

INJURY ISSUES MONITOR

7,820 injury deaths in 2002

Contents

- 1 2002 injury deaths
- 1 Conference report: Mackay 2004
- 3 Injury mortality among Aboriginal and Torres Strait Islander people
- 4 Conference photos
- 7 Queensland safe communities
- 8 Conference award winners
- 8 Injury in the gay and lesbian community
- 10 Injury caused by mangoes
- 11 Falls prevention in hospitals and residential aged care facilities
- 12 Safe Communities Foundation
- 13 Award for injury researcher
- 14 ICECI in the real world
- 17 From the Coroner
- 18 SCI Register Workshop
- 18 8th World Injury Conference
- 18 National Injury Prevention Plan Update
- 19 SIPP Communique
- 21 New on the RCIS website
- 21 New RCIS phone numbers
- 22 Mortality among Korean war veterans
- 22 Falls prevention exercise manual
- 22 Directory of Injury Personnel
- 23 Something to read
- 23 Diary

5,271 males and 2,549 females died from injuries they sustained in 2002 according to a report released late last year by the Australian Institute of Health and Welfare.¹

Injury Deaths, Australia 2002 shows that, during 2002, injury was the cause of 50% of deaths at ages 1–44 years. Young adults, in the age range 20–39 years, accounted for one-third of all injury deaths. Young males, alone, accounted for more than one-quarter of the total.

The age-adjusted rate of injury death in 2002 was 39% lower than the rate in 1979. The fall in rates slowed in the 1990s and rates have changed little in the latest few years, although there is a slight downward trend (Figure 1).

The age distribution of major causes of death in 2002 is shown in Figure 2.

Suicide was the most frequent cause of injury death, accounting for 30% of all fatal injuries. The next most frequent cause of fatalities was transport, which accounted for 24% of all injury deaths.

There were 2,320 suicide deaths in 2002. The male suicide rate in 2002 was the lowest since 1985, and was 20% lower than in 1997. The much lower female rates have changed very little in recent years. In 45% of cases, the method was hanging, strangulation or suffocation. The next most common methods were poisoning (31%) and use of a firearm (9%).

1,907 deaths were associated with some form of transport. Close to three-quarters of these involved males. The majority of transport-related deaths involved a motor vehicle (n=1,666, 87%). Of the 1,666 motor vehicle traffic deaths, 66% were motor vehicle occupants, 15% were pedestrians, 13% were motorcyclists and 2% were cyclists. Drivers represented the largest group of vehicle occupant deaths 66% (n=725).

A total of 1,517 people died as the result of an accidental fall. Fall-related deaths were most frequent in older age groups, and particularly high among both

Continued on page 2

Conference Report: Mackay 2004

Nearly 200 delegates from as far afield as the United Kingdom, Egypt, Canada, USA, Hong Kong, Vietnam and New Zealand along with practitioners and researchers from all around Australia attended the 7th Australian Injury Prevention Conference and the 2nd Pacific Rim Safe Communities Conference held in Mackay in September 2004.

Entitled *Safe Living on the Edge*, the injury conference aimed to facilitate a dialogue between injury prevention researchers and safety promotion practitioners as they explored the impact of risk on our lives and how we can work together to effectively manage risk in our

communities.

The scientific program was comple-



Canada's Paul Kells quizzes children from the Northview Primary School about their injury experiences during the opening plenary session

mented by an energetic social program with a strong local flavour. The audience showed great enthusiasm during the opening ceremony featuring a performance by the Northview Primary School Signing Choir after which keynote speaker Paul Kells set the scene for the conference during a brief discussion with choir members in which he clearly demonstrated the impact of injury on our most precious social resource—our children.

Keynote speakers included Carolyn Coggan from the Injury Prevention Research Centre of Auckland University, Paul Kells from the Canadian Safe Communities Foundation, David Sleet from

Continued on page 6

7,820 injury deaths in 2002

Continued from page 1

males and females over the age of 85.

Unintentional drowning accounted for 232 deaths in 2002. There were more than 3 times as many males as females. Of the total number of accidental drownings, 42 involved children. 16 of these children died in a swimming pool and 14 after having fallen into some other body of water.

Unintentional poisoning by drugs was the cause of 605 deaths. Around two-thirds of these cases were males. Males between 20–39 years of age had rates around 3½ times higher than females in the equivalent age group. 37% of unintentional poisonings involved a narcotic. Multiple drug use was also common.

Unintentional deaths related to smoke inhalation, fire or hot substances accounted for 115 deaths in 2002. Of these, 57% were the result of an uncontrolled fire in a building or structure.

Clothing ignition accounted for 7 deaths. The ignition of highly flammable materials (e.g. petrol or kerosene accounted for 7 deaths). A further 10 deaths were the result of scalds, 9 from hot tap water and one from another type of hot fluid. In most cases, deaths from scalds involved older people.

There were 303 homicides. Of the 199 male deaths, 68 were due to assault by a sharp object, and 34 resulted from the use of a firearm. For females, 30 of a total of 104 deaths were the result of assault by a sharp object, and 15 resulted from hanging, strangulation or suffocation.

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Copies of the report are available in the form of a pdf file, on the RCIS website: www.nisu.flinders.edu.au Enquiries about printed copies can be directed to Stacey Avefua, Tel: 08 8201 7620, E-mail: stacey.avefua@flinders.edu.au

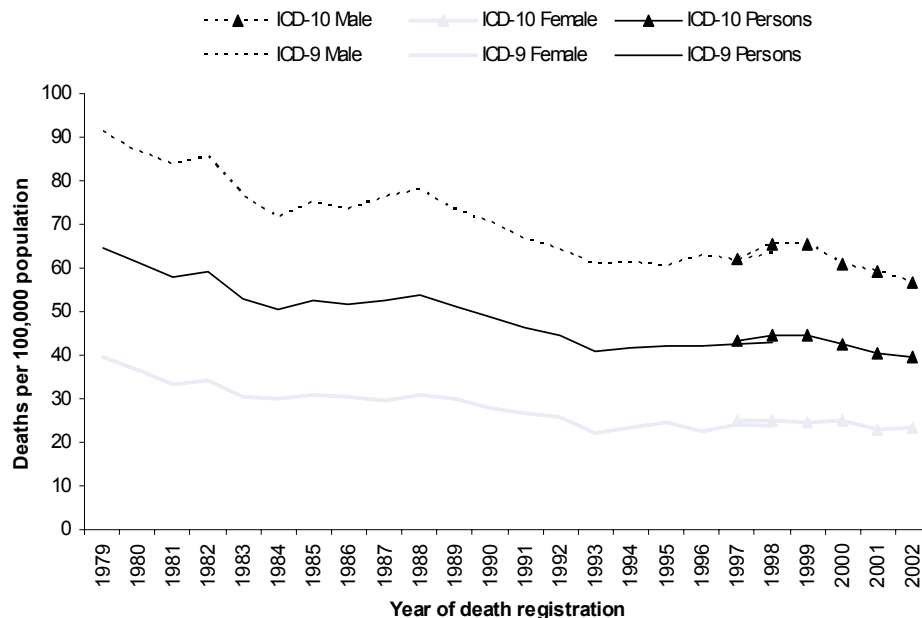


Figure 1: Age-adjusted rates of injury death from all causes, by sex, Australia 1979-02

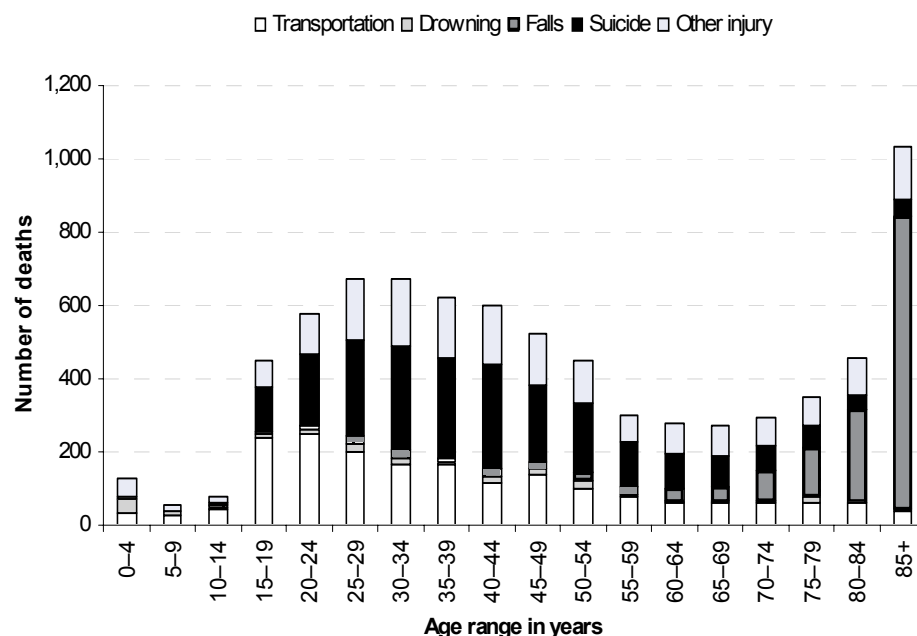


Figure 2: Age distribution of deaths for selected major causes of injury death, Australia 2002

Injury mortality among Aboriginal and Torres Strait Islander Australians

A new NISU technical report presents the results of an exploratory analysis of reported Aboriginal and Torres Strait Islander injury mortality data.² The findings will inform future statistical reporting.

The principal purpose of the report was to examine technical aspects of describing injury mortality among Aboriginal and Torres Strait Islander Australians and does this in considerable depth and detail.

The data used for the report were national mortality data drawn from the Australian Bureau of Statistics mortality database. Compilation of statistics on Aboriginal and Torres Strait Islander deaths presents a major challenge for researchers. Available data is known to have considerable limitations. These include:

- Incomplete ascertainment of Aboriginal and Torres Strait Islander status in deaths data, and variation in identification between places.
- Data quality varies over time, preventing reliable measurement of trends.
- Limited validity and reliability of Aboriginal and Torres Strait Islander population estimates, used as the denominators for rates.
- Small cases numbers limit reporting for individual jurisdictions.

Epidemiological findings

The mortality information reported is for the four jurisdictions in which Aboriginal and Torres Strait Islander data is thought to be relatively complete: Western Australia, South Australia, Queensland and the Northern Territory (Region A on the map). All rates quoted are directly standardised and stated per 100,000 population.

The injury death rate was 2.8 times higher for Aboriginal and Torres Strait Islander people than for other people in Australia in the period 1997–2000.

Intentional self-harm (suicide) and transport crashes were the most common

causes of injury death for Aboriginal and Torres Strait Islander people, as they were for the remainder of the population. However, the Aboriginal and Torres Strait Islander suicide rate was nearly twice as high as the rate for the remainder of the population, and the transport injury death rate was nearly three times as high.

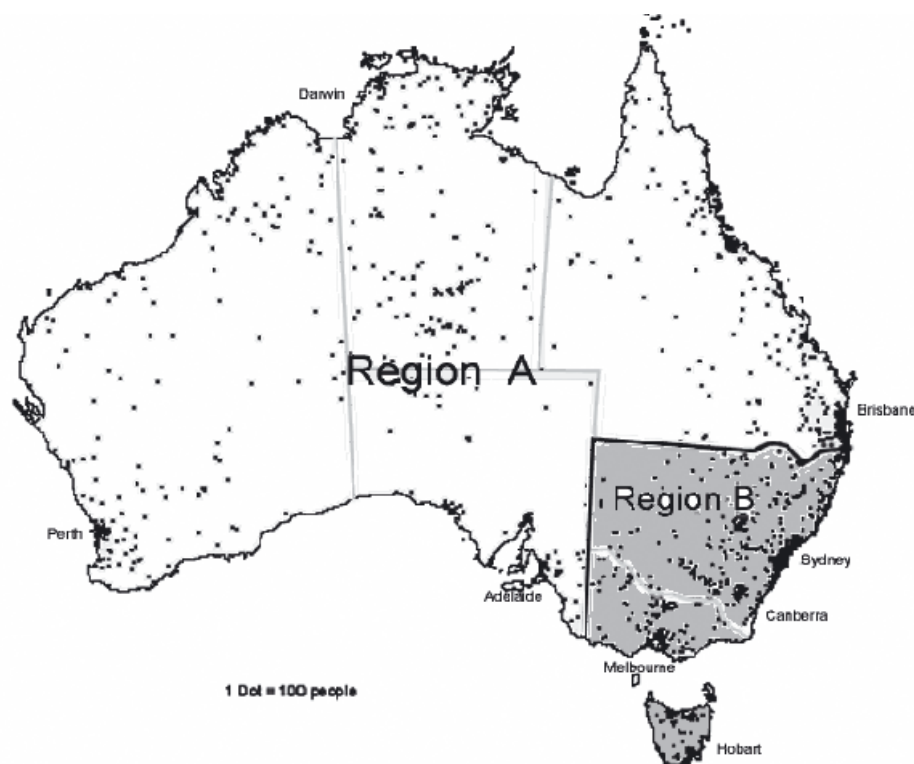
Fatal assault (homicide) was a less common cause of injury death than transport crashes or suicide, but rates were high in comparison to those for the rest of the population. The recorded rate for Aboriginal and Torres Strait Islander males was over 7 times higher than the rate for other males, and the rate for females was over 11 times higher than the rate for other females.

Recorded injury death rates were about twice as high for Aboriginal or Torres Strait

Islander people who lived in remote areas as for those who lived in major cities. However, injury death rates for Aboriginal and Torres Strait Islander people were higher than those for other residents of each remoteness zone: about twice as high for residents of major cities and three times as high for residents of remote areas. Aboriginal and Torres Strait Islander injury death rates were particularly high in remote areas for transport crashes, suicide (especially for men) and homicide.

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Figure 1: Distribution of usual place of residence of Aboriginal and Torres Strait Islander persons in 1996



Conference Pix



Blanche Diamond and Paul Kells, Canada; Richard Franklin, Royal Life Saving Society Australia

Marde Hoy and Jessica Pearse, National Coroners Information System



Maree Fisk, Falls Prevention Project, Tasmania University Department of Rural Health and Stan Bordeaux, Tasmanian Department of Health & Human Services

Conference Pix



Peter Sternhell, Safe Communities Coordinator and part-time doctor at South Eastern Area Health Service, NSW; Ian Raymond, NSW Collaborative Centre for Aboriginal Health Promotion

Dawn Spinks, Queensland Safe Communities Support Centre; Adrienne Isanova, Safe Communities Townsville and Fran McFadzen, Queensland Health's Rockhampton Office



Back row, left to right: Rae Scott, Department of Health & Ageing; Nicola Rabot, Victorian Department of Human Services; Lynne Galanti, Hume City Council, Victoria

Front row, left to right: Samantha Diplock, Annamaree Reisch (both from the Commonwealth Department of Health & Ageing)

Conference Pix



Peta Mackay, Queensland Ambulance Service, Toni Simpson, Gold Coast District Health Service, Chris Simpson, Queensland Ambulance Service (Gold Coast Division)

Rose-Alma McDonald, USA and Kathie Clapham, George Institute for International Health



Conference Report: Mackay 2004

Continued from page 1

the US Centers for Disease Control, and Rob Lee Director of the Bureau of Air Safety Investigation. Over 100 papers were presented along with eight workshops exploring topics as diverse as research methods, working with the media, violence in gay and lesbian communities and using musical drama to convey safety messages to teenagers, with live performances by

the Central Queensland University's Conservatorium of Music.

In this edition of the *Monitor* we're including just a few items from the Conference: a presentation on a Queensland project aimed at preventing falls in hospitals and aged care facilities (this was awarded the prize for best oral presentation at the conference); a presentation on a little

publicised injury issue—skin irritation and lesions caused by mango sap; news about the accreditation by the World Health Organization of two safe communities programs in Queensland; information about the issue of injuries in the gay and lesbian community; and details of awards presented for injury research and practice.

WHO accredits two Queensland Safe Communities

Toowoomba Safe Communities

The beautiful garden city of Toowoomba, situated atop the Great Dividing Range in South-East Queensland, was designated as a WHO Safe Community on 11 September 2004.

A large contingent of the local business sector supported Toowoomba City Council, government agencies and community groups involved in the Toowoomba Safe Community Task Force, and those involved in local community safety and crime prevention programs, to celebrate this special community event at a formal dinner.

The designation ceremony was conducted by WHO representative, Associate Professor Carolyn Coggan, Director of the Injury Prevention Research Centre, School of Population Health, University of Auckland. The Mayor of Toowoomba City Council, Cr Dianne Thorley, and Chair of the Toowoomba Safe Community Task Force, Cr Michele Alroe, were co-signatories of the WHO



Safe Community Agreement with Associate Professor Carolyn Coggan. The document was previously signed and endorsed by Professor Leif Svanstrom

from the WHO Collaborating Centre on Community Safety Promotion in Sweden.

The community celebrations continued the following day in Queens Park with a number of bands, school groups, youth from the Police Citizens Youth Club and choral groups performing prior to a short official ceremony. Peace doves and balloons were released as a symbol of peace and safety for the City of Toowoomba, following short speeches by the Mayor, Cr Dianne Thorley and Task Force Chair, Cr. Michele Alroe. A number of safety displays were provided by Emergency Services agencies. Celebrations were topped off with a free sausage sizzle that gave the gathered community an opportunity to chat and enjoy the glorious spring weather.

Enquiries about Toowoomba Safe Communities can be directed to Neroli Stayt, Tel: 07 4688 6496, E-mail: n.stayt@toowoomba.qld.gov.au

Mackay Whitsunday Safe Communities

On Tuesday the 31st of August 2004, the Mackay Whitsunday Safe Communities Project was designated a WHO Safe Community at a ceremony held during the Local Government Association of Queensland Conference. Associate Professor Carolyn Coggan, the Director of the Injury Prevention Research Centre at Auckland University represented the World Health Organization. The award was proudly accepted by Mackay Mayor, Julie Boyd, and Whitsunday Mayor, Mario Demartini, on behalf of the project.

Mackay Whitsunday is the first Safe Communities Project to achieve designation in Queensland, Australia in recognition of a four-year campaign to reduce injury rates in the region.

Since its launch in February 2000 the project has grown considerably and now consists of a network of over 100 members, representing 47 government, business and community organisations. Strategic partners include: Mackay City Council, Whitsunday Shire, Queensland Health, Department of Emergency Services,



Queensland Transport, Main Roads, Education Queensland, Queensland Police, Department of Communities, James Cook University and Mackay Bulk Sugar Terminal. Action Groups in Child Safety, Senior Safety, Road Safety, Occupational Health and Safety and Safe Alcohol Use have been established.

The Mackay Whitsunday Safe Community Program was initiated in 1999 by the Tropical Public Health Unit Network, Queensland Health after high mortality and morbidity rates for injury were observed in the Mackay Whitsunday region. The program was endorsed by Mackay City Council in November 1999 and Whitsunday Shire Council in February 2000.

Injury surveillance data is collected at Emergency Departments of all public hospitals in the region (Mackay Base Hospital, Proserpine Hospital, Sarina Hospital, Dysart Hospital, Moranbah Hospital and Clermont Hospital) and the major private health institution servicing

Continued on page 8

Mackay Whitsunday Safe Communities

Continued from page 7

the region (Mackay Mater Private After Hours Medical Practice). Injury data is analysed by collaboration of Queensland Health, Queensland Injury Surveillance Unit. Age standardised hospital separation rates are more than double those observed for other Queenslanders.

The program currently covers the following safety promotion activities:

- Child Safety
- School Safety
- Senior Safety
- Bike Safety
- Road Safety
- Alcohol Safety

Further enquiries about Mackay Whitsunday Safe Communities can be directed to Dale Hanson, Tel: 07 4968 6638, E-mail: dwhanson@mackay.matilda.net.au

Information about Queensland safe communities is available on the Internet: www.safecommunitiesqld.org

Conference Prize Winners

The Australian Injury Prevention Network awarded a number of prizes at the National Injury Conference. An extraordinary award for sustained achievement was given posthumously to Eric Young. We've included an article about Eric's contributions to the injury field on page 13.

Katherine McFarlane of Queensland Health was given an award for injury prevention practice.

The award for the best oral presentation was made to Paul Vardon for his report on a project aimed at preventing falls in hospital and residential aged care facilities. Paul's presentation appears on page 12.

The prize for the best poster presentation went to our own Geoff Henley for his description of a project which assessed the National Coroners Information System as an information tool for injury surveillance.

Preventing injury in the gay and lesbian community

Sharon Isle

A workshop was convened by the Anti-Violence Committee (AVC) of Townsville & Thuringowa at the September 2004 National Injury Conference in Mackay. The workshop was an interactive session which aimed to brainstorm a long-term and sustainable solution to a hypothetical situation of homophobic abuse/assault. The hypothetical event had its basis in a real-life situation in which a young person, the victim of homophobic attacks from peers and adults in his daytime community, contacted a local community organisation for help. Participants at the workshop were asked to come up with ways in which the local community could assist both the individual, other young people and, ultimately, the wider community. Despite the fact that the session was not well attended, the presenters felt it was a success. Members of the AVC were invited to publicise their activities through an interview, at the Conference venue, with ABC radio. The workshop was also given high priority by conference organisers who ensured that it was highlighted in an editorial that appeared in the international *Safe Communities* newsletter.

The Anti-Violence Committee (AVC) of Townsville & Thuringowa in Queensland is a group of volunteers made up of community members and community organisations including Local Council, The Aids Council, Self Health for Queensland Workers in the Sex Industry (SQWISI), Family Planning, Anti-Discrimination, and Queensland Education, to name just a few. It's an enthusiastic body which generates a number of activities such as:

- *Establishing and maintaining the*



Regional Gay Lesbian Bisexual and Transgender (GLBT) Liaison Officer

Project. Run in conjunction with the Queensland Police Service, this project now has five serving Police Officers fulfilling a community policing role. The project convenes community consultation group meetings where GLBT Police Officers, service agency providers and community members meet for round table discussions.

- *Running community education and public awareness programs.* The AVC

Continued on page 9

Preventing injury in the gay and lesbian community

Continued from page 8

is committed to providing education on why people should 'say no to homophobic violence/homophobia' in the twin cities. So far the Council has provided training to service providers, including Lifeline telephone counselors at all stages of their training, James Cook University medical students and youth workers. The AVC has also provided training to high school students, and teachers at government and independent high schools. Other groups the AVC has worked with are young male detainees and young men attending groups at Lifeline. They have also provided training for Police recruits at the North Queensland Police Academy, and for GLBT Liaison Officers.

- **Initiating the 'Report the Violence Campaign'.** The AVC has set up a centralised reporting system where members of the public can report crimes of violence—anononymously if they wish. In conjunction with Crime Stoppers, the AVC has set up a file where people can report crime details. They have also worked with local Police in the Townsville community by the sharing of information.
- **Establishing the 'Safe Place Project'.** Based on the belief that we all have the right to go about our daily lives in safety, the *Safe Place Project* addresses the issue of homophobic harassment and violence. The Project aims to lessen these threats through the establishment of a network of business and other organisations known as *Safe Places*. *Safe Places* are not only GLBT friendly environments, they also provide a haven for those who are in fear for their safety. People accessing a *Safe Place* can expect non-judgmental help in returning to a feeling of safety and can receive referrals there to agencies active in relation to GLBT related issues.

The AVC produces and distributes resources, lobbies for legislative change

in the interests of its constituency, and operates a website. The website can be accessed at www.glbtavc.org.au

The AVC is currently participating in a bid by Townsville Thuringowa Safe Communities to obtain World Health Organisation accreditation. They've set

themselves a date of 2006. Fingers crossed!

Enquiries about the AVC can be directed to Sharon Isle, Tel: 07 4772 1462, Mobile Tel: 0409 091 929, E-mail: sisle@fpq.com.au

Homophobia survey

Between May and August 2004, the AVC conducted a survey about the personal perceptions and experiences of safety of gays and lesbians living in Townsville and Thuringowa.

The survey was very comprehensive, taking about 20 minutes to complete. Ninety-six responses were received. Data were collected by leaving questionnaires in a deposit box at various businesses in Townsville and Thuringowa, and at gay and lesbian venues. The survey form was also inserted into *QPride* and was available for download from the AVC website. 47% of the respondents identified as gay, 28% as lesbian, 16% as bisexual, and 4% as transgender. 5% did not respond to the question.

Preliminary results of the survey were as follows:

- 72% of the sample felt that their personal safety was at risk from homophobic abuse/assault.
- 43% said they had experienced homophobic abuse/assault in the last 12 months and that the threat comes from everywhere—family, workplace, neighbours, strangers.
- Only 5% had reported the crime to the Police. Respondents said that they didn't feel the crime was important enough and they feared the Police would not deal with it seriously.
- 59% said they had made changes in their behaviour to minimise the risk of homophobic abuse and assault—e.g. act straight, dress

conservatively, not show affection in public, self-defense training, additional home security, always carry a mobile phone.

- Many people said that they had never been subjected to homophobic abuse/assault but still felt unsafe. Several of them said that politicians' actions and inactions demonstrate it is not OK to be homosexual, and that legislative bias was a factor.
- 78% of people felt there was a need for more action by governments at all levels (Federal, State, local).
- 56% felt that legislation—e.g. Queensland's new anti-vilification laws—increased their sense of personal safety and 51% felt it deterred perpetrators.

The survey has served to validate the need for the work of the AVC and reinforces its commitment to its future goals of continuing to work with the Queensland Police Service for greater understanding and relevant procedures, for advocating for specialist services for GLBT people in Townsville, and for continuing to lobby for legislative change at both State and Federal Government levels.

Enquiries about the survey can be directed to Sharon Isle, Mobile Tel: 0409 091 929, E-mail: sisle@fpq.com.au

Mango Misery

Anne Sutherland

Burdekin Centre for Rural Health

Australia produces more than 60,000 tonnes of mango fruit annually. The Burdekin, in far north Queensland, produces 48% of all mangoes in Queensland and 26% of all mangoes in Australia.

The mango tree is a member of the *Anacardiaceae* family. There are 600 species of these plants including Cashew, the Japanese Lacquer tree, Poison Ivy, Poison Oak and Poison Sumac.

Contact with mango sap can cause acid burns, Rhus Dermatitis (type IV hypersensitivity reaction) and severe allergic responses.

Sensitivity to mango sap varies. People who have grown up in a mango producing area are thought to have acquired some level of resistance to the fruit as the result of early and oral exposure. However, itinerant workers, who make up the major proportion of the picking and processing workforce in the Burdekin, are often very sensitive to the fruit, and some individuals can suffer a severe allergic reaction when they come into contact with mango sap.

Sap burn causes blistering and discolouration of the skin. It may lead to secondary infections. Scar formation can also result from deep sap burns or secondary infections. Rhus dermatitis begins within 24-72 hours of exposure. Not all individuals are equally susceptible. New skin lesions may appear on different parts of the body as long as two weeks after the initial outbreak—eg delicate skin around the eyes will react more quickly than thick skin on the feet. Symptoms can persist for up to 4-6 weeks.

The most concerning condition, a severe allergic reaction, usually begins with itching around the eyes, followed by an asthma attack, swelling of the face and breathing difficulties. Only a quick response by medical staff can deal with such an emergency.

Every year, thousands are affected around Australia. Yet this type of injury is completely preventable.

Burdekin Project

Staff of the Burdekin Centre for Rural Health were aware that there was a problem with mango sap injuries in its region. A search for relevant literature found considerable material about the prevention and treatment of sap injuries but no evidence of research studies.

After consultation with a number of organisations, the Centre developed educational resources that dealt with prevention strategies, first aid and treatment. These resources were trialled during 2002.

During 2002 and 2003, the Burdekin Centre conducted an awareness raising campaign in their region. This campaign included community education sessions and mass distribution of the educational resources they had developed to worker accommodation, employment agencies, laundromats, hotels, video stores—indeed anywhere in the community that may be frequented by itinerant workers. The resources were also distributed to workplaces including orchards, transport depots and agricultural suppliers as well as health service providers, including general practitioners, the hospital, pharmacies, and pathology labs.

It was found that fewer sap related injuries were recorded during the 2003 mango season. It was concluded that there could be several reasons for this: a significant reduction in the mango crop due to a drought; that a downturn in the sugar industry had resulted in more locals and fewer itinerant workers being employed in the mango harvesting industry; Work Health and Safety Queensland conducted well publicised random shed and field audits on the mango industry. There appeared to be a heightened awareness of legislative requirements by employers; for the second consecutive year, Centre staff conducted awareness sessions and distributed educational materials to employers and employees.

It was concluded that a fully developed research project would be needed to test the success of the educational intervention.



Mango sap burns

Prevention of mango burns

- When sorting or packaging mangoes, workers must wear gloves, closed-in shoes, shorts, a long-sleeved shirt and sunscreen.



A mango de-sapper in action

- When picking mangoes, they should wear long pants, long-sleeved, collared shirts, a wide-brimmed hat, 30+ sunscreen, closed-in shoes, gloves and sunglasses.
- Good picking and de-sapping practices need to be followed.
- There needs to be a balance between speed and quality—if the fruit is getting sap burn, so is the worker!
- Workers should bathe as soon as possible after finishing work.

Continued on page 18

Reducing harm from falls in Australian hospitals and residential aged care facilities

The following presentation by Paul Vardon of Queensland Health won the best paper award at the National Injury Prevention and Control Conference held in Mackay in September 2004. The presentation was prepared by the project team of Susan Brandis and Michael Bourke of Queensland Health and Vicki Grant from the Office of the Safety and Quality Council to describe the Australian Falls Prevention Project for Hospitals and Residential Aged Care Facilities.

Background

The Australian Falls Prevention Project is an initiative of the Australian Council for Safety and Quality in Health Care in association with Queensland Health.

The Council was established in January 2000 by Australian Health Ministers in response to national concerns about patient harm. The Council's charter is to lead national efforts to improve the safety and quality of health care in Australia. Its main focus is on patient safety in the context of quality improvement, and the principal approach is one of identifying and promoting best practice in national action to support improvement of clinical services at the frontline.

Ageing population and incidence/impact of falls

The Council has recognised that falls and fall-related injury are a growing problem in Australian hospitals and residential aged care facilities due to the increase in the ageing population.

The incidence of falls and their negative impact is apparent at both the individual and organisational levels. Approximately one in three community dwelling people aged 65 years and over fall each year, with the rate of falls and associated injuries even higher for older people in residential aged care and hospital settings³. In the residential aged care setting, up to 50% of residents experience one or more falls in a 12 month period³. In the acute care hospital setting, fall rates have been reported from 2-5% per 1,000 bed days³. In the sub acute or rehabilitation setting, over 40% of patients with specific clinical problems such as stroke, are experiencing one or more falls during their admission³. The reduction of adverse events is a key goal of the Council.

In addition to injuries, the effects of falls are costly to the individual in terms

of impaired function and quality of life.

As well as the effects of falls on the individual as the result of a fall, at an organisational level there is the issue of failure to provide a duty of care and the subsequent risk of litigation.

Existing work/activity by Queensland Health

Since 2000, Queensland Health, through its Quality Improvement and Enhancement Program, has developed and implemented falls prevention guidelines within each of its hospitals and residential aged care facilities.

The development of the guidelines was based on a literature review and piloting approaches within 16 self nominated sites – metropolitan, rural and remote, acute, rehabilitation, large and small across the State.

Recent evaluation results indicate that 67% of facilities within Queensland Health's 37 health service districts now have sustainable falls prevention strategies in place with anecdotal reports identifying large reductions in falls rates.

The Queensland guidelines were endorsed by the Council in 2002 and approximately 6,500 compact disk copies of them were distributed nationally. Feedback received by the Council identified that value could be added by developing the guidelines into national best practice guidelines.

Australian Falls Prevention Project for Hospitals and Residential Aged Care Facilities

The Australian Falls Prevention Project for Hospitals and Residential Aged Care Facilities aims to promote a nationally consistent approach to the reduction and prevention of falls in the adult population in both public and private hospitals and residential aged care facilities within the

context of recognising other existing work at local, State and national levels. The multidisciplinary project team is supported by a national taskforce and expert panel representing key stakeholders.

Project deliverables

Upon its completion in early 2005, the Australian Falls Prevention Project for Hospitals and Residential Aged Care Facilities is expected to have achieved the following outcomes:

1. Development of nationally endorsed falls prevention guidelines based on existing work by Queensland Health and informed by the latest literature. (There is not a lot of randomised controlled trials evidence on falls prevention in hospitals and residential aged care facilities. However, while randomised controlled trials are the gold standard for evidence-based medicine, this is not necessarily appropriate for assessing interventions to improve patient safety⁴. The paucity of randomised controlled evidence does not necessarily indicate that programs are not effective³). The new guidelines will also draw upon expert opinion and a consultation process.
2. Resource materials will be developed to support implementation of the guidelines.
3. Recommendations for the standardisation of processes for reporting and recording falls related incidents in hospitals and residential aged care facilities.
4. Recommendations for a national accreditation standard for falls prevention activities.

Continued on page 12

Reducing harm from falls in Australian hospitals and residential aged care facilities

Continued from page 11

Progress to date

Consultation process

In June/July 2004, national consultations were undertaken through 16 workshops, teleconferences, contact with peak industry groups, health professionals and consumer groups, an on-line survey and submissions. Special attention was paid to consulting with service providers for culturally and linguistically diverse and Indigenous communities.

Some key findings of the consultation process

The consultation process found that a broad spectrum of falls prevention related activity exists, ranging from no activity/unsustained activity, to advanced and comprehensive falls prevention programs, with a range of innovative practices.

Exploration of why falls prevention activities were not sustained often identified that the activity relied on either external short term project funding, or a coordinator who, if they leave the organisation, there is no one willing or able to continue the program.

Exploration of the non-existence of falls prevention related activity often identified that the constructs of what constituted a falls prevention program existed, but in isolation, and it was not seen as a coordinated approach to preventing falls.

It was noted within residential aged care facilities that, in many instances, falls prevention activity was coordinated by allied health personnel (particularly physiotherapists).

A number of hospitals and residential aged care facilities with advanced and comprehensive falls prevention programs reported significantly reduced rates of falls in relatively short periods of time.

This indicates that national guidelines need to cater for hospitals and residential aged care facilities at the divergent ranges of falls prevention activity.

Generally the following are needed:

- a more coordinated, collaborative and standardised approach to falls prevention across the continuum of care (greater follow through from assessment to intervention)
- active involvement by medical professionals and consumers
- increased funding/resourcing
- raised awareness of all staff, patients/residents and the general community
- promotion of changes to some practices and exploration of perceived conflicts and potential opportunities with others
- more quality research
- increased awareness and access to resources
- recognition of the role of cognition
- with specific considerations noted for the tertiary education sector, the building design/renovation of hospitals and residential aged care facilities, cultural groups and rural and remote hospitals and residential aged care facilities.

Not all of this is within the scope of the project. However, there is opportunity to refer these to the Taskforce and other key stakeholders.

Barriers to implementation of programs

A range of barriers to implementation were identified within the following categories:

Environmental: associated issues of design and construction (safety *versus* aestheticism).

Organisational: the issue of sustainability (particularly when there are competing priorities) and a lack of funding (for staff, service provision and resources).

Individual: issues such as staff compliance (due to organisational demands, staff turnover and staff shortages) and staff confidence. Barriers also exist in relation to consumers—a lack of consumer demand/responsibility, falls being seen as inevitable and a part of ageing, compliance and impaired cognitive ability.

Future plans

Currently, the project is in a development phase, including the collation of the national falls prevention guidelines (attempting to succinctly identify recommendations for best practice within a quality improvement framework focused towards implementation).

Implementation of the national falls prevention guidelines by States and Territories and hospitals and residential aged care facilities will be facilitated by developing a range of support resources including a video for staff, step by step implementation guide and Indigenous specific resources.

For more information about the project, visit the Queensland Health website: www.health.qld.gov.au/fallsprevention/project/default.asp Enquiries can be directed to Paul Vardon, Tel: 07 3275 6419; E-mail: australianfallsprevention@health.qld.gov.au

Safe Communities Foundation

There are 14 designated Safe Communities in Australia, and many other communities apply the WHO Safe Communities criteria to their safety planning. Such a level of vitality in this area of injury prevention lead a team of representatives from around the country to set up a Safe Communities Foundation.

The new entity will build support for the fast growing Safe Communities program.

For further information contact Henk Harberts, Tel: 03 5173 5634, E-mail: henkha@latrobe.vic.gov.au

Posthumous award for injury researcher

Richard Franklin*

Eric Young
Died 2 August 2003

The National Injury Conference held in Mackay in September 2004 provided the Australian Injury Prevention Network with an opportunity to acknowledge the contribution made by Eric Young to the field of injury prevention. The AIPN posthumously awarded Eric an Extraordinary Award for Sustained Achievement. Eric was nominated for the award by Lesley Day of the Monash University Accident Research Centre.

Eric Young had a diverse professional life devoted to public service. After spending seven years in Government Administration in Papua New Guinea, he returned to Australia and took up a number of roles in health management before being appointed as the Industrial Liaison Officer with the Melbourne Metropolitan Board of Works. In 1985, Eric was seconded to the then Department of Employment and Industrial Relations for a one year assignment, and was subsequently appointed to a substantive role in 1986. Eric remained with the Department's successor organisations, including ultimately the Victorian WorkCover Authority (VWA) in a range of senior and strategic roles, until his death.

In 1998, Eric took on the brief of rural safety within the VWA. This area had become a passion for him and he worked tirelessly to make a difference to the toll of death and injury in the agricultural sector. He brought his substantial people skills and community networks to bear on the issue and was able to effect real change in community attitudes and farm safety practice.

Among his many contributions in this sector, Eric's role in the reduction of tractor roll-over related deaths in Victoria is particularly noteworthy. In 1997/98, the VWA and the Victorian Farmers Federation (VFF) implemented a tractor roll-over protection rebate program, prior to the introduction of new regulations which requires roll-over protection on virtually all tractors. Although many people contributed to the development of this program, it would not have happened without Eric's stewardship. His significant communication skills nurtured an excellent working relationship between the VWA and the VFF to the point where there was acceptance of the need for a change in regulation. During this period, Eric had to keep the commitment to the rebate program and regulatory change alive in the VWA. In the evaluation of the rebate program conducted by Monash University, it was estimated that about 2 lives per year would be saved for at least 10 years as a direct result of the 12,129 tractors



which were retrofitted during the program. The trends since the end of the program have confirmed this estimate. Inspired by the Victorian experience, other States in Australia are now implementing similar programs, and the Victorian model has also drawn attention from the United States, where tractor roll-over deaths remain a significant issue in the agricultural sector. Eric always made himself available to other jurisdictions interested in the Victorian program, including visiting the US and making presentations at key institutions.

Eric had a broad view of safety and made contributions beyond the traditional bounds of workplace safety in which he was employed. In the mid 1990s, Victoria developed an injury prevention strategy. The process of development drew together many government departments and authorities, as well as other organisations. This developed a spirit of cooperation between the different key stakeholders across the whole

field of safety. Eric was prominent in this cooperative effort.

Eric also played a role in developing Community Safety Week, which has now developed into Community Safety Month. He was an active participant in SafeComm 5, the World Health Organisation's Fifth International Conference on Safe Communities, held in Victoria in 1996. Eric held initiate community safety programs in the workplace, providing support and encouragement to programs in Hume and Latrobe cities.

Eric was a courageous and tenacious contributor who was always optimistic about what could be achieved and unfailing in his commitment to make a difference. The Award was made in recognition of his important contributions to injury prevention at local, State, national and international levels. Eric's unrivalled communication and networking skills, and his natural collaborative style provided unique opportunities to bring together key players in agricultural safety. He willingly gave support and guidance to many colleagues, and had great respect for people's abilities. His contributions extended well beyond his role in the VWA, extending to injury prevention activities outside the workplace and a contribution to the development of the injury prevention field.

** The author acknowledges that the material for this article was partly drawn from documents and letters written by Greg Tweedly, CEO, VWA, and Michael Bourne, Chairperson, Victorian Safe Communities Network.*

ICECI in the real world

Considerable time and effort has gone into the development of the International Classification of External Causes of Injury which has now been accepted into the fold of the WHO's family of classifications or a Related Classification. Has this effort been worthwhile? The final verdict must rest with end users. Several presentations at the 7th World Conference on Injury Prevention and Safety Promotion held in Vienna in June 2004 reported on projects in which the ICECI had been used. Those presentations are described here. James Harrison of RCIS, who is a member of the ICECI development consortium offers some comments.

Switzerland

Two researchers from the Swiss Council for Accident Prevention set out to apply ICECI Version 1.0 to 2,034 Swiss death certificates issued in 1998 which had previously been classified by the Federal Office of Statistics as unintentional injuries falling within the range ICD-10 V01–X59.

Anonymous copies of the official death certificates were coded twice according to a question that contained the first level codes of the ICECI data elements (intent, mechanism, object/substance producing injury, activity when injured, etc).

The results of the study were that inter-rater reliability was very good. The amount of available information was good for intent and the mechanism of injury. The object/substance producing injury could be coded in 55% of the cases. Of these, almost half were land vehicles. In general, the information on motor vehicle crashes was much better than the information on other unintentional injuries.

The researchers concluded that the coding of death certificates according to ICECI is easily possible for motor vehicle crashes. For other unintentional injuries, the available information is usually incomplete or sparse, limiting application of the ICECI. Better information on external causes of fatal injury would enable more complete application of the ICECI, and would be helpful for the improvement of prevention.

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Nicaragua and el Salvador

Since 2001, the Centers for Disease Control and the Pan American Health Organization have been collaborating with health officials in Nicaragua and el Salvador to introduce hospital-based injury surveillance systems in those countries.

An injury surveillance system based on the ICECI was piloted in the emergency departments of two hospitals in Nicaragua and three hospitals in el Salvador. Demographic, clinical and injury-related information was collected for each injured patient presenting to the ED. Injured patients were defined as any person presenting with a first time injury, intentional or unintentional. Persons presenting with pain only, or with psychological injuries, were excluded.

Between 1 August 2001 and 31 July 2002, the surveillance systems detected 27,482 injuries in two hospitals from Nicaragua (population 5 million). In the six month period between 16 May 2002 and 15 November 2002, the system detected 9,011 injuries in three hospitals from el Salvador (population 6.3 million). 5,456 (20%) and 1,197 (13%) injuries were found to be intentional in Nicaragua and el Salvador respectively. The surveillance system allowed for the detection and analysis of injuries in the cities where the hospitals are based. It also allowed for the detection of often unrecognised problems such as suicide attempts—a growing problem among some sectors of the population, especially adolescents and young adults. The system was well accepted by hospital staff. Data were collected on a daily basis and were analysed weekly/monthly producing timely information. However, data management tools were not well standardised. The standardised methodology used allowed comparisons between countries and within the same country. Because hospital-based injury surveillance systems are passive, some types of injuries, such as violence against women might have been underestimated.

Based on the piloting experience, hospital-based injury surveillance systems can successfully be implemented as a sentinel surveillance approach. Limitations of the surveillance system should be addressed, such as the use of

standardised surveillance tools, analytical packages, etc. Ministries of Health from Nicaragua and el Salvador are benefiting from the data generated by the surveillance system as it enables them to identify areas for public health intervention.

Enquiries: Carmen Clavel-Arcas, Centers for Disease Control, E-mail: CClavelArcas@cdc.gov

Colombia

The objective was to test the ICECI in two hospitals in Cali, Colombia. The test was part of a multi-centre initiative in Latin America. Two emergency departments (EDs) with a high patient flow of external causes of injury were selected. ED doctors were trained to pilot the ICECI. The data collection form used was an adaptation of a questionnaire previously tested in Nicaragua and el Salvador. The form was adapted to local needs and coded with categories proposed by the ICECI. Over a 4 month period (18 weeks), information was collected for all of the cases that presented to the emergency departments. A quality control process was put in place at each site, records were kept of reported errors and followed up through a process of correction which was also recorded. Double entry data was performed using EpiInfo 2000. Univariate and bivariate analyses were done using SPSS 9.0.

The results of the analyses showed that there was a higher proportion of male cases (71%). 63% of the cases were unintentional, 33% were intentional injuries. Among the latter category, interpersonal violence accounted for 31% and suicide for 2%. A comparison of intentionality between men and women showed significant differences with respect to both intentional and unintentional injuries at $p < 0.001$. Injuries take place principally at home and on the streets, with significant differences in frequency between men and women. 1,254 traffic injuries were recorded, motorcycle cyclists being the largest group (33%), followed by pedestrians (25%) and cyclists (24%).

During the first week of the study, 44% of the data collection forms contained errors. This proportion decreased progressively to a level of 9% in the last week.

Continued on page 15

ICECI in the real world

Continued from page 14

From this experience, the study team concluded that ICECI is a useful and novel tool for characterising injuries. It represents a conceptual advance over existing classification schemes in that it keeps in mind the complexity and multidimensional aspects of injuries. Beginning with the information gathered using this tool, public health policies for the control and prevention of injuries of external causes can be generated.

For the operation of the ICECI classification, its theoretical advantages must be considered against any associated operational difficulties. In this way, a balance can be struck between the necessity for information and the complexity of the instruments used to collect it. Therefore, the structure and the number of categories used by the ICECI classification should be simplified, so that its operation as the central tool of the injury surveillance system be practical, acceptable, and sustainable in countries with few resources, such as those from Latin America and the Caribbean.

In an investigative context, the ICECI Classification provides a useful reference framework for international comparisons of injury epidemiology.

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Singapore

A surveillance system for unintentional childhood injuries was established in Singapore based on WHO/CDC guidelines for datasets and the use of the ICECI data classification system.

The study consisted of a cross-sectional descriptive survey run over a two-year period (February 2002 to January 2004). The subjects were all children aged 0 to 16 years who sought medical attention for, or died from, unintentional injuries or poisoning, at the Emergency Departments of three hospitals, two primary care polyclinics and the Forensic Medicine Department of the Health Sciences authority. The following information was collected for each patient: demographic

data; circumstances of injury; host factors, environmental factors (including safety features and devices, protective equipment); injury particulars such as the type and severity of injury, treatment clinical outcome, disposition, duration of hospitalisation, cost of treatment and hospitalisation. Data were collected through the use of questionnaires for outpatients. Inpatient records and coroners' reports were reviewed. Data collection was incorporated as part of the normal ED or polyclinic consultation and work routine.

A data dictionary was compiled using CDC/WHO guidelines. Data were entered into the computer database, which was custom designed on an Oracle SQL platform.

ICD-9 codes were used for all injuries sustained. E-codes were used for external causes and place of occurrence and ICECI Version 1 was used to code the details of circumstances of injury. The injury severity measures used included the Pediatric Trauma Score (PTS), Abbreviated Injury Score (AIS) and Injury Severity Score (ISS). The computer database has the capacity to produce detailed morbidity and mortality data on childhood unintentional injuries with a search function which allows analysis of specific categories of injury. A full-time research nurse was employed, with the investigators serving as coordinators in their respective centers.

A total of 9,975 cases were reported during the first year from 2 February to 3 January. The average age of the cohort was 56.1 years. The male to female ratio was 1.7:1. The racial distribution was comparable to the national population census. The most common activity during the time of injury was recreation and leisure, comprising 45% of the reported cases. The most common mechanism of injury was a fall, comprising 52% of the cases. The objects or substances most frequently producing injury were the injured child itself or another person (21%). Household furniture was responsible for another 20% of the cases. The most common place of injury was the home (62%). There were 210 cases of road traffic injuries. 68% of the patients managed in

the polyclinics were discharged. Among the cases managed at emergency departments, 37% were discharged, 48% required specialist outpatient review and 9% required hospitalisation (10 cases to intensive care). 5 patients died on arrival. 69% of the patients had an ISS score of 1, 18 cases (0.2%) had an ISS score > 22. 91% had a PTS score > 10, while 76 cases (0.8%) had a PTS score < 8.

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Comments from James Harrison, ICECI Development Team

The first fairly mature edition of the ICECI was version 1.0, which was released in March 2001. The 7th World Conference on Injury Prevention and Safety Promotion, held in June 2004, was the first of this series of international conferences at which one might expect to see reports based on use of the ICECI. (Note that version 1.2, published in July 2004, is the first version following adoption of the ICECI as a *Related Classification* in the *WHO Family of International Classifications*. Version 1.2 has been improved in comparison to version 1.0 in several ways, including provision of an index.)

The four projects reported here exemplify some of the factors that prompted development of the ICECI. They also point to unmet needs, and to constraints on the implementation of systems like the ICECI.

Salvisberg and Ewert present what is, to my knowledge, the first application of the ICECI to code injury deaths based on death certificate data. They found that the ICECI worked well – when sufficient information was available in the source records. Sufficient information tended to be available for deaths resulting from motor vehicle crashes, but was less likely to be available for other unintentional injury deaths.

The coding system of the National

Continued on page 16

ICECI in the real world

Continued from page 15

Coroners Information System (NCIS) in Australia incorporates much of an early (1998) draft version of the ICECI. The case information recorded by coroners tends to provide codable information on most injury deaths. We compared information from the NCIS with information from the Australian Bureau of Statistics' (ABS) routine deaths data collection, coded according to ICD-10 external cause codes.⁵ The more detailed information from the NCIS was useful for injury surveillance purposes.

Salvisberg's findings, along with the experience of the NCIS, suggest that the ICECI can be used to code injury deaths in a way that is useful for injury surveillance, provided the information available to coders is sufficient. This is more likely to be so where coders have access to sources such as the records of death investigations than where access is limited to the brief information usually recorded on death certificates.

The projects reported by Clavel-Arcas and Fandiño-Losada are examples of types of use of the ICECI that the development group particularly hoped would occur. Central America is one of several regions of the world that exemplify the paradox that injury surveillance information tends to be least available where it is needed the most. These authors report projects that have begun to fill the gap.

Commencement of injury surveillance in a setting in which little or no infrastructure is in place presents special challenges, and also opportunities. A key challenge is to find, or develop, a surveillance system that is feasible in the setting and will provide useful information. Developing each new system from scratch is inefficient, and has the disadvantage that information from one system is unlikely to be comparable with information from other sources. The ICECI was designed to ease the process, and to be a force for standardisation, by providing an 'off-the-shelf' system to classify external causes of injury, designed specifically for injury surveillance and related purposes. As both Clavel-Arcas and Fandiño-

Losada point out, this is useful but only part of what is needed for effective injury surveillance in settings with limited resources.

Clavel-Arcas points, in particular, to a need for standardised data management and analysis tools, to complement standardised classifications. Fandiño-Losada observed that the study team in Cali concluded that the ICECI was a useful tool for characterising and standardising the recording of injuries, but they saw a need for simplification.

Clavel-Arcas' comments can be generalised to make the point that a classification system is only one component of a surveillance system. The WHO Injury Surveillance Guidelines (whqlibdoc.who.int/hq/2001/WHO_NMh_VIP_01.02.pdf) provide other components, but there are not yet freely available standardised data management tools tailored to serve the purposes of injury surveillance.

Fandiño-Losada's call for simplification reflects a tension that was recognised throughout the development of the ICECI. Classification systems with few items and few categories have the appeal of simplicity. However, very broad categories tend to be less useful than more specific categories, and the particular categories of greatest importance are not the same in all settings. The approach taken in ICECI was to develop a full system that is quite large in terms of numbers of items and categories, but to design it to be modular and hierarchical. This enables smaller subsets to be derived from the full system to suit the needs and resources of various users, while retaining comparability at the level of broad categories. While some subsets have been developed (one developed by the CDC is particularly well-documented—see www.cdc.gov/ncipc/pub-res/icecibk.pdf), there is a need to take this process further, learning from practical experience of projects like this one.

Tan and colleagues report a thorough cross-sectional study of child injury in Singapore, in which ICECI was used to classify one aspect of a data set which

also included demographic characteristics, trauma diagnoses, severity scores and administrative data, including costs. This project is towards the sophisticated end of the spectrum of injury surveillance models. The collection of extensive case information, and the employment of a full-time research nurse for the project, imply that costs were fairly high. Interestingly, external causes were coded according to ICECI and to the ICD-9 external causes chapter. An assessment of the relative strengths and weaknesses of the two classification systems in the context of this project would be of considerable interest.

These projects demonstrate that the ICECI has begun to be applied in a wide range of settings and for a variety of purposes. Where source data were adequate, the classification system seems to have been found to be workable and useful. There is more to surveillance than classification, and there may be an unmet need for a data management and analysis tool, in which ICECI is embedded. Translation of the ICECI into at least the most commonly used languages other than English is also necessary. (Translations into Spanish and French are in progress.)

The ICECI is an international collaborative project. Its further development depends on feedback from users and on their active participation in future revisions. I, and the other members of the ICECI Coordination and Maintenance Group, warmly welcome feedback, advice and assistance. We look forward with interest to presentations of work using the ICECI at the next World Conference on Injury Prevention and Safety Promotion, in South Africa in April 2006.

James Harrison

Co-ordinator of updates and revisions, ICECI Coordination and Maintenance Group, www.iceci.org
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From the Coroner

Victorian research reports

The Victorian Department of Human Services, in a joint initiative with the State Coroner's Office, engaged an Injury Prevention Research Officer in October 2001 for a period of three years. The purpose of the position was to conduct detailed analyses of coronial files across a range of topic areas on unintentional death in Victoria. Some of the following reports are now available on the Internet. The remaining ones will be added soon to the State Coroner's website: www.coronerscourt.vic.gov.au Follow the link to 'research'. Enquiries about the availability of the reports can be directed to Lyndal Bugeja, Tel 03 9567 0024, E-mail: lbugeja@rlssav.org.au

- Commercial vessel fatalities—www.marinesafety.vic.gov.au Follow link to 'publications'
- Recreational vessel fatalities—www.marinesafety.vic.gov.au Follow link to 'publications'
- Drowning deaths at public swimming pools: www.vic.royallifesaving.com.au/uploads/res/4_2220.pdf
- Drowning of children aged 0-5 years in bathtubs: vic.royallifesaving.com.au/uploads/res/4_4131.pdf
- Drowning of children aged 0-5 years in private swimming pools and spas: www.vic.royallifesaving.com.au Follow link to 'Research' and then to 'New drowning research'.
- Farm related fatalities
- Fatal falls in children
- Fires, burns and scalds
- Poisoning in children
- Unintentional drowning: toddlers in dams: www.health.vic.gov.au/injury/publications

A case of drowning in a dam prompts Coroner's comments and recommendations:

During 2004, the Victorian Coroner, Graeme Johnstone, concluded his investigation into the death of a toddler who had drowned in a dam.

The Coroner observed that drowning

has long been established as a significant risk factor to young children. According to the National Injury Surveillance Unit (NISU), drowning is the second leading cause of unintentional injury deaths of 0-4 year old children in Australia. A number of research findings have reported that drowning is the leading cause of death of children living on farms, and the most common location of these drownings is dams.

This issue was the subject of a research project conducted by the State Coroner's Office and Department of Human Services. Twenty-seven deaths were identified in Victoria during the period 1989–2001. Sadly, this boy's death is the 28th such death in Victoria, and is remarkably similar in circumstance to the deaths of these other children. In particular:

- 74% of the children were male;
- 74% were aged between one and three years of age;
- In 89% of cases, the dam was located between 15 and 300 metres from the house;
- With the exception of one, all children were playing outside the house with their carer's knowledge and permission;
- In 63% of the cases, there was a barrier between the house and dam, however, it was easily negotiated by the child;
- There were no cases where the child was under constant visual eye contact by their carer immediately prior to the incident.

Coroner's recommendations

Based on these and other findings, a number of recommendations were formulated from the findings of this study. These were:

- Future public awareness campaigns by water safety organisations should be broadened to include safety messages that account for the differences between rural and urban water hazards, in particular the use of the "be dam careful" slogan should be reconsidered by the Victorian farming

industry;

- Any public awareness campaign should address carers' consciousness of how quickly toddlers can get into danger, especially those most at risk, in the one to three year age bracket;
- The idea of creating "child safe areas" on properties containing dams should be widely publicly promoted; and the feasibility of conducting Home Safety Parties in rural towns such as Ballarat, Bendigo, Echuca, Warrigal, Geelong and Horsham should be undertaken by the Victorian Farmer's Federation in conjunction with the Royal Children's Hospital Safety Centre, the Country Women's Association and Kidsafe to determine whether they would be a successful forum for education carers and disseminating information on appropriate safety measures for children.

The Victorian Department of Human Services has recently funded the FarmSafe Alliance to implement the recommendations related to assisting to raise awareness of the dangers dams pose to young children and to assist with the promotion of "child safe play areas" on properties containing dams.

In addition, the Rural and Regional Services and Development Committee (a Joint Investigatory Committee of the Parliament of Victoria) is conducting an inquiry into the main causes of death and injury on Victorian farms. The issue of drowning of young children in dams is part of this inquiry, which is due to report to Parliament by the end of 2004.

Life Saving Victoria (formerly the Royal Life Saving Society) is seeking funding to manage an advertising campaign structured around the rural and regional version of their toddler drowning awareness program "Keep Watch". This would build on the links with FarmSafe Australia and Farm Safety Alliance Victoria and consist of materials to assist in the promotion of "Keep Watch" across Victoria.



SAFETY 2006
SOUTH AFRICA

The 8th World Conference on Injury Prevention and Safety Promotion will be held in Durban, South Africa from the 2-5 April 2006.

A conference announcement and call for papers was scheduled for distribution in November 2004.

The deadline for abstracts and scholarships is July 2005.

We'll keep you informed, through the *Monitor*, about future developments with the Conference.

Conference website: www.safety2006.info

Workshop on spinal cord injury registers

The Flinders Centre for Epidemiology and Biostatistics (FCEB) held a workshop on the national Spinal Cord Injury Register in November 2004. Invited guests heard presentations by keynote speakers Michael DeVivo, Professor and Director of the National Spinal Cord Injury Statistical Center (NSCISC) in the USA, and Paul Jelfs, Head of the Epidemiology Branch of the SA Department of Health, as well as a number of speakers, address two questions: What makes a good register?; and How can a good register be used for research? Attendance at the workshop, which was held in conjunction with the 2004 Australian and New Zealand Spinal Cord Society Conference, was by invitation.

Copies of all presentations made at the workshop are available at the FCEB website: <http://som.flinders.edu.au/fceb>

The latest published statistics from the Australian Spinal Cord Injury Register can be accessed at: www.nisu.flinders.edu.au/pubs/reports/2003/injcat58.php

Mango Misery

Continued from page 10

- Everything that may have been contaminated with sap, including clothes, shoes, equipment and pets, needs to be washed.
- Gloves, clothing, boots, etc. which have been contaminated with sap may continue to damage the skin days, weeks or months later.
- Nothing replaces good skin care and personal hygiene.
- Mango sap injuries to the face and genital areas should be avoided by washing hands with soap and water before rubbing eyes or going to the toilet, even if the worker has been wearing gloves.

For further information, contact Anne Sutherland at the Burdekin Centre for Rural Health, Tel: 07 4783 2711, E-mail: annes@bcrh.org

National Injury Prevention Plan Update

The *Draft National Injury Prevention and Safety Promotion Plan: 2004 Onwards* was released for public consultation in August 2004 with submissions closing in September 2004. Thirty seven submissions were received and summarised into an issues paper which was discussed at a national workshop in Canberra on 5 November 2004. A broad range of stakeholders (including government and non-government representatives from both within and outside the health sector) attended the national workshop.

A number of suggestions put forward at the workshop have been incorporated into the Plan, which has been finalised. The Plan was submitted to the National Public Health Partnership for endorsement in January 2005, before going to the Australian Health Ministers Advisory Council, and the Australian Health Ministers Conference. It is anticipated that the plan, now known as *The National Injury Prevention and Safety Promotion Plan: 2004-2014*, will be publicly released in July 2005.

Communique

14 September 2004

The 13th Meeting of the Strategic Injury Prevention Partnership was held in Mackay on 14 September 2004. Members attending the meeting were Rod McClure (Co-Chair), James Harrison (AIHW), Rae Scott (Australian Government, Department of Health and Ageing), Rebecca Mitchell (NSW), Michael Tilse (QLD), Nicola Rabot (VIC), Nicole Bennett (WA), Stan Bordeaux (TAS), Steven Skov (NT), Ron Somers (SA), John Wunsch (Consumer Safety Unit, Treasury, Australian Government), and Richard Franklin (AIPN). Also in attendance was Annamaree Reisch (SIPP Secretariat) and Rex Milligan (WA) as an observer.

Apologies were received from Jackie Steele (Co-Chair), Maureen O'Brien (ACT), and Sandy Brinsdon (NZ).

Evaluation of the National Injury Prevention Plan

The Evaluation Report on the National Injury Prevention Plan 2001-2003 was released under embargo to SIPP members. There was general consensus that the Evaluation Report is a valuable tool that will be fully utilised in the development of the National Injury Prevention Plan 2004 onwards. SIPP has endorsed the distribution of the Report and is seeking approval to publicly release the report.

Development of the National Injury Prevention Plan: 2004 Onwards

The first draft of the National Injury Prevention Plan: 2004 Onwards (the Plan) was released for public consultation in August, with submissions closing at the end of September. Distribution and avenues for feedback are through SIPP members, the NPHP website, and direct e-mail of stakeholders. Copies were also provided to all persons attending the Australian Injury Prevention Conference from 15-17 September 2004. A contractor will analyse submissions received through the public consultation process and produce an issues paper that reflects issues raised. A National Symposium with representatives from all jurisdictions and peak organisations will be held in Canberra on 5th November to discuss the issues paper and further development of the Plan. The third and final draft will be discussed by SIPP members at the meeting to be held 25-26 November in Sydney.

ATSIIPAC Update

The first draft of the National Aboriginal and Torres Strait Islander Safety Promotion Strategy (the Strategy) was released for public consultation in August, with submissions closing at the end of September. Distribution and avenues for feedback are through SIPP and ATSIIPAC members, the NPHP website, and direct e-mail of stakeholders. Copies were also provided to

all persons attending the Australian Injury Prevention Conference from 15-17 September 2004. A workshop is being held in Canberra on 18-19 October to discuss further development of the Strategy.

Standards/Legislative Clearing House Project

A special account is being established to enable the Standards/Legislative Clearing House Project to commence. A SIPP subcommittee has been formed to oversee the project. Three newsletters will be produced, with topics to include an Update on child restraints and Pharmaceutical Packaging.

ICD-10 AM

James Harrison informed SIPP members that a workshop on changes to ICD-10-AM will be held at the Australian Injury Prevention Conference. Changes are to be finalised over the next few months to fit in to the revision cycle of ICD-10-AM.

Updates from jurisdictions

Members provided updates on their recent work.

New South Wales

- Boundary changes to NSW Health's 17 Area Health Services (AHS) with 8 new AHS boundaries established.
- NSW Health Minister launched NSW management policy to reduce fall injury among older people on 3 July 2004, with a funding package of \$8.5 million over four years.
- Coordinator's position for the implementation of the *NSW Aboriginal Safety Promotion Strategy* has been moved to the new Collaborative Centre for Aboriginal Health Promotion (CCAHP). A forum for Aboriginal health workers in NSW regarding injury prevention and safety will be held by CCAHP on 24 September 2004.
- NSW Water Safety Taskforce functions and NSW Water Safety Framework 2001-03 have been reviewed. It is likely the Taskforce will become the NSW Water Safety Council, have an Advisory Committee and subcommittees attached, and seek an independent Chair. A new NSW water safety plan is being developed. It is likely a review of the *Swimming Pool Fencing Act 1992* (NSW) will be undertaken by the Department of Local Government early in 2005, following the release of the revised Australian Standard for Swimming Pool Fencing. NSW Water Safety Week is being held during 19-25 September 2004.
- NSW Injury Risk Management Research Centre (IRMRC) has updated its internet site (www.irmrc.unsw.edu.au), and includes information on research projects being undertaken

Continued on page 20



STRATEGIC INJURY
PREVENTION PARTNERSHIP

Communique

14 September 2004

by the IRMRC, profiles of staff, and reports completed by the Centre. IRMRC is currently producing an updated Injury Profile for NSW which should be available in late October 2004.

- 4th Annual Safe Communities Symposium: Planning Safe and Strong Communities held 28-29 July 2004, with over 200 delegates attending. A statewide capacity building program for new and emerging Safe Communities has been developed and includes a two day training package, a model for a one day community planning forum, and a 'starter' brochure for new and interested Safe Community partners. Local councils expressing an interest in the Safe Communities model include: Great Lakes, Coffs Harbour, North Sydney, Goulburn, Blacktown, Sydney, Leichhardt, Eurobedalla, Sutherland, Shoalhaven, Wollongong and Queanbeyan.

Victoria

- Safe Start Program has been completed (18 months). The evaluation shows a need for the program to be run over 3 years, but good results have been identified after the first 18 months.
- Injury Prevention has targeted a number of areas to raise awareness, including booklets in 4 CALD community languages, injury in corporate plans for local governments through fostered partnerships, built a safe kitchen for use by disadvantaged groups and people with a disability through community and local government partnerships.
- Part one of the research project on poisoning is complete and the results will be available to this group. The focus is on qualitative rather than epidemiological factors and the messages are aimed at the community and parents through education and awareness raising opportunities. Part two is due for completion in 12 months.
- Victorian Safe Communities Conference aimed at practitioners will be held in mid November.

Queensland

- Looking at putting together a proposal for a business case to increase investment in falls prevention activities. This represents a significant commitment by Queensland Health to this priority issue.
- Implementation Plan for the Falls Strategy is being developed as falls in the elderly is a major issue in Queensland.
- Mackay is Queensland's first safe community.

South Australia

- Changes to legislation requiring dogs to be restrained when walked on footpaths.
- Progress on pharmaceutical project, with 3 panel tests completed. Packaging used in Australia doesn't comply with

British standards and is currently very easy for children to access.

- Mandatory "size-based" child restraints are being promoted by an SA Minister for adoption as a national standard.
- High level committee being established to provide advice on suicide prevention.

Western Australia

- Seniors Falls prevention is progressing and was identified as the 3rd recommendation on the health reform agenda for WA, specifically calling for a targeted health promotion program.
- Injury Prevention Branch is taking a greater role in seniors falls prevention and health promotion, and has attracted some resources (non-recurrent) for a social marketing strategy for *Stay On Your Feet WA* to be run in 2004/2005.
- Policy developed around water safety, the *Western Australian Water Safety Framework 2004-2007* is about to be launched.

Northern Territory

- Increase in focus on Injury Prevention in NT Health.
- Epidemiology Unit is reporting on suicide, morbidity and mortality data with the Injury Prevention Unit

Tasmania

- Child Injury Coalition is being funded and will support a couple of initiatives.
- A fire safety project targeting parents of young children in disadvantaged areas.
- Information on injury included in the Child Health Book/Record has been updated.
- The Falls Audit is progressing.
- Falls risk assessment clinics are to be provided across the State.

Commonwealth Department of Health and Ageing

- Department of Health and Ageing in Caretaker mode due to Federal election on 9 October 2004.
- Injury Prevention Team is now part of the 'Targeted Prevention Programs' Branch within Population Health Division.

Commonwealth Department of Treasury

- Treasury is in Caretaker mode due to Federal election on 9 October 2004.
- New tobacco regulations came into effect as of 1st September 2004. These regulations include a significant increase of

Continued on page 21



STRATEGIC INJURY
PREVENTION PARTNERSHIP

Communique

14 September 2004

health risk advice on cigarette packages. The new information also covers cigars and nasal snuff.

- A baby bath aids awareness campaign is being progressed with posters and information brochures. NSW has introduced legislation requiring specified warnings on these products. WA and QLD are moving towards similar legislation. The Treasury is also preparing a regulation impact statement on proposed mandatory warnings on baby bath aids under the Trade Practices Act.
- A vehicle jack risk awareness campaign is being developed in conjunction with the Department of Health and Ageing.

Australian Injury Prevention Network

- 196 registrations received for the Australian Injury Prevention Conference to be held in Mackay 15-17 September 2004.
- AIPN website has been updated to be more user friendly and accessible.

- Next AIPN Conference in Sydney in 2006 and NZ Injury Prevention Conference in Wellington in 2005.
- Richard Franklin will be retiring as AIPN President and therefore SIPP member at the end of 2004.

National Injury Surveillance Unit

- Recent reports are available on Mortality, Aboriginal Mortality, and Spinal Cord Injury.
- National Coronial Information System (NCIS) is moving from the Monash University to the Victorian Institute for Forensic Medicine, with an increase in funding and staff security.

Future Meetings

The next face to face meeting is to be held in Sydney on 25-26 November 2004.

New on the RCIS Website

- Cripps R, Spinal cord injury, Australia 2002-03
- Kreisfeld R, Newson R, Harrison J, Injury deaths, Australia 2002
- Helps Y, Harrison J. Reported injury mortality of Aboriginal and Torres Strait Islander people in Australia, 1997-2000
- Bradley C and Harrison J. Descriptive epidemiology of traumatic fractures in Australia

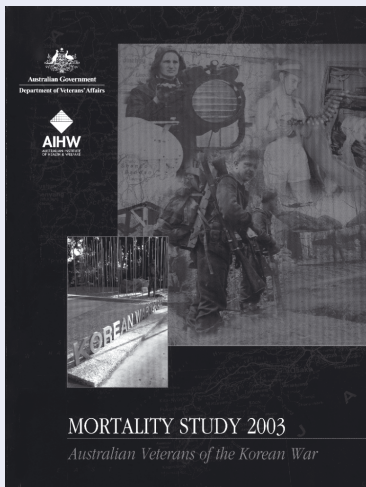
www.nisu.flinders.edu.au

New RCIS Phone Numbers

We've changed our phone number, and have acquired direct lines for all of our staff. Our fax number remains the same (08 8374 0702)

<i>Reception</i>	+61 8 8201 7602
<i>Stacey Avefua</i>	08 8201 7620
<i>Jesia Berry</i>	08 8201 7626
<i>Clare Bradley</i>	08 8201 7625
<i>Raymond Cripps</i>	08 8201 7627
<i>Yvonne Helps</i>	08 8201 7623
<i>Geoff Henley</i>	08 8201 7621
<i>Lachlan Johnson</i>	08 8201 7629
<i>Renate Kreisfeld</i>	08 8201 7624
<i>Steve Trickey</i>	08 8201 7628
<i>James Harrison</i>	08 8201 7602

Mortality among Australian Veterans of the Korean War



The Department of Veteran's Affairs, in conjunction with the AIHW, recently released a new report of mortality among Korean War Veterans. It covers deaths that occurred during the period 27 June 1950 to 31 December 2000 following completion of Korean service.

The findings of the report show that Korean veterans had elevated mortality rates for a number of conditions: diseases of the circulatory system (13%), ischaemic heart disease (10%) and stroke (17%); cancer (31%); respiratory diseases (32%); digestive diseases (35%).

The death rate from all external causes (homicides, accidents and suicides) was elevated by 37%. The study investigated two specific injury issues: suicide and motor vehicle accidents. The former was significantly elevated, whereas deaths for motor vehicle accidents are the same as for the Australian community.

Suicide

There are 211 Korean War veterans who are recorded as having committed suicide. This resulted in a statistically significant 31% increase in suicide. Further analysis reveals that the risk of increased suicide is confined to the Army Korean War veterans. Neither Navy nor Air Force veterans have an increased risk. A *post hoc* analysis showed there is no indication of a correlation between the number of days served in Korea and the risk of suicide among Army veterans. When the Army deaths were further analysed by period of service in Korea, an interesting pattern emerged. Those who served prior to 1952 had a significantly lower mortality from suicide whereas those who served after this time had a significantly elevated suicide rate.

The report is available as a pdf file on the AIHW website: www.aihw.gov.au/publications/index.cfm/title/10044

New manual gets thumbs up from exercise leaders

The *NoFalls Exercise Program* was designed as one of the interventions in a large trial run by the Monash University Accident Research Centre in the local government area of Whitehorse, in Melbourne, Australia. The exercise program was shown to protect balance and significantly reduce the number of falls experienced among community dwelling people aged 70 years and over, and these results were published in the *British Medical Journal* in 2002⁶.

Since then, the *NoFalls Exercise Program Manual* has been produced, with funding from the Commonwealth Department of Health and Ageing, in response to significant interest in this exercise program. *NoFalls* is a 15-week group exercise program of one session a week, focusing on improving balance, flexibility and leg strength. Exercises include stepping, squats against a wall, the use of ankle weights and balance boards, as well as eye exercises to improve processing of visual cues for balance.

The manual is designed for use by qualified exercise professionals, and is not intended to be a self-help manual. It presents detailed descriptions and photographs to clearly explain each of the *NoFalls* exercises. It also gives details of precautions, suggested modifications for special needs and progression to more challenging levels. It includes a week-by-week guide to the timing of exercises, a weekly class program and a home program. The manual has been designed to be used as a convenient flip chart (it comes with its own stand) for easy reference during classes.

Feedback from exercise group leaders who have already used the manual indicates that it is serving a very useful function. Users remark that it is a valuable resource, comprehensive, well set out and easy to understand.

The *NoFalls manual* is available in two formats: The electronic version is available at no charge, and a hard copy version (including stand) can be purchased for \$10 per copy. Orders for either version need to be made through the *NoFalls* website at: www.general.monash.edu.au/muarc/projects/nofalls

For further information contact nofalls.enquire@general.monash.edu.au

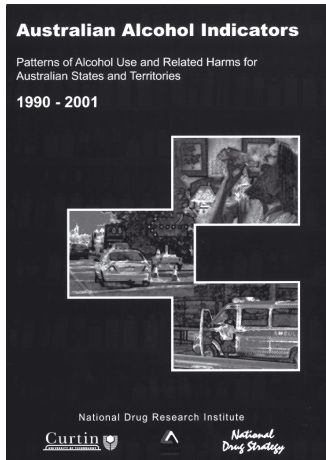
Australian Directory of Injury Control Personnel

Do you work in the field of injury research and prevention? If the answer is yes, you should have your details included in the *Directory of Injury Control Personnel*. The Directory is an on-line, fully searchable, networking tool which puts injury control personnel in easy contact with one another.

To have your details included, contact Stacey Avefua at RCIS, Tel: 8201 7620, E-mail: stacey.avefua@flinders.edu.au

Something to read ...?

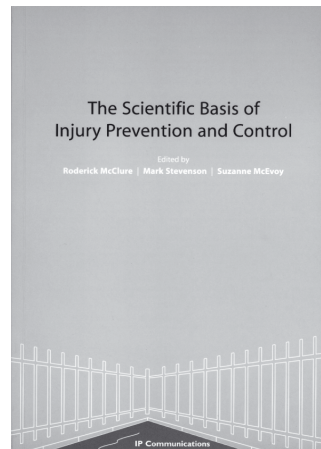
Australian Alcohol Indicators



This National Drug Strategy publication by the National Drug Research Institute describes the patterns of alcohol use and related harms for Australian States and Territories for the period 1990-2001. It uses health, road safety, industry and survey data to report on the following topics: alcohol indicators for Australia; national trends and patterns of alcohol use; national trends in alcohol-caused deaths; national balance of lives lost and lives saved; national trends in alcohol-caused hospitalisations; and State and Territory variations in alcohol use and related harms.

The executive summary for the report can be viewed on the Internet: www.nationaldrugstrategy.gov.au/pdf/naip.htm Printed copies can be ordered by contacting the National Drug Research Institute, Tel: 08 9266 1622 or by visiting their website at: www.ndri.curtin.edu.au/pdfs/naipaifullreport.pdf

The Scientific Basis of Injury Prevention and Control



Edited by Rod McClure, Mark Stevenson and Suzanne McEvoy, this book contains 24 chapters by 38 specialist contributors. The book begins with an

historical perspective on injury and goes on to focus on measurement and classification, the tools for visualising the nature and extent of injury. Epidemiological, biomechanical and ergonomic approaches to risk factor identification are discussed, as is the way in which interventions and countermeasures are developed, implemented and evaluated. Epidemiological, biomechanical and behavioural science approaches are covered, and acute care management and rehabilitation of injury are outlined. The science of implementation is the focus of the book's final section which focuses on policy development, law and regulation, advocacy, social marketing, behaviour change programs, community-based programs, program evaluation, and economic evaluation.

The book retails for \$75.00 plus \$7.50 to cover packing and postage within Australia. It is available from IP Communications, Level 1, 123 Camberwell Road, East Hawthorn VIC 3123, Tel 03 98 11 6818, E-mail: ipcomm@bigpond.com

Diary

Note: where available, Internet addresses have been provided below for conference websites. For those meetings that don't have their own website, more detailed descriptions of the events are normally available at our website: www.nisu.flinders.edu.au/events/

AFR 7th Annual Health Congress

22-24 February 2005

Sydney

Contact: IBC Conferences, Tel: +61 2 9080 4307, Fax: +61 2 9290 3844, E-mail: enquiries@informa.com.au

Website: www.informa.com.au/health2005

Bold perspectives, Shared Objectives Conference

21 March 2005

Auckland, New Zealand

Contact: Bold Perspectives Conference Secretariat, Tel: +64 4 918 4204, E-mail: hayley@boldperspectives.co.nz Website: www.acc.co.nz

Safety in Action 2005

21-23 March 2005

Melbourne

Contact: Conference Coordinator, Tel: +61 3 9654 7773, E-Mail: safety@aec.net.au Website: www.safetyinaction.net.au

9th National Centre for Classification in Health Conference

16-18 March 2005

Perth

Contact: Tina Stanhope, National Centre for Classification in Health, Tel: +61 2 9351 9648, Fax: +61 2 9351 9603, E-mail: t.stanhope@fhs.usyd.edu.au Website: www.fhs.usyd.edu.au/ncch

Marine Safety 2005

12-13 April 2005

Hobart, Tasmania

Contact: Marlene Glenister, Tel: 02 9247 2124, Fax: 02 9247 5203

Best Practice Risk Assessment in Consumer Safety

21-22 April 2005

Edinburgh, Scotland

Contact: Joke Broekhuizen, Tel: +31 20 511 4513, Fax: +31 20 511 4510, E-mail: secretariat@ecosa.org Website: www.ecosa.org/csi/ecosa2003.nsf/news

14th International Conference on Safe Communities

13-15 June 2005

Bergen, Norway

Contact: Camilla Indreane, Tel: +47 55 17 16 86, Fax: +47 55 17 29 00, E-mail: camilla@safebergen.com Website: www.safebergen.com

1st World Congress on Sports Injury Prevention

23-25 June

Oslo, Norway

Contact: Oslo Sports Trauma Research Center,
Tel: +47 23 26 20 00, E-mail: ostrc@nih.no
Website: www.ostrc.no/congress2005/

International Conference on Engaging Communities

14–17 August 2005
Brisbane

Contact: OzAccom Conference Services, Tel:
+61 7 3854 1611, Fax: +61 7 3854 1507, E-
mail: info@engagingcommunities2005.org
Website: www.engagingcommunities2005.org

International Association for Suicide Prevention: XXIII Congress

12–16 September 2005
Durban, South Africa

Contact: International Association for Suicide
Prevention, Tel: +27 31 260 1607/1584, Fax:
+27 31 260 1606,
E-mail: IASP2005@ukzn.ac.za Website:
www.med.uio.no/iasp

XVIth World Congress on Safety and Health at Work

18–22 September 2005
Orlando, Florida, USA

Contact, Congress Secretariat, Tel +1 630 285
1121, Fax: +1 630 285 1315, E-mail:
customerservice@nsc.org

11th European Burns Association Conference

21–24 September 2005
Estoril, Portugal

Deadline for abstracts: March/April 2005
Contact: Maria Angelic de Almeida, Tel: +351
21 884 12 01, E-mail: dircp@hsjose.min-saude.pt Website: www.eba2005-portugal.com

2005 IRCOBI Conference on the Biomechanics of Impact

21–23 September 2005
Prague, Czech Republic

Contact: Antoinette Charpenne, Tel: +33 4 72
14 24 20, Fax: +33 4 72 14 26 66, E-mail:
charpenne@inrets.fr Website: www.ircoibi.org

36th Public Health Association of Australia Annual Conference

25–28 September 2005
Perth

Contact: PHAA Secretariat, Tel: +61 2 6285
2373, Fax: +61 2 6282 5438, E-mail:
conference@phaa.net.au
Website: www.phaa.net.au

Fourth National Sports Injury Prevention Conference

15–16 October 2005
Melbourne

Contact: Gary Moorhead, Sports Medicine
Australia, Tel: Fax: +61 2 6230 5908, E-mail:
gary.moorhead@sma.org.au

8th World Conference on Injury Prevention and Safety Promotion

19–22 March 2006

Johannesburg, South Africa

Contact: Conference Secretariat, Tel: +27 12
4812094, Fax: +27 12 4812112, E-Mail: sec@safety2006.info Website: www.safety2006.info

Diversity in Health Conference 2005

17–19 October 2005

Melbourne

Contact: Conference Secretariat, Tel: 03 9457
7130, E-mail: info@amf.net.au Website:
www.mmha.org.au/News/DiversityHealthConference

International Traffic Medicine Association 20th World Congress

5 January 2006

Melbourne

Deadline for Abstracts: 31 March 2006.
Contact: Mick Gould, Convention Associates,
Tel: +61 3 9684 4480, Fax: +61 3 9684 4481,
E-mail: traffimed@vifm.org

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- 3 National Ageing Research Institute. An analysis of research on preventing falls and falls injury in older people: community, residential care and hospital settings (2004 update). Report to the Australian Government, Department of Health and Ageing, Injury Prevention Section by the National Ageing Research Institute. Canberra, Australia: Australian Government Department of Health and Ageing, 2004.
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- 5 Driscoll T, Henley G, Harrison J. The National Coroners Information System as an information tool for injury Surveillance. Injury Research and Statistics Series Number 21. Adelaide: AIHW (AIHW cat no. INJCAT 60).
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Editor's Note

The *Injury Issues Monitor* is the journal of the Research Centre for Injury Studies at the Flinders University of South Australia.

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