

Food allergy, a summary of eight cases in the UK criminal and civil courts: effective last resort for vulnerable consumers?

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Abstract

Food allergy has a forensic context. The authors describe eight cases in the UK courts involving fatalities, personal injury or criminal non-compliance with food law from mainly 'grey' literature sources. The potentially severe consequences for people with food allergy of contraventions of labelling law have led to enforcement action up to criminal prosecution for what might otherwise be regarded as 'trivial' non-compliance. The authors suggest there should be central collation of such cases. Non-compliances should be followed up in a more rapid and robust manner. Evidence of fraud in the catering supply chain supports recent calls for zero tolerance of food fraud. Businesses must guard against gaps in allergen management, for which there are readily available sources of training and guidance, but also against fraudulent substitution in the supply chain, about which training and guidance should be developed. New allergen labelling legislation and case law appear to place responsibility on food businesses even for the forensically problematic area of allergen cross-contamination. The courts can be an effective last resort for vulnerable consumers; however, there is evidence of knowledge and skill gaps in both the investigation and prosecution of potentially serious incidents of food allergen mismanagement and mislabelling. Thorough investigation of food allergy deaths is required with a tenacious and skilled approach, including early realisation that samples of the food and/or stomach contents from a *post mortem* examination should be retained and analysed. The supply chain must be rigorously examined to find out where adulteration or contamination with the fatal allergen occurred.

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INTRODUCTION

Food allergy, a significant public health concern, has a forensic context. The authors describe eight cases in the UK courts on food allergy-related fatality, personal injury or criminal non-compliance with food law.

Food allergy is an increasingly prevalent global health problem both in the industrialised world^{1–3} and in less developed countries where, owing to poor labelling and awareness, a very significant challenge may exist. There are well-documented detriments to the quality of life for allergic consumers and their families.^{4,5} Peanut allergy and tree nut allergy are frequently severe and for that reason have received widespread publicity. There are about ten food-related anaphylaxis deaths (and potentially more near misses) every year in the UK.⁶ There are a significant number of food allergen-related incidents and food recalls increasing year on year, with a concomitant impact on food businesses.⁷ Although many consider that the introduction of thresholds or action levels for food allergen risk management will deliver improvements for all stakeholders,⁸ published thresholds remain to be generally accepted.^{9–11}

THE LAW

European food law aims for a high level of protection of human health and consumers' interests. Article 8 of Regulation (EC) No

178/2002¹² prohibits adulteration of food and fraudulent, deceptive or any other practices which mislead consumers. Article 14 prohibits the sale of unsafe food such as food injurious to health, including the particular health sensitivities of any specific category of consumers [e.g. but not exclusively people with food allergy] where the food is intended for that category of consumers. More specifically, Regulation (EU) No 1169/2011¹³ addresses allergen avoidance risks relating to composition, labelling and food safety. The inclusion in prepacked food of any of 14 major allergens defined by Annex II to Regulation 1169/2011 (replacing Annex IIIa to Directive 2000/13/EC) triggers, with certain limited exemptions, specific labelling requirements¹⁴ extended on 13 December 2014 to non-prepacked food, including catering establishments.

The Codex Alimentarius General Standard for the Labelling of Prepackaged Foods¹⁵ harmonises globally the concept of mandatory disclosure on prepacked food labelling of the presence

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of allergens, with a list of eight major allergens. Gendel¹⁶ has helpfully reviewed country-specific implementation of Codex requirements on allergens. In the main the food industry has made strenuous efforts to deal with food allergens, although risk assessment and management remain suboptimal for consumers, with widespread use of 'may contain' statements seen as unhelpful.¹⁷ The food industry seeking to provide safe products, consumer choice and subject to the law must label products accurately and minimise cross-contamination in harvesting, storage, transport, processing of food and cleaning of equipment. The development of 'allergen-free' product lines places a particular burden of responsibility on allergen control. For food businesses there are potentially serious financial impacts and reputational risks of increased food recalls.^{18,19} Compensation in civil law for loss or damage caused by an allergic reaction to a food supplied is a foreseeable risk for food businesses.

In the UK the Food Safety Act 1990 provides the enabling powers under which all food regulations, including those on food labelling, are made. The main criminal offences are rendering food injurious to health (Section 7), selling, to the purchaser's prejudice, food which is not of the nature or substance or quality demanded (Section 14) and falsely or misleadingly describing or presenting food (Section 15).

The General Food Regulations 2004 (as amended) provide for the enforcement of certain provisions of Regulation (EC) 178/2002 (including imposing penalties) in Great Britain and amend the Food Safety Act 1990 to bring it in line with Regulation (EC) 178/2002. Similar legislation applies in Northern Ireland.

Legal redress may also be invoked in civil law and under the European Framework Directive on Safety and Health at Work (Directive 89/391 EEC and daughter legislation) that covers liabilities in the workplace.

GUIDANCE

The UK Food Standards Agency (FSA) has published comprehensive best practice guidance on allergen cross-contamination and 'may contain' labelling²⁰ and innovative online food allergy training that is available via <http://www.food.gov.uk/safereating/allergyintol/>. The training includes factory and non-prepacked food scenarios, including in catering, and aims to provide a greater understanding of the issues surrounding enforcing relevant legislation in the area of food allergens for local authority enforcement officers. The online food allergy training course was launched in 2008. The latest FSA guidance was published in August 2014 to help small and medium-sized (SME) businesses comply with new rules on allergen labelling and information, which take effect from 13 December 2014 as part of the European Union Food Information for Consumers Regulation (EU FIC) 1169/2011.²¹ The guidance makes clear that the new requirements of Regulation 1169/2011 apply to businesses that provide non-prepacked foods (such as restaurants, delis, takeaway businesses, food suppliers and institutional caterers). Such businesses must from 13 December 2014 declare the inclusion of any one of the 14 legislated allergens to customers in a variety of possible ways, such as on menus and chalkboards, by clear signposting to where the information can be obtained and through oral communication. The allergen information must be accurate, consistent and verifiable upon challenge (for example, when asked by a consumer or a local authority food safety officer).

THE COURTS

Despite a significant increase in advice, guidance and training on food allergy over the past 5 years, problems persist, some of which ultimately end in the courts. We describe eight such cases in the period 2002–2013 that arose from contraventions of food or health and safety law, and civil litigation following deaths from food allergy. Prepacked food on retail sale and non-prepacked food including in catering situations are dealt with. The cases came before the civil (including appeal) courts, magistrates' and coroners' courts in the UK.

METHOD

Information collection was both active and passive. Legislation was reviewed on a quarterly basis. A Google™ news search with keywords 'allergy', 'anaphylaxis', 'coroner', 'died', 'peanut' and 'allergic reaction' was monitored. Information recorded and investigated by the Anaphylaxis Campaign (AC) from reports of allergic reactions by members and others was collated. Passive collection of data was as a result of unsolicited inquiries for assistance (mainly to MHG) with cases in progress. In the absence of published judgments, the details herein are based on various media-published accounts except where otherwise stated. Cases were selected to represent all aspects where food allergy resulted in fatalities, serious illnesses and litigation and/or prosecutions in the civil and criminal courts and when this subject matter resulted in inquests. Table 1 summarises the cases described.

THE CASES

Case 1. Fatality, Health and Safety Act prosecution, baby Thomas Egan

In April 2002, baby Thomas Egan, 5 months, died of heart failure following an anaphylactic reaction to cow's milk (skimmed milk powder). The milk powder was contained in a cereal product fed to baby Egan at a privately owned day nursery. On 28 January 2003 an inquest jury at Milton Keynes Coroner's Court returned a verdict of accidental death contributed to by neglect [by the nursery]. An investigation by police and environmental health officers ensued and the nursery was prosecuted at Milton Keynes Magistrates' Court on 8 August 2003. The firm pleaded guilty to one charge of failing to ensure health and safety under Section 3 subsection 1 of the Health and Safety at Work Act 1974 and was remitted to Aylesbury Crown Court for sentencing on 30 October 2003, receiving a fine of £60 000.00 with £19 000 costs.

Baby Egan was diagnosed allergic to cow's milk in December 2001. However, at 5 months he was too young to be prescribed an adrenaline autoinjector. His allergy was explained to the nursery at registration. Notices were put up in the nursery to the effect that baby Egan had breakfast at home and that for lunch he would have fruit and vegetables and his mother's milk. In April 2002, baby Egan was dropped off at the nursery soon after 09:00 by his mother along with some expressed milk and his inhaler, prescribed after bronchiolitis. A comment made by Mrs Egan to an untrained support worker was misinterpreted when another staff member took it to mean that he had not had breakfast and proceeded to prepare prepacked baby food Sunrise Banana Cereal by adding water to it. Shortly after being given the cereal, baby Egan began struggling to breathe and was seen to be cyanosed. His mother was called and the baby was rushed to hospital and received emergency treatment, but he died shortly thereafter.

Table 1. Summary of cases

Case and date of original incident	Details	Law	Outcome
Case 1 Fatality Inquest, Health and Safety prosecution Child care, 2002	<i>Milton Keynes Council v Jigsaw Day Nurseries Ltd, unreported</i> Thomas Egan, 5 months, died from anaphylaxis to cow's milk in a day nursery. His parents had told staff not to give him cow's milk. The inquest verdict was 'accidental death contributed to by neglect [by the nursery]'. Local EHOs undertook a fatal accident investigation and prosecuted the nursery for a series of management failures	Health and Safety at Work Act 1974 Section 3 subsection 1	£60 000 fine and £19 000 legal costs, criminal record
Case 2 Fatality Inquest, civil action, appeal Catering, 2003	<i>Amjarit Kaur Bhamra (Widow & Administratrix of the Estate of Kuldeep Singh Bhamra, Deceased) v Prem Dutt Dubb (T/A Lucky Caterers) (2010) [2010] EWCA Civ 13 CA (Civ Div) (Sir Anthony May [President QB], Wall LJ, Moore-Bick LJ) 20 January 2010</i> Mr Kuldeep Bhamra died from egg allergy at a Sikh wedding having consumed a dessert, ras malai. Invitations indicated that food would be served under temple rules, which exclude egg to which Mr Bhamra had a known food allergy. No food sample was retained for testing. Mr Bhamra's widow succeeded in a civil action against the caterer; an appeal was dismissed	Tort of negligence, (upheld) Contracts (Rights of Third Parties) Act 1999 (dismissed)	Mr Bhamra's widow awarded £415 000 plus costs
Case 3 Food Law prosecution Prepacked food, 2009	<i>Telford and Wrekin Trading Standards, unreported</i> Market trader selling imported prepacked chocolates was prosecuted for 'placing on the market food that was unsafe namely Milka Frühlingsblumen in that the labelling did not declare the presence of allergenic ingredients namely Almond and Hazelnut in a language easily understood'. The ingredients were only labelled in German and French	Regulation 4(a) of General Food Regulations 2004 Regulation (EC) 178/2002 Article 14(1)	Trader fined £3500 plus costs, criminal record
Case 4 Food Law prosecution Prepacked food, 2010	<i>Royal Borough of Kensington and Chelsea v Whole Foods Market, Fresh and Wild Ltd, unreported</i> A customer who has a severe nut allergy bought a portion of Aubergine Rollatini Spinach, checked the label and nuts were not listed in the ingredients or on the label. She bit into it and suffered an allergic reaction and was admitted to hospital for emergency treatment and discharged after 8 h. Defendants pleaded guilty at West London Magistrates' Court on 7 September 2011	Regulation 4(c) of General Food Regulations 2004 Regulation (EC) 178/2002 Article 16	Fined £2000, £2321.03 in costs and £15 victim surcharge, criminal record
Case 5 Food Law prosecution Prepacked food, 2012	<i>Essex County Council v Minidelikatesy Kubus Ltd, unreported</i> Food not labelled in English	Regulation 4(a) of General Food Regulations 2004 Regulation (EC) 178/2002 Article 14(1)	Company director fined £870 and company fined £2250 on basis of first offence, costs of £1350 and victim surcharge of £120, criminal record
Case 6 Food Law prosecution Catering food, analysis, 2009	<i>Derbyshire County Council v New China House Takeaway Restaurant, unreported</i> A peanut-allergic customer asked a Chinese takeaway for a meal without peanuts, ate the meal and suffered a severe allergic reaction requiring emergency life-saving treatment and stabilisation in hospital. The remaining food was analysed and found to contain peanut protein at a level of 31 mg kg ⁻¹ . The food business operator was prosecuted for supplying unsafe food by failing to declare the presence of peanuts	Food Safety Act 1990	Fined a total of £2660, £1000 costs, £15 victim surcharge and told to give diner £200 in compensation, criminal record

Table 1. Continued

Case and date of original incident	Details	Law	Outcome
Case 7 Food Law prosecution Prepacked food, analysis, 2011	Hull City Council v RK Sweets Ltd, unreported Severe allergic reaction to a South Asian confection, marble laddoo, said, when asked, not to contain peanuts when sold at an Indian food festival	Food Safety Act 1990	Company: £5000 fine, £1661.88 costs Director: £2500 fine, criminal record
Case 8 Food Law prosecution Catering, analysis, 2011	Cumbria County Council v Euro Foods, unreported, Appeal Euro Foods Group v Cumbria County Council [2013] EWHC 2659 (Admin) Euro Foods Ltd had supplied groundnuts (peanuts) instead of almond powder as requested to another wholesaler who had in turn supplied takeaway outlets which themselves had no knowledge that the product they were introducing into their meals was not almond powder. Euro Foods was initially found guilty on charges of supplying almond products adulterated with peanuts. It was said that this arose because of the price differential. Euro Foods later successfully appealed the conviction and it appears that the grounds of appeal included the error in law of laying information under both Sections 15(2) and 15(3) of the Food Safety Act	Food Safety Act 1990 Sections 15(2) and 15(3) Magistrates' Courts Rules 1981 Criminal Procedure Rules 2005 onwards	Fined £6000 with £12 000 costs, quashed on appeal

At the inquest it was indicated that the baby food fed to baby Egan, which was suitable for children aged 4 months and over, contained skimmed milk, which was clearly labelled. The nursery staff member apparently assumed that cereals for babies that age would not contain milk, failed to read the 'with milk protein' printed on the top of the packet and did not read the list of ingredients. She also was said to have failed to read the signs posted in the nursery saying that baby Egan should be fed only breast milk, baby rice and pureed fruit and vegetables. The coroner, Mr Rodney Corner, noted that there was conflict over how much information had been passed to the nursery. The baby's personal documentation, filled in by his key nursery worker from information from his mother, recorded that he had a milk allergy, but not that it was medically advised that he should avoid milk and dairy products as well as peanuts. It also emerged that the staff at the nursery believed that if baby Egan was fed milk it would make him sick and did not appear to have appreciated the potentially serious consequences. Baby Egan had a cold prior to his death and it was also said that his airways were restricted by 'hyperactive airways disease' following the bronchiolitis. The coroner commented 'Thomas should not have died as a result of the milk allergy, but because the airways had been damaged, once the anaphylaxis began to take hold, it was that much more difficult for him'.

As a result of investigations by Milton Keynes Council Environmental Health Department, the nursery, part of a corporate group, was prosecuted under the Health and Safety at Work Act 1974:

Section 3: General duties of employers and self-employed to persons other than their employees,
subsection 1: It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

It appears to have been accepted that baby Egan was fed a cereal product containing skimmed milk powder. No sample was taken for analysis. The prosecution case²² was that the nursery had contributed to the baby's death by failure to:

- ensure that food supplied did not contain milk;
- comply with parental instructions not to serve the child with breakfast;
- have any or any adequate handover procedures for children/infants when they arrive at or depart the nursery;
- provide any or any adequate training for care staff in relation to food allergies;
- provide any or any adequate training of care staff in relation to the importance of checking the contents of food via the food labels;
- implement any or any adequate system to identify the level of risk to children/infants in care from food allergies;
- carry out any or any suitable and sufficient risk assessment relating to the specific hazards to children/infants with specific dietary needs and/or those with food allergies;
- have any or any adequate treatment plan in place for children/infants with food allergies who consumed inappropriate food;
- have any qualified first aiders on duty at the nursery;
- ensure that care staff were adequately informed of emergency procedures;
- have all meals for children/infants with special dietary requirements placed on identifiable coloured plates.

Imposing a fine of £60 000 with £19 000 costs in the Crown Court, Judge Christopher Tyrer said 'At the root of this appalling tragedy, one fact seems to me to stand clear, that this death was preventable'. He said he did take into account the fact the company had reacted swiftly and with great seriousness to what had happened – spending a total of £10 000 in retraining its some 800 staff employed at 36 nurseries across the country.

It should be added that what happened to baby Egan, tragic in itself as it is, remains very rare. Anaphylaxis Campaign advice is that 'Parents or childcare staff can be assured that a robust management plan, covering allergen avoidance, medical procedures and staff training, will protect allergic children'. It is also the case that meeting the needs of children with allergies is now part of daily life in nurseries around the country. An informal survey found common features in the policies and procedures of nurseries to be to collect information about allergies when a child is registered, to agree a care plan with the parents, to include the care of allergic children in staff inductions, to ban nuts completely from the premises, to display lists of children's allergies in every room, to use as much fresh food as possible (to avoid problems with poor labelling on packaged foods), to operate a coded system of dishes when serving meals and to double-check dishes before serving them.²³ The nursery concerned subsequently put in place updated policies with a risk assessment for each child and a tiered response to children's allergies to ensure that staff can devote time to undertaking the most rigorous checks for those with the most acute needs. The National Day Nurseries Association (NDNA) issues guidance to its members, including on allergies and allergic reactions. It should also be noted that although responsibility rests with the food business the nursery had been inspected by environmental health officers and Ofsted (Office for Standards in Education, Children's Services and Skills) inspectors who failed to impose requirements to remedy the defects that were subsequently the subject of prosecution.

Media references to the case of baby Thomas Egan not otherwise referenced in the text are shown in Table 2.

Case 2. Fatality, civil action and appeal, Mr Kuldeep Bhamra

Mr Kuldeep Bhamra died from egg allergy at a Sikh wedding having consumed a dessert, ras malai. The bride's family had organised a wedding feast for some 500 people in August 2003 and engaged a caterer to provide the food. Mr Bhamra's symptoms started shortly after he ate ras malai, an Indian sweet dish consisting of small, flat cakes of paneer (curd cheese) in sweetened, thickened milk²⁴ with many recipe variations.²⁵ He was taken to hospital but died several days later. No sample of the food was retained, but a *post mortem* examination was carried out. The wedding invitations indicated that the food would be served under temple rules, which exclude meat, fish, alcohol and egg. Mr Bhamra had a food allergy to egg, but as a Sikh, he did not expect to find egg in temple food. Following an inquest in June 2004, Mr Bhamra's widow sued the caterer for personal injury caused by his breach of contract and negligence in serving food that contained egg. At trial (2008, Oxford County Court, His Honour Judge Charles Harris QC), Mrs Bhamra's claim under the Contracts (Rights of Third Parties) Act 1999 was dismissed and that remained unchallenged. However, the court found in favour of Mrs Bhamra on her claim in negligence and entered judgement for her in the agreed sum of £415 000.

The caterer then appealed the decision on both the facts and the law. On the facts it was submitted that it was wrong to find that eggs had been an intentional ingredient of the ras malai rather

than a trace contaminant from an unidentified source. On the law it was submitted that it was wrong to hold that the caterer:

- owed a duty of care to prevent Mr Bhamra suffering physical harm through eating eggs;
- was in breach of a duty of care without considering whether he knew or ought reasonably to have known that the ras malai he bought in might contain eggs; and
- that in the circumstances of this case a burden had passed to Mr Dubb to show that Mr Bhamra's death had occurred despite the exercise of reasonable care on his part.

This case was heard on 13 October 2009 in the Court Of Appeal (Civil Division) by Sir Anthony May, then President of the Queen's Bench Division, Lord Justice Wall and Lord Justice Moore-Bick. In this instance we have the benefit of a closely argued judgement delivered on 20 January 2010,²⁶ and commentary in the legal literature.^{27–30}

Both at trial and appeal the question of how some of the ras malai served at the wedding contained egg was considered and there was case-specific evidence to suggest that additional food had been brought in from elsewhere without checking for the presence of egg.

In the absence of a sample to analyse, the question of whether the egg was a trace contaminant or an intentional ingredient turned on medical expert testimony. Fatal anaphylaxis episodes^{31,32} suggested that although trace contamination can cause a severe reaction culminating in death, ingestion of small quantities generally has only mild consequences. The high level of mast cell tryptase found in Mr Bhamra's blood and the severity and rapidity of the reaction led to the conclusion that Mr Bhamra had suffered a major reaction to a substantial dose of egg protein. Mrs Bhamra's evidence on the sequence and timing of previous similar allergic reactions to egg appears also to have been taken into account, and the Appeal Court confirmed that the County Court was entitled to come to the conclusion that one of the dishes served at the wedding must have contained egg as an intentional ingredient. There was evidence that recipes for ras malai were in circulation which included egg as one of the ingredients.

The Appeal Court dealt at some length with liability and the duty of care owed to Mr Bhamra. It was not an issue that the caterer, in providing food on a commercial basis for consumption by others, owed a duty to take reasonable care to ensure that it did not contain harmful substances and was thus fit for human consumption, although of course uncontaminated eggs are safe and widely used in catering. The County Court considered, and the Appeal Court did not disagree, that in the absence of any evidence of what is considered to be good practice in this area, caterers would not normally give warnings that dishes may or do contain eggs. This situation will be materially altered by the provisions of the Food Information Regulations¹⁰ coming into effect on 13 December 2014 when such information will be required for the 14 major groups of EU allergens. The particular circumstance of this case was that the caterer, from a similar background, understood that for religious reasons the food to be served at the wedding should not contain egg.

The Appeal Court rehearsed the controlling principle that the imposition of a duty of care should be 'fair, just and reasonable' in all circumstances and explored (a) foreseeability of harm, (b) 'proximity' (the relationship between the claimant and the defendant) and (c) the kind of damage which the defendant can or should

Table 2. Media references to baby Thomas Egan

Article source and title	URL [14 August 2014]
BBC News, 23 January 2003, Milk allergy baby died after meal	http://news.bbc.co.uk/1/hi/england/2687485.stm
Leigh Day, Solicitors, London, 28 January 2003, Milk allergy verdict announced	http://www.leighday.co.uk/News/Archive/2003/January-2003/Milk-allergy-verdict-announced
BBC News, 28 January 2003, Neglect was factor in baby death	http://news.bbc.co.uk/1/hi/england/2702111.stm
BBC News, 30 January 2003, Baby death nursery fined	http://news.bbc.co.uk/1/hi/england/beds/bucks/herts/3226675.stm
Birmingham Post & Mail Ltd, 2003, Baby boy died after an allergic reaction; Nursery tragedy: errors and failings by staff	http://www.thefreelibrary.com/Baby+boy+died+after+an+allergic+reaction%3B+Nursery+tragedy%3A+Errors+and+...-a096988076
Alison Mercer, Nursery World, 5 February 2003, Further action may follow death	http://www.nurseryworld.co.uk/nursery-world/news/1099787/action-follow-jigsaw-death
Nilufer Atik, London Evening Standard, 8 August 2003, Nursery admits guilt over baby death	http://www.standard.co.uk/news/nursery-admits-guilt-over-baby-death-6986169.html
Stewart Payne, The Telegraph, 31 October 2003, Nursery fined over baby's allergy death	http://www.telegraph.co.uk/news/uknews/1445564/Nursery-fined-over-babys-allergy-death.html
James Tweed, Nursery World, 5 November 2003, Chain fined for death of baby	http://www.nurseryworld.co.uk/nursery-world/news/1103442/chain-fined-death-baby

reasonably foresee as being the likely consequence of an act or omission.

In relation to foreseeability, the County Court found that egg allergy is common; however, the Appeal Court bore in mind that it is present in only 0.1% of the adult population. There was no evidence before the County Court [in 2008] that good practice requires caterers to warn customers that dishes contain eggs. However, the Appeal Court added that the position in respect of nut allergy may differ, an indication that publicity and official guidance on peanut allergy had gained judicial notice by the time of the appeal.

As to 'proximity', the risk that one of the guests at this wedding would be allergic to eggs was no greater than at any other gathering of comparable size and thus ordinarily it was not sufficient to give rise to a duty of care to prevent harm of that kind. However, the unusual nature of the occasion was such as to extend the ordinary duty of care in that, for religious reasons, egg should have been absent and there could be expected of the caterer some knowledge that some people are allergic to eggs. Any egg-allergic guest would expect the food to be completely free of egg and therefore feel confident that no harm would come. Mr Bhamra knew he was egg-allergic but had every reason to rely without inquiry on the caterer to supply food which did not contain egg.

Lastly, did the caterer take reasonable care to ensure that there was no egg? The trial judge thought that the caterer might easily have given evidence that he had contracted for egg-free, wholly vegetarian ras malai, or examined labels. The Appeal Court did not think that the judge was right to hold that the facts in themselves proved that the caterer was in breach of duty. A significant aspect was whether or not the caterer knew that ras malai is sometimes made with egg. The case-specific evidence is detailed but it was found that he did. Added to its other findings, the Appeal Court considered this sufficient to establish that the caterer was in breach

of his duty of care to Mr Bhamra and was liable for his death even though the evidence did not enable the court to identify the precise nature of the caterer's shortcoming.

FOOD LAW PROSECUTIONS

Prepacked food – labelling

Prior to the mid-2000s, prosecutions in the UK for labelling offences such as labelling not in English or irregularities in the list of ingredients were rare. The matter was dealt with informally under the Food Labelling Regulations 1996 implementing Directive 2000/13/EC. Prepacked food must be labelled with a name, a list of ingredients and other details. There are 'intelligibility' criteria that must be met. The labelling must be '... easy to understand, clearly legible and indelible and ... marked in a conspicuous place in such a way as to be easily visible'. Required labelling must not '... in any way be hidden, obscured or interrupted by any other written or pictorial matter'. From 2003, allergens were recognised in labelling law,³³ with the deliberate presence of any (initially 12 now 14) allergen groups in prepacked food having to be declared. The 1996 Regulations are replaced in 2014 by Regulation (EU) 1169/2011, so no further discussion of the 1996 Regulations seems warranted. However, the intelligibility requirements are carried over into the new labelling law,¹⁰ bolstered by minimum letter height requirements. Thus, as it became increasingly realised that labelling non-compliance puts people with allergies at risk, a more robust attitude developed. Three examples are given.

Case 3. Market trader, imported prepacked food

A market trader in Wellington, Shropshire selling improperly labelled imported prepacked chocolates was prosecuted in 2009 by Telford and Wrekin Trading Standards Officers. The alleged offence was 'placing on the market food that was unsafe namely

Milka Frühlingsblumen in that the labelling did not declare the presence of allergenic ingredients namely Almond and Hazelnut in a language easily understood', contrary to Regulation 4(a) of the General Food Regulations 2004 and Regulation (EC) 178/2002 Article 14 paragraph 1. The ingredients of the food were labelled only in German and French. The trader was convicted and fined £3500 plus costs and a victim surcharge of £1445.³⁴

Case 4. Walnuts omitted from ingredients list, prepacked food

On 5 July 2010 at a deli counter food business in Kensington a portion of Aubergine Rollatini Spinach was bought. The customer, who suffers from severe nut allergy, checked the label and found that walnuts were not listed in the ingredients or on the label. She bit into it and immediately realised that it contained nuts, suffered an allergic reaction and was admitted to hospital for emergency treatment and discharged after 8 h. Prosecuted by the Royal Borough of Kensington and Chelsea Environmental Health Department, the defendant company pleaded guilty at West London Magistrates' Court on 7 September 2011 to labelling and presenting food in a manner that misled the consumer on the presence of walnuts and was fined £2000.00 with £2321.03 costs and a £15 victim surcharge. The company asserted that allergic reactions such as this are rare; prior to this incident they already had systems in place which addressed the handling of known food allergens, and they believed that the incident was caused by an oversight in which labelling of walnuts was accidentally omitted. Following the incident, they reviewed their labelling process and have added tighter controls on the store operations side of the business. In sentencing, the District Judge said he was impressed with the steps taken by the business. The consequences of this matter could have been very different, although thankfully the victim made a full recovery.³⁵

Case 5. Example of an escalating enforcement approach

A case in January 2014 appears typical of the gradually escalating approach generally adopted by Trading Standards Officers. A Polish company owning three food shops in Essex was ordered to pay more than £3500 after pleading guilty at Chelmsford Magistrates' Court to 20 charges of selling food not properly labelled in English. The prosecution brought by Essex County Council's Trading Standards Department resulted from an inspection following a complaint in 2012 that food was not correctly labelled. Advice was issued and five further visits took place between then and 2013, with written infringement notices issued each time, explaining what needed to be put right. Two more detailed advisory letters were also issued in July and September 2012. Trading Standards Officers estimated the rate of non-compliance of correct labelling being at around 50%, rising to around 80% on the final visit on April 9 when all three stores were inspected. The significance of allergen ingredients that could cause a wide range of problems ranging from minor irritation to, in extreme cases, death was referred to in the prosecution. A director of the company was personally fined £870 and the company was also ordered to pay £2250 on the basis of the first offence, costs of £1350 and a victim surcharge of £120.³⁶

Prosecutions – non-prepacked food

Non-prepacked foods, especially catered meals, have been known to be problematic for people with allergies for some time. Pumphrey³¹ found in 2000 that up to 75% of food-induced anaphylaxis fatalities occurred as a result of catered meals. A baseline survey in Northern Ireland found that one in five takeaway

meals purporting to be suitable for a peanut-allergic customer contained peanut protein.³⁷ More recent work by Pumphrey and Gowland³⁸ indicated that of the food-induced anaphylaxis fatalities between 1999 and 2006 some 38% were due to catered meals. The case of Bhamra is the only civil action relating to catering for which we have full details, but there have been several criminal prosecutions, three examples of which are given below.

Case 6. Catering, severe reaction to a takeaway meal

One of the first takeaway cases occurred in Derbyshire in January 2010 following an incident in 2009 when a peanut-allergic customer asked a Chinese takeaway for a meal without peanuts owing to his severe allergy. He ate the meal and suffered a severe allergic reaction requiring emergency life-saving treatment and stabilisation in hospital. The remaining food was analysed and found to contain peanut protein at a level of 31 mg kg⁻¹ (ppm). The food business operator was prosecuted at Chesterfield Magistrates' Court by Trading Standards Officers under the Food Safety Act 1990 for supplying unsafe food by failing to declare the presence of peanuts. He was fined a total of £2660 and ordered to pay £1000 in costs, a £15 victim surcharge and £200 in compensation to the diner.³⁹

Case 7. Catering, hospitalisation of a student

In April 2011 a student suffered a severe allergic reaction to a South Asian confection, said not to contain peanuts, purchased at an Indian food festival. After 8 days in hospital, including 3 days in intensive care, a full recovery was made. The manufacturer of the food, trading for more than 25 years, was prosecuted at Hull Magistrates' Court in April 2012 and on conviction was fined £5000 with £1661 costs, and the director was fined £2500. The food was marble laddoo, a sweet marbled Indian cake (mithai) made from ingredients including semolina, vermicelli, sugar, various nuts (pistachio, almonds, cashew, etc.), ghee and khoya (a milk product). The cake had been bought by the student's mother, who asked the stallholder if it contained peanuts and was assured not. Eating the food initiated throat constriction, recognised as the possible onset of anaphylaxis. Consciousness was lost and cardiac arrest ensued; death or brain damage was prevented only by rapid treatment at hospital. Although the family was very allergy-aware, a severe reaction had never been previously encountered and a prescribed adrenaline autoinjector was not to hand. The company were initially unresponsive to a Trading Standards investigation and found not to have suitable procedures in place, and peanuts were found to be the main ingredient (55%) of the laddoo. Hull City Council's Trading Standards Manager is reported to have considered that the owner of the small food-manufacturing business would have been fully aware of the allergen risk posed by peanuts and added 'Such serious offences will always be investigated by the trading standards service'.⁴⁰

Case 8. The Euro Foods case and appeal

Local authority surveys of compliance in the catering, specifically takeaway, sector have proliferated since the work of Leitch *et al.*³⁷ focusing on allergens and other areas such as nutrition, species substitution and excessive colours. One such survey has had far-reaching consequences. In 2010–2011, 30 local authorities in England and Northern Ireland participated in a Local Government Regulation nationally coordinated Food Standards Survey of the composition of certain types of takeaway food. Food

containing allergens was recognised to have a high public profile, and in this survey, several authorities chose specifically to request that meals should be nut-free and peanut-free. In 22% (five of 36) of sampled Indian takeaway meals, unexpected allergens were detected (five almond protein and three peanut protein) and peanut protein was also found in one of 50 sweet and sour chicken meals requested to be free from nuts/peanuts/allergens. The survey concluded that specifically asking for an allergen-free meal may lull the consumer into a false sense of security but provides little real protection, and urged local authorities to ensure further efforts to work with ethnic kitchens to reduce the occurrence of false information.⁴¹ Even more significantly, when two of the non-compliant chicken tikka masala samples were followed up, the ingredients were traced back to a large Indian food supplier, Euro Foods Ltd. It appears to have been established that Euro Foods had supplied groundnuts (peanuts) instead of almond powder as requested to another wholesaler who had in turn supplied the two takeaways which themselves had no knowledge that the product they were introducing into their recipe for chicken tikka masala was not almond powder.⁴² Euro Foods was prosecuted by Cumbria County Council Trading Standards Department and initially found guilty on charges of supplying almond products adulterated with peanuts. It was said that this arose because of the price differential between the two. The firm was fined £6000 with £12 000 costs⁴³ but later successfully appealed the conviction. A full report of the appeal appears not to be publicly available; however, the grounds of appeal included the error in law of laying information (charges) under *both* Sections 15(2) and 15(3) of the Food Safety Act 1990.^{44,45} Section 15(2) creates the offence of falsely describing or misleading as to the nature or substance or quality of the food, while Section 15(3) creates the offence of presentation of which is likely to mislead as to the nature or substance or quality of the food.

The FSA refers in its Annual Report of Incidents 2012 to investigations of severe allergic reactions following the consumption of curry dishes purchased from Indian restaurants and takeaways. Noting that some of these incidents resulted in fatalities, the FSA reports that investigations suggest some incidents were caused by the use of a ground almond ingredient which also contained ground peanut (groundnut). The FSA identified weaknesses in the food chain where such contamination and loss of clear information occurred, including poor understanding of the significance of substituting peanuts for almonds, incorrect allergen information provided at a point of sale, and unclear labelling and confusion between peanuts and tree nuts (almonds) leading to the potential for accidental substitution. However, the FSA also reported possible economically motivated adulteration driven by the financial incentive to replace ground almonds with ground peanut.⁴⁶

DISCUSSION

The literature up to the end of 2013 is sparse on legal action in relation to food allergy, substantive analysis and comment being confined, to our knowledge, to a discussion on access to day care in the USA⁴⁷ and a South African paper on medical negligence.⁴⁸ The forensic science and allergy literature contains reports of food-related deaths^{49–52} but no detail of any subsequent court action. The Bhamra case attracted comment mainly confined to reporting the facts.^{27–30} As will be seen from this paper, much of the material gathered has been in the media or from direct contact with local authorities rather than the peer-reviewed literature. It is timely therefore to review and collate extant material.⁵³

Food must be safe, authentic and properly labelled, responsibility for which falls to those who make and sell it.¹² There is, however, a public expectation of regulatory oversight by government. The regulatory landscape in the UK is a complex one, with policy set by central government and enforcement mainly a local government responsibility.⁵⁴ Broadly speaking, in the non-metropolitan areas of England, food standards (Trading Standards) work is carried out by Trading Standards Officers (TSOs) in the county councils, while food safety (Environmental Health) work is carried out by Environmental Health Officers (EHOs) in the district councils. The London boroughs and the metropolitan authorities carry out both functions. In Wales and Scotland, all food law enforcement is carried out by the unitary authorities. In Northern Ireland, this work is undertaken by the Environmental Health Departments of district councils. Moreover, regulation and enforcement have traditionally followed two separate tracks – food safety, e.g. hygiene, contaminants and residues, and food standards, e.g. labelling, authenticity and fraud (consumer choice issues). The latter has historically been accorded a lower priority for attention and funding. For example, Phillips and French,⁵⁵ noting that in 1874 a Parliamentary Select Committee considered that the public was being ‘cheated rather than poisoned’ by food adulteration, commented that official prioritisation of food safety over food authenticity was cemented by the transfer of food regulation policy to the newly created Ministry of Health in 1919. ‘[T]he new Ministry [rejected] the need for any legislation that was not justifiable on health grounds’. The government assumed a limited regulatory role, persuaded that market forces and the commitment of large producers to quality and scientific research were better guarantees of safety than statutory legislation.⁴⁹ Patel *et al.*,⁵⁶ addressing the enforcement roles of TSOs and EHOs and the nature of enforcement theory and practice, noted that formal legal action is seen as a last resort, with advice and guidance often seen as a more productive and efficient means of securing compliance. Case 5, *Essex County Council v Minidelikatesy Kubus Ltd*, cited above illustrates this well. In addition, EHOs and TSOs found themselves at first (say up to the mid-2000s) only slightly ahead of the learning curve on food allergy than the businesses they inspected.⁵⁷ Hence legal action has lagged considerably behind the acquisition of knowledge, provision of guidance and legislation on food allergy. There was also a notion that labelling, the crux of much avoidance behaviour on the part of people with food allergy, was a trivial aspect of enforcement. As we have seen, the consequences of contraventions of labelling law in respect of allergens can be far from trivial both for the person with the allergy and for the food business that produced the food. The regulation of the law on food allergens blurs the already somewhat artificial distinction between ‘safety’ and ‘standards’ and we have seen a number of labelling cases in the recent past that would not previously have been expected to satisfy the threshold for prosecution were it not that they involved allergens.

Anaphylaxis Campaign has collected details of fatal and near-fatal reactions since 1992, with seven to ten food allergy deaths a year, mostly from peanuts but also from tree nuts, milk, fish, shellfish and egg. Peanut allergy is the most common. The Euro Foods case appears to confirm what has long been suspected, that some ingredients in the supply chain for curry takeaways are not what they seem and may explain some of the severe food-allergic reactions reported around the UK. At least one fatal reaction per year and a number of ‘near misses’ involve a curry or similar takeaway meal. The cases we have examined represent a spectrum from negligence to perhaps outright criminality, jeopardise the safety and peace of mind of those with food allergy,

especially children and their carers, and undermine the generality of the food industry managing allergens in a responsible manner. The DH/Defra Elliott Review into the Integrity and Assurance of Food Supply Networks issued its interim report in December 2013⁵⁸ and recommended that a new culture of zero tolerance is required. Elliott noted '*In sectors where margins are tight and the potential for fraud is high, even minor dishonesties must be discouraged and the response to major dishonesties deliberately punitive*'. Thorough investigation of food allergy deaths particularly in the catering sector is required where there seems growing evidence that fraud has infiltrated. Such investigations require a tenacious and skilled approach, with the early realisation for example that samples of the food and/or stomach contents from a *post mortem* examination will be required to be retained and analysed. The supply chain of the meal ingredients must also be rigorously followed up to find out where any adulteration or contamination with the fatal allergen occurred.

In the absence of a current cure, health protection for those with food allergy depends on accurate diagnosis, informed food allergen avoidance and the effective management of symptoms. These strategies depend in turn on the multilayered approaches adopted by food businesses, allergic consumers (and those providing their food), regulators, clinicians and scientists. Risk assessment hinges in large part on the ability analytically to detect allergens, and although allergen quantification requires more development, rapid methods are available, e.g. lateral flow enzyme-linked immunosorbent assays (ELISAs) and biosensors.^{59,60} Effective food allergen avoidance depends on the diagnosed consumer knowing what to avoid, being able to access correct ingredient information and relying on the absence of allergen cross-contamination. Food alerts due to the presence of an undeclared allergen, in the UK from the FSA by email and text messages and reproduced by many patient support groups, have a role to play in reducing the incidence of reactions by requiring corrective action and alerting consumers about potential exposure to an allergen. Access to ingredient information may be via a label, menu or other printed means, or by enquiring of a staff member who may not always appreciate the implications of such a request or be competent in managing food allergy risks. Lapses in any of these areas may have forensic consequences beyond even their initial (sometimes severe) personal impact. A person with food allergy/allergies, once diagnosed and aware of what foods they must avoid, must also be proactive in dealing with their allergies when eating out. There is thus a shared responsibility with the caterer to manage the situation. In the event of any civil litigation on foot of an anaphylactic incident, the attitude and actions of the plaintiff might well be explored with a view to establishing contributory negligence if it could be shown they did not make their condition known and enquire about allergens.

The baby Egan case catalysed improvements for children with allergies in a whole sector, and the deficiencies identified by the prosecution provided a template for best practice for child care nurseries. The detail of the prosecution allegations in the case should also be borne in mind for EHO and Ofsted inspections of day care nurseries. One avenue that was at the time unavailable to prosecutors was a charge of corporate manslaughter. This changed in 2007 in the UK with the Corporate Manslaughter and Corporate Homicide Act.⁶¹ This Act allows prosecution of companies and organisations for manslaughter as a result of serious management failures resulting in a gross breach of a duty of care for such a death. By contrast, the Bhamra case had no discernible impact on the catering sector. This may well have been due to its perceived

limited scope, confined as it was to a set of unusual circumstances. Contrasting the case with the seminal *Donoghue v Stevenson* 1932 'snail in the bottle' case that established English tort and Scottish delict law on negligence and duty of care, O'Sullivan²⁷ considered that the Appeal Court fell into error in '... tailoring the duty [of care] question to the precise allegation of negligence ...' and also that the percentage of egg-allergic people in the population was a 'fault' rather than a duty of care issue, questioning the assertion that a duty of care was owed in relation to serving of egg under religious principles. Nevertheless, it was agreed that 'fault' encompassed '... the nub of the case ... that a reasonable caterer would know that some people have egg allergies and that such people would relax at a wedding where no egg was meant to be served ...'. The Appeal Court considered there was no evidence before the County Court [in 2008] that good practice requires caterers to warn customers that dishes contain eggs and there was no general duty to provide a warning about eggs, but noted that the position in respect of nut allergy may differ. This is interesting and reflects the preponderance of advice and guidance on and salience of the risks associated with peanuts for people with a peanut allergy. In fact, Health Departments and patient support groups issued advice on peanut allergy as far back as 1994. The Ministry of Agriculture, Fisheries and Food first delivered 'Be Allergy Aware' information to UK food businesses in 1997–1999. The FSA held a stakeholder meeting in 2001 to explore with consumers, enforcement authorities and industry how to improve information provision in catering outlets and on food sold loose, including on allergens, although the emphasis then was on peanuts. However, by 2006 the FSA was consulting on comprehensive guidance on 'provision of allergen information for foods that are not prepacked'. This covered caterers, although that may not have been obvious from the title. This guidance was issued in 2008 (in parallel with national food allergy training programme for local authority food control teams) and would have been influential in the advice that EHOs gave to catering businesses when they were inspected. From December 2014, caterers will be obliged by Regulation 1169/2011 EC to provide the information that the Appeal Court in the Bhamra case found was unnecessary. It is important to recall that although 14 allergen groups are covered by Regulation 1169/2011 EC, caterers should consider allergens in general, as food allergies vary across regions and populations. If a consumer suffers harm owing to the inadvertent presence of an allergen not covered by legislation, the advice given by EHOs inspecting the caterer may act to negate the Bhamra Appeal Court opinion that may otherwise remain an influential legal view. Thus, in investigating an incident, it would be necessary to ask the specific question: what advice was given by EHOs and to which allergens did it extend?

On the other hand, if a customer with an allergy asks, as they ought to (see above), about the presence of any ingredient and is assured of its absence, if that ingredient is found to be present, the food could be considered 'not of the substance' demanded by the purchaser contrary to Section 14 of the Food Safety Act 1990.

Cross-contamination

Taken together, European Regulations 178/2002 and 1169/2011 may limit the scope of legal protection for consumers in the event of cross-contamination of food by allergens not deliberately added as ingredients, although in the main the food industry is far from complacent on this. It has been argued that cross-contamination is not covered by food safety law as it is an issue only for some and not all consumers.

Rothstein⁶² considered there is some support for that view in that there is no liability if the wrong-doing would have caused no damage to someone of reasonable robustness and the injury suffered by the victim was not foreseeable by the defendant. From that point of view it is unreasonable to expect foods to be free from undeclared trace contamination or to require businesses to conduct a hazard analysis on foodstuffs that present allergy risks to only a few people. Rothstein goes on however to cite the case of *Cullen v McNair* (1908)⁶³ that established the offence of selling food that was injurious to vulnerable groups such as children and invalids even if it was not injurious to normal adults. Cullen deals with the adulteration of cream with boric acid (a preservative now banned) and held that the presence of boric acid is harmful to children and invalids but not to adults, giving rise to the proposition that if an article is shown to be injurious to a substantial proportion of the community, it will be deemed injurious to health, and opening up a line of argument under Section 8(2) of the Food Safety Act 1990. The recognition that allergic reactions, including eczema, asthma and hay fever, are now among the most common chronic diseases and that their prevalence is increasing, as well as Bhamra with the view that an allergy is 'common' if affecting 0.1% of the population,²⁷ appears to tend to shift responsibility back onto food businesses. Crevel and colleagues^{64–66} have discussed allergen cross-contamination, termed by many 'cross-contact', which may occur at any point in the supply chain. While much progress has been made in establishing reference doses for 'thresholds' of elicitation by allergens,¹¹ there are gaps in knowledge (typical cross-contact concentrations of allergens in foods and severity of allergic reactions) and disparity between probabilistic predictions of likelihoods of encountering allergens and recorded reactions. Attempts to deal with the cross-contact problem by precautionary labelling ('may contain ...') have met with disapproval, distrust and disregard.⁶⁷ Allergen contamination risk management options are currently under active debate.

Litigation or prosecution in this area would entail scientific and legal difficulties, but if embarked upon, some considerations are worthy of note. The Court of Appeal (Civil) clearly was possessed of an inclination that caterers' salience (of peanut) imposed an obligation (disclosure of its presence). Hence three things may operate to impose a duty of care in respect of allergens arising by cross-contamination and negate legal protection therefrom by 'may contain' labelling: (a) salience of the possibility of its occurrence and allergic consumers' distrust and disregard of precautionary labelling, (b) the case of *Cullen v McNair* and (c) Articles 8 and 14 of Regulation (EC) 178/2002, which prohibit adulteration of food and fraudulent, deceptive practices and the sale of unsafe food such as food injurious to health, including the particular health sensitivities of any specific category of consumers. Lastly, while it is beyond the scope of this paper to discuss in detail the applicability of the 'due diligence' defence⁶⁸ in assessing culpability, it is possible to distinguish between cross-contamination which may be unavoidable through procedures consistent with good manufacturing practices (GMPs) and that which becomes a violation of GMPs because of, for example, poor cleaning of equipment or inappropriate handling of ingredients.

CONCLUSIONS

There is a spectrum of options to protect food-allergic consumers, short of litigation and prosecution by enforcement authorities, including self-policing by the industry and allergen alerts.

However, the courts remain as a potential backstop and we have described typical cases involving food allergens with a view to providing a collated resource from disparate, mainly 'grey', literature sources. Consideration of these cases suggests the following conclusions that would enhance forensic effectiveness for vulnerable consumers.

1. There is no system by which cases such as these are reported, as evidenced by the disparate sources the authors were obliged to use to collect the information herein. There should be central collation of such cases.
2. Calls for a culture of zero tolerance for food fraud are appropriate.
3. Enforcement of food labelling and traceability law can reduce the risk to vulnerable consumers, since documented traceability of ingredients can lower the risk of including undesired allergen ingredients.
4. Enforcement authorities should accelerate their escalation of action against poor labelling and misleading food description when they pose an allergen risk.
5. Thorough investigation of food allergy deaths particularly in the catering/non-prepacked sector is required where there seems growing evidence that fraud has infiltrated.
 - a. Such investigations require a tenacious and skilled approach with more widespread awareness that analysis of food for allergens is possible and the need for early realisation for example that samples of the food and/or stomach contents from a *post mortem* examination will be required to be retained and analysed with due regard for the forensic chain of custody of evidence.
 - b. The supply chain of the meal ingredients must also be rigorously followed up to find out where any adulteration or contamination with the fatal allergen occurred.
 - c. Investigation of the incident should have regard to what advice had previously been offered to the food business by enforcement officers.
 - d. A charge of corporate manslaughter in the case of an allergen-related fatality may be available under the Corporate Manslaughter and Corporate Homicide Act 2007.
6. Salience of the risks of all food allergens should be maintained by patient support groups, regulators and enforcers (given the influence such salience had on the Appeal Court's views in Bhamra).
7. Food businesses must guard against short cuts or gaps in allergen management; there are many readily available sources of advice, training and guidance, and an up-to-date awareness of these is required by staff at all levels.
8. New training and guidance on guarding against unwitting or fraudulent substitution in the supply chain need to be developed.
9. Skills gaps that have emerged in properly prosecuting fraud cases should be addressed.
10. The baby Egan case catalysed improvements for children with allergies in a whole sector, and the deficiencies identified by the prosecution provide a template for best practice for child care nurseries and inspection of the same.
11. The impact of forthcoming legislation and a careful consideration of case law appear to place responsibility onto food businesses even for the currently problematic area of allergen cross-contamination/cross-contact.

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