Department
for Education

Allergy safety in schools

Statutory guidance for governing bodies of maintained schools and proprietors of academies in England

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Summary

About this guidance

This document is statutory guidance issued under section 100 of the Children and Families Act 2014, as amended by section 34 of the Children's Wellbeing and Schools Act 2026, setting out how local authority (LA) maintained schools, academies and pupil referral units (PRUs) should fulfil their statutory duty to put allergy safety policies in place.

The governing bodies of maintained schools, proprietors of academies and management committees of PRUs must "have regard to" this guidance when carrying out their statutory duty to put allergy safety policies in place.

To "have regard to" means to take account of the guidance and to carefully consider it. A decision not to comply with the guidance should be supported by a clear or justifiable reason. Where advice is flagged as good practice, itis non-statutory.

Early years settings and schools which offer provision for "young children" (from birth until the 1st September following their fifth birthday) should continue to apply the Statutory Framework for the Early Years Foundation Stage (EYFS).

Who is this guidance for?

This is **statutory** guidance for the following education providers (i.e. they must "have regard" to it in fulfilling their statutory duties):

- governing bodies of maintained schools, including special schools but excluding maintained nursery schools
- management committees of PRUs
- proprietors of academies, including free schools and alternative provision academies (but excluding 16–19 academies)

While it is not currently statutory guidance, the Government intends to introduce equivalent allergy safety requirements through the relevant regulatory standards for:

- independent schools (including independent special schools)
- non-maintained special schools

In addition, it will also be of assistance to other education providers as they fulfil their wider statutory duties, including:

- early years settings
- further education (FE) colleges and other post-16 institutions (including 16-19 academies)

This guidance may also assist the following bodies in discharging their related responsibilities:

- local authorities
- home to school transport providers
- Integrated care boards (ICBs), including executive leads for SEND
- Designated clinical officers / designated medical officers
- Staff working for NHS providers
- School nursing teams delivering the Healthy Child Programme

It will also be of interest to children, young people and their parents or carers

Definitions

In this guidance:

- references to “schools” includes academies and pupil referral units;
- references to “schools, colleges and early years settings” means any institution where this guidance may be of relevance;
- references to “governing bodies” includes the governing bodies of maintained schools, proprietors of academies and management committees of PRUs, together with the governing bodies of non-maintained special schools and the governing body or proprietor of post-16 institutions;
- references to “parents” includes anyone with parental responsibility, including carers.

Allergy is a medical condition in which the body’s immune system has an abnormal reaction to normally harmless substances such as food, insect stings, contact allergens and airborne allergens.

Anaphylaxis is a potentially fatal reaction affecting the Airway/Breathing/Circulation (“ABC”). Many individuals with allergies to food or insect stings are at risk of anaphylaxis.

Asthma is a lung disease caused by inflammation and tightening of the airways, it is frequently associated with allergy and anaphylaxis, because exposure to allergens can provoke an asthma attack, a potentially life-threatening condition.

Intolerance to foods or an ingredient that the body is unable to digest is different to allergy and does not cause a serious allergic reaction. It can cause long term health problems if not avoided. Common food intolerances include lactose and gluten. Coeliac disease is intolerance to gluten, found in rye, barley and wheat.

What legislation is this guidance issued under?

Section 100 of the Children and Families Act 2014 places a duty on governing bodies of maintained schools, proprietors of academies and management committees of PRUs to

make arrangements for supporting pupils at their school with medical conditions (excepting those who are "young children" from birth until the 1st September following their fifth birthday and subject to the requirements of the EYFS). In meeting the duty, the governing body, proprietor or management committee must have regard to statutory guidance on Supporting pupils with medical conditions at school issued by the Secretary of State for Education under this section.

Section 34 of the Children's Wellbeing and Schools Act 2026 amends this by placing a further requirement on LA-maintained schools, academies and PRUs to have allergy safety policies, publish them and keep them under review. Schools must also have regard to statutory guidance on allergy safety. Regulations will permit the Secretary of State to make further allergy safety requirements, including to require schools to stock "spare" adrenaline devices and to require allergy safety training.

This guidance is concerned with the allergy safety requirements introduced by section 34 only. It sits alongside the statutory guidance on Supporting pupils with medical conditions at school. References to wider medical conditions or wider statutory duties should be read only to the extent that they are relevant to allergy safety and to the arrangements schools should make to identify, reduce and respond to allergy-related risks.

This guidance does not establish a framework for the delegation of healthcare activities from regulated healthcare professionals to education staff. Where support for a child or young person requires healthcare activity that falls under NHS responsibility, this should be arranged through appropriate legal, clinical governance, training, competency and accountability arrangements.

While the duties in the Act apply to LA-maintained schools, academies and PRUs only, the Act also requires the Secretary of State to impose equivalent allergy safety measures on independent and non-maintained special schools through the Independent School Standards and Non-Maintained Special School Regulations. *This guidance will be updated in due course when equivalent allergy safety requirements are placed upon independent schools and non-maintained special schools through the relevant regulatory standards.*

In addition, other statutory duties are of relevance to children and young people with allergy, including:

- The duty of care under section 3 of the Children Act 1989 for any person with the care of a child to do all that is reasonable for the purposes of safeguarding or promoting the welfare of the child;
- The duties to safeguard and promote the welfare of pupils and students under sections 20 and 175 of the Education Act 2002, the Education (Independent School Standards) Regulations 2014 (and associated statutory guidance Keeping Children Safe in Education) and the Non-Maintained Special Schools (England) Regulations 2015;

- The duty of the employer under section 2 of the Health and Safety at Work etc Act 1974 to take reasonable steps to ensure that employees are not exposed to risks to their health and safety;
- The duties under the Equality Act 2010 to provide equality of opportunity for all, including those who are disabled.
- The Special Educational Needs and Disability (SEND) SEND code of practice: 0 to 25 years.
- The Early Years Foundation Stage (EYFS) statutory framework.
- The common law duty of care which requires schools, educational settings, and other persons responsible for children and young people to take reasonable care to avoid acts or omissions which could reasonably be foreseen to cause injury or harm. This includes taking appropriate steps to identify, assess and manage allergy-related risks and to respond appropriately in the event of an allergic reaction.

This guidance will therefore be of relevance to early years settings and post-16 institutions and should be treated as good practice for these settings.

Expiry or review date

This guidance will be kept under review and updated as necessary.

The Government intends to introduce additional allergy safety requirements through Regulations and will place equivalent requirements on independent schools and non-maintained special schools through the relevant regulatory standards. The guidance will be reviewed and updated to reflect these changes.

Key points

Schools, colleges and early years settings should have a dedicated **allergy safety policy**. A named senior leader should be responsible for the policy, which should be reviewed at least annually and published. The allergy safety policy should set out:

- how the school, college or setting will **identify** children and young people with allergy and **minimise the risks of exposure** to known allergens, including **managing the risk of food allergy**;
- how staff will be **trained** in allergy awareness and emergency response; how individuals at risk of anaphylaxis will have **access** to their prescribed adrenaline devices, alongside **"spare" adrenaline devices**;
- how children and young people with allergy will be able to participate in **visits and trips**;
- how **Individual Healthcare Plans** will capture specific arrangements (including any Allergy Action Plan and/or Asthma Plan); and
- how the **wellbeing** and **inclusion** of children and young people with allergy will be promoted.

Any child or young person whose allergy will require the school, college or early years setting to put supportive arrangements in place should have them captured through an **Individual Healthcare Plan**. Individual Healthcare Plans set out what needs to be done to support a specific child or young person with an allergy, how, when and by whom, including in an emergency. Individual Healthcare Plans should be developed in collaboration with the child or young person and their parents, taking account of any advice received from healthcare professionals.

Where **serious incidents or "near misses"** occur involving a child or young person with an allergy, the incident should be recorded. It should be reported to the child or young person's parents and the governing body alongside any statutory reporting. Following investigation, lessons should be learned from any serious incident or "near miss", prompting a review of the relevant policies and arrangements.

Allergy safety

Allergy is a medical condition in which the body reacts to normally harmless substances, such as a food, insect sting, contact allergen (e.g. nickel) or an airborne allergen such as pollen. Many individuals with allergies to food or insect stings are at risk of anaphylaxis, a reaction that can progress rapidly and may cause death. Anaphylaxis typically affects the Airway/Breathing/Circulation ("ABC").

It is essential that schools, colleges and early years settings take steps to reduce the risk of individuals being exposed to their known allergens, in order to reduce the risk of a reaction. Around one in five children and young people with allergy have their first allergic reaction while in their school, college or early years setting. Therefore, it is not sufficient only to organise allergy safety measures around children and young people with known allergy. All staff in schools, colleges and early years settings must be able to recognise anaphylaxis and know how to treat it. Schools, colleges and early years settings must have robust emergency response plans. This should include being able to administer adrenaline while awaiting the arrival of emergency services. Schools (though not colleges or early years settings) are permitted to stock "spare" adrenaline devices for emergency use, and should do so.

Allergic conditions

Common allergic conditions include:

- **Hay Fever (Allergic Rhinitis)**, triggered by allergens carried in the air ("aeroallergens"), such as pollen, house dust mite, animal fur/feathers, or mould. Symptoms include sneezing, a runny or stuffed nose, itchy or watery eyes.
- **Skin allergies** (e.g. eczema, contact dermatitis, contact urticaria/hives) caused by contact with allergens including house dust mite, pollen and substances like nickel, latex and some chemicals. Symptoms include itching, hives and dry, flaky skin. Reactions can be delayed, occurring many hours after contact.
- **Food allergy**, which can cause symptoms ranging from mild itching in the mouth to "whole body" reactions including anaphylaxis (see below). Some food allergies do not cause immediate reactions, but result in delayed gastrointestinal symptoms (e.g. stomach pain, vomiting, diarrhoea) some hours later, sometimes occurring with an eczema flare. While 90% of food allergic reactions are caused by peanut/tree nuts, cow's milk, egg, wheat, fish/seafood and sesame, any food can cause an allergic reaction.
- **Asthma** in children is usually allergic in nature, meaning that it may be triggered by airborne allergens such as e.g. dust mite, animal dander or

pollen. On average, there are two or three children with asthma in every classroom in the UK.
- Less common allergic conditions in children include allergy to **insect stings** (e.g. bee, wasp) and **medicines**.

Allergic reactions vary in severity: from mild local reactions (e.g. mild hay fever) to "whole body" reactions (common with food allergy) to more serious reactions like anaphylaxis. In general, most allergic reactions are not severe. Even for food allergy, most allergic reactions do not affect the Airway/Breathing/Circulation ("ABC") and can be treated with a non-drowsy oral antihistamine (available over-the-counter for those aged over 6 years) or local treatments such as nose sprays or eye drops. However, some children and young people are at risk of anaphylaxis and require emergency medication (e.g. self-administered adrenaline).

The most common causes of "whole body" allergic reactions – including anaphylaxis – are:

- food allergens;
- insect stings (e.g. bee, wasp);
- medication (e.g. antibiotics, pain medicines such as ibuprofen);
- latex (e.g. rubber gloves, balloons, swimming caps).

Even for food allergy, the vast majority of anaphylaxis reactions require the person to have eaten the food, although less severe allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare.

Rarely, anaphylaxis may occur without obvious exposure to an allergen, for example, after exercise or in people with an underlying "mast cell" disorder such as mast cell activation syndrome (MCAS). Such individuals should have a personalised plan provided by a healthcare professional to assist the school/educational setting.

What types of allergy are in scope

Allergy is a spectrum of different allergic diseases. Reactions occur when a susceptible person is exposed to something (an "allergen") they are allergic to. Asthma, food allergy, eczema and seasonal rhinitis (hay fever) are all forms of allergy.

Schools, colleges and early years settings will need to consider what arrangements should be put in place to support children and young people with allergy, for example:

- Children and young people with food allergy

- Children and young people at risk of anaphylaxis (usually allergic to food or bee/wasp sting)
- Children and young people with allergic rhinitis (hay fever), allergic eye disease or eczema, who may need to be given treatments for their condition in school (e.g. eczema creams, nasal sprays, eye drops), particularly if they have more severe allergic disease or need adaptations e.g. with sport
- Children and young people with eczema or asthma, who may need additional precautions (e.g. avoiding sand pits, some swimming pools)
- Children and young people with more severe allergy to animal fur, who may need to take avoidance measures (e.g. exposure to pets in school, visits to petting zoos)

Some children and young people have medically recognised sensitivities or triggers which may not meet the clinical definition of allergy but may nonetheless result in serious or potentially life-threatening reactions (for example mast cell disorders or other systemic hypersensitivity conditions). Any known trigger with the potential to cause significant harm should be identified and managed. In such scenarios, the relevant healthcare professional should provide them with a medical letter explaining potential triggers to be avoided, and how to manage any reaction.

Allergy and the Equality Act

The Equality Act 2010 places statutory duties on schools, local authorities and other education providers, intended to prohibit discrimination and promote equality for all including those who are disabled. Under the Act, a person is disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal day-to-day activities. Case-law (Wheeldon v Marston's plc ET/1313364/2012) has established that severe allergy can fall within this definition. Seasonal rhinitis (such as hay fever) is explicitly excluded from the definition of disability, unless it aggravates the effect of another health condition.

Asthma

Asthma is the most common long-term condition among children and young people and one of the leading causes of school absence. Asthma remains among the top 10 causes of emergency hospital admissions among children and young people in the UK. There were 54 child deaths due to asthma and 19 from anaphylaxis between April 2019 and March 2023, as set out in the National Child Mortality Database Report on Asthma and Anaphylaxis. All of the children who died from anaphylaxis

and had known allergies were also diagnosed with asthma. All of the children who died due to asthma were exposed to air pollution above WHO guidelines.

Asthma exacerbations are typically precipitated by identifiable triggers. In individuals with allergic asthma, exposure to airborne allergens such as pollen, house dust mite debris, pet dander and mould spores is a common trigger of worsening symptoms and exacerbations in sensitised people. Viral respiratory infections (such as rhinovirus, flu, RSV, and COVID-19), allergen exposure, and air pollution are recognised as among the most common contributors to acute asthma exacerbations, with evidence of synergistic interactions that can increase severity in sensitised children. Exercise and cold air can also cause symptoms. Common symptoms include coughing, wheezing and breathlessness out of proportion to effort, and a tight chest. An asthma attack occurs when symptoms are severe, and breathing becomes difficult.

Poor air quality worsens asthma and increases asthma attacks, and those in deprived areas with poorer nutrition suffer increased negative health effects from poor air quality. Clean air is a core asthma control measure. Good ventilation, air quality monitoring and supplemental HEPA air filtration are essential, especially when ventilation is limited and outdoor air is polluted. Systematically integrating and embedding clean indoor air into legal health and safety duties, policies, procedures and practices will reduce pressure on staff and ensure consistency and support without too much extra work.

Children and young people known to have asthma should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them. In some cases children and young people with suspected asthma will be prescribed a reliever inhaler before they receive a formal diagnosis.

Following amendment in 2014, the Human Medicines Regulations 2012 permit schools to buy an emergency asthma reliever inhaler (salbutamol inhaler device and spacer), without a prescription, for use in emergencies. The inhaler can be used if the child or young person's prescribed inhaler is not available (for example, because it is broken or empty). Guidance is available on Emergency asthma inhalers for use in schools. It is recommended that schools keep emergency asthma reliever inhalers alongside "spare" adrenaline devices.

Further information is available through Asthma schools posters – Asthma + Lung UK, including information on asthma action plans.

Coeliac disease

Coeliac disease is an autoimmune condition where the small intestine (gut) is hypersensitive to gluten in wheat and other gluten-containing grains (e.g. rye, barley). It is not an intolerance. Consuming gluten can cause significant illness (including abdominal pain and vomiting shortly after eating) which may be prolonged and result in absence from school for several days. Repeated exposure to gluten carries serious long term health risks. However, such events are not “allergic” and should not be treated as an allergic reaction. Coeliac disease cannot cause anaphylaxis, although anaphylaxis can occur in some with coeliac disease if they also have an allergy.

Effective management of coeliac disease depends on strict and consistent avoidance of gluten and robust cross-contamination controls – similar to the measures needed for a child or young person with food allergy to wheat.

Schools, colleges and early years settings need to support children and young people with coeliac disease, normally through dietary avoidance. This will be arranged as part of the school, college or setting’s wider medical conditions policy and would not fall in scope of the allergy safety policy.

Food intolerances

Food intolerance is a non-immune system reaction where the body struggles to digest specific foods, causing symptoms like abdominal pain, bloating and diarrhoea for hours or days after eating. Unlike food allergies, intolerances cannot cause anaphylaxis. They are usually managed by identifying specific triggers, for example lactose intolerance or non-coeliac gluten sensitivity.

Schools, colleges and early years settings need to support children and young people with food intolerance, normally through dietary avoidance. This will be arranged as part of the school, college or setting’s wider medical conditions policy and would not fall in scope of the allergy safety policy.

Allergic reactions

Allergic reactions occur when a susceptible person is exposed to something (an “allergen”) they are allergic to. Most allergic reactions do not affect the **A**irway/**B**reathing/ **C**irculation (“ABC”) and can be treated with an oral antihistamine. The features of an allergic reaction are shown in Figure 2.

Allergic reactions are unpredictable. Most reactions do not result in anaphylaxis. However, when anaphylaxis occurs, reactions usually start off as less severe (e.g.

skin rash, vomiting) but then become anaphylaxis – so someone having a reaction should always be monitored (e.g. in a first aid room) for at least 60 minutes afterwards, just in case the reaction gets worse.

Symptoms of a mild to moderate allergic reaction (not anaphylaxis) include:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Mild throat tightness
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Mild reactions can worsen and become **anaphylaxis**, affecting the **A**irway/**B**reathing/**C**irculation ("ABC"):

Figure 1: SIGNS OF ANAPHYLAXIS (a potentially life-threatening allergic reaction)

- **A: Airways**: Swelling in the throat, tongue or upper airways (tightening in the throat, hoarse voice, difficulty swallowing)
- **B: Breathing**: Sudden onset wheezing, breathing difficulty, persistent cough, noisy breathing
- **C: Circulation**: Dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness

Anaphylaxis reactions involve the **A**irway/**B**reathing/**C**irculation ("ABC"). Reactions usually progress quickly and can be life-threatening – so anaphylaxis **always** requires an immediate emergency response. The features of an anaphylaxis reaction are shown in Figure 2.

The vast majority of anaphylaxis reactions require the individual to have eaten food to which they are allergic. Contact through skin or the air tends to produce less

severe allergic reactions. Anaphylaxis reactions solely due to skin contact are very rare. As noted above, anaphylaxis may rarely occur without a clearly identified allergen or without ingestion of a food trigger. Emergency planning should therefore be based on the individual child or young person's documented triggers and clinical history, rather than any assumption over whether the person has eaten a trigger food.

Anaphylaxis

Anaphylaxis reactions to food usually begin within 30 minutes of eating the trigger food, but can sometimes occur 4-6 hours later (e.g. allergy to mammalian meat). They typically affect the breathing (**A** and **B**, i.e. mimic an asthma attack) rather than the **C**irculation (blood pressure).

Once started, anaphylaxis reactions progress quickly. Investigations into fatal anaphylaxis show that **there is only a 20–30-minute window of opportunity during which steps can be taken to prevent death**. Giving emergency adrenaline **immediately** and calling Emergency Services (999) is essential. **Anaphylaxis always requires an emergency response**.

Anaphylaxis can occur without any other signs (such as a skin rash) being present. **Always consider anaphylaxis in someone with a known food allergy who has sudden difficulty in breathing.** Giving adrenaline in this context is very safe and may be lifesaving.

Figure 2: Management of anaphylaxis

Responding to an allergic reaction and anaphylaxis

Mild to moderate allergic reactions which do not involve **A**irway/**B**reathing/**C**irculation can be treated with oral antihistamines. For a child or young person, telephone their parent or emergency contact to tell them about the reaction. Do not leave the child or young person unattended. The child or young person does not normally need to be sent home or require urgent medical attention. They should be observed in a safe place for at least 60 minutes after reaction, as mild reactions can sometimes develop into anaphylaxis.

Anaphylaxis commonly occurs alongside mild symptoms or signs, such as an itchy mouth or skin rash. Anaphylaxis can also occur on its own, without a skin rash or other mild signs being present.

Anaphylaxis (i.e. any reactions which involve the **A**irway/**B**reathing/**C**irculation) must be treated promptly with emergency adrenaline (see figure 2). The individual's prescribed adrenaline device – for example an adrenaline auto-injector (AAI) or nasal adrenaline device – should be used if it is available. If not, a "spare" adrenaline device can be used (see below). If in doubt whether the reaction is anaphylaxis, treat with adrenaline. Always dial 999 to request an ambulance if someone is experiencing anaphylaxis. The emergency ('999') operator can provide advice over the telephone if needed.

Always stay with someone having an allergic reaction for at least one hour.

- **If in doubt, always treat for anaphylaxis**
- If the child or young person has a Allergy Action Plan issued by a healthcare professional, it should be followed
- Treatment of anaphylaxis is with a dose of adrenaline (e.g. an AAI "pen" or nasal adrenaline device)

Action in an emergency

If an individual (whether a child, young person, member or staff or visitor) experiences a life-threatening medical emergency, **anyone – staff, volunteers or bystanders – may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure**.

People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis.

Staff in schools, colleges and early years settings should be reassured that mistakes, hesitation, or imperfect technique do **not** amount to serious and wilful misconduct. The expectation is simply that staff act reasonably, to the best of their ability, in an emergency.

Food allergy and asthma

Many food-allergic children also have asthma. "Wheeze" is a common symptom of asthma and also happens during food-induced anaphylaxis. The Allergy Action Plan

may include instructions to give a reliever medicine (e.g. using a salbutamol inhaler) **after** giving a dose of adrenaline if the person is still wheezing. Many schools keep an emergency asthma reliever inhaler containing a salbutamol inhaler device and spacer. The Department of Health and Social Care (DHSC) has published guidance on Emergency asthma inhalers for use in schools. **Never give the reliever inhaler instead of adrenaline to treat anaphylaxis.**

Learning from anaphylaxis deaths in schools

One in five anaphylaxis deaths among school-aged children in the UK happen in school. Key learnings from these events are listed below.

- Always give adrenaline immediately to treat anaphylaxis. **If in doubt, give adrenaline.** Delays in giving adrenaline are associated with fatal outcomes.
- NEVER let a person having anaphylaxis stand or walk around: always bring help and medicines to the person, and not the other way round.
- Always dial 999.
- Give a further dose of adrenaline if there is no improvement after 5 minutes.
- If someone known to have asthma and food allergy suddenly gets difficulty in breathing, always consider anaphylaxis. Giving adrenaline in this context is very safe and may be lifesaving.
- Children and young people may be at risk of anaphylaxis while travelling to or from school, college or their early years settings. If they have been prescribed adrenaline devices, they should carry these devices with them at all times, including while travelling to or from school.

Managing allergy safety policies

Governing bodies, academy trusts and proprietors are responsible for ensuring the school, college or early years setting has an allergy safety policy which sets out the arrangements to reduce the risk of individuals coming into contact with their known allergens (e.g. food or contact allergens) and sets out emergency response plans for cases of anaphylaxis. Risks relating to children and young people with allergy should be included on the school, college or setting's risk register and actively managed by the governing body.

Section 34 of the Children's Wellbeing and Schools Act 2026 requires that LA-maintained schools, academies and PRUs must have an allergy safety policy. *The Government intends to require independent schools and non-maintained special schools to have an allergy safety policy through the relevant regulatory standards.*

A named member of the senior leadership team in each school, college or early years setting should have responsibility for allergy safety, including driving the implementation of the allergy safety policy and contributing to or leading review of the policy. Responsibility for allergy safety should not be left with a catering manager. While schools do not need to have a named governor overseeing allergy safety, some schools do so as a matter of good practice.

The Government intends to introduce a statutory duty for schools to have a named senior leader responsible for allergy safety through forthcoming Regulations.

In the case of academy trusts and similar groups of schools or settings, the trust is responsible for the allergy safety policy in its capacity as the governing body. Each individual academy should have a named allergy safety lead, responsible for implementation of the policy in their school. Trusts should determine how oversight is exercised in individual schools, ensuring that this is clearly set out within the scheme of delegation and enables effective monitoring, support, and challenge.

Producing and reviewing allergy safety policies

Allergy safety policies should be reviewed at least annually. Policies can be reviewed more frequently, particularly where incidents or "near misses" suggest areas for improvement. Any review should take account of any incidents and "near misses" and should seek to learn lessons from them. This is essential where incidents suggest that policies or procedures may leave individuals with allergy at risk.

Schools, colleges and early years settings should involve individuals with allergy (whether children, young people or staff) in developing and reviewing the allergy safety policy.

The Government intends to introduce a statutory duty for schools to review their allergy safety policy at least annually and to consider reviewing it following any serious incident or near-miss through forthcoming Regulations.

A template allergy safety policy is available.

It is good practice for schools, colleges and early years settings to conduct allergy safety drills, in the same way as fire drills or in an active training exercise. A simulated case of anaphylaxis can be used to test out how staff respond, without risk to any individual. The results of the drill should be recorded in a similar way to an incident or "near miss" and used to inform the ongoing review of the allergy safety policy. In some cases, it may be appropriate to include children and young people in such tests, for example where one of their peers has a high risk of anaphylaxis. If so, the child or young person should be involved in the planning of the drill to avoid a negative impact on their wellbeing. This can support the person at risk of anaphylaxis and provide reassurance to them and their family.

Publishing safety policies

Governing bodies should ensure that allergy safety policies are readily accessible to parents and staff. Policies should be published on the school, college or setting's website and be made available in hard copy on request.

The Government intends to introduce a statutory duty for schools to publicise their allergy safety policy to pupils, staff and parents and to publish it on their website through forthcoming Regulations.

Allergy safety policies and inspection

Inspectors will consider medical conditions and allergy safety policies and how well they are implemented as part of the inspection process. In gathering evidence about the management of safeguarding, inspectors may consider the extent to which leaders have made arrangements to support pupils with medical conditions and have a dedicated allergy safety policy.

Supporting children and young people to manage their allergy

Schools, colleges and other educational settings should help children and young people to understand how to manage their allergy, and ultimately, how to take responsibility for doing so themselves. They should be allowed and encouraged to carry their own medication and adrenaline devices where appropriate, or to be aware of where they can be found. Children and young people who are able to self-manage their allergy may nonetheless need an appropriate level of supervision and support.

Decisions about self-management should be made on an individual basis, in discussion with the child or young person, their parent and, where appropriate, relevant healthcare professionals. This will depend on the child or young person's competence, understanding of their allergy, level of risk and local safeguarding considerations. The child or young person's safety and best interests should always be of primary concern.

Unacceptable practice

Governing bodies should ensure that a school, college or early years setting's allergy safety policies are explicit about what practice is not acceptable. Examples of unacceptable practice include (but are not limited to):

- preventing children and young people from easily accessing their medication (for example prescribed adrenaline devices);
- ignoring the views of the child or young person or their parents or carer;
- ignoring medical evidence or the opinion and advice of healthcare professionals;
- assuming that every child or young person with allergy requires the same support;
- assuming that older children and young people do not require support, even if they are able to take increasing responsibility for managing their allergy;
- assuming that a child or young person does not have an allergy because they do not yet have a diagnosis, for example while medical investigation is under way;
- discriminating against children or young people with allergy by sending them home frequently for reasons associated with their allergy or prevent them from staying for normal school activities or extracurricular activities, including lunch;
- sending a child or young person who becomes unwell to a school office or medical room without suitable supervision. In the case of an allergic emergency (e.g. anaphylaxis), help must come to the child or young person rather than the other way round;
- penalising children or young people for their attendance record if their absences are related to their allergy, e.g. hospital appointments and health management. This includes excluding children and young people from rewards for 100% attendance where their non-attendance is the result of a medical condition or allergy. This should be reflected in attendance policies;
- requiring parents / carers (or otherwise making them feel obliged) to attend the school, college or setting to administer medication or provide medical support to their child;

- parents and carers should not have their work or other responsibilities impacted because the school, college or setting is failing to support their child's allergy; and
- preventing children and young people from participating, or creating unnecessary barriers to them participating, in any aspect of school, college or setting life, including external visits and trips, e.g. by requiring parents to accompany the child.

Sources of support

A template allergy safety policy and Individual Healthcare Plan for allergy is available on Gov.uk.

The British Society for Allergy & Clinical Immunology (BSACI) is the national, professional and academic society which represents the specialty of allergy. It has created www.spareadrenalineinschools.uk in conjunction with DHSC, DfE and members of the National Allergy Strategy Group (NASG), including patient organisations. The website brings together relevant information, advice for schools, teachers, parents and young people, together with Allergy Action Plans and other resources.

In addition, free resources including example allergy safety policies and example Individual Healthcare Plans, can be found at Allergy Training and Support for Schools, Allergy School: Teaching Children About Food Allergies and AllergyWise in Education.

What an allergy safety policy should contain

An allergy safety policy will set out how the school, college or setting will ensure children and young people with allergy are both enabled and supported to attend as fully as possible, and to participate as fully as possible in all aspects of life in the school, college or setting, including trips and extracurricular activities, and the role played by all staff in doing so.

Schools must have regard to this statutory guidance in fulfilling their duty to produce an allergy safety policy. We expect that schools' allergy safety policies should cover the following areas:

Theme	Policy area	Content
Culture	Awareness training	How staff will be **trained** in allergy awareness and emergency response, for both anaphylaxis and acute asthma
Culture	Wellbeing	How the **wellbeing** of children and young people with allergy will be promoted. What strategies will be used to recognise when **bullying** of children and young people with allergy is happening, and how this will be addressed
Culture	Minimising risk	How the school, college or setting will take reasonable steps to **minimise the risks of exposure** to known allergens
Culture	Food allergy	How the school, college or setting will **manage the risk of food allergy** and provide clear information on allergens in food provided
Individual children and young people	Identification	How the school, college or setting will **identify** children and young people staff and visitors with allergy (in particular food allergy and/or asthma)
Individual children and young people	Individual Healthcare Plans	How children and young people with allergy who require specific support arrangements will have them documented through an **Individual Healthcare Plan**
Individual children and young people	Prescribed adrenaline	How individuals at risk of anaphylaxis and/or asthma will have **access** to their prescribed adrenaline devices and/or asthma inhalers
School-wide policies	Spare adrenaline devices	How the school, college or setting will stock, store and use **"spare" adrenaline devices** and asthma inhalers, ensuring they remain in date
School-wide policies	Visits and trips	What arrangements and adjustments will be put in place to ensure children and young people with allergy are able to participate in **visits and trips**, and do so safely (including access to emergency medication where required)
School-wide policies	Serious incidents and "near misses"	How **serious incidents and near misses** will be identified. How information from parents and carers on serious incidents and near misses will be taken into account
School-wide policies	Information	How **information** will be shared about children and young people with allergy
School-wide policies	Awareness of the allergy safety policy	How the policy will be **communicated** to staff, children and young people and parents How the policy will be **published**

A template allergy safety policy is available. Further guidance is provided below.

Allergy awareness training

An allergy safety policy should set out arrangements for whole-school allergy awareness training, so that staff receive regular (at least annual) allergy awareness training.

All staff present during times when pupils are scheduled to be on site should receive allergy awareness training. This includes permanent staff, temporary staff, supply teachers, peripatetic staff, agency workers and regular volunteers. It includes catering staff and others who may oversee children and young people at breakfast or after school clubs. It is not intended to include contractors carrying out work with no pupil-facing role such as builders, electricians or other ad hoc maintenance personnel.

The Government intends to introduce a statutory duty for schools to ensure all staff receive regular allergy awareness training through forthcoming Regulations.

Schools must have regard to this statutory guidance in fulfilling their duty to produce an allergy safety policy. First aid training is not sufficient. We expect that allergy awareness training should ensure all staff:

- Have an **awareness** of allergy, the risks it poses, how allergic reactions can occur and how to manage it;
- Understand that allergy includes multiple conditions (food allergy, asthma, eczema, hay fever, others), which can co-exist;
- Understand the difference between food allergy, coeliac disease and food intolerance;
- Know where to find information on **allergy triggers**;
- Can identify the range of **symptoms** of allergic reactions;
- Understand and can recognise **anaphylaxis**;
- Know how to respond in an **emergency**, including:
    - calling emergency services and informing parents;
    - how to locate and administer emergency medication (adrenaline for anaphylaxis, asthma reliever inhaler for an asthma attack).
    - training on how to use the medication/device in an emergency (whether prescribed to a given person or a school's "spare" adrenaline devices);
- Understand the **impact** allergy can have on a child or young person's wellbeing;
- Understand the school, college or setting's **allergy safety policy**;

- Know how to check whether an individual is on the record of those with known allergy and how to use an Allergy or Asthma Action Plan;
- Understand their **responsibilities** in reducing the risk of individuals with known allergy coming into contact with their known allergens;
- Understand how to **report** an allergic reaction or case of anaphylaxis (whether an incident or a “near miss”).

Training under this guidance should be understood as allergy awareness and emergency response training. It should not be read as replacing any separate clinical governance, competency or delegation arrangements that may be needed where a child or young person requires individual healthcare support beyond school-level allergy safety arrangements.

The allergy safety policy should set out induction arrangements for new staff, as well as arrangements to ensure supply and cover staff have received allergy awareness training.

Wellbeing of children and young people with allergy

The allergy safety policy should set out how the wellbeing of children and young people with allergy should be supported. Many children and young people with allergy become anxious as a result of the risk of exposure to allergens and the potential for anaphylaxis, which may be compounded by living with difficult-to-control asthma or eczema. The school, college or setting should be active in providing support, both in providing reassurance that steps are being taken to minimise the risks of exposure to allergen and that robust measures are in place in the event of anaphylaxis.

The allergy safety policy should set out measures to prevent and respond to bullying related to allergy. Bullying can range from excluding peers from activities by deliberately using known allergens, to denigrating or making fun of the need to avoid allergens – and even threats to force-feed known allergens. This contributes to higher levels anxiety among children and young people with allergy, not least since they may already feel singled out or different by virtue of the arrangements in place to support them (e.g. at meal times).

Examples of good practice include:

- Regular communication to children, young people, parents and staff about allergy, ensuring ongoing awareness and appreciation of the severity of the potential risks.
- Proactive engagement with new joiners with known allergy, setting out the school, college or setting’s policies and the support available.

- Inviting new joiners with allergy to have a tour of the kitchen and canteen so they can meet staff and get used to the mealtime environment. This may reduce anxiety and helps everyone to get to know one another, which will support staff to identify children and young people with allergy, intolerances and coeliac disease in the dining hall.
- Introducing “allergy champion” roles for staff and students (not just within the catering team). Acting as a point of contact for children, young people and staff with allergy, they can share feedback and support new joiners or anxious children and young people.

Schools, colleges and early years settings should involve individuals with allergy (whether children, young people or staff) in developing and reviewing these arrangements.

Minimising risks of exposure to known allergens

The allergy safety policy should set out how the school, college or setting will minimise the risk of individuals (whether children, young people, staff or visitors) coming into contact with their known allergens. This should include:

- Measures to manage the risks of exposure to a food allergen through food provided by the school, college or setting.
- Measures to manage the risks of exposure to a food allergen through food brought in by others (for example parents, children and young people or staff).
- Where children and young people have known allergy to airborne or contact allergens, how the school, college or setting will put reasonable measures in place to manage the risk of the child or young person being exposed to such allergens.
- An expectation that staff planning any activity should consider the risk of exposure to allergens, for example in craft, science, musical or cooking activities, or where activities involve animals.
- Specific risk assessments to manage the risks of exposure to allergens in individuals with an allergy when planning external visits or trips.

Children and young people should not be prevented from taking part in activities alongside their peers simply because of a risk of coming into contact with one of their allergens. Where an activity would involve most children and young people using a material which might contain an allergen known to affect one of the group (for example), alternatives will need to be found for the whole group which do not exclude individuals. Staff should consider:

- old food boxes or packaging may contain traces of allergens;

- some products contain wheat flour, including ”play dough”;
- some glues contain milk, wheat or soya;
- bird feed may contain nuts and sesame.

Reducing the risk of allergen exposure in children with food allergy

- Bottles, other drinks and lunch boxes provided by parents or the school for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- **School caterers** must provide information on food allergens to parent/carers, and have this available for the child to be able to check independently. Catering staff should be available to meet with parents/carers to discuss provision of allergen safe meals.
- **Leaders** need to be aware of, and engage with, caterers to understand the controls in place to ensure that food service conforms with legislation.
- Where food is provided by the school, **school staff** should be educated about how to read labels for food allergens and instructed about measures to prevent cross-contamination during the handling, preparation and serving of food. Examples include: preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Where food is not directly provided by the school (e.g. brought in as treats or to celebrate birthdays) parental engagement and permission should be sought in advance to ensure inclusion and safety for children with allergy.
- Implement policies to avoid trading and sharing of food, food utensils or food containers.
- Unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary ("may contain") labelling suggesting a risk of contamination with allergen. This applies to foods used within the classroom curriculum (e.g. cooking) as well that from the school kitchen or canteen.
- Use of food in crafts, cooking classes, science experiments and special events (e.g. fetes, assemblies, cultural events) needs to be considered and alternatives used when needed.
- In arts/craft, an appropriate alternative ingredient should be substituted (e.g. wheat-free flour for play dough or cooking). Food containers (egg cartons, yoghurt pots etc) can also be contaminated with food: use alternative, non-food containers for craft activities, where possible. If essential to the activity, e.g. junk modelling, ensure that all materials used are free from any allergens that might pose a risk for a specific child.
- When planning out-of-school activities such as sporting events, excursions (e.g. restaurants and food processing plants), school outings or camps, think early about the catering requirements of the child with food allergies and emergency planning (including access to emergency medication and medical care).

“Nut free” policies

Some schools, colleges or early years settings adopt policies such as “nut-free” environments. This is not the most effective approach as it can create a false sense of security. Nuts are only one of a number of food allergens, all of which can have serious consequences for individuals. Allergen guidance for food businesses identifies fourteen key food allergens which cause over 90% of reactions, but any food can cause an allergic reaction. Many foods do not contain nuts as an ingredient, but may carry a precautionary allergen labelling, for example “may contain nuts”, which causes confusion and can make such policies difficult to implement. For this reason, we recommend an “allergy aware” (e.g. “nut-aware”) environment rather than a “nut-free” policy.

While schools, colleges or early years settings may wish to discourage certain foods being brought on site, it is more important to remain actively aware of the risk posed by allergens, take steps to minimise the risk of exposure and to have robust emergency response plans in place.

Air quality

Air pollutants, both outdoors and indoors, can trigger allergies, asthma, and other respiratory illnesses. An explanation of air pollution and the associated health impacts can be found at Air pollution: applying All Our Health. Schools, colleges and early years settings should consider both environmental air quality and infection prevention measures as part of their wider health and safety responsibilities.

Food provision

The allergy safety policy should set out how the school will manage the risk of food allergy and provide clear information on allergens in food provided.

Where children and young people require reasonable adjustments relating to food (for example avoiding specific foods), these should be captured through an Individual Healthcare Plan.

The Requirements for School Food Regulations 2014 (known as ‘The School Food Standards’) regulates the food and drink provided at breakfast service, lunchtime and across the school day. Compliance with the School Food Standards is mandatory for maintained schools, academies and free schools. Whilst schools must adhere to the School Food Standards, we expect schools to make reasonable efforts to cater for pupils with medical conditions, including food allergies and

hypersensitivities. Headteachers and governors should work with caterers, parents and pupils to ensure risks are identified, minimised and managed effectively so that individuals with allergy and hypersensitivities can be fully included in meals.

It is good practice to have at least two robust methods of identifying children and young people with known allergy at mealtimes to ensure they receive a safe meal, for example a member of staff checking who the children or young people with allergy are, or children and young people wearing coloured lanyards or photographs alongside details of their allergy in the kitchen or serving area. The identification methods chosen will depend on the size of the school and the age of the children and young people. It is important to balance safety and inclusion. Children and young people with food allergies should not be segregated from their peers at mealtimes (e.g. by being required to sit at a separate table). Children and young people with allergy and food hypersensitivities should be able to enjoy school meals alongside their peers, with any risks managed effectively.

Schools may substitute items from their usual menus if certain items are in short supply. If menus need to be adapted at short notice, the needs and safety of children and young people with food allergies and hypersensitivities, and statutory allergen requirements, must still be met and changes should be highlighted.

Food brought from home, such as packed lunches or food used in food technology lessons, should also be considered when developing approaches to allergy safety. Clear expectations should be set for children, young people and parents on ensuring lunchboxes and classroom ingredients are clearly labelled, prepared and stored safely. With regards to packed lunch policies, while schools, colleges or settings may wish to discourage certain allergens (for example, nuts) being brought on site it is more important to remain actively aware of the risk posed by allergens and to have robust emergency response plans.

Statutory requirements relating to food allergy

There are a number of statutory requirements relevant to food allergy:

- The Food Information Regulations 2014 require all food businesses, including school and college caterers, to provide information about the 14 regulated allergens present in the food they serve. This makes it easier for schools, colleges and early years settings to identify the food that children and young people with allergy can and cannot eat. An amendment in 2021 ("Natasha's Law") requires that any food which is pre-packed for direct sale (PPDS), i.e. freshly prepared and then packaged and displayed before being sold, must be labelled with a full ingredients list and clearly emphasise any of the 14 mandated allergens.

- **EU Regulation 828/2014** (assimilated into UK law) mandates that food labelled “gluten-free” must contain 20 parts per million (ppm) or less, while “very low gluten” is restricted to 100 ppm or less. These standards apply wherever such claims are made, including on prepacked foods and, where used, on non-prepacked foods, and are relevant for the safe provision of food for individuals with gluten intolerance and coeliac disease.

- Schools, colleges and early years settings that operate as **food businesses** should record and review all allergen incidents and near-misses and seek advice from their local authority environmental health team or Primary Authority where appropriate. A legal duty to notify competent authorities arises where a food business has reason to believe that unsafe food (for example, food that is injurious to health, such as food containing an undeclared allergen) has left its immediate control and may pose a risk to consumers, in line with Article 19 of Regulation (EC) 178/2002. In practice this will depend on whether there is potential for wider consumer exposure beyond a single, contained incident. Where an issue is isolated and there is no ongoing risk to other consumers, formal notification is unlikely to be required. For example, this may include situations where a meal is provided in error but immediately identified and contained, although this will depend on the circumstances of the individual case. Further information can be found at Report a food problem and Food incidents, product withdrawals and recalls.

Schools, colleges and early years settings are considered “food businesses” when supplying food. The requirements therefore apply to **all food they provide to children and young people**, whether it is prepared on site or sourced from a third party. Schools, colleges and early years settings must also ensure that parents and carers of children with food allergies or intolerances are provided with information about relevant allergens and, where appropriate, ingredients used in the foods available. Allergen information must be clearly provided and be easily accessible to pupils and their parents or carers.

- **Food that is prepacked for direct sale (PPDS)** (for example, items prepared and packaged on site before being selected) must be labelled with the name of the food, a full ingredients list, and any of the 14 regulated allergens clearly emphasised within that list.
- **Non-prepacked food** (food that is not packaged before it is selected, such as meals served in a canteen or food made to order) must have information provided about the presence of the 14 regulated allergens. This information must be clear, accurate and easily accessible to pupils and their parents or carers.

Food supplied on school premises will only be covered by food information law if it is supplied by a "food business" (that is, where food is provided on a regular and organised basis, such as by the school itself or an on-site caterer, including provision through breakfast or after-school clubs). Food provided on a more occasional basis, such as by a parents' association at events or cake sales, is unlikely to fall within scope. However, as good practice, clear information about potential allergens should be provided for any food brought in by others.

Further guidance is available from the Food Standards Agency on Allergen Information for Non-Prepacked Foods Best Practice, Allergen guidance for food businesses and Prepacked for direct sale (PPDS) allergen labelling changes for schools, colleges and nurseries. Providers may also find the FSA allergen checklist for food businesses helpful, as it is widely used in education catering to support day-to-day allergen management, cross-contact controls and staff training.

Free school meals

Pupils may be eligible to receive free meals under the Department for Education's benefits-based and universal infant free school meals policies.

For pupils entitled to Free School Meals, schools are required to make reasonable adjustments to enable pupils with allergy to access their free school meal entitlement, as part of their duty under section 100 of the Children and Families Act 2014 to "make arrangements for supporting pupils at their school with medical conditions" (which includes allergy).

Schools are best placed to determine the exact nature of a reasonable adjustment in relation to food provision, taking into account the individual circumstances of the child and their family, as well as the school's obligations under the School Food Standards. Schools should work with their caterer, the pupil and their family, and any other professionals involved, to agree the necessary support. Reasonable adjustments should be captured through an Individual Healthcare Plan.

Safer eating and the Early Years Foundation Stage (EYFS)

Whilst babies and young children in early childhood settings, such as nurseries, childminders and pre-school settings, are eating there should always be a member of staff in the room with a valid paediatric first aid certificate for a full course consistent with the criteria set out in Annex A of the EYFS.

Before a child is admitted to the setting, the provider must obtain information about any special dietary requirements, preferences, food allergies and intolerances that the child has, and any special health requirements. This information must be shared

by the provider with all staff involved in the preparing and handling of food. At each mealtime and snack time providers must be clear about who is responsible for checking that the food being provided meets all the requirements for each child.

Providers must have ongoing discussions with parents and/or carers and, where appropriate, health professionals to develop Individual Healthcare Plans for managing any known allergy and intolerances. This information must be kept up to date by the provider and shared with all staff. Providers should refer to the child's Allergy Action Plan. Providers must ensure that all staff are aware of the symptoms and treatments for allergy and anaphylaxis, the differences between allergy and intolerances and that children can develop allergies at any time, especially during the introduction of solid foods, which is sometimes called complementary feeding or weaning. Providers should refer to the NHS advice on Food allergy and treatment of Anaphylaxis.

Identifying children, young people, staff and visitors with allergy

The allergy safety policy should set out clear arrangements for identifying individuals with allergy (not just children and young people but also members of staff and visitors, where appropriate), their known allergens and whether they carry medication (for example adrenaline devices). The school, college or setting should keep a record of all individuals with allergy, including whether children and young people have Individual Healthcare Plans and/or an Allergy Action Plan.

The allergy safety policy should set out arrangements for gathering information about known allergy. This may include asking a child or young person, their parents and their previous setting for relevant information, including known allergens and whether the child or young person may require medication (for example prescribed adrenaline). Copies of any Individual Healthcare Plan (from a previous school, college or setting) and/or Allergy Action Plan should be sought. The relevant healthcare professional responsible for the child or young person's allergy management should adhere to the Care Quality Commission requirements around sharing care plans with other providers responsible for care. This should always be in line with local data sharing agreements. The child or young person and their parents should always be involved in decisions about sharing health information.

For children and young people starting at a new school, college or setting, arrangements should be in place in time for the start of the relevant school term. In other cases, such as children and young people moving to a new school, college or setting mid-term, every effort should be made to ensure that arrangements are put in place within two weeks, where it is appropriate for the school to do so. For members

of staff, arrangements should be in place when they commence work. For visitors, information on allergy should be sought in advance of their visit wherever possible.

It is good practice to keep a list of individuals with known allergy (including up to date photos and lists of their known allergens) in places where food may be served or handled (including food technology, science, craft and art classrooms). Such lists should be kept in areas accessible to staff only.

Staff and visitors with allergy

As part of the allergy safety policy, schools, colleges and early years settings should consider how staff and visitors with allergy are identified and supported. The measures intended to keep children and young people with allergy safe will be equally relevant to adults.

It is good practice to ask visitors if they have allergy which the school, college or setting should be aware of, especially if they are likely to be served food.

Individual Healthcare Plans

Children and young people should have an Individual Healthcare Plan (IHP) if:

- they have an allergy which has a functional impact on them in their school, college or setting;
- they are at risk of harm as a result of their allergy **and**
- they require arrangements which are additional to or different from those made generally.

The IHP will set out the additional and/or different arrangements that will be in place in the school, college or early years setting for supporting the child or young person with their medical condition or allergy, including in emergency situations.

The allergy safety policy should set out how children and young people with known allergy will be supported through Individual Healthcare Plans. Where a child or young person has been issued with an Allergy and/or an Asthma Action Plan by a healthcare professional, it should be attached to their Individual Healthcare Plan. Further information is provided on Individual Healthcare Plans.

Allergy and Asthma Action Plans

Children and young people who have a known allergy to a food or insect stings should be issued with an appropriate Allergy Action Plan by their healthcare professional. Allergy Action Plans are medical documents designed to facilitate

emergency response to reactions including anaphylaxis, by people without any special medical training or equipment other than access to an adrenaline device (e.g. adrenaline autoinjector "pen"). The relevant healthcare professional is responsible for determining the content of each child or young person's Allergy Action Plan. The healthcare professional may wish to draw on the British Society for Allergy and Clinical Immunology (BSACI) Allergy Action Plans.

Children and young people with asthma should be provided with an Asthma Action Plan by the relevant healthcare professional. This provides everything staff need to know about a child or young person's asthma in one place, including information about their triggers, symptoms, medicines to be used if they have asthma symptoms and when to seek emergency help when they have an asthma attack. Asthma+Lung UK provides template asthma action plans for use by healthcare professionals and a poster to help school staff help children and young people if they have an asthma attack.

Allergy and/or asthma Action Plans should be attached to the child or young person's Individual Healthcare Plan. The plans include medical and parental consent for staff to administer emergency medicines, such as adrenaline for anaphylaxis or reliever inhaler in the event of an asthma attack. Action Plans are reviewed and updated by healthcare professionals at regular intervals. Whenever an updated Action Plan becomes available, the child or young person's Individual Healthcare Plan should be reviewed to incorporate it.

Prescribed adrenaline devices

People at risk of anaphylaxis are usually prescribed self-administered adrenaline for use in an emergency. Currently two types of adrenaline devices (ADs) are licensed for use: an adrenaline auto-injector (AAI) and a non-injectable nasal adrenaline device. Clinical advice recommends that people at risk of anaphylaxis **carry two devices with them at all times**, regardless of the type of device, since two doses of adrenaline may be required.

The allergy safety policy should set out how the school, college or setting will ensure that children and young people who are prescribed ADs have rapid access to their devices **at all times**. This includes while travelling to and from school, in the lunch area, playground and sports fields or when on visits or trips.

- Children and young people should be encouraged to keep their ADs with them in their school bags (even in primary school), ensuring they have access to them when travelling to or from the school, college or setting;

- If a child or young person cannot keep their ADs with them in the classroom (due to age or other considerations), then the devices should be stored in an appropriate central location that is unlocked and accessible at all times;
- The school, college or early years setting should also stock “spare” ADs for use in an emergency, in the event a child or young person’s own devices are not available or misfire;
- In a case of anaphylaxis, adrenaline should be administered within five minutes. If a child or young person does not have their prescribed ADs with them, they should be close enough to hand that they can be used within five minutes. If necessary, “spare” ADs should be used instead;
- If a child or young person has been prescribed non-injectable adrenaline devices (nasal spray) but it is not available, the school’s “spare” ADs may be used instead;
- It is good practice to keep a copy of the individual’s Allergy Action Plan together with their medication, since it will include instructions on how it should be used in an emergency situation.

The allergy safety policy should set out:

- Arrangements for children, young people and parents to take individually prescribed ADs home (for example at the end of the day for the journey home) and for checking that they remain in date;
- How records will be kept of which children and young people have been provided with prescribed adrenaline (and an Allergy Action Plan).

In addition, the school, college or setting should set out through its medical conditions policy:

- Arrangements for the storage and use of “spare” ADs which can be used in an emergency for the treatment of anaphylaxis (see below).
- Arrangements for disposing of ADs safely when they have been used, following requirements for the safe disposal of medicines (noting that AAIs include needles).

Guidance is available on Using emergency adrenaline auto-injectors in schools, issued by DHSC. Adrenaline auto-injectors (AAIs): guidance and resources for safe use is issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Storage of adrenaline devices

All adrenaline devices (ADs) – including those prescribed to the child or young person themselves, as well as any spare ADs – must be stored at room temperature (in line with manufacturer's guidelines) and not be exposed to extremes of heat. They should not be refrigerated or left in direct sunlight.

ADs should not be locked away or kept in an office where access is restricted. Severe anaphylaxis is a time-critical situation: delays in administering adrenaline have been associated with fatal reactions. If the school, college or early years setting considers that ADs may pose a risk to children and young people (noting that adrenaline auto-injectors contain needles), they should ensure that they are stored out of reach of children and young people.

"Spare" adrenaline devices should be accessible at all times in a safe and central location (e.g. reception, school office or staff room).

Disposal of adrenaline auto-injectors

Once an AAI has been used it cannot be reused and must be disposed of according to the manufacturer's guidelines.

Medications contain active ingredients that, if not disposed of correctly, can have harmful effects on people, animals, and the environment. For example, AAIs include needles. Medications should be separated from other types of waste, such as general rubbish or clinical waste. This ensures that they are handled and disposed of correctly.

Used AAIs can be given to ambulance paramedics on arrival, taken to a pharmacy or can be disposed of in a pre-ordered sharps bin for collection by the local council. AAIs which have expired without being used should be disposed of in the same way.

"Spare" adrenaline devices

Anaphylaxis reactions are unpredictable. In addition, up to 20% of anaphylaxis reactions in schools happen in children without a pre-existing diagnosis of allergy. **We expect that all schools will stock "spare" adrenaline devices of the correct dosage for their pupils, for use in emergency situations**.

The Government intends to introduce a statutory duty requiring schools to stock "spare" adrenaline devices for use in emergency situations through forthcoming Regulations.

The Human Medicines (Amendment) Regulations 2017 permit schools in England to purchase "spare" AAI devices without a prescription for emergency use to treat anaphylaxis. The Regulations only apply to schools and **not** to early years setting or FE colleges, which are not permitted to stock "spare" devices in this way.

Any ADs held by a school in this way should be considered a "spare" device and not a replacement for a child or young person's own AD. Children and young people at risk of anaphylaxis should have their prescribed ADs with them at school for use in an emergency and **should have access to both of their two prescribed ADs at all times**.

Currently the Regulations **only** permit AAIs to be purchased as "spare" devices. Non-injectable adrenaline devices (nasal spray) may be prescribed to individuals but cannot currently be stocked as a "spare" device. If an individual who is prescribed nasal adrenaline suffers anaphylaxis, a school's "spare" AAIs may be used in an emergency.

The Government will review this guidance in the event that schools are permitted to purchase other forms of adrenaline device as "spare" devices.

Managing "spare" adrenaline devices

Schools can purchase AAIs (but not non-injectable adrenaline devices (nasal spray) from a pharmaceutical supplier, such as a local pharmacy, without a prescription. A supplier will need a request signed by the principal or head teacher (ideally on appropriate headed paper) stating the name of the school for which the product is required, the total quantity needed and confirming that the purpose for which the supply is being requested is that of supplying or administering the relevant medicinal product to pupils at the school in an emergency. A template letter which can be used for this purpose can be downloaded at Spare Pens in Schools.

Guidance in terms of how many AAIs (and which doses) should be purchased can be found in Using emergency adrenaline auto-injectors in schools published by DHSC. When considering this, schools should keep in mind that:

- Schools will need to stock "spare" AAIs of the correct dosage for their pupils.
- "Spare" AAIs should always be stocked and stored in pairs.
- In the event of an anaphylaxis reaction, adrenaline should be brought to the child or young person and administered within five minutes, i.e. **adrenaline**

devices should be no more than five minutes away from wherever they might be needed.

This means that most schools will need to obtain two pairs of "spare" AAIs:

School type	**AAIs for children under age 6 years** (150 micrograms) e.g. EpiPen Junior, Jext 150	**AAIs for individuals over 6 years of age** (300 micrograms) e.g. EpiPen, Jext 300
State-funded nursery school	One pair of "spare" AAIs	n/a
Primary school	One pair of "spare" AAIs	One pair of "spare" AAIs
Secondary school	n/a	One or two pairs of "spare" AAIs *
Special school	One pair of "spare" AAIs	One pair of "spare" AAIs

* Secondary schools with large sites should consider having two pairs of "spare" AAIs, so that a pair of "spare" AAIs are available within five minutes of wherever they may be needed.

Where schools operate across more than one site, they should ensure there are spare AAIs of the appropriate dosage on each site as required.

When storing "spare" adrenaline devices:

- "Spare" AAIs must be readily accessible and not locked away;
- In the event of an anaphylaxis, adrenaline should be administered as soon as possible. In practice, this should be no more than five minutes, i.e. adrenaline devices must be able to be brought to the person having anaphylaxis within 5 minutes. Schools should consider how to achieve this as part of their allergy safety policy. In larger schools, more than one set of "spare" ADs may be needed (for example one near the central dining area and another near the playground);
- "Spare" AAIs should be stored in pairs, so that if a second one is necessary it is on hand rather than needing to be obtained from elsewhere on site;
- "Spare" ADs should be clearly labelled, to avoid any confusion with ADs prescribed to a named person. Some schools choose to have a clearly marked "emergency anaphylaxis kit" containing the spare ADs, any emergency asthma reliever inhaler and spacers and instructions for their use.

“Spare” asthma inhalers

Following amendment in 2014, the Human Medicines Regulations 2012 permit schools to buy an emergency asthma reliever inhaler (salbutamol inhaler device and spacer), without a prescription, for use in emergencies. The inhaler can be used if the child or young person’s prescribed inhaler is not available (for example, because it is broken or empty). This is a different legal position from the use of “spare” adrenaline devices. Emergency asthma inhalers may **only** be used in the circumstances set out in the relevant guidance, i.e. for a child or young person who has been prescribed a reliever inhaler, but where their own prescribed inhaler is not available. Importantly, emergency asthma inhalers can only be used where written consent has been obtained.

Guidance is available on Emergency asthma inhalers for use in schools. It is recommended that schools keep emergency asthma reliever inhalers alongside “spare” adrenaline devices.

“Spare” adrenaline devices in the allergy safety policy

A school’s allergy safety policy should set out how “spare” ADs will be used and managed, including:

- How and when “spare” ADs should be used.
- Where “spare” ADs will be located.
- How “spare” ADs will be stored (see above).
- How “spare” ADs and salbutamol inhalers will be checked to confirm that they are in date.
- Processes for replacing “spare” ADs when they are used (this includes safe disposal of autoinjectors as they contain a needle) or go out of date.

Using “spare” adrenaline devices

Anaphylaxis is a medical emergency and can be fatal. The allergy awareness training set out above, will ensure all staff in schools, colleges and early years settings have received prior training in recognition and management of anaphylaxis.

The Human Medicines (Amendment) Regulations 2017 permit “spare” adrenaline devices to be used for the purpose of saving a life. This might be, for example, a child presenting for the first time with anaphylaxis due to an unrecognised allergy.

In the event of an anaphylaxis reaction:

- The child, young person or individual should be placed flat with legs raised. Adrenaline devices should be brought to them (whether their own prescribed

ADs or “spare” ADs as opposed to the patient being taken to where the adrenaline devices are).

- Adrenaline should be administered as soon as possible, within five minutes. Do not wait to contact the emergency services before administering adrenaline.
- Immediately call 999 and request an ambulance.
- If the child, young person or individual **has their own prescribed adrenaline devices**, these should be used in the first instance.
- If the child, young person or individual **does not have prescribed adrenaline devices**, “spare” adrenaline devices can be used.
- If the child, young person or individual’s **prescribed adrenaline devices are not available or misfire**, “spare” adrenaline devices can be used.

Using “spare” ADs in an emergency situation without prior consent

The Human Medicines (Amendment) Regulations 2017 do not require consent to have been obtained for “spare” adrenaline devices to be used in an emergency. It is good practice for the school, college or setting to obtain advance consent from parents or the young person for “spare” adrenaline devices to be used, so that in an emergency, consent can be assumed to be in place. However, in an emergency situation anyone may take reasonable action to save a life without checking whether prior consent has been given, in order to avoid delays in treatment.

School trips and external visits

Schools, colleges and early years settings should conduct a risk assessment for any child or young person at risk of anaphylaxis taking part in a trip off the premises. Children and young people at risk of anaphylaxis should have their own adrenaline device with them, and there should be staff trained to administer adrenaline in an emergency. Schools, colleges and settings may wish to consider whether it may be appropriate, under some circumstances, to take “spare” adrenaline devices in case of emergency use on some trips. However, this should not cause a lack of “spare” adrenaline devices on school/college premises.

Serious incidents and “near misses”

The allergy safety policy should set out how the school, college or early years setting will record, report and respond to serious incidents or “near misses” involving allergy safety. Alternatively, it may point to or summarise the relevant information set out in a medical conditions or medication policy.

In some cases, the impact of exposure to an allergen while in an education setting may be delayed, i.e. not recognised the child or young person is back at home. It is therefore important that incident reporting is not limited to staff in the school, college or setting. The child or young person, their parents or others (for example healthcare professionals) may need to report that there has been an incident.

The Government intends to introduce a statutory duty requiring schools to record serious incidents and near misses relating to allergy safety through forthcoming Regulations.

Serious incidents and “near misses” should be used as a prompt to learn lessons. Part of the response should be to consider whether the arrangements in place were appropriate or whether changes might be needed to the allergy safety policy and/or to the Individual Healthcare Plan. Failure to learn lessons from serious incidents and “near misses” has contributed directly to the deaths of children and young people in schools.

Further information can be found in the section on **Serious incidents and “near misses”**.

Information sharing

The allergy safety policy should set out how the school, college or early years setting will share information about children and young people with allergy. Alternatively, it may point to or summarise the relevant information set out in a data protection policy.

Information concerning a child or young person’s medical conditions (including allergy) can be deeply personal. Nevertheless, school, college and early years settings will need to hold, use and share this information in order to ensure the child or young person receives the support they need to stay safe and be included in education.

Health data and GDPR

A child or young person's health information is considered special category data under UK GDPR, which means it is highly sensitive and has additional legal protections. Schools, colleges and early years settings have a lawful basis to hold, use and share a child or young person's special category health data when this is necessary, but it should always be done in a controlled and respectful way, because unnecessary sharing can reduce children's confidence in practitioners and can be embarrassing for children and young people who may not want to be singled out.

Further information is provided by the Department for Education through Information sharing advice for safeguarding practitioners.

Awareness of the allergy safety policy

The allergy safety policy should set out how the school, college or early years setting will raise awareness of the policy. The allergy safety policy should be published on the school, college or setting's website. All staff should be aware of, and understand, the policy, as part of annual allergy awareness training.

The Government intends to introduce a statutory duty requiring schools to publish their allergy safety policy on their website and to raise awareness of the policy with pupils, parents and staff through forthcoming Regulations.

Schools, colleges and early years settings should consider how to raise awareness of allergy safety among children and young people. This is particularly important to combat the risk of bullying.

Where children and young people are prescribed adrenaline devices, it may be appropriate for their friends to be made aware of how to seek help in an emergency. Any wider awareness or training should be considered carefully and discussed with the child or young person and their parents. Such wider awareness or training should not replace staff emergency response arrangements.

Individual Healthcare Plans for allergy

Schools, colleges and early years settings should use Individual Healthcare Plans (IHPs) to set out the arrangements they will put in place to support a specific child or young person with their allergy which are additional to or different from those offered generally. They should be developed in collaboration with the child or young person and their parents. IHPs are not clinical documents. Rather, they should attach relevant care and action plans issued by healthcare professionals.

IHPs are essential communication tools. They will provide the child or young person and their parents with clarity about the arrangements which will be in place and how they will ensure the child or young person is as fully included in the life of the school, college or setting as possible. The IHP will provide staff in the school, college or setting with clarity about what they need to do. It will also include information which will be essential in managing an emergency situation. If the child or young person moves, their new school, college or setting will need to draw up a new IHP. While this might be very similar to the old one, it needs to reflect the arrangements required in the new school, college or setting.

Individual Healthcare Plans and clinical advice

Staff in schools, colleges and settings are not expected to have clinical expertise. Schools, colleges and early years settings are not responsible for making clinical assessments or judgements and should not do so. Neither are they responsible for healthcare activities that fall under the responsibility of the NHS.

An Individual Healthcare Plan (IHP) is **not** a clinical document. It is a description of how the school, college or setting will respond to the information and advice they have received concerning a child or young person's medical condition or allergy, including from the child or young person themselves, their parents and any healthcare professions involved in their care. The school, college or setting will "hold the pen" on the IHP because they are responsible for making arrangements to support the child or young person while they are in education. Schools must "make arrangements" for supporting pupils with medical conditions, including allergy. They are not responsible for clinical judgement or healthcare plans provided by health professionals. Each school, college or setting will draw its own IHPs because it best understands its own circumstances and can therefore best judge what arrangements or adaptations may be required to support the children and young people on its roll.

- Where a healthcare professional has drawn up a **care plan** for the child or young person which the school, college or setting will need to follow, the IHP should refer to the attached care plan, noting the health provider that issued it, the healthcare professional who prepared it and the relevant review date. The

IHP should also set out any actions staff may need to undertake in supporting its delivery and identify which staff are involved.

- Where a healthcare professional has drawn up an emergency **action plan** for the child or young person (for example an Allergy or Asthma Action Plan) which the setting must follow, the IHP should refer to the attached action plan, including the issuing health provider, the responsible healthcare professional and the review date. The IHP should set out the actions required of staff in an emergency and specify which staff are involved.
- If the child/young person has **prescribed medication** which they need to take while in their school, college or setting (including medication which may be required in an emergency) to help manage their allergy, the IHP should note what medication was prescribed, by whom and when; whether and when parental consent has been received for the medication to be administered; and note where the medication is stored.
- Where a healthcare professional has offered **advice on management** of a child or young person's allergy, the arrangements the school, college or setting makes should reflect their advice. A range of healthcare professionals may offer such advice – for example school nursing teams, GPs or allergy specialists.

Care plans, action plans, medication plans and advice letters are distinct documents, separate from the IHP. Where a plan issued by a healthcare professional contains information that staff need in order to support the child or young person safely (including in an emergency) the IHP should refer to the relevant plan and ensure that staff who need to act have appropriate access to it. The IHP should not duplicate or summarise clinical instructions in a way that could become a substitute for the original plan (potentially introducing errors). Schools, colleges and settings should consider data protection requirements alongside the need for version control, clear accountability and safe access to relevant clinical information by staff who need it.

The IHP should always refer to the most recent clinical advice, noting when it was provided and by whom.

Schools, colleges and early years settings should take the advice or instruction provided by healthcare professionals at face value. It is not for education professionals to insist on letters or advice from consultants rather than GPs or community nurses.

Individual Healthcare Plans where no clinical advice is available

In some cases, children and young people will have or be suspected of having allergy where no clinical advice is available. This may be the case where symptoms have newly emerged or where the process of diagnosis is still under way. In such

cases the school, college or setting should **not** dismiss the child or young person or the information they receive. They should put arrangements in place to support them based on the best assessment that can be made of the likely risk to the child or young person's health, education and wellbeing.

In doing so they should engage closely with the child or young person themselves and with their parents. They may also wish to seek advice from school nursing teams. Their local authority's Designated Medical Officer and/or Designated Clinical Officer may be able to help identify and engage with relevant specialists if necessary. Schools, colleges and early years settings are not responsible for making clinical judgements. Where the support required cannot be safely determined without clinical advice, schools, colleges and settings should seek advice from appropriate healthcare professionals.

Who may need an Individual Healthcare Plan for allergy

Children and young people should have an IHP if:

- they have an allergy which has a functional impact on them in their school, college or setting;
- they are at risk of harm as a result of their allergy; **and**
- they require arrangements which are additional to or different from those made generally.

The IHP will set out the additional and/or different arrangements which the school, college or early years setting will put in place for supporting the child or young person with their allergy, including in emergency situations. The child or young person might not require any specific support with their allergy for long stretches of time. This does not make an IHP unnecessary. If a severe allergic reaction or anaphylaxis is triggered, the IHP will be needed to signpost to the relevant clinical plan so that the right emergency response is put in place. Similarly, children and young people whose allergy requires flexibility and "reasonable adjustments" should have them captured through an IHP.

A single IHP should encompass any supportive arrangements made by the school, college or setting. A child or young person should not have multiple IHPs covering different conditions.

It is not necessary for a child or young person to have a formal diagnosis of allergy for them to have an IHP. Healthcare professionals may decide that it is more appropriate to accept that the individual shows symptoms, rather than proceeding to a formal diagnosis. Schools, colleges and early years settings should be therefore guided by the functional impact and risk of harm, whether allergy is diagnosed or

suspected. Where a child or young person requires specific arrangements to be put in place to manage allergy or to avoid triggers which pose risks to their health, these should be recorded on an IHP so that they can engage effectively in education and be fully included in the life of the school, college or setting.

- *Adrian has a severe food allergy which could cause anaphylaxis. He has been issued an Allergy Action Plan. His secondary school prepares an Individual Healthcare Plan which notes his known allergens and outlines how the school will reduce the risk of exposure to them. The IHP refers to his Allergy Action Plan (which is attached to the IHP). Adrian has been prescribed adrenaline auto-injector devices. His IHP sets out arrangements for him to have access to his AAIs at all times and outlines how staff and friends in his class would recognise and respond to anaphylaxis.*
- *Priya has an allergy to egg. She does not have a history of anaphylaxis or have prescribed ADs, but she has been prescribed antihistamine to take in case of a reaction. Her school produces an Individual Healthcare Plan which records her known allergen and outlines the practical steps the school takes to reduce her risk of exposure. Her IHP also sets out how staff would recognise an allergic reaction and the steps they would take to respond, including if she did have a severe allergic reaction.*
- *Daniel has severe eczema (a skin condition related to and often co-occurring with allergy). His school produces an IHP setting out the adjustments it will make to support him, including permission to carry moisturisers, extra time to apply emollients, access to cool rooms and support for sleep-related fatigue.*

Not all children with an allergy will require an Individual Healthcare Plan. Some allergies will have little or no impact on the child or young person while they are at school, college or in an early years setting, or will not pose a risk to the child or young person. Some allergies will not require arrangements which are additional to or different from those made generally.

Schools, colleges and settings should consider the following principles:

- If the arrangements or support which a child or young person requires would be available to **any** individual as part of the setting's normal policies, an IHP may not be required.
- If the child or young person only needs **non**-prescription medication **and** the setting's medical conditions policy would permit them to carry and administer it, an IHP may not be required.

- *Farah has mild hay fever (allergic rhinitis) which does not pose a risk to her and has a limited functional impact. The school's medical conditions policy*

permits her to carry and use non-prescription (over the counter) antihistamine tablets and eye drops which she is able to self-administer. The school and Farah's parents agree that an IHP is not required.

It is ultimately for head or principal of the school, college or early years setting to decide (in discussion with the parents and any relevant healthcare professionals) whether the allergy can be managed through the adjustments made under the school's medical conditions policy or whether an Individual Healthcare Plan is required to specify arrangements that reflect the child or young person's circumstances.

Content of Individual Healthcare Plans

Individual Healthcare Plans (IHPs) should capture key information about the child or young person's allergy and record the arrangements which the school, college or early years setting will put in place to keep them safe, included and supported. The level of detail within plans will depend on the complexity of the child's condition and the degree of support needed. Different children with the same health condition may require very different support. IHPs should be easily accessible to all who need to refer to them, while preserving confidentiality.

A template Individual Healthcare Plan for allergy is available. .Other examples can be found through Sources of support.

An IHP for allergy should contain the following information.

IHP section	Content
Key information	The child or young person's name, date of birth, class and emergency contact details Include a current photo Who does the IHP need to be shared with in the setting?
Allergy	What allergies does the child or young person have? Identify the known allergens Is the child or young person likely to be aware that they are having an allergic reaction? Can they alert others?
Managing the allergy	Have healthcare professionals issued any care or action plans? Has the child or young person been prescribed medication? Can the condition be managed through adjustments to practice? How far can the child or young person take responsibility for managing their allergy? Do they require support or monitoring?
Impact on education	What is the potential impact on health? What is the potential impact on learning? What is the potential impact on wellbeing? If relevant, note any interaction between allergy and SEN
Arrangements for support	What support or adaptations will the school, college or early years setting put in place? How will the risk of exposure to known allergens be managed? How will food allergy be managed at meal or snack times? How will educational progress be maintained where absence or missed learning occurs due to allergy?
Visits and trips	What arrangements and adjustments may be needed to ensure participation in visits, trips etc outside the setting? What needs to be considered in a risk assessment?
Emergency response	Refer to and attach any Action Plan issued by a healthcare professional covering emergency response. What are the signs and symptoms of an emergency? What should happen in an emergency? Who should be contacted? Where are "spare" adrenaline devices located?
Review	When was the IHP issued and by whom? When was the IHP last discussed with the child or young person and their parents? When is the IHP next due to be reviewed?
Annex – Medication	*If applicable*, record any prescription medication (e.g. adrenaline) which the child or young person may require while in education Where is the medication stored? How and when may the child or young person need access? Is this emergency medication? Is there parental consent to administer medication? When was it given?
Annex – Action plans	*If applicable*, attach any Allergy or Asthma Action Plan issued by a healthcare professional Note which healthcare professional issued the plan, their role and the date issued

Annex – Care plans	*If applicable*, list any care plan issued by a healthcare professional Note where the relevant care plan can be found Note what staff are responsible for delivering and supporting delivery of the care plan Note which healthcare professional issued the plan, their role and the date issued

It is particularly important for IHPs to include:

Key information about the child or young person:

- Record the child or young person's name, date of birth and a current photo.
- Record contact details for the child or young person's parents or carer. Where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child's condition should be specified.
- Note who needs to be aware of the child or young person's allergy and the support required.

While this information will be available through the school, college or setting's management information system, it is good practice for it to be set out on the IHP, so that key information is easily available in an emergency.

The child or young person's or allergy:

- Note what allergies the child or young person has.
- Note any known allergens.
- Note whether the child or young person is likely to be aware that they are having an allergic reaction and whether they can alert others.

Schools, colleges and settings are not expected to make clinical assessments. Instead they should focus on the functional impact of the allergy (or a suspected allergy) on the child or young person. The child and their parents or the young person themselves should be closely engaged in setting this out.

How the allergy is managed:

- Note any care or action plans or prescribed medication issued by healthcare professionals.
- If the allergy can be partly or wholly managed by practical adjustments (for example avoidance of known allergens), these should be noted.
- Note the extent to which the child or young person is able to take responsibility for their own health needs, including in emergencies, should be noted. If a child or young person is self-managing their medication, this should be clearly stated, indicating whether they need arrangements for monitoring.

The child and their parents or the young person themselves should be closely engaged in setting this out. Schools, colleges and settings are not expected to make clinical assessments. Instructions and advice provided by healthcare professionals (whether those involved in the child or young person's care or others such as school nurses who are supporting the education setting) should be reflected here.

The impact of the allergy on health, education and wellbeing:

- Indicate the potential harm which might come to the child or young person if their allergy is not managed properly.
- Indicate how the allergy may impact on the child or young person's learning.
- Indicate how the allergy may impact on the child or young person's emotional wellbeing.
- If relevant, note any interaction between allergy and SEN.

The child and their parents or the young person themselves should be closely engaged in setting this out. Advice provided by healthcare professionals (whether those involved in the child or young person's care or others such as school nurses who are supporting the education setting) should be reflected here.

Arrangements for support:

- Give details of the specific support or adaptations which the school, college or early years setting will put in place, within its educational remit. This might include measures to reduce the risk of contact with known allergens.
- Give details of the specific support or adaptations to manage food allergy at meal and snack times.
- Note arrangements for maintaining educational progress where absence or missed learning occurs due to allergy. This should include how missed work will be communicated and supported, what assistance will be provided to help the child or young person catch up, expectations regarding workload on return, and how the child or young person will be supported as they return (which may include flexibility or part-time attendance to prevent relapse or deterioration).

The school, college or setting should take the lead in setting out the arrangements it will put in place.

Visits and trips:

- Give details of any arrangements or procedures which may be required for school trips or other activities outside of the normal timetable that will ensure the child can participate.

- Note any requirement for a risk assessment and prompts for specific issues which should be considered.

The school, college or setting should take the lead in setting out the arrangements it will put in place.

Emergency response:

- Where an Action Plan issued by a healthcare professional covers emergency response, refer to it and ensure it is attached to the IHP. Otherwise summarise the signs or symptoms which would indicate an emergency.
- Set out what to do in an emergency, including whom to contact.
- If relevant, note where "spare" adrenaline devices are located. A summary of the signs or symptoms which would indicate an emergency.

The school, college or setting should refer to any advice received by healthcare professionals in this section.

Medication:

- Where a child or young person has a prescription medication for allergy prescribed by a healthcare professional, it should be indicated.
- Note the healthcare professional who issued the plan, their role, contact details and the date.
- Note whether it is emergency medication; where the medication is stored; and how and when the child or young person may need access.
- Note whether consent has been given for the allergy medication to be administered, and the date of consent.
- Note whether consent has been given to administer adrenaline (e.g. using "spare" adrenaline devices) in an emergency.
- If relevant (i.e. the child or young person is prescribed an asthma reliever inhaler), note whether consent has been given to use a "spare" salbutamol reliever inhaler.

The school, college or setting should refer to the prescribing decisions made by healthcare professionals in this section.

Care or Action plans:

- Where a child or young person has a personalised care plan and/or action plan issued by a healthcare professional, it should be indicated. Allergy Action Plans should be attached to the IHP.
- Note the healthcare professional who issued the plan, their role, contact details and the date.

The school, college or setting should refer to the care and/or action plans issued by healthcare professionals in this section.

Drawing up an Individual Healthcare Plan

Schools, colleges and early years settings should be active in seeking information about whether children and young people on their roll have allergy. This is most obvious when children and young people join the school, college or setting. It is equally important where a child or young person already on roll is diagnosed with allergy, develops allergy or where their condition changes in such a way that existing arrangements need to be reviewed.

The school, college or setting will draw up the child or young person's Individual Healthcare Plan (IHP) since they are responsible for making arrangements to support them while they are in education. This does not transfer responsibility for clinical judgement or healthcare plans provided by health professionals. Where a child or young person with an IHP moves to a new school, college or setting, a new IHP will need to be drawn up. The new setting should consider the arrangements put in place in the previous setting; provided the child or young person's allergy has not changed, they may offer a useful guide to the type of arrangements will need to be put in place.

It is essential that IHPs are personalised around the child or young person and their current needs.

- The school, college or setting should always discuss the circumstances with the child or young person themselves and with their parents. This is essential to understand the impact the allergy has on the individual – in particular the impact on their health, education and wellbeing. The same condition can have very different effects on individuals. Strong co-production with the child or young person and their parents is crucial to establish confidence that the allergy will be well managed, thereby reducing or avoiding anxiety.
- The school, college or setting should refer to the advice provided by the healthcare professionals involved in providing care to the child or young person. This can include letters or advice from a GP, consultant or community nurse. It will also include care plans and Allergy Action Plans issued by healthcare professionals and any instructions for prescribed medication (for example adrenaline devices) which may to be administered while the child or young person is in education. The school, college or early years setting will need identify arrangements that need to be in place, taking account of advice from the relevant healthcare professionals. This may include school-level adjustments and emergency response arrangements,

alongside arrangements involving health services, where support falls under NHS responsibility

- Where an allergy is suspected but no advice is available from a healthcare professional, the school, college or setting should **not** dismiss the child or young person or the information they receive. They should put arrangements in place to support them based on the best assessment that can be made of the likely risk to the child or young person's health, education and wellbeing. They should then seek further advice from healthcare professionals.
- Schools, colleges and early years settings may also wish to seek advice from school nursing teams on how best to support children and young people with specific allergies. In some cases (especially rare, complex or multi-system conditions), advice should also be sought from clinicians with relevant specialist knowledge. The local authority's Designated Medical Officer and/or Designated Clinical Officer may be able to help identify and engage with relevant specialists if necessary.

Where a child is returning to school following a period of hospital education or alternative provision (including home tuition), schools should work with the local authority and education provider to ensure that the IHP identifies the support the child will need to reintegrate effectively.

A flow chart for identifying and agreeing the support a child or young person needs and developing an IHP is provided below.

A CYP comes onto roll of school, college or EY setting. Parents or the young person identify they have allergy. Advice and instruction from relevant healthcare professionals (e.g. Allergy Action Plan) is provided.

OR

A CYP already on the roll of the school, college or EY setting is identified as having a allergy (including a new diagnosis) or develops an allergy.

School, college or setting considers the advice or instruction provided by relevant healthcare professionals. They meet the CYP and their parents to discuss the circumstances, the impact of the allergy and consider whether an Individual Healthcare Plan (IHP) is required. If necessary, the school, college or setting seeks advice from relevant healthcare professionals.

If the allergy has a functional impact on the CYP or poses a risk to them, the school, college or EY setting should discuss what supportive arrangements may be required with the CYP and their parents and should draw up an IHP to specify them.

If healthcare professionals have provided advice or instruction (e.g. an Allergy Action Plan, their IHP will refer to it.

IHP is shared with the CYP, their parents and those staff who need to be aware of its contents.

School, college or setting delivers the arrangements set out in the IHP.

IHP is reviewed at least annually. Any serious incident, “near miss” or change in circumstances (including changes in instructions or advice from relevant healthcare professionals such as changes to care plan, action plan or medication) should prompt review of the IHP.

Amended IHP is shared with the CYP, their parents and those staff who need to be aware of its contents. School, college or setting delivers the revised arrangements.

Figure 3: flow chart for creating and reviewing Individual Healthcare Plans

Reviewing and updating Individual Healthcare Plans

IHPs must be kept as "live" documents, since they may need to be updated to reflect changes in the allergy, new advice from healthcare professionals and changes to care plans or medication.

- The school, college or early years setting should ensure that Individual Healthcare Plans are reviewed at least **annually**. They can be reviewed more frequently if the child or young person's needs have changed.
- Whenever the school, college or setting receives new advice from healthcare professionals concerning the child or young person, their **IHP should be updated** to reflect it:
    - IHPs should always refer to the most recent care plan or action plan issued by a healthcare professional. The date when the plan was issued and the name of the responsible healthcare professional should be recorded.
    - IHPs should always refer to the most recent information about medication prescribed by a healthcare professional. The date when the medication was prescribed and the name of the responsible healthcare professional should be recorded.
- A **significant incident or a "near miss"** is a trigger that the arrangements in an IHP may need to be reviewed. The child or young person and their parents should be involved in reviewing the IHP. See the section on **Serious incidents**.

As children and young people get older, they may be able to take increasing responsibility for managing their allergy. Where this is safe and possible it should be encouraged, to help prepare the child or young person for managing their allergy in adult life. It is important that children and young people remain actively supported by their school, college or setting; the child or young person should be closely involved in discussions about the extent to which they feel able to take ownership and what support they might need. The IHP will need to be reviewed and amended as necessary to ensure the arrangements put in place by the school, college or setting remain appropriate and relevant for the needs of the child or young person.

Transition between settings and education phases

Where a child or young person moves on to a new school, college or setting, their Individual Healthcare Plan (IHP) should be shared as part of the transition. The new school, college or setting will need to draw up a new IHP since different arrangements will be put in place. It is always helpful for the new setting to see the old IHP, together with any relevant care plans and action plans. Provided that the child or young person's allergy has not changed, the arrangements put in place to

manage it in the old setting will provide a useful indication of the support likely to be needed in the new setting.

As noted above, schools, colleges and early years settings have a lawful basis to hold, use and share a child or young person's health data when this is necessary, for example as part of transition to a new setting.

Serious incidents and “near misses”

Children and young people may be at heightened risk of harm as a result of their allergy. If not treated quickly, anaphylaxis can be fatal. This is why it is so important for schools, colleges and early years settings to be active and conscious in managing the risks associated with allergy. The most effective settings are self-reflective, regularly challenging and testing their own arrangements and seeking to improve them wherever possible.

However effective a setting’s policies are, they can never remove the risk of a serious incident involving a child, young person, member of staff or visitor with a medical condition or allergy. Incidents may occur for reasons which are wholly beyond the control of the setting. Children and young people with no prior history of allergy may come into contact with and have a severe reaction to an allergen for the first time while in an education setting. In such cases, the response by the school, college or early years setting will be critical: prompt recognition and effective emergency response action may be essential to saving a life.

Action in an emergency

If an individual (whether a child, young person, member or staff or visitor) experiences a life-threatening medical emergency, **anyone – staff, volunteers or bystanders – may take reasonable action to save their life**.

The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis.

Staff in schools, colleges and early years settings should be reassured that mistakes, hesitation, or imperfect technique do **not** amount to serious and wilful misconduct. The expectation is simply that staff act reasonably, to the best of their ability, in an emergency.

In line with this principle, **schools, colleges and early years settings should approach serious incidents and “near misses” in a “no blame” spirit of seeking to learn lessons** and address any issues which the incident identified, so that children and young people are better protected in the future.

What are serious incidents?

- A **serious incident** is any event relating directly to a medical condition (including allergy) in which a child, young person, member of staff or visitor with a medical condition or allergy is harmed or is placed at an immediate and significant risk of harm, including situations requiring emergency medication, urgent clinical intervention or attendance by emergency services.
- A "**near miss**" is an event relating directly to a medical condition (including allergy) that did not result in harm but had the clear potential to do so, for example, where an error, omission, or system failure could reasonably have led to a serious incident had circumstances been only slightly different.

"Near misses" are as important as actual incidents, since they may highlight weaknesses in a school, college or early years setting's policies, procedures, training or communication and arrangements which, if not addressed, might have serious consequences in the future. While the "near miss" may not have led to harm on this occasion, they are a warning that, if circumstances had been different, serious harm could have occurred.

Not all serious incidents and "near misses" will result in an immediate emergency situation. In some cases, the impact may be delayed. The consequences might not become apparent until the child or young person is back at home – and in some cases might not be seen for several days. It is therefore important that incident reporting is not limited to staff in the school, college or setting. The child or young person, their parents or others (for example healthcare professionals) may be the ones to identify that there has been an incident.

- *Jonah has a severe food allergy. He suffered an anaphylaxis reaction while at school and was given adrenaline, as required by his Allergy Action Plan, before being taken to hospital. This is a serious incident.*
- *Rachel has a severe food allergy. She was served food containing one of her known allergens. She queried this. Catering staff confirmed that the food did contain the allergen and a different option was provided. This is a "near miss"*
- *William has a food allergy. He was exposed to one of his known allergens through cross-contamination from another child's food and suffered a mild allergic reaction. This was not a significant incident or a "near miss". Nevertheless the school, college or setting should consider whether lessons can be learned from the incident.*

Following any serious incident or "near miss" involving a child, young person, member of staff or visitor with a medical condition or allergy, the school, college or early years setting should record what happened; report it as appropriate; and consider what lessons can be learned.

Incident recording

Schools, colleges and early years settings should ensure any serious incident or near miss involving a child, young person, member of staff or visitor with a medical condition or allergy is recorded as soon as is feasible. The incident should be recorded in the Accident book. A report should set out:

- **Who** was affected;
- **What** happened, **when** and **where**;
- **Why** the incident occurred (as far as is known);
- **How** staff and students responded; **what** was done to support the individual; whether **emergency services** were called;
- **How** the incident concluded.

Reports do not need to be long or complicated. It may be more important to capture key information quickly, while it is fresh in the minds of those involved.

Incident reporting

The parents or carers of a child aged up to sixteen should be notified of the incident or "near miss" as soon as possible. In the case of a young person (CYP) aged over sixteen, the school or college should confirm that they agree that their parents or carers should be informed.

The report should be shared with the child's parents, the young person or the individual involved. They should be given the opportunity to discuss what happened and to contribute their views to the consequent lessons learned review. The school, college or setting should then confirm what it has learned from the incident and should outline any actions it is taking as a result.

The report should always be shared with school, college or setting's designated leader responsible for medical conditions and/or allergy. They will need to consider what lessons to learn and whether changes are required to the school, college or setting's medical conditions and/or allergy safety policies and/or to the arrangements in the child or young person's Individual Healthcare Plan. Any learning should be shared appropriately with staff so they can act on them, reducing the chance of an incident reoccurring.

In addition, it may also be necessary to share the report with other agencies.

- Schools, colleges and early years settings acting as food businesses must report any allergen-related food safety incidents to their local authority (Report a food safety issue).

- Schools, colleges and early years settings must report incidents which arose directly from the way they undertook a work activity which resulted in death or immediate hospitalisation to the Health and Safety Executive (RIDDOR – incident reporting in schools (accidents, diseases and dangerous occurrences)).
- In the event that the incident or "near miss" related to the delivery of a care plan or action plan issued by a healthcare professional, the relevant healthcare professional should be notified.

Reporting allergen-related food safety incidents

The Food Standards Agency works to ensure that food is safe and what it says it is. It is responsible for aspects of food policy, including allergen labelling, and provides guidance and oversight in relation to food incidents, including supporting product withdrawals and recalls.

Schools, colleges and early years settings that operate as food businesses should record and review all allergen incidents and near-misses and, where appropriate, seek advice from their local authority environmental health team or Primary Authority. A legal duty to notify competent authorities arises where a food business has reason to believe that unsafe food (for example, food that is injurious to health, such as food containing an undeclared allergen) has left its immediate control and may pose a risk to consumers, in line with Article 19 of Regulation (EC) 178/2002.

In practice, this will depend on whether there is potential for wider consumer exposure beyond a single, contained incident. Where an issue is isolated and there is no ongoing risk to other consumers, formal notification is unlikely to be required. For example, this may include situations where a meal is provided in error but is immediately identified and contained.

If a child or young person is given food which is clearly labelled as containing an allergen, this would not usually be considered unsafe food and would not typically require notification, as the allergen has been properly declared. These events should be treated as serious incidents or "near misses" and therefore be recorded and reviewed. Where proportionate, they could be discussed with the local authority environmental health team or Primary Authority as part of good practice and continuous improvement. Larger catering providers may handle this through their Primary Authority arrangements, while smaller in-house or local operators may seek advice from their local authority environmental health team.

Further information can be found at Report a food safety issue.

Investigating serious incidents: HSE

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) require employers such as schools, colleges and early years settings to report certain accidents, diseases and dangerous occurrences arising out of or in connection with work to the HSE. This also applies in education settings, regardless of whether an accident happens to a child or young person, member of staff or visitor.

Schools, colleges and early years settings are **only** required to report incidents which arose out of or in connection with a work activity which resulted in death or being taken directly to hospital for treatment, for example where a child or young person had been given their allergen by a member of staff and suffered harm. There is no need to report incidents where individuals are taken to hospital purely as a precaution, when no injury is apparent.

Many of the common incidents that cause injuries to children and young people in a school, college or early years setting will not be reportable under RIDDOR, as they do not arise directly from the way the school, college or setting undertakes a work activity. HSE's guidance on Incident reporting in schools (accidents, diseases and dangerous occurrences) is clear that a child or young person being taken to hospital because of a medical condition (e.g. an asthma attack or epileptic seizure) would not be reportable, as it did not result from a work activity.

Reporting issues to healthcare professionals

Where there is a serious incident or "near miss" relating to the delivery of a care plan or action plan issued by a healthcare professional, the school, college or early years setting should notify the relevant healthcare professional or team, providing a copy of the report. The healthcare professional may wish to provide further information or instructions or to review the care plan. If necessary, the local authority's Designated Clinical Officer / Designated Medical Officer may be able to help engage the relevant healthcare professionals.

Medical conditions and safeguarding

The statutory guidance on Working together to safeguard children is clear that preventing the impairment of children's mental and physical health or development forms part of safeguarding and promoting the welfare of children.

The primary focus of DfE's statutory guidance (Keeping children safe in education) on safeguarding children in schools and colleges is to provide guidance on the policies and procedures they should, or must, have in place to respond to incidents

of neglect, abuse and the exploitation of children posed by intra or extra familial harms, rather than health and safety or the management of child medical conditions.

The fact that there has been an incident relating to the management of a child or young person's medical condition (including allergy) would not in and of itself warrant a referral to local safeguarding partners. A safeguarding referral would only be needed where an incident highlighted concern that the child or young person might be at an increased risk of being neglected, abused or exploited by persons inside or outside of their family unit because of their medical condition. This might occur where relevant information about a child or young person's medical condition or allergy is not provided to a school, college or setting, or where they are repeatedly sent without essential medication, thereby putting the individual at risk.

Supporting wellbeing following a serious incident

An incident or a "near miss" with the potential to put a child or young person's life at risk is a serious event. The school, college or early years setting should consider its impact not only on the individual and their family, but also on those involved in responding and any children or young people who may have witnessed it.

The school, college or setting should take time to review the incident or near miss with the child or young person and their parents, since they may be understandably concerned that the environment may not be safe. The child or young person and their parents should be involved in reviewing the arrangements made (for example in the Individual Healthcare Plan) to ensure they are robust and appropriate. This is essential to retaining confidence that the school, college or setting is safe for the child or young person.

The school, college or setting should consider how it supports the staff involved. This might involve giving them time to reflect on what happened, in a constructive spirit. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

The school, college or setting should consider how it communicates the incident or near miss internally. This can provide a valuable opportunity to remind all members of the community of the importance of supporting those with medical conditions (including allergy) and of the school, college or setting's medical conditions and/or allergy safety policies. However, care should be taken to respect the privacy of the child or young person involved.

Learning lessons from incidents and “near misses”

Schools, colleges and early years settings should **approach serious incidents and “near misses” in a “no blame” spirit, seeking to learn lessons** and address any issues which the incident identified, so that children and young people are better protected in the future.

The report should be submitted to the school, college or setting’s designated leader responsible for allergy. The designated senior leader and any staff involved in supporting the child or young person with their allergy should consider:

- Could the school, college or setting reasonably have foreseen an incident of this nature?
- Might the incident or near miss have been avoided through reasonable preventative steps? If so, what steps might have been taken?
- Were the circumstances of the incident covered by a policy (for example a medical conditions policy, allergy safety policy) and/or a plan (for example an Individual Healthcare Plan or a care or action plan issued by a healthcare professional) which set out how to respond to an incident of this nature?
- If so, was the policy and/or plan followed? If the policy and/or plan was not followed, are there staff training, capability or even disciplinary issues to consider?
- Was the policy or plan adequate? If the policy and/or plan was not adequate, what changes might be required?
- Should the school, college or setting’s policies be changed as a consequence?

The child or young person and their parents should be involved in reviewing the arrangements made (for example in the Individual Healthcare Plan) to ensure they are robust and appropriate.

Where the incident related to the delivery of a care plan issued by a healthcare professional, they or the relevant team should be involved in reviewing the arrangements to ensure they are robust and appropriate. The designated senior leader should consider whether the incident or near miss indicates that any statutory duties may have been breached, or at significant risk of being breached, and whether there were weaknesses in the design or delivery of the relevant policies, the Individual Healthcare Plan and/or any care or action plan. If so, they will need to ensure steps are taken to review and where necessary amend the relevant policies or practice.

“Near misses” are particularly important in this respect, since they highlight weaknesses or risks and offer an opportunity to learn lessons without causing actual

harm to a child, young person, member of staff or visitor. Some settings have used simulated drills, active training and role play to test out how staff would respond to a medical emergency or case of anaphylaxis, without putting individuals at risk.

A serious incident or “near miss” is therefore a prompt to consider whether the school, college or setting’s policies should be reviewed and revised. It is not expected that policies should be revisited after every single incident, if they are considered to be fit for purpose.

The governing body, proprietor or management committee of the school, college or early years setting should receive periodic reports on serious incidents and “near misses”. When the school, college or setting reviews its allergy safety policy, all recent serious incidents and “near misses” which have occurred should be considered, since they will indicate potential areas for improvement.

Complaints

The governing body, proprietor or management committee of the school, college or early years setting should ensure that their complaints processes permit complaints to be raised and investigated following a serious incident or “near miss” relating to a child or young person’s allergy. This includes complaints arising from a prolonged failure to put arrangements in place or to deliver arrangements agreed (whether through an allergy safety policy or an Individual Healthcare Plan).

Serious incidents and specialist providers

The frequency or rarity of serious incidents or “near misses” involving medical conditions or allergy will depend on the circumstances of the school, college or early years setting. Mainstream settings may not experience any serious incident for several years. Specialist settings (for example special schools and special post-16 institutions) may experience a much higher rate of incidents, where a significant proportion of the children and young people they support have complex medical conditions including allergy. This may be no reflection on the school, college or setting or the quality of its support, but simply a consequence of the higher risks posed by the cohort of children and young people.

The school, college or setting’s approach to serious incidents and “near misses” should reflect this. The fact that a specialist setting experiences such incidents relatively frequently does not mean they are any less significant for the child or young person or the staff involved, and so they should not be treated with any less gravity. It is important that serious incidents and “near misses” should be reported and recorded as set out above.

The higher likelihood and frequency of serious incidents and “near misses” may mean that specialist providers need to keep their medical condition and/or allergy safety policies under more active review. In some cases, it may be more proportionate to consider the cumulative lessons learned from a number of incidents (for example over the course of a term) rather than expecting to respond to each one individually.

Child deaths

The death of a child or young person with a medical condition while in school, college or an early years setting is a rare and tragic event. Further information on child death reviews can be found in the statutory guidance Working together to safeguard children. Schools, colleges and early years settings should be aware of the Child death review: statutory and operational guidance (England).

The unexplained death of a child or young person may be subject to investigation by the police and a Coroner’s inquest. Schools, colleges and early years settings should be aware that materials such as residues of food consumed or handled or samples of fluids may constitute evidence, which may need to be seized and retained.

Schools, colleges and early years settings should consider how to support children and young people and their own staff following a child’s death. They should also consider how they can support the grieving family, and in particular any siblings. Support can be found through organisations such as Child Bereavement UK and the Child Death Helpline.

Department
for Education

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