

INVITED EDITORIAL

Keeping food-allergic children safe in our schools—Time for urgent action

Children have a right to be safe in school: schools, in turn, have a statutory responsibility to provide a safe environment for children.¹ Schools are required to have policies to support pupils with any medical condition—including food allergies—which must be developed in the context of statutory guidance from the Department of Education.¹ However, this guidance is wholly generic and does not provide detail about specific medical conditions. Consequently, schools must develop their own food allergy policies, from scratch. This inevitably leads to inconsistency: there are examples of excellent practice, but we frequently hear about schools where the opposite is true. Some parents, distressed by their school's inability to manage their child's allergy in a safe way, take the decision to stop sending their child to school altogether, risking educational and further social compromise for the child. A recent petition to make allergy management policy in schools mandatory, set up by two mothers with such experiences, was supported by over 10 000 signatures.²

The need for change was brought into sharp focus by two of Her Majesty's Coroners following the inquests into the deaths of Mohammad Ismaeel Ashraf and Karanbir Cheema, in school, as a result of anaphylaxis.^{3,4} The inquests flagged the key issues of lack of adequate staff training, resulting in delayed and incorrect administration of adrenaline, along with policy implementation issues around adrenaline auto-injectors (AAI) being out of date and not readily available.

About 17% of fatal food-anaphylaxis reactions in school-aged children in the UK happen in schools;⁵ about 20% of anaphylaxis reactions in schools are in children with no prior history of food allergy.⁶ Food Allergy Policies must result in a clear understanding of which children are at risk, how the risk of reactions can be minimised and ensure that when reactions happen (which clearly they do), staff are adequately trained to identify anaphylaxis and administer rescue adrenaline early.

Policies also require effective implementation: both Allergy UK [allergyuk.org/information-and-advice/for-schools] and the Anaphylaxis Campaign [anaphylaxis.org.uk/schools/schools-help] have developed resources to support schools. The most successful approaches have utilised a “whole school” approach, where policies are developed in partnership with parents, pupils and healthcare professionals and involve “whole school” education—pupils, teaching and non-teaching staff alike—with a focus on training, risk assessment and communication.

AAIs are prescription items: they can only be prescribed to an individual patient and not for “generic” use in the way that defibrillators

are widespread in public areas. Many schools insist on a supply of two AAIs per affected pupil; with an average of one child in 30 being at risk of anaphylaxis in the UK, schools hold multiple AAI devices, often produced by different manufacturers. In an emergency, staff waste valuable time identifying a child's own AAIs, as they cannot use those belonging to someone else. Furthermore, the presence of different brands of AAIs can be confusing to staff—a contributory factor in some fatalities.

The USA and Australia have passed legislation to allow supply of AAIs to schools, with a documented improvement in management of allergic reactions.⁷ In 2016, the BSACI, in partnership with RCPCH, the Anaphylaxis Campaign and Allergy UK, were successful in lobbying for a change in legislation to allow schools to purchase “generic” or “spare” AAIs.⁸ To support the new legislation, the Department of Health and Social Care (DHSC) published non-mandatory guidance on the best-practice management of children at risk of anaphylaxis in schools,⁹ which was incorporated into a DHSC-funded website (www.sparepensinschools.uk).

There remain some significant shortcomings. “Spare” AAI can only be used in preference to a child's own AAI where this would cause a significant delay.⁹ Most schools still insist that pupils bring their own (usually two) devices to school; GPs are frequently asked to prescribe at least four devices, two for school and two for home/personal use (this is unfortunate, given the current and ongoing issues over AAI supply). No funding has been provided to allow schools to purchase spare, back-up AAIs. Indeed, since these AAIs are supplied without prescription, schools have to pay the full private charge to obtain an AAI (around £50 per device), rather than the NHS prescription fee. Furthermore, no additional resources have been forthcoming for training school staff.

Most schools have not taken up the opportunity to obtain spare AAIs, and the level of staff training is still well below what we consider to be acceptable. There remains a clear need for a change in culture around how allergies are managed in school. While progress has been made in Australia and the USA, we continue to lag behind: children are suffering and even dying as a result. We believe that further action is required:

- The Department for Education will be reviewing the statutory guidance in 2020. There is a need to develop a level of specific detail to sit below the generic statutory guidance, in conjunction with representative organisations. Schools already have a statutory duty to provide for children with medical needs (which

includes food allergy); the Department for Education should recommend schools do so by adhering to the (currently non-mandatory) guidance published by DHSC in 2017.⁹

- Funding for anaphylaxis training in schools, supported by high quality resources, for both pupils and staff.
- Funding for schools to be provided with “spare” AAls by the Government, and a review of the legislation to allow “spare” AAls to be used for the first-line, emergency treatment in any pupil having anaphylaxis.
- Provision of such measures to be mandatory (potentially forming part of school assessments by Ofsted), as they are in certain states in Australia and the USA.

These measures would help schools will become a safer place for food-allergic children. The above could be achieved with minimal cost implications: with mandatory “spare” AAI provision, families would no longer need to provide the school with a supply of AAls for each child, something which would avoid confusion and delay in an anaphylaxis emergency (as highlighted by Her Majesty’s Coroners). Evidence suggests that this model of provision is optimal in terms of health benefits and cost-effectiveness.¹⁰ To achieve this would require a far-sighted approach, with the Department for Education and DHSC working together. It is what children with food allergy and their families deserve.

CONFLICT OF INTERESTS

All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: PJT is current chair of the Paediatric Section of the British Society for Allergy and Clinical Immunology (BSACI) and has received research grants from the Medical Research Council, National Institute for Health Research, J P Moulton Charitable Foundation and End Allergies Together Foundation (USA); LR is Chief Executive of the Anaphylaxis Campaign; CJ is Chief Executive of Allergy UK; ATF is current President of the BSACI; all authors were involved in the working group on improving management of food allergies in schools; no other relationships or activities that could appear to have influenced the submitted work.

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