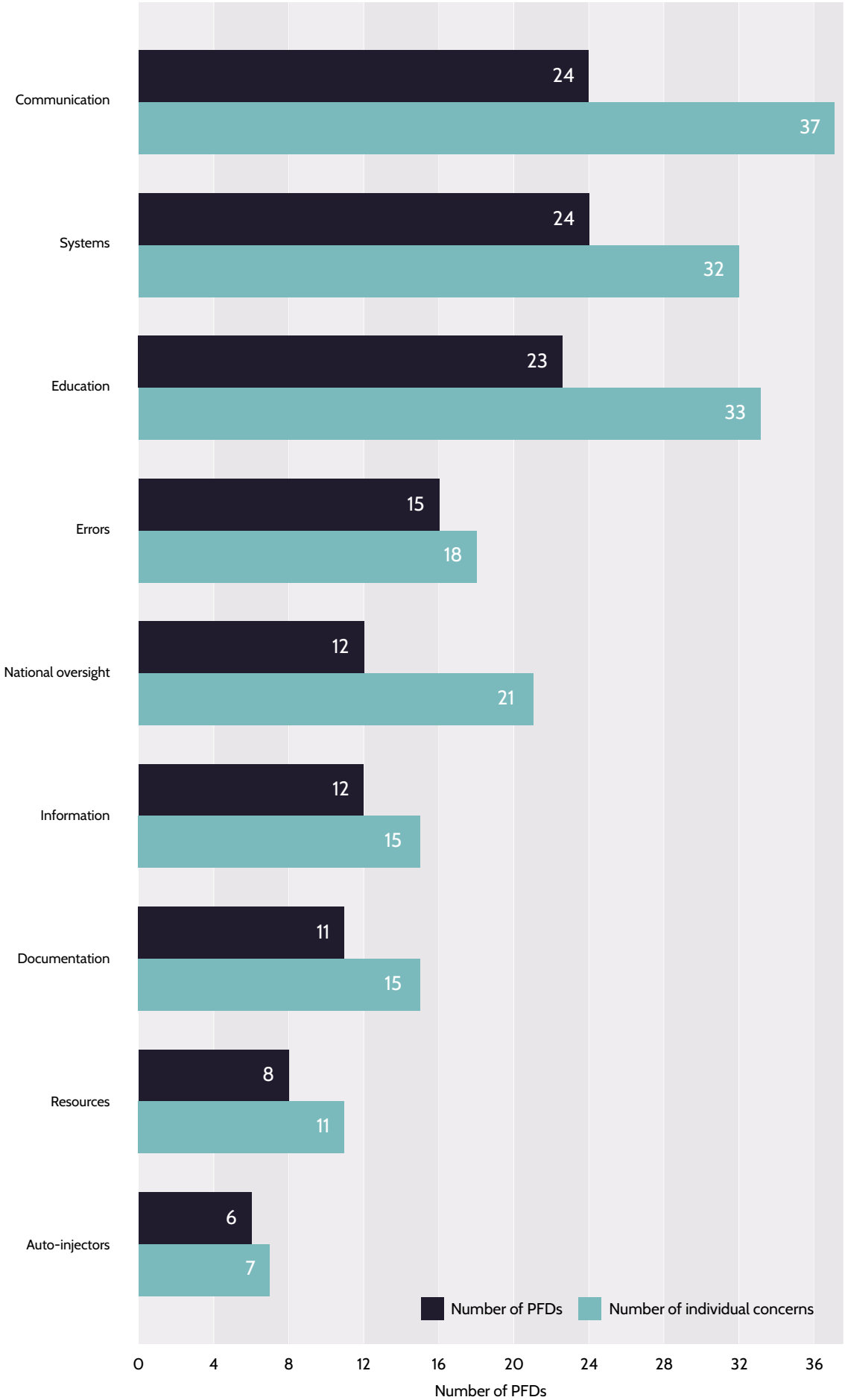


Concerns raised by coroners

Coroners raised 189 concerns in PFDs that were thematically assigned into 9 groups **(Figure 8).**

The most common (75%, n=24PFDs) were inadequate communication and systems, followed by the lack of education and training (n=23 PFDs), errors (n=15 PFDs) and need for national oversight (n=12 PFDs).

Figure 8: Concerns raised by coroners in the 32 Prevention of Future Deaths reports following fatal anaphylaxis.



Repeated concerns by coroners: case studies

In cases of anaphylaxis caused by food, the pattern is clear. A failure to learn from and implement the lessons of past tragedies means people with allergies continue to be exposed to greater risk.

Following food anaphylaxis deaths, three PFDs mentioned previous, similar deaths, and cross-referenced previous PFDs in their reports. This included the death of 13-year-old Karanbir Cheema at school in 2017 after being exposed to cheese by a classmate, with the coroner stating, ***"...some issues I raised before Karanbir's death, in PFD reports I made in May 2017 following the death of Nasar Ahmed on 14 November 2016."*** The death of 14-year-old Nasar Ahmed similarly occurred at school in 2016 after he consumed tandoori chicken that contained milk powder to which he had a known allergy. In both PFDs, the coroner reported that the expert witnesses who gave evidence at the inquests suggested adrenaline auto-injectors (AAI) be publicly available like defibrillators. The availability of AAIs in public places was endorsed by the Commission on Human Medicines' (CHM) Adrenaline Auto-injector Expert Working Group (AAI EWG) in November 2021[25] but, it is not clear whether any of the recommendations have been taken forward.

Repeated concerns were also raised following the death of 18-year-old Shanté Turay-Thomas who consumed hazelnuts at home in 2018 after being diagnosed with a peanut allergy. Twenty concerns were raised by the coroner, including one where the NHS 111 call handler failed to ask to speak directly to the patient, stating that "***this is not the first time that the issue has been brought to the attention of NHS Digital",*** describing another PFD written to NHS Digital in 2018 following the death of 69-year-old Susan Longden. The coroner concluded that ***"if NHS Digital does not have a grasp of this sort of detail, specifically brought to its attention by a coroner in a prevention of future deaths report, it is difficult to see how there can be effective improvement,"*** demonstrating the inability of public organisations to learn from PFDs and the need for national tracking. Following the death of 14-year-old Ruben Bousquet in 2019 after consuming popcorn at a cinema that was contaminated by milk protein, the coroner raised concerns regarding the lack of a national reporting and registering system, stating that the Food Standards Agency (FSA) recognised the need for ***"access to information on all fatalities if it is to have effective oversight of food safety. It [FSA] 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,"*** highlighting the need for a national database of all deaths referred to the coroner that can be easily shared with relevant organisations such as the FSA. Furthermore, the coroner confirmed that ***"there was no national register (the subject of a PFD report from this jurisdiction in November 2019),"*** and ***"that a national process was needed"*** involving a range of stakeholders.

In 2023, following the death of 17-year-old Alexandra Briess, who had no known allergies, from an anaesthetic, the coroner reported that ***"this is not new territory",*** listing three PFDs, including the deaths of Shanté Turay-Thomas, Ruben Bousquet, and Celia Marsh where ***"several coroners have raised concerns similar to mine."*** While there were no concerns raised regarding the clinical management of Alexandra Briess, the coroner raised concerns regarding the need for gathering information nationally and funding appropriate research to improve the understanding and prevention of similar deaths.

"A failure to learn from and implement the lessons of past tragedies means people with allergies continue to be exposed to greater risk."

Responses to PFDs

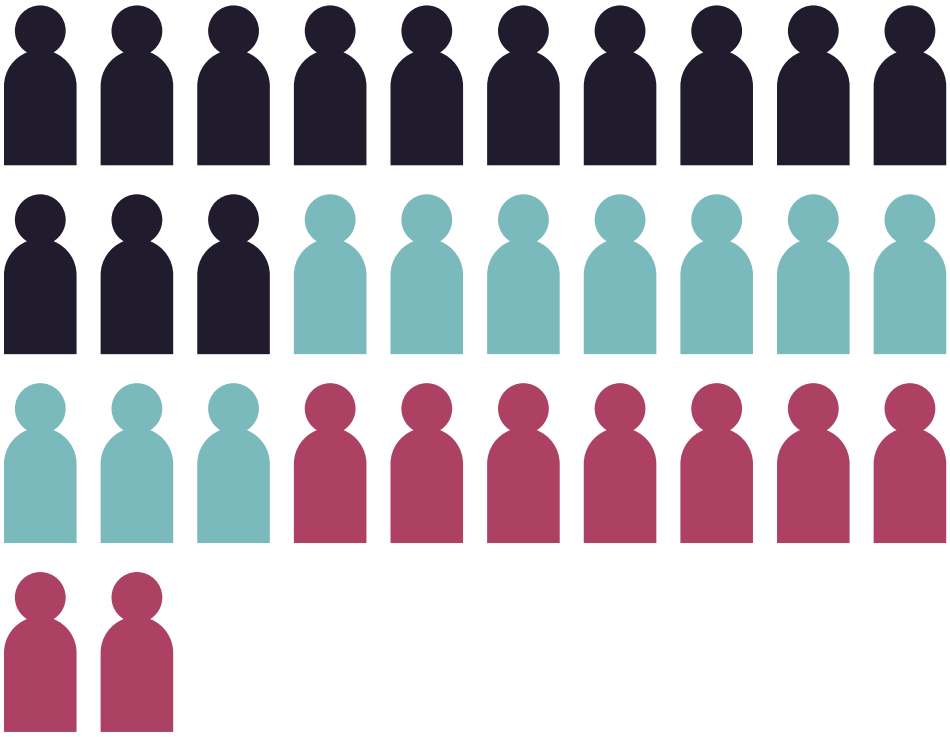
Coroners write PFDs to organisations when they believe that action must be taken to prevent similar deaths.

The 32 PFDs analysed were sent to **68 organisations,** with most (62%) being sent locally - reducing the ability of coroners' concerns to have a national impact on preventing future deaths.

This issue was similarly highlighted in a PFD (2020-0124), where a coroner stated, "The issues ... are predominantly national issues, but I heard at inquest that there is no person with named accountability for allergy services and allergy provision at NHS England or the Department of Health as a whole."

Forty per cent of organisations (n=27) had overdue responses, meaning that they are not complying with Regulation 29 of the Coroners (Investigations) Regulations 2013[13], which requires a response within 56 days. Overdue or unpublished responses are not followed up; and there is no tracking to ensure compliance with the statutory requirement to respond and take action. Overall, only 13 PFDs (40.6%) had all expected responses published **(Figure 9)** - further demonstrating a lack of compliance with Regulation 29 of the Coroners (Investigations) Regulations 2013[13].

Figure 9: Status of the responses to PFDs, where reports have all required responses published (dark blue), partial responses (teal), and no published responses (red).



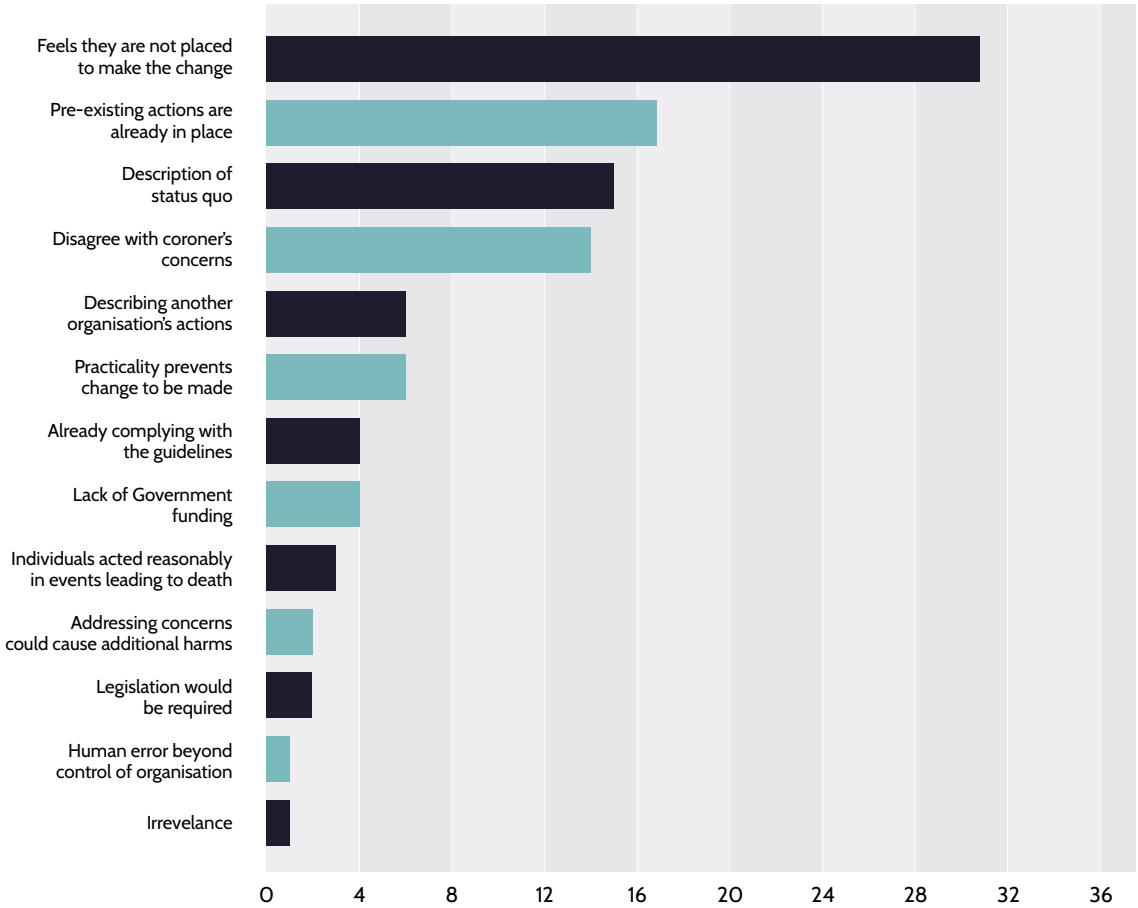
Two-thirds of PFDs were sent to public organisations, including the government, the health and social care sector, regulators and oversight bodies.

The Department for Health and Social Care received the most reports (31%), followed by NHS England (16%), the British Society for Allergy and Clinical Immunology (16%), and the Medicines and Healthcare Products Regulatory Agency (16%).



The content of responses was analysed, and this identified 198 inactions (52%), 174 actions (45%), and 11 vague intentions for improvement (3%). The most common justification for inaction was that the organisation felt they were not placed to make the changes **(Figure 10),** citing regulatory/legislative challenges and funding limitations, among other justifications.

Figure 10: Categories of justification for inaction in 48 responses to PFDs following anaphylaxis in England and Wales.



Conclusions and recommendations

This research is the first analysis of all published PFDs following all-cause fatal anaphylaxis in England and Wales, using a bespoke surveillance tool - the Preventable Deaths Tracker - to ensure this vital information is identified and analysed in real-time.

The 32 anaphylaxis-related PFDs are just the tip of the iceberg and do not represent all fatal anaphylaxis between July 2013 and August 2025. Furthermore, the analysis of coroners' concerns demonstrates repeated issues where too little action is being taken nationally to learn from and prevent these tragedies.

Preventing future deaths

While mortality statistics are held by the ONS and the UKFAR voluntarily collects information about anaphylaxis deaths, there is no way to determine the number of anaphylaxis deaths referred to and investigated by coroners in England and Wales in real-time. Furthermore, from PFDs alone, it is not possible to determine the full preventative potential of the Coroner Service - to achieve this a national database of all inquests is needed. The UK system is in stark contrast to other countries in the world, such as Australia, Canada and New Zealand which routinely collect, analyse, and use coronial data to inform policy and practice[26,27].

"The UK system is in stark contrast to other countries in the world"

In Australia, the National Coronial Information System (NCIS), which began in 2000 - more than 25 years ago - works alongside the Coronial Prevention Unit (CPU) and the Victorian Institute of Forensic Medicine (VIFM) to deliver a world-leading Coroner Service for bereaved people that safeguards the public by enabling evidence-based prevention.

While the NCIS is funded by Justice departments across states and countries (including New Zealand), it also receives ongoing funding from several ministerial departments and public bodies which actively use the data to inform policy - including the departments for health, Safe Work Australia, the Australian Competition and Consumer Commission, and the Australian Institute of Criminology, among others.

The CPU enables a preventative role for the Coroner Service and VIFM provides independent scientific services, including timely autopsies, toxicology, organ donation, and support for victims and the bereaved. VIFM's direct link with Monash University means that its education of the next generation helps reduce workforce shortages and provides the necessary training to upskill professionals. They conduct rigorous academic research that results in the evidence required to continually improve the justice system, public health and death prevention.

5 steps to help save lives

We have five clear recommendations to ensure lessons are not just learned but acted upon to prevent future deaths.

1. **A national database** of all deaths investigated by coroners.
2. **Mandatory investigation** of all anaphylaxis deaths by coroners.
3. **Parliamentary oversight** for ensuring responses to Prevention of Future Deaths reports.
4. **Appoint an Allergy Tsar** - a national allergy champion to drive change.
5. **Mandatory national reporting** of all anaphylactic events, including near-fatal ones.

These aren't complicated ideas. They're simple, sensible, and long overdue.

The gaps in the English and Welsh coronial system were repeatedly highlighted by coroners across the 32 PFDs, with one coroner stating, *"it concerns me that there is no national register recording the circumstances of these deaths,"* and another emphasising that *"the only way to improve understanding and prevent or reduce future deaths is to gather information nationally and fund appropriate research"*.

This concern was similarly acknowledged by Sir Robert Neill KC during the follow-up inquiry into the Coroner Service where he informed the Minister for Courts and Legal Services in May 2024, that *"I am also very concerned that the UK is falling behind other jurisdictions in the efficient and effective use of coronial data.*

The Government should scope the creation and maintenance of a Coronial Information Service, similar to that already provided in Australia and New Zealand[28]." The Minister responded in December 2024 stating that they *"will be undertaking further work with key stakeholders, such as Dr Georgia Richards, to better understand the case for a new approach*[29]*"*, but such work and engagement have not occurred. An analysis and development of a live surveillance tool of all deaths investigated by coroners would ascertain whether there are further learnings from fatal anaphylaxis not reported in PFDs. Therefore, the first recommendation of this research is:

Recommendation 1: Establish a statutory national database of all deaths investigated by coroners in England and Wales and sustainably fund an independent research unit to routinely analyse and report findings from the database, using live dashboards and surveillance tools that enable real-time learning.

In support of Recommendation 1, we have launched a national campaign to reform the Coroners and Justice Act 2009 and The Coroners (Investigations) Regulations 2013 to make this database and learning statutory. Learn more and register your support here[30]:

Join the campaign





As fatal anaphylaxis is sudden and unexpected, it should fall within the statutory requirement of coroners to investigate who, when, where and how the death occurred as well as whether action should be taken to prevent future deaths. We identified that a median of two deaths per year from anaphylaxis resulted in a PFD, which varied across coroner areas. From PFDs alone, it is not possible to determine how often fatal anaphylaxis is referred to the coroner for investigation. Coroners reported that *"it should be mandatory to refer fatal anaphylaxis cases"* and raised concerns regarding the need for *"immediate investigation into a suspected death from anaphylaxis, that the evidence obtained at this time, with the right approach, can be invaluable to preventing deaths, but that to achieve this changes are required. This would need changes in the death investigation process and the wider investigation..."*, one suggestion being that *"A standard protocol should be available to ensure appropriate samples are taken at the correct time to assist later investigation."* Furthermore, coroners highlight the need for improving the quality of autopsies following anaphylaxis, sharing that *"...there is no regular (independent) peer review of coronial autopsy reports and processes in order to maintain consistency of agreed standards, governance, and accountability as was advised within the 2006 National Confidential Enquiry to Patient Death and Outcome (NCEPOD) and reiterated with the Hutton review of forensic pathology of England and Wales in 2015".* As the 32 deaths reported by coroners in PFDs amounted to 1,368 years of life lost, costing almost £96 million, understanding accurate statistics on the full extent of fatal anaphylaxis is essential to enable learning, prevention and measure progress.

Therefore, the second recommendation of this research is:

Recommendation 2: Ensure mandatory investigation of all anaphylaxis deaths by coroners. The Ministry of Justice, working with the Chief Coroner's Office and key stakeholders, should mandate the referral and immediate investigation of all suspected deaths from anaphylaxis to the coroner, similar to that for work-related accidents and deaths in state custody, and ensure timely reporting of such deaths to support evidence-based public health responses. Guidance should be developed to improve how these deaths are investigated, including improving the collection of samples, timeliness and quality of autopsies. This guidance should be developed with key stakeholders so that its relevant for all organisations involved, including coroners, pathologists and police.

The 32 anaphylaxis-related PFDs were sent to 68 organisations which have a statutory requirement to respond to the coroner within 56 days and for these responses to be published at the discretion of the Chief Coroner. Similar to previous research[17,19,31], we found that most (60%) anaphylaxis PFDs did not have all responses published. This concern has been the subject of two inquiries into the Coroner Service conducted by the Justice Select Committee in 2020 and 2024[32,33], which led to the Chief Coroner publishing a list of "Non-responses to Prevention of Future Deaths (PFD) reports" in January 2025[34]. However, this list is static, and it is difficult to see how many reports are yet to receive responses and when changes are made to both the list and the publication of responses. In contrast, the tools created by the Preventable Deaths Tracker (PDT) update in real-time providing the infrastructure for immediate statistics and reporting of this vital information.

An audit of the Chief Coroner's new static list using the PDT's dynamic tools in July 2025 uncovered a series of errors and omissions from both the list and responses published on the Judiciary website, which the Chief Coroner's Office has since updated. This work and the PDT's tools demonstrate the power of using data in the Coroner Service to improve outcomes, as the overall response rates to PFDs for 2024 is now at 93% - the highest on record[16]. However, coroners in this study highlighted the inability for national organisations to know about previous PFDs, stating *"If NHS Digital does not have a grasp of this sort of detail, specifically brought to its attention by a [different] coroner in a prevention of future deaths report, it is difficult to see how there can be effective improvement".*

The PDT tools provide the infrastructure for organisations to understand how many PFDs they have received and if responses are published. Sir Robert Neil KC acknowledged the importance of this work, stating in his **letter to the Minister for Courts and Legal Services in May 2024,** that *"it seems extraordinary that such an important national service [the Preventable Deaths Tracker] is reliant on the initiative and energy of a single academic working without reliable funding. The Tracker should be placed on a secure footing and used as the basis for further work - whether this means it is brought within Government or central funding is found for it should be the subject of further consideration[28]."*

Therefore, the third recommendation of this research is:

Recommendation 3: Enable Parliamentary oversight for ensuring responses to Prevention of Future Deaths reports, similar to that of the Freedom of Information Act 2000, which requires public, private and third sector organisations to respond to coroners within 56 days, and sustainably support the digital infrastructure that allows the public to track responses to ensure transparency, accountability, and open justice.



Preventing fatal and non-fatal anaphylaxis

Coroners raised repeated concerns regarding the failure of local and national systems that contributed to anaphylaxis deaths. The failure to prevent exposure to allergens, the inability to identify anaphylaxis, deliver effective and timely emergency treatment, inadequate autopsies and the challenges in the assignment of the causes of death, and identifying areas for training and reform across the range of organisations involved in fatal anaphylaxis.

This includes improved public education, action plans and policies for food service outlets, schools, local authorities, hospitals, prescribers, emergency services, pathologists, patients and their carers or guardians.

While coroners recognised that *"there is significant goodwill and desire to improve amongst numerous organisations involved in anaphylaxis work"* they also noted that *"what is lacking is national leadership and funding... consideration should be given to creating a leadership role and responsibility within NHS England [Department of Health and Social Care] to coordinate a national approach".*

Further, a coroner stated, *"the issues within this prevention of future deaths report are predominantly national issues, but I heard at inquest that there is no person with named accountability for allergy services and allergy provision at NHS England or the Department of Health as a whole".*

Thus, the fourth recommendation of this research is:

Recommendation 4: Appoint an Allergy Tsar. The Department for Health and Social Care should create a national leadership role, an Allergy Tsar, with key performance indicators to champion for people living with allergies, as well as coordinate existing systems that deal with anaphylaxis, including leading public education campaigns, training for organisations, staff, patients and carers, investigations of fatal and non-fatal anaphylaxis, including monitoring coroners PFDs, and following up on recommendations and policies that involve and impact people with allergies.

"What is lacking is national leadership and funding... consideration should be given to creating a leadership role and responsibility within NHS England [Department of Health and Social Care] to coordinate a national approach"





The gold standard treatment for anaphylaxis in the community, including schools, is: 1) allergen avoidance; 2) intramuscular adrenaline, administered as soon as anaphylaxis is suspected (often via adrenaline auto injectors (AAIs); 3) administration of a second adrenaline dose after 5 minutes, or if there is deterioration, and 4) immediate medical attention, particularly due to risk of biphasic attacks[35,36].

However, across all 32 PFDs none detailed the optimal adrenaline administration in the community, with coroners citing issues in the availability of AAIs and paramedics informing first aiders not to use available AAIs.

Since the three deaths in 2016 and 2017 due to anaphylaxis at school were reported by coroners in PFDs, it has become possible for schools to purchase AAIs for unprescribed use under the Human Medicines (Amendment) Regulations 2017, the only situation where unprescribed adrenaline can be given by a non-healthcare professional. However, the law does not allow a non-prescriber to administer an adrenaline auto-injector, which has been specifically prescribed to a named person, to another individual[35].

This means these 'spare' AAIs are vital in situations where an individual is missing one or more of their own.

Despite these regulatory changes for schools, access to and use of AAIs in the community remained a repeated area of concern in PFDs, including AAIs not being readily available, second doses not being administered as per guidelines, responders not knowing when or how to use AAIs, and no system for recognising when AAIs were out-of-date. As there is no provision for AAIs in public places, coroners reiterated evidence from expert witnesses at inquests that suggested AAI should be made publicly available like defibrillators, with comments such as *"the respiratory paediatrician who gave evidence at inquest was firmly of the view that generic adrenaline auto-injectors should be available, in much the same way as defibrillators, in public spaces".*

"Despite these regulatory changes for schools, access to and use of AAIs in the community remained a repeated area of concern"



This was investigated and endorsed by the Commission on Human Medicines' (CHM) Adrenaline Auto-injector Expert Working Group (AAI EWG), but since their publication in November 2021[25], it is not clear whether any of the recommendations have been taken forward or considered. As adrenaline can reverse the symptoms of anaphylaxis, with a 98% success rate when used following guidelines[37], the AAI EWG recommendations should be reconsidered by national leadership (i.e. Recommendation 4).

In eight PFDs, anaphylaxis occurred following the purchase of food from food outlets, including two from Pret-a-Manger, two restaurants, Costa Coffee, Byron Burgers, a takeaway shop and a cinema. All individuals were known to be allergic to the allergen which triggered the anaphylactic reaction and thus were preventable.

"All individuals were known to be allergic to the allergen which triggered the anaphylactic reaction and thus were preventable."

The key factors identified by coroners that contributed to fatal food anaphylaxis were cross-contamination, miscommunication, lack of training and awareness, and human error.

The Food Information (Amendment) (England) Regulations 2019[38], also known as Natasha's Law, came into effect on 1 October 2021 to mandate that pre-packaged food for direct sale must be labelled with all ingredients and allergens in bold after the tireless campaigning of Nadim and Tanya Ednan-Laperouse.

Their daughter Natasha died aged 15 in 2016 after eating a Pret-A-Manger baguette that was made with sesame seeds but not disclosed to Natasha on the food label. However, there is no legal requirement for allergen labelling on menus, nor do businesses need to disclose all ingredients present in an item. This was debated in Parliament in 2023 following the death of 18-year-old Owen Carey after eating a chicken burger that contained milk despite making the servers aware of his allergies. His family wants to develop a law that clearly labels allergens and ingredients on menus (i.e. 'Owen's Law'), but while recent FSA guidelines incorporate many of the recommendations of the Owen's Law campaign they currently remain best practice rather than legally binding regulations, a matter which should be revisited as a matter of urgency by national leadership (i.e. Recommendation 4).

Although 14 food allergens are regulated in the UK[39], there are no regulations for terms such as 'vegan'[40], which was found by coroners to cause confusion and deaths. The Food Standards Agency (FSA) has said that it does not regulate terms such as vegan, as they are 'lifestyle' terms that should not be used to determine whether a food is safe to eat; the strict standards which apply in 'free from' products do not apply to 'lifestyle' terms[41].

The FSA has updated guidance in 2025 to encourage organisations to label all food if any of the 14 regulated allergens are present, but there is no legal requirement to do this in unpackaged food[42]. This requires review by national leadership (i.e. Recommendation 4) as well as immediate public education to prevent further confusion that could result in preventable deaths.

Coroners identified the absence of a coherent, co-ordinated national system for recording and investigating non-fatal anaphylactic events. Evidence from PFDs highlighted the inability of food services, such as Pret-a-Manger to collect, share and communication information on allergies, where the coroner reported that *"there was no coherent or co-ordinated system for monitoring customer allergic reactions despite sales of more than 200 million items. In some cases, concerns were notified to Customer Services and in some they were noted to the safety department. The two did not know what the other was responding to. It was clear that there was no overarching monitoring system in place... In my view sales of 200 million items some with expressly commissioned but hidden allergens require a robust safety auditing system."*

Furthermore, coroners found that there were no processes in place for sharing information between different organisations, including health services, Trading Standards, and the FSA, leading to missed opportunities for timely public health interventions.

Despite progress - such as the FSA's start on developing a reporting platform for allergic reactions and initiatives like anaphylaxie.net[43] - there remains no statutory requirement to report anaphylaxis, no integration of allergy information across health records, and no mechanism to rapidly alert authorities to emerging allergen risks.

"Coroners found that there were no processes in place for sharing information between different organisations."



Coroners highlighted the need for a *"mandatory reporting system"* and a *"robust system of capturing and recording cases of anaphylaxis... to provide an early warning of the risk posed to allergic individual by products... Such a system could involve mandatory reporting of anaphylaxis presenting to hospitals, analogous to the current system used for notifiable diseases (including some food-borne illnesses), whereby registered medical practitioners have a statutory duty to notify the 'proper officer' at their local council or local health protection team of suspected cases of certain infectious diseases."*

They also provided examples of how such systems work in other jurisdictions, including sharing *"an example of such a reporting system for anaphylaxis already exists in the State of Victoria in Australia, and allows for rapid alerts of serious cases to public health authorities to expedite investigation and evaluate public health risk".*

Therefore, the fifth recommendation of this research is:

Recommendation 5: Ensure a mandatory national reporting of all anaphylactic events, including near-fatal ones. The Department of Health and Social Care, working with the UK Health Security Agency, the Food Standards Agency, and devolved administrations, should establish a mandatory national reporting system for all anaphylactic events, including near-fatal reactions. This system should mirror the statutory notification process for infectious diseases, requiring registered medical practitioners, emergency departments and food service outlets to report all suspected anaphylaxis cases. Reports should be shared with relevant public health and food safety authorities to enable rapid investigation, improve traceability, and identify emerging allergen risks.

Concluding remarks

Despite PFDs being a statutory requirement for coroners in England and Wales, only 32 were written following anaphylaxis deaths since July 2013, with few responses and actions taken. While a lack of mandatory national reporting makes it difficult to ascertain the true number of deaths caused by anaphylaxis, we know that these 32 are only the tip of the iceberg.

The ongoing failure to share and apply the vital lessons highlighted in these PFDs undermines efforts to improve safety for people with allergies and risks further tragedy.

National leadership and systematic changes are needed to prevent future deaths. We developed a real-time surveillance tool to support ongoing efforts to monitor anaphylaxis and have launched a campaign to call for action to prevent future deaths.

The routine monitoring of PFDs, their responses and need for action should be transparently conducted across government, public, private and third sector organisations to learn lessons for preventing future anaphylaxis deaths.

Scan to go to PFD Tracker





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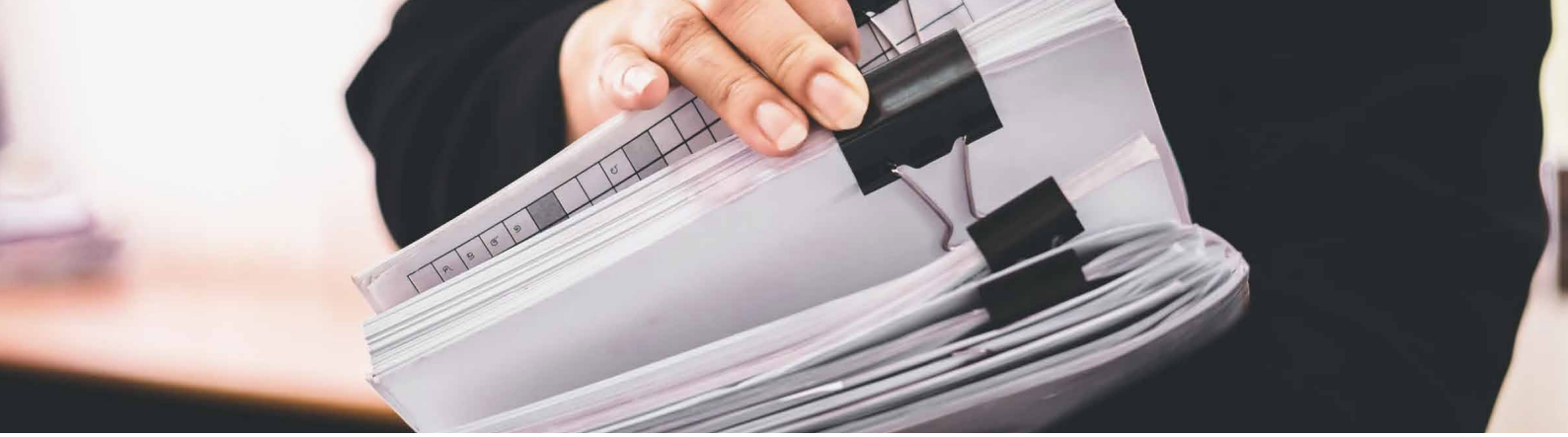
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Annexes

Annex A: Keyword used in the Preventable Deaths Tracker to identify PFDs

Key words	Hits in PDT until August 2025
• Rash	**215**
• Allerg*	**141**
- Allergic	**58**
- Allergy	**59**
- Allergies	**94**
- Allergen	**19**
• Swelling	**96**
• Asthma	**94**
- Asthmatic	**11**
• Fish	**91**
• Oedema	**88**
• Steroid	**74**
• Anaphyla*	**68**
- Anaphylaxis	**49**
- Anaphylactic	**44**
• Egg	**67**
• Adrenaline	**45**
• AAI	**33**
• Milk	**27**
• Peanut	**21**
• Nuts	**19**
• Cortisone	**13**
• Hydrocortisone	**12**

Key words	Hits in PDT until August 2025
• Epipen	**10**
- Epi-pen	**4**
• Corticosteroid	**10**
• Soy	**9**
• Auto-injector	8
- Autoinjector	7
• Wheat	7
• Histamine	7
• Insect	5
• Antihistamine	5
• Immunoglobulin	4
• Antigen	4
• Angioedema	3
• Latex	3
• Gluten	3
• Wasp	3
• Chlorphenamine	2
• Celery	1
• Sesame	1
• Shellfish	1
• Sulphur	1

Dr Georgia Richards

Dr Georgia Richards is an Epidemiologist, Health Research Scientist, and King's Prize Research Fellow at King's College London.

She founded and leads the Preventable Deaths Tracker, a national vigilance platform that harnesses information from coroners to learn lessons following inquests. She has a Doctor of Philosophy (PhD/DPhil) from the University of Oxford and a BSc in Biomedical Sciences with First Class Honours in Pharmacology from the University of Queensland, Australia.

Dr Richards has expertise in evidence-based healthcare, open science, drug safety and death investigations. Her research focuses on improving the safety of health interventions and care by understanding how to prevent premature deaths using information from coroners. Georgia's interests are in patient safety, harms, pharmacoepidemiology and pharmaco-device-vigilance, with a focus on opioids and interventions used in the management of people with chronic pain. She has developed several tools to improve the dissemination of research, including the Catalogue of Opioids, the Healthy Cities Toolkit, and the Preventable Deaths Tracker.

Dr Richards has freelanced in the private sector as a Consultant Safety Epidemiologist for AstraZeneca and advised the Government on systems and data for death investigations by delivering written and oral evidence in the Palace of Westminster for the follow-up inquiry into The Coroner Service. In June 2024,



Georgia received the King's Prize Fellowship and joined the Department of Analytical, Environmental and Forensic Sciences.

Prior to King's, Georgia was a Research and Teaching Fellow at the University of Oxford where she coordinated modules in Evidence-Based Medicine and Systematic Reviews for the Oxford Medical School and MSc in Evidence-Based Healthcare. She has supervised the research of over 40 undergraduate and graduate medical students and is actively supervising 2 MSc and 4 PhD students. She has more than 50 academic publications and has a H-index of 16.

"Anaphylaxis is the worst illustration we have seen to date, where coroners are not only raising the same concerns in PFDs time and time again, but are repeatedly referring to other PFDs written by their colleagues, still - nothing is being done. Harnessing information from coroners could save lives from anaphylaxis. Urgent action is needed to prevent future deaths, including the appointment of a national allergy lead – an Allergy Tsar – to drive through change."

Dr Georgia Richards, epidemiologist, founder of the Preventable Deaths Tracker



The Natasha Allergy Research Foundation

The Natasha Allergy Research Foundation is the UK's food allergy charity.

Nadim and Tanya Ednan-Laperouse set up the Foundation after their daughter Natasha died aged 15 from an allergic reaction to a baguette that had sesame seeds baked into the dough and were invisible to the naked eye. Natasha was severely allergic to sesame. Sesame wasn't listed as an ingredient on the label. Had it been, she'd be alive today.

Following Natasha's death, the Foundation successfully campaigned for improved labelling on pre-packed foods for direct sale, and Natasha's Law came into force in 2021.

The Foundation also funds medical research, bursaries to train the next generation of allergy specialists, and campaigns for a safer world for people with food allergies. This work is vital because food allergies are increasing, with children and young people most affected.

The Foundation's mission is to #MakeAllergyHistory.

Nadim and Tanya have been awarded OBEs in recognition of their services to charity and for people with allergic disease.

Natasha Allergy Research Foundation

The UK's Food Allergy Charity

Keep up to date with the work of The Natasha Allergy Research Foundation

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