STRATEGIES FOR CHILD ACCIDENT PREVENTION

ADDRESS GIVEN BY CAROL MAJOR TO THE CHILDREN'S BUREAU OCTOBER 28th 1986.

1986 is the International Year of Peace. "Live and Grow Free" is the slogan.

In Australia we have many choices to make to ensure a peaceful, safe and nurturing world in which our children can reach their maximum potential. We have decisions to make regarding our involvement with nuclear power – decisions regarding the balance between industrial and economic advancement and conserving our natural heritage.

The desolation of nuclear war and the bleakness of a polluted natural environment are of great concern to all of us. However, while we make steps toward ensuring a world where our children indeed can "Live and Grow Free", perhaps we should also consider the immediate threats that face Australian children in the relative safety of our own country.

In Australia accidental injury is the biggest single cause of death among children aged between 1 and 14 years. Each year, on average, one in two of them will need medical attention because of accidental injury. That is over 1.5 million accidents each year. Many of these children will be permanently disabled and an estimated 600 will lose their lives. The cost in pain and suffering to the individuals involved cannot be measured – the cost to the community in health care dollars that could be better spent on the treatment and prevention of disease is estimated to be at least 160 million dollars each year.

A large percentage of these injuries occur on the road. Some 4 to 5 thousand children will be seriously injured this year in road crashes. Close to half of these children will be unrestrained passengers in cars.

It is interesting that Victoria in 1970 was the first government in the world to introduce legislation for adults to use seatbelts with a corresponding dramatic drop in deaths. Sixteen years later in 1986 we are only beginning to take steps to ensure the safety of children in cars. Yet these passengers without doubt are the most innocent and in need of protecting legislation.

While many children are injured on the road it is also important to note that 91% of all injuries to pre-schoolers occur in the home. Drowning, obstruction of breathing and burns currently lead the list of major causes of accidental death and falls and poisonings are frequently involved in hospital admissions.

So how do we tackle the problem?

The first question that needs to be raised when investigating any accident is to ask, *what went wrong?* Unfortunately this is often translated into, *who was to blame?*

At the Child Accident Prevention Centre, we provide information/workshop sessions for a variety of health workers. During these sessions we will often present them with an accident scenario and then ask them to identify what went wrong.

A typical example might involve an accidental poisoning. The scenario could occur (as many accidents do) during holiday time.

There are three children in the family. One six year old, one two year old and one infant. Mother is taking iron tablets to build herself up after the birth of the last child. She keeps them on top of the refridgerator so she will remember to take them. They are also relatively out of the children's reach. It is 6.00 a.m. Sunday morning. The night before the family had a terrific party and the parents are fast asleep. The two year old has risen at the crack of dawn, as two year olds have an obnoxious habit of doing. He climbs out of his cot and wanders into the kitchen. He has watched mum take her iron tablets before and thinks they are stored up high like lollies and biscuits because they are good to eat. He pushes a chair towards the kitchen counter, climbs up and easily reaches the top of the fridge. In an instant he has opened the bottle and eaten all the iron tablets. Thankfully he does not die. But he is taken to hospital for some nasty treatment with stomach tubes and charcoal.

In response to the, *what went wrong* question in the scenario, it is interesting how many of our group participants take the, *who was to blame* stance. In most cases they want to blame the parents, particularly mother.

She shouldn't have slept in.

She should have known the iron tablets were toxic.

She should have locked them away.

There seems to be a well held belief that all babies released from hospital come with a detailed instruction booklet and that all new parents are provided with an endless amount of physical and emotional resources to cope with children. Whether they do or whether they should is really not the issue. The most important point is that attributing blame, labelling parents or other people responsible for children, as careless is not going to solve the problem.

Any accident involves a chain of events of which human behaviour may be only one part. All events must be carefully investigated so that we can pin point the contributing factors.

The National Safety Council runs an excellent program for industrial safety officers to help them with this process. It teaches a *systems approach* to identifying hazards and for choosing appropriate strategies for controlling them.

If we use this approach in analysing, the poisoning scenario, we would see that mother's behaviour is only one part in a chain of events. In addition, mother's behaviour may be the most difficult to change. Everyone at sometime is tired, forgetful and inattentive to children. There is always going to be an occasion when that occurs.

The child's behaviour is also difficult to change. Two year olds will sample everything by putting it in their mouth. They will imitate and they will climb. Perhaps the most important solution to both of these behavioural hazards it to recognise they exist and to look at easier and more permanent changes that can be made.

These solutions can involve design changes such as altering the packaging of medication. Indeed moves to have more products in child restraint containers significantly contributed to a reduction in child poisonings.

Design changes to packaging could also involve the development of clear, uniform, warning labels on household products.

It can mystify parents when a caustic substance like Draino has a large red poison label and caustic dish powder for dishwashers has a milder label saying warning. Granted Draino will do a great deal more damage faster that dish washer powder. However, a good mouthful of the latter is still very dangerous. Yet we know from mothers visiting the Child Accident Prevention Centre that many feel quite complacent about automatic dishwashing products.

Another design alternative may include changes in building regulations to ensure all homes have enough child resistant cupboards to store potentially toxic products. It may also be in the case of poisoning that some thought has to be given to the kinds of products that are being developed for home use. Are they necessary? Are their pest control, cleaning, deodorising, qualities more important than the risks they impose?

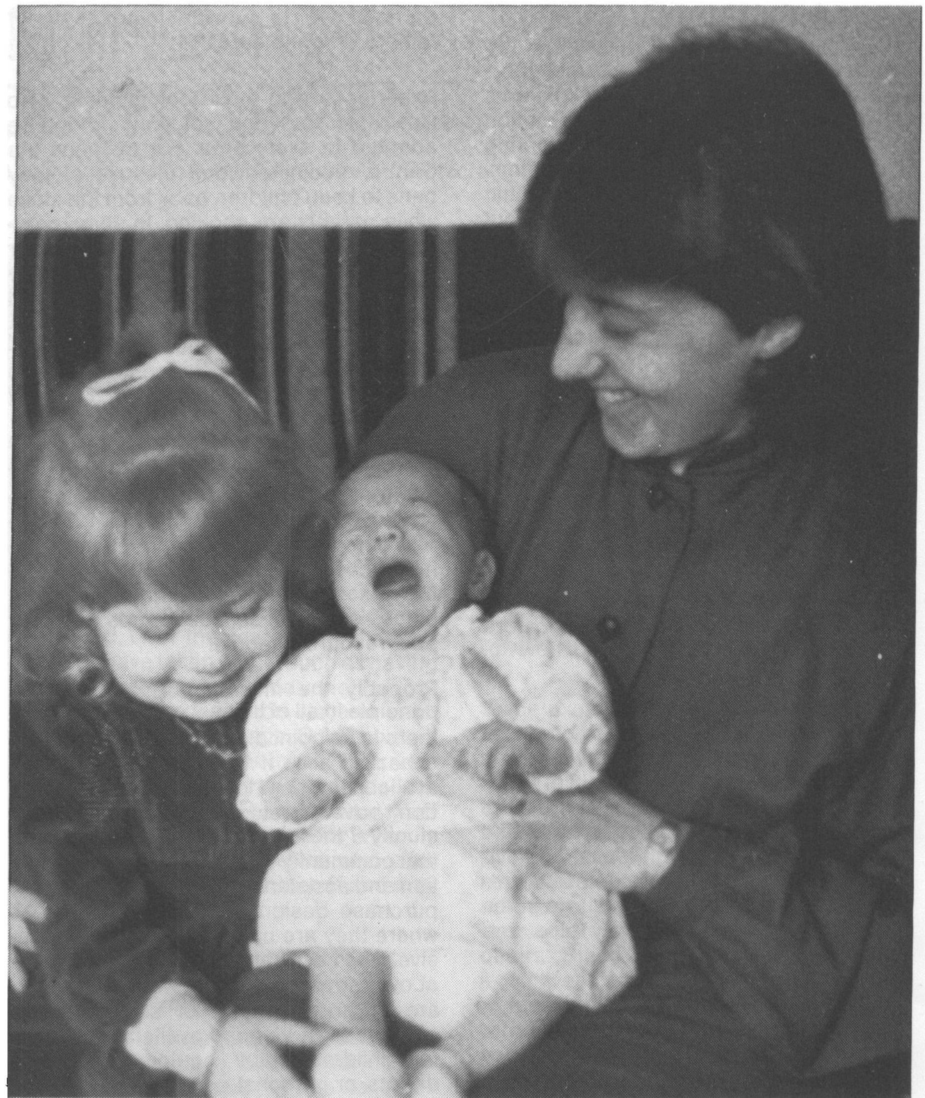
These environmental suggestions may not be the only solutions, but they are a reminder that there are other areas to tackle in strategies to reduce child injuries when human behaviour is so hard to change.

On the other hand it must be remembered that moves to change the environment can be very unpopular. Unpopular enough that in Victoria the State Government opted for a "Watch Em Near Water" campaign in lieu of uniform, pool fencing legislation – even though drowning is the major cause of accidental death among pre-schoolers and many of these children die in unfenced pools.

Although public awareness and community educton programs have their place, a "Watch Em Near Water" campaign in lieu of other design safe-guards makes no allowance for the fact that parents can and will be distracted and that a pool fence may just be the design 'safety net' to fill in this gap.

As part of a comprehensive water safety program that included pool fencing, water safety education strategies could be aimed at alerting parents to the hazards of water (particularly to pre-schoolers), advising on the appropriate use of pool fences (such as the importance of not placing garden furniture close to the fence to facilitate climbing), reinforcing the importance of still supervising all children when they are using the pool, and teaching relevant first aid skills.

Given the serious problem of pre-school drownings in backyard swimming pools, moves to ensure they are fenced seems appropriate even if it does trample on the personal liberties of pool owners who may feel the added expense and loss of aesthetic value created by fences is more important.



When considering personal liberties we must remember that children do not have a powerful lobbying voice. Our world is still very much an adult world where roads and homes are made to suit adult tastes. Many people feel vehemently opposed to the introduction of safety legislation which modifies an individual's lifestyle – "simply to save the lives of children whose parents should be caring for them", as one individual complained to the chairman of the Child Accident Prevention Foundation's Research Committee.

The same Chairman, Dr. Pearn, Head of the Department of Child Health, at the University of Queensland summarised the debate between enforced environmental changes and personal freedom in an article in the Australian, New Zealand Journal of Medicine.

He states, "The controversy centres on the degree to which the personal freedoms of adults should be curtailed for the safety of the young, of the helpless and innocent... There is no logical reason why the rights of adults should be greater than the rights of children (or vice versa); and there is no way to resolve this controversy, other than by recourse to a humanitarian plea. In recent years, enlightened societies have introduced safeguards which reflect the evolving ethic that children are persons in their own right and that their safety should not be in any sense discretionary. The theme of conflicting rights (adult freedom versus a safe environment for children) is a philosophical one, but in practice comes to the pragmatic question of how much? Although philosophical, its practical expression is seen in how much of available resources will be expended in an effort to prevent the accidental deaths of a finite number of children"?

Given the enormity of this very practical question as stated by Dr. Pearn, one important area to consider is accurate data collection. We cannot say that a design, equipment or legislative change is the solution if we don't know our facts. We cannot lobby for any sort of prevention programs unless we have accurate data to support our claims.

Unfortunately for a long time the facts in child injuries have been pretty hazy. We can say for instance that X amount of children have been injured by falls, but we can't say with any great degree of certainty what they fell from or why or onto what.

Thankfully in the last two years, moves have been made by the Child Accident Prevention Foundation to develop an injury surveillance system that is now being piloted in Queensland, South Australia and Western Australia. The Royal Children's hospital, Melbourne is eager to participate in this project and is currently seeing avenues to encourage accurate collection of accident facts on patients presenting to the hospital and to acquire resource people to support the coding of this information. These moves to develop a comprehensive approach to data collection, research hazard areas, promote environmental changes and develop community education programs will assist in ensuring an Australia wide attack on problem areas.

However, it is important that state and national organisations do not lose sight of the role of local communities in accident prevention strategies. At the Royal Children's Hospital, Child Accident Prevention Centre we spend most of our time working at a local level in implementing programs. We believe that since the demographic profiles of communities differ throughout Victoria, it is appropriate that strategies for education programs fit individual needs. Too often, uniform programs launched on a state or national scale do not take into consideration the differences between communities, their priority areas, their particular problems and the resources they may or may not have to cope with them.

The Centre has had some interesting experiences in community education. The first involved a program run in 1984 to prevent scalds. Titled "Hot Water Burns Like Fire", the program was piloted in five communities. In each of the communities the program changed as health educators defined their target groups and how to reach them.

In one middle class area they noted that most young parents spent their weekends viewing model display homes. To reach this group they asked permission from the Jennings Building Company to outfit one of the homes with design ideas, audiovisuals and printed literature on scald prevention. The response was a surge in the sale of items such as safety taps and coiled cords.

In another community it was found that fathers were responsible for the care of children during the day because they often worked night shift and their wives worked day shifts. A program was then developed to assist these exhausted parents and to provide information for fathers on child care.

Experience with these communities also illustrated that one solution cannot be adapted to every area. For instance the Centre recommenwded the use of play pens to keep children back from the stove while parents are cooking. In some communities they were far too expensive for parents to consider. In another community we found the parents lived in caravans and could not fit them in their living area. In these cases we found the residents themselves with some assistance were able to come up with better solutions for their own particular situations.

We also found community networks for health education varied throughout the state. Sometimes it was the infant welfare and community health centres who were most active in education. At other times we found key figures in local hospitals, shire offices and even service groups to be our best resource people.

Probably the most important overiding principle in all of these experiences is that there is no point alerting the community to a hazard area if there is no assistance available to them to solve it. Quite simply, don't advertise safety messages to a community if there are no resource people in that community to provide further information and assistance. Don't suggest people purchase design modifications in areas where they are unavailable or too expensive. Don't aim safety education programs at over stressed parents when they really are in greater need of some general support such as good available day care for children, baby equipment lending depots, or personal counselling.

The Centre now spends a great deal of time encouraging communities to identify their local problems and pool together their key resource people. With this information we can work together to plan safety programs.

Our strategies are just one part in what can hopefully emerge as an overall blue print for accident prevention. The Child Accident Prevention Centre fills a vital role in the delivery of educational programs, particularly in a community setting. But without the support of groups such as the Child Accident Prevention Foundation, particularly in the areas of research and law reform, the expertise in ergonomics, hazard identification and systems approaches provided by the National Safety Council and the invaluable service provided by so many other groups, we would not be doing anything at all.

Therefore the first and last strategy in accident prevention has to be inter organisational co-operation. Together we can ensure a safer environment for children. Together we can also ensure that injury prevention is given a high enough profile to warrant action.

Harking back to the opening of this paper just a few of the pressing issues that threaten humanity today were mentioned. They are difficult issues to resolve. Many of them depend so much on the co-operation of countries over which we have no control. This does not mean that we do not address them, but surely it should activate us all to do something about issues over which we do have control.

Accidental injuries to children can be controlled. It is simply not good enough that the potential of so many children is impaired each year. Given commitment it is something together we can change.

References

1. Moller J. *Safeguard* Child Accident Prevention Foundation of Australia. 3rd Quarter, 1986.

2. O'Connor P.J. An Analysis of Australian Child Accident Statistics. Child Accident Prevention Foundation of Australia, 1982.

3. Pearn, J.H. "Current Controversies in Child Accident Prevention. An Analysis of some areas of Dispute in the Prevention of Child Trauma". *Aust NZ J. Med,* 1985, 782-787.

4. Report for the Minister for Local government (Victoria). Safety Concerning Accessibility to Private Swimming Pools, July 1984.

PLANNING FOR PLAY

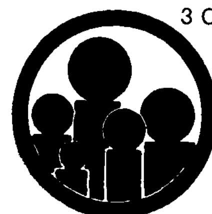
A HANDBOOK FOR TEACHERS AND PARENTS.

$20 Plus Postage & Packing.

The Children's Bureau of Australia Inc.

3 Chesterville Road,
Cheltenham, Vic. 3192

The Bureau needs YOU ~ check about membership



3 Chesterville Road,
Cheltenham,
Vic. 3192

PHONE:
(03) 584 6444