Spare pens save lives—so why aren't they in every school?

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At least one pupil in every classroom is at risk of food-induced anaphylaxis. Early intervention with adrenaline [epinephrine], by intramuscular injection or more recently the intranasal route, is critical in managing anaphylaxis. To facilitate this, adrenaline is available in many countries as an adrenaline autoinjector (AAI) device for self-administration by patients or caregivers/lay people including school staff. The UK Medicines and Healthcare products Regulatory Agency (MHRA) recommends people at risk of anaphylaxis have access to two adrenaline autoinjectors (AAIs) at all times.[1] The MHRA advice is interpreted in different ways: some GPs will provide four AAIs (two for the patient, and two for school), while others will only prescribe two per patient. This variability is clearly described in an analysis by Turner and colleagues in this issue of Archives of Disease in Childhood.[2]

The rationale for requesting pupils to keep additional AAIs in schools (in addition to the two AAIs they should keep on them) is simple: the child/family may forget to bring AAIs to school every day, or they may be out of date. However, in an emergency, school staff can waste critical minutes in trying to find and identify a pupil's own AAIs, particularly when there are multiple pupils and therefore staff have to look through a number of different sets of AAIs to match them to the correct pupil.[2] In addition, many children with food allergy are not prescribed AAIs, and 30% of school-based reactions happen in children without a prior diagnosis of food allergy.[2]

Legislation introduced in 2017 allows schools to purchase spare AAIs to help improve anaphylaxis care.[3] However, uptake remains inconsistent—held back by lack of funding (schools must pay private costs for spare AAI), awareness, uncertainty around roles and responsibilities, and complacency. Around half of UK schools still don't hold spare AAIs.[4] Where they do, it's often thanks to local champions or fundraising—hardly a sustainable model for life-saving care.

THE POLICY GAP

UK legislation allows schools to buy spare AAIs, but there is no mandate or state funding for them to do so. This creates a postcode lottery, where a child's protection can depend on where they go to school. Many schools are unclear who is allowed to administer the AAIs, where they should be stored or how they are replenished.[4]

This uncertainty introduces dangerous delays. The National Child Mortality Database shows that 76% of fatal allergic reactions in children involve modifiable factors, including delays in treating with adrenaline.[5] Prevention of Future Death reports issued by HM Coroners echo the same failures.[2] Countries like Canada have had laws mandating allergy safety in schools for two decades.[6] In the UK, we're still shaking buckets to raise money for potentially life-saving medication in our schools.

THE PROPOSED MODEL: BENEDICT'S LAW

First presented to the Department for Education in 2023, Benedict's Law[7] calls for schools to:

- Hold spare AAIs (or non-injectable adrenaline devices, as they become available)—centrally funded by government
- Train all staff in allergy awareness and emergency response
- Implement and publish a school-wide allergy policy.

Named in memory of 5-year-old Benedict Blythe who died from anaphylaxis at school in 2021, the proposal builds on existing legislation. At his inquest, the Coroner concluded that school staff were not adequately trained, spare AAIs were not available, and appropriate policies were not in place to keep him safe. Had these things been in place, his death may have been prevented. This is not just a moral imperative—it's also a financially sound policy. It will likely save lives and release system-wide savings that can fund training and implementation.

Box 1 Case study, South London

Launched in 2020 by St George's University Hospitals NHS Foundation Trust, the Emergency Allergy Bag Scheme has equipped over 140 schools in Wandsworth and Merton with a kit containing two adrenaline auto-injectors (AAIs) for use in an emergency. The initiative, prompted by two allergy-related deaths in London schools, was made possible through a business case supported by local GPs, school nurses, pharmacists and Wandsworth and Merton ICBs (integrated care boards).

Each school also receives annual training for staff, with both in-person and online formats. In September 2024 alone, more than 100 staff were trained, with 98% reporting improved understanding of anaphylaxis, and 94% feeling confident to use an AAI in an emergency.

To date, the spare AAIs have been used in at least five incidents, including for a student with expired devices and another with no known allergy. Parents have welcomed the scheme, with one saying, "It's a great reassurance that schools are prepared. This will save lives."

The benefits of the scheme are clear: a replicable model that combines emergency preparedness with education, and at the same time can be cost-neutral. It demonstrates how health bodies, schools and local partners can collaborate to deliver rapid, safe care—setting a strong precedent for regional or national adoption to protect children with allergies across the UK.

A QUESTION OF EQUITY AND SAFETY

Children in deprived areas are more likely to attend schools without spare AAIs—and are also less likely to be prescribed AAIs.[2 4] This places the most vulnerable children at greatest risk. When allergy safety is inconsistent, safeguarding is incomplete. Allergy safety *is* safeguarding—and it's time we treated it that way.

Benedict's Law would standardise access, ensuring no child is less protected due to geography or school funding. It proposes that spare AAIs be centrally funded and delivered directly to schools—not just prescribed individually.[7] This model offers four key advantages:

1. Faster response—staff can act immediately from a known, accessible location: they will not need to look through lots of medications to locate a child's own AAIs.[8]

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Box 2 Case study, Leicestershire

In 2021, spare adrenaline auto-injectors (AAIs; and since 2023, emergency salbutamol/spacer for asthma) have been made available in Leicester City and Leicestershire through charitable donations in 76 secondary schools. The project gained further momentum, and was extended to include 213 primary and secondary schools in 2023/24. In the first 2 years, the spare AAIs were used four times. In two cases, one child and one member of staff did not have access to an AAI, and access to the spare AAI was potentially life-saving. In a third, the spare AAI was used by a child whose own AAI was out of date. As of 2025, 458 schools (every school in the region) have received spare AAIs and salbutamol, at a cost of £49,145 through further charitable donations. The plan for 2026 is to achieve ICB (integrated care board) funding but subsidised by the savings resulting from no longer having to provide pupils with two AAIs solely for school use.

2. Less confusion—having a single brand of device for school-held AAIs would avoid confusion over any differences in how they are used in an emergency.[8]
3. Protects undiagnosed pupils and staff—30% of reactions in school happen in pupils without a prior diagnosis.[2]
4. Cost-efficient—cuts duplication in prescribing and releases funds for training.
5. Reduces the environmental impact by reducing the number of AAIs prescribed per child—over 2.3 million AAI devices are dispensed each year in the UK, but only about 2% are actually used.[9]

A MODEL THAT WORKS

Across the country, regional pilots and local initiatives have shown that it's possible, practical and financially sound to equip schools with AAIs (see boxes 1 and 2). These case studies show that delivering allergy safety in schools can be done—and offer a blueprint for national implementation. The evidence for this model can now be demonstrated across the UK: providing 'spare' AAIs to all schools (at no cost to the school)—instead of dispensing additional AAIs on a named-patient basis to multiple students within a school, purely to be kept on school premises—would be a cost-neutral strategy for the vast majority of integrated care boards, and one that would improve emergency access to adrenaline to all pupils, irrespective of whether they had been prescribed AAIs.[2]

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