IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1212 / 07

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: NATHAN FRANCIS

Hearing Dates:	6-10 December 2010 13-16 December 2010
Representation:	• Mr P O'Dwyer SC with Mr A Clements on behalf the parents of Nathan Francis, Brian and Jessica Francis • Mr J Ruskin QC with Mr O'Meara on behalf of Scotch College • Mr S Cash on behalf of Dr Anne Waterhouse • Mr G Livermore on behalf of the Commonwealth of Australia and witnesses Pearce and Williams • Mr D McWilliams on behalf of the Department of Sustainability and Environment • Mr M Wilson SC with Ms D Foy on behalf of Ambulance Victoria
Police Coronial Support Unit	• Leading Senior Constable Tania Cristiano, Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	1 June 2012
Delivered At:	Level 11, 222 Exhibition Street, Melbourne 3000

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives and counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered. Furthermore, I have attempted to avoid, where possible, reciprocating all of the facts including the Agreed Facts (Exhibit 66) as depicted in the Decision of Justice North in *Comcare v Commonwealth of Australia* [2009] FCA 700, except as deemed necessary to demonstrate the scope of my investigation.

I, AUDREY JAMIESON, Coroner having investigated the death of NATHAN FAZAL FRANCIS

AND having held an inquest in relation to this death on 6-10 December 2010 & 13-16 December 2010

at the County Court of Victoria at Melbourne

find that the identity of the deceased was NATHAN FAZAL FRANCIS

born on 16 August 1994

and the death occurred on 30 March 2007

at the Royal Children's Hospital, Flemington Road, Parkville 3052

from:

1 (a) ANAPHYLAXIS (INGESTED PEANUTS)

in the following summary of circumstances:

1. On 29 March 2007, Nathan Francis[2] attended the annual Scotch College Army Cadet Unit (SCACU) Bivouac at Firth Environmental Park in the Wombat State Forest.
2. On 30 March 2007, at approximately 1.55pm, after preparing his meal from an Australian Defence Force (ADF) supplied combat ration pack, Nathan ingested some of his meal, a beef satay containing nuts, triggering a severe allergic reaction. He was transported by vehicle to the camp headquarters and received first aid from the volunteer camp medical practitioner, Dr Anne Waterhouse, as his condition was rapidly deteriorating.
3. At 2.08pm, a call was made to Ambulance Victoria. Four ambulances were subsequently dispatched from different locations. The air ambulance was also dispatched. At 2.48pm the first ambulance arrived at the camp. At 3.27pm Nathan was airlifted to the Royal Children's

[2] Mr and Mrs Francis requested that their son be referred to as "Nathan" during the course of the Inquest. For consistency I have endeavoured where possible to also use only his first name in this Finding.

Hospital, arriving at approximately 4.20pm. A short time later, Nathan was declared deceased. Nathan was 13 years old at the time of his death.

BACKGROUND CIRCUMSTANCES

4. At the age of one year Nathan was diagnosed with asthma. At the age of approximately four years, Nathan was diagnosed as having a severe allergy to peanuts.[3] He was prescribed prednisolone and preventer therapy (flixotide[4]) for his asthma which he administered on a "needs basis".

5. In 2005, Nathan commenced his Year 7 schooling at Scotch College, 1 Morrison Street, Hawthorn. The college required students to join one of several offered activities. In March 2007, Nathan joined the Scotch College Army Cadet Unit after submitting a record of outcome of a medical examination. The record reflects that Mrs Francis wrote the response: *Use of EpiPen for peanut allergy* - to a question on the record requesting advice about appropriate treatment for existent medical conditions.

Scotch College Army Cadets

6. The Australian Army Cadets are a recognised part of the Australian defence community and are established pursuant to s.62 of the *Defence Act 1903*. On 25 November 1999, the Minister for Employment, Workplace Relations and Small Business made a declaration under s.9 (5) of the Act, that the Australian Army Cadets were deemed to be employed by the Commonwealth. All 236 cadet units throughout Australia were entitled to receive full support from the Australian Army, including uniforms, transport, equipment and food rations including the combat ration packs.

7. SCACU organised its 2007 annual cadet camp, called Bivouac 07, to be held at Firth Park within the Wombat State Forest near Gisborne in central Victoria. The camp was arranged for the period 29-31 March 2007, with 320 staff and cadets participating. On 3 March 2007, the SCACU notified the ambulance service, the police and the Kyneton Base Hospital of the location of the unit's base camp at Firth Environmental Park in the Wombat State Forest, by

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[3] A/Prof Jo Douglass prepared a report at the request of Comcare for the Federal Court proceedings. Her report provides useful background information that highlights the seriousness of peanut allergy and adds additional insight into the associated risks of asthma, which Nathan also suffered from.

[4] Flixotide is an inhaled corticoid steroid medication which can be used to prevent asthma attacks: T @ p659

reference to a 1:25,000 topographical map of the area[5].

8. Prior to the camp, Nathan's parents completed a number of forms including a parental authorisation form. In a section dedicated to obtaining information about the cadet's medical conditions, Mrs Francis wrote *Yes* next to the enquiry about 'allergies'. In addition, in response to the question "Does your child have any severe allergies (if yes, please state each one)", Mrs Francis circled the word "Yes" and wrote *PEANUTS – but all nuts to be avoided.*[6]

9. The forms returned to Scotch College by Nathan's parents included Scotch College Army Cadet Unit Parent Consent Form and an Army Cadet Medical Information Form completed by Dr Stobie.[7] Mrs Francis added additional information to this form by writing in "*Use of EpiPen for peanut allergy*".

10. Ms Joanne Fisher, staff member of the college who also acted as the administrative secretary to the cadet unit, compiled a list of the medical conditions of each of the cadets who were to attend the camp. A teacher, Mr Robert Papuga who was also a Lieutenant in the cadet unit, assisted her. Mr Papuga was in charge of A Company and responsible for producing a list of medical conditions of the cadets in his company. Teacher, Mr Geoffrey Dans, a Second Lieutenant in the cadet unit and advisor to A Company, assisted him. Nathan belonged to A Company. The final form of the list of medical conditions identified Nathan as suffering from asthma and peanut allergy and in line with Mrs Francis' instructions noted that all nuts were to be avoided. Teacher, Mr Peter Riley, a Major in the cadet unit and Second in Charge and Safety Officer to the camp, received a copy of A Company's final list from Mr Papuga.

11. Dr Waterhouse, volunteer medical practitioner to the camp, however, did not receive a copy of the compiled list of medical conditions prior to her departure to the camp.

Food information from Scotch College Cadet Unit

12. Instructions in relation to permissible food at the camp were also sent home to parents with the forms for completion. Parents were advised that:

> *Cadets should not bring any food with the exception of a very small amount of sweet energy food. They are to be reminded that a large amount of time and money has been invested into the menu for Bivouac. Cadets are not expected to feed themselves...*

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[5] Transcript (T) @191

[6] Exhibit 5

[7] Exhibit 1 and T @ 10

The source of the supply of food for the cadet camp and its distribution

13. The Army supplied one-man combat ration packs for the cadet camp. The ration packs are designed for use by ADF personnel in the field. People with allergies are not permitted to join the ADF. Scotch College saved approximately $39,000.00 by sourcing the food for the cadet camps through the Army.

14. The ration packs are not for sale to the public so are not subject to food labelling legislation. Details of the contents of the packs do not appear to have been produced in anticipation that the user may have an interest in the contents, or any need to know the content ingredients.[8] Five different ration packs designated by the letters "A" to "E" were supplied for the camp. Each pack contained two main meals. The "C" pack contained one main meal stamped with the words "Beef Satay" and the other meal stamped as "sausages and vegetables". The beef satay was made with peanut butter.

15. The distribution of the ration packs occurred on 29 March 2007 just prior to the cadets leaving for camp. Mr Norman Bain, Major in the cadets and who was also acting as one of the Quarter Masters, was responsible for the distribution of the packs. They were distributed at random. No information about the contents of the packs was provided to the cadets save for them being advised that "E" pack was suitable for vegetarians. At the time of the distribution of the ration packs, Mr Bain had not been provided with any of the information regarding food allergies or other special dietary requirements that had been supplied by the parents. Nathan was supplied with ration pack "C".

SURROUNDING CIRCUMSTANCES

16. Teachers and staff of Scotch College assume their position of rank in the Army for the purposes of SCACU activities. There were no Army personnel *per se* at the camp, other than teachers and staff of Scotch College.

17. In the morning of Friday 30 March 2007, Nathan participated in a navigation exercise with his section. He was observed to be lagging behind his colleagues and using his salbutamol puffer on several occasions. The boys returned to the campsite and commenced preparing their meals for lunch. Soon after, Ryan Melville, Year 10 student and a Corporal in the section, saw Nathan spit out his food as he jumped up from his seated position. Nathan then proceeded to

[8] See p 10 of Reasons for Judgement of Justice North in *Comcare v Commonwealth of Australia* [2009] FCA 700

drink a lot of water before sitting down again. Nathan looked *very panicked* according to Ryan who went over to Nathan to enquire what was wrong. Nathan told Ryan that he was allergic to peanuts and that he thought he had just eaten something with peanuts in it. He said that his lips and tongue were tingling. Ryan could see that Nathan's lips looked slightly swollen. Ryan ascertained that Nathan had an EpiPen® contained in his webbing which was on the ground where Nathan had been sitting. Nathan retrieved his EpiPen® and gave it to Ryan. The boys then walked up to A Company Headquarters during which time, in response to Ryan enquiring with Nathan as to how he was feeling, Nathan said he was *finding it a little harder to breathe and then took a puff of his asthma puffer*. When they arrived at A Company Headquarters, Ryan sat Nathan down on a chair and removed Nathan's japara and jacket while Nathan removed his webbing that he had put back on before the walk to headquarters. Ryan placed Nathan's EpiPen® on top of the first aid kit and alerted others to the situation.

18. No one administered Nathan's EpiPen® to him.

19. From A Company Headquarters, Nathan was driven approximately 400 metres to the Unit Headquarters at Johnson's corner, by Mr Peter Riley, arriving at 2.05pm. Dr Anne Waterhouse, voluntary camp medical officer administered Nathan's EpiPen® at approximately 2.08pm.[9] At or about the same time Mr Riley telephoned 000 requesting an ambulance. He provided the name of the park within the State Forest and provided a Melways map reference. Dr Waterhouse asked for additional EpiPens® to be located.

20. At 2.12pm, Nathan became unconscious. At 2.13pm, Nathan went into respiratory arrest. Cardio-pulmonary resuscitation (CPR) measures were implemented. At 2.29pm, a second EpiPen® is administered. At 2.38pm, a third EpiPen® is administered to Nathan. At 2.42pm, a fourth EpiPen® is administered. At 2.48pm, an ambulance arrived at the camp. Ambulance paramedics observed that Nathan exhibited no independent signs of life. CPR continued.

21. At 3.42pm, Nathan was transported by the Air Ambulance to the Royal Children's Hospital (RCH). On arrival at 4.20pm, Dr Simon Young pronounced Nathan deceased.

[9] Most stated times within the Finding are approximates due to some variations within the evidence and the time recording of the emergency call.

JURISDICTION

22. At the time of Nathan's death, the *Coroners Act* 1985 (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[10]

23. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the new Act.[11]

24. Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[12] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

25. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[13] A coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the coroner has investigated including recommendations relating to public health and safety or the administration of justice.[14]

Identification

26. The identity of Nathan Francis was without dispute and required no additional investigation.

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[10] Section 119 and Schedule 1 - Coroners Act 2008

[11] See for example, sections 67(3) & 72 (1) & (2)

[12] Section 67(1)

[13] Section 67(3)

[14] Section 72(1) & (2)

INVESTIGATION

Medical Investigation

27. Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy. There were findings in the lung suggestive of chronic asthmatic state and the lungs appeared hyper expanded. The vocal cords appeared oedematous, there were petechiae on the larynx and thoracic viscera, which Dr Woodford stated, were suggestive of an asphyxial component in the ultimate mechanism of death. There was no other natural disease identified likely to have caused or contributed to the death. Analysis of multiple specimens of post mortem blood showed varying (but predominantly markedly elevated) level of mast cell trypase and specialist haematology/immunology investigations confirmed the presence of an elevated level of peanut specific IgE.

28. Dr Woodford analysed the post mortem findings in light of Nathan's medical history, a witness statement of his condition around the time of his collapse and the history of probable peanut ingestion and opined that the most probable mechanism of death to be one of anaphylaxis.[15]

Police Investigation

29. Senior Constable J. McDonald from Bendigo Police Station undertook the investigation and compilation of the Inquest Brief on behalf of the coroner. The investigation was undertaken collaboratively with Mr Stewart Williams, Investigator, Comcare.

FEDERAL COURT PROCEEDINGS

30. Mr Stuart Williams, on behalf of Comcare[16], investigated the circumstances of Nathan's death and in particular, the provision of one-man combat ration packs (CRP's) containing a satay beef food pouch which contained peanuts or peanut protein for the consumption of Nathan

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[15] Anaphylaxis is a severe and potentially life-threatening allergic reaction that results in breathing difficulty. This may be due to either swelling of the larynx or asthma and/or a drop in blood pressure, which can cause collapse or alteration of consciousness. Other symptoms may include reddening of the skin, generalised itching, hives and vomiting.

Common allergens include peanuts, tree nuts, shellfish, soy, gluten, egg and dairy products, insect stings, some pharmaceutical products including antibiotics, and materials such as latex. Peanuts and tree nuts are of particular concern as they are the most common trigger for an anaphylactic reaction in children.

[16] Comcare has a statutory function in relation to the Commonwealth. Its investigation focused on the responsibilities of the Commonwealth.

and two other cadets, despite having been informed that the three cadets were allergic to peanuts. The Commonwealth entity to which the conduct related was the Chief of Army.

31. Prior to the coronial investigation into Nathan's death being listed for inquest, the role of the Army in Nathan's death had been dealt with in Federal Court proceedings. His Honour Justice North, in the decision of *Comcare v Commonwealth of Australia* [2009] FCA 700, imposed penalties on the Commonwealth, acting through the Chief of Army, for breaches of section 16(1) *Occupational Health and Safety Act 1991* (Cth).

32. Significantly, one of the undertakings given by the ADF was to affix a warning label to each inner bag in the combat ration pack titled: CAUTION FOOD ALLERGIES.

WORKSAFE VICTORIA INVOLVEMENT

33. WorkSafe did not investigate Nathan's death as they formed the view that the camp was under the management and control of ADF and therefore within the Commonwealth's jurisdiction. They did however, access documents related to the investigation *per se* for the purposes of assessing Scotch College's compliance with a guidance tool, developed as part of a project commenced on 1 July 2006, called "Student Safety and Risk Management".

34. WorkSafe did not seek leave to appear at the Inquest.

INQUEST

35. A Direction Hearing was held on 28 May 2010.

36. An inquest was held pursuant to section 52(1) *Coroners Act 2008*. The issues identified as requiring further examination through a public hearing included:

- The role of Scotch College in Nathan's death
- The role of Ambulance Victoria including their response time, their ability to locate medical emergencies in rural settings and the distribution and filing of information regarding future events
- The role of the Department of Sustainability and Environment (DSE) in relation to risk assessments for groups attending the State Forest and signage in the State Forest

Viva voce evidence was obtained from the following witnesses:

- Dr Michael STOBIE – General medical practitioner
- Mr Peter GLOVER – teacher and Lieutenant Colonel (AAC), Commanding Officer
- Mr Adrian PEARCE – Adjutant for Cadet Unit and Captain (AAC)
- Dr Anne WATERHOUSE – medical practitioner
- Mr Robert PAPUGA – teacher and Lieutenant (AAC)
- Mr Geoffrey DANS – teacher and Second Lieutenant (AAC)
- Joanne FISCHER – school staff member and administrative secretary to Cadet Unit
- Mr Norman BAIN – Major (AAC) & Quartermaster
- Mr Peter RILEY – teacher and Major (AAC)
- Mr Nicholas DEMIRIS – teacher and Lieutenant (AAC)
- Mr Lindsay COOKE – Acting Manager of Operational Communications of Ambulance Victoria
- Mr Wayne DAWKINS – Ambulance Paramedic
- Ms Janine SUTTON – Ambulance Paramedic
- Ms Karyn CALLAWAY – MICA Paramedic
- Mr Bret HARDING – Ambulance Paramedic
- Mr Timothy GEARY – MICA Flight Paramedic
- Mr Barry FILES – Site Services Officer, Department of Environment and Sustainability
- Mr Ian BATTY – Principal, Scotch College (from July 2008)
- Ms Kris ARCARO – Assistant General manager of the Student Wellbeing Division in the Office for Government School Education, Department of Education and Early Childhood Development (DEECD)
- Ms Maria SAID – President, Anaphylaxis Australia
- Associate Professor (A/Prof) Jo Ann DOUGLASS – Department of Allergy, Immunology & Respiratory Medicine, Alfred Hospital

37. During the course of the inquest, other issues arose including:

    - the adequacy of first aid training for anaphylaxis

- compliance with Ministerial Order No. 90 with respect to the management of anaphylaxis in Victorian schools
- preparation for the cadet camp, including compilation and collation of medical information provided by parents (including the timely return of forms by parents back to the school), the supply of the collated medical summary to Dr Waterhouse only after her arrival at the camp, and the lack of cross checking of the medical information of allergies against the contents of the food supply[17]

38. A summary of the development of legislation relevant to the management of anaphylaxis was distributed in the course of the Inquest and accepted by the parties (See **ATTACHMENT A** to this Finding). The Coroners Prevention Unit (CPU) in consultation with Kris Arcaro prepared the document on behalf of the Coroner.

FINDINGS, COMMENTS & RECOMMENDATIONS

39. I acknowledge the apology publically conveyed by Mr Ruskin on behalf of Scotch College to Nathan's parents for *the failures which contributed to the tragic death of Nathan.*[18]

Compilation of student medical information

40. The evidence from the camp organisers about their knowledge of allergies, the extent of the risk to exposure of an allergen and the use of the medical summaries as a reactive document rather than a proactive document was, at times, difficult to reconcile.

41. The evidence indicates that the medical summaries were used primarily as a *reactive* document or *ready reckoner*[19] – something to be referred to in the event an incident occurred at the camp that required a medical response. According to Mr Glover:

> *...if there was a medical emergency, we'd have the information at hand in order to provide the boy with the most appropriate medical care and first aid.*[20]

42. The medical parade may have occurred in order to conform to Army instruction that each cadet be properly equipped with his medication, however, it was a process followed that

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[17] Transcript of Proceedings (T) @ p275

[18] T @ p7

[19] T @ 208

[20] T @ p50

reflects a forward thinking use of material contained in the medical summaries. Mr Ruskin submitted that *the medical parade was not in response to a conscious appreciation of any particular risk* but lining a number of boys up and checking that they have their medication on them must invoke a conscious appreciation of some risk to these individual boys. If a conscious appreciation were invoked, then the logical next step would be to inform yourself of what the particular risk is. I do not accept that the medical summaries were not used at all for a proactive purpose – that is how they were being used for the medical parade but even in this process, when the opportunity was there, it was not logically considered but handled by rote.

Knowledge of allergies

43. The Minister for Skills, Education Services and Employment, Jacinta Allan MP, and the then National President of the Australian Medical Association, launched the *Anaphylaxis Guidelines for Victorian Government Schools* on 22 February 2007. A copy of the guidelines and additional material were distributed to all Victorian schools from this date however, the inquest was unable to ascertain whether Scotch College had received the guidelines prior to the departure of the camp.

44. The first aid training undertaken only nine months earlier in 2006 and the contents of the First Aid Emergency Care Handbook[21] as well as the workings reflected in the course workbook[22], appear to have left little or no impression on Mr Glover, Mr Riley or Mr Papuga. Similarly, knowledge of the use/purpose of an EpiPen® particularly as they are referred to in, not only Nathan's medical summary but in a number of other cadet's medical summaries, was indeed limited and reflects a level of complacency for the safety of children that is not acceptable. Mr Riley's reference to feeling 'uncomfortable' about using an EpiPen® is an explicable emotion for almost all that are required to administer it on a person in need. The device is not intuitive[23] which itself creates a level of discomfort but the heart of it goes to the heightened level of anxiety created by the circumstances, which warrant its use. To feel 'uncomfortable' is understandable. To do nothing to familiarise oneself with the medical summaries or to take any steps to reduce one's level of discomfort in the event that the safety officer or other leadership personnel may be required to administer an EpiPen®, is less understandable. For Scotch College to describe it as a *"disconnect"* between knowledge obtained earlier and its

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[21] Exhibit 27

[22] Exhibit 28 – Mr Glover's Workbook

[23] See Finding into Death of Alex Baptist –Coronial Case No: 3268/2004 & T @ 681

potential for application at a later date, namely the camp, is not acceptable. The parent population of Scotch College have a right to expect adult teachers undergoing education of general first aid principles including general principles about anaphylaxis, will not *"disconnect"* from those learnings particularly when they are going to be participating in a cadet camp.

Distribution of the ration packs

45. Mr Bain was not a teacher but a College Marshall. He had 21 years experience in the regular Army, 17 years in the Reserves, 30 years in the cadets and had attended approximately 50 Scotch College Cadet camps. Mr Bain distributed the ration packs to the cadets. He decided that ration Pack E was the most suitable for vegetarians and cadets with food allergies. Mr Pearce was also of the view that ration Pack E was vegetarian. Mr Bain's attention to the details of the ingredients was however, questionable as Ration Pack E in fact contained barbeque chicken. Furthermore, his method of distribution appears to have lacked consistency, as the seven students on the camp with peanut allergy did not receive Ration Pack E as per Mr Bain's distribution plan. In short, three cadets with peanut allergies received ration Pack C – the ration pack containing peanuts.

46. This lackadaisical approach to the distribution of the ration packs possibly represents a certain mindset about the 'type' of boy/man that should be in the Army/Army cadets but at a minimum represents a lack of respect or prejudice towards those with dietary preferences and/or requirements. The systematic failures may have commenced at the level of the Army but whatever lay behind and drove the process of distribution, it lacked rigor at the Scotch College level and operated in a way without regard to the consequences. The consequences, which we know, were fatal for Nathan.

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

Response to Nathan's ingestion of the beef satay

48. Nathan and Ryan Melville identified that Nathan required medical attention. Ryan escorted Nathan to A Company Headquarters in a timely manner and recovered Nathan's EpiPen® from him. As a Year 10 student and Corporal in the cadets, Ryan acted responsibly and with a level of maturity beyond his years.

49. Mr Demiris was present at A Company HQ when the boys arrived. Minutes later, Mr Riley arrived with his vehicle and drove Nathan to Central Headquarters where he was met by Dr Waterhouse who administered his EpiPen®. The period from ingestion/realisation and the administration of Nathan's EpiPen® was approximately 10 minutes. Within those 10 minutes, there were opportunities for either Mr Demiris or Mr Riley to administer Nathan's EpiPen® but unfortunately, these were lost. The 10 minutes to receive the first EpiPen® was a 10-minute delay. A/Prof Douglass agreed with the proposition that the longer the delay in the injecting of the EpiPen®, the less likely that the dose of adrenaline will have the requisite response because:

> *....if you think of it as a cascade of events once the cascade is really moving it will take more to antagonise it than if you get it early. That's the theory. And that would seem to be supported from the studies of anaphylaxis death.*[24]

50. Dr Waterhouse's call for any additional EpiPen® was appropriate. It was the only source of adrenaline available to her. She had no prior knowledge of the number, if any, that may have been available, as she had not received the completed medical lists prior to her arrival at the camp. The lack of a 'spare EpiPen®' within the camp first aid kit is explicable at the time and despite a previous recommendation in the matter of Alex Baptist[25], funding for additional/spare EpiPen® for schools with identified children with anaphylaxis, is still not a resource met by the Victorian Government but rests on the individual school to obtain. (see **Recommendation 2** below).

51. I make no adverse findings in relation to Dr Waterhouse's involvement with Nathan and to the contrary, acknowledge her perseverance in her endeavours to maintain Nathan's life. I accept that there was no additional treatments available to her or that might have been available that is likely to have changed the outcome for Nathan.

Ambulance Services use of future event information

52. Australian Army Cadet Camp preparation requires prior notification to Emergency Services. Mr Adrian Pearce sent Rural Ambulance Victoria (RAV[26]), Ballarat a letter on behalf of the

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[24] T @ p686

[25] Coronial Case No: 3268/2004

[26] Rural Ambulance Victoria was incorporated into Ambulance Victoria in July 2008

Commanding Officer, Mr Peter Glover, with details of the Bivouac 07.[27] He also confirmed that RAV had received his letter of notification. However, he did not confirm the topographical map references of the location of the camp accorded with maps used by Ambulance Victoria. Furthermore, the descriptive directions on how to get to the camp that Mr Pearce prepared for other parties, including Dr Waterhouse, were not provided to Ambulance Victoria.

The 000 system

53. Telstra conducts the 000 system in rural Victoria. A Telstra operator or call taker receives the call, identifies the nature of the emergency then switches the call over to the relevant emergency services for all further management. A 000 call from a mobile phone is picked up by the nearest mobile phone tower to the call. The Telstra operator identifies the closest ambulance operations centre to the tower before switching the call through. The 000 call made from Johnson's Corner by Mr Riley must have been picked up by a mobile phone tower in the Ballarat area for the Telstra operator to switch the call through to the Ballarat Operations Centre of Ambulance Victoria – the same Centre that Mr Pearce had written to on 3 March 2007, with the details of the camp.

54. Once Ballarat Operations Centre received the call they were required by Ambulance Victoria policy to respond to the call even though Bendigo Operational Centre was strictly speaking, the closest centre to Firth's Park. Once the call is switched to Ballarat, it is up to Ballarat to dispatch its own available resources. At the time, the Ballarat Operations Centre had no capacity to identify available resources outside its own region. Only once Ballarat dispatched its nearest ambulance at Daylesford, were they permitted to contact another region for assistance if deemed necessary.

55. Mr Cooke, Acting Manager of Operational Communications of Ambulance Victoria indicated an exception to this process when he stated that *if a caller asked for Ballarat specifically, the call would be put through to that centre by the operator.*[28]

56. I make no criticism of the call taker switching the call from Mr Riley to the Ballarat Operations Centre and accept that this was in accordance with the procedure at the time. However, it was the handling and use of the future events material by RAV Ballarat that was

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[27] Exhibit 9

[28] Exhibit 38 – Statement of Lindsay Cooke dated 6 December 2010

lacking. The material provided by Mr Pearce was not scrutinized at the Ballarat Branch. The topographical map coordinates provided by Mr Pearce were not checked and hence identified that the Firth Environmental Park was in fact in the Bendigo dispatch area not the Ballarat area. The whole incident could have been handled with greater precision.

57. Additional resources were expended that might have otherwise been required. An ambulance was despatched from Daylesford at 2.11pm, arriving 37 minutes later at 2.48pm. An ambulance was dispatched from Ballarat at 2.17pm arriving 33 minutes later at 2.50pm. An ambulance was dispatched from Kyneton at 2.18pm arriving 38 minutes later at 2.56pm and the ambulance from Gisborne was dispatched at approximately[29] 2.29pm arriving approximately 33 minutes later at 3.02pm.

58. The prior planning by Scotch College in this regard was not reciprocated by RAV. Response times on the day may well have been improved upon if the Ballarat Branch, upon receipt of Mr Pearce's information, had indeed performed future planning. The dispatching of an ambulance from Gisborne, the closest station to the emergency, could have occurred in a more timely manner rather than the approximated 21 minutes from the time of Mr Riley's call to 000, if the Ballarat Branch had given the prior notification the attention it deserved. They would have known at the outset that Bendigo Operational Centre should have handled the call for an ambulance from the Scotch College cadet camp. This would have been justified in referring it through to that Centre immediately. Bendigo was notified within two minutes of the conclusion of the call to Daylesford but that was six minutes from the time Ballarat received the call. Furthermore, if RAV Ballarat had given the prior notification the attention it deserved, they should have referred it on to Bendigo and should have informed the camp organisers in advance that the appropriate ambulance operations centre was indeed Bendigo. If this had been done, Mr Riley may well have known to ask the call taker to be put through to Bendigo, which again could have reduced the response time.

59. Nevertheless, I find that there was no unreasonable delay in the dispatching times from Ballarat Operations Centre. The delay that occurred in an ambulance arriving at the Firth Environmental Park in the Wombat State Forest occurred because of the lack of care and attention given to the prior notification details provided by the camp organisers. The use of different topographical maps and incorrect map references given at the time of the emergency

[29] The approximate times in respect of the Gisborne ambulance arise from a discrepancy of times in the ESTA transcript and the relevant dispatch card (Exhibit 44)

are another symptom of the breakdown in meaningful feedback to Mr Pearce by RAV Ballarat.

60. I make no adverse finding in respect of the time taken by the individual ambulances/paramedics to arrive at the location. To the contrary, I find that they all endeavoured to travel to the location as expediently as possible given their combined lack of knowledge/familiarity of the location, the distance from their respective dispatch centres, the conditions and specifically, the need to drive slower on unmade/unsealed roads albeit that one paramedic, Ms Sutton, described it as quite a good country road.[30]

Locating medical emergencies in rural settings

61. Mr Cooke gave evidence that if the camp notification was received today, the information would be logged on as an upcoming event in the Ambulance Victoria computer system. The current system provides more accurate information about a location such for example, the coordinates of Firth Environmental Park would be used as a verifiable location making it easier to direct ambulances to that identified location.

62. Changes to the emergency communications systems in late 2007/early 2008 enable a dispatcher in a region to see where the closest available ambulance is even if the ambulance is in another region. The dispatching policy still however, required the receiving Operations Centre to send its nearest available ambulance to an incident even if the incident is in another bordering region. Ambulance Victoria uses a satellite navigation system known as Rav Net which is able to plot the course of an individual ambulance on a computer screen as it travels to a particular address. Ambulances are not fitted with individual GPS units such that if paramedics are unsure of a location they must still rely on the dispatcher to navigate them. According to Mr Cooke, the Rav Net is better equipped than individual GPS systems for each vehicle because it is coordinated with other agencies[31] and it is updated regularly with new information whereas the varying ages of Ambulance Victoria's vehicles apparently makes such a proposal too resource intensive and less reliable.

63. In late 2007/early 2008, as well as retaining the Melways and the VicRoads maps, Ambulance Victoria first used a new spatial map called VICMAP Book[32]. Each vehicle has a copy of the VICMAP Book and it is on Ambulance Victoria's computer system in each Operations

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[30] T @ 513

[31] T @ 434

[32] Exhibit 42A

Centre. According to Mr Cooke, Ambulance Victoria adopted the special vision map books because the VICMAP Book is generally recognised as the most appropriate and available mapping system across Victoria[33] and is now the universal mapping system across emergency telecommunications in Victoria.

The role of the Department of Sustainability and Environment

64. The Department of Sustainability and Environment (DSE) manages and is responsible for the Wombat State Forest. DSE granted Scotch College a permit for the camp at Firth Environmental Park on 22 March 2007 after requiring an amendment to the initial application.[34] In granting the application, Mr Files was satisfied that the Scotch College Cadet Unit had a good knowledge of the Wombat State Forest.[35]

65. The evidence of Mr Files, the Site Services Officer, DSE and the photographs he supplied[36] indicate that there was adequate signage within the park. The roads are dirt roads, which I accept, are to be expected in a State Forest. Apart from one paramedic, Karyn Calloway, who raised a concern about the camber of the roads, no significant concerns were raised about the conditions for entry or exit into the State Forest. In his 23 years with the DSE at Daylesford, Mr Files was not aware of any difficulty emergency services have had in accessing the Wombat State Forest.[37]

66. I find that there is no relationship between the role of DSE in the exercise of its duties in performing a risk assessment before granting the application to Scotch College and Nathan's death.

67. Similarly, I find no relationship between the role of DSE in maintaining signage and the conditions of the roads in the Wombat State Forest and Nathan's death.

68. The lack of relationship between the DSE's role and Nathan's death has not discouraged the department from responding positively to the evidence in this inquest. I commend them for their foresight and notification to the Court of changes to the DSE application form, albeit that they made lengthy closing submissions about the scope of my ability to make comments pursuant to section 67(3) *Coroners Act 2008*. The DSE publicly reported that they intended to

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[33] T @ 462

[34] Exhibits 15, 17 & 51. T @ 183 & 536

[35] T @ 542

[36] Exhibit 52

[37] T @ 541

amend their application forms by 1 March 2011, for defence force training and members of the public wishing to use Victorian State Forests to include:

- an indication on the application that the applicant has informed the police, ambulance, SES and local hospital of their proposed location by reference to VICMAP Book
- all map references are to be made by reference to the VICMAP Book; and
- on the non-defence force application, the inclusion of a description of the 'route in' and 'route out'.

69. Greater interrogation of applicants and a consistent use of the VICMAP Book by Emergency Services and the DSE represent a co-ordinated approach to public health and safety and prevention of like events connected with Nathan's death.

System Changes at Scotch College since Nathan's death

70. A number of changes have since been made to the Scotch College and Scotch College Army Cadet Unit procedures since Nathan's death.[38] Mr Batty gave evidence of the College's system for management of risk, which included the abolition of the army rations, the extensive and regular training of the teachers with respect to allergy and anaphylaxis and its ongoing nature. The organising and writing to the parents seeking information and interviews with respect to management of food allergies. Cadets who have food allergies eat separately and prepare food separately. There are spot checks, spare EpiPen® at camp and the compilation of the medical information onto Scotch College's Student Information System (SIS).[39] There are procedures for communication, action management plans and in preparation for camps, there is a review of what that camp is going to require in terms of police, ambulance and medicines. The Scotch College Allergy and Anaphylaxis Management Policy[40] and individual action management plans depend upon regular communication with parents and students according to Mr Batty, of which I make further comment below.

Legislative requirements regarding anaphylaxis management[41]

71. The effective management of our children with food allergies in schools and by our schools is an increasingly challenging public health and safety issue. According to A/Prof Douglass:

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[38] T @ p731, Exhibit 10 & Exhibit 55 – Statement of Ian Thomas Batty dated 14 December 2010

[39] Exhibit 21

[40] Attachment "TP- 7" to Exhibit 55

[41] See ATTACHMENT A

Severe allergic reactions to foods appear to be increasing in the community with estimates of prevalence at approximately 5% in children and approximately 1% in adults. More recent evidence supporting an increase in the prevalence of food allergies can be drawn from Australian hospital admission data which reveals a 4-fold increase in the prevalence of admissions of children to hospital due to severe food allergies.[42]

72. Victoria is the only State that currently has legislation in place in relation to anaphylaxis management in schools. The legislation came into effect on 14 July 2008, with the requirements being outlined in Ministerial Order No. 90.[43]

73. Despite their best intentions to comply with or even exceed the legislative requirements set out under Ministerial Order No. 90, the inquest heard that Scotch College technically did not comply because the students' individual management plans (described as 'action management plans') did not set out strategies to minimise the risk of exposure to allergens for those students.[44]

74. Rather, the management plans more closely resembled an emergency procedures plan, a required component of the overall management plan.[45] A range of prevention strategies had however been documented in the school's *Allergy and Anaphylaxis Management Policy: An Allergy Aware School.*[46]

75. The importance of individual management plans containing prevention strategies was outlined in the evidence by Ms Said when she stated, *Managing a prep child who is at risk of anaphylaxis is very different to managing a child at risk who is 17.*[47] I understand Scotch College has students from Prep to Year 12. A comprehensive example of an individual management plan can be found in Appendix 1 of the Anaphylaxis Guidelines (2006).

76. Another concern raised was that parents of at-risk students were not meeting with a

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[42] Exhibit 63 – Report of A/Prof Jo Douglass dated 19 February 2008

[43] Exhibit 60 – Statement of Kris Arcaro dated 13 December 2010

[44] T @ 636. Also see Exhibit 55, TB11.

[45] Under Ministerial Order No. 90, individual anaphylaxis management plans must contain an emergency procedures plan provided by the parent (7c(vi)). An example of the emergency procedures plan is the ASCIA Action Plan.

[46] Exhibit 55, TB7.

[47] T @ 635

representative of the school on an annual basis to review the contents of these plans.[48] I do acknowledge that copies of the plans were sent to parents prior to any excursion.

77. Varying interpretations of the legislation by Ms Ancaro of DEECD, Maria Said of Anaphylaxis Australia and even A/Prof Douglass highlight the confusion of current school requirements. Compliance with the legislation is purported to be achieved using the self-assessment tool supplied by the Victorian Registration & Qualifications Authority (VRQA)[49], and I note that in 2009 Scotch College satisfied the requirements of an audit by the VRQA, based on a review of the self-assessment checklist completed by the school.[50]

78. I remain sceptical as to whether this tool is sufficiently detailed to assess a school's fulfilment of the requirements under Ministerial Order No. 90. Conversely, the *Anaphylaxis Risk Management Checklist*, produced at the time Ministerial Order No. 90 came into effect, does provide schools with a detailed checklist to assess their compliance. This checklist for example clearly distinguishes an individual anaphylaxis management plan from an action/emergency response plan (for example the Australasian Society of Clinical Immunology and Allergy (ASCIA) Action Plan).

The purchasing of back-up adrenaline auto-injection devices

79. Scotch College now requires parents to provide a second EpiPen® for their child.[51] The school also holds spare generic EpiPens® in various locations including the first aid centre, the junior school reception, and the health centre for boarders and various other locations on campus.[52]

80. The inquest touched on the issue of schools purchasing back-up or spare adrenaline auto-injection devices for use on diagnosed students in the event that their own device is misplaced, incorrectly used or otherwise fails. The counter-intuitive nature of adrenaline auto-injecting devices is an ongoing concern. I have been advised that a new design EpiPen® is now available in Australia, which goes some way to address this concern. The introduction of the Anapen® however, which operates in direct contrast to the EpiPen®, may lead to further

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[48] Under Part 3, clause 7(d)(i) of Ministerial Order No. 90 a school's anaphylaxis management policy must require that the school review the student's individual anaphylaxis management plan in consultation with the student's parents/carers *annually*.

[49] Exhibit 61

[50] T @ 574

[51] Exhibit 55 - Statement of Thomas Batty, p5

[52] Exhibit 55, p6.

confusion and potential for failure, particularly among the non-medically trained.

81. In the Finding into the death of Alex Baptist, I had recommended the provision of funding to children's services to purchase a back-up EpiPen®. In 2009, the Department of Human Services' Allergy Working Party further recommended that all schools and children's services purchase a back-up device.[53] The Minister's subsequent response was that it was the discretion of schools as to whether they wished to purchase a back-up device.[54] This is reflected in the Anaphylaxis Guidelines for Victorian Government Schools (2006, p10) which states that *Schools may consider purchasing a generic EpiPen® as a 'backup', particularly if there is no single, central, easily accessible location on the site.* With respect to camps and remote settings *Schools can consider purchasing a back-up device to be kept in the first aid kit* (p23). I note that A/Prof Douglass remained neutral on whether back-up devices should be made compulsory in schools.[55]

Anaphylaxis Guidelines for Victorian Government Schools

82. The Anaphylaxis Guidelines for Victorian Government Schools were first published in November 2006. While the guidelines had been developed for government schools, they were distributed to all Victorian schools including Catholic and independent schools. Significant developments have occurred since 2006, including the introduction of legislative requirements for anaphylaxis management in all Victorian schools and the introduction of the Anapen®.

83. The apparent confusion around the specific requirements of Ministerial Order No. 90 as identified in this inquest suggests that all schools would greatly benefit from updated and specific guidance. As recently as 28 May 2012 there was no evidence either forthcoming to the court or on the Department's website that such a review had occurred.

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[53] Recommendation 2(a) of the Report from the Department of Human Services Allergy Working Party to the Minister for Health (April 2009).

[54] Victorian Health Minister's Response to the recommendations presented by the Allergy Working Party

[55] T @ 647

RECOMMENDATIONS:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

Recommendation 1

I recommend that the Department of Education and Early Childhood Development review the 2006 'Anaphylaxis Guidelines for Victorian Government Schools' publication to ensure that the content and advice to schools reflects current best practice in anaphylaxis management, and includes the requirements set out under Ministerial Order No. 90.

Recommendation 2

I recommend that the Department of Education and Early Childhood Development provide specific guidance to all schools in Victoria with respect to the purchasing of spare or 'back-up' adrenaline auto-injection devices for first aid kits to ensure that in the event that a student experiences a life-threatening allergic reaction a spare device is available. The number of diagnosed children attending the school, and the likely availability of a spare device in various settings including school excursions and camps, should be considered as part of this assessment. A review of the 2006 'Anaphylaxis Guidelines for Victorian Government Schools' would provide an opportunity to convey this advice to schools.

Recommendation 3

I recommend that the Minister for Education introduces a requirement for all schools to complete an Anaphylaxis Risk Management Checklist on an annual basis as a means for ensuring ongoing compliance with the specific requirements under the Ministerial Order – whether that be by an amendment to Ministerial Order No. 90 or by creation of a new Order.

Recommendation 4:

If Recommendation 3 is not feasibly capable of being implemented, I recommend that in revising the 2006 'Anaphylaxis Guidelines for Victorian Government Schools', the Department of Education and Early Childhood Development include a detailed Anaphylaxis Risk Management Checklist as a means for ensuring compliance with the specific requirements under Ministerial Order No. 90.

Recommendation 5:

I recommend that Scotch College, if not already done so, revise its student's 'action management plans' to incorporate strategies to prevent exposure to allergens for the individual student in both in-school and out-of-school settings – a required component for individual anaphylaxis management plans under Ministerial Order No. 90. The plan should also be reviewed annually by the school together with the parent/carer – also as per the requirement of Ministerial Order No. 90.

CONCLUDING COMMENTS:

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:

1. I accept the submissions made on behalf of Mr and Mrs Francis that there was a common thread in the evidence of the organisers of the camp of an ignorance of the necessary facts to make a connection between the contents of the cadet ration packs and the risks to the health and safety of cadets with peanut allergies. Tragically, it was the culmination of this collective ignorance that resulted in Nathan's death. Scotch College, at that time, appears to have been oblivious to the heightened media attention to the dangers of peanut allergies consequent of the commencement of the Inquest into death of Alex Baptist on 26 March 2007 – that is, within days of the cadets departing for the Wombat State Forest. Individuals can be excused for not following a story in the media about the death of child at a kindergarten but those in leadership positions at the school should have been aware of the Minister's launch of the Anaphylaxis Guidelines on 22 February 2007, and their impending distribution to all schools. Scotch College should have received the Guidelines before the cadet camp but regardless, the development of the guidelines did not occur in a vacuum and schools would have been forewarned of the contents and likely standards and impositions that the guidelines were going to require. In addition, I note that the Association of Independent Schools of Victoria were represented on the Advisory Group responsible for developing the Guidelines. Nevertheless, there is no indication of any fore-planning or proactive action taken by the college in this regard.

2. I accept that the Scotch College teachers failed to comprehend the seriousness of peanut allergy in March 2007 and that since mid-2008 the level of legislative, documentary and public awareness has greatly improved. However, I find that there was a body of information on allergies and anaphylaxis and in particular anaphylaxis related to peanut allergy, readily available to Scotch College at the time of the preparation of their 2007 cadet camp and that they failed to properly avail themselves of that knowledge in their preparations. 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 well-being of its students/cadets.

FINDING as to cause of death

I accept and adopt the cause of death as identified by Dr Noel Woodford and find that Nathan Fazal Francis died from anaphylaxis from ingesting peanuts. A/Prof Douglass also stated that she was in no doubt, that anaphylaxis was the cause of death and that an additional risk factor to Nathan was his asthma. She stated that *unstable asthma was a major risk factor for death in the occurrence of anaphylaxis* and there was *considerable evidence that Nathan had unstable asthma prior to his fatal event.*[56]

AND I further find that the cause of Nathan's death is 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's responsibility to their students is not absolved by the admissions of the ADF.

AND I find that the death of Nathan could have been prevented had Scotch College exercised reasonable care and attention to the obtaining of and distribution of the cadet camp ration packs in light of the medical information that was known or should have been known to them.

[56] Exhibit 63 @ pp14-15

I make no adverse findings in respect of individual teachers at Scotch College but direct these adverse findings at systemic deficiencies within the school. Any comment about an individual's involvement in Nathan's death are to be read as to include them within the systemic deficiencies.

AND I am unable to make a definitive finding that Nathan's death was preventable once he consumed his beef satay meal in the remoteness of the Wombat State Forest. He received the best available medical treatment at the time of his collapse from Dr Waterhouse. Medical treatment that was both unreserved and delivered relentlessly. Asthma may have played a significant part in Nathan's failure to respond to Dr Waterhouse's resuscitation attempts. A/Prof Douglass stated:

> *...it is asthma that is one of the terminal features leading to respiratory arrest in those who have a pre-existent asthma and co-existent food allergy.*[57]

A/Prof Douglass also stated, *not all deaths from anaphylaxis are preventable, even when the anaphylaxis occurs within a major hospital*[58] and once Nathan suffered a respiratory arrest it would have been difficult for any practitioner to revive him outside of a fully equipped and staffed intensive care unit.[59]

AND having regard to the remoteness of the location and its isolation from the level of intensive medical intervention that was required to reverse and or manage Nathan's acutely compromised state, it is probable, that even with earlier administration[60] of the EpiPen® and ambulance control more certain of the location, that Nathan's death was no longer preventable.

AND I acknowledge the research assistance of the Coroners Prevention Unit in this matter.

Pursuant to section 73(1) of the **Coroners Act 2008**, this Finding will be published on the internet.

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[57] T @ 665

[58] Exhibit 63 – Report of A/Prof Jo Douglass dated 19 February 2008

[59] Exhibit 63 & T @ 668

[60] T @ 686

I direct that a copy of this finding be provided to the following, noting that Recommendations are directed to them:

- Scotch College (Perry Maddocks Trollope lawyers)
- Richard Bolt - Secretary, Department of Education and Early Childhood Development
- The Hon. Martin Dixon MP, Minister for Education

AND direct that a copy of this finding be provided to the following individuals and agencies:

- Brian and Jessica Francis
- Senior Constable Jennifer McDonald, investigating police member
- Dr Anne Waterhouse
- Anaphylaxis Australia
- Department of Sustainability and Environment
- Commonwealth Department of Defence
- Comcare
- Ambulance Victoria
- Victorian Registration and Qualifications Authority
- Department of Health
- WorkSafe Victoria
- A/Prof Jo Douglass

Signature:

AUDREY JAMIESON
CORONER
Date: 1 June 2012

Attachment A

Anaphylaxis Management in Victorian Schools

Requirements at the time of Nathan Francis' death

1. As of 30 March 2007 there were no legislative requirements in place specifically in relation to anaphylaxis management for Victorian schools.
2. As of 30 March 2007 the Department of Education and Training (DE&T) had a policy on anaphylaxis management in schools. It was the DE&T's policy that any school with a student at risk of anaphylaxis, have the following in place:[61]
    a. an Anaphylaxis Management Plan for the student, developed in consultation with the student's parents/ carers and medical practitioner;
    b. prevention strategies for in-school and out-of-school settings;
    c. a communication plan to raise staff, student and school community awareness about severe allergies and the school's policies; and
    d. regular training and updates for school staff in recognising and responding appropriately to an anaphylactic reaction, including competently administering an EpiPen®.

Anaphylaxis guidelines for Victorian government schools

3. The DE&T established an Anaphylaxis Advisory Group in 2006 which led to the development of the *Anaphylaxis Guidelines – A resource for managing severe allergies in Victorian government schools* (hereon referred to as the "Anaphylaxis Guidelines").
4. The Anaphylaxis Guidelines were published in November 2006 and officially launched on 22 February 2007 by the Minister for Education Services.[62]
5. Following the launch, the Guidelines were distributed to all government and non-government schools in Victoria in the form of a kit that included:[63]
    a. an anaphylaxis fact sheet;
    b. posters to raise awareness among school staff, parents and students about food allergies;
    c. a canteen poster; and
    d. a trainer Epipen®.

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[61] Anaphylaxis Guidelines: A resource for managing severe allergies in Victorian government schools (November 2006: page 4).

[62] Media Release from the Minister for Education Services. *Schools better equipped for food allergy cases.* 22 February 2007. Retrieved from: http://www.legislation.vic.gov.au/domino/Web_Notes/newmedia.nsf/798c8b072d117a01ca256c8c0019bb01/087cb6be709171c1ca25728a007f9632!OpenDocument

[63] Media Release from the Minister for Education Services. *Schools better equipped for food allergy cases.* 22 February 2007.

Development of legislation

6. The *Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act 2008* received royal assent on 4 March 2008 and came into effect on 14 July 2008.

7. This Act amended the *Education and Training Reform Act 2006* to introduce as a requirement for registration, that a school develops an anaphylaxis management policy containing matters required by a Ministerial Order, where the school knows or ought to reasonably know that a student has been diagnosed as at risk of anaphylaxis.

8. This Act amended the Education and Training Reform Act to enable the Minister to make Orders setting out the matters to be required in an anaphylaxis management policy.

9. The Minister for Education made Ministerial Order No #90 - Anaphylaxis Management in Schools on 23 May 2008. The Ministerial Order came into operation on 14 July 2008.

Current legislative requirements

10. From 14 July 2008, all schools in Victoria must by law have an anaphylaxis management policy if they have a student enrolled who has been diagnosed at risk of anaphylaxis. The policy must include procedures for:

    a. individual management plans for each student at risk;

    b. a communication plan to inform staff, parents and students about anaphylaxis and the school's anaphylaxis management policy; and

    c. staff training and emergency response.

11. The requirements in the Ministerial Order are consistent with, and build on the Anaphylaxis Guidelines.

12. A presentation with speaking notes and a facilitation guide has been developed to help schools ensure they are meeting their requirements under Ministerial order 90.

13. All schools that are seeking new registration, or have existing registration as a school, must comply with minimum standards, enforced by the Victorian Registration and Qualifications Authority (VRQA).

14. These minimum standards include the requirement for each school to have an anaphylaxis management plan, as outlined in Ministerial Order 90.

15. The VRQA's self-assessment tool for schools stipulates this minimum standard and provides a link to the anaphylaxis page of the Department's website.

Anaphylaxis Management Training

16. Since 2005, the Department of Education and Early Childhood development has provided free anaphylaxis management training to government school staff who have a duty of care for children and young people at risk of anaphylaxis. Prior to 2005 training was provided on an ad-hoc basis under the School Care Program, run by the Royal Children's Hospital for the Department. Licensed children's services are also able to access funded training.

17. Between 2005 and December 2008 the Department funded training for staff in Government schools via contracts between the Department of Education and the Ambulance Victoria First Aid service. Since 2009 this training has been provided by St John Ambulance Victoria. Since

2005 the Department has conducted three tenders to determine the successful anaphylaxis management training provider.

18. The *Course in First Aid Management of Anaphylaxis 21659VIC* is currently being delivered to government schools by St John Ambulance Victoria and has a currency of 3 years.

19. The Department of Education and Early Childhood Development has also entered into an agreement with the Royal Children's Hospital to provide anaphylaxis management advice to schools and early childhood services. This advice line can be accessed on weekdays between 8:30am and 5:00pm and is able to provide assistance in the development of school-wide communication strategies, emergency response plans as well as anaphylaxis management plans.

20. In May 2009 a second adrenaline auto-injector device came onto the market. This device, Anapen®, has a substantially different injector mechanism to the EpiPen®. For those staff who have attended Course 21659VIC within the last three years Anapen® training would not have been integrated into the course.

21. Where a child or young person presents at a government school with an Anapen®, schools can receive additional funded training in Anapen® administration through St John Ambulance Victoria. St John Ambulance Victoria has also integrated Anapen® administration training into their existing course.

22. The Department has also purchased a trainer Anapen® for every school in Victoria and will provide the trainer Anapen® before the end of the 2010 school year.