



Food
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DINING OUT: THE CHALLENGE FOR THOSE WITH A FOOD ALLERGY OR FOOD INTOLERANCE

EVALUATION RESULTS: Northern Ireland



Dining out: The challenge for those with a Food Allergy or Food Intolerance

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1 Executive Summary

The food allergen aspects of Regulation (EU) No 1169/2011 of the European Parliament and the Council on the provision of food information to consumers came into effect in December of 2014 when the obligation for caterers to have allergen information proactively available for their customers will become a legal requirement. This is designed to ameliorate the risks to consumers with food allergy and intolerance. In advance of this, **safefood** and the Food Standards Agency in Northern Ireland (FSA-NI) conducted a survey of these consumers to ascertain their experiences when dining out. To achieve this, the questionnaire was exclusively sent to the members of Allergy NI, the primary non-governmental support organisation in Northern Ireland (NI) for those with food allergy and intolerance. The majority of respondents were guardians of young children (especially mothers). Most responses concerned those who were unique in their own families in having food allergy / intolerance. All had been medically diagnosed, primarily in childhood, but occasionally later in life. The majority also had allergies/intolerances to two or more food allergens. The top four reported food allergies / intolerances were to peanut, tree nut, egg and milk, all of which are listed in Annex II to the EU FIC. Kiwi allergy ranked sixth in reported incidence. This allergen is not listed in Annex II.

In terms of the history of adverse reactions that happened outside the home, the majority were reported to have taken place in a commercial food establishment. Respondents cited a lack of control of cross contamination as being the chief cause of adverse reactions. They were quite clear as to what caterers should do to ensure a safe dining experience for their food sensitive customers. They also highlighted a lack of adequate information provided by the catering staff (this will be unacceptable under the impending legislation). Almost a third of all respondents to this survey reported having been refused service during 2012 and most of those had been refused more than once with concerns about cross-contamination underpinning most of these refusals. The food allergic/intolerant customer will tend toward loyalty to those restaurants where they will be courteously and safely accommodated and cross contamination from allergens is controlled. Therefore, there are both legal and economic imperatives for caterers to ensure proper control of food allergens on their premises. It would be erroneous to assume that those with food allergy or intolerance never eat out: this survey shows they are no different when compared to the general population, despite the increased risks and challenges. The survey highlighted the need to ensure that frontline staff are sufficiently trained and updated in all aspects of food allergen control. Caterers need to be not just aware of food sensitivities, but knowledgeable about them. The caterer must work with their food sensitive customers to safeguard their health and ensure a safe and pleasurable dining out experience.

2 Introduction

Protection of consumer health when dining out is underpinned by a dynamic body of food safety and hygiene legislation which clearly places the onus on the food businesses (including caterers) to ensure that the risks of ill-health due to food poisoning are kept to a minimum. In accordance with the requirements of Article 5 of Regulation EC No. 852/2004 on the hygiene of foodstuffs, all food businesses, whether retail or catering, are obliged to operate a food safety management system that is based on the principles of Hazard Analysis and Critical Control Points (HACCP)¹. Further legislation gives effect to the different elements of the regulatory regime to enforce the provisions of food safety and hygiene legislation through a programme of on-site inspections backed up by a network of analytical capacities as well as recourse to the law. The evolution of this regulation and enforcement structure has also witnessed the development of a number of guidance documents and training materials that are designed to assist the food business operator meet their legislative obligations²⁻¹⁰.

The Food Labelling Regulations (Northern Ireland) 1996 concerning the labelling of allergens on pre-packed food products for retail sale is, due to the nature of the industry, more prescriptive than that covering food produced in a catering environment¹¹. So whereas labelling requirements exist for fourteen specified food allergens where used as deliberate ingredients in pre-packed food, these requirements have hitherto not been applied to foods sold loose. Similarly, the obligation to control cross-contamination during food manufacturing has led to the development of precautionary or 'May contain' allergen labelling for pre-packed foods but again this is not an information requirement for foods sold loose. In October 2011, the European Parliament and the Council adopted Regulation (EU) No 1169/2011 on the provision of food information to consumers (EU FIC)¹². The food allergen aspects of the Regulation will not address the issue of food allergen cross-contamination.

Identifying and controlling cross-contamination by food allergens is an essential element of HACCP food safety management in both the retail and catering industries. Caterers routinely control microbiological risks and the risk of allergen contamination can be controlled through much the same approach, although it has to be emphasised that, unlike harmful bacteria, allergens are not destroyed during cooking. A number of guidance documents have been published to assist caterers in the control of food allergens including *The Provision of Allergen Information for Non Pre-packed Foods* produced by the UK Food Standards Agency (UK-FSA), *Food Allergy & Intolerance: Guidance for the Catering Industry* produced by **safe food**, and the joint FSA-NI / Food Safety Authority of Ireland (FSAI) *Safe Catering pack*^{2,3,13}. All of these guidance resources are designed to assist caterers factor food allergen control into their food safety management systems.

In the absence of focused legislative requirements, the impact of these guidelines is uncertain. In 2010, the UK-FSA published an evaluation of their guidance document, *The Provision of Allergen Information for Non Pre-packed Foods*. They found that allergen management and notification was

not as high a priority amongst caterers as say the traditional issues relating to food hygiene and safety. Furthermore, most food businesses were doing the bare minimum in terms of allergen control and information was provided on a reactive basis. Only a quarter of food businesses which handled foods sold loose were aware of the guidance document but those that were aware found it very beneficial. This was correlated with an increase in the provision of allergen controls and information to customers. An unrelated telephone survey of table-service restaurants in the Brighton area in the UK was also carried out in 2010¹⁴. The objective was to ascertain the level of knowledge amongst staff of anaphylaxis and food allergy in general. Of the restaurants contacted, 90 respondents (56%) agreed to participate and of these, 90% had received food hygiene training while a third had received food allergy training specifically. Approximately half of those interviewed could name three or more food allergens while over 80% expressed confidence that they could provide a safe meal for a food allergic customer. However, when probed with specific questions it became clear they still had a fundamental lack of understanding of the risks associated with a food allergy (or any other food sensitivity for that matter). Almost 40% of respondents believed drinking water to dilute the allergen would help someone during an allergic reaction while 23% of respondents thought it safe to consume a small amount of an allergen. Furthermore, a fifth of respondents thought that a meal would be rendered safe if the allergen-containing component was directly removed and 16% agreed cooking food renders it non-allergenic. Alarmingly, a further 12% did not realise that a food allergic reaction could be fatal.

Further evidence of a dearth in knowledge and awareness of food allergies and allergen control was obtained through a number of research projects carried out on the island of Ireland (Iol). Research carried out in 1999 in NI found that Local Council environmental health officers (EHOs) did not incorporate food allergen control in their HACCP-based inspections due to a fundamental lack of knowledge and appropriate training¹⁵. Another NI survey in 2002, which investigated the potential for obtaining an allergen-free meal on request in a take-away setting returned a failure rate of 20%¹⁶. Most front-of-house staff did not consult with the chef or manager and the majority of EHOs who carried out the sampling expressed a need for more training. A similar survey conducted throughout the Iol in 2007 highlighted the risk of an allergic reaction due to inaccurate information received in catering businesses¹⁷. Using peanut as the test allergen, 10% of staff had no understanding or awareness of peanut allergy and only a third were confident in the advice they gave. Across the Iol, over half of the foods that tested positive for peanut protein were sold with the wrong advice and the levels of peanut protein in a number of these products indicated that peanut was used as a deliberate ingredient as opposed to being present due to cross-contamination. Once again, the sampling EHOs expressed a desire to receive training on this issue.

These deficits in knowledge and awareness may well be a consequence of an absence of focused legislation for allergen control in catering. Equally, it may well have been a consequence of an historic absence of consumer demand for foods free from specific allergens. However, they could also be a consequence of a general knowledge gap with regard to food safety and hygiene in the

catering industry. A survey of chefs and catering managers throughout the Iol in 2006 showed that 20% of head chefs had no formal training in food preparation and a similar percentage had no hygiene training¹⁸. Furthermore, almost a fifth of head chefs defrosted meat in an unsafe manner while 8% of respondents did not effectively control cross-contamination between cooked and raw foods. Almost 80% of head chefs showed a poor knowledge of current food safety legislation and the survey found that the concept and application of HACCP principles were poorly understood. It is against this background that regulators are fostering an increased awareness of what is essentially an emerging food safety hazard. Inculcating food allergen control into the safety and hygiene culture within the catering industry is a long-term objective.

These deficits in general food safety/hygiene awareness and knowledge contrast with the increased popularity of dining out in our culture. In recent decades, this has become an integral part of life for a great many people on the Iol. Data from Bord Bia (the Irish Food Board) in 2011 shows that while the current economic situation has had an impact on people's pockets, the numbers who dine out frequently still remain relatively high with 23% of respondents in NI and 25% of those in the Republic (RoI) reporting dining out at least once per week and a further 33% and 29% respectively, reporting they dine out at least once per month¹⁹. Unsurprisingly, the risks to the food allergic and other food sensitive consumers have been modulated accordingly. In one UK study into so-called asthma-related deaths, upwards of 40% of the recorded fatalities were associated with the consumption of catered food and food sold loose²⁰.

There are no food-allergy related mortality data available for NI or ROI specifically. There are at least six confirmed fatal incidents of food related anaphylaxis each year in the UK in a total population of around 60 million²¹. The prevalence of food allergy on the Iol is generally considered to be similar to that in the UK with 1-2% of adults and 5-8% of children affected. The justification for this is based on the assumption that diet, genetics and geography between the populations in both islands are similar. One of the rare sets of hard data emanating from the Iol is the RoI Hospital Inpatients Enquiry database records for the period 1995 – 2004 which recorded an average of 45 people discharged from hospital with a principal diagnosis due to food related anaphylaxis each year²². For cases where the culprit food was specified, peanut was the highest principal cause of hospital discharges due to food-induced anaphylaxis: tree nuts, eggs and fish were also significant causes.

With regard to the other types of food sensitivity, the prevalence of coeliac disease in the populations on the Iol is now generally accepted to be similar to that in other Western populations at 1%²³. The prevalence of food intolerance in general has not been established due in part to an absence of agreed clinical definitions for many adverse food reactions^{24,25}. However, the prevalence of lactose intolerance alone is considered to be approximately 5%²⁶. The prevalence of specific food allergies or intolerances may seem insignificant: collectively however they add up to a significant proportion of the overall population. Given that risk management for all food sensitivities is based on an avoidance diet, the significance of good allergen control in the catering industry cannot be overstated.

The EU-FIC modifies existing food labelling provisions in the EU and one of the principle objectives is to allow consumers to make informed and safe choices with regard to the purchase of food through the provision of clearer allergen information¹². Among the changes introduced by the Regulation is the requirement for information on allergens used as deliberate ingredients in non pre-packed foods, i.e. food sold loose, including those sold in restaurants and cafés. This requirement is mandatory and caterers must be proactive in providing this information. It cannot simply be made available on request but must be evident and easily accessible by consumers. The mechanism by which this is achieved is open to interpretation at national level. The allergen information aspects of the EU FIC came into effect in December 2014.

3 Methodology

This report presents the results of the NI segment of a joint survey that was conducted on an all-island basis by a **safefood**-FSA NI partnership in NI and **safefood** in RoI. The purpose of the survey was to find out the experiences and opinions of consumers who have food allergy or food intolerance with regard to eating out in catering establishments such as restaurants, hotels, cafes, etc. The survey was conducted on a voluntary basis in co-operation with Allergy NI which was at this time the registered charity that represented the interests of, and provided support for, consumers with allergies including food allergies and other food sensitivities as well. During the period 1st January 2013 to 8th February 2013, an electronic survey questionnaire prepared jointly by FSA-NI and **safefood** was circulated by Allergy NI to their membership. The survey was not limited electronically to one response per IP address. This was to capture those families where more than one member who had a food allergy/food intolerance and who would have used the same computer to participate in the survey. The survey consisted of just twenty questions which were designed to probe the experiences of respondents when dining outside the home in a catering environment (see Appendix 1).

A primary concern when disseminating the survey questionnaire was to exclude potential respondents who did not have a food allergy/food intolerance. The survey was limited to members of Allergy NI and as such does not capture food allergy or intolerance data for non-members who may be affected.

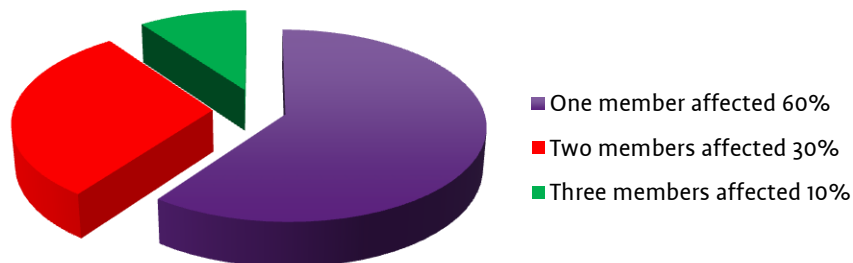
4 Results

4.1 Details of the survey respondents

The questionnaire was disseminated by email to 180 members of Allergy NI. In total, there were 123 responses to the survey questionnaire which represents a 68% response rate. It is assumed that all respondents were notified members of Allergy NI. In total, 10 respondents indicated they did not have a food allergy or food intolerance (question 4). A further 2 such respondents did not answer any further questions. These were deemed to be invalid responses and were excluded from any further analyses giving a total valid cohort of 111 respondents. All of the respondents indicated the District or Borough Council in which they lived (Appendix 2). There was no clear association between the reported incidence of food allergy/food intolerance and either population size or urban-rural divide.

Respondents were asked to indicate the number of family members that had food allergy or food intolerance and there was a 100% response rate to this question. The majority (60%) of respondents were associated with families where just one person was affected. The number of respondents reporting 2 and 3 family members affected was 30% and 10%, respectively. No respondent reported coming from a family with 4 or more affected members (Figure 1). Therefore, 40% of respondents are from families where more than one member has a food allergy/food intolerance. The atopic status of these families is unknown and was not possible to determine from this survey.

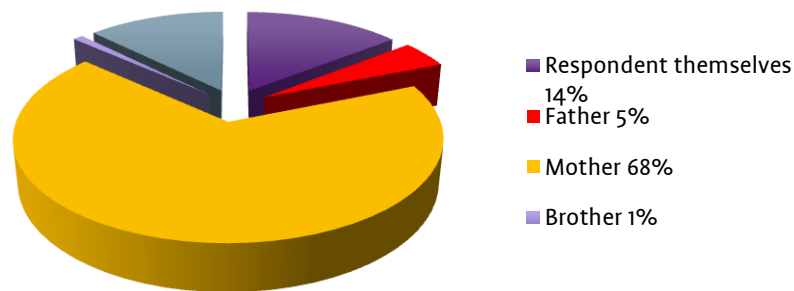
Figure 1: Reported number of respondent's family members who have a food allergy / food intolerance



In all, 15 of the 16 respondents who completed the survey on behalf of themselves were in the 13-70 year old age bracket. This accounted for 14% of returns which indicates the level of survey

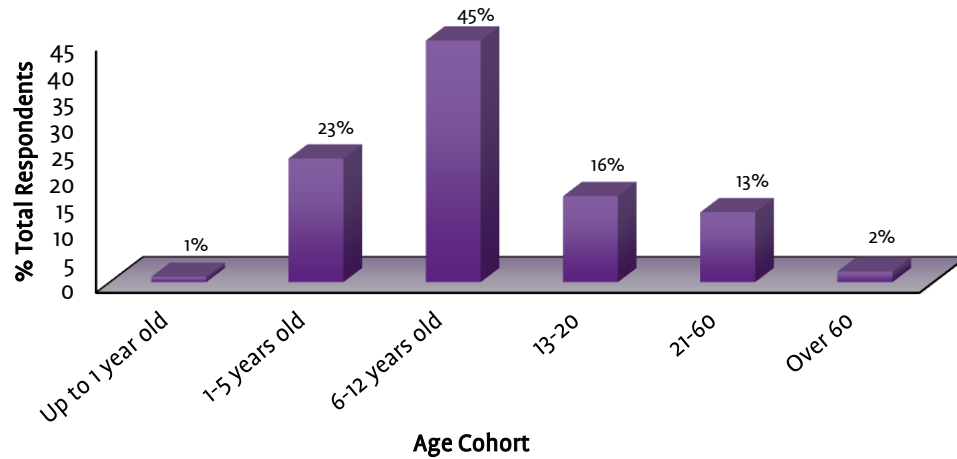
completions by the guardians of sufferers. Therefore, this is primarily a 'Guardian' survey (Figure 2). 73% of all returns were completed by a parent. Of the 77 responses concerning those in the 0-12 year old group, 82% were completed by a parent (majority mother). Concerning the 18 responses in the 13-20 year old age group, 83% of responses were completed by a parent (again majority mother). However, this falls to 29% in the 21-30 year old age range (7 responses) and to zero for those aged 31 years or more. This is a clear indication of the level of concern and anxiety among parents of children/young adults with a food allergy or food intolerance. However, it cannot be concluded that these responses are evidence for increased food allergy rates in younger generations as they may simply reflect a lack of membership (or membership renewal) of Allergy NI by adults with food sensitivity.

Figure 2: Relationship of the respondent to the food allergic/intolerant individual



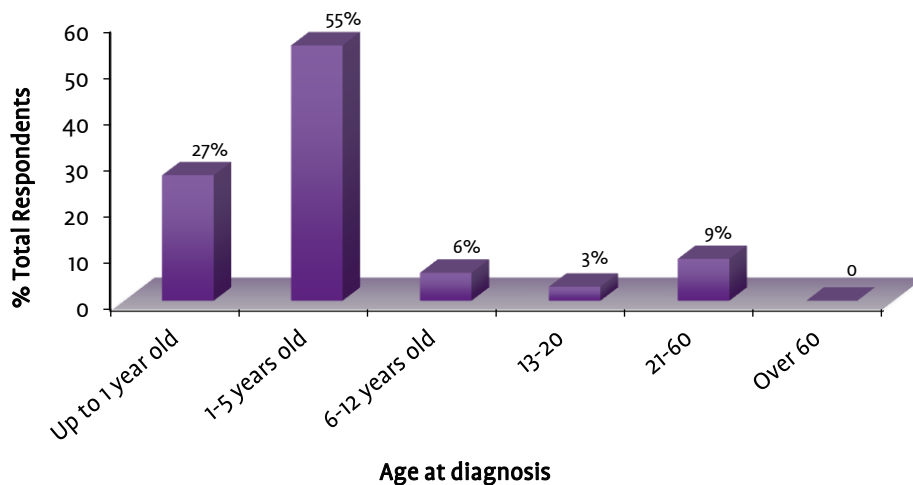
The age of the food allergic/intolerant person was identified by all respondents. The age category choices provided roughly correspond to changes in the exposure environment generally experienced with increasing age. 69% of survey responses were concerned with 0-12 year olds. This increases to 86% when the 13-20 year-old cohort is factored in. Again this emphasises the level of survey completions by guardians which was at 86% (Question 6) and confirms the survey returns were skewed toward the younger age groups (0-20 year olds). The age distribution of the subjects of the survey responses (i.e., the food allergic / food intolerant individuals on who completed the survey or on whose behalf the survey was completed) is given in Figure 3.

Figure 3: Age of the subjects of the survey responses



Similarly, the age at which the food allergy/food intolerance was diagnosed was given by all respondents. 27% of all respondents had been diagnosed in infancy (up to 1 year old) rising to 82% by age 5 years. This is particularly true for respondents aged up to 20 years. The diagnosis history for those in the 20+ age categories is less clear with some reporting having been diagnosed as children or teenagers but most diagnosed in adulthood; some respondents reported being diagnosed in their forties and fifties. Perhaps this indicates that food allergy/food intolerance can develop clinically at any stage in life although the individual in question may have lived with the condition for some time prior to diagnosis. The age at which the survey respondents were diagnosed is given in Figure 4.

Figure 4: Age at which the subjects of the survey responses were diagnosed



The respondents were asked if the food allergy or food intolerance had been medically diagnosed. All respondents answered this question and overwhelmingly (99%) reported that the food sensitivity in question had been medically diagnosed. Approximately 65% of respondents indicated the medical personnel and/or clinical setting at which the diagnosis was made (Table 1).

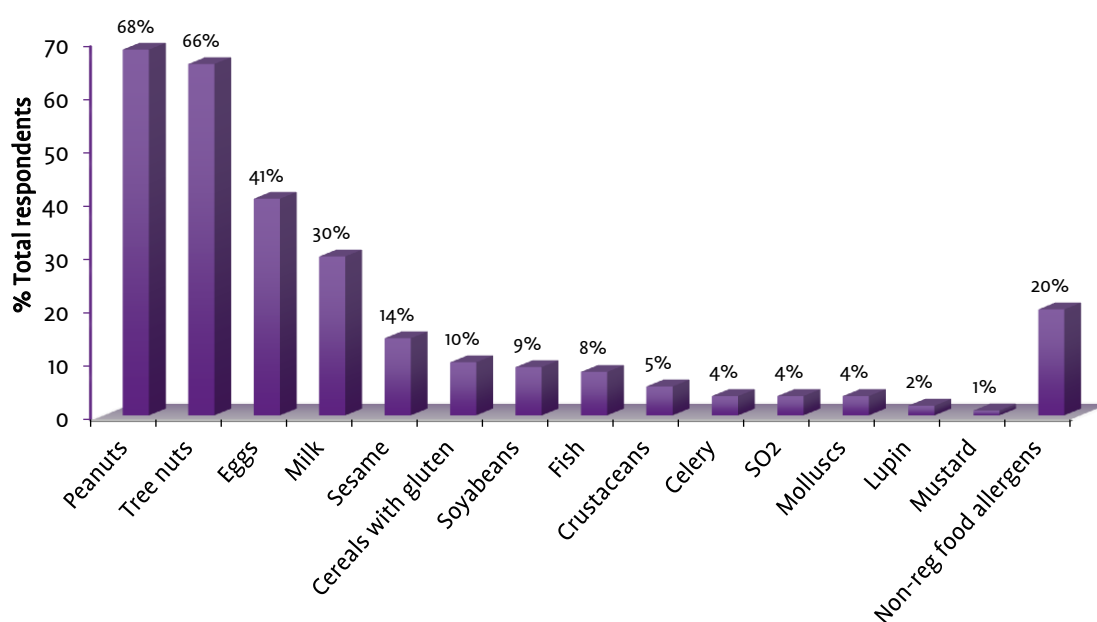
Table 1: Locations and personnel identified as being involved in the diagnosis of the food allergy/food intolerance

Means of diagnosis	Total respondents/% total respondents
Allergy clinic	4(4)
Allergy specialist	14(13)
Doctor named	21(19)
Un-named doctor	16(14)
Hospital named	23(21)
Hospital unnamed	6(5)
Non-medical	1(1)
Unknown	0(0)

4.2 Range and prevalence of food allergies/intolerances

There was a 100% response to the question concerning the kind of food the subject of the survey response was allergic / intolerant to. Respondents were asked to identify from a list of foods that cause food allergy/food intolerance based on Annex II of the EU FIC¹². When ranked in terms of prevalence, the top five reported allergens were peanut, tree nut, egg, milk and sesame, in that order. The majority of respondents were peanut (68%) and tree-nut (66%) allergic (Figure 5). Note, cereals containing gluten is included although the survey was not designed to pick up responses from coeliac sufferers and therefore the true prevalence of sensitivity to gluten is under-represented.

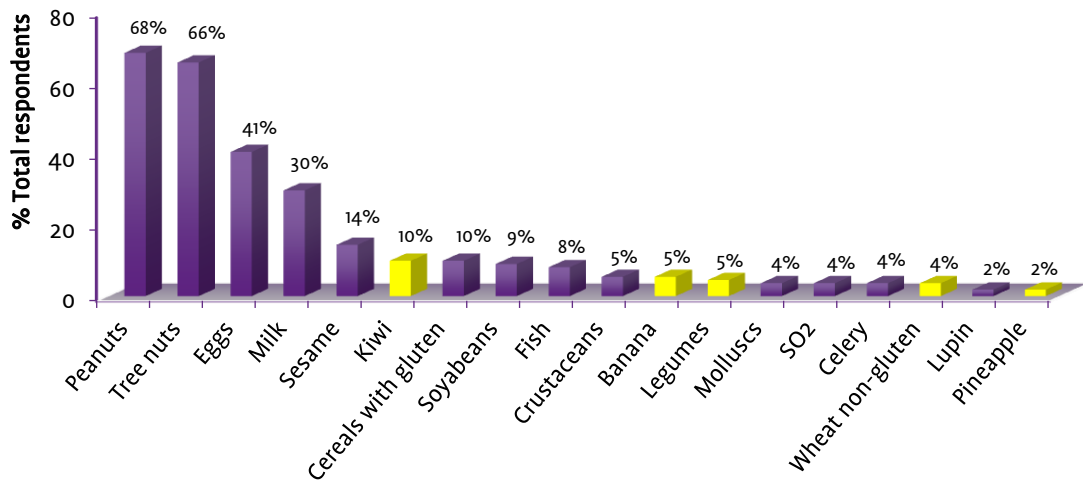
Figure 5: Percentage of survey respondents who are allergic/intolerant to the 14 allergens identified in Annex II of the EU FIC and non-regulated food allergens



Respondents were also asked to identify any other foods they were allergic or intolerant to. Within the “Non-reg food allergens” category there were 22 responses relating to substances not listed in Annex II to the Regulation. These included two non-food allergens (salicylates and food colours) and 16 food-related allergens (unregulated food allergens). These were mostly varieties of fruit and vegetables but also types of meat. This emphasises the fundamental paradigm that a food sensitivity can develop to just about any kind of food. Figure 6 shows the top eighteen reported food allergens in rank order of prevalence. The food allergens highlighted in yellow are currently not required to be declared under EU food labelling legislation¹². Allergies/intolerances to kiwi were more prevalent than those to soyabean, fish, crustaceans, molluscs, sulphites (SO₂), celery, lupin and mustard. Bananas, legumes and pineapple were also in the top eighteen reported food allergens. Returns were also registered for ‘Wheat non-gluten’ which probably reflects wheat allergy or non-

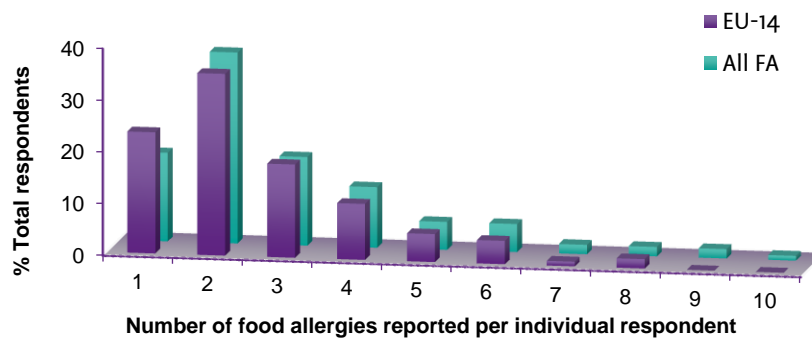
coeliac wheat intolerance. Although the survey did not focus on coeliac disease, it is possible that a respondent may have had this condition and other food intolerances as well. The full list of returns is given in Appendix 3.

Figure 6: Top eighteen reported food allergens in rank order of prevalence



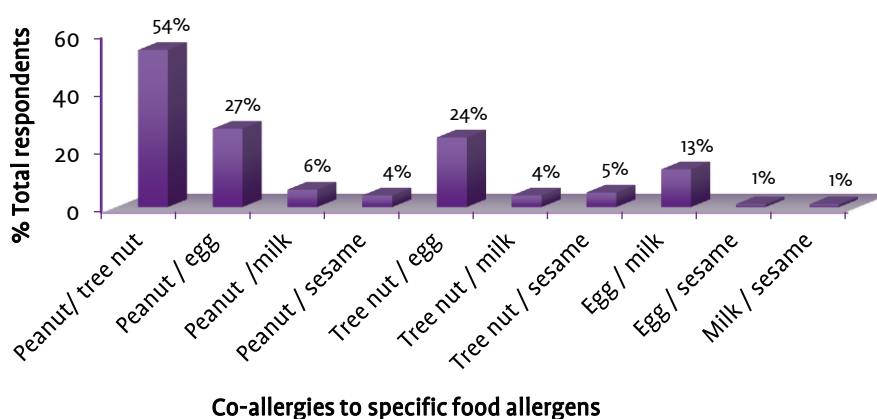
As is evident from the Figure 5, there were respondents who were allergic/intolerant to more than one food. Indeed, about 80% of respondents reported being allergic/intolerant to more than one food allergen. Allergies to two food allergens were most commonly reported with roughly 36% of respondents affected. This decreased to 17% of respondents implicating three foods, 12% implicating four foods and 5% implicating five or six foods. This is shown in Figure 7.

Figure 7: Prevalence of multiple food allergies among respondents based on all food allergies reported in the survey returns (All FA) and responses to the EU-14 food allergens only



Of the top five reported allergens (peanut, tree nut, egg, milk and sesame), 54% of respondents were allergic to both peanut and tree nut while 27% were allergic to both tree nut and egg (23% of respondents were allergic to all three food allergens). 13% of respondents were allergic to both egg and milk while 3% were allergic to peanut, egg and milk (10% were allergic to peanut, tree nut, egg and milk). The prevalence of multiple food allergies among respondents for specific combinations of the top five reported food allergens is shown in Figure 8.

Figure 8: Prevalence of multiple food allergies among respondents for specific combinations of the top five reported food allergens



It has been established that certain food allergies can resolve with age while others are more tenacious. For instance, an allergy to milk protein in childhood usually resolves by eight years of age whereas a peanut allergy usually remains into adulthood. The prevalences of the different food allergies in each age cohort were ranked (Table 2).

Table 2: Prevalence of different food allergies in the different age cohorts

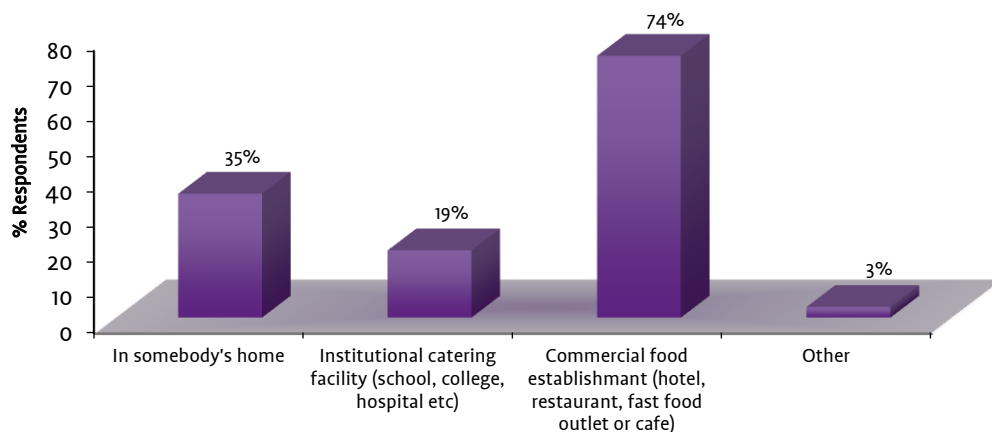
Age Cohort	0 – 5	6-12	13-20	21-30	31+
No. of respondents	27	50	18	7	9
Most prevalent FA	Egg	Peanut/Tree nut	Peanut	Peanut	Tree nut
2 nd most prevalent	Peanut	Egg	Tree nut	Tree nut	Peanut
3 rd most prevalent	Tree nut/Milk	Milk	Molluscs	Multiple foods	Sulphites
4 th most prevalent	Soybean	Sesame/Kiwi	Multiple foods		Multiple foods

Because of the low number of respondents in some cohorts, the results were grouped (0-5 year olds and those aged 31 years and over). Peanut and tree nut are in the top three most prevalent food allergens in all age cohorts. Milk allergy is more noticeable in childhood while sulphites and molluscs show up in the adult cohorts. Interestingly, soybean and sesame/kiwi are the 4th most prevalent food allergens in the 0 – 5 and 6 – 12 year old age cohorts, respectively.

4.3 Respondent’s experiences when dining out

The remaining questions in the survey were designed to probe the respondent’s previous experiences when eating outside the home in a catering setting. In total, 62 respondents (56%) indicated if they (or the person on whose behalf they were completing the survey questionnaire) had ever experienced an allergic/intolerant reaction whilst eating outside the home (Figure 9). All but one of these respondents specified where the reaction had taken place with a majority (74%) of adverse reactions happening while eating out in a commercial food establishment such as a hotel, restaurant, fast food outlet or café, etc. A further 19% reported reactions in an institutional catering setting while 35% reported reactions in someone else’s home. These figures probably reflect an absence of proper control in an environment where food allergy/food intolerance is not a feature.

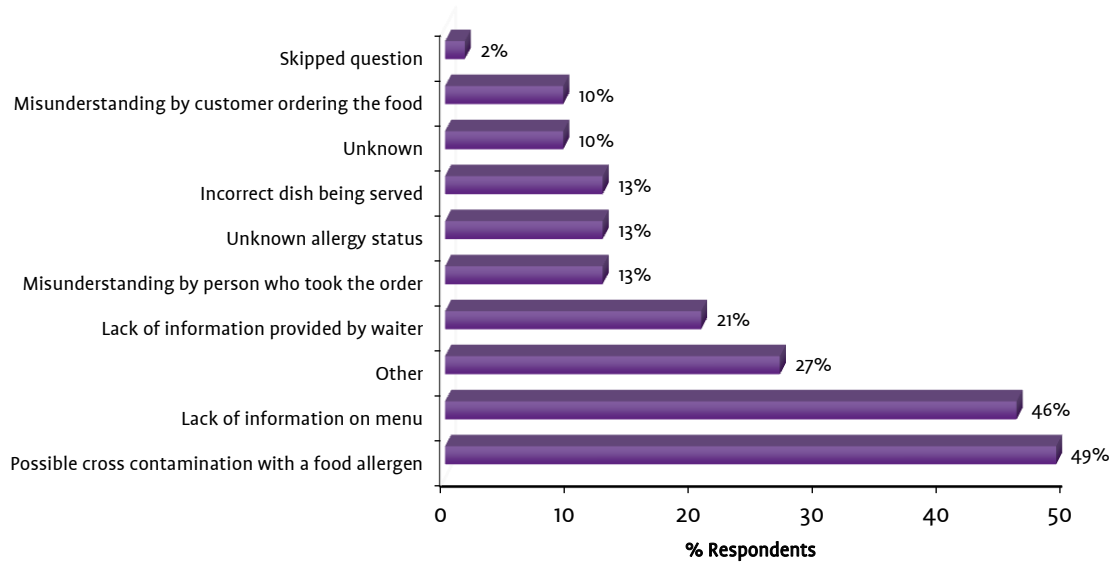
Figure 9: Dining out settings where a food allergic/intolerant reaction occurred



Under the response choice ‘Other’ which gave respondents the option to highlight other dining out settings, just two respondents reported experiencing a food allergic/intolerant reaction in a nursery and after eating from an ice cream stall.

When probed as to the reasons for the failure in the management of risk that led to the food allergic / intolerant reaction taking place, all 63 respondents gave reasons (Figure 10). The most commonly reported reason was the possibility of cross contamination with a food allergen (49%) and this is followed with lack of information on the menu (46%) or lack of information provided by the staff (21%). Seventeen comments were received for this question (Appendix 4). When analysed, it was clear that, in addition to the eight possible reasons proffered in the survey questionnaire, a further category of response could be identified namely, that many respondent’s food allergy/intolerance had not actually been diagnosed at the time of the event.

Figure 10: Reasons proffered by respondents as to why the food allergic/intolerant reaction occurred when dining out

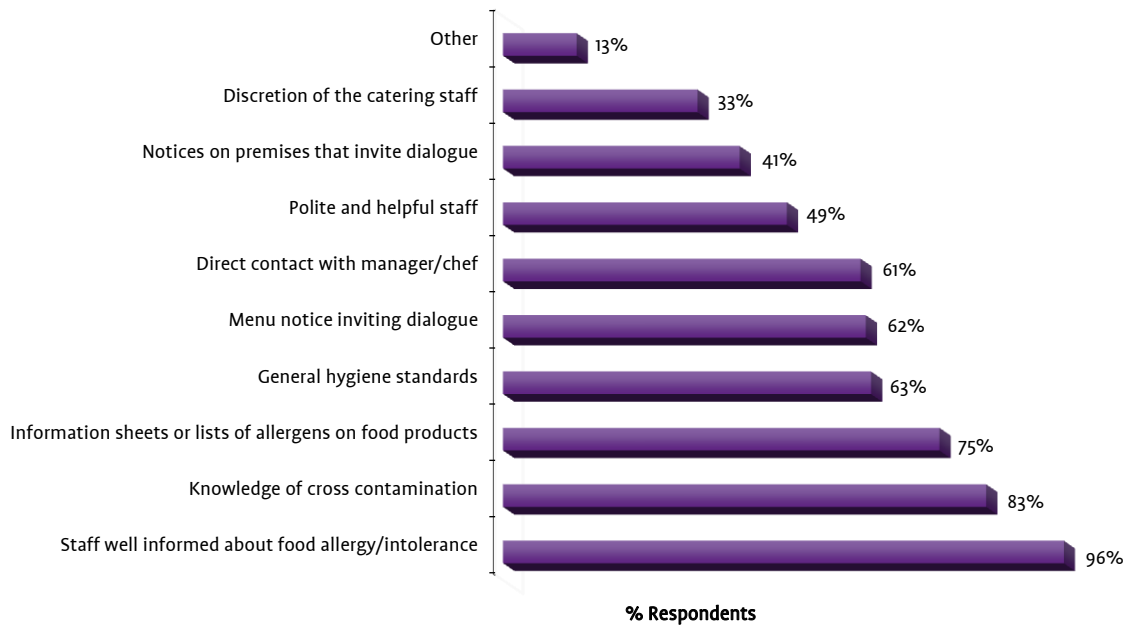


The respondents were forthcoming when asked to identify what they considered to be essential elements of an allergy-safe dining experience. All respondents chose from ten pre-determined essential elements:-

1. General hygiene standards
2. Staff well informed about food allergy/intolerance
3. Polite and helpful staff
4. Direct contact with manager/chef
5. Knowledge of cross contamination
6. Menu notice inviting dialogue
7. Notices on premises that invite dialogue
8. Discretion of the catering staff
9. Information sheets or lists of allergens on food products
10. Other (please specify)

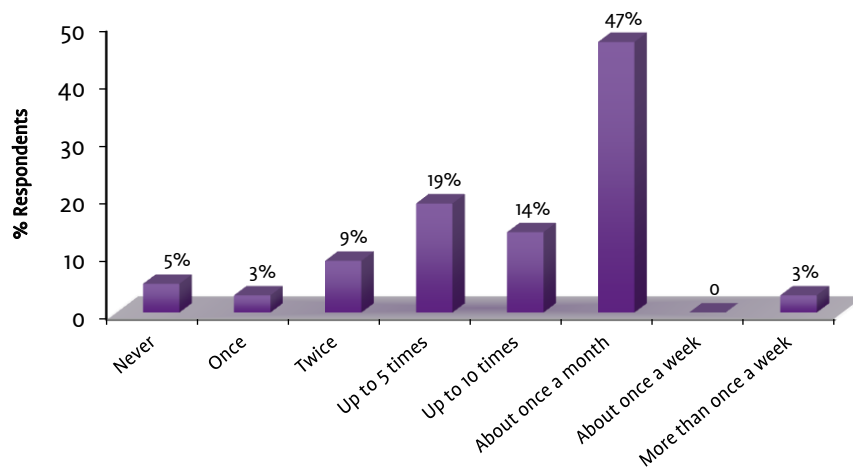
Respondents indicated that when looking towards a safe dining out experience they ranked highest the need for staff in catering settings to be well informed about food allergy/food intolerance (96%) followed with a need for knowledge of potential for cross contamination (83%). Figure 11 demonstrates the importance the respondents attached to the pre-determined elements.

Figure 11: Respondents ranking of elements that constitute a safe dining-out experience



Under the response choice 'Other', 14 (13%) of respondents took the opportunity to draw attention to their concerns. It was evident that, in addition to the pre-determined elements in the survey questionnaire, a further category of response could be identified from the comments namely, flexibility on the part of the caterer to facilitate the customer. The comments also emphasised the need for staff training to increase their level of awareness. A full list of responses is contained in Appendix 5.

Figure 12: Frequency at which respondents dined out during 2012

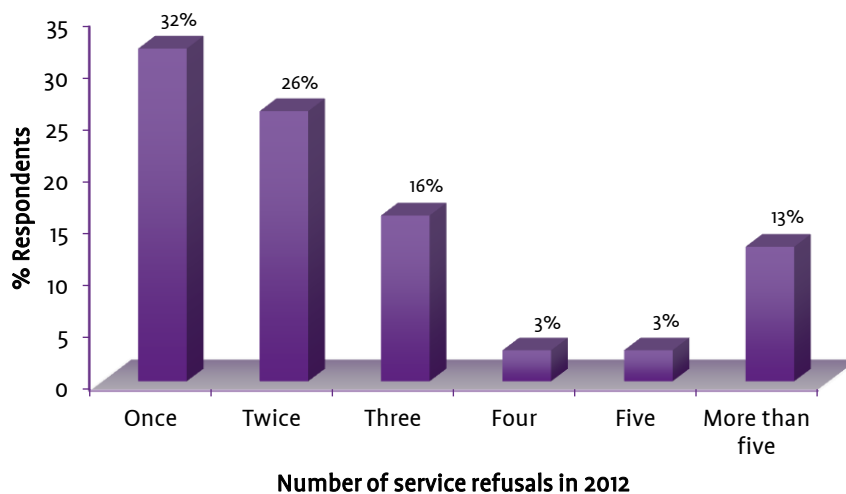


All 111 respondents commented on the question concerning the frequency at which the food allergic/intolerant individual dined out during the year 2012. 61% of respondents eat out once a month or almost once a month. 31% do so less frequently while 5% never eat outside in a commercial catering setting (this was exclusively due to food allergy/food intolerance considerations; economic considerations were not a factor). 3% eat out more frequently than once per month. Figure 12 describes the frequency with which respondents ate outside in a catering setting during 2012.

Once again under the response choice 'Other', 15 (14%) respondents took the opportunity to convey their opinions and experiences with regard to eating out (Appendix 6). It is clear from the comments that people with food allergy/intolerance will return to a restaurant where they have had a safe and pleasurable dining experience and in many cases will not eat out anywhere else. They are also quite prepared to bring food along for the person who is allergic/intolerant and require understanding of this by the restaurant. Furthermore, respondents are keenly aware of their responsibility toward protecting their own health when venturing to eat outside the home. For this to work, they need accurate reliable information and good engagement with catering staff.

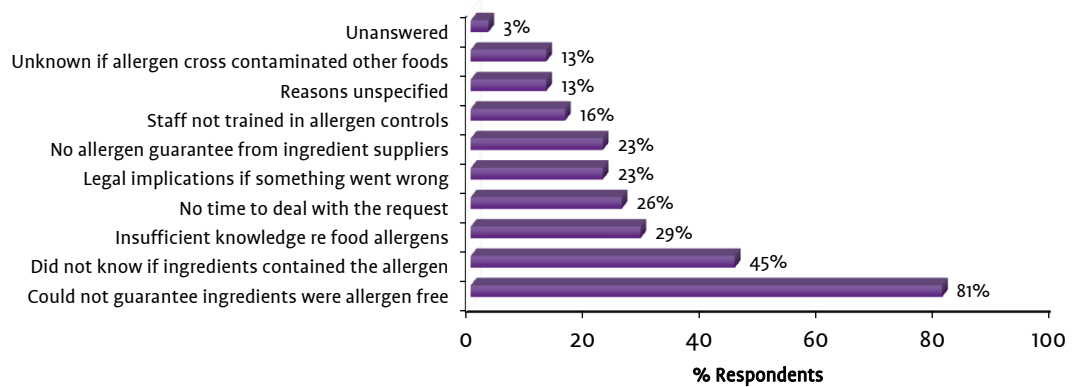
When further probed on whether or not they had been refused service when trying to dine out during the year 2012, 31 respondents (28%) had been refused service. All indicated the number of service refusals they had experienced during 2012. The number decreases progressively from one through to five refusals during that year (Figure 13) but interestingly 4 (13%) respondents reported being refused service on more than five occasions.

Figure 13: Number of service refusals experienced by respondents during 2012



All of the respondents who had experienced a service refusal during 2012 reported the reasons given by the caterer at the time. To facilitate a response, a choice of nine possible reasons was given. The percentage responses are shown in Figure 14:-

Figure 14: Reported caterer's reasons for service refusal



Clearly, an inability to guarantee allergen-free food was reported to be the chief concern of caterers where a service refusal was reported. Presumably this was due to an inability or unwillingness to determine and control cross-contamination as ascertaining the presence of allergens from the ingredients information is relatively straightforward. 45% of respondents reported not knowing if the ingredients contained the allergen as a reason for a refusal of service. Under the EU FIC, this explanation will no longer be acceptable. Also, 29% reported the caterer had insufficient knowledge regarding food allergens. Again, this cannot be used as a valid excuse under the provisions of the EU FIC. 26% reported the caterer had no time to deal with the request while 23% reported the caterer was worried about the legal implications if something went wrong. 23% of respondents also reported the caterer had not received allergen guarantees from their ingredient suppliers which proves the necessity of accurate labelling and information right along the supply chain. Under the response choice 'Other', 4 comments were documented (Appendix 7). From these it is clear that some food business operators claim that they cannot guarantee anything or will restrict what will be made available.

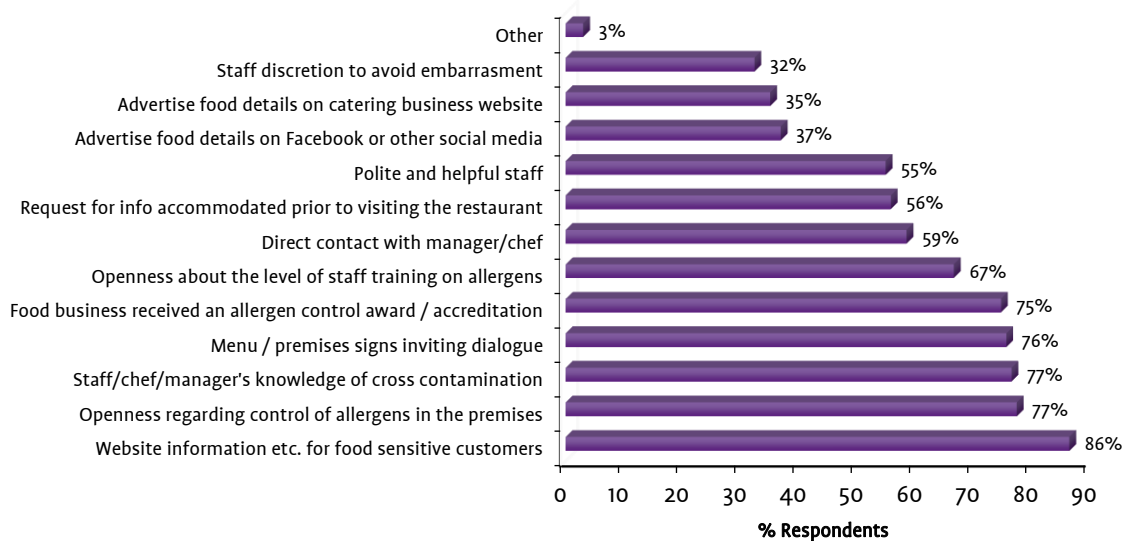
Finally, 98% of all respondents gave their opinion as to how exactly caterers could advertise their ability to provide food free from specific allergens. To facilitate a response, thirteen possible pre-determined elements of 'good advertising' were presented:-

1. Menu or premises signage inviting dialogue
2. Request for info accommodated prior to visiting the restaurant
3. Website information etc. for food sensitive customers

4. Polite and helpful staff
5. Direct contact with manager/chef
6. Staff/chef/manager's knowledge of cross contamination
7. Staff discretion to avoid embarrassment
8. Openness about the level of staff training on allergens
9. Openness regarding control of allergens in the premises
10. Food business received an allergen control award / accreditation
11. Advertise food details on Facebook or other social media
12. Advertise food details on catering business website
13. Other (please specify)

The extent to which respondents agreed with each choice is demonstrated in Figure 15.

Figure 15: Communication approaches that respondents would favour from caterers



It is clear from the responses that the provision of accurate and accessible information is considered important as is the honesty of the staff with whom the customer interacts. Respondents also highlighted the importance of the staff/chef/manager's knowledge of cross contamination and a majority would favour interaction with the chef or manager. Interestingly, respondents did not rate social media or staff discretion as being that important, although a majority did cite the importance of politeness. Furthermore, respondents favoured the idea of an accreditation or award for food businesses as a sort of adjudication on their ability to accommodate their food sensitive customers and take the issue seriously. Under the response choice 'Other', 3 comments were documented which emphasised some of the choices provided (Appendix 8).

5 Discussion

5.1 Details of the survey respondents

This survey was targeted at a specific population cohort, namely those with a food allergy or food intolerance and was disseminated through the NGO support organisation for this cohort, namely Allergy NI. The underlying assumptions here are (a) their membership should capture only those who have food allergy or intolerance and (b) this organisation probably has the most complete database of consumers in NI who have food allergy or intolerance. It is not known to what extent the total population of this cohort is captured in the membership suffice to say the services provided are unique. Most respondents were from the Belfast City, Down and Castlereagh Borough Council regions. However, there was no clear association between the incidence of food allergy/food intolerance and either population size or urban-rural divide.

In total, there were 111 valid responses to the survey. The degree to which the respondents were engaged with the subject matter can be deduced from the number and detail of the comments where this option was provided. Furthermore, the evidence clearly indicates this was predominantly a survey of 'guardians' (mothers accounted for 68% of completions) of food allergic/intolerant individuals who were the focus of the questionnaire completions. This was corroborated by the age profile of the persons who completed, or on whose behalf a guardian completed, the questionnaire. Approximately 69% of all completions were concerned with 0-12 year olds and this increase to 85% when the 13-20 year-olds are factored in. This is a clear indication of the level of concern and anxiety among parents/guardians of children/young adults with a food allergy or food intolerance. It probably also reflects the membership profile of the support organisation.

The food allergy/intolerance had been medically diagnosed in 99% of cases with most respondents citing the clinical setting and/or personnel involved in the diagnosis. Interestingly, the majority of those in the 20+ age categories had been diagnosed in adulthood. These diagnoses were not associated with a particular allergen; peanut and nut allergies predominate in this age cohort as in childhood diagnoses. These individuals may have lived with the food allergy/food intolerance since childhood but with sub-clinical symptoms. It may also simply indicate improvements in clinical care.

Most (~90%) questionnaire completions concerned individuals who were the only members of their family with a food allergy/intolerance or had just one other affected family member. Taken together with the age and guardian profiles, this may indicate an increasing awareness and diagnosis accuracy of food allergy/intolerance in recent years. However, it may also simply indicate the age cohort affected that would most likely result in membership of a support organisation.

5.2 Range and prevalence of food allergies/intolerances

The survey respondents specified the foods causing the allergy or intolerance. These not only included the 14 allergenic foods listed in Annex II of the EU FIC, but 16 other foods as well as 2 non-food allergens. Over 80% of respondents reported being allergic/intolerant to more than one food allergen. Allergies to two food allergens were most commonly reported with 37% of respondents affected. In terms of incidence, the top four allergens reflect what has been documented in other surveys from time to time, namely peanut, tree nut, egg and milk. Peanut and tree nut were in the top three most prevalent food allergens in all age cohorts of respondents. Milk allergy was more noticeable in childhood while sulphite and mollusc allergies were apparent in the adult cohorts. Soybean and sesame/kiwi are the 4th most prevalent food allergens in the 0 – 5 and 6 – 12 year old age cohorts, respectively. Sesame allergy appears to be more prevalent than fish allergy. Kiwi allergy ranked sixth while legumes and banana, which are also not in Annex II, ranked higher than molluscs, sulphites, celery, lupin and mustard. In the EU FIC, there is provision for the EU Commission to review the Annex II list of food allergens. The incidence of self-reported kiwi allergy in this survey suggests that it may be worthwhile investigating the prevalence in other EU Member States with a view to adjudicating on its possible inclusion to the Annex. Since the survey did not focus on coeliac condition, the returns for ‘Cereals containing gluten’ probably reflect gluten intolerance.

5.3 Respondent’s experiences when dining out

The majority of adverse reactions that happened outside the home were in a commercial food establishment such as a hotel, restaurant, fast food outlet or café, etc. These constitute the highest risk environments for those with food sensitivities. Interestingly, 35% of respondents reported an adverse reaction while in someone else’s home where, one could speculate, food sensitivity may not have been an issue. Institutional catering establishments such as a school, college or hospital, were also mentioned as well as a variety of other locations. Fundamentally, wherever food is served there is a risk of an adverse food reaction.

Respondents cited lack of control of cross contamination as being the chief cause of adverse reactions outside the home. A lack of information was also highlighted which perhaps substantiates the objectives of the EU FIC in which the obligations for caterers to have allergen information proactively available for their customers became a legal requirement from December 2014. (It is worth noting that, in a number of cases, the adverse reaction occurred because the individual didn’t actually realise at the time that they had a food allergy/intolerance.) Caterers should take note that customers with food allergy/intolerance will return to a restaurant where they have had a safe and pleasurable dining experience and in many cases will not eat out anywhere else. With conservative estimates of the total prevalence of food sensitivities in the population at around 10%, this highlights the size of the potential market that caterers can exploit. They must be more flexible in dealing with their food sensitive customers who are also quite prepared to bring food along for the

person who is allergic/intolerant and require understanding of this by the restaurant. The respondents themselves favoured the idea of an accreditation or award for food businesses as a sort of adjudication on their ability to accommodate their food sensitive customers and take the issue seriously.

Respondents were quite clear as to what was necessary for caterers to do to ensure a safe dining experience for their food sensitive customers. This is understandable when the reported rate of dining out is compared with figures for the general population. From the survey, 47% of respondents dine out once a month while 14% dine out up to ten times a year (those who reported never dining out did so due to their food allergy/intolerance; economic constraints were not a factor.) This compares to the ROI Bord Bia 2011 data from the general population in which 33% of respondents ate out a few times/once a month. Therefore, the assumption that food sensitive consumers do not eat out is grossly misleading as this survey has shown that there is no difference when compared to the general population, despite the increased risks. The implementation of the EU FIC will go some way towards ameliorating this risk as it compels the caterer to take a more proactive role in the provision of accurate information on food allergens, at least for the major allergens that are used as deliberate ingredients. However, the survey showed that the variety of food allergies and intolerances is quite broad so a generic approach to the dissemination of accurate information on the foods they sell will probably allow the caterer to best meet the requirements of the Regulation. Control of cross contamination is still critical to protecting the health of the food allergic/intolerant customer and, although not provided for in the Regulation, must nonetheless be an essential element of a caterer's food allergen control plan. Given the barriers which those with food allergy/intolerance face when dining out, it is not surprising that they tend to return to those restaurants where they will be courteously and safely accommodated and cross contamination from allergens is controlled.

Consumer with food allergies and intolerances face challenges when dining out which the general population don't have to consider. Almost a third (28%) of all respondents had been refused service during 2012 and most of those had been refused more than once. Indeed 13% of respondents who had experienced a refusal of service reported being refused on more than five occasions. The reasons for a refusal of service by caterers were primarily concerned with a lack of knowledge as to the allergenic ingredients. This may have been backed up by recourse to precautionary statements, the equivalent of 'May contain'. This has relevance for the implementation of the EU FIC as such an absence of knowledge is now unacceptable, at least in the case of a deliberate ingredient. In this context, it is interesting to note that only about a fifth of caterers were reported to have been concerned about the legal implications if anything went wrong.

But ensuring current obligations are met is also important: the survey returns indicate there is still a need to ensure that all staff are sufficiently trained and updated in all aspects of food allergen control. Caterers need to be not just aware of food sensitivities but knowledgeable about them. Clear and accurate information on which to make an informed choice will be dependent on the caterer's familiarity with the issue. This was considered by respondents to be more important than basic

politeness which is however necessary for generating the right kind of environment where the customer can be encouraged to engage more with the staff. Respondents are keenly aware of their responsibility toward protecting their own health and to do so they need accurate and reliable information and good engagement with catering staff. Respondents were also concerned about the use of precautionary 'cover-all' statements such as 'we can't guarantee' or 'may contain'. This reflects either continued uncertainty with regard to cross-contamination or an unwillingness to accommodate the customer. Since the EU FIC does not address the issue of cross-contamination, there is a danger that such 'precautionary statements' could become commonplace.

In recent years, best practice guidelines on the control of food allergens in the catering industry have been issued by a number of agencies in Ireland and the UK. These have advocated an awareness of the ingredients used and the competence to address the potential for cross-contamination. They have also sought to foster better accommodation of the needs of the food sensitive consumer when dining out. The **safefood** resource pack *Food Allergy and Intolerance: Guidance for the Catering Industry* will assist caterers in ensuring their staff have a basic grounding on the subject. The Safe Catering manual available from the Food Standards Agency is based on HACCP principles and contains a dedicated section on food allergens. The manual highlights the danger allergens present for the food sensitive customer and the obligations of the caterer in mitigating this risk.

6 Conclusion

The main observations from the survey are as follows:-

- Given the response rate to the survey and the extent to which written comments were provided by respondents, we can conclude that the risks associated with dining out are a key issue for those with food allergy/food intolerance.
- The high rate of guardian responses to this survey may indicate a high level of anxiety and concern among the parents/guardians of children with food allergy/food intolerance. Conversely, it may simply reflect the membership of Allergy NI which, as a local support organisation, will be regarded as a resource for assisting in the management of food sensitivities.
- Peanut was the most common food allergy, followed by tree nut, egg and milk allergy. This reflects findings elsewhere in the developed world.
- The incidence of reported food sensitivities in this survey does not necessarily reflect current labelling legislation. Kiwi allergy was relatively common amongst the survey respondents. This emphasises the fundamental paradigm that a food sensitivity can develop to just about any kind of food.
- The risk of an allergic/intolerant reaction whilst eating outside the home is high with more than half of respondents reporting having experienced same. An inability to control cross-contamination and deficits in information were proffered as underlying causes for these failures.
- There is a clear requirement for caterers to have knowledge, and be aware, of food allergy and food intolerance and how these can impact on health and quality of life. There are both legal and economic imperatives to do so, as food sensitive customers will show loyalty to those establishments whom they can trust.
- Food sensitivity consumers dine out just as frequently as their non-sensitive counterparts. Being refused service is par for the course.
- Flexibility on the part of the staff is greatly appreciated. Customers are quite prepared to bring food along for the person who is allergic/intolerant. They will return to those establishments where they have had a safe and pleasurable dining experience and in many cases will not eat out anywhere else.
- Caterers should be aware that control of cross-contamination remains an essential element of food allergen control even though it is not addressed in the EU-FIC regulation.
- Resorting to precautionary 'cover-all' statements such as 'we can't guarantee' or 'may contain' in the absence of a proper evaluation of the cross-contamination potential demeans the quality-of-life of food sensitive customers and does not make good business sense.
- Caterers must take their obligations toward protecting the health and quality of life of their food sensitive customers seriously. They must include allergen control as part of their food safety management system.

7 Acknowledgements

safefood and the Food Standards Agency of Northern Ireland wish to thank Mrs. Maureen Paul, co-ordinator of Allergy-NI, her team and her members for their patience and co-operation in carrying out this survey.

8 Appendices

Appendix 1

The survey questionnaire

- Q1 Please indicate which region you live in.
- Q2 Please select the district council region in Northern Ireland in which you live.
- Q3 Please select the county in the Republic of Ireland in which you live.
- Q4 Do you or a member of your family have a food allergy or food intolerance?
- Q5 How many members of your immediate family (including yourself) have a food allergy or food intolerance?
- Q6 Choosing one family member with a food allergy or food intolerance, what is your relationship to this person?
- Q7 Has the food allergy/food intolerance been medically diagnosed?
- Q8 What is the age of the person with the food allergy/food intolerance?
- Q9 At what age was their food allergy/food intolerance diagnosed?
- Q10 What kind of food(s) is the person allergic or intolerant to? (Please tick all that apply.)
- Q11 Did the person ever experience an allergic/intolerance reaction whilst eating outside the home?
- Q12 Please select the setting where eating the food that caused the reaction occurred?
- Q13 Was the allergic/intolerance reaction possibly as a result of one or more of the following? (tick all that apply)
- Q14 When planning to eat out in a catering establishment e.g. hotel, restaurant, fast food outlet or cafe etc, what do you think are the essential elements of an allergy-safe dining experience? (tick all that apply)
- Q15 Since January 2012 how often did the person with the food allergy/food intolerance eat out in a catering establishment?
- Q16 If you answered "Never" in the last question in respect of eating out was it because of (a) food allergy or food intolerance considerations or (b) economic considerations?
- Q17 During the year 2012, did a caterer ever refused to serve the food allergic/intolerant person because of their condition?
- Q18 On how many occasions has service been refused?
- Q19 What reason(s) was given by the caterer? (tick all that apply)
- Q20 In your opinion how could catering establishments advertise their ability to provide allergen free food? (tick all that apply)

Appendix 2

Geographical distribution of Allergy NI respondents

District Council Region	Total count	Percent
Antrim District	7	6
Ards District	9	8
Armagh City and District	2	2
Ballymena District	5	5
Ballymoney	0	0
Banbridge District	1	1
Belfast City Council	12	11
Carrickfergus District	2	2
Castlereagh Borough	11	10
Coleraine Borough	2	2
Cookstown District	2	2
Craigavon Borough	2	2
Derry City	2	2
Down District	11	10
Dungannon and South Tyrone Borough	3	3
Fermanagh District	1	1
Larne District	2	2
Limavady District	2	2
Lisburn City	8	7
Magherafelt District	2	2
Moyle	0	0
Newry City and District	2	2
Newtownabbey District	9	8
North Down Borough	6	5
Omagh District	6	5
Strabane District	2	2
TOTAL	111	100

Appendix 3

Total returns for food allergens

Allergen	Count	%		Allergen	Count	%
Peanuts	76	68		Mustard	1	1
Tree nuts	73	66		Citrus	1	1
Eggs	45	41		Melon	1	1
Milk	33	30		Avocado	1	1
Sesame	16	14		Chicken	1	1
Kiwi	11	10		Coconut	1	1
Cereals with gluten	11	10		Peach	1	1
Soyabeans	10	9		Cherry	1	1
Fish	9	8		Barley	1	1
Crustaceans	6	5		Turkey	1	1
Banana	6	5		Onion	1	1
Legumes	5	5		Berries	1	1
Molluscs	4	4		Peach	1	1
SO ₂	4	4		Salicylates	1	1
Celery	4	4		Food colouring	1	1
Wheat non-gluten	4	4		Fruit	1	1
Lupin	2	2		Vegetables	1	1
Pineapple	2	2				

Appendix 4

Comments received for Q13- Was the allergic/intolerance reaction possibly as a result of one or more of the following?

(NB Names have been redacted)

1. Allergy was never known at that stage
2. Before allergy was known
3. Didn't know i had an allergy
4. Failure to understand or take seriously the extent of allergen and ingredients of food served. Eg, when asking for a plain meat burger to be served on a bed of lettuce - the majority of establishments can't fulfil this, instead serving burgers containing rusk (wheat), taking meat out of bread bap and serving it (contamination). General contamination all round due to lack of understanding by staff.
5. High chair tray had previously contained allergen or had been wiped with cloth containing allergen.
6. I was unaware when ordering that my child had an allergy and therefore I was not cautious about finding out the ingredients in the food.
7. In fact the person serving food said product did not have nuts in it, when it was made from peanut butter
8. In one instance, Dish had a side salad, which unfortunately contained cheese. Blame myself (mother) as should have checked it.
9. It was my first reaction. I didn't develop my allergy until I was 6.
10. Kids party and Peanuts present.
11. No sign/information at stall to indicate the ice cream contained egg
12. Other person buying nut product
13. Put nuts on a dish my daughter inhaled them
14. server not sure of ingredients when asked
15. The first occurrence took place at a relative's home before we knew my daughter was allergic to nuts. The second time it took place in a hotel restaurant because we didn't realise the cake had a cream made with nuts.
16. The reaction occurred prior to diagnosis
17. We didn't know she was allergic at the time

Appendix 5

Comments received for Q14 - When planning to eat out in a catering establishment e.g. hotel, restaurant, fast food outlet or cafe etc., what do you think are the essential elements of an allergy-safe dining experience?

(NB Names have been redacted)

1. Having meal options available for a range of food allergies i.e. actually being able to cater for customers with allergies. 2. Staff being aware that food allergies can be serious even life threatening & therefore taking allergies seriously.
2. Also in children's experience the willingness of eatery to cook safe food brought in by customer of allergic child whilst non-allergic parents eat food served by eatery. We currently bring cooked food for our child to all restaurants at home and on holiday.
3. Establishment specifying the foods that allergic person CAN eat, rather than what they can't. It's good if they go out of their way to make a meal from scratch rather than sticking rigidly to a menu - it's very simple to do this. Case study - chef came out to stroppy child who was sick of not having chips or desserts and after discussion made lovely chips and dessert. One happy child!
4. Have systems already in place to prepare food for allergy sufferers - separate area available or the possibility of a chef preparing food separately. Knowledge of food products and their contents.
5. If English isn't the staff member's first language and they say the food has no nuts, being able to ascertain if they know what they are talking about.
6. It seems to me that it is easier for the Chef and Staff just to say that all their products may contain nuts rather than make any real effort to provide a suitable meal. Some chefs do not like to admit that they do not make all the food being served themselves eg desserts are often brought in from suppliers rather than made from scratch. Openness and honesty is required given the seriousness of the consequences.
7. It would be fantastic but probably not realistic to think that all establishments could have staff trained in food allergy awareness. So helpful & accommodating staff are essential.
8. Marked beside actual food if hidden allergens- eg perhaps I should have realised pesto was made with nuts but thought it was a spinach avocado type purée- it was in a pizza!
9. Notices are all well and good but need to have, substance behind that - which is a manager, chef with relevant info or information sheets
10. Sometimes I have to see the packaging their ingredients come in - eg potato chips, many establishments buy in their raw chips already sliced, many contain wheat powder, yet the staff think their serving potato only.
11. Speaking to the chef is advance to plan an appropriate meal and to ensure that the establishment has an understanding of the seriousness of food allergy
12. Staff are key. When we eat out now we bring pre made food for our son, the rest of family eat out.
13. That staff don't make claims that they haven't checked Always carry your epipen
14. To take my requests seriously and not think that I am an over-protective mother. I always worry about cross contamination. My son is anaphylactic to dairy. We don't feel confident to eat out that often.

Appendix 6

Comments received for Q15 - Since January 2012, how often did the person with the food allergy/food intolerance eat out in a catering establishment?

(NB Names have been redacted)

1. 99% of the time taking our own food for her
2. Becoming more difficult as Catering Businesses do not want people with Allergy, they would not treat a disabled person in the same way or they would be in court under Disability Discrimination Legislation. Every where you go there are disclaimers, which in our view basically say don't eat in our premises we are not responsible for the food we provide In fact we feel very uneasy in this climate/culture in the food industry. Because it says to us as a family that the business does not care about it's customer
3. Brought own cooked food each time.
4. But tend to stick to places we know are ok. If going out for the day to an area we don't know we would bring a picnic or ring somewhere in advance.
5. Family eat out at least once a week but he accompanies us with his own food
6. I have only taken my child to one establishment as I am happy with the training of the staff and their awareness of food allergies. I would usually bring my own food to other establishments unless I have had a recommendation from other allergic families.
7. There is not enough information available for me to take my child out and no one knows the answers so its just safer not to go
8. This is not every month but the number of visits to a catering establishment has greatly reduced as not comfortable with the unknown surroundings and the ever present risks to health.
9. too scary after my daughter had an anaphylactic shock at 21 weeks to oats milk formula
10. Usually a restaurant we know and are confident with and the staff know us from regular visits.
11. Very hard to explain the importance of cross contamination to people, they just dont understand the risks.
12. We do eat out but I always bring food for Isla. Then If there is nothing appropriate on menu we at least have food for her.
13. We often dine in restaurants but now bring our own pre-packaged (supermarket bought) toddler meals for our allergic child to ensure no risk of allergen in his food. Restaurants are always happy to heat the ready meal for us. Most waiters assume it is acceptable to simply remove the allergen from the food and are not aware of cross contamination so we do not feel happy ordering food for our son off the menu.
14. We tend to go to places where we have already established a relationship.
15. We tend to stick to restaurants/take away establishments that we know now and trust, or where there In response to question 16 below we have never been refused food but they make sure you know that it is your problem not theirs. In fact in the business were my child took ill they put up signs afterwards but now they have come down.

Appendix 7

Comments received for Q19 - What reason(s) was given by the caterer (for refusal of service)?

(NB Names have been redacted)

1. INFORMATION REDACTED owner was very unhelpful (and rude) in front of a packed shop when I enquired if the ice cream had nuts in it. She didn't know and didn't have time to check. The INFORMATION REDACTED franchise was able to assure me that the ice cream was nut free.
2. Couldn't be bothered to make an effort!
3. On a number of occasions as soon as we mention the allergy the immediate response is 'we can't guarantee anything'. We used to try to bring them round and discuss it, but now we just leave it and go somewhere else.
4. While not a restaurant, a well-known ice cream chain refused to sell me any product, even plain vanilla ice cream, because of the risk of cross contamination. The manager said the company policy was that they could not guarantee any food served on the premises was nut free and could therefore not serve me, even at my own risk. The reasons cited were potential cross contamination during production and potential cross contamination during serving (because of nuts on the counter top, etc).

Appendix 8

Comments received for Q20 - In your opinion how could catering establishments advertise their ability to provide allergen free food?

(NB Names have been redacted)

1. Allergen control awards sound like an excellent idea!
2. First contact response is key, also being able to see on a website before you go is helpful.
3. We note that they are very good with gluten free products, why not nuts?

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