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UKCPI response to the Coroner's Prevention of Future Deaths report – Elizabeth Van Der Drift

The UK Cleaning Products Industry Association (UKCPI) is the leading trade association representing UK producers of cleaning and hygiene products used in the home as well as in industrial and institutional workplaces.

Our UK members manufacture soaps, detergents, dish wash, laundry, air care products, surface cleaners, polishes and disinfectants including sanitisers. Products that – perhaps uniquely – are used in every home, in every workplace, every day, by everyone to provide the clean, safe and hygienic environment we take for granted.

As a trade association we work in partnership with our stakeholders including policy makers, the public and the media, to inform discussions about cleanliness, hygiene and sustainable cleaning and to ensure that our products are used safely and as intended.

We were saddened to hear of Elizabeth Van Der Drift's accidental death and the circumstances in which this happened. This is especially so given the purpose of our products is to enhance and provide a safe home or workplace for families and individuals.

This tragic accident is extremely rare. The National Poisons Information Service or NPIS receive approximately 40,000 telephone enquiries per year. Typically 8% of enquiries per year involve adults aged > 74 years.

The majority of these exposures (>80%) involve medicines, with household products accounting for <10% of exposures. Of these 300 exposures per year 78% involve washing up liquid, anti-bacterial or disinfectant products, 10% kettle descalers, 6.5% laundry powders and liquids and 5% (or 15 exposures) are attributable to laundry capsules and dishwasher tablets.

In approximately 2% of enquiries regarding patients in this age group (>74 years), a diagnosis of Alzheimer's was documented, and dementia recorded in around 10%. Most exposures (85%) occur in the home and 12% in nursing/residential homes. NPIS has a classification (the PSS or Poisoning Severity Score) for assessing the severity of poisoning at the time of the enquiry. 'Moderate' toxicity is observed in 3% and 'severe' toxicity in a similar number of cases. The majority of exposures reported to the NPIS (>90%) result in no or minor clinical features only.

The circumstances in which this accident happened was described (media reports) as 'assisted living' and could provide laundering through a shared or communal laundry room. If this was the case it would likely have been unsupervised, where the product might have been easily available especially if the packaging was not secured properly after use or stored safely.

What this data highlights is that accidental exposures occur from a range of household products and reinforces our approach to raise awareness of the need for safe storage of all cleaning and hygiene products.

What follows is a short background and review on liquid capsules safe use and then our proposed action addressing the concern of safe storage of household cleaning products including laundry capsules in the elderly / dementia sufferer environment.

Liquid laundry detergent capsules (LLDC) - background

- a. LLDC are a single or unit dose of detergent contained in a water-soluble film. They most commonly contain a mix of anionic and non-ionic surfactants together with solvents, colourants, fragrance and other ingredients such as enzymes in biological products.
- b. LLDC enable the user to accurately dose for a laundry wash (one capsule per load) to avoid overdosing and are in a soluble format for use at low temperature to reduce energy use.
- c. They are therefore seen as a convenient and sustainable laundry washing product with over a billion capsules sold annually in the UK alone. They have been on the UK market since 2000.
- d. However, as their popularity increased there were a small number of accidental exposures, mostly involving young children. Although the majority of those exposed to liquid laundry detergent capsules were asymptomatic or suffered only minor clinical features after exposure, a small proportion required a hospital visitⁱ. [Reference: NPIS Clinical Tox 2017 paper](#)
- e. There have been no known UK infant fatalities due to these exposures and almost all were the result of unintended access to the product in the home, i.e. either the capsule container was left open and / or stored in an easily accessible location for an unsupervised infant.

Ensuring safe use and preventing infant accidents

- a. Due to growing concern by the industry over the accidental exposures, in 2012 AISE, the European trade association for detergent manufacturers, established its own voluntary set of safety measures. This is named the [Product Stewardship Programme \(PSP\) for Liquid Detergent Capsules](#)ⁱⁱ.
- b. These safety measures were quickly adopted by all EU capsule manufacturers, including in the UK, and require manufacturers to:
 - i. ensure the outer packaging is obscure or opaque
 - ii. modify the closures to an industry standard to impede the access by infants
 - iii. provide icons and safe use messages prominently on the outer packaging by use of a visible industry-wide safety icon and panel – examples below for both pouches and box packaging:



- iv. adopt an advertising code of conduct and industry-wide safety message in brand communication including broadcast
 - v. Maintain a dedicated web-based campaign namely www.keepcapsfromkids.eu
- c. In 2014, this then became the template for adoption into EU legislation; the Classification, Labelling and Packaging Regulation or CLP.ⁱⁱⁱ This added further protective measures such as imposing a minimum resistance of the soluble film membrane, retaining its liquid content for at least 30 seconds when the soluble packaging is placed in water at 20°C and adding an aversive bittering agent ‘which elicits oral repulsive behaviour within a maximum of 6 seconds’.
- The industry’s own PSP programme was retained as it goes beyond the regulatory requirement in areas of on pack communication and advertising.
- d. In 2014, AISE carried out a large-scale prospective research study in collaboration with five Poison Centres, to help better understand accident circumstances and thus to confirm that the most appropriate measures are taken to address any safety concerns. It found that since the introduction of the industry’s PSP, the number of incidents reported to the Poison Centres have decreased on average by 32% and that the preliminary findings of the data indicate that unsafe storage was the main cause of accidents involving children.
- e. In 2017, the European Commission produced a final report on Detergent Mixtures in Soluble Packaging ([the ‘LiquiCaps’ study’](#))^{iv} to study i) LLDC safety, ii) the impact of measures on LLDC safety and iii) appraise possible additional safety measures. The report in full can be found [here](#), but in summary it also concluded that the majority of accidental exposures occurred when the products were easily accessible by children in the home.
- f. In the UK, and in addition to the above voluntary and regulatory requirements, we established a home safety campaign with RoSPA (The Royal Society for the Prevention of Accidents), to promote safe storage in the home.

[‘Take Action Today’](#)^v is a communications and awareness programme delivered through existing home visit programmes aimed at families with new babies and / or families in areas of deprivation known to have high rates of infant accidents.

It is now in its 11th year with over 50 regional launches taking the safe storage message directly into over 700,000 families to help prevent poisoning accidents in the home. The professional home visitor has a simple checklist to go through with the parent and there is a kitchen ‘magnetic’ leave behind with safe storage messages. The campaign has been hugely successful in reducing hospital admissions due to accidental exposures amongst infants by 45% for period 2022/23 and 50% for 2023/24 (NHS data provided by RoSPA). Detailed campaign presentation can be found [here](#).^{vi}

Extrapolation of measures to reduce infant accidents to the elderly/dementia sufferer

There is a significant overlap in the cognitive state of young children and that of elderly dementia sufferers which is best described as an “absence of inhibition”, or said differently, an absence of risk awareness around the house. ([Covey, H. C. \(1993\). A return to infancy: Old age and the second childhood in history. The International Journal of Aging and Human Development, 36, 81–90](#))^{vii}

This similarity could allow us to extrapolate the conclusions of the research and campaigning with parents of infants to carers / care managers of cognitively impaired persons/dementia sufferers.

We know that infants build up their inhibitions about what to put into their mouth and what not to put in their mouth by experience, hence initially many items are explored by mouth.

For dementia sufferers, as the disease progresses they often lose these learned inhibitions and / or the ability to distinguish hazardous materials from non-hazardous such as foodstuffs.

This loss of inhibition can be gradual, intermittent i.e. extremely difficult to predict and as manufacturers have no control over the product use in the user environment, so the role of the care giver becomes critical in ensuring that the user environment is safe.

The measures industry currently takes, both regulatory and voluntary, mean that the product itself and the packaging it is in is inherently safe and the likelihood of accidental ingestion should be extremely low for all age groups.

Our ‘[Take Action Today](#)’ campaign aims to make the home environment safe for infants which means ensuring that the parent is suitably informed about safe use and safe storage.

This approach could be applied to the care environment and has the added benefit that it also helps remind and therefore prevent accidental exposure to other cleaning product types (acid and bleach based corrosive cleaners) as well as other substances such as medicines.

Proposed action

The industry has demonstrated that it is prepared to take appropriate and proportionate action to ensure the safe use of its products.

As described above, we have had and continue to have a leading role in addressing infant accidental exposure in the home and believe this experience can be applied with similar success in the elderly / dementia care environment.

Our actions laid out below are quick to deliver, reliable in terms of ongoing impact, applicable to the safe storage of all cleaning products (such as bleaches and disinfectants etc), reinforce the message for the safe storage of other products such as medicines and are proportionate to the level of accidental exposure currently being recorded.

Speaking to the CQC and charities including RoSPA, Age UK, Dementia UK and The *Alzheimer's Society*, there does not seem to be any clear guidance on the safe use or storage of cleaning chemicals in a care environment - be that in the home of a sufferer or in a care home setting (unlike for medicines).

There is [The fundamental standards - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk)^{viii} which apply to all registered care facilities regulated by the CQC in England. Included in the standards is 'premises and equipment' and this includes ensuring that premises are safe, and so can include care homes responsibilities on safety around the home on chemical storage etc.

It is relevant to note that responses to our [Keep Caps From Kids](#) website include emails from elderly consumers (often with reduced hand strength or arthritis) complaining about the difficulty in opening laundry containers (and having to resort to knives and scissors) and they admit that they do not reclose the hard to open containers.

We know that the majority of large care and residential homes will have professional laundering and cleaning services on or off site and the likelihood of patients accessing hazardous products is minimal.

However, in the smaller establishments, assisted living, independent living and ultimately in the home of say an early-stage dementia sufferer we believe that risks of accidental exposure can be best managed and minimised by ensuring that the care giver has greater awareness of safe use and storage of household chemicals. NPIS data shows that 80% of accidental exposures occur in the homes of the elderly <74yrs.

There is already an established requirement for the safe use and storage of medicines with regulation (Medicines Act 1968) and guidance ([NICE](#)^{ix} and [CQC](#)^x) existing to ensure effective storage in a lockable cupboard for example.

However, guidance on providing a safe environment tends to be general in nature and not specific to avoid accidental exposure to household cleaning products, including LLDC. For example:

https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/making_your_home_dementia_friendly.pdf

As previously described, UKCPI has a longstanding and successful national campaign delivered by RoSPA targeting families with infants.

'[Take Action Today](#)' aims to reduce accidents amongst children under 5 by ensuring parents understand how to use and store safely all household cleaning products (including laundry capsules), to prevent infant access, i.e. the campaign builds on the safety measures already built into the product and product packaging and addresses the home environment where the cleaning products are used.

We believe that in partnership with the appropriate agencies or charities we could research, develop and tailor such a campaign to target care givers in assisted living, independent living, care homes, residential care and in the home of the sufferer to ensure that they are fully aware of the need to ensure safe and secure storage of household cleaning products including LLDC.

Our action would be to explore how such a campaign could be executed with industry support and delivered through organisations such as the CQC and charities such as RoSPA, Age UK, Dementia UK and The Alzheimer's Society, all of whom we have already had preliminary discussions.

Such a campaign would deliver a broad range of reduced risk not just of accidental ingestion but also skin and eye damage from all household products as well as other products categories such as medicines and garden chemicals.

We would expect to be able to report back within 12 months on campaign messages, delivery partners and how to measure impact.

Annex The Coroner's concerns

- a. The Coroner specifically references LLDC 'as being colourful and potentially sweet-like in their appearance'.
The bright colour of capsules was also claimed to be a factor in infant poisonings and led to a body of [research work](#)^{xi} and an [EU Commission report](#)^{xii} concluding that there was no discernible colour preference when infants were exposed to a range of coloured household laundry products.

Also, an inquest only recently reported that a male dementia sufferer died after pouring a liquid laundry product on his breakfast cereal. The detergent was purple so unlikely to be confused with milk/foodstuff. This would support the view that it is not colour but simply a dementia sufferer's inability, at some point in their disease progression, to distinguish between hazardous and non-hazardous materials.

UK legislation specifically requires manufacturers to avoid any confusion over their product use, for example:

Under CLP there is a provision that "Packaging containing a hazardous substance or a mixture supplied to the general public shall not have either a shape or design likely to attract or arouse the active curiosity of children or to mislead consumers, or have a similar presentation or a design used for foodstuff or animal feeding stuff or medicinal or cosmetic products, which would mislead consumers."^{xiii}

Under the Biocidal Products Regulation; "In addition, products which may be mistaken for food, including drink, or feed shall be packaged to minimise the likelihood of such a mistake being made. If they are available to the general public, they shall contain components to discourage their consumption and, in particular, shall not be attractive to children."^{xiv}

Finally, it should be noted that as far as the industry is aware there have been no successful cases brought against any cleaning product including laundry under the criteria of The Food Imitations (Safety) Regulations 1989. The regulation looks at the form, odour, colour, appearance, packaging, labelling, volume or size when determining if it is imitating a food.

- b. The Coroner specifically mentions 'no obvious design feature, in terms of the packaging, that makes accessing the content particularly difficult'. This is confusing given the various measure previously described required under CLP.

I have requested and received samples of the pouch packaging for this SKU and can confirm that it is fully compliant with the requirements of GB CLP Regulation and industry PSP.

Whilst unable to verify the situation at the time of the accidental ingestion, as previously mentioned, it is possible that the packaging was left open or damaged because the container was difficult to open.

References

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- ⁱ [A review of 4652 exposures to liquid laundry detergent capsules reported to the United Kingdom National Poisons Information Service 2008–2018](#)
- ⁱⁱ [Product Stewardship Programme \(PSP\) for Liquid Detergent Capsules.](#)
- ⁱⁱⁱ Retained EU legislation Commission Regulation (EU) No 1297/2014 amending Part 3 of Annex II to Regulation (EC) No 1272/2008
<https://www.legislation.gov.uk/eur/2014/1297/annex>
- ^{iv} [Study on hazardous detergents mixtures contained in soluble packaging for single use \('LiquiCaps Study'\)](#)
- ^v [Take Action Today, Put Them Away campaign](#)
- ^{vi} [RoSPA Take Action Campaign presentation](#)
- ^{vii} [\(Covey, H. C. \(1993\). A return to infancy: Old age and the second childhood in history. The International Journal of Aging and Human Development, 36, 81–90\)](#)
- ^{viii} [The fundamental standards - Care Quality Commission \(cqc.org.uk\)](#)
- ^{ix} <https://www.nice.org.uk/guidance/ng46>
- ^x <https://www.cqc.org.uk/guidance-providers/adult-social-care/storing-medicines-care-homes>
- ^{xi} <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199976>
- ^{xii} https://ec.europa.eu/health/scientific_committees/consumer_safety/docs/sccs_o_056.pdf
- ^{xiii} Retained EU legislation Regulation (EC) 1272/2008 Article 35 Para 2
https://www.legislation.gov.uk/eur/2008/1272/pdfs/eur_20081272_2008-12-16_en.pdf
- ^{xiv} Retained EU legislation Regulation (EU) No 528/2012 Article 69 Para 1
<https://www.legislation.gov.uk/eur/2012/528/article/69>