Department of Health

From Jane Ellison MP
Parliamentary Under Secretary of State for Public Health

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20 JAN 2015

Mr S Nelson
Senior Coroner
HM Coroner's Court
The Phoenix Centre
L/Cpl Stephen Shaw
MC Way Heywood
OL10 1LR

Dear Mr Nelson

Thank you for your letter following the inquest into the sad death of Eliza Bashir.

Eliza suffered an accidental death as a result of ingesting a button battery which had come from a torch that she had been playing with whilst at home. Damage to her oesophageal wall, which led to her death, was caused by either pressure from the battery, electrical discharge from the battery, or leakage of alkaline material or heavy metals from the battery core.

I understand the button battery was removed by rigid endoscopy performed at the Royal Manchester Children's Hospital and Eliza was discharged home and remained well over the next five days. Unfortunately, she then collapsed and suffered a cardiac arrest. She was taken to Accident & Emergency Department of the Royal Oldham Hospital but extensive resuscitation could not prevent her death.

You raise the following concerns for our attention:

- Evidence from the Trading Standards Officer confirmed that because the torch was not classified as a toy, it did not require a lockable battery compartment, notwithstanding compliance with safety regulations.

- The Consultant Paediatric Surgeon at the inquest said in evidence that both he and his colleagues were unsure how best to deal with incidents such as this. Whilst awareness of the risks and complications arising from ingested button

batteries was being raised locally, there was a need for the profile of those risks to be raised nationally.

- Such batteries are sold in supermarkets and other retail establishments and are often on display at a level that would enable small children to gain access to them whilst unobserved.

Although your concern relating to the display and placement of button batteries in retail outlets is a matter for the retailers concerned, my officials have however, shared a copy of your report with colleagues in the Department of Business, Innovation and Skills (BIS). I expect them to liaise with the Royal Society for the Prevention of Accidents (RoSPA) and the National Trading Standards Board (NTSB) to explore a way to address this concern with retailers.

Regarding your concern that awareness of the dangers of button batteries be raised nationally, my officials have discussed this case with BIS. BIS have informed us of several awareness campaigns that are being run on both a national and international level.

The NTSB developed a national poster safety campaign on behalf of BIS. The campaign was promoted across England and Wales and colleagues in Scotland and Northern Ireland are now also becoming involved. Over 100,000 posters were distributed through sure start centres and nurseries.

In addition, BIS supports the home safety campaign, concerning button batteries, which is run by RoSPA - further details can be found at:

http://www.rospa.com/homesafety/adviceandinformation/product/button-cell-batteries.aspx

On an international level, the Organization for Economic Co-operation and Development (OECD) launched an *International Awareness Week on Button Batteries* in June 2014 to raise awareness worldwide of the risks and dangers posed by this product.

This initiative was aimed at consumers, relevant authorities and stakeholders worldwide, to encourage them to take steps necessary steps to reduce the risk of injuries and deaths due to button batteries. Throughout the week, participants co-ordinated media, social media, online and on-site initiatives. Details of media releases and online content links are attached. More information on the awareness week can be found at the following link:

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http://www.oecd.org/science/button-battery-safety-awareness-week.htm

In addition, the European Commission addressed similar issues by hosting a press event on button batteries in Brussels on 17 June 2014 during the 2014 International Product Safety Week.

Further to this, the College of Emergency Medicine in the UK has also issued awareness guidance on button batteries on its website, linked to an item on the National Poisons Information Service and the National Capital Poisons Center in America. This provides emergency advice for those who have swallowed a button battery and for those clinicians presented with a potential button battery case.

There are some scientific developments in the area of button battery safety and research continues into producing button batteries with special coatings that stops them causing harm if they are swallowed.

I share your concerns about the dangers of button batteries and hope that the above examples help to reassure you that awareness of these dangers is being raised at both a national and international level.

However, I will ensure that the information in your letter and this reply is shared with health visitors, school nurses and the child health leads at Public Health England's regional centres so that awareness of the risks of button batteries is further raised. My officials will give consideration as to how these professionals can best be supported to use this information to make parents and child carers aware of this issue.

In addition, my officials will contact the membership of the National Social Partnership Forum, which includes NHS trade unions and employers, to raise awareness of the issues concerning button batteries as outlined in your report. I hope that this response is helpful and I am grateful to you for bringing the circumstances of Eliza's death to my attention.

Kind regards, [redacted]

JANE ELLISON