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8 July 2019

Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006

By email: cpuresponses@coronerscourt.vic.gov.au

Court reference: COR 2015 000592

Dear Coroner English,

Re: Recommendation to the Australasian College for Emergency Medicine

Thank you for highlighting to the Australasian College for Emergency Medicine (ACEM, The College) the issues associated with diagnosing occult button battery ingestion following the death of Isabella E. Rees. Our letter outlines the process that ACEM has pursued following your report in response to this death, the timeframe for a decision and the contact details for the person responsible for consideration of the recommendation.

We note that the Coroner recommended that ACEM "use this finding as an educational tool to raise awareness of occult button battery ingestion and highlight the need for urgent management of ingested batteries; and to ensure there is inclusion within core curricula guidelines for management".

On 8 April 2019, the College received the report from the Coroner regarding the investigation into the death of Isabella E. Rees. Following receipt of the Report, the College convened a group of Fellows with expertise in paediatrics to prepare a summary of the findings and recommendations of the Coroner's report. This summary was reviewed by the Quality and Patient Safety (QPS) Committee, which is responsible for reviewing findings and recommendations from Coroners across Australia and New Zealand and providing advice on matters concerning quality and safety in emergency medicine. The QPS Committee met on Friday 28 June 2019 and discussed the evidence, guidelines and potential issues associated with diagnosing and treating paediatric occult button battery ingestion.

It was agreed that ACEM will review our educational resources in order to raise awareness within the emergency medicine community of occult battery ingestion in children and the need for urgent management. In particular, ACEM will use this case as an educational tool to FACEMs and trainees by communicating a summary of the case and the findings via the weekly Bulletin and through inclusion as a case study in the August edition of the quarterly *Your ED* publication, which is distributed to all ACEM Fellows and trainees. Secondly, at the time of writing, the ACEM Curriculum Framework requires trainees to gain competency in the diagnosis of presentations involving toxic ingestion or exposure and foreign body ingestion, of which button batteries would be included under. Button battery ingestion is also covered in core Emergency Medicine textbooks that trainees use in preparation for Fellowship, and is part of the Fellowship examination questions.



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On behalf of ACEM, we extend our condolences to Isabella's family for their loss. ACEM is committed to raising awareness of button battery ingestion amongst all its trainees and Fellows.

Please contact Helena Maher, Manager, Policy and Advocacy, on Helena.Maher@acem.org.au or telephone 03 9320 0444 if you require further information.

Yours sincerely

Dr Simon Judkins

President

Australasian College for Emergency Medicine

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Dr Carmel Crock Chair, Quality and Patient Safety Committee Australasian College for Emergency Medicine