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ENHANCING SUCCESS

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A venture into dangerous teritory: An overview of the responsibilities of schools and teachers in off-campus care for students with serious medical conditions such as anaphylaxis

The Coroner's Court of Victoria recently delivered its findings into the death of a schoolboy from a severe allergic reaction while on school camp.

The requirement for teachers to care for students with medical conditions is in no way a new occurrence.

However, an increase in the prevalence of allergies with severe reactions has no doubt raised the level of responsibility, training and awareness required of today's teachers.

These responsibilities are brought into sharper focus when students are taken off-campus on camps and excursions.

Most will recall the tragic death of thirteen year old Scotch College student Nathan Francis while on camp in March 2007. His death was the result of an anaphylactic reaction to peanuts.

Anaphylaxis is a life-threatening allergic reaction, often triggered by food allergies, especially to peanuts. In some cases it can be fatal.

The Coroner's finding into Nathan's death, which we detail below, was released on 1 June 2012 and included a finding that Scotch College erred in the duty of care it owed to Nathan.

In the lead up to the busy camp and excursion season, the Coroner's finding provides a timely reminder to schools of their responsibilities in providing care for students off-campus.

Duty of care

It is a well enshrined principle that teachers and schools owe a duty of care towards their students.

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As part of the duty of care owed by schools and teachers, it is their responsibility to assist and care for students with medical conditions.

The duty exists when students are engaged in any type of school related activity, be it during class, extra-curricular activities, sports, camps or excursions or in the playground before or after school.[1]

The courts have held that the responsibility includes a positive duty to act to ensure against risk of injury[2] and this has been characterised as follows:

> *'[It is] the need of a child of immature age for protection against the conduct of others, or indeed himself, which may cause injury, coupled with the fact that, during school hours the child is beyond the control and protection of his parent and is placed under the control of the schoolmaster who is in a position to exercise authority over him and afford him, in the exercise of reasonable care, protection from injury.'*[3]

A school cannot delegate its duty of care to any single employee or third party. Where an off-campus activity is run by an external organisation, a school cannot delegate its responsibility to ensure the safety of its students to that organisation. A school will remain liable for a student who is injured even if no school employee was involved with running the activity and even if the activity did not occur on school premises.[4]

The Coronial finding into the death of Nathan Francis[5]

The Coroner's Report sets out the events of this tragic occurrence. On 29 March 2007, Nathan Francis attended the annual Scotch College Army Cadet Unit Bivouac at Wombat State Forest.

Nathan's parents had submitted a number of forms prior to the camp stating that Nathan had an allergy to peanuts and required the use of an EpiPen as treatment for his peanut allergy.

Parents of the students were advised that students were not permitted to bring their own food to camp save for a very small amount of sweet energy food because time and money had been invested into the menu for the camp.

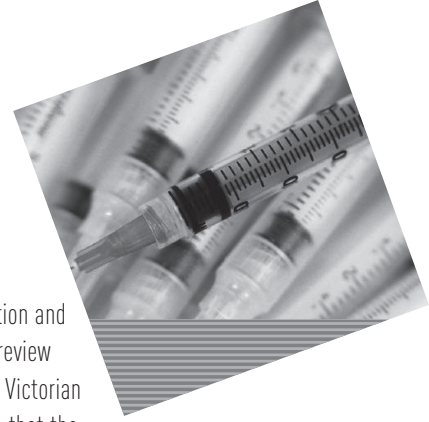
On 22 February 2007, the Minister for Skills, Education Services and Employment and National President of the Australian Medical Association, launched the *Anaphylaxis Guidelines for Victorian Schools*. A copy of the guidelines was provided to all Victorian schools from this date; however, it was not clear whether Scotch College had received the guidelines prior to the departure of the camp.

On 30 March 2007, the students were distributed with army ration packs by the College Marshall. He decided that ration pack 'E' was the most suitable for students with food allergies. A year 10 student saw Nathan spit his food out, looking panicked. The student was then informed by Nathan that he was allergic to peanuts and thought he had eaten something with peanuts in it. The student observed that Nathan's lips looked swollen.

Nathan retrieved and gave his EpiPen to the student and they both made their way to the camp headquarters by which stage Nathan was finding it harder to breathe and puffed on his asthma puffer. The student placed the EpiPen on top of the first aid kit at the headquarters and alerted others to Nathan's situation. Two teachers were present at the headquarters. Neither administered Nathan's EpiPen.

From the camp headquarters, Nathan was driven to another camp headquarters where a voluntary camp medical officer administered Nathan's EpiPen and called emergency services. Shortly after, Nathan became unconscious and then went into respiratory arrest. Cardio-pulmonary resuscitation was implemented, as were three

1 *Geyer v Downs* (1977) 138 CLR 91
2 *Commonwealth v Introvigne* (1982) 150 CLR 258
3 *Richards v State of Victoria* (1969) VR 136 at 138-139, per Winneke J
4 *De Beer v The State of New South Wales and Anor* [2009] NSWSC 364
5 Jamieson, Audrey, Coroner, Finding into Death with Inquest, *Inquest into the Death of: Nathan Francis*, Court Reference 1212/07



further EpiPens. Once Ambulance paramedics arrived, Nathan was showing no independent signs of life. He was transported by Air Ambulance to the Royal Children's Hospital where he was pronounced deceased.

It was established that Nathan had been provided with ration pack 'C', which contained beef satay made with peanut butter.

The Coroner, Audrey Jamieson, noted the 10 minute period between the time Nathan ingested peanuts and the administration of the first EpiPen. The Coroner said that within those 10 minutes were opportunities for other teachers who were present at the first headquarters to administer the EpiPen. The finding noted that the longer the delay in the injecting of the EpiPen, the less likely that the dose of adrenaline will have the requisite response.

The Coroner said that Scotch College failed to properly avail itself of readily available information regarding anaphylaxis and in particular anaphylaxis related to peanut allergy and went on to say:

> *'This failure stems from the college's failure to have so little regard to the medical information of the students in their possession that the seriousness of some of the information was lost in a system driven by Army procedure and devoid of any meaningful concern for the wellbeing of its students/cadets.'*

In finding that Scotch College had breached the duty of care owed to Nathan, the Coroner said:

> *'Nathan's death [was] directly related to Scotch College's failure to take reasonable steps to ensure the health and safety of the boys attending the cadet camp in the Wombat State Forest. Scotch College failed to exercise reasonable care and attention to the medical and food allergy information provided and known to them at the time preparations were being made for the camp and in particular at the time of the distribution of the ration packs.'*

Scotch College acknowledged that the system of distribution of the ration packs was deficient and now requires cadets with food allergies to provide their own food when attending a camp.

Since Nathan's death, Scotch College has changed its systems for managing risk including:

a. the abolition of army ration packs;

b. extensive and regular training of its teachers with respect to allergy and anaphylaxis;

c. organising and writing to parents to seek information with respect to the management of food allergies;

d. requiring students with allergies to eat separately and prepare food separately;

e. maintaining a spare EpiPen at camp; and

f. compiling medication information on the College's student information system.

Scotch College also requires parents to provide a second EpiPen for their child and holds generic EpiPens in various locations on the school grounds.

In addition, the Coronial inquest into Nathan Francis' death made the following recommendations with regard to updating the current law:

1. that the Department of Education and Early Childhood Development review the Anaphylaxis Guidelines for Victorian Government Schools to ensure that the content and advice to schools reflects current best practice in anaphylaxis management;
2. that the Department of Education and Early Childhood Development provide specific guidance to all schools in Victoria with respect to the purchasing of spare 'back-up' adrenalin auto-injection devices for first aid kits;
3. that the Minister of Education introduce a requirement for all schools to complete an Anaphylaxis Risk Management checklist on an annual basis;
4. or, if the above recommendation is not feasible, that a checklist be included in the revised Guidelines.

Legislative requirements for the management of students affected by anaphylaxis

Victoria is currently the only state with legislation in place regarding anaphylaxis management in schools. The legislation, known as the *Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act* (**Act**), came into effect on 14 July 2008.

The Act has mandated specialist first-aid training for teachers to deal with students affected by anaphylaxis. The Act requires schools, kindergartens and childcare centres with children at risk of anaphylactic shock to ensure there are management plans in place in case of an emergency.

Any school that has a student or students at risk of anaphylaxis is required to have the following measures in place:

1. an Anaphylaxis Management Plan for each student, developed in consultation with the student's parents/carers and medical practitioner;
2. prevention strategies for in-school and out-of-school settings;
3. a communication plan to raise staff, student and school community awareness about severe allergies and the school's policies; and
4. regular training and updates for school staff in recognising and responding appropriately to an anaphylactic reaction, including competently administering an EpiPen/Anapen.

Ministerial Order 90 Anaphylaxis- Anaphylaxis Management in Schools of the Education and Training Reform Act 2006, outline the matters that schools need to be mindful of when adhering to their anaphylaxis management policies.

Schools are also required to use *Ministerial Order 90 Anaphylaxis- Anaphylaxis Management in Schools and the Anaphylaxis Guidelines for Victorian Government Schools* to assess and review their current management policies and practices.[6]

Reducing risk

Schools must make appropriate use of the information provided by students and parents regarding medical conditions, particularly anaphylactic conditions that require legislative guidelines to be followed.

In more general terms, before undertaking any activity that involves taking students off-campus, schools should have regard to the following (as a general guide only), in order to minimise their risk:

a. obtain written consent from parents for students to attend the camp. It would be useful if parents/guardians were made aware, before giving consent, of the activities their child will be engaged in;

b. be aware of the medical needs of students;

c. incorporate knowledge of medical needs in the planning of the activity;

d. not attempt to include exemption clauses into permission slips – a school or teacher is not able to contract out of the duties owed to students;

e. plan and organise the camp with great detail – over-planning is better than under-planning;

f. have risk management processes in place to assess and identify risks and plan responses to these;

g. monitor, follow and have recourse to the finalised plans while engaged in the activity and be aware of the movements of all students during each day of the camp/excursion;

h. have adequate knowledge of and be familiar with the camp/excursion site – the duty of care owed by teachers and schools to their students remains in place even if the camp or excursion site is controlled by a third party. This is particularly important for the bushfire prone areas;

i. ensure students are constantly supervised and instructed on what is expected of them;

j. ensure students are instructed on the use of equipment;

k. tailor the activities on the camp to suit the age and physical abilities of the students without being exclusionary to any student;

l. ensure students are educated on any risks and dangers;

m. ensure students and staff have access to first aid kits;

n. ensure access to telephones or radios to make emergency calls for help; and

6 *Anaphylaxis Management in Schools*, Department of Education and Early Childhood Development – http://www.education.vic.gov.au/healthwellbeing/health/anaphylaxisschools.htm

o. know the address of the camp/excursion site and its exact location on the land in order to advise the relevant authority in an emergency – police, ambulance and so on – of their location. In some cases, it may be worthwhile to inform emergency services of the exact site prior to the commencement of the camp/excursion if it is a particularly isolated location or is hard to locate.

Conclusion

The death of Nathan Francis was a tragic event and one which with proper training and planning should not be repeated.

Schools and teachers cannot shy away from their increasing responsibilities towards students in order to ensure their health and safety.

A well organised, informed and prepared school will be best placed to manage risk so as to maximise benefits and minimise negative outcomes.

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