Chapter 9
'Other' non-intentional injury-related deaths

"Children are born into an adult world, without experience or appreciation of risk but with a natural desire to explore … the potential for injury is particularly great during childhood" (Standards Australia 2004:v)

Key issues

- Eleven children and young people died as a result of 'other' non-intentional injury in Queensland between 1 July 2005 and 30 June 2006. Accidental injury deaths accounted for 11.8% of all external causes of child deaths in the reporting period (a rate of 1.1 deaths per 100,000 children aged from birth to 17 years in Queensland).
- Continued use of the term 'accident' has been debated in academic circles. The Commission has continued to use the term 'accidental' injury interchangeably with 'non-intentional' injury as it is felt that the word 'accident' does not necessarily imply that non-intentional injury is unpreventable.

Accidental injury-related deaths defined

By definition, the word 'accident' refers to an unexpected or unforeseen event, occurring without intention or by chance. Many injury prevention professionals argue that the use of the term 'accident' reinforces common public misconceptions that injuries are neither predictable nor preventable, and are instead due to fate (Davis & Pless 2001a:1; Evans 1993:1438; Girasek 1999:19). Public perceptions such as this are thought to obstruct injury prevention efforts – individuals are less likely to engage in safety behaviours if the event (accidental injury) is seen as unpreventable (Smith et al. 1999:316–17). Calls have been made for the abolition of the use of the term 'accident' in medical and injury prevention literature (Davis & Pless 2001a:1; Doege 1978:509, 1999:427; Langley 1988:6).

Counter-arguments to this position cite evidence which suggests that most people do, in fact, consider most accidents to be preventable and *not* random or chance events (Girasek 2001:461).[159] The Commission continues to use the term 'accident' as it is considered that most people "have a clear concept of what is meant when the term 'accident' is used" (Byard 2004:5).

The Commission analyses accidental (or non-intentional) injury-related deaths according to five major categories: falls; strangulations, suffocation and choking; poisoning; exposure to electrical current; and 'other'.[160] Accidental deaths are those occurring as a result of circumstances beyond those covered by other external causes examined elsewhere in this report.[161]

Preventability

Child death review teams worldwide consider the concept of preventability in the analysis of childhood deaths. A preventable death is one which may have been avoided with reasonable medical, educational, social, legal or psychological intervention (Durfee, Tilton-Durfee & West 2002:621; Jenny & Barron 2001:14). However, prevention often relies on foresight or the predictability of an event (McConnell, cited in Davis & Pless 2001b:372). Judgements of preventability are frequently made with the benefit of information unavailable at the time of death, and therefore a finding of preventability does not imply that the circumstances leading to death were predictable (Durfee, Tilton-Durfee & West 2002:621).

159 See also Eichelberger et al. 1990, Hu et al. 1996 and Colver et al. 1982, cited in Girasek 2001:456.

160 Refer to Appendix 9.1 for a comprehensive outline of all types of 'other' accidental deaths.

161 That is, all deaths which cannot be classified as the result of a transport accident, suicide, drowning, fire, fatal assault or sudden unexpected death in infancy, or as a result of a disease or other morbid condition.

Accident prevention strategies

Early research proposed that unintentional injury is the outcome of the interaction of a number of factors: person factors, environmental factors and agent factors (for example: DeHaven 1942, Gordon 1949 and Haddon 1964, 1968, cited in Garzon 2005:441). The recognition and modification of these factors can lead to the prevention of many injuries (Mace et al. 2001:406).

An *agent factor* is the means by which an injury actually occurs – that is, the physical properties of the injury event, such as the speed of a vehicle, the heat of a fire, or the sharp edges of a surface (Garzon 2005:442; Mace et al. 2001:407). The modification of agent factors through careful product design is noted as the most successful strategy of injury prevention (Garzon 2005:442). Examples include child-resistant packaging for medication and the inclusion of self-inflating airbags in cars to minimise the risk of injury in the event of a collision.

Environmental factors relate to characteristics of neighbourhoods, homes and social surroundings, such as safe play areas, home fire prevention equipment and the level of parental supervision (Garzon 2005:443; Mace et al. 2001:407). A high level of environmental risk is associated with lower socio-economic status (Community Affairs References Committee 2004:253–54; Reimers & LaFlamme 2005:1488), and methods of reducing environmental risk are often not as viable for people in such situations (Reimers & LaFlamme 2005:1492). Intervention at this level typically rests in the hands of policy makers, with strategies such as subsidised safety equipment and targeted public awareness campaigns.

Person/child factors relate to the developmental, physical and behavioural characteristics of children at particular ages, such as undeveloped fine motor skills and cognitive inability to recognise risk and impulsivity (Garzon 2005:443; Mace et al. 2001:407).

Adult supervision, recognition of injury risk and intervention also have an impact on injury outcome:

> *Research establishes that parental behaviour modification is crucial to preventing childhood injury. A combined approach of parental supervisory behaviour modification and removal of environmental injury hazards is highly effective in decreasing [preschool unintentional injury] incidence (Garzon 2005:444).*

Injury prevention strategies which target all three influencing agents have been identified as the most effective (Garzon 2005:445). Intervention strategies can be classified as taking one of three forms (Deal et al. 2000:5):

- *Education* of parents to raise awareness of injury risk and to increase individual safety-related behaviours. This may be undertaken by professionals in clinical settings, or it may take the form of a public safety awareness campaign
- *Environment or product modification* includes altering a child's immediate environment to minimise hazards, as well as re-modelling products used by or accessible to children. Examples include the fencing of swimming pools, and re-designing toys so that they do not have small parts that could be swallowed by young children, and
- *Enforcement of legislation or regulations* may produce changes in individual behaviour, such as adherence to legislation requiring the use of bicycle helmets. Changes in industry standards may also occur, such as mandatory safety standards for products such as blinds and curtains.

An additional strategy type suggested by Mace et al. (2001:406), *economic strategies*, relies on financial incentives to persuade the public to apply injury prevention measures (for example, rebates for households that install a temperature limiting device on their hot water systems).

Injury prevention strategies can also be classified as *active* or *passive* – active strategies require individuals to change their behaviour, while passive strategies "provide automatic protection independent of any individual behaviour" (Deal et al. 2000:8). Education strategies are generally

active, while product modification is an example of a passive strategy. Passive strategies have been demonstrated to be more effective (Deal et al. 2000:8; Mace et al. 2001:408; McClure & Spinks 2002:6).

Non-intentional injury-related deaths: trends and patterns, 2005–06

Eleven children and young people died in 'other' non-intentional injury-related incidents in Queensland between 1 July 2005 and 30 June 2006. 'Other' non-intentional injury-related deaths accounted for 11.8% of all external causes of child deaths in the reporting period (a rate of 1.1 per 100,000 children aged from birth to 17 years). This represents a decrease in the rate of non-intentional injury-related deaths from the previous 12-month reporting period.[162] Gender and age breakdowns are given in Table 9.1.

Table 9.1: Other non-intentional injury-related fatalities by gender and age group

Age at death	Females *n*	Males *n*	Total *n*
Under 1 year	2	0	2
1–4 years	1	2	3
5–9 years	1	2	3
10–14 years	0	1	1
15–17 years	0	2	2
Total	**4**	**7**	**11**
Rate per 100,000	0.8	1.4	1.1

Data source: Queensland Child Death Register (2005–06)

Note: 1. Rates are calculated per 100,000 females, per 100,000 males and per 100,000 children aged 0–17 in Queensland.

Gender

Consistent with findings of the Child Death Annual Report, 2004–05, male children were more likely than females to die of 'other' non-intentional injury, with males constituting 63.6% of non-intentional injury-related deaths. In line with this finding, males were also found to have a higher rate of non-intentional injury-related death (1.4 per 100,000 male children aged from birth to 17 years) compared with females (0.8 per 100,000 female children aged from birth to 17 years).[163] Australian and international research has also found a higher rate of injury deaths in male children (Al-Yaman, Bryant & Sargeant 2002: 241; Roberts, DiGuiseppi & Ward 1998:10; United Nations Children's Fund 2001:18).[164] Suggested reasons for gender differences include a greater degree of risk-taking behaviour by boys, and caregivers displaying a more permissive attitude towards boys' behaviour (United Nations Children's Fund 2001:18; Morrongiello 2005:543).

Age

The greatest number of 'other' non-intentional injury-related deaths occurred in the 1–4 and 5–9 year age groups (3 deaths each, 27.3%). The Child Death Annual Report, 2004–05 also found 1–4 year olds to have a high number of non-intentional injury-related deaths in the 18-month period covered, as did 15–17 year olds. Research suggests that children's risk of injury (and death from injury) is greater at younger ages, peaking between the second and fourth year of life (Abboud Dal Santo et al. 2004:273; Al-Yaman, Bryant & Sargeant 2002:242; United Nations Children's Fund 2001:18). At these ages, children's motor skills are rapidly developing and children are exposed to a greater range of environments in which these skills are untested. This development is not necessarily mirrored by an equivalent perception of risk or appreciation of hazards (Abboud Dal Santo et al. 2004:273; Lam, Ross & Cass 1999:576).

Aboriginal and Torres Strait Islander status

The death of 1 Indigenous child from 'other' non-intentional injury-related causes was registered in this reporting period. This child was identified as being both Aboriginal and Torres Strait Islander.

Because of the small number of Indigenous child deaths from non-intentional injury-related causes

162 Comparative figures for the 12-month period between 1 July 2004 and 30 June 2005 are given in Chapter 3 of this report.

163 Caution should be exercised when interpreting results due to the small number of deaths analysed. As a result a change in one or two deaths over the course of a year may have a significant impact on findings.

164 The terms 'injury' and 'injury death' are used in a variety of ways across studies. These categories may include intentional injury such as homicide and suicide, as well as unintentional injuries such as transport accidents, fire, drownings, falls, poisoning, choking, burns and scalds. It is noted that the deaths cited in the literature do not always correspond to the specific causes of accidental injury death examined in this chapter.

in this reporting period, rates of non-intentional death for Indigenous children were unable to be calculated. However, research has established that Aboriginal and Torres Strait Islanders suffer injury, and death from injury, at a greater rate than the non-Indigenous population (McClure & Spinks 2002:7; Lehoczky et al. 2002:22; National Public Health Partnership 2004a:3). Studies undertaken by the Australian Institute of Health and Welfare found that the average rate of death from injury of Indigenous children (from all external causes) was 2.8 times that of other Australian children (Al-Yaman, Bryant & Sargeant 2002:243).

The one Indigenous child death was the result of contact with a box-jellyfish.

Geographical distribution (ARIA+)

The majority of 'other' non-intentional injury-related child deaths (5 deaths, 45.5%) were of children living in metropolitan areas of Queensland; 3 deaths occurred in regional areas and 2 in remote areas. One death was unable to be classified as the child's usual place of residence was outside Queensland.

Children in metropolitan areas died as a result of unintentional injury at a rate of 0.9 per 100,000 children and young people aged 0–17 years living in metropolitan areas.[165] The Child Death Annual Report, 2004–05 indicated that, while metropolitan areas had the greatest number of deaths in the 18-month period covered, rates of death were highest in remote areas.[166]

Studies of Australian children have found that rates of injury deaths are higher in remote areas than in rural and metropolitan areas (Al-Yaman, Bryant & Sargeant 2002:243; Australian Institute of Health and Welfare 2003:258; Draper, Turrell & Oldenburg 2004:38). It is suggested that children living in rural and remote areas are exposed to different types of injury risk (such as exposure to chemicals, and hazards associated with living in a workplace) (Al-Yaman, Bryant & Sargeant 2002:223; Mission Australia 2006:30).

Socio-economic status (SEIFA)

Low or very low socio-economic areas recorded the greatest number of child deaths (4 deaths, 36.4%), with deaths occurring at a rate of 1.0 per 100,000 children aged 0–17 living in low to very low socio-economic areas.[167] Three deaths occurred in moderate areas and 3 in high to very high socio-economic areas. One child was not able to be classified as their usual place of residence was outside Queensland.

Research suggests that injuries and injury-related death are more common in lower socio-economic areas, both within Australia and internationally (Draper, Turrell & Oldenburg 2004:65; Victorian Injury Surveillance and Applied Research System 2002:11). The rate of child death from accident and injury has been found to increase as the level of disadvantage worsens[168] (Draper, Turrell & Oldenburg 2004:68; Zwi & Henry 2005:155).

Child protection population

None of the children and young people who died as a result of 'other' non-intentional injury-related incidents in the 12-month period between 1 July 2005 and 30 June 2006 were known to the Department of Child Safety (DChS).

Coronial findings

At the time of reporting, coronial findings were available for 5 of the 11 deaths. Coronial findings were outstanding in 6 cases. In all of these cases an autopsy report was available, giving an official cause of death.

Circumstances of non-intentional injury-related deaths

Types of accidental deaths

Of the five major classifications of non-intentional injury-related deaths previously mentioned, no poisoning or electrocution deaths occurred in this

165 Rates were unable to be calculated for regional and remote areas because of the small numbers of deaths in these areas.

166 Although comparison rates should preferably be drawn from the 2004–05 12-month period, rates of accidental injury death for the 12-month period were not available in all areas because of small numbers.

167 Rates for moderate and high to very high socio-economic areas were unable to be calculated because of the small numbers of deaths in these areas.

168 For children aged 0–14 years of age.

reporting period. A large proportion of the deaths fell into the 'other' category. Table 9.2 outlines the types of accidental deaths which occurred, by gender and age group.

Table 9.2: Types of accidental deaths by gender and age group

Age	Females *n*	Males *n*	Total *n*
Falls			
15–17 years	0	1	1
Subtotal	**0**	**1**	**1**
Strangulation, suffocation and choking			
Under 1 year	2	0	2
1–4 years	1	0	1
Subtotal	**3**	**0**	**3**
Other			
1–4 years	0	2	2
5–9 years	1	2	3
10–14 years	0	1	1
15–17 years	0	1	1
Subtotal	**1**	**6**	**7**
Total	**4**	**7**	**11**

Data source: Queensland Child Death Register (2005–06)

Note: 1. Age categories were excluded from each accidental subcategory where no children of this age group died in the reporting period.

Falls

One child in the 15–17 year age group died as a result of a fall.[169] This child was working for income when he fell from a ladder. This compares with 3 children who died as a result of falls in the 18-month period covered by the Child Death Annual Report, 2004–05.

Fall-related injury

The Queensland Injury Surveillance Unit (QISU) found that falls accounted for half of the injuries to children aged less than 1 year, 40% of injuries in 1–4 year olds, 43% in 5–9 year olds and 37% in 10–14 year olds (Hockey, Miles & Baylis 2001). According to the QISU, 8129 children were injured in falls in 2004–05.[170] [171] Over 13% of injuries required hospital admission, with admissions being most frequent in children under the age of 1 year.

Strangulation, suffocation and choking

The death of 1 toddler in the 1–4 year age group was the result of accidental strangulation by a blind or curtain cord. One child died in similar circumstances in the previous reporting period, after becoming entangled in an electrical cord.

An additional child in the 1–4 year age group died as a result of the inhalation of gastric contents. This child had an existing debilitating condition, and died after choking while sleeping.

Two infants died as a result of accidental suffocation or strangulation in bed. These deaths have been classified as sudden unexpected deaths in infancy, and are discussed in detail in Chapter 12 of this report. Three infants died in this way, or because of other specified threats to breathing, in the previous 18-month reporting period.

Strangulation, suffocation and choking-related injury

Strangulation, suffocation and choking are most common in younger age groups (Queensland Injury Surveillance Unit 2006); 77 children presented to hospital following such incidents in 2004–05, with 60 of these being under 5 years of age (77.9%). Almost 25% of children required admission to hospital.

169 This child was injured in a fall in New South Wales but was later transferred to a Queensland hospital for treatment. Although the death occurred in Queensland, this matter will be considered in the New South Wales Coroner's Court and therefore no additional information is available to the Commission regarding this death.

170 QISU data are based on emergency department presentations to a number of selected hospitals. This information is therefore not a complete overview of childhood injury in Queensland, but provides a good indication of injury trends.

171 Full-year data were only available for the 2004–05 period. Similar trends to those outlined appear to be present in the six-month period from July to December 2005.

Other

Seven children died from non-intentional injury related causes not discussed above (63.6%). These causes are detailed below:

• Contact with other and unspecified machinery	1 death
• Striking against or struck by other objects	1 death
• Striking against or bumped into by another person (accidental)	1 death
• Struck by falling objects	1 death
• Contact with venomous marine plants and animals	1 death
• Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	1 death

Six of the 7 deaths from other non-intentional injury were of male children; 5–9 year olds were the most likely to die of other non-intentional injury causes, accounting for 3 of the 7 deaths.

One child in the 5–9 year age group died after being stung by a box-jellyfish. Stings from a box-jellyfish may lead to respiratory failure and cardiovascular collapse, with death occurring in as little as 10 minutes (Brown 2005:4). Surf Life Saving Queensland (2004) suggests that jellyfish stings can be prevented by swimming in netted areas and wearing protective clothing (such as lycra body suits) in areas where jellyfish and other marine stingers are common. Coronial recommendations in this case included erecting warning signs and installing safe swimming enclosures in the area.

Place of incident

Six of the 11 non-intentional injuries resulting in child deaths occurred in the home (54.5%). This is consistent with findings both from literature and from the Child Death Annual Report, 2004–05. Two of the remaining deaths occurred at public beaches, 2 at a workplace and 1 at a hospital.

The majority of non-intentional child injuries happen at home. The QISU reports that up to 57% of all injuries in Queensland occur in the home. This is particularly true for preschool children, who spend much of their time in and around the home (Hockey et al. 2001:1).

Of the 2 deaths that occurred while the child or young person was at a workplace and/or working for income, 1 death was machinery-related, while the other was due to a fall.

Workplace injuries

The QISU recorded 148 workplace injuries in 2004–05, mostly in the 15–17 year age group. Machinery-related injuries were the most common (25.0%), followed by cuttinsg/piercing injuries (18.9%). Six percent of workplace injuries required hospital admission.

Prevention and intervention

Legislation and product standards

Falls

Agencies such as the QISU have examined the issue of falls in some detail and have recommended the use of nursery products compliant with relevant safety standards and parental supervision to minimise the risk of falls in infants. For older/more mobile children, the installation of gates on stairs and secure windows and balconies is recommended (Hockey, Miles & Baylis 2001:6).

Strangulation, suffocation and choking

Accidental strangulation hazards are posed by items as diverse as blind and curtain cords, electrical cords, clothing, bunk beds and cots, prams, strollers and car restraints (Byard 2004:32–33; Office of Fair Trading 2005; Standards Australia 2004:7, 9). Blind and curtain cords are particularly dangerous to children under the age of 3 (Australian Competition and Consumer Commission 2005:32).

The accidental strangulation of young children in such situations has been the subject of coronial recommendations in several Australian states. Tasmanian and Victorian coroners have

recommended mandatory safety standards for blind and curtain cords and a public safety campaign aimed at raising the awareness of parents to the dangers of blind cord strangulation, and have suggested affordable means of prevention.

In line with other states, the Queensland Government has recently introduced a mandatory safety standard for corded interior window coverings. Under the Fair Trading Regulation 2001,[172] a looped blind or curtain cord must be "... at least 1600mm above the base of the covering when the covering is lowered to its lowest point". Warning labels with specified wording must be attached, and accompanied by written instructions on the installation and operation of the product and any associated safety device. These standards only apply to new products.

In recognition of the problem of blind and curtain cord strangulation, a number of government agencies have released safety campaigns aimed at awareness and prevention. The Commonwealth Department of Treasury and Department of Health and Ageing launched a joint awareness campaign for blind and curtain cord safety in 2003 (Department of Family and Community Services 2003:5). Brochures and statements have been published by the Australian Competition and Consumer Commission (2005:32; n.d.) and the Office of Fair Trading (2005), notifying the public of affordable means of modifying existing blinds.

Workplace deaths

Children are particularly vulnerable to workplace accidents, with the QISU reporting that children are twice as likely to be injured in the workplace as other workers (Scott et al. 2004:1). Suggested reasons for this include a lack of empowerment – young people are often not aware of their rights in the workforce and are insecure in exercising them. The level of training provided and the types of tasks given to young workers have also been raised as problem areas (Commission for Children and Young People and Child Guardian 2005:16; Scott et al. 2004:3).

The Commission's recent publication *Queensland Review of Child Labour* (2005) highlighted the risks faced by young workers, as well as deficiencies in the current Queensland regulations. This report proposed a four-tiered model of child employment protection, including specific legislation, service delivery, policy and a child employment guide.[173]

As a result of this report, the Queensland Parliament has recently introduced legislation designed to protect the rights of children in the workplace. The *Child Employment Act 2006* came into effect on 1 July 2006, and features restrictions on the type of work which can be performed by young people up to the age of 15, and the maximum number of hours to be worked during school terms (Barton 2006).

In conjunction with this legislation, the Department of Industrial Relations (DIR) is in the process of producing a code of practice for young workers, which gives advice to employers on assessing and managing workplace risks for children and young people. This includes both young workers and children who live in or may be visiting a workplace. The DIR has also produced guidelines for young workers advising of their rights and responsibilities.[174]

The Commission is working collaboratively with Workplace Health and Safety Queensland to assist in the prevention and reduction of workplace accidents involving children and young workers. A memorandum of understanding is currently being progressed which would allow the Commission to receive notification of any serious or fatal workplace injuries to children in Queensland.

Department of Housing

Smart Housing design initiative

In 2002, the Department of Housing launched its Smart Housing initiative, aimed at promoting socially, environmentally and economically sustainable housing design. Social sustainability refers to the impact of house design on occupants (Department of Housing 2004:1). This element takes

172 Schedule 5B.

173 For further information, see the Commission for Children and Young People and Child Guardian, Queensland Review of Child Labour: Summary of findings (2005), available at http://www.ccypcg.qld.gov.au/pdf/publications/reports/child_labour_report_0405.pdf

174 For further information, see www.dir.qld.gov.au

into consideration child safety and injury prevention in the home. *The Smart Housing: Design Objectives* publication outlines a number of measures for child injury prevention which can be implemented when designing new homes. Significant causes of childhood injury that are targeted include poisoning, burns and scalds, and falls, as well as drowning, fire and driveway run-overs.

The Smart Housing initiative uses environment or product modification, listing practical ways to avoid injuries through home design. Examples include:

- the inclusion of at least one lockable cabinet for the storage of medicines and poisons
- cupboard and drawer handles below bench height to be mounted vertically to avoid children using them as a step
- balcony railings to comply with the Building Code of Australia's non-climbable balustrade requirements, and
- window sill heights to be at least 1m above floor level or above furniture placed immediately below, to avoid falls from windows.

Child safety in the home is also addressed by the Department of Housing in publications such as *Smart Housing 2: Safety and security* (2003) and various Smart Housing Fact Sheets. Version 2 of *Smart Housing: Design Objectives* is due for release later in 2006 (Department of Housing 2006).[175]

National Public Health Partnership

National Injury Prevention and Safety Promotion Plan: 2004–2014

This nationwide strategy was developed by the National Public Health Partnership[176] and came into effect in July 2005. With a vision of collaboration of government, private sector and community to ensure safe environments, this strategy encourages strong and effective partnerships in approaches to injury prevention and safety promotion. It recognises that accidents can be prevented through the modification of both environment and individual behaviours, and aims to create:

- a 'positive safety culture', in which individuals and communities believe that injury is preventable, and take steps to achieve this (most likely through awareness raising), and
- 'safe environments' achieved by the creation of safer social and cultural environments, "… as well as safer products, workplaces, roads, homes and public spaces" (National Public Health Partnership 2004b:4).

Children and young people, Indigenous people and those living in rural and remote communities have been identified as some of the target populations. An accompanying *National Aboriginal and Torres Strait Islander Safety Promotion Strategy* has also been released (National Public Health Partnership, 2004a).

Department of Emergency Services/ Queensland Health

Child Injury Prevention Project

In 2001, the Department of Emergency Services and Queensland Health became joint sponsors of the Child Injury Prevention Project (ChIPP), to be implemented in the Queensland communities of Mackay and Mt Isa (McClure & Spinks 2002). The project aimed to reduce injury-related morbidity and mortality in children aged from birth to 4 years within these communities over 3–5 years, and focused on four types of injury – falls, thermal injuries, poisoning and immersions (Yorkston et al. 2006:17, 21). Given the demonstrated efficacy of passive prevention strategies, the project directs efforts towards social and physical environmental modifications which would reduce children's exposure to hazards (Yorkston et al. 2006:17, 21). Although results gathered after 3 years do not lead to definite conclusions (because of the long-term nature of the project), positive outcomes are indicated. A large range of interventions have been implemented in each community, including:

- individual counselling sessions by health professionals during child health checks at various ages

175 For more information on the Smart Housing initiative, visit www.housing.qld.gov.au

176 As of June 2006, the National Public Health Partnership no longer exists. It has been replaced by the Australian Population Health Development Principal Committee and the Australian Health Protection Principal Committee.

- awareness-raising campaigns such as providing safety checklists for nursery furniture and cardiopulmonary resuscitation (CPR) instruction charts to parents
- media campaigns (including 'Hot water burns like fire' and 'Lock them up, store them high'), and
- industry involvement.

The program intends to run until 2007, when a final evaluation will be available.

Australian Competition and Consumer Commission (ACCC)

Keeping Baby Safe: A guide to nursery furniture

As part of its consumer protection role, the ACCC releases information on product safety. The *Keeping Baby Safe* publication (2005) is a guide to purchasing nursery furniture, identifying those items which may be hazardous for infants. Checklists of features to look for when purchasing new or second-hand furniture are provided, along with tips for safe use and maintenance of products.

As well as covering standard furniture such as cots, high chairs and prams and strollers, the publication deals with those products not recommended for use, such as cot and bed restraints and baby walkers.

Additional ACCC publications include *Safe Toys for Kids*, a booklet aimed at helping parents select safe toys for their children, as well as safety alerts on a number of products such as baby bath aids, bunk beds and baby walkers.[177]

Office of Fair Trading

About Baby and Children's Safety

The Office of Fair Trading offers public education about child-related product safety to enable parents to identify unsafe products and counteract such hazards. One such publication, the *About Baby and Children's Safety* booklet, informs parents that they should:

- read and act on product warnings on labels
- never use a product in a way other than the one for which it was originally intended, and
- check products regularly for wear and tear (Office of Fair Trading, 2002:5).

The booklet deals with child-related products ranging from nursery furniture to toy boxes, bicycle helmets and children's nightclothes. Information is provided on what key safety features to look for (including any relevant product standards), maintenance and tips for safe use of the product within the home.

The Office of Fair Trading also produces a range of fact sheets covering issues such as child restraints and bicycle safety.

Standards Australia

Product standards

Standards Australia has also published a handbook of guidelines for child safety, which outlines potential hazards in a number of environments. Child development and behaviour are discussed, illustrating the types of hazards to which children are vulnerable at various developmental stages. Specific types of hazards discussed include mechanical, thermal, chemical and electrical hazards. Possible product modifications to avoid these hazards are listed.

Standards Australia has also developed a number of safety standards for equipment for use by children. Products covered include cots, prams and strollers, high chairs, dummies and cradles.[178]

The injury prevention strategies outlined above are supported by the Commission. The Commission commends the relevant Queensland Government Departments and organisations on their efforts in preventing injury-related fatalities. Updates on current strategies for the prevention of accidental injury and fatalities will be provided in future reports.

177 For more information, see www.acc.gov.au

178 For more information on product safety standards, see http://www.saiglobal.com or www.standards.com.au