

AUSTRALIAN INJURY PREVENTION *Bulletin*

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Bicycle helmets and the law

Victorian legislation making helmets for bicycle riders compulsory is a world first, "so the world is watching us", says Dr Joan Ozanne-Smith of Monash University's Accident Research Centre.

"Already there's a lot of interest from Sweden, New Zealand and the US in our results," she added.

Hopes for a decrease in head injuries since the introduction of the legislation in July last year have been rewarded with statistics revealing not only a decrease in head injuries, but fewer bike riders presenting with injuries altogether.

Bicyclists, especially young ones, figure too prominently in road accident statistics. In the 12 months to February 1991, they accounted for 3.2 per cent of all road deaths but 5-16-year-old bicyclists accounted for 16.7 per cent of road deaths in their age group.

Legislation for compulsory wearing of helmets will soon be a national achievement, but Victoria and NSW have led the way. The former made helmets compulsory in July 1990, and the latter introduced similar legislation in January this year for people over 16, and from July 1 for the under-16s as well.

Encouragement from the Commonwealth Government has provided impetus for other States and Territories to move the legislation along.

As well as supporting a national public education program, \$110 million was made available to States and Territories participating in the

Commonwealth's Road Safety Package, aimed at improving road safety performance.

The introduction of compulsory helmet wearing for all cyclists on public roads and in public places throughout Australia by January 1, 1992, was one of 10 items in the package.

But is the proof in the pudding?

Ozanne-Smith and colleague Karen Sherry discussed the earliest statistics in the December issue of HAZARD, a publication of the Victorian Injury Surveillance System (VISS). Using pre- and post-legislation data, a trend for a lower proportion of head injuries was apparent, although not quite reaching the level of statistical significance.

Ozanne-Smith and Sherry have continued to monitor VISS data and further results - to be published in a forthcoming issue of Hazard - confirm the earlier trend.

The results show a 44 per cent reduction in the number of children aged less than 15 years presenting to VISS hospitals with a head injury between July 1990 and March 1991 in comparison with the period July 1989 to March 1990.

The total number of child cyclists presenting to VISS hospitals after crashes has also decreased by 28 per cent when the pre- and post-legislation periods are compared.

Commenting on these gratifying results, Ozanne-Smith said: "It's still early days yet, as far as estimating the effect on severe head injuries is concerned, because so far we have been looking at the least severe end of the scale. But of the bicyclists who present to hospital emergency departments we know now that many fewer have head injuries than before the introduction of the legislation."

Since Victoria already had a high level of public awareness and helmet usage before the legislation, there is

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WELCOME

Welcome to the first issue of the Australian Injury Prevention Bulletin.

Injury is a big topic, and it often seems very different from different perspectives, as did the blind men's elephant.

The National Injury Surveillance Unit's aim in publishing the Australian Injury Prevention Bulletin is to provide a forum in which the many perspectives on injury and its control can be shared and debated.

We hope it will encourage the sharing of information on injury problems and solutions, and also help develop a sense of common purpose among those working in the area.

In this first issue we look at important recent developments in two long-standing injury control issues: the fencing of domestic swimming pools to prevent young children from drowning; and moves to require cyclists to wear helmets.

Both issues illustrate the intersection of information and social policy in achieving injury control, and highlight the questions of how and why effective injury control measures are - or are not - used.

We report on the development of a State injury control strategy in NSW, on the formation of the National Road Trauma Advisory Council, and on recent international meetings on child safety, held in Perth. We also introduce ourselves, with a guide to what NISU is and does.

The bulletin will be successful only if you find it useful. We want to hear what you think of this issue, and will welcome your suggestions and contributions (short articles or letters) for future issues. Please let us know of events or activities we should announce. Phone or write to NISU if you want to be added to the Bulletin mailing list.

JAMES HARRISON
Director

Bicycle helmets a must

Legislation requiring bicycle riders to wear safety helmets will be in force in all States and Territories by 1 January 1992. Introduction dates are: Vic - 1 Jul 1990; NSW - 1 Jan 1991 (adults), 1 July 1991 (children under 16); Tas - 1 Jan 1991; Qld - 1 July 1991; SA - 1 July 1991; WA - 1 Jan 1992; ACT - 1 Jan 1992; NT - 1 Jan 1992.

Directory of Injury Control

Responsibility for maintaining and updating the Australian Directory of Injury Control Personnel, published by the Injury Control Unit of the Health Department of Western Australia, the Better Health Program (Queensland) and the Child Accident Prevention Foundation of Australia, will now rest with the National Injury Surveillance Unit (NISU).

The Directory contains details of more than 360 people with expertise and interest in injury control or related areas.

The Directory will be used as the basis for this Bulletin's mailing list, so if you aren't already in it, you should be. A form has been enclosed with this Bulletin for new entries or amendments to existing entries. Please pass on or copy the form for others who should also be included and return completed to:

**National Injury Surveillance Unit
78-80 Main North Rd
Prospect
SA 5083**

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reason to hope that results in other States may be even more marked when legislation is introduced.

The trend showing that fewer people altogether are presenting with any kind of injury from bicycle accidents since helmets were made compulsory is interesting and unexpected.

The reasons are unclear, but Ozanne-Smith says there may be several factors. People who don't own helmets may not be cycling, or cyclists wearing helmets may be more visible to other vehicles, and thus less of a risk for accidents.

Monash University's Accident Research Centre is currently doing a study to see if indeed there are fewer cyclists on the roads since the legislation.

Facial injury among bicyclists may be the next area to attract research and legislation. Studies are currently being conducted to determine whether modifications to helmets, like vizors of some kind, may protect riders against facial injury.

VISS: Phone (03) 345 5087

Dog attack figures highlight use of injury surveillance data

Surveillance, as defined by the United States Centers for Disease Control (CDC), involves much more than data collection alone.

It is "the ongoing systematic collection, analysis and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know. The final link in the surveillance chain is the application of these data to prevention and control." (CDC, 1986).

Clearly, there are a number of ways in which injury surveillance data can be analysed, interpreted, and disseminated. The South Australian Health Commission's Injury Control and Prevention Unit applies surveillance data in a number of ways, but in particular uses its "Injury Surveillance Bulletin" as a major form of information dissemination to a wide audience. The Bulletin has been published since July 1986, with 33 issues produced by May 1991.

The February 1991 issue of the Bulletin was devoted to what has now become a major topic for public debate, and possible action by a number of jurisdictions – the issue of dog attacks, and what to do about them.

The Bulletin presented the results of research which combined injury surveillance data with information from other sources. The research showed that six dog breeds accounted for over three-quarters of all dog attacks yet only represented about one-fifth of the dog population.

In addition to the findings, a number of intervention measures were proposed, including restrictions on ownership of the six dog breeds identified in the study, and greater enforcement of laws relating to uncontrolled dogs.

Future issues of this Bulletin will highlight other examples where a strong link between injury data collection and its eventual use has been demonstrated.

Injury Control Handbook

- *A community health worker is asked to plan a program to reduce slips and falls among the elderly.*
- *A lecturer in a university department of architecture would like to include a section on injury control in a course.*
- *A health policy-maker is trying to come to grips with injury as a public health issue.*

These are just some of the people likely to want information about injury prevention. But at present there is no convenient source of information on injury and its control – relevant to Australia – which people can turn to.

A project to fill this gap got under way in Adelaide on June 4, with a meeting of an expert advisory panel, convened by the National Injury Surveillance Unit to provide technical expertise and advice to produce an Australian Injury Control Handbook.

The Commonwealth Department of Community Services and Health, through the National Better Health Program, has provided a grant of \$60,000 for this project.

Most of the funds will be used to employ a number of writers and researchers who, guided by the expert panel, will research and compile the mass of information needed. The project is scheduled to be finished by the end of 1991.

National Injury Surveillance Unit

The main responsibility of the National Injury Surveillance Unit (NISU) is to provide information for the purposes of injury prevention, chiefly through improving data collection and by better use of data already collected.

The basic role of NISU is to ensure that information necessary for injury control is available, in appropriate forms, to those who can use it, and to encourage use of the information. Achievement of this goal requires work in three areas.

The first task is to ensure that suitable data are collected. NISU participates variously in planning, operating and evaluating surveillance systems, and we aim to promote relevant research.

The second task is to make information more available and more useful, by providing an injury information service, and by other means.

The third task is to develop interest and activity aimed at achieving injury control, by encouraging intersectoral liaison and co-ordination, providing resources (such as the Injury Control Handbook, now in preparation), and encouraging activities such as the provision of training opportunities.

The establishment of NISU reflects emerging recognition in the health sector of the importance of injury as a public health problem. While some aspects of injury – such as injury on the roads and at work – have received considerable attention, other aspects have been neglected. The Unit will give special attention to areas such as child injuries, injury in the home and injury of the elderly as well as providing an overview of injury from all causes.

Part of the Australian Institute of Health, NISU is based in Adelaide with a staff of five. It is funded by the Commonwealth under the National Better Health Program and is academically affiliated with Flinders University.

Surveillance

NISU's main contribution to preventing injury is through public health surveillance of injury.

The term 'surveillance' might imply the collection of data alone, but NISU's surveillance role is much broader than that. It is really the development of a system for

managing information about injury so that information can be used in public health practice.

The first function of such a system is to collect, analyse and interpret injury data. The information must then be disseminated to 'those who need to know' – public health workers, public policy makers and individuals and groups within the community. Prevention and control of injury can then be planned and undertaken in public health practice.

NISU will also assist other groups to undertake aspects of surveillance.

ISIS

An important part of NISU's information management system is the Injury Surveillance Information System (ISIS), a computerised data collection system designed by Mr Jerry Moller in the mid-1980s.

Although some data collection systems already existed, the emergence of interest in injury at that time highlighted the lack of 'all ages, all injuries' surveillance. Also, most injury data collections provide little information on the circumstances in which injuries occur – information necessary for prevention.

ISIS was developed to correct these deficiencies and continued to be developed and applied over the four years of the National Injury Surveillance and Prevention Project (NISPP). ISIS has been further developed by NISU.

Data for ISIS is mainly collected from people attending the accident and emergency departments of about 50 participating hospitals. Confidential details about the circumstances and outcomes of injurious events are entered locally into a specialised database, computerised database. The information is transferred electronically from time to time to NISU, to be added to the national database.

ISIS is well suited for use at a local or regional level, as a source of information on injury for local and community-based injury prevention programs. ISIS data can also be used at the national level to characterise defined sub-groups of cases, such as the events leading to injury from particular consumer products.

ISIS is currently being reviewed by NISU and other users of the system to clarify both the purposes for which it is used and the purposes to which it is most suited.

Injury information

NISU is also seeking to make injury information more accessible and useful.

Copies of major data collections are held at NISU and relevant data sources are being consolidated to make them more accessible.

NISU holds a national aggregation of ISIS data on injury attendances at selected hospitals; relevant demographic data – mainly that collected by the Australian Bureau of Statistics (ABS) – are being obtained; and Australia-wide deaths and hospital separations data for most States and Territories are being obtained from within the Australian Institute of Health.

Analysis

Periodically, NISU will undertake analyses of compiled injury data as well as regional analysis and analysis of particular population sectors or specific topics on request. Other investigators can also evaluate data held by NISU.

Dissemination

Information in the form of periodic summary reports, topic specific reports and general injury information bulletins will be disseminated both at NISU's instigation and on request, to public health policy makers, public health workers and people engaged in injury prevention programs.

For further information phone NISU on (08) 269 5133 or write to 78-80 Main North Rd, Prospect, SA 5082.

Other activities

NISU participates in an international working party on injury surveillance methodology; is improving the use of injury deaths data; investigating means for improving surveillance of poisonings, intentional injuries, and non-fatal injuries; and is involved in supporting a national spinal injury register.

NISU's involvement is sought in a variety of activities beyond the Unit's main areas of responsibility. It has a major role in organising the 3rd World Conference on Accident and Injury Prevention (to be held in Australia in 1995 or 1996), is managing the development of an injury prevention handbook, and is prompting improvement of opportunities for training in injury prevention.

Injury fact file

Injuries account for a significant proportion of ill health, disability and death in Australia.

The social and economic costs of injury, although not easily quantifiable, are high. They impact on the injured, their families and communities, and on the health care and rehabilitation sectors. The following brief summary provides an overview of some aspects of injury in Australia.

In the general Australian community, injuries account for around 10.3 million consultations with doctors each year (Note 1). This represents a consultation rate of around 620 per 1,000 persons and accounts for about 7.5 per cent of all doctor visits.

Injuries also represent an important fraction of hospital casualty department activity, but accurately quantifying the real impact of injury is hampered by poor data. It has been estimated, however (see Note 2), that Australians use hospital outpatient services at the rate of around 2,400 treatments per 1,000 population each year (or 794/1,000 "visits" per year).

Assuming that on average, half of all outpatient services are provided through casualty departments, and that about 40 per cent of these relate to injured people, the injury presentation rate is estimated at 159 per 1,000 persons, or around 2.6 million cases annually. Thus the injury component of overall hospital outpatient activity is around 20 per cent (Note 3). Further work is under way at NISU to estimate this proportion more accurately.

While most people presenting at casualty departments are treated and return home, it is estimated that around 350,000 injured people are admitted to hospital (Note 1).

The Australian Institute of Health estimates the injury admission rate to hospital at 20.9 per 1,000 people per year. Injuries (and poisonings) account for around 10 per cent of all hospital admissions (Note 1 and 4).

Apart from the immediate morbidity associated with injury, the longer term consequences of injury-caused disability and handicap are major in Australia.

For example, a 1988 survey of disability and handicap (Note 5), estimated that there were around 518,700 handicapped people where

Ranking of five most common disease categories for males and females

[from most common (top) to least common (bottom)]

Males	Hospitalisation	PYLL70	Deaths
Acute Symptoms Respiratory Musculoskel Mental Nervous syst. INJURY/POISON	INJURY/POISON Digestive Circulatory Respiratory Musculoskel	INJURY/POISON Circulatory Neoplasms Congen./Perin. Respiratory	Circulatory Neoplasms INJURY/POISON Respiratory Digestive
Females			
Mental Respiratory Musculoskel Nervous syst. Genito-urinary	Preg./childbirth Genito-urinary Digestive Circulatory INJURY/POISON	Neoplasms INJURY/POISON Congen./Perin Circulatory Respiratory	Circulatory Neoplasms Respiratory INJURY/POISON Digestive
Notes: PYLL70: Potential years of life lost to age 70 due to death. Source: Adapted from Goss (1991)			

the primary disabling condition was attributable to injuries. A wide range of disabling conditions was reported, but significant types included mental disorders, sight loss, hearing loss, nervous system, and musculoskeletal system related disabilities.

Notwithstanding the dramatic changes in patterns of morbidity and mortality this century, injuries still account for around 7 per cent of all deaths. In 1989, deaths due to injuries and suicides exceeded 7,700 – a death rate of 45 per 100,000 people (Note 6).

A common way of interpreting the relative importance of deaths due to various causes is found in the concept of "years of potential life lost" or YPLL – a measure of the number of potential years of life lost in a population as a result of premature death.

While injury accounts for about 7 per cent of all deaths, it accounts for 26 per cent of years of potential life lost before the age of 70 years. The large contribution of injury to YPLL reflects the young age at which injury deaths often occur.

An overall summary of the importance of injury relative to other health conditions is shown in the table above (Note 7).

SOURCES AND NOTES:

1. Australian Institute of Health (1990) "Australia's health 1990: the second biennial report of the Australian Institute of Health". AGPS, Canberra. (Data are from

Table 3.1 p.41)

2. Mathers, C.D. and Harvey R.D. (1988) "Hospital utilisation and costs study. Vol. 2 Survey of public hospitals and related data". AGPS for Australian Institute of Health, Canberra.

3. There are few reliable data on total hospital outpatient activity and emergency utilisation patterns in Australia. Methods of counting non-inpatient activity vary between hospitals and between States, and both have varied over time. The proportions used here are estimates only and will be corrected when better data becomes available.

4. Australian Bureau of Statistics (1991) "1989-90 National health survey, preliminary results", Australian Bureau of Statistics, Canberra. Cat #4361.0

5. Australian Bureau of Statistics (1990) "Disability and handicap Australia, 1988". Australian Bureau of Statistics, Canberra. Cat.#4120.0

6. Australian Bureau of Statistics (1990) "1989 Causes of Death Australia". Australian Bureau of Statistics, Canberra. Cat #3303.0. (Data from Table 5 p.19)

7. Goss J. (1991) "The burden of illness in Australia: implications for the collection of health statistics". Paper presented as part of the Australian Institute of Health contribution at the "Forum, priorities for national health statistics", Canberra, February 1991. (The summary data in the above Table are indicative only – ideally, for valid comparisons, data are best defined and collected in the same ways and should relate to the same period of time.)

Aboriginal death rates

Death rates from all causes are significantly higher in Aborigines than for Australians generally.

In a recently published collection of papers focusing on Aboriginal mortality, Dr Don Hicks analysed Aboriginal death rates for 1983 in Western Australia, and calculated that for "all causes of death the [male] Aboriginal rate was 2.43 times the total Western Australian rate and for females it was 2.92 times higher" (Note 1).

Injuries were the third most common cause of death in both sexes (and also third highest death rates). The injury death rates for males and females were respectively, 3.6 and 5.0 times higher than for the general community.

Accurate data on Aboriginal morbidity are scant but, in general, echo the pattern for deaths. For example, a study by Dr Neil Thomson and colleagues, aimed at identifying Aborigines in hospital admissions in the North Coast Region of NSW, showed that Aboriginal admissions were under-identified and that this may be a contributing factor to differences in proportions of types of admission observed in their study and those reported for other locations (Note 2).

The authors noted that while injury and poisoning accounted for 11 per cent of Aboriginal male hospital admissions in the North Coast Region, "in comparison, in Western Australia 'external causes of injury and poisoning' was the leading cause of hospitalisation among Aboriginal males, contributing to almost 20 per cent of admissions".

The proportions were 21 and 17 per cent in the Northern Territory and South Australia respectively. In the general community, injuries and poisoning account for around 10 per cent of all admissions (males 14 per cent, females 7 per cent).

Notes:

1. Hicks D.G. "Aboriginal Mortality Rates in Western Australia", in Gray A. (ed) 1990 Institute Report Series. A Matter of Life and Death - Contemporary Aboriginal Mortality Aboriginal Studies Press, Canberra. p71-79.
2. Thompson N., Paden F. & Cassidy G. (1990) Identification of Aborigines in hospital admissions in the North Coast Health Region, New South Wales. Australian Institute of Health & North Coast Health Region of the NSW Dept of Health. Canberra.

Injuries over time

Trends in death rates in Australia

General trends

The overall male injury death rate has slowly fallen from around 116 deaths per 100,000 persons in 1921 to around 75 per 100,000 in 1988.

While the male rate has steadily fallen, the much lower female rate has not shown the same downward trend - indeed, the 1988 rate of 28.2 per 100,000 is not much lower than the 1921 rate 33.7 per 100,000. In the 1950s and 1960s, however, female injury death rates were generally higher than both the 1920s and the period from 1975 onwards. (General source: d'Espaignet et al, 1991).

Although death rates from injury have fallen since 1921, injury has continued to account for between 6 and 8 per cent of all male deaths. In contrast, female injury deaths, as a proportion of total female deaths, rose from around 2.5 per cent in 1921 to a peak of 6 per cent in 1967, and subsequently fell to around 5 per cent in 1988.

Age and sex-specific trends

In general, most male age groups showed falls in injury death rates. The major exceptions were males aged 15-29, where rates rose, and males over 85 years, where rates fluctuated about a high rate.

For females, rates rose in the 15-24 year age group (as with males), but rates were either steady or fluctuated for females 30-59 years. Only the young and older female age groups experienced falling death rates.

Injury death rate compared with other causes

The relative importance of injury-related deaths in Australia has changed considerably over the course of this century. While injury has always been a major cause of death in people aged 15-24 years (particularly in males), injury and poisoning death rates have steadily risen during the 1900s.

On the other hand, deaths caused by infectious diseases have fallen dramatically over the same period. The following table provides some insight into these changes for the 15-24 year age group (Lancaster & Gordon 1988).

Selected Causes of Death, Males and Females 15-24 years Australia, 1908-1980

(Deaths per million per annum)

Cause of Death	Year			
	1908-10	1930-40	1951-60	1971-80
Males				
Tuberculosis	582	197	11	0
Other infections	509	138	57	8
Malignant tumours	35	41	53	49
Respiratory diseases	218	150	45	29
Injury & poisoning	809	937	1172	1302
Females				
Tuberculosis	934	373	15	00
Other infections	369	92	42	5
Malignant tumours	36	33	35	35
Respiratory diseases	158	125	52	24
Injury & poisoning	199	177	184	333

Source: Lancaster H. & Gordon D. (1988)

REFERENCES CITED:

- d'Espaignet E.T. et al (1991) Trends in Australian mortality 1921-1988. Australian Institute of Health: Mortality Series No. 1, AGPS, Canberra.
- Lancaster H. & Gordon D. (1988) "Health and Medicine", in Vamplew R. (ed) (1988) Australians - Historical Statistics. Fairfax Syme & Weldon, Sydney. pp. 314-327.

Shooting deaths

Gunshot accounts for about one in 12 injury deaths in Australia.

During the period 1979-87, an average of 689 deaths per year were recorded as resulting from firearms, 8.7 per cent of all injury deaths. The crude annual incidence rate was 4.7 per 100,000 population.

More than three-quarters of the firearm deaths were recorded as suicides (77.1 per cent). The rest were recorded as homicides (15.1 per cent), accidents (6.0 per cent), and a group where intent was unclear (1.8 per cent).

Death from injury and poisoning generally is more common in males than in females, and this is so especially for death from firearms: females made up 12.1 per cent of firearm deaths, and 29.6 per cent of all injury and poisoning deaths.

Male and female deaths from gunshot show very different patterns of intent. Over four out of five of the males had shot themselves (81.1 per cent), while 43.5 per cent of the females had been shot deliberately by another person. Less than half the female firearm deaths were recorded as suicides (48.2 per cent). Accidental shooting accounted for about 6 per cent of firearm deaths in each sex.

[Source: ABS deaths data, 1979-89]

Pool drownings

Continued from page 8

to make safety fencing compulsory for all new domestic pools. The Conference stopped short of requiring owners of already existing pools to instal safety fencing, but suggested fencing should be encouraged. Existing pools are much more numerous than new pools.

State and Territory developments will be monitored and included in a future Bulletin.

- The Queensland Department of Health has produced two videos on water safety – one on children's safety around swimming pools and the other on water safety for children around the home. For further information contact Dawn Spinks, Better Health Program, on (07) 234 1237.

National Road Trauma Council

Sir Nicholas Shehadie, Chairman of the Special Broadcasting Service, has donned another worthwhile community service hat: Chairman of the National Road Trauma Advisory Council.

Speaking of the extent of road trauma in Australia, Sir Nicholas said: "It's frightening. I wasn't aware of the massive problem that exists out there. The doctors are the ones who really see the end result of poor road safety, not so much in fatalities – it's too late for them – but in the dreadfully injured people they spend months trying to repair."

"The council will look at every aspect of road safety, from road quality, to alcohol consumption, to helmets for skateboard riders, inflatable airbags in cars and many other kinds of safety equipment."

"I've started by talking to representatives of the trucking industry and I'll be talking to drivers next. It seems fatigue might be the biggest problem of all for the owner/drivers who are pushing themselves that extra bit. All the organisations I've spoken to in the trucking business have been most co-operative."

"The long-term goal of the National

Road Trauma Advisory Council is to make a safer Australia by making it one Australia. We're sending information to various State and Territory departments with the aim of standardising safety regulations across Australia.

"It makes sense to have national standards for things like compulsory bike helmets and the legal blood alcohol limit."

Council members include Professor Sir Dennis Paterson, Chief Orthopaedic Surgeon, Adelaide Children's Hospital; Mr Bill Horman, Director of Investigations, National Crime Authority; Mr Ray Brown, Engineering Director, Toyota; Mr Peter Makeham, Director of the Federal Office of Road Safety; and Dr James Harrison, Director, National Injury Surveillance Unit.

The Council is urging compulsory wearing of helmets by motor cyclists and bicylists to reduce head injury, and Sir Nicholas believes that compulsory helmets should also be considered for skateboard riders.

Other concerns expressed by the Council are child harnesses in cars, fitting of anti-lock brakes to heavy vehicles, and passenger car safety standards for light commercial and four-wheel-drive vehicles.

Role of Council

The National Road Trauma Advisory Council was established in August 1990 by Prime Minister Bob Hawke as part of his road safety initiative.

The Council was appointed to advise the Government on effective and achievable ways to further reduce the number of people killed and injured on Australian roads.

Council members include Australians eminent in trauma management and rehabilitation and transport economics, as well as representatives of the motor vehicle industry and law enforcement agencies.

Strong bipartisan support has been a key feature in the establishment and early operation of the Council. All State and Territory governments and the Federal Opposition have expressed strong support for the

Council and the task it is undertaking.

The Council hopes this wide-ranging support will enable it to develop a truly national approach to road safety and encourage all parties to work together in a spirit of cooperation.

When Mr Hawke opened the inaugural meeting of the Council in December 1990, he emphasised the great opportunity members had to make a significant contribution to road safety.

The Council has a strong commitment to the task of reducing road trauma. Members believe the activities of the Council can achieve real reductions in both road fatalities and injuries.

- For further information contact the Federal Office of Road Safety, (06) 274 7111.

Congress spotlights child injury

An international workshop on child injury has urged national paediatric societies to play a greater role in advocating child safety.

The workshop, attended by representatives of 17 nations in the South-East Asian region, was held in Perth in conjunction with the Seventh Asian Congress of Paediatrics and the national conference of the Child Accident Prevention Foundation of Australia (CAPFA).

The international workshop, Child Injury: A Regional Threat to Child Survival, was sponsored by a number of key international agencies including UNICEF, the International Paediatric Association, the Association of Paediatric Societies of South-East Asian Region, the Australian College of Paediatrics and CAPFA.

The conference outlined a number of principles necessary for the development of injury prevention strategies for children which were considered and supported by the international workshop.

The principles included:

- The need to develop advocacy and intersectoral collaboration on behalf of child injury prevention;
- The development of data bases on child injury;
- A scientific approach to injury prevention methods;
- The importance of starting "small" in injury prevention projects and sharing results with other workers;
- The importance of inbuilt safety in products and the environment;
- The need for professional development of injury prevention workers.

The workshop was the first associated with any of the Asian Congresses of Paediatrics to deal with the issue of injury prevention in childhood. There was strong support for another workshop to be held in association with the 8th Congress in Delhi in 1994 to discuss progress in the area.

DIARY

Please advise NISU of any courses, conferences or events for inclusion in future Bulletins.

Injury Research and Prevention: A Short Course.

2-6 December 1991

Monash University, Melbourne

Conducted by the Monash University Accident Research Centre (MUARC), this course is funded through the National Better Health Program. Contributors will include Dr Gordon Smith (John Hopkins University, Baltimore USA) and Dr John Langley (Injury Research Centre, Otago University NZ). Places still exist in the course (full fee \$310, some subsidised places).

Contact: Marie Bond, MUARC, tel (03) 565 4371.

Road Trauma: The Medical Engineering Link

Seminar, 19-20 July 1991

**Royal Australasian College of Surgeons,
Spring Street, Melbourne**

Sponsored by the Association for the Advancement of Automotive Medicine. Cost \$320.

Contact: Brian Fildes (03) 365 4369 or Gordon Trinca (03) 622 1033.

Injury Scaling Course

17-18 July 1991 (Melbourne)

22-23 July 1991 (Sydney)

The first of two courses will precede the "Road trauma: The Medical Engineering Link" seminar in Melbourne on 17-18 July 1991. A

second course will follow in Sydney on 22-23 July 1991. Sponsored by the Association for the Advancement of Automotive Medicine. Cost \$180. (If taken in conjunction with seminar, total cost is \$400.)

Contact: Brian Fildes or Gordon Trinca (as above).

Public Health Association (Injury Control Special Interest group)/National Injury Surveillance Unit Seminar: 'Using Local and Regional Injury Surveillance Data for Injury Prevention.'

27 September 1991

Adelaide

A one-day seminar is planned for 27 September 1991 in Adelaide. The meeting will precede the PHA Annual Conference in Alice Springs (30 September - 2 October). The seminar will be preceded on 26 September by an ISIS Users Technical Meeting.

Contact: John Payne, NISU (08) 269 5133.

Second World Conference on Injury Control

20-23 May 1993

Atlanta, Georgia, USA

Further information can be obtained from:

World Injury Control Conference
Co-ordinator
Division of Injury control (F36)
CEHC, Centres for Disease Control
Atlanta, Georgia 30333 USA
(Fax 01 040 488 4422)

Since injury data collection is inadequate in many countries within the South East Asian region, it was agreed that Australia and New Zealand could play a strong role in the area of child safety.

About 80 people attended the CAPFA conference, held at the University of Western Australia on May 3, immediately before the international workshop and Paediatrics Congress.

Keynote speaker was Dr Wim Rogmans, Director of the Dutch Consumer Safety Institute, who spoke

on current developments in child and consumer safety in Europe. Rogmans stressed the importance of data as the foundation for all intervention strategies and the need for cooperation between different sectors.

Australian speakers provided an overview of child epidemiology in Australia and reported on new safety programs which have demonstrated potential. Dr Dan Tyson, from the National Injury Surveillance Unit, described NISU's role in improving the accessibility of information for injury prevention purposes.

Domestic pool drownings

New findings published in the Medical Journal of Australia add to evidence supporting the importance of safety fencing in the prevention of domestic swimming pool drownings.

The findings are detailed in an article by Dr Robert Pitt and Dr Kevin Balanda in the May 20 issue of the Journal.

Pitt and Balanda estimate that "the risk of a drowning or near-drowning involving unintended access to an unfenced pool is 3.76 times higher than the risk associated with a fenced pool". They conclude that pool fences are an effective method of preventing child drownings, and are more effective if compliance with gate closure is enhanced.

Drowning is the most common cause of accidental death in young children in Australia. Seventy-seven children aged from 1-4 years drowned in 1989, and an average of 73.3 per year during the six years 1984 to 1989. In 1989, drownings accounted for 18.5 per cent of all deaths, and for 39.1 per cent of accidental deaths in this age group.

Of all child drownings (ages 0-14 years), 80 per cent occur at ages 1-4 years. In addition to deaths, there is a less well-defined number of severe non-fatal immersions, resulting in brain injury and consequent disability.

Due to limitations on data sources, comprehensive information on drownings and near drownings in domestic pools is not available. Available data indicate that about half of all drownings of young children occur in domestic swimming pools, and that most children who drown in domestic pools are toddlers (1-4 years).

Many Australian studies over nearly 20 years have confirmed the magnitude of domestic pool drowning as a cause of death in young childhood.

Issues surrounding legislation for pool fencing in Australia are complex because States, Territories and local governments may have individual building codes which can interact differently with Australian Standards requirements.

Even definitions can cause problems. What exactly does "fencing" mean? Is it the perimeter of the whole property, or a barrier around the pool? Can a wall of a dwelling constitute part of a fence, and

if so, what if it has a door in it?

The issue of the prevention of domestic swimming pool drownings was dealt with recently by the Australian Health Ministers' Advisory Council (AHMAC) and the Australian Health Ministers' Conference (AHMC) when submissions by the Commonwealth and Queensland were considered.

Queensland, which has enacted stronger legislation for pool fencing, sought agreement from the Health Ministers to a broad range of recommendations.

Amendments to the building code were sought, stipulating isolation fencing where the pool would be fenced on all four sides and direct access from the house to the pool would be totally restricted.

Existing pools should also be

satisfactorily fenced to restrict access from the house to the pool. A door/window could be an access point if it had self-closing, self-latching catches to Australian standards.

Public education and awareness programs about fencing and safety procedures should also be provided, as should training and education at local government level to ensure effective administration of regulations.

Nationally coordinated data on drownings and the implementation of prevention strategies should also be developed.

The Health Ministers' Conference did not accept all the Queensland recommendations but agreed to seek

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Prevention strategy in NSW

An injury control strategy document is being developed in NSW, reflecting the priority area which injury prevention has become for Health Promotion in that State.

The task of the Injury Prevention Working Group, convened by the NSW Health Department in August 1990, is to develop the strategy, and the strategy document will be workshopped in August this year.

The working group is chaired by epidemiologist Dr David Lyle. Dr Jane Elkington, who recently completed a PhD in Injury Epidemiology and Prevention at the University of Minnesota, has been appointed Project Officer in Injury Prevention.

The NSW Health Department has also recently established an Epidemiology Department with responsibility for injury surveillance, and Public Health Units throughout the State have a responsibility to develop strategies for injury in their terms of reference.

Speaking about the growing attention to injury prevention in Australia, Dr Elkington said: "There is more and more recognition of the need for injury prevention in this country."

"It was first recognised as a major problem when people became aware of the road toll, but over the last five years there has been increasing awareness of the need for injury prevention in other areas – in the workplace, at home, and in the community."

There are already a number of applied injury prevention activities in NSW, including Childsafe, Farmsafe, and the Rural Injury Prevention Unit. The strategy document is intended to set a statewide direction for injury prevention activity and to stimulate more local injury prevention plans.

The strategy will incorporate four elements:

- Provision of appropriate, timely information about the distribution, occurrence, causes and outcome of injuries;
- Targets for injury prevention;
- Establishment of injury surveillance systems and develop an infrastructure for injury prevention, including developing links with other key organisations responsible for injury prevention; and
- Development of strategies for reducing death and disability from injury.