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Consumer Product Safety

DEVELOPING A CULTURE OF SAFETY

Early in February 1994, the Federal Minister for Consumer Affairs, Ms Jeanette McHugh released a report by the Australian Consumer's Council. The report, Safety in the Making: Product Safety for the Year 2020, recommends five major strategies aimed at improving the overall safety of consumer products.

In releasing the report, the Minister referred to the proliferation of the goods on offer to Australian consumers and the difficulties this presents for ensuring the safety of individual products. She emphasised the importance of developing a culture of quality and safety in our manufacturing and importing procedures. Such a culture would result in "...less litigation for the producers, fewer product recalls for the retailers, and a lot less trauma for consumers...". She also emphasised the need for the development of guidelines to cover entire types of products, eg a generic or 'horizontal' standard dealing with entrapment hazards for children (see report on ECOSA Conference, page 4).

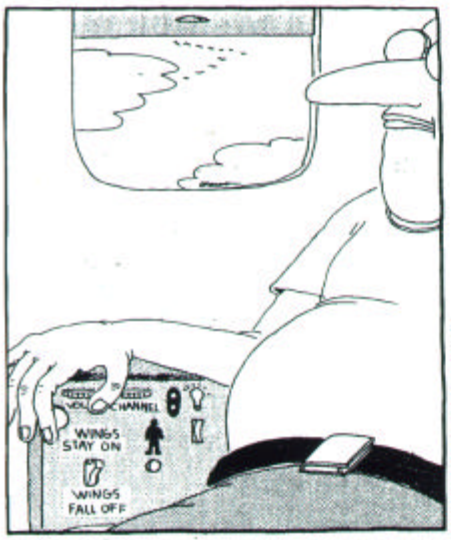
Briefly, the Report recommends

- The establishment of a Consumer Safety Institute to bring together data on product-related injuries and technical expertise on product safety.
- A review of consumer product safety standards to determine their technical merit and the current level of compliance.
- A review of legislation controlling the importation of hazardous products.
- The enactment of legislation requiring manufacturers and suppliers to report to the Federal Bureau of Consumer Affairs (FBCA) all complaints about the safety of products.
- An investigation by the Ministers into the influence of GATT agreements on Australian product safety codes.

The FBCA is currently reviewing the document and will report to the Minister on its assessment of the feasibility of implementing the recommendations.

Further information can be obtained from the Federal Bureau of Consumer Affairs in Canberra, Tel: (06) 250 6666, Fax: (06) 273 1992.

The case for safe product design...



Fumbling for his recline button, Ted unwittingly instigates a disaster

EVALUATION INDICATORS

Some months ago, NISU surveyed health sector agencies about their injury prevention programs. When asked about the type of evaluation indicators being used, one agency provided us with this little gem:

Number of warm fuzzies received in relation to blood, sweat and tears expended.

EDITORIAL

The consumer society has brought with it many benefits. It has also brought with it new hazards. The motor vehicle has transformed society by increasing mobility, but has brought a considerable load of injury and death through road crashes. Risk assessment and management systems have been developed and put in place and past decades have seen the reversal of the earlier spiralling road injury statistics. There are, however, many other consumer products which could benefit from a consistent risk assessment and risk management approach. Mechanisms are in place to ban or recall hazardous products. A system for developing safer products which effectively covers the huge range of consumer goods and services has yet to be developed. With the globalisation of trade, this system will need to work internationally. It is essential that Australia participates fully. This edition of the *Monitor* revisits consumer safety and considers some current activities and visions in this field.

PUTTING THE BRAKES ON BABYWALKERS

by Ian Scott, KidSafe Australia

Why the Interest in Babywalkers?

A growing body of data reflecting a significant incidence and severity of injury associated with babywalkers has led to a call for a review of their use and sale. For example, a study conducted by Childsafe in NSW found that, for children under one year of age, babywalkers were associated with 6% of injuries, 15% of head injuries and 9% of skull fractures.[1] More than half of the babywalker injuries are associated with falling down steps or stairs, around a quarter are the result of the babywalker tipping over, and a significant number result from the child being elevated sufficiently to pull an item, such as a hot cup of coffee, from a table or bench top and thereby sustain a burn.[2]

Australian Action and Review

Concern about babywalkers has been expressed by the medical and injury control communities which have lobbied governments, both in Australia and abroad, to review the safety of these products. This concern has not fallen on deaf ears: at the State level, a number of governments have considered taking action to reduce the incidence of babywalker injury and, in mid-1993, the Commonwealth Minister for Consumer Affairs instituted a review of the products.

The review process initiated by the Commonwealth saw the production of a discussion paper, copies of which were directed to all agencies identified as having an interest in the issue. The review sought submissions from these groups, and from the public in general, about how the problem of babywalker injuries might be remedied. The consultation process specifically sought information about the safety and usefulness of babywalkers, their design and construction, and their stability. It also sought to elicit suggestions about appropriate action, such as warning labels and consumer education. In soliciting public comment, the Minister indicated that a total product ban was being considered.

Around 50 submissions were received. These emanated mainly from health departments, injury prevention groups, individual health professionals, consumer agencies, retailers and manufacturers, and interested individuals. Most submissions either supported a product ban or rejected a ban while supporting a voluntary or mandatory performance standard and consumer education efforts.

In general, the submissions which supported a product ban came from health and consumer agencies; those which opposed a

■ Commonwealth Powers

The Federal Minister for Consumer Affairs, through the provisions of the Trade Practices Act of 1974, has a range of powers in relation to consumer product safety. The Minister can:

- Warn the public that certain products may be hazardous. Such warnings appear in the *Commonwealth Gazette* together with advice that these products are under investigation.
- Proclaim consumer product safety and information standards for some classes of goods. In some instances, the Minister may declare these standards to be mandatory.
- Recall hazardous products.
- Issue a temporary ban, for an 18 month period, pending investigation of a product and conference with interested parties.
- Issue a permanent ban of unsafe products.

The Federal Minister's powers, under the Trade Practices Act, apply to all Australian corporations.

For further information, contact Mr Garth Buchanan, Acting Director, Product Policy at the Federal Bureau of Consumer Affairs, Tel: (06) 250 6666, Fax: (06) 273 1992.

■ Industry moves to correct a problem

In Australia, the potential for injury associated with babywalkers lead the Myer/Grace Bros chain of department stores to cease stocking these items. In February 1993, in a letter to the Injury Surveillance and Control Unit at the SA Health Commission, the Company explained its decision as follows:

"The Myer and Grace Bros national department store group ceased ranging baby walkers about four years ago, along with infant portachairs and baby bath seats.

"Although the move has proved costly for our business in terms of lost sales, we have maintained our original decision which was made on the grounds of child safety.

"After studying child accident figures from various sources, it was clear to us that the unsupervised use of baby walkers contributed to accidents in the home. As we saw similar potential in the use of portachairs and infant bath seats, we withdrew those products from sale at the same time.

"Our company forms its merchandise ranging decisions on a commercial basis yet our approach to the three products ... identified was an exception to the principle, fundamentally supporting our overall commitment to safety."

product ban came from retailers and manufacturers. There were, however, a couple of notable exceptions: one State health department did not support a product ban on the basis that there was insufficient evidence that babywalker injury is over-represented in relation to other injury causes amongst young children. In the same State, a consumer affairs department review of babywalkers recognised their potential to cause injury, but urged the use of stronger, mandatory warnings as a counter to the problem.

The Commonwealth's discussion paper outlined a range of options for dealing with the babywalker problem, each of which drew support in one or more of the submissions received. Broadly, the options were:

- a total ban of all babywalkers
- a total ban plus a recall of existing babywalkers
- a selective ban on some products
- adoption of the British Standard covering babywalkers
- use of warning labels and associated education campaigns
- innovative design with a specified performance requirement to prevent head injury.

To ban ... ?

All calls for a ban on babywalkers rested on the view that they are an unsafe product which is associated with an unacceptably high, yet preventable, risk of injury. A number of the submissions advocating a ban presented data highlighting the major serious injury risks. A few submissions also drew on professional experience to assert that the use of babywalkers has the potential to produce developmental ill-effects in some children. For example, some physiotherapists suggested that the use of baby walkers could, for some children, have a detrimental effect upon their gait development, and chiropodists expressed concern about the potential for lower-back stress.

A few submissions suggested a partial or selective ban on the basis that the design of certain babywalkers makes them hazardous (eg they are particularly unstable) and, therefore, these particular models should be withdrawn from the market. An accompanying suggestion was that a standard be developed to ensure safe design of babywalkers.

Many other submissions argued that only a total product ban would be completely effective in reducing injury and that the use of alternative strategies would not be viable. The reasons given included:

- Because of the nature of the injury risk associated with babywalkers, design modifications aimed at improving babywalker stability would only have the potential to reduce some of the injuries. Although around 25% of injuries are associated with the babywalker tipping over on relatively level surfaces, in the remaining instances injury normally results from falls down steps and stairs or through access to hazards such as stoves, or hot beverages on benchtops.
- That warnings and education campaigns have not proved to be successful and that the speed at which children in babywalkers can gain access to a hazard and the role which babywalkers have in child care, renders useless the power of supervision to prevent an injury.

A submission advocating a total ban also recommended that existing products be recalled because they are intrinsically unsafe. Those arguing for a product ban did not generally support a product recall because of the practical difficulties and cost involved.

Or not to ban?

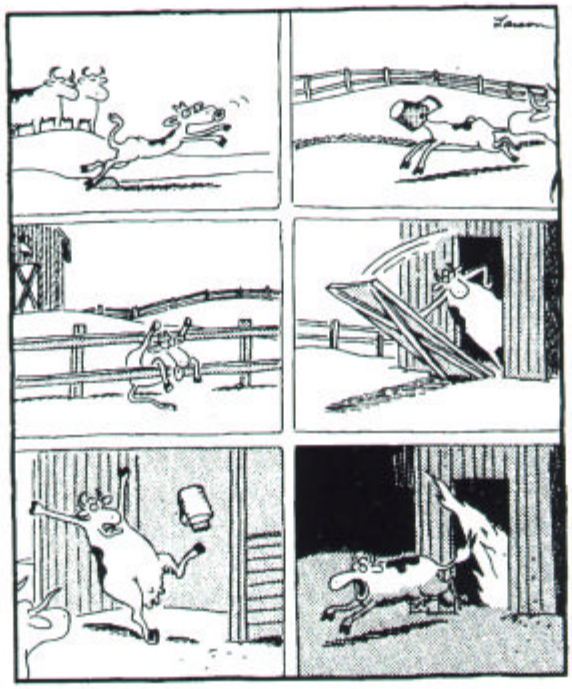
Two major arguments were advanced against a generic ban on babywalkers. The first was that available information about the relative frequency of such injury incidents does not support such a ban at the moment. The second argument was that it is inappropriate to ban a product when the problem of injury is associated with the lack of parental supervision or an absence of common sense in the use of that product.

Some submissions stressed the need for Australia to act in accord with international standards and practice. Particular mention was made of the decision, by the US Consumer Product Safety Commission, to reject a product ban [although investigation of this issue is continuing in the US].

Where are things at now?

The Federal Bureau of Consumer Affairs has prepared a summary of the submissions received and the options for action. This material is currently under consideration by the Minister.

In the past, banning powers have been applied to specific products. Legal opinion is currently being sought to ascertain whether generic bans are possible.



The life and times of Lulu, Mrs O'Leary's ill-fated cow.

NEW CONSUMER SAFETY JOURNAL

The European Consumer Safety Organisation (ECOSA) has announced a new journal. To be known as the International Journal for Consumer Safety, it will aim to inform practitioners, as well as researchers and policy makers, on recent developments in consumer safety. The Journal will contain reports on the results of studies and research from a wide variety of disciplines such as injury epidemiology, accident research, ergonomics, engineering, consumer law, social sciences and communication. The first issue will include an article on the role of injury surveillance by NISU's Director, Dr James Harrison and the Director of the Netherlands Consumer Safety Institute, Dr Wim Rogmans.

Interested in subscribing?

Copies of the subscription form are available from NISU. Contact Renate Kreisfeld or Pam Albany, Tel: (08) 374 0970, Fax: (08) 201 7602.

Interested in submitting a paper?

The Journal welcomes contributions dealing with:

- general policy regarding consumer safety and product safety
- relevant regulatory developments
- standards development for consumer products
- enforcement and control of consumer safety legislation
- communicating safety for consumers (education and information)
- vocational training and informing professional groups
- coalition building and safety community programming
- epidemiology of consumer product related injuries
- product safety and research into improved technology for design and development

Special topics of interest in this respect:

- child safety, including the prevention of suffocation and drowning, poison control, prevention of scalds and burns and fall-injury prevention
- school injury prevention
- sport injury prevention
- promotion of safety for the elderly
- fire safety in private dwellings and public buildings
- specific risk groups or high risk activities.

Full instructions for authors are available from the Editor-in-Chief, Wim Rogmans, Consumer Safety Institute, PO Box 75169, 1070 AD Amsterdam, The Netherlands, Fax: +31 20 511 4510

ECOSA CONFERENCE

The European Consumer Safety Organisation's (ECOSA) Product Safety Research Conference was held in Amsterdam on 22-23 November 1993. The Conference, one of a series of regular meetings of product safety researchers, covered a range of subjects with an emphasis on a systematic and scientific approach to consumer product design and the development of standards.

The subjects covered were injury statistics and accident mechanisms, injury biomechanics and protective equipment, ergonomics and product safety, fire safety, chemical and toxic hazards, construction and design, risk assessment and product information, and evaluation and enforcement.

A description of the Queensland-based Accident & Emergency Department injury surveillance computer system, presented by Denise Jones of QISPP, attracted a great deal of attention and interest. The need to maximise information about how each injury occurred in order to drive prevention, was a recurrent theme in many of the papers presented.

The development of European product safety standards is proceeding rapidly, spurred on by European Community directives on product safety and product liability. It is apparent that many of the measurements in existing standards and many of the testing procedures will need to be revised in the light of the extensive anthropometric and ergonomic data now available. The need for better anthropometric data, especially for children and the elderly, was continually stressed.

The first attempts at workable horizontal standards for product safety were discussed. A publication prepared by Dirk Von Akens of the Netherlands Consumer Safety Institute laid out guidelines for dealing with a wide range of entrapment hazards. The publication includes decision trees and extensive and pertinent anthropometric data. A horizontal standard for the safety of children's products is to be developed by a committee based in Sweden. It will deal with physical and chemical hazards to children and will attempt to devise a set of standards which can be applied both to products designed specifically for children and to products to which children are exposed. The aim is to ensure consistent safety across different products, such as cots, prams, high chairs and toys, where similar hazards are encountered. This will assist manufacturers of new products to design them according to clearly specified safety principles and reduce the need for a new, specific, standard for each new product type.

It was apparent, from the discussion that, in Europe, there is far more interchange between ergonomists, engineers, safety researchers and standards committees than there is in Australia. There is also a far greater availability and use of anthropometric data and a significant commitment to the technical quality of consumer product safety standards.

For further information contact Jerry Moller at

INJURY PREVENTION: WHAT WORKS?

...according to Lyn Clarke

Dr Lyn Clarke is the District Medical Superintendent for six hospitals in North-West New South Wales, and Director of the Australian Agricultural Health Unit based at Moree. Lyn has been actively involved in the national and NSW State Farmsafe movement from its beginnings and has worked for many years as a public health consultant in Papua New Guinea. In this issue of the Monitor, we've asked Lyn about her experiences in PNG. A further interview, about her Farmsafe experience, will appear in a future issue.

Monitor:

You've spent many years working in Papua New Guinea as a public health doctor. Based on that experience, can you identify ways in which injury prevention must be approached differently in lesser developed countries (LDCs)?

Lyn:

I can't speak for countries apart from PNG, but I'd imagine that the situation would be very similar. The injury problems of such countries are not the same as ours. I think that the difference is primarily an economic one where a country like PNG must decide how to use its very scarce resources to greatest effect in improving the health and well being of its communities. I think we've got to be careful that we don't see the difference as being primarily cultural.

In the LDCs, the overwhelming public health imperatives are to do with the infectious diseases such as pneumonia, malaria and diarrhoea which are the major causes of illness and death, particularly amongst children, and of malnutrition.

As such countries become industrialised, occupational injuries do become more similar to ours and, as they become more urbanised, the road traffic injury problems become more similar, as do the diseases of urban communities, such as diabetes and cardiovascular disease.

However, in terms of the sort of injury patterns and problems that confront people living in a rural setting, these will be rather different and relate to people's lifestyles, work and leisure activities, and so forth.

In Western societies, where the impact of infectious diseases has been significantly reduced, injury is relatively high on the list of leading causes of death and disability. It's harder to know where injury fits as a priority in societies like PNG which have very limited resources that must go towards solving the problems of infectious disease. But they obviously have to think about at what point that they will need to address those issues. From my observation, there are a couple of points at which they could begin tackling the problem. Certainly in the OH&S area, there are well developed principles of injury control and, as new technologies are being introduced, OH&S measures should be included in the establishment of those industries. This would also mean that resources wouldn't necessarily have to be taken from the overall economy.

A second point for intervention could be in road traffic injury. Although, if there were an expectation that LDCs should have all the safety features that we take for granted in western countries, this could well mean the difference, in many cases, between having a vehicle and not having one. An analysis of where our biggest safety gains have been made in terms of injury prevention for road accidents would be very useful for the LDCs in terms of having to make those very difficult economic choices. Those countries don't have the luxury of being able to hand on the safety cost to the consumer in the way which has occurred in Australia.

Monitor:

I guess those decisions about which particular intervention to use are just so much more vital in LDCs?

Lyn:

We may well decide, in Australia, that all cars should have airbags, and that might be, for us, the most appropriate thing to do, because it will enable us to achieve a marginal improvement on where we are now. But such a step would not be at all relevant in the LDCs where many passengers ride on the back of trucks. We can't even presume that road safety is a priority injury issue in these countries, or that there should be resources directed into that as distinct from, for example, more malaria control.

Monitor:

Even assuming that injury were accorded some priority in a setting like PNG, for example in the OH&S area , would you envisage that things there would still be quite different? For example, some of the things we take for granted here in the OH&S area may not be appropriate because they're just too expensive?

Lyn:

It may be. I could well take a position, from a social justice point of view, that a number of the LDCs don't have the same level of OH&S regulations because they want to attract investment. Accordingly, a number of large multinational

companies operate there with lesser safety controls than they may be required to implement in their home country. It would seem to me that maybe that's an area in which one could start to develop sound OH&S practice.

Monitor:

Are you suggesting some kind of a universal set of standards ...?

Lyn:

I guess that needs to be thought about. It seems to me that it would still be economically feasible for those companies to carry out their operations in LDCs if the governments of the countries concerned had access to minimum safety work practice standards and insisted on compliance with them. And this wouldn't have a negative impact on any other program. It wouldn't mean, say, that they'd have to take money out of an immunisation program to do it.

Again, there's a problem in PNG, and some other countries, in that injury deaths information is not so easy to get. The deaths reporting system (of cause of death) often only comes through the deaths that occur in institutions. So if you die at home, unless it's a police matter, your cause of death is not recorded. I had a particular dilemma trying to determine deaths in the logging industry. It would seem to me that we may in PNG be systematically underestimating the proportion of deaths that relate to injury, and so perhaps some work could be done to investigate or put in place better cause of deaths data systems.

Monitor:

Do you think that there are things which Australians working in injury control could do to assist LDCs in grappling with their injury problems? One of the things you've alluded to is the possibility of developing internationally agreed minimum standards for occupational health and safety. Would pushing for this be an appropriate role for injury control people in Australia?

Lyn:

I think that that is the sort of thing that could well be the subject of discussion. It's really important that we don't try to solve anything on behalf of LDCs from within our western country. If we are asked to get involved in something, then I think we should. And I think we are in a sound and strong position to respond to a request that might be made. And I certainly think that we are in a position to 'open the conversation'. I think that what we've got to do is to listen to people in the LDCs, to find out the points at which we may be able to offer some assistance.

I would imagine that a cost-benefit analysis of any of our major successes in injury control would be of assistance to LDCs. But, again, we shouldn't begin to undertake this before we've had dialogue with people who are trying to work through the problems in those countries, because we may be answering the wrong questions.

Monitor:

Can you see ways of initiating this kind of dialogue?

Lyn:

I think that the Third International Conference in 1996 offers an opportunity to have some sessions that belong to countries in Asia and the South Pacific. Delegates from those countries would discuss injury prevention from their own setting's perspective and we should have people available from the various sectors who are good listeners, can hear what's being said, and can then identify where there might be the skills, the data, and other resources available within the western world, that can be brought into play on the request from folk from those countries. I think if we try to do it too much from our own framework, and try to set it out too closely, we'll get it wrong.

Monitor:

From time to time people like yourself are asked to visit LDCs as consultants. Are there any cautions or practical advice you could offer?

Lyn:

They should examine the framework within which the issue is being considered and obtain broader information about a country or a region's resources, its programs, its priorities, its whole public health, road safety, and engineering infrastructure, and spend a lot of time listening and looking to see what might suit. The training of the staff in these countries will be extremely good and relevant to their own setting and to the jobs that they are doing. We don't necessarily have answers to their injury problems. It's a bit different with some other health problems. For example, we know how to treat pneumonia - we've got the technical answers to that. But I don't see that we immediately have injury prevention answers that are relevant and it is really important that we don't go in thinking that we have.

Monitor:

The local circumstances, perceptions and values in LDCs will determine the way in which those countries deal with their health problems. How should a consultant, whose way of looking at things is contrary to the host country's, deal with the problem of conflicting perspectives?

Lyn:

I think that the practicality is that Australians will be invited to work in LDCs under arrangements whereby whoever is invited to work has to be acceptable both to the host government and to the sending agency. Consultants will have an understanding of the country's situation, and a willingness not to compromise either the host country's or the contributing agency's position in terms of providing the input that has been requested. So, for example, the PNG government looks for someone who the development agency considers to be suitable because they've had developing country experience, or because they understand this particular tropical health problem, or they've had training which is relevant - so you have a negotiated job to do.

I guess it's more in the context of the Third International Conference that these different perspectives could get in the way of effective and constructive dialogue. My concern for the Conference is that we try to help such dialogue. Maybe one way would be to involve the Australian tropical public health specialists (such as the Department of Community Health at the University of Queensland, and others) who are doing public health training for LDCs, in the process. They may not be injury prevention specialists, but they are certainly public health specialists with sound expertise who can advise our injury control discipline about appropriate ways to proceed.

HOT OFF THE PRESS...

Cost-effectiveness of 'black spot' treatments - a pilot study

This report presents the results of an evaluation of 51 Victorian and NSW 'Black Spot' projects funded by the Australian Government. It is a pilot study intended to provide an early indication of the degree of effectiveness of Black Spot Program expenditure. A full-scale evaluation of the cost-effectiveness of 'Black Spot' is planned.

For further information, contact Sue Elderton at the Bureau of Transport and Communications Economics in Canberra, Tel: (06) 274 6800; Fax: (06) 274 6816.

Traffic accident insurance data

This report, prepared by Dr David Andreassen of the Australian Road Research Board on behalf of the Road Injury Information Program, documents the data collected by insurance companies (motor vehicle and third party) in Australia. Analysis of the data revealed that there is a wealth of information collected which could be used for the surveillance and prevention of road crashes and injury. However, due to the lack of a common data standard, the data are of limited use at present. The report strongly recommends the adoption, by insurers, of a minimum data set which is included in the report.

Copies of the report are available, free of charge, from NISU, Tel: (08) 374 0970.

Road injury in Australia

The contents of this report are described in the article "Did you know ...?" on page 8.

Copies are available, free of charge, from NISU, Tel: (08) 374 0970.

Family day care guidelines

Intended for use by family day care co-ordinators and providers, the document contains information on hazards associated with causes of injury such as falls, scalds, ingestion, etc. It also includes a section of safety management and a safety checklist organised by safety issue and room.

For further information, contact Kidsafe, 10th Floor, 123 Queen Street, Melbourne 3000, Tel: (03) 670 1319.

Safety in the making: product safety for the year 2020

Released in early February, this report by the Australian Consumer's Council recommends five major strategies aimed at enhancing the safety of consumer products. (See "Developing a Culture of Safety" on page 1 for further details).

Copies of the Report are available from the Federal Bureau of Consumer Affairs in Canberra, Tel: (06) 250 6666, Fax: (06) 273 1992.

Injury impairment scale 1994

The Injury Impairment Scale (IIS) was developed as a system to assess the long term consequences of non-fatal injuries and to standardise the collection of injury data. Modelled on the Abbreviated Injury Scale (AIS), the IIS assigns a numerical ranking from 1 (minor impairment) to 6 (totally dependent) to each injury description in the AIS judged to have some level of impairment one year after injury. Impairment is

based on whole body function. Studies to validate the scale have yet to be undertaken.

Copies of the IIS are available, by airmail, at a cost of US$50. Order forms are available from Renate Kreisfeld or Pam Albany at NISU, Tel: (08) 374 0970 Fax: (08) 201 7602.

Injury in New South Wales

This supplement to the Public Health Bulletin published by the NSW Health Department sheds light on many facets of the State's injury problem. In particular, the supplement reports on the 'big picture' (eg the major causes of injury death in NSW), and provides injury rates by age and sex and by locality.

For details, contact Dr David Lyle in the Epidemiology Branch of the New South Wales Health Department, Tel: (02) 391 9210; Fax: (02) 391 9232.

Road crashes resulting in hospitalisation

This new publication from the Federal Office of Road Safety is the first edition of an annual statistical summary of road crashes resulting in hospital admission. It replaces and enhances the discontinued Australian Bureau of Statistics publication Road Traffic Accidents Involving Casualties, Australia.

Copies of the report are available, free of charge, from the Federal Office of Road Safety. Tel: (008) 026 349.

DO YOU HAVE ANY IDEA...??????????????

1 Which body region is most frequently injured in road crashes resulting in hospital admission?

- Head ☐
- Face ☐
- Chest ☐
- Abdomen ☐
- Spine ☐
- Upper extremity ☐
- Lower extremity ☐

2 Which body region accounts for more life-threatening road injuries than any other?

- Head ☐
- Face ☐
- Chest ☐
- Abdomen ☐
- Spine ☐
- Upper extremity ☐
- Lower extremity ☐

3 What proportion of deaths from road injury occur either instantaneously or before medical or ambulance attention arrives?

- 20% ☐
- 30% ☐
- 40% ☐
- 50% ☐
- 60% ☐

4 Which road user group has the greatest aggregate length of stay in Australian hospitals?

- Motor vehicle driver ☐
- Motor vehicle passenger ☐
- Motorcycle rider ☐
- Motorcycle passenger ☐
- Pedestrian ☐
- Cyclist ☐

5 Which body region injured in road crashes generates the greatest aggregate length of stay in Australian hospitals?

- Head ☐
- Face ☐
- Chest ☐
- Abdomen ☐
- Spine ☐
- Upper extremity ☐
- Lower extremity ☐

Turn to page 11 to see how you scored on the quiz.

No, we're not being frivolous! These are just some of the questions which have been answered by a study recently completed as part of NISU's Road Injury Information Program. Research of this kind hasn't been undertaken before, which is quite surprising when one begins to consider the implications that this knowledge could have for injury prevention.

The study focussed attention on the most *severe* injuries, not just the most *frequent* ones. The findings will assist in setting priorities for preventive action. They will also assist hospitals in reducing their total number of occupied bed-days by providing them with a better understanding of which types of road injury are consuming the greatest bed-day resources. Such a better understanding will help to inform decisions about where to place resources in order to reap the greatest injury prevention benefits. For example, time of death is an important indicator of the need for primary, secondary and tertiary preventive activity. If relatively few road accident deaths occur before medical or ambulance attention arrives, then attention focuses on improved trauma management, medical care, patient transportation, etc. If, however, most deaths occur instantaneously, then attention focuses on primary prevention (ie prevention of the crash through, for example, improved road design) or prevention of the injury (for example, through improved occupant protection).

Trends over time for variables such as body region of injury, timing of death and average length of stay in hospital can be used to monitor and evaluate safety improvements. For example, one would expect to see:

- a reduction in head injury subsequent to the introduction of air bags in motor vehicles
- a reduction in the number of deaths in hospital and average length of stay through improved medical attention and trauma management
- changes in the severity of injury in road crashes through increased preventive attention to sites of severe body injury
- a reduction in the extent and severity of head injury in cyclists due to helmets
- differences between States and regions as different safety measures are implemented.

The current report, Road Injury in Australia, covers 1990. The next edition, to cover 1992, is in preparation.

3rd INTERNATIONAL CONFERENCE

Work is continuing on the planning of the Third International Conference on Injury Prevention and Control. Some of the milestones reached since our Conference Newsletter was released in May 1993 include the following:

- Committees have been established to oversee the planning of the scientific program for the conference, to co-ordinate the planning of affiliated meetings, to develop a social program, and to plan and undertake publicity for the event. The first two of these sub-committees have already been very active.
- A major emphasis of the Conference will be to increase collaboration between countries. The NOC has decided to seek sponsorship to enable a number of delegates from countries in Asia and the South Pacific to participate.

We'll be keeping you informed about developments throughout the period leading up to the Conference in March 1996. Watch out for the second edition of the Conference Newsletter. It will invite abstracts, let you know deadlines for submission, and about early plans for social events and associated meetings. In the meantime, if you have any queries, please direct these to Pam Albany or Renate Kreisfeld, Tel: (08) 374 0970.

NEW PUBLIC HEALTH NETWORK

Late last year, the Public Health Association (PHA) launched the Public Health Network (PHN). The establishment and development of the PHN is being managed as a pilot project with funds from the Commonwealth Department of Health and Human Services.

What is the Public Health Network?

PHN is a computer-based communications network which offers users two basic forms of communication:

- E-mail: enables one-to-one private communication with individuals in Australia and abroad;
- Conferences: enable many users to share in debate and discussion of a variety of public health issues.

The aim of the PHN is to enhance communication links between people working in public health, to increase the efficient sharing of information and to enable effective collaboration.

Within this framework, it is planned to establish a range of conferences on injury issues. The first of these has been set up.

How does injury fit into the PHN?

Several conferences directed specifically towards the injury community will be established. Their establishment will be a gradual process, co-ordinated by NISU's Injury Prevention Services Program.

To date, a general injury prevention conference has been established. Anyone with access to the PHN network can read or respond to the information on this conference. When connecting to the conference, however, it should be recognised that the success of this venture will depend on developing a critical mass of users: to be a useful forum, the conference will need a regular injection of information and comment from users.

Basic requirements:

You'll need a personal computer with a spare communications (serial) port. Most computers have one or two serial ports, although one is sometimes used to operate a mouse. You'll also need a modem and a cable to connect it to the computer.

The modem plugs into a phone line. It can share a line with a handset or a fax machine by means of a double adaptor. For large offices with a high volume of e-mail communication, a dedicated line is a worthwhile investment.

Cost:

Becoming a member of PHN is by subscription to the Pegasus Network at an initial cost of $95 ($50 for PHA members). The joining fee includes the first 200 minutes of off-peak time (or 100 minutes of peak time), valued at $38. It also includes a comprehensive user manual and a shareware communications disk. In addition to the joining fee, users are required to pay a monthly administration charge of $20 to Pegasus, their connection charges and on-line usage charges after the first 200 minutes (off-peak).

If you are already using the AARNET network, you'll be able to e-mail members of PHN.

Why you can't afford not to join!

When fully functional, PHN will provide injury control professionals with:

- a cheap alternative to interstate and international telephone and fax communication;
- an avenue for gaining feedback on draft documents, etc.;
- access to a wide range of information (eg available data sources, current research, forthcoming meetings, new publications, etc);
- a means of sending out an 'SOS' to colleagues for urgently required information;
- a facility for arranging private conferences (ie with limited access to a designated group of individuals).

Further information

For further information about joining PHN, contact Jackie Roberts, the Project Co-ordinator (e-mail: jrobertson@peg.apc.org), Tel: (06) 285 2373.

For information about the plans for injury conferences, contact Pam Albany (e-mail: nipja@flinders.edu.au) or Renate Kreisfeld (e-mail: nirk@flinders.edu.au) at NISU, Tel: (08) 374 0970; fax (08) 201 7602.

KIDSAFE: FUTURE DIRECTIONS

Kidsafe (the Child Accident Prevention Foundation of Australia) has completed a major review of its national strategic direction. The process included extensive consultation with the injury community and the Kidsafe Board has now approved a strategic plan concentrating on advocacy and co-ordination. Kidsafe was advised to assume advocacy as a primary function, to increase its focus and resources in this area and to take a more pro-active and assertive role.

Other areas highlighted in the consultation process and agreed to as issues for further exploration include: non-English speaking and low socio-economic status groups, aboriginal injury, rural injury, youth, the linkage of child protection and unintentional injury, tertiary prevention and sport.

For further information contact Ian Scott at Kidsafe, Tel: (03) 670 1319, Fax: (03) 670 7616.

INTERSTATE CO-OPERATION

For some time, there has been a recognition that closer co-operation between health department managers of injury prevention programs would offer many benefits. For this reason, NISU has arranged a two-day meeting to facilitate the forging of stronger links between key personnel. State and Commonwealth managers will attend.

Prior consultation has produced an agenda which will focus discussion on the following:

- current activities of State and regional health offices;
- current State planning activities;
- methods of injury surveillance and the potential for data exchange;
- roles of State managers with respect to regional development;
- establishment and management of a private 'conference' on the PHN network for State health injury managers; and
- advantages of establishing an annual meeting of State and Commonwealth injury managers.

For information about the outcomes of this meeting, contact Pam Albany, Tel: (08) 374 0970.

A LITTLE MORE FORMALITY

A recent meeting of personnel from community-based injury prevention programs around Australia saw the formalisation of a network which has been operating informally since 1991.

The decision to move towards a more formal structure came about for a number of reasons: It was felt that, in order for the particular concerns and priorities of community-based injury prevention to find their way onto the wider health agenda, workers in this area need to find a united voice and an easily identifiable public presence. It was also felt that greater formalisation would lead to the development of communication and decision making systems which would, in turn, promote the development of important initiatives such as a recently held 2-day travelling seminar taking in the sites of major community-based programs.

The new structure is based on representation from people working in each of the States involved. A representative from New Zealand is also included. The day-to-day decision-making will rest with an executive committee and secretariat support will be provided by the Monash University Accident Research Centre (MUARC).

Amongst the first tasks that the Network has set itself are:

- finding a suitable name and logo;
- developing a strategy for its involvement with the 3rd International Conference on Injury Prevention and Control in 1996; and
- formulating plans for its next national meeting (tentatively scheduled for March 1995).

The elected office bearers for the Network are as follows:

State Contacts:

SA	Elizabeth King (National Safety Council of Australia)
WA	Jan Dawson (Health Department of WA - Geraldton Region)
NSW	Katherine van Weerdenburg (Illawarra Safe Communities)
QLD	Doug Brownlow (Queensland Transport)
VIC	Henk Harberts (Latrobe Valley Better Health Program)
NZ	Cynthia Maling (NZ Public Health Commission)

Executive Committee Members:

Richard Arnold (Bulla Safe Living Program)
Doug Brownlow
Katherine van Weerdenburg
Henk Harberts
Joan Ozanne-Smith (MUARC)

For further information, contact Joan Ozanne-Smith at MUARC, Tel: (03) 903 2880; Fax: (03) 903 2882.

BACK BY POPULAR DEMAND: LEIF SVANSTRÖM

Leif Svanström's visit to Australia in late 1992 met with great enthusiasm from injury practitioners with a commitment to a community development approach. Leif, who is Professor of Social Medicine at the Karolinska Institute in Sweden, has been one of the major international proponents for the use of a community development model in response to injury.

Leif was invited to return to Australia this February by the Community Based Injury Prevention Network. [The Network is an informal coalition which meets at least once a year for the exchange of information, professional development and mutual support.]

While in Australia, Leif visited community-based injury prevention programs operating in NSW, Victoria, SA and WA, and conferred 'Safe Community' status on programs running in the Illawarra and Bulla regions of Victoria.

NISU also took advantage of Leif's presence to secure his attendance at meetings of the National Organising Committee and the Scientific Program Committee for the Third International Conference on Injury Prevention and Control. Leif played a significant role in the planning of the first two conferences in this series and the organisation process for the 3rd Conference will draw heavily on his experience for international contacts and advice.

COMING OUT SOON...

Issue 6 of the *Australian Injury Prevention Bulletin* will contain detailed tables of 1992 Australian injury mortality data. It is expected to be released during the next six weeks.

A FAMILIAR FACE IN A NEW PLACE

NISU is pleased to announce that Jerry Moller took up the position of Assistant Director (Injury Information Services) in early January.

Jerry's name will already be familiar to many of our readers through his long-standing involvement in injury prevention. Indeed, Jerry can be regarded as being of 'pioneer injury stock'. He was instrumental in setting up one of the first hospital-based injury data collection systems in Australia and has made an on-going contribution to many facets of injury work. In recent years, Jerry has developed a particular interest in product safety issues, an interest which is sure to flourish in his new role.

INJURY GOALS AND TARGETS UPDATE

In the last issue of the *Monitor* we included an article on the subject of goals and targets for injury. Since that item appeared, the process of setting goals and targets has been moving steadily forward. In 1993 AHMAC established the Health Goals and Targets Implementation Group for Injury, one of four such groups dealing with the focus areas of injury, mental health, cancer and cardiovascular disease.

The deliberations of the Implementation Group for Injury have led to the development of draft goals and targets and a draft strategic plan for injury control which covers significant injury problems. The strategy defines national priorities for injury prevention over the next five years. The draft strategy went to AHMAC for comment in late February and has now been released for public comment.

For copies of the draft strategy, Tel: 1 800 658 616.

QUIZ SOLUTIONS

1 Lower extremity. In 1990, 18% of all the diagnoses recorded for road injury cases involved lower extremity injury. Equivalent proportions for other body regions were: 13% for upper extremity, 13% for head, 8% chest, 6% face, 4% spine, 3% abdomen and 35% other . [Table 2.4]

2 Head. In 1990, 73% of cases in which the principal diagnosis was rated as severe (AIS 5) or critical (AIS 6) involved injury to the head. Equivalent proportions for other body regions were 0% face, 7% chest, 10% abdomen, 9% spine, 0% upper extremity and 1% lower extremity. [Table 4.12]

3 60%. In 1990, 19% died instantly with a further 41% dying before medical or ambulance assistance arrived. [Table 3.11]

4 Motor vehicle drivers. In 1990, the aggregate length of stay for drivers was 80,000 bed-days compared with 62,000 by passengers, 47,000 by motorcycle riders, 25,000 by pedal cyclists and 61,000 by pedestrians. [Table 4.21]

5 Lower extremity. In 1990, lower extremity injuries accounted for 115,000 bed-days, 36% of total occupied bed-days for road injury. [Table 4.22]

References are to tables in O'Connor, P. *Road Injury in Australia*, National Injury Surveillance Unit 1993.

UPDATE: MINIMUM DATA SET

In the last issue of the *Monitor* we reported that revisions were being made to the newly developed draft standard for routine injury surveillance. This process of amendment has now been completed and copies of the revised draft have been made available to those agencies that participated in the consultation process that led to the development of the Standard, and to others known to have an interest in it. The data set has been submitted to the National Health Data Committee, as a candidate for inclusion in the *National Health Data Dictionary*.

Copies of the Standard are available from NISU. Contact: Renate Kreisfeld, Tel: (08) 374 0970.

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The Injury Issues Monitor is the journal of the National Injury Surveillance Unit (NISU), Mark Oliphant Building, Laffer Drive, Bedford Park SA 5042,
Tel: (08) 374 0970,
Fax: (08) 201 7602
Letters to the Editor are welcome
Editor: Renate Kreisfeld

AUSTRALIAN INSTITUTE OF
HEALTH & WELFARE

National Injury Surveillance Unit

DIARY

13th World Congress of the International Association for Accident and Traffic Medicine

16-20 May 1994

Sao Paulo, Brazil

Topics will include the epidemiology and cost of crashes, medical impairment in traffic, alcohol and drugs as factors in crashes, rehabilitation of crash victims, traffic education and safe car design.

Contact: The Congress Secretariat, Rua Atlantica, 81 - CEP 01440-000, Sao Paulo, Brazil.

Third International Conference on Safe Communities

6-8 June 1994

Harstad, Norway

The Conference theme, "Safe Communities - what works where and why?" provides a framework for participants through the world to share experiences in developing, promoting, and evaluating strategies for developing safe communities and to discuss and adapt successful methods for injury prevention.

Contact: HOARR, PO Box 654, 9401 Harstad, Norway, Fax: 47 77 06 6303.

Public Health Association's 26th Annual Conference

25-28 September 1994

Ramada Grand Hotel, Adelaide

The theme of the conference is "Australia's Role in Public Health in Asia & the Pacific Region - Building Partnerships". It will focus, in particular, on Australian and Australian institutions working collaboratively with the governments and peoples of Indonesia, Papua New Guinea, the island nations of the Pacific, the Indian subcontinent, and the countries of Indo-China.

Contact: PHA Conference Secretariat, Tel: (06) 2185 2373; Fax: (06) 282 5438.

Australian Tropical Health & Nutrition Conference - Workshops

24-29 September 1994

Adelaide

To complement the PHA Conference, the Australian Tropical Health & Nutrition Conference Organising Committee will offer workshops on the following: strategic planning; qualitative analysis using Ethnograph; Pacific Women; Aboriginal and Torres Strait Islander Health; Quantitative Analysis using Epi Info; and Acute Respiratory Infections

Contact: Wendy Gardiner, ATHN Conference Co-ordinator, Tel: (07) 365 5408; Fax: (07) 365 5599; E-mail: W.Gardiner@mailbox.uq.oz.au.

Australasian Epidemiological Association - One day meeting

25 September 1994

Ramada Grand Hotel, Adelaide

Will offer an opportunity for epidemiologists of the Asia-Pacific region to gather, immediately prior to the PHA Conference, for a scientific meeting with plenty of opportunity for discussion.

Contact: Charles Guest, Department of Community Medicine, University of Adelaide, Tel: (08) 303 4637; Fax: (08) 223 4075.

International Conference on Recent Advances in Neurotraumatology and Neurosurgical Society of Australasia's 1994 Annual Scientific Meeting

25-28 September 1994

Marriott Surfers Paradise Resort, Queensland

Both conference programs will cover updates on traditional neurosurgical topics; trauma surgery; neuro-oncology; management of spinal injuries; sports injuries.

Contact: Rhonda Hendicott, Tel: (07) 369 0477; Fax: (07) 369 1512.

FOOTNOTES

1 Childsafe NSW Submission to the Commonwealth Consumer Product Safety Review of Babywalkers, 1993.

2 Federal Bureau of Consumer Affairs, Discussion Paper - Trade Practices Act 1974, Division 1A of Part V, Consumer Product Safety, Need for Mandatory Action: Baby Walkers, 1993.