

# Press release: Emollient cream build-up in fabric can lead to fire deaths

The Medicines and Healthcare products Regulatory Agency (MHRA) is recommending that labelling and product information for these emollient products should include a warning about the fire hazard, with clear advice not to smoke or go near naked flames and information about the risk of severe burn injury or death when clothing, bedding and dressings with emollients dried on them are accidentally ignited.

Emollients are moisturising treatments applied directly to the skin to soothe and hydrate it. They cover the skin with a protective film to trap in moisture. Emollients are important treatments, widely used to help manage dry, itchy or scaly skin conditions such as eczema, psoriasis and ichthyosis.

The likelihood of fabric that has been in contact with emollient products catching fire through an individual smoking or being near a naked flame is low, but if this does occur it could cause severe burns which may result in death. We want users to be aware that fabrics which have come into contact with an emollient can be highly flammable, even after washing. The risk is greater when emollients are applied in large quantities or to large areas of the body.

Following an extensive review of the available evidence, the Commission on Human Medicines (CHM) recommends that:

- outer packaging and product containers should include a warning about the fire hazard and advice not to smoke, accompanied by short explanatory text and a picture warning in the most prominent field of view
- where available, the Patient Information Leaflet or Instructions for Use and the Summary of Product Characteristics (SmPC) should be updated to include warnings about the risk and how best to minimise it

The text will clearly warn users not to smoke or go near naked flames due to the risk of severe burns, that as fabric (such as clothing, bedding and dressings) which has been in repeated contact with these products burn more easily and can be a serious fire hazard. Washing clothing and bedding may reduce product build-up but not totally remove it.

The MHRA and industry are working together to apply the CHM recommendations and develop suitable ways to make sure the warning is appropriately prominent. Additionally, we are setting up a specific stakeholder group to manage education and awareness of this issue.

It was previously thought the risk occurred with emollients which contain more than 50% paraffins. However, evidence now points to a risk with emollients which contain lower levels of paraffin and with paraffin-free emollients. This advice therefore applies to all emollients whether they

contain paraffin or not.

It is important people prescribing, dispensing or using any emollient, or caring for someone who uses an emollient, are aware of the potential fire risks and take appropriate action to reduce it.

June Raine, Director of MHRA's vigilance and risk management of medicines division said:

We don't want to unduly worry people into not using these products which offer relief for what can be chronic skin conditions, but it is equally important people are aware of the risks and take steps to mitigate them.

Our new evidence-based recommendations are intended to empower proper use of these tried and trusted treatments and we are working with industry to support delivery of prompt packaging and labelling warnings and advice.

If you use emollients and have any questions or concerns, we'd recommend speaking to a healthcare professional, such as your pharmacist or GP.

Patient safety is our highest priority. We strongly encourage anyone to report any issues with this product, or more generally with any medical device, to our [Yellow Card Scheme](#).

Watch Manager Chris Bell from West Yorkshire Fire and Rescue Service and National Fire Chiefs Council's lead for emollient creams, said:

We welcome this recommendation. There have now been in excess of 50 deaths in the UK where the build-up of emollients on bedding, dressings or clothing may have contributed to the speed and intensity of the fire. Many of these fires were caused by people who smoked and were unaware of the fire risks associated with emollient build-up on fabrics.

We have been trying to raise awareness about this issue with the public and health and care professionals. Ensuring that these products carry warnings will certainly help us as we continue to work with pharmacists, the NHS and care sector to prevent any future deaths.

John Smith, Chief Executive of PAGB, the consumer healthcare association, said:

Emollient products are an important and effective treatment for chronic and often severe dry skin conditions, such as eczema and

psoriasis. People should continue to use these products, but it is vital they understand the fire risk associated with a build-up of residue on fabric and take steps to mitigate that risk.

Safety is of paramount importance to the consumer healthcare industry and PAGB member companies are committed to adding a clear warning statement to the packaging of emollient products. We have been working with MHRA during its review of the evidence to ensure the warning is implemented consistently across industry and to support efforts to raise awareness of this issue.

---

## **Press release: Somerset rivers stocked with fish ahead of Christmas**

Thousands of fish have found new homes just in time for Christmas thanks to the Environment Agency's Christmas restocking of Somerset's rivers.

Every year, the Agency's Calverton Fish Farm, near Nottingham, breeds fish of many varieties to repopulate England's rivers.

Agency officers from Bridgwater's fisheries team spent a busy day on Friday 14 December putting 7,800 fish into the Blind Yeo near Clevedon, Burtle Road Lakes in Burtle, and the King Sedgemoor's Drain at Parchey.

Restocking will conclude on 19 December with 6,300 fish introduced to the Somerset Frome in Frome, which lost a large number of fish after a slurry spill in 2016.

Kevin Austin, Environment Agency Deputy Director of Fisheries, said:

We encourage anglers to enjoy fishing through the festive holidays. A fishing rod licence also makes an excellent Christmas gift for someone who doesn't have one but wants to give it a go.

The work of our National Fish Farm is funded by income from licence fees, so in the lead up to Christmas it's great to see the fish farm continuing to produce strong and healthy fish needed for re-stocking and recovery.

In the first 4 weeks of the stocking season (14 November to 14 December) 143,000 fish reared for up to 18 months have been driven from the fish farm in Nottinghamshire and released into 41 still waters and 30 rivers, with plenty more planned for the coming weeks.

The restocking activity is part of an annual programme, funded by income from rod licence sales. Restocking occurs in winter because water temperatures are low and this minimises any stress on the fish, giving them the best possible survival rates.

Restocking is done where numbers are low, have been depleted following a pollution incident or to create new fisheries and opportunities for anglers.

You need a rod fishing licence to fish for salmon, trout, freshwater fish, smelt or eel with a rod and line in England. Get yours from <https://www.gov.uk/fishing-licences>.

### **Notes to editors**

- The 7,800 fish restocked included 3,000 roach, 2,000 bream, 1,000 chub, 800 tench, 600 crucians and 400 dace.
- The 6,300 fish restocked will include 2,000 roach, 1,500 chub, 1,000 bream, 600 tench, 600 crucians and 600 dace.

---

## **[Press release: Somerset rivers stocked with fish ahead of Christmas](#)**

Thousands of roach, bream, chub, tench, crucians and dace find homes in Clevedon, Burtle, Parchey, Yeovilton and Frome.

---

## **[Press release: Report 20/2018: Near miss with track workers and trolleys at South Hampstead](#)**

RAIB has today released its report into a near miss with track workers and trolleys at South Hampstead, London, 11 March 2018.

---

# [Press release: Report 20/2018: Near miss with track workers and trolleys at South Hampstead](#)

PDF, 5.86MB, 43 pages

If you use assistive technology (such as a screen reader) and need a version of this document in a more accessible format, please email [enquiries@raib.gov.uk](mailto:enquiries@raib.gov.uk). Please tell us what format you need. It will help us if you say what assistive technology you use.

## **Summary**

At around 00:35 hrs on 11 March 2018, a group of track workers narrowly avoided being struck by a train while placing trolleys on the track alongside South Hampstead station, north London. The train was travelling at 49 mph (79 km/h) towards London Euston station when the driver saw the group, sounded his horn and applied the brake. Three other members of the work group, who were around 100 metres away from the staff placing the trolleys on the track, saw the train seconds earlier and shouted a warning to their colleagues who managed to remove the trolleys and get clear around two seconds before the train passed. One member of the group received a minor injury and many were distressed.

The incident occurred because the track workers had placed the trolleys on a line which was still open to train movements, instead of on the intended adjacent line that was blocked. The RAIB investigation found that the safety arrangements that had been established were ineffective. The work group did not have anyone designated as the 'Person in Charge', an individual who has sufficient knowledge and competence, and is specifically appointed to manage all the risks associated with the work, including the danger from moving trains. There were also a number of unofficial working practices being used by the workgroup and the person asked to take charge of safety for the work group believed the open fast lines were the blocked slow lines.

## **Recommendations**

As a result of its investigation the RAIB has made six recommendations to Network Rail. These relate to:

- clarifying to staff the exact responsibilities of a 'Person in Charge'
- making sure that managers are aware of their responsibilities
- improving location information that staff are provided with when working on or near the track
- signage at the access point at South Hampstead
- undertaking an audit of how Network Rail standard NR/L2/OHS/019 Issue 9 has been implemented across the network in order to determine how the

standard has been interpreted and understood, and areas of good and bad practice

- reviewing how the changes from issue 8 to issue 9 of NR/L2/OHS/019 were managed, in order to identify any areas for improvement in the management of change

The RAIB has also identified one learning point; that those in charge of safety should be careful to check safety critical information when challenged by others in their team.

**Simon French, Chief Inspector of Rail Accidents said:**

The recent tragic death of a track worker on the Brighton main line at Stoats Nest Junction is a stark reminder of the risk of working on the railway tracks. Prior to this accident, it had been nearly five years since a track worker was struck and killed by a train. However, in that time there have been too many near misses, such as this one at South Hampstead, in which people have had to jump for their lives at the last moment. In the case of the near miss at Egmonton in October 2017, a multi-fatality accident was only avoided with two seconds to spare. "The number and type of near misses in recent years is hugely disappointing given the efforts made to address track worker safety during that time. Every near-miss, however caused, should be viewed as a failure of the system to deliver safety.

Over the same period, Network Rail has introduced a number of changes to procedures, and several new initiatives, to try to reduce the risk. One of these re-introduced the concept that there should be a 'person in charge'. This was intended to make an identifiable and capable person responsible for all aspects of the planning and delivery of safe work, for each job. It is disappointing that our investigation found that the way in which this concept had been implemented lacked clarity, and the result of this was confusion on site.

As well as this organisational issue, we found that staff were disorientated, and did not know which line was which. This could have been readily solved if they had had proper diagrams, and if clear signs had been provided at the point where they entered the railway. RAIB has raised this issue before – it's time that the industry thought long and hard about the way it provides critical safety information to its staff and contractors. As I once discovered in my early career, it is all too easy to become disorientated on railway infrastructure, particularly at night.

I am concerned that, despite much effort and many initiatives, we are not seeing the hoped-for improvements in safety for track workers. Despite all the efforts that the industry has made, this kind of alarming incident is still happening – in the last two years we have published three investigation reports and four safety

digests covering narrowly avoided collisions between trains and track workers. Our class investigation into the safety of track workers, published last year, took data from over 70 incidents which happened in a single year.

In this report we make six recommendations, all aimed at improving the safety of people who have to work on or near the line. There needs to be complete clarity about who is in charge, where the work is to take place, and which lines are open to traffic. I hope that the railway industry will do what's necessary to ensure that track workers properly understand the track safety processes and the roles of everybody involved in their implementation.

### **Notes to editors**

1. The sole purpose of RAIB investigations is to prevent future accidents and incidents and improve railway safety. RAIB does not establish blame, liability or carry out prosecutions.
2. RAIB operates, as far as possible, in an open and transparent manner. While our investigations are completely independent of the railway industry, we do maintain close liaison with railway companies and if we discover matters that may affect the safety of the railway, we make sure that information about them is circulated to the right people as soon as possible, and certainly long before publication of our final report.
3. For media enquiries, please call 01932 440015.

**Newsdate: 18 December 2018**