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Submission to the Senate Standing Committee on Education and Employment

Inquiry: Quality and Safety of Australia's Early Childhood Education and Care System

Submitted by the Australian Paediatric Society (APS)

Date: October 2025

1. EXECUTIVE SUMMARY

The Australian Paediatric Society formally notifies the Senate that current Commonwealth-endorsed arrangements for managing high-risk medical conditions, specifically Type 1 Diabetes (T1D) and life-threatening allergy/anaphylaxis, within Australia's Early Childhood Education and Care (ECEC) system are already causing unacceptable, unlawful, and preventable clinical risk to children and to ECEC educators.

This represents a "**Pink Batts" style systemic failure**: a federally funded, nationally endorsed program was rolled out before lawful workforce competence and authorisation were ensured and preventable harm is already occurring. In the case of Type 1 Diabetes, a child has already died, and a criminal conviction has already been recorded for not providing the requisite training to employees. Within the last few weeks, a 3-year-old child almost died from severe anaphylaxis in a day care facility after being fed her allergen by an employee who lacked the requisite training to appropriately manage a child with severe allergy.

This submission is lodged to **prevent further deaths**, not explain them after the fact.

2. THE AUSTRALIAN PAEDIATRIC SOCIETY

The Australian Paediatric Society (APS) represents over 250 consultant paediatricians practising across regional, suburban, and remote Australia. Our members are frontline specialists who directly support children with complex and high-risk medical conditions, including Type 1 Diabetes, severe allergies/anaphylaxis, epilepsy, congenital and neurodevelopmental disorders within homes, hospitals, schools, and early childhood education environments.

APS is Special Society of the Royal Australasian College of Physicians and is independent, non-commercial, and clinically led. We operate without financial influence from third-party organisations and are careful to avoid any "alliance" situation that could impede our ability to advocate on behalf of our patients. We are considered the "Voice of Rural Child Health", and our prime mandate is the safety, rights, and health of children, and the legal and regulatory integrity of the systems in which they receive care.

APS paediatricians frequently act as the final escalation point when failures occur in ECEC settings. We are therefore submitting to this Inquiry not as commentators, but as physicians who have already witnessed preventable harm, and who are now serving fair and formal notice to Parliament that the risk is live, systemic, and escalating.

3. THE CORE COMPLIANCE FAILURE: ALREADY PHYSICALLY UNSAFE AND LEGALLY NON-COMPLIANT

At present, ECEC services nationwide are being encouraged by the Federal Government to perform high-risk medical care, including insulin administration, and anaphylaxis prevention and management (including adrenaline autoinjector use), without legally adequate training, authorisation, or workforce readiness.

In both Type 1 Diabetes and anaphylaxis care, the same systemic failure is present: the Commonwealth **has relied on workforce 'awareness' rather than legally accredited competence and authority**. In Type 1 Diabetes, this has taken the form of funding and endorsing a non-accredited, non-Registered Training Organisation (RTO) program (Diabetes in Schools) as if it met Work Health and Safety (WHS) and medicines-law obligations, which it does not. For anaphylaxis management, the National Regulations require only a single staff member per service to hold anaphylaxis training, despite established clinical guidance that all educators must be trained. Because one trained person is inadequate if that staff member is absent, in another room, or replaced by untrained relief staff, creating a known and foreseeable safety gap.

This error has **misled ECEC services into believing they are compliant**, when in truth they **remain in breach of several legal frameworks**:

- Work Health and Safety Act 2011 - duty to ensure "requisite" and "appropriate" training proportionate to risk
- State and territory Medicines and Poisons legislation - insulin is a Schedule 4 restricted medicine, lawful only when administered by *authorised and qualified personnel*.
- Disability Discrimination Act 1992 - creating a "no-win compliance trap" where services must either exclude the child or risk committing a WHS breach
- National Quality Framework (ACECQA) - which demands "safe systems" and "appropriate training" under Quality Areas 2 and 7

Put bluntly — **the ECEC sector has been placed in an impossible legal position by federal policy design failure.**

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4. ACCREDITED ALLERGY TRAINING EXISTS — BUT IS NOT REQUIRED FOR ALL EDUCATORS. DIABETES TRAINING IS NOT ACCREDITED AT ALL.

A critical distinction must be clearly understood by the Senate:

Clinical Area	Is Nationally Accredited Training Available?	Is It Mandated for All Staff?	Is Current Practice Legally Safe?
Anaphylaxis / Allergy	**Yes.** First Aid + Anaphylaxis Competency Units (ASQA-recognised)	**No.** Only one or a few staff are typically trained	**System remains fragile.** Coverage gaps lead to preventable danger
Type 1 Diabetes	**No.** The Diabetes in Schools program is **not accredited**, not RTO-delivered, does **not** confer any qualification or authorisation	**Not applicable.** There is *no lawful training pathway* available	**Already legally unsafe.** This is why criminal convictions have occurred

In other words:

- Allergy care has at least a proper accredited training pathway available. It is simply not universally implemented to all educators.
- Type 1 Diabetes has *no accredited training pathway at all* for non-clinical educators. Yet they are being asked to perform Schedule 4 medicine administration daily.

This is not a training uptake problem. In the diabetes case, it is a **federal policy design failure**.

5. SAFE WORK AUSTRALIA HAS ALREADY CONFIRMED THE LAWFUL, ACCREDITABLE STANDARD — AND IT IS NOT CURRENTLY BEING IMPLEMENTED

The International Society for Paediatric and Adolescent Diabetes (ISPAD) is considered the world authority on T1D. In 2024, it released an international consensus Position Statement on Management of Type 1 Diabetes in Schools (attachment 1) legally validated by Arnold Bloch Leibler. Much of the ISPAD Position Statement, especially relating to workplace safety, is applicable to ECEC settings.

On 25 March 2025, Safe Work Australia CEO Marie Boland wrote directly to the APS in relation to the ISPAD Position Statement, recognising *"the importance of schools meeting their duties under the model Work Health and Safety (WHS) Act to ensure, so far as is reasonably practicable, the health and safety of children under their care - including those with medical conditions such as type 1 diabetes."* She noted *"Justice Ellis' judgment in the case of DPP v Kilvington Grammar School Ltd and World Challenge Expeditions Pty Ltd [2025] VCC 21. The case emphasises the importance of duty holders doing all that can reasonably be done, within a given set of circumstances, to meet their health and safety duties."*

Ms Boland acknowledging that: *"It would be open to any PCBU* (a person conducting a business or undertaking) *to adopt the ISPAD Position Statement on Type 1 Diabetes in Schools..."* and emphasised that duty holders are legally obliged to ensure employees receive: *"appropriate training required to manage WHS risks effectively."*

This is an unambiguous regulatory acknowledgement from Australia's peak WHS authority that:

- ISPAD is already a valid and lawful standard for adoption
- Duty holders cannot rely on generic awareness training (such as Diabetes in Schools) where the risk is high
- No regulator has ever declared existing diabetes training in schools or ECEC services to be legally sufficient
- "Appropriate training" for high-risk medical procedures must meet WHS standards, not convenience or familiarity standards

This statement confirms beyond dispute that the Commonwealth's current reliance on non-accredited, awareness-only education is insufficient, and does not shield providers from liability.

The APS urges the Commonwealth to align its national programs with this legal precedent to ensure schools, and governments, are not left exposed to preventable harm or criminal liability.

6. THERE IS NO "WORKSAFE APPROVAL" — AND CLAIMING SO IS MISLEADING

Currently, some peak bodies are recommending that ECEC services be "trained" by completing the Diabetes in Schools program. Although originally designed for school-aged settings, the **program is now being used and promoted within ECEC**, making its adequacy and legality a direct matter for this Inquiry.

Some education sector stakeholders have attempted to imply that "WorkSafe has approved current systems" or that the Diabetes in Schools model has been accepted as meeting "industry standards." This is incorrect and potentially misleading.

From APS's official evidence to regulators, and confirmed by multiple jurisdictions, three facts are clear:

- No Australian Work Health and Safety regulator has ever formally endorsed the Diabetes in Schools program or declared it safe or compliant. Despite the claim that the Diabetes in Schools architects "consulted widely" they failed, despite requests, to include WHS representatives. The absence of a criminal conviction against a school using the program does not indicate WHS compliance, only that legal proceedings have not yet occurred.
- There is no audited, accredited, or federally declared "industry standard" for diabetes care by non-medical ECEC staff.

- WorkSafe ACT has previously issued an Improvement Notice (2017), and WorkSafe Victoria has referred serious diabetes-related failures for criminal prosecution (2025), indicating regulatory concern, not approval.

At the Heads of Workplace Safety Authorities (HWSA) meeting on 27 June 2024, state and territory WHS regulators formally determined that the Diabetes in Schools program is a **regulatory issue**, and the CEO of Safe Work Australia advised she would write to the Secretary of the Department of Health to **raise concern over its compliance status**.

Unless the government can produce a formal, published determination stating that Diabetes in Schools is WHS-compliant and medicines-law authorised, any claim of regulatory approval must be treated as **false reassurance and system-risk amplification**.

7. THE DIABETES IN SCHOOLS PROGRAM FALSELY IMPLIES THAT PRINCIPAL "DESIGNATION" IS SUFFICIENT AUTHORITY TO ADMINISTER INSULIN

Diabetes Australia's Diabetes in Schools "Level 3" module claims that **upon completion of its online skills module**, "*participants should be able to administer insulin with an insulin pen, syringe or insulin pump.*" The program further states that **school principals may simply "identify" staff as "designated"**, and that *"in some cases, designated staff will administer insulin."*

This is legally incorrect and dangerously misleading. School principal identification does not confer lawful authorisation to administer a Schedule 4 prescription medicine under any WHS or Medicines and Poisons legislation in Australia. No WHS regulator or medicines regulator recognises school principal designation as a substitute for accredited training with formal competency assessment and legal authorisation**.**

Similarly, in ECEC services, the mere act of appointing a staff member as the "Responsible Person" under the National Law and National Regulations does not create legal authority to administer a Schedule 4 medicine such as insulin. The Responsible Person role relates to supervising the service and ensuring regulatory compliance. It does not override medicines and poisons legislation, nor does it equip educators with the clinical competencies required to safely calculate insulin doses, adjust for carbohydrate intake or physical activity, or respond to hypoglycaemia. Any suggestion that "designation" or role-based responsibility alone permits insulin administration in an ECEC context is therefore equally incorrect, exposing educators and providers to significant personal and organisational liability under WHS law.

8. CURRENT HARM — AUSTRALIAN CHILDREN ARE ALREADY AT RISK OR EXCLUDED

To ensure the Committee understands this is not theoretical, APS provides results of a recent survey of children with severe allergy or Type 1 Diabetes in ECES and three recent anonymised, representative vignettes reflecting patterns documented in evidence already before the Inquiry:

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1. Unsafe incidents for allergy and T1D

On 22nd September 2025, a 3-year-old boy who had known anaphylaxis to cow's milk, was attended his usual daycare who were in possession of his anaphylaxis management plan and adrenaline autoinjector. His mother stated: "*an educator at the daycare fed X a bowl of cereal with cow's milk. The educator didn't think there was an issue/ didn't realise he was in a state of distress and thankfully, only by sheer luck the centre manager walked into the room and immediately administered his EpiPen and called for Ambulance Victoria.*" "*His discharge paperwork shows an additional 6 shots of adrenaline were required in addition to several other medications and oxygen. He has not returned to daycare, and I have reservations about their ability to keep him safe.*"

In an ECEC environment, a 2-year-old child with Type 1 Diabetes received a massive insulin overdose requiring urgent ambulance escalation and intravenous glucose treatment. The incident is consistent with reported cases where ECEC staff trained only via awareness modules misinterpret Continuous Glucose Monitor alarms and dosing instructions. The Schedule 3 drug Glucagon is prescribed for all children with Type 1 Diabetes as the "antidote" to excessive insulin administration. One parent stated, *"Daycare have said they legally can't administer glucagon due to syringe/needle."* This left a two-year-old with no legally authorised first responder on site during a medical emergency.

This is not a training gap. It is a structural systems failure. The only life-saving medication available could not lawfully be used, and the child's survival depended on ambulance response time, not workplace readiness.

2. **Exclusion from ECEC participation:**

In September 2025, a toddler with Type 1 Diabetes was refused enrolment at an early-learning service because staff were "not comfortable injecting insulin," despite the service advertising that it had completed diabetes "training." Families report repeated refusals and withdrawal from services due to safety concerns and lack of authorised and qualified staff.

A mother of a two-year-old girl, diagnosed with Type 1 Diabetes on 7th May 2025 has been excluded from day care after the local council-run facility received **legal advice that their staff could not be adequately trained.**

The Centre Manager advised the parent that *"the issue with administration of the insulin is not the means that it is administered (whether injection or machine), it is that it is a scheduled drug that requires specific training to administer and the training isn't available in Victoria for the team to be accredited to administer. Ventolin and epi-pens are not scheduled and do not carry the same risk of overdose. The legal team have closed the case providing this clarity."*

In a letter to her local state member, the parent stated *"I am seeking your urgent support to address a serious and systemic barrier preventing her from returning to her early childhood education setting. X now uses an insulin pump, which requires active monitoring and adjustments during the day to keep her blood glucose levels safe. Under Victorian law, insulin is a Schedule 4 (prescription-only) medicine, and current legislation states that only trained*

health professionals or non-health professionals who have completed appropriate accredited training, can administer or assist with insulin therapy.

I hope you can appreciate the importance of inclusion in early learning, not only for educational development but for the child's emotional wellbeing and social growth. X's right to ***access early education is being denied because of a systemic gap, not because of any unwillingness*** *from our educators who have been nothing but supportive.*

"...more families will be left "stuck" in the ***same impossible position*** *we are in now; unable to work, unable to access childcare, and with no sustainable alternative."*

Currently, as **correctly advised** by the Council legal team, accredited training in Type 1 Diabetes simply does not exist for early childhood educators.

3. **Burden-shift to parents (unsafe systems of work):**

Type 1 Diabetes - A parent was required to attend the centre daily to administer insulin because no staff member was qualified/authorised to perform insulin administration. The family's workforce participation was reduced, and the child's day was repeatedly disrupted.

The parent states: *"Since X's diagnosis, I have been* ***unable to return to work due to the lack of safe and lawful care option****s. This has had a profound personal impact. I feel constant guilt for not being able to contribute financially to our household, particularly in the current economic climate. I also feel frustrated that I can no longer "switch off" from my role as a mother and carer or use my professional skills in a productive and stimulating way. I have invested years of study and financial resources into building my career, which is now indefinitely on hold. In addition, I've lost the daily sense of purpose, connection, and identity that came from my workplace relationships. Being in a 24/7 caring role with no clear endpoint due to the systematic gaps we are facing, often leaves me* ***feeling isolated and emotionally drained****."*

These examples reflect a broader national pattern captured in Type 1 Voice Submission No. 90, which documents that **over 70% of families report participation barriers** in early childhood settings, **more than 50% have withdrawn or reduced workforce participation** due to safety concerns, and **multiple clinically dangerous near misses,** including insulin overdoses and treatment delays exceeding 30 minutes, have already been documented in ECEC environments.

9. EDUCATION DEPARTMENTS HAVE STATED THE REQUIREMENT; HEALTH CREATED THE MISALIGNMENT

APS notes that Education portfolios (Commonwealth and state) publicly set out compliance duties under the NQF/NQS and link them to WHS-aligned training expectations for high-risk care. However, the **Commonwealth Department of Health funded and endorsed Diabetes Australia's *Diabetes in Schools* program, despite being non-accredited, non-RTO, and conferring no qualification or authorisation**. As a result of Federal endorsement, this program is widely used, including in the ECEC sector, as the **default training "solution**." Federal

acknowledgements already on record confirm that this program does not confer any qualification to administer insulin.

Heads of Workplace Safety Authorities (HWSA) have also treated the program as a regulatory issue, prompting Safe Work Australia's CEO to communicate the matter to the Commonwealth Health portfolio, again underscoring that Health, not Education, enabled the legal misalignment.

In short: Education has described what is required; Health funded something that transgresses it. **The misalignment is federal and inter-portfolio, not an ignorance gap in the sector**.

10. SYSTEMIC PARALLELS — ALLERGY VS TYPE 1 DIABETES (SAME FAILURE, DIFFERENT STAGE)

Dimension	Severe Allergy / Anaphylaxis	Type 1 Diabetes
Training architecture	**Accredited** first-aid/anaphylaxis units exist (ASQA-recognised).	No accredited pathway for first aid, insulin/ketone management. Diabetes in Schools is **not accredited** and confers **no authorisation**.
Implementation reality	Often **one or few** trained staff; coverage gaps persist (absences, room moves).	"Awareness" sessions common. **No qualified/authorised staff** for S4 medicine dosing.
Legal posture	Framework exists but **under-implemented** (risk = variable readiness).	**No lawful pathway** so providers cornered between WHS breach or exclusion. Incidents and prosecutions have occurred.
Regulatory signal	Expectation that high-risk medication requires trained competence.	**SWA CEO confirms** adoption of ISPAD is open to duty holders. **No regulatory approval** for current diabetes "training."

11. APS ENDORSEMENT OF NATIONAL ALLERGY COUNCIL POSITION

The APS formally supports the recommendations of the National Allergy Council (NAC) that:

- All ECEC staff should be supported and ultimately mandated to undertake formal ACECQA-approved anaphylaxis training and food allergen management training.
- This training should be fully accredited, competency-based, and refreshed regularly, in alignment with the NAC's recommendation of:
    - full certified training every two (2) years, and
    - 6-monthly refresher micro-training for all staff.

The APS further endorses the NAC call for a change to the National Regulations to make this **training mandatory for *all* ECEC staff** not limited to one or two nominally designated first aiders.

APS submits that the *identical regulatory logic* applies to Type 1 Diabetes given that both anaphylaxis and T1D are *rapid-onset, life-threatening medical emergencies* requiring time-critical medicine administration (adrenaline vs insulin). It is **clinically and ethically indefensible to mandate training for one but leave the other unregulated and unaccredited**.

12. LEGAL PRECEDENT: LACHLAN COOK (JUSTICE ELLIS) FINDING; LIABILITY REMAINS WITH THE EMPLOYER, EVEN WHEN A PARENT GIVES INCORRECT MEDICAL ADVICE

The Victorian Justice Ellis judgment into the preventable death of Lachlan Cook established a critical legal fact: an untrained teacher sought advice from Lachlan's parent during a medical deterioration and the advice given by the parent to the teacher was tragically incorrect. Yet it was the school (the employer), not the parent, that was prosecuted.

This confirms that **workplace training must be sufficiently robust to recognise clinical danger even when receiving well-intentioned but incorrect parental guidance**. Parent instruction does not transfer legal responsibility under WHS law, nor does it meet the standard of "requisite training."

This precedent eliminates any policy argument that "parent handover" or "parent-designed care plans" can replace accredited workforce training or lawful authorisation.

13. PROFESSIONAL AND INSURER POSITION — NO CLINICIAN CAN LAWFULLY "TRAIN" UNQUALIFIED EDUCATORS

In correspondence to Victorian Minister for both Education and WorkSafe, Ben Carroll MP (attachment 2) in March 2025, the APS advised (on behalf of diabetes medical specialists and certified diabetes educators) the **following insurer advice**:

*"It is **not the responsibility of clinicians to 'train' medically unqualified school or ECEC employees, nor to certify their competency**. Legislation makes clear that training and competency assessment of employees is the legal responsibility of the school or employer and must occur via a Registered Training Organisation — **not via treating health professionals**."*

The letter further clarified that, since the WorkSafe criminal conviction of Kilvington Grammar, schools now understand they are legally liable, but no lawful training pathway exists in Victoria for authorising non-medical staff, unless they complete a nursing qualification.

As a result, **schools are increasingly refusing access to off-campus activities** (e.g. school camps) **for students with Type 1 Diabetes** rather than fund a qualified and authorised nurse, breaching the Disability Discrimination Act and excluding children from ordinary participation.

14. PINK BATTS PARALLEL — A FEDERAL DESIGN FAILURE WITH FORESEEABLE HARM

- **Then:** A National program scaled without accredited workforce competence led to deaths and a subsequent Royal Commission.
- **Now:** National ECEC inclusion aims pursued without accredited, lawful training for high-risk medical tasks has led to documented harm in both ECEC and schools and in the case of schools and commercial camp /tour operators, prosecution, coronial findings citing absence of requisite training.

The Commonwealth **cannot deflect responsibility to states when funding, endorsement, and program design signals originate federally**, and the national WHS authority (SWA) has already indicated that ISPAD-level training is open to adoption yet not implemented.

15. WORKPLACE SAFETY REGULATORS HAVE ALREADY ESCALATED THIS AS A LIVE REGULATORY FAILURE (HWSA — JUNE 2024)

As confirmed in Type 1 Voice Submission No. 90 to this inquiry, this issue is already before the Heads of Workplace Safety Authorities (HWSA):

"*On 27 June 2024, a meeting of the Heads of Workplace Safety Authorities (HWSA) discussed the advice and practices of the Diabetes Australia program. It was determined that the state and territory WHS regulators consider the Diabetes Australia program to be a regulatory issue. Subsequently, the CEO of Safe Work Australia stated that she would write to the Secretary of the Department of Health advising him of the regulatory issue.*"

This confirms the matter is already recognised, at the national WHS regulator level, as a **present legal and compliance failure**, not a future policy concern.

16. THE COMMONWEALTH IS ACTIVELY FUNDING AND CONTRACTUALLY ENFORCING A NON-ACCREDITED, LEGALLY NON-COMPLIANT TRAINING MODEL

Through FOI disclosures, APS notes that Diabetes Australia has paid millions of dollars to major public hospitals under **contracts that bind them to exclusively deliver the Diabetes in Schools program.** No Commonwealth funding has been directed to developing or delivering an accredited RTO-based training pathway because one does not exist. (Attachment 3 FOI 4814). This program is not accredited, not RTO-delivered, and has not been declared WHS-compliant by any Australian safety regulator.

These exclusive contracts have the **policy effect of structurally entrenching a non-accredited model, and preventing the development and adoption of a lawful, RTO-delivered accredited training pathway.**

It is therefore clear that the Commonwealth is not merely tolerating an interim model - it is **actively funding and enforcing the continuation of a non-lawful system**, despite its escalation as a regulatory concern by HWSA and the availability of ISPAD as a recognised lawful standard under WHS law.

17. NEW FEDERAL POWERS WILL ACCELERATE EXCLUSION OF TYPE 1 DIABETES CHILDREN IF TRAINING FAILURES ARE NOT IMMEDIATELY FIXED

In July 2025, the Australian Parliament passed the Early Childhood Education and Care (Strengthening Regulation of Early Education) Act 2025, granting the Commonwealth direct power to suspend or cancel funding to childcare centres that breach safety law or fail to meet NQS safety obligations.

These powers were enacted to lift safety and quality standards, but in the current context they will have the opposite effect.

If the Commonwealth simultaneously enforces a higher safety compliance threshold while continuing to fund and endorse a non-accredited, unlawful training model for diabetes care. Services will default to exclusion, not safety.

The APS warns that without urgent correction of the training and authorisation framework and a moratorium, these **new powers will accelerate the wholesale exclusion and discrimination of children with Type 1 Diabetes from early education settings**. They will not prevent risk but drive it underground.

This represents a direct and foreseeable breach of the Disability Discrimination Act (DDA) if left uncorrected.

18. APS IS READY TO PROVIDE THE TYPE 1 DIABETES SOLUTION — AND HAS ALREADY COMMENCED DEVELOPMENT

The APS confirms that the solution already exists.

In 2017, the APS has previously developed the international award winning (2019) and ISPAD-endorsed T1D e-learning modules used in schools. (t1d.org.au) In conjunction with the National Type 1 Diabetes Council, APS has already commenced development of a new RTO-deliverable training and qualification pathway specifically designed to satisfy WHS, Medicines & Poisons law, and ACECQA/NQF integration.

APS stands ready to work with the Commonwealth to deliver this lawful national training and authorisation model immediately upon government direction.

19. RESTORING PUBLIC TRUST — SUPPORT FOR THE NATIONAL TYPE 1 DIABETES COUNCIL UNDER A CLEAN-SHEET GOVERNANCE MODEL

The Australian Paediatric Society confirms that it is committed to contributing to the solution and welcomes collaboration under a lawful, accredited, nationally consistent framework.

It is, however, a matter of record that APS and Type 1 Voice first formally raised WHS and clinical safety concerns regarding diabetes care in schools and early learning in early 2017, two years before the death of Lachlan Cook. Those warnings were not acted upon, and the organisations with influence at the time, including Diabetes Australia and its Alliance partners, have since become financially tied to the delivery of the Diabetes in Schools program.

This has understandably **eroded public and clinical confidence**, particularly where health service providers are now seen to be **safeguarding a program they are simultaneously funded to deliver.**

APS submits that restoration of safety and trust requires leadership to be exercised through the existing National Type 1 Diabetes Council, which, like the National Allergy Council, already includes unconflicted clinicians and consumer representatives.

APS respectfully recommends that any organisation with direct financial entanglement in the current non-accredited model should not continue in a leadership role over national T1D safety reform.

20. RECOMMENDATIONS (APS — FOR IMMEDIATE ADOPTION)

1. **Commonwealth-underwritten moratorium (time-limited).**

Protect ECEC providers and employees from enforcement/exclusion while an accredited, lawful pathway is built for Type 1 Diabetes and simultaneously mandate interim risk controls (two competent adults present, drills, medicine/device access audits) for both allergy and Type 1 Diabetes. This aligns with consumer evidence already before the Committee. A similar moratorium, perhaps over a shorter period, should be enacted for expanded allergy training.

2. **Create an accredited national qualification & authorisation pathway.**

Commission ASQA and ACECQA with APS, the National Allergy Council and the National T1D Council to develop RTO-delivered, competency-assessed units covering Type 1 Diabetes First Aid, insulin dosing/administration, high/ low and exercise glucose protocols, Automated Insulin Device troubleshooting, and anaphylaxis prevention and response, aligned to state medicines law, the ISPAD Position Statement on Management of Type 1 Diabetes in Schools and the National Allergy Council recommendations.

3. **Integrate into the NQF/NQS (QA2 & QA7).**

Require services enrolling children with Type 1 Diabetes or severe allergy in ECEC centres to demonstrate staffing sufficiency (>2 qualified/authorised on-duty whenever the child is present), documented drills, and audited access times to medicines.

4. **Clarify the regulatory record.**

The Commonwealth should publish a statement confirming that no WHS regulator has endorsed Diabetes in Schools as compliant, and that ISPAD levels of education and training (ISPAD Position Statement) is an available lawful standard under WHS risk management.

5. **National incident & near-miss reporting.**

Fund a central register for T1D (insulin dose and other serious errors) and inadvertent allergen exposure incidents/near-misses in ECEC to track risk reduction and inclusion effects post-reform. Consumer reports already indicate high exclusion and harm.

CONCLUSION

This Inquiry is not being asked to speculate, but to **act on what is already known**:

- The legal standard for safe, lawful practice is clear (WHS, medicines legislation and legally validated ISPAD Position Statement).
- The national WHS authority has confirmed that adopting ISPAD Position Statement standards is open to duty holders.
- The Commonwealth Department of Health funded and endorsed non-accredited training that does not meet that standard, creating a foreseeable, preventable risk now realised in documented harm and a criminal conviction.
- The same failure model is evident in allergy (accredited pathway exists but is under-implemented) and diabetes (no accredited pathway at all).
- Without decisive reform, the Committee will be forced to study further avoidable tragedies **after the fact**.

APS urges the Senate to immediately:

(1) endorse a time-limited moratorium for severe allergy and Type 1 Diabetes management

(2) commission an accredited, lawful qualification and authorisation pathway, and

(3) integrate it into the NQF/NQS so that no child's safety depends on whether the one "trained" person is on shift.

ATTACHMENTS (attached with this submission)

1. **ISPAD Position Statement on Type 1 Diabetes in Schools (2024)** - clinical benchmark for "requisite training" and lawful authorisation pathway (referenced within evidence).
2. **Correspondence to Victorian Minister Ben Carroll** (Minister for Education and WorkSafe) in March 2025
3. **FOI documentation relating to Diabetes in Schools program**

Australian Paediatric Society (APS) *on behalf of its membership*

Hormone Research in Paediatrics

Guidelines

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ISPAD Position Statement on Type 1 Diabetes in Schools

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Preface

The International Society for Pediatric and Adolescent Diabetes (ISPAD) strongly supports compliance with legal protections for children and adolescents with type 1 diabetes (T1D) to attend school, to be safe at school, and to receive optimal medical management during all school-associated activities [1]. ISPAD's Clinical Practice Consensus Guidelines [2–7] provide clinicians with concepts and standards for best clinical practice. To implement best clinical practice while the student is in the custody of the school requires understanding, respect, and compliance with the relevant legal frameworks [1–3]. The task is to execute medically complex management in a workplace designed for education. In recognition of the unique workplace requirements, ISPAD first commissioned the ISPAD Position Statement on Type 1 Diabetes in Schools in 2018 [1] to assist schools to implement the Clinical Practice Consensus Guidelines' concepts [2]. This 2024 Position Statement aims to clearly inform education authorities, schools, school personnel, parents and policy-makers on defined roles, legal responsibilities, human rights, and stakeholder obligations for the benefit of all students with T1D. Implementing best practice while students with T1D are in compulsory custody of a school has life-saving potential and reduces the risk of short- and long-term harm to enable the student to experience a rich and supportive academic environment [2–6]. ISPAD's primary role is to deliver advocacy and leadership [7] to ensure that children and young people with T1D are provided with a safe and

The information in this document is based upon publicly available documents and should not be relied upon as constituting legal advice.

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secure learning environment in school and address confusion regarding roles and obligations that exist within school systems. This revised ISPAD Position Statement, authored by members of the ISPAD Diabetes in Schools Special Interest Group [8], contains globally applicable principles and fundamentals [9, 10].

Definitions

Child	a person under the age of 18 who is not yet sufficiently mature and capable of making and putting into effect their own decisions
Parent	parent(s), legal guardian(s), or carer/caregiver(s)
Medical team	the usual health care team treating the student with T1D
School personnel	school nurses, teaching staff, and other school employees or contractors who may be involved with the care of the student with T1D
School	primary and secondary schools
Student	students of the requisite ages attending school
Glucose levels	blood glucose or sensor glucose levels
Medical orders	diagnostic or treatment directives prescribed by a physician or equivalent provider regarding the specific activities to be performed or delivered as part of a diabetes management plan for a child with T1D while in the custody and care of a school
T1D education	gaining of knowledge and perspective about T1D
T1D training	skill development and practical application of the education on the student with T1D
Requisite training	training required to qualify and authorize the performance and safe execution of necessary tasks, skills, and responsibilities in accordance with local jurisdictional requirements
Delegation	physician requesting another health care professional to provide care on behalf of the physician while the requesting physician retains responsibility for patient care

1. Background

1.1 T1D is a complex chronic medical condition that requires skilled medical and psychosocial management with a multidisciplinary team approach [1–6].

1.2 There is overwhelming evidence supporting the benefits of spending maximal time in normoglycemia and the harms associated with spending time outside that target range [1–6]. The aim should be to maintain glucose targets as close as possible to normoglycemia during the school day and other school sponsored activities.

1.3 Intensive insulin therapy (IIT) is the recommended therapy for young people with T1D because it leads to improved health outcomes and reduced risk of short-term and long-term complications. Intensive insulin therapy usually comprises frequent glucose monitoring, carbohydrate quantification, insulin dose calculation, insulin administration with meals, and insulin and nutrition adjustments for physical activity [1–6].

1.4 ISPAD recognizes that those living with T1D across the globe face a wide variation in access to modern insulins, advanced technology devices, glucose control material and proficient and skilled diabetes education resources. This results in different levels of clinical care internationally. Individual management is also influenced by unique family circumstances and personal or parental skill levels [1–6].

1.5 ISPAD acknowledges that these principles will apply to other forms of diabetes that require administration of insulin whilst the student is in the custody of the school.

2. T1D Management at School

2.1 ISPAD advocates that the absolute minimal level of T1D care at school in all countries abides by the following principles:
- The student with T1D has the right to safely attend school.
- The student with T1D has the right to experience equal opportunity, obtain equal education and participate equally in activities with their peers, including physical exercise and other extracurricular activities, with trained school personnel providing needed care [1–3].

2.2 A student with T1D may spend more than half of their waking hours in the custody and care of school, including time spent away from the security of home participating in after-school activities, school sports days, field trips, excursions, school camps, and commuting to and from school [1–3].

2.3 Time at school often presents as the most challenging part of the day for glucose levels to stay in target range. The usual school day comprises many variables that influence

glucose levels, such as sedentary learning times, physically active times, meal and snack times, and emotional variation including excitement and stress [1–6, 11–15].

3. Student and Family Emotional Health

3.1 T1D causes substantial impact on the student's life, as well as that of their siblings, family relationships, and parental working lives. Each family will have different access to physical, emotional and support resources, coping skills, economic circumstances, and medical education and support [1–3].

3.2 The emotional health of the student with T1D is optimized by a positive, proactive approach to all challenges of T1D, especially at school. The student should be supported by peers and school personnel to do anything their peers can do and not be restricted or limited in activities. The student should be provided with as little special care as possible, but as much as necessary [1–3, 11–15].

3.3 Parents are obliged to advocate for their child, knowing the short-term and long-term safety issues and the risk of complications or shortened life span which may result from inappropriate care [1].

3.4 If the parent considers the student is not yet sufficiently mature and capable of making and putting into effect their own decisions, the student will require assistance and/or supervision [1].

3.5 While the development of self-management skills is encouraged, the student should not experience disadvantage because of their ability to independently manage T1D. Students may be capable but should never be solely responsible for their management at school [1–3, 11].

3.6 Schools should not expect that young students will "learn responsibility" for self-managing T1D by leaving them unsupported during school hours. Schools should also understand that the duration the student has lived with T1D does not determine their ability to be self-sufficient [1–3].

3.7 The privacy and confidentiality of the student's T1D diagnosis and management must be respected, acknowledged by the school, discussed with the student and parent, and protected by the school [1–3].

3.8 Because of the relentless public demands of managing T1D, and the ongoing public discussion about "diabetes," students may be exposed to stigma and experience anxiety, depression, and social isolation. These feelings may lead to reluctance to effectively self-manage, especially during adolescence [1, 2, 8, 16, 17].

4. Medical Orders for T1D Management in Schools

4.1 ISPAD recommends the student's medical orders comprise of the following:

4.1.1 A concise emergency response plan (ERP) outlining recognition and individualized treatment protocols for low glucose levels and for high glucose levels [1–3].

4.1.2 Detailed individualized medical orders, also known as the diabetes management plan (DMP) consented by the parent or student and signed by the prescribing physician or delegated medical team member. The DMP outlines the physician's medical instructions for that student at school. The DMP should specify what diabetes responsibilities can or cannot be undertaken by the student based on the student's age, diabetes self-care abilities, and cognitive maturity. These include blood glucose checking, insulin administration, meal planning and adjustment, and adjustments for exercise [1–3, 18].

4.1.3 No other party can be a signatory to prescribed and consented medical orders [1, 19].

4.2 The student's individualized medical orders (DMP) and ERP cannot be altered by a third party under any circumstances without the consent and authorization of the parent and physician [1, 18, 19].

4.3 The school's obligation to execute measures to accommodate the student's medical needs while the student is in the school's custody does not result from the physician delegating those responsibilities to the school or school personnel. The physician is not responsible for the school's actions that are adopted to fulfil the duty of care owed to the student [18, 19].

4.4 Parents are the final arbiters of whether their child can self-manage certain aspects of T1D, including glucose monitoring and self-administration of insulin. The medical team should guide and support parents to ensure the student is not subject to inappropriately unrealistic expectations [1].

4.5 The medical team should advise on the content of training required to best execute the medical orders and include these requirements in the order (DMP) [1–3].

4.6 Schools, in conjunction with the parent (and student), should develop a written accommodations plan on how the student's medical orders are implemented. This document is known in various jurisdictions as a "504 Plan" (USA), "Health Support Plan" (Australia) and "Individual Care Plan" (Canada) [1–3, 11–18].

4.7 A parent cannot be expected to "fill the gap" of school resources and provide their child's medical management during the school day and school-sponsored activities [1–3].

4.8 Schools must permit students with T1D to monitor their glucose levels, administer insulin, and treat both low glucose and high glucose levels according to the medical orders (DMP) and written accommodations plan, in an appropriately safe place chosen in collaboration with the student and parent [1–3, 18].

4.9 T1D management should occur with minimal disruption to normal class routines and activities [1–3].

4.10 Students with T1D have the right to be encouraged and enabled to participate in physical activity with the appropriate adjustments for safety and optimal performance clearly outlined in the student's medical orders (DMP) [1–3, 11–15].

4.11 Managing nutrition during school hours, including calculation of carbohydrate content of school meals, is an important requirement of optimal T1D management. It requires a defined approach between parent, student, and school personnel. Whoever (parent or school personnel) is responsible to provide/calculate/check the carbohydrate content of meals and snacks should be identified in each case and in each circumstance, both on-campus and off-campus [1–3].

4.12 Schools should establish processes regarding the use and handling of diabetes equipment including lancets, syringes, or needles, and used test strips. Jurisdictional requirements and workplace safety should inform schools on the requirements to manage sharps and biological waste to minimize risks to both students and school personnel. It is recommendable that parents should provide the necessary resources such as sharps containers or other means of disposal, depending on local circumstances [1–3].

4.13 When sitting an examination, students with T1D are entitled to appropriate adjustments and provisions, including access to glucose self-monitoring devices (which may include a smart phone or other electronic device for CGM), access to low-glucose treatment, access to insulin, access to water, access to toilet, and be granted extra time if required. Education programs to assist school personnel to safely execute the appropriate adjustments during exams should be readily accessible [1–3].

5. Communication Requirements

5.1 The parent (and student where appropriate) should clearly define how to execute the student's medical orders at school, both on and off campus, and the school should clearly define how they will execute the student's medical orders at school, both on and off campus.

5.2 Communication strategies for the student with T1D should be clear, respectful, timely, and simple. Parents, and the student's medical team (with parental consent), should be accessible points of escalation for school personnel. For continuity of care, the medical team contact should be identified for each student [1–3].

5.3 Positive outcomes for the student can be achieved with a mutually supportive approach with effective communication between parents and school, augmented by modern communication technology if available [1–3].

6. The School Workplace and T1D

6.1. Schools are workplaces, subject to workplace safety legislation in many jurisdictions. Schools are obliged to manage the risks to the health and safety of all participants in their workplace. This includes ensuring schools provide safe systems of work, do not endanger the health of their students, and ensure their employees have the skills, knowledge, abilities, and appropriate standard of training to perform duties [18, 20–23].

6.2. ISPAD recognizes and acknowledges that school personnel comprise a diverse range of education professionals [23], whose primary expertise is in educating young people. They are not lay persons but a professional class of employees [23]. School personnel are entitled to education and training to work safely [17].

6.3. Most school personnel have no medical qualifications, no medical training, and no medical experience [23].

6.4. Some school personnel may be uncomfortable with health-related information and procedures [1–3, 11]. Various resources exist, and tools have been developed and evaluated [8, 19], to educate and train school personnel.

6.5. The contributions made by school personnel to appropriately assist the student with T1D should be acknowledged and appreciated by all stakeholders involved in the student's care [1–3].

7. International Legal Rights for T1D

7.1. Legal frameworks and medicolegal obligations for safe and optimal management of T1D at school provide clarity of roles and purpose that can be successfully used to promote best medical practice to serve the best interests of the student, family, school personnel, and school [1–3, 5, 17, 18, 24].

7.2. The World Health Organization recognizes T1D as a disability. Many countries recognize

T1D under common law as a disability [1, 16, 25–30].

7.3. Recognition of T1D as a disability should be accurately represented to patients and stakeholders, acknowledging that such terminology does not define the person. Rather it provides the legal framework obligations for optimal management and equal opportunity. Disability should not equal exclusion and can be managed with inclusive interaction [25].

7.4. Accordingly, legal frameworks exist in many countries to protect children and adolescents with T1D against discrimination. Those frameworks affirm the student's legal and human rights to have an equal opportunity to participate in all aspects of school life on the same basis as their peers [1, 4, 5, 11–15, 18].

7.5. International human rights law lays down the obligations of governments to act in certain ways, or to refrain from certain acts, to promote and protect human rights and fundamental freedoms of individuals or groups. The rights of children with disabilities are specifically recognized in the *United Nations Convention on the Rights of the Child* and the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) [1, 25–29].

7.6. Most countries, including less resourced countries, are signatories or parties to the CRPD, which should protect young people with T1D from discrimination. This may be direct discrimination, for example, refusing school enrolment, or indirect discrimination, such as schools refusing to allow self-care in school or provide appropriately trained personnel to enable the child to participate in school life on an equal basis with their peers [1, 24].

7.7. In countries where legislative protections to support students with T1D are not expressly defined, ISPAD advocates that those countries adhere to their obligation under the CRPD [1].

7.8. All students with T1D should be allowed to attend school in a safe and supportive environment that enables best practice of management of T1D with trained staff in accordance with international legal principles [1–3, 11–15, 18, 22].

8. Reasonable Adjustments or Accommodations

8.1. A common form of disability and discrimination legislation obliges schools and education authorities to make reasonable adjustments or accommodations to facilitate prescribed complex T1D medical care, including the provision of appropriately trained personnel while the school maintains custody and care of the student [1–3, 16, 17, 23, 30–32].

8.2. In such legislative contexts, reasonable adjustments for a student with T1D may include insulin or glucagon administration where prescribed. In some countries, it may also include, where prescribed with parental consent in the medical orders (DMP), complex diabetes management relating to the requirements of optimal use of advanced diabetes technology including insulin pumps, continuous glucose monitors, and automated insulin delivery systems [1–3].

8.3. In settings where regular blood glucose checks and glucagon are not readily available, ISPAD advocates for the most optimal interventions possible, including basic first aid management of hypoglycemia with adult supervision of the student until full recovery. Optimal management also includes allowing and supervising insulin administration during school hours when prescribed. Schools' obligations have been clarified in various courts and are consistent across jurisdictions [1–3, 7, 22, 23].

9. Schools' Duty-of-Care Obligations to Protect from Foreseeable Harm

9.1. Where government education systems require compulsory school attendance, authority over the student is delegated to the school. This creates a positive duty for schools to proactively take steps to protect students from foreseeable harm [1, 2, 18].

9.2. Generally, under common law and comparable systems of law, all school students, irrespective of their medical diagnosis, are legally protected through the schools' duty-of-care obligations. Schools are required to take care to protect students from harm that is reasonably foreseeable. The legal concept of negligence imposes duties and responsibilities to avoid injury to a person, whom, it can be reasonably foreseen, might be injured by an act or omission [1–3, 18].

9.3. There is foreseeable harm for the student with T1D experiencing out-of-target glucose levels. By executing prescribed medical orders, the school gives the student the best opportunity to maintain target glucose levels [1–6, 10, 17, 22].

9.4. There is foreseeable harm for the student with T1D experiencing discrimination, bullying and stigmatization that impacts self-esteem, motivation, and emotional health [1, 4, 5, 16, 19].

9.5. In countries with legislative obligation for parents to send their child to school, the standard of care required of schools is high. The duty-of-care obligations for schools consider the vulnerability of students and require schools and school personnel to act positively to best ensure against the risk of injury. This includes protecting students from harm caused by themselves or others [1, 26, 33].

9.6. It is important that school personnel are informed about the seriousness of T1D and the school's obligations while they have custody and care of the student [23]. The school's custodial role for students ensures that the obligations to the student with T1D are not diminished or relinquished by a student being deemed to be "self-managing" [1, 23].

9.7. To assist the school and education authority to meet their duty-of-care requirements and legal obligations for a student with T1D, those schools and education authorities should:

9.7.1 Educate all school personnel about T1D and the need to actively respond to emergency situations [1–3, 11–15, 18, 23].

9.7.2 Educate and train school personnel who have supervisory responsibilities for the student on first aid management. The individual nature of such education and training requires parental and student input [1–3, 11–15, 18, 23].

9.7.3 Provide trained staff, which may include a school nurse or other trained staff member, who can execute complex individualized T1D medical care, including insulin administration [1–3, 11–15, 18, 23].

10. Stakeholder Roles and Responsibilities

10.1. Individualized, person-centered care is the preferred approach to the planning, delivery and evaluation of health care that is grounded in mutual understanding, cultural awareness and partnerships between the accountable medical team, students and their families, and school personnel [1–3].

10.2. The responsibilities of the three main stakeholders are:

- Parents are ultimately responsible for the medical decisions made on behalf of their child. Therefore, the parents' informed consent and decisions regarding the health and wellbeing of their child are paramount. It is imperative that parents remain engaged as part of the team even when the student with T1D reaches adolescence [1, 22].
- The student's physician or nurse practitioner is responsible for prescribing medications. The medical team is responsible for outlining in detail the recommended medical orders for that student. The medical team usually comprises a doctor and diabetes educator and preferably also includes dieticians, psychologists, social workers, and exercise specialists who work directly with the student and family [1].
- School and the education authorities are responsible for executing the medical orders and parental guidance for the student's individualized care requirements. Schools are responsible for education and training of school personnel to ensure that they meet the requirements and are competent to execute medical orders provided by the parent and medical team including complex care and drug administration [1].

11. Education and Training for School Employees

11.1 To meet their obligations to an enrolled student with T1D, schools have a responsibility to provide education and requisite training for their staff.

11.2 Education is the gaining of knowledge and perspective about T1D.

11.3 Training is the skill development and practical application of the education on the student with T1D.

11.4 Education and training implementation must comply with local jurisdictional requirements and regulations.

11.5 The ISPAD recommended levels of T1D care, education and training are outlined in the attached infographic (Fig. 1).

12. Education Requirements for All School Employees – ISPAD Level 1 Education

12.1 All school personnel have duty-of-care obligations to a student with T1D. Accordingly, school personnel should receive appropriate, continual, and updated (at a minimum annually) foundation education to develop a clear understanding about school-related needs for the student with T1D [1, 12, 18, 34]. ISPAD refers to this education as Level 1.

12.2 The level 1 education curriculum should include the principles of T1D and how it impacts on students and families. This includes the recognition of signs, symptoms, and urgency to treat low glucose levels,

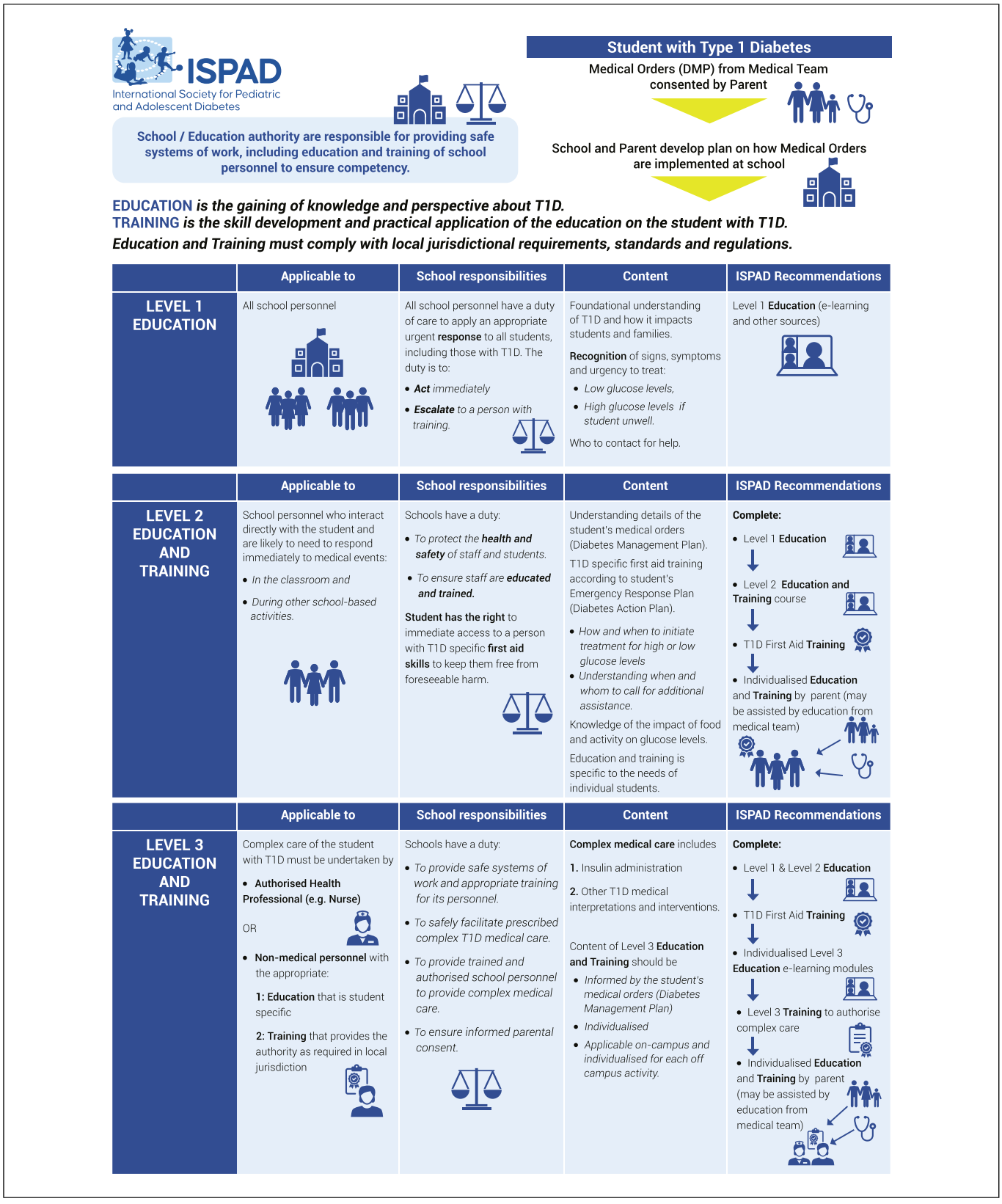

Fig. 1. Student with T1D.

the requirements to act if the student is unwell, and the escalation protocols for that student [1, 4, 5].

12.3 Accordingly, it is important to have current, accessible, language and culturally appropriate T1D education materials to enable flexible and rapid education of new or substitute school personnel, including clear pathways of escalation when required [1]. There are several ISPAD endorsed, culturally appropriate education materials available [8, 12, 13].

13. First Aid T1D Training and T1D Individualized Education – ISPAD Level 2 Education and Training

13.1 Schools have an obligation to protect the health and safety of all students, irrespective of a T1D diagnosis, and to protect the health and safety of all staff [23]. This includes providing a First Aid Emergency Response, defined as emergency care and/or treatment given to preserve life, to prevent the condition from worsening, and to promote recovery. Such assistance is usually performed by a member of school personnel with basic first aid training [19, 35–42].

13.2 School personnel with day-to-day supervisory responsibilities for the student with T1D, or those with greater oversight of the student while in the school's custody and care, are likely to need to respond immediately to medical events or schoolwide emergencies. Therefore, to assist such school personnel to discharge their duty-of-care obligations to the student, they must have T1D First Aid training as a workplace obligation [1–3].

13.3 Those school staff should also have detailed education on the individual's strengths, capabilities, challenges, and prescribed medical orders as outlined in the student's individual medical order (DMP) and written accommodations plan [1–3]. They should also be educated on the knowledge of the impact of food and activity on that individual's glucose levels for planning for special events in the classroom.

13.4 The student with T1D has the right to immediate access to a person with T1D-specific first aid skills to keep them free from foreseeable harm [1–3, 11–15, 18].

13.5 The T1D first aid response includes recognition and treatment of hypoglycemia and the escalation of any complex medical care requirements to qualified personnel [1–3, 11–15, 18].

13.6 Accordingly, requisite T1D first aid training may include, subject to local jurisdictional requirements:

- How and when to initiate prescribed individualized treatment for high or low blood glucose levels [1]. This will include treatment without delay for suspected hypoglycemia if glucose testing is not available [1–3, 15, 16]. It may include glucagon administration in some jurisdictions [3, 15, 16, 29].
- Knowing and understanding when and whom to call for assistance including those school personnel who have the appropriate authority and training to undertake complex medical needs, emergency responders, parents, and medical team [1–3].
- Competently checking glucose levels (blood or sensor) if equipment is available and according to that student's medical orders (DMP) [1–3, 11–16, 18, 20, 41].

13.7 The recommended process to complete level 2 education and training is to complete:

1. Level 1 education course
2. Level 2 education course specific to the needs of that student
3. T1D first aid training course
4. Individualized education and training by parent. The medical team may assist individualized education with parental consent.

14. Complex Medical Care of the Student with T1D – ISPAD Level 3 Education and Training

14.1 For a student with T1D, complex medical care includes administration of insulin and glucagon [1].

14.2 Complex care may also require medical interpretations and interventions that could impact the health of the student [1–3]. These may include but are not limited to:

- Monitoring glucose levels, including interpretation to support decision making where applicable.
- Insulin dose calculation.
- Carbohydrate counting.
- Knowledge of the student's insulin delivery device.
- Ketone monitoring.
- Glucagon administration (if not prescribed in level 2).

14.3 Complex care of the student with T1D, including administration, or careful supervision of insulin administration via injections or insulin pump, requires school personnel to be specifically trained and legally authorized to then obtain informed parental consent [1–3, 16, 18].

14.4 Most school personnel are not medically authorized to execute complex medical care. While those personnel have duty-of-care obligations to provide first aid assistance, they are not obliged to be trained to execute complex medical care [1, 4, 5, 11, 12, 16, 18].

14.5 Schools and education authorities are obliged to provide personnel who are available and trained to safely execute and manage the complex medical needs of a student with T1D to fulfil:
- The duty of care owed by the school to the student with T1D to keep the student free from foreseeable harm [1, 16, 18].
- Legal and regulatory requirements for occupational health and workplace safety that require schools to provide safe systems of work and appropriate training of their staff [1, 37, 38].
- Training registration and accreditation compliance requirements [1, 3, 11, 16, 18].

14.6 If a medically authorized health professional (nurse) is unavailable in the school environment, ISPAD supports non-medical personnel with the appropriate education, recognized training, and authority to provide consented complex T1D care in accordance with local jurisdictional, legal, and regulatory requirements [1, 4, 5, 11, 16, 18].

14.7 The content of level 3 education and training should be student specific, with clear understanding of when and how to perform each task outlined in the student's medical orders (DMP) and should incorporate a clear and consented communication plan [1, 3, 16, 18].

14.8 Parental education and training of school personnel – after the staff have completed level 1 education and level 2 education and first aid training – assists the school personnel to understand the medical requirements of that individual. The parent may engage the student's medical team, including the diabetes educator, to support the advice to the school on that student's individual needs [43].

14.9 The T1D education and training of nonmedical qualified school personnel and school nurses on complex T1D care is referred to as ISPAD level 3 education and training.

14.10 The recommended process to complete level 3 education and training is to complete:
1. Level 1 and level 2 education courses
2. Requisite T1D first aid training course
3. Level 3 education course specific to the needs of that student (as informed by consented medical orders)
4. Level 3 requisite training course consistent with local jurisdictional training, registration and accreditation compliance requirements that authorizes the nonmedical staff member to undertake medical care, including the administration of insulin.
5. Individualized education and training on that student by the parent. This may be supported by the medical team at parental request.

14.11 While it is the responsibility of the medical team to provide training to parents and students, it is not the responsibility of the medical team to provide training to employees, including school personnel. Nor is it the responsibility of the medical team to assess school personnel competence in executing complex T1D care.

14.12 While the medical team may direct the school to appropriate educational materials, the medical team is not responsible for ensuring delivery of the education or monitoring completion rates.

15. On-Campus versus Off-Campus Requirements

15.1 Prescribed medical orders do not change whether the student is on campus or off campus [9, 16, 18, 23, 29, 30], though specific adjustments may be made to the medical orders to address variables in specific circumstances, for example, physical activity.

15.2 However, the training required for school personnel may change for off-campus activities to safely execute prescribed medical care [23]. The school must consider and address the risks specific to the off-campus location, remoteness, access to transport, communication availability, local language, and vicinity of medical services [16, 18, 23, 44].

15.3 The circumstance of off-campus activities should be cooperatively planned in a timely manner between all parties to assist the school in meeting its obligations to the student's safety and well-being [15, 16, 18, 23, 44].

15.4 To assist with compliance with jurisdictional, legal, and regulatory obligations, schools should mitigate risk by considering the worst-case scenario for each off-campus activity. Schools should ensure level 3 trained school personnel are always available in case the student becomes incapable of their usual standard of self-care to deal effectively with diabetic ketoacidosis, severe hypoglycemia, other medical conditions that may impair conscious state [23, 44], and psychosocial challenges.

15.5 The medical team may advise on the content of training required to best execute the medical orders off campus, but it is the school's obligation to implement those medical orders while the student is in the school's custody and care [1, 3, 16, 18, 23].

15.6 Parents should provide to the school to accompany the student on camp:

- The DMP with detailed, written medical orders to account for physical activity and dietary requirements.
- The ERP with adequate supplies of prescribed treatments for low glucose levels (simple carbohydrate, snack, glucagon).
- Parent, medical team, and emergency center contact details and instructions.
- Supplies specific to that student's needs including medical supplies, glucose and ketone monitoring devices, delivery devices, sharps containers, charging devices, storage containers, and ensuring supplies are within their use by date.
- Other specific requirements.

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The authors declare that there is no conflict of interest.

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Australian Paediatric Society.

The voice of rural child health

Hon Ben Carroll MP
Minister for WorkSafe and TAC
Minister for Education

17th March 2025

Management of students with Type 1 Diabetes (T1D) in Victorian Schools

The recent WorkSafe criminal conviction of Kilvington Grammar School for work, health and safety failure relating to the death of Lachlan Cook has irrevocably established that:

- While any student is in custody of school, **the school is responsible** for that student's safety and wellbeing.
- The school is legally bound to provide employees the requisite training - it is not optional. "Requisite training" for T1D at school is defined by the international authority ISPAD as **"training required to qualify and authorize the performance and safe execution of necessary tasks, skills, and responsibilities in accordance with local jurisdictional requirements"** (Ref 1)
- Workplace training must be sufficiently robust to **recognise safety risks** even in the face of receiving errant advice from a parent.
- School employees are unambiguously classed as **employees** under workplace safety law. This is consistent with legal advice provided to the Department by Arnold Bloch Leibler in 2014, Mazy (ref 2) and WorkSafe ACT Notice of Improvement issued to schools in 2017 (ref 3).

The recent unambiguous court determinations (Victorian Coroner and WorkSafe) have destroyed the myth of the Department of Education's arguments the school employees are "support persons/carers" or "agents" of the parent. Kilvington Grammar School would not have been convicted of workplace criminal offences if they were acting as an "agent" of the parent, especially when the student's parent gave the Kilvington employees errant management advice when her child was seriously ill.

As Minister for WorkSafe and Education, you are in a unique position to demand that state government policies that clearly breach work, health and safety regulations in Victorian schools be amended. Over half Victorian parents recently reported safety issues for their child with T1D at school. One child, as you are aware, has been unable to attend school for over a year because of several safety errors and the refusal of the school to provide qualified and competent staff.

Students with T1D have been significantly disadvantaged since the Department of Education colluded with Diabetes Victoria in 2015 to establish the charade that school employees could be

defined as "carers" (that is, they are not "employees" when "caring" for a student) to avoid providing requisite training required by employees to lawfully execute complex medical care.

The Department, with Diabetes Victoria developed the advice for schools that later then became the Diabetes Australia "Diabetes in Schools" (DIS) program. The DIS program, promoted and used by the Department has inherited the "school employees are carers not employees" to falsely claim that DIS Level 3 informal, unregulated "training" can **authorise non-medical school staff to administer insulin** to children at school. Federal Health Minister Mark Butler has already confirmed that the Diabetes Australia DIS program confers no qualification and states that DIS is a voluntary program. Unfortunately, stating that **the DIS program is voluntary** seems to have been misinterpreted that providing **requisite training for employees is voluntary**. Your leadership is required to ensure that schools and parents are not misled about obligatory health and safety requirements in the school workplace.

The Diabetes Victoria/ Department of Education collusion has proved to be a significant disadvantage to students with T1D and now a child has unnecessarily died because his school employees were not provided with requisite T1D training.

Over the past few years, medical practitioners and diabetes educators, with the advice of their insurers and ADEA, have increasingly understood that it is not their responsibility to "train" medically unqualified school employees or judge their competency. Legislation says that employee training is clearly the responsibility of the school and the law requires such training and competency assessment must be via a Registered Training Organisation. Yet the Department policy states that insulin and g*lucagon injection training can be obtained from the diabetes treating team who usually care for the child's diabetes or from other health professionals such as a general practitioner or Division 1 Registered Nurse*.

Since the WorkSafe criminal prosecution of Kilvington Grammar, schools also now understand that they are responsible yet requisite training to authorise non-medical staff is non -existent in Victoria (unless they complete a nursing degree). The product is that schools are increasingly reluctant to allow students with T1D to attend school camps. Rather than provide a nurse who is qualified and authorised (a significant expense) they elect to breach Disability and Discrimination legislation by claiming that engaging staff with requisite training (a nurse) is beyond a "reasonable adjustment." So, the student is refused access to an off-campus school activity that their peers without T1D can enjoy.

A practical, and compliant solution to ensure the safety of students and employees is urgently required. Such a concept is supported by ISPAD (ref 1)

Schools and education authorities are obliged to provide personnel who are available and trained to safely execute and manage the complex medical needs of a student with T1D to fulfil:

- *The duty of care owed by the school to the student with T1D to keep the student free from foreseeable harm*.
- *Legal and regulatory requirements for occupational health and workplace safety that require schools to provide safe systems of work and appropriate training of their staff*.
- *Training registration and accreditation compliance requirements*.

The current Victorian Department of Education policy for students with Type 1 Diabetes breaches several laws, including work, health and safety laws. It also fails to disclose the conflicted interests created by lucrative contracts, created by Diabetes Australia that binds the Royal Children's Hospital and Monash Children's Hospital to exclusively use the unlawful Diabetes in Schools program.

Minister Carroll, your urgent action is required to:

1. Issue a moratorium to protect school employees while proper and lawful training is being developed that is compliant to workplace health and safety legislation.
2. Facilitate the development of training courses that can be used by RTOs to authorise / qualify school employees. The APS and National Type 1 Diabetes Council are willing to assist.
3. Establish specific legislation to authorise non-medical school employees to administer insulin after completion of approved requisite training.
4. Bring together the major stakeholders WorkSafe, Teacher Unions, National Type 1 Diabetes Council and other stakeholders to endorse the plan.

A bipartisan political approach would be preferred to resolve this issue of child safety.

The Australian Paediatric Society, that bases its advice on the legally validated international best practice (ref 1) is willing and able to assist you as both Minister for WorkSafe and Minister for Education to provide the solution, including to assist you produce a legitimate, lawful and comprehensive program that keeps students with T1D safe at school so they can participate in all school activities on the same basis as their peers.

Peter Goss
Chair Diabetes APS

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Cc Georgie Crozier MLA CDE Shadow Minister for Health, Jess Wilson MLA Shadow Minister for Education, Dr Jill Tomlinson President AMA Victoria, Marie Boland CEO, Safe Work Australia WorkSafe Victoria Enforcement, Victorian Registration and Qualifications Authority (VRQA), National Type 1 Diabetes Council, Australian Education Union, Child Safety Commissioner. Human Rights Commissioner, United Voice, Type 1 Voice.

Diabetes Australia

Amount paid by Diabetes Australia to the Diabetes in Schools (DIS) program in financial years 2021-22 and 2022-23:

1. **For program access to DIS Level 1 (total amounts and amount per Level 1 completion)**

   There is no payment made by Diabetes Australia for program access to DIS Level 1 (online).

2. **For program access to DIS Level 2 (total amounts and amount per Level 2 completion)**

   The total amount paid by Diabetes Australia relating to the Diabetes in Schools program for program access to DIS Level 2, as it relates to the provision of face-to-face Level 2 education:
   FY 2021-22: $208, 202
   FY 2022-23: $213, 407

   There is no payment made by Diabetes Australia for program access to DIS Level 2 (online).

3. **For program access to DIS Level 3 (total amounts and amount per Level 3 completion)**

   The total amount paid by Diabetes Australia relating to the Diabetes in Schools program for program access to DIS Level 3, as it relates to the provision of Level 3 training:
   FY 2021-22: $1,171,917
   FY 2022-23: $1,501,102

4. **For staff costs related to the Diabetes in Schools program**

   The amount paid by Diabetes Australia relating to the Diabetes in Schools program for staff costs related to the program is:
   FY 2021-22: $458,024
   FY 2022-23: $437,500

5. **For costs related to employment of State Coordinators of the Diabetes in Schools program**

   The amount paid by Diabetes Australia relating to the Diabetes in Schools program related to the employment of State Coordinators of the Diabetes in Schools program is:
   FY 2021-22: $666,829
   FY 2022-23: $683,500

6. **For administrative/other costs relating to the Diabetes in Schools program**

   Due to the lack of specificity regarding what administrative/other costs are, Diabetes Australia is unable to quantify these costs.

7. **To health services (individual tertiary centres and total amount paid by the NDSS for Service Agreements to each year)**

The total amount paid by Diabetes Australia relating to the Diabetes in Schools program to health services is:
FY 2021-22: $1,171,917
FY 2022-23: $1,501,102

8. **Amount NDSS paid to Australian Diabetes Society and ADEA for sponsorship of activities, including postgraduate education.**

   Nil

9. **Amount NDSS paid to Diabetes Australia (including administrative / other costs) to facilitate activity of "The Alliance".**

   Nil