

REGIONAL REPORTS

Consumer activism pays big dividends in USA

Homer said that "The mark of wisdom is to read aright the present, and to march with the occasion".¹ In this regional report from the US, I commend those businesses and media outlets in America who have had the wisdom to listen to the concerns of injury prevention advocates and to either voluntarily withdraw their questionable products from the market and/or to change their advertising strategies. A few examples from various injury risk areas follow.

Newsweek (choking prevention)

In spring of 1997, *Newsweek* published a special edition entitled, "Your Child From Birth to Three".² One chart called "Building Health Habits" contained a serious error. It said that 5 month old babies could hand feed themselves zwiebacks or raw carrot chunks—a clear choking hazard for young children. In response to the concerns of the safety community, *Newsweek* published a correction in a subsequent issue, promising to send corrected versions of the early childhood issue to newsstands, hospitals, and doctors' offices. Any subscriber who wanted a corrected version of the chart was invited to call a toll-free number.³

Mattel (toy safety)

In 1996, Mattel introduced the Cabbage Patch Snacktime Kids who were supposed to munch on plastic cookies and French fries. About 500 000 dolls were sold. In response to more than 100 reports that the snacking doll preferred to eat children's hair and fingers, Mattel pulled the dolls off the toy store shelves, ordering retailers to return any unsold dolls and offering \$40 refunds to any dissatisfied consumers who had bought the dolls.⁴

Haggar pants (fire prevention)

In 1997, Haggar Clothing Manufacturers produced a commercial in which a man re-enters a burning building to retrieve his pants. Upon seeing this ad, a New York fire chief called Haggar to complain that the fire safety community spends considerable time and energy trying to teach the public to "get out and stay out" of a burning building (personal communication). The fire chief alerted the National Fire Protection Association as well, and working together, they convinced Haggar to pull the ad immediately.

Northwest Airlines (drowning prevention)

On 26 April 1997, *USA Today* published a Northwest Airlines ad which depicted a child bending over with his head in a five gallon bucket.⁵ The copy read, "Great summer sav-

ings on Northwest Airlines. Looking for a new vacation spot?" Ann Brown of the US Consumer Product Safety Commission called the Chief Executive Officer of Northwest and he agreed to pull the ad immediately. As a result, the ad ran only once anywhere—in that issue of *USA Today*. In addition Northwest published an article on hidden hazards in the home in its September 1997 in-flight magazine, *World Traveler*.⁶ Unfortunately, the same stock photo ran again in an advertisement for Nature's Solutions herbal supplements in the February 1999 issue of *Parenting*. The editor printed an apology in a later issue, stating that "we regret that the picture slipped through our normally stringent ad review process. Nature's Solutions has stopped using the ad, and has appointed a child safety advocate to review all of its promotional and advertising materials".⁷

My thesis is that every single one of us in the injury prevention community can make a difference in influencing corporate America.

Taking five minutes to communicate our concerns about a new product or its promotion in writing or by telephone is no little thing, but rather can produce tremendous results in the safety arena. As Ralph Waldo Emerson said, "Sometimes when I consider what tremendous consequences come from little things—a chance word, a tap on the shoulder, or a penny dropped on a newsstand—I am tempted to think there are no little things."¹

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- 1 Morris TV. *If Aristotle ran General Motors: the new soul of business*. New York: Henry Holt and Company, 1997.
- 2 Your child from birth to three—special edition. *Newsweek* Spring/Summer, 1997.
- 3 Hays CL. *Newsweek* recalling special issue on children. *New York Times* 7 May 1997.
- 4 Mayer CE. Munchkin or mistake: how a snacking doll engulfed Mattel, Inc. *Washington Post* 6 January 1997.
- 5 US Consumer Product Safety Commission. *Northwest airlines pulls ad at CPSC request* (news release). 25 April 1997.
- 6 Essex M. Safe at home. *World Traveler*. September 1997: 26-31.
- 7 Editor's note. *Parenting Magazine* May 1999: 15.

Report from Portugal

Inedibles in food

In May, Portugal became the first EU member state to publish a law forbidding unwrapped inedibles from being sold with food. Portugal's child safety organisation, APSI, sought unsuccessfully to toughen the requirements to protect children, recommending that the inedible article should be aimed at the minimum age of the consumers of the food product. For example, if a cereal is for a baby aged from 6 months, the trader should not be allowed to claim that the object present is for 3 year olds. In addition, APSI called for the inedible object to be packaged to prevent accidents—it should have holes if rigid or the characteristics of the plastic should not allow a child to suffocate or to choke on it. This was proposed because there have been complaints in Portugal about children almost choking on the rigid capsule that contains the toy of Kinder Eggs. These com-

ments were not considered by the government so the law, that came into force in November, is not as effective as it could be.

School buses in Portugal

Since the beginning of 1998, APSI has been raising awareness of the public for the need to improve children's safety when they are carried by school buses. There are many injuries and accidents due to overloading, the bad condition of the bus, unsupervised children, lack of seat belts, and poorly located bus stops. Even babies and children under 3 years old when they go to daycare centres are carried in buses or minibuses without any kind of restraint. APSI has written to the Prime Minister about it but nothing has changed. The Ministry of Health is concerned about it, and in its strategies for the year 2002 it aims to have a law defining minimum requirements for the safe transport of children.

Children in cars

It is still possible to buy child restraints to the now out of date European regulation R44.02 in Portugal, mainly old models from Portuguese manufacturers. APSI has been undertaking regular surveys of the way children are carried in cars. The most recent was in June 1999, and although the number of children properly restrained is slowly rising, it is still very low—only 21% of children under 12 are properly restrained. For children aged 3 years and under, half of the children were restrained although the observers, who were checking from outside the vehicle, reported that one third of these are obviously misused. The main errors noted were infant seats facing forward, infant seats lying on the car seat without being restrained, children unrestrained while the seat is restrained, and children restrained in an unrestrained seat!

Accident prevention in Portugal's health strategies

The Ministry of Health has published the Strategies for Health including targets for a reduction by 2007 of 30% in road crash deaths and a reduction in injuries at home and school and during leisure activities. The targets for 2002 include a fall by 15% of the road accident mortality rate by raising of restraint use, legislation for safe school bus transportation, compulsory use of cycle helmet and other issues related to cycling.

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Injury surveillance in Northern Ireland

A recent development in Northern Ireland shows much promise for injury control in the province. A new electronic injury surveillance system has been introduced at the Royal Belfast Hospital for Sick Children, our only paediatric hospital. Information on the cause of injury is being collected on all children presenting to the accident and emergency department. The first six months' data has been examined for completeness and accuracy.

Of the 11 683 cases, 4567 (39%) were injuries and of these 3883 (85%) had complete coded injury surveillance data—external cause, location, activity, intent. The free text narrative was used to assess the accuracy of the coding of external cause of injury and 71% were deemed to be correctly coded. The areas of greatest confusion were foreign bodies being coded as poisonings, falls from a height being classed as low level falls, and swimming pool immersions which were in fact other injuries at a swimming pool. Over 200 cases that were coded as other or unspecified were capable of being allocated to other codes on the basis of the free text. Accuracy was greatest for burns, scalds, and poisoning by medication.

To determine the overall value of the information we developed a scoring system against which a 10% sample (457) was assessed. The system allocated points for the following pieces of information: the coded data fields of external cause, location, activity, intent (4 points); the free text—nature of complaint (1 point), specific details on location, activity and mechanism of injury (3), measurement in terms of height, quantity, volume etc (1), safety precautions (1). The highest score possible was 10 but our highest score was 8 (in 12 cases), followed by 66 cases at 7 points, and 211 cases at 6 points. If all four coded fields are correctly completed it is easy to get at least 4 points so this showed us that improvements need to be made to the quality of information in the free text field.

Some initial discoveries:

- Two thirds of the burns by touching a hot object were to boys and one third were by touching an iron.
- Scalds to children were evenly divided between boys and girls and half pulled something hot on to themselves.
- After paracetamol solution, white spirit and essential oils were the agents most commonly associated with poisonings.

Although this is not earth shattering for countries that have well established injury surveillance, it is the first time that we can produce detailed and specific information for those working in injury prevention in Northern Ireland.

Our short evaluation showed the need for “help” documents and a more structured training programme for the nurses responsible for completing the injury surveillance data. The technical problems with the system link to the length of the free text field, the need for mandatory fields, and some additions to the external cause of injury codes. These are in the process of being addressed with a training manual and comprehensive index being written. Feedback of some of the initial findings to the staff is being planned in order to highlight the importance of the data for injury control. When we come to undertake a second evaluation one measure against which we will review the quality of the data is the scoring system we devised. This work was undertaken by a medical student on a short studentship. Funding is being sought to enable on-going analysis and dissemination of the findings.

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A memorial to Colonel John Stapp

Colonel John Stapp, whose sled testing resulted in the basic design for present day safety harnesses, died recently. Sue Baker writes below about a fellowship in his memory.

The death of Colonel Stapp leaves a big hole in our universe. The gap will always be there, but to encourage the next generation of leaders, the Johns Hopkins Center for Injury Research and Policy has established the John Paul Stapp Endowed Fellowship. Interest from the endowment will go to students whose research and study focus on aviation safety, highway safety, or biomechanics—areas that have benefited greatly from Colonel Stapp’s historic research.

Contributions of any size will be welcomed. Gifts of \$500 to \$2500 will be matched by faculty members at the Johns Hopkins School of Public Health. A gift or pledge of \$50 000 or more payable over five years to the Stapp Fellowship will be matched by a gift from Michael Bloomberg, chairman of the Johns Hopkins University Board of Trustees. In addition, up to 10 bequests or planned gifts of \$100 000 or more will be matched through the Bloomberg Challenge.

For more information about the endowment contact Sue Baker (tel: +1 410 955 2078 or e-mail: sbaker@jhsph.edu). Contributions or pledges to Johns Hopkins University, earmarked for the Stapp Fellowship, can be sent to the Johns Hopkins University School of Public Health, 614 N Wolfe St, Baltimore, MD 21205, USA.

BOOK REVIEW

Demonstrating Your Program’s Worth: A Primer on Evaluation for Programs to Prevent Unintentional Injury. By N J Thompson and H O McClintock. National Center for Injury Prevention and Control, Atlanta, Georgia, 1998. No ISBN, obtainable free of charge from CDC Publications web site.

This book comes with a comment form so that readers can evaluate its worth. I found this a very useful starting point when reviewing the text and would encourage everyone else to use it too. As a researcher and practitioner who has had experience of evaluating injury prevention programmes, I was interested to see what this United States text has to offer, and how applicable it is to the UK.

The purpose of the book is to help those working in injury prevention understand (1) why evaluation is worth the resources and effort involved, (2) how evaluation is conducted, and (3) how to incorporate evaluation into programmes.

The book is divided into three main sections as outlined above. Section one is brief but covers important issues such as why

evaluate, what components go into good evaluation, who should conduct evaluations and what type of information evaluation will provide. In general the content of this section is good, however is not always easy to follow as it often refers to pages further on in the book. The least useful element of this section (for me) is the part that looks at “choosing the evaluator”. I believe most people reading this book will be doing so because they themselves will be carrying out an evaluation, or teaching others how to evaluate—not hiring an evaluation consultant.

Section two describes each of the four stages of evaluation: formative, process, impact, and outcome and discusses the most appropriate time to carry out each stage. There is a wealth of valuable, important, and relevant information in this section, particularly the comprehensive descriptions of each of the stages of evaluation. It is ideal as a reminder, and for anyone who is not clear about different types of evaluation and why each method is appropriate at different stages of a programme.

The methods for conducting evaluation that will help any reader carry out simple evaluation are dealt with in section three. Again, this section contains comprehensive and valuable information on various qualitative and quantitative methods that could be used to evaluate programmes. It is also encouraging to see that both the qualitative and quantitative methods are given equal importance. The quality of the information in this section is well balanced and is perhaps most appropriate for personnel who are not that familiar with evaluation methods. Any more detail would deter a beginner from ever evaluating anything! Once again I find myself wondering about the relevance of including information on how to communicate with, hire, and supervise evaluation consultants. This may be more relevant to a US situation but have less application in other cultural contexts.

The appendices contain basic samples of “questions to ask, events to observe, and who or what to count” during evaluation, with the ideas included being based on injury prevention programmes the CDC currently fund. Although most injury prevention programmes world wide would most likely fit into one of their 12 categories, I feel that this is not appropriate for an international audience. Appendix C contains a comprehensive and well structured checklist of tasks that can be used for reference. Appendix E, the glossary, is absolutely essential for anyone starting out in the evaluation of unintentional injury prevention programmes, and appendix D contains a basic bibliography.

On the whole I think this is a good resource for practitioners in the field of injury prevention. I do feel, however, that the book tries to cater for too wide an audience—for those with little or no experience of evaluation, to those who will use it as a teaching tool. The quality of the information presented ranges from being very useful and relevant, to extremely basic and perhaps a little condescending to the reader. Despite these criticisms I would definitely recommend this book to practitioners for personal reference. I would suggest, however, it would be best used as a teaching resource for injury prevention coordinators who are training others in programme evaluation.

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Advance notice

The full text of the Haddon Memorial Lecture, presented in New Delhi at the Fifth World Conference on Injury Prevention and Control by James Hedlund this month, will appear in the June issue.

CALENDAR

MPH Course in Safety Promotion

15–26 May 2000, Stockholm, Sweden. *Further information:* Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

11th International Conference on Circumpolar Health

4–9 June 2000, Harstad, Norway. Symposia are planned on topics of particular importance to arctic indigenous peoples. *Further information:* <http://www.hoarr.no/icch/> (e-mail: administrasjon@hoarr.no).

International Child Passenger Safety Conference

11–14 June 2000, Arlington, Texas. The conference will include both technical information regarding child restraints and programs that are being used to encourage their use. *Further information:* Center for Injury Prevention, Wisconsin (tel: +1 715 344 7583, e-mail: merritt@cipsafe.org).

Safety Promotion Research: Third International PhD Course

16–27 October 2000, Stockholm, Sweden. *Further information:* Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

First National Conference on Injury Prevention and Control

19–21 October 2000, Kananaskis, Alberta, Canada. This event will be preparation for Canada to welcome the injury world to Montreal in May 2002 for the 6th World Conference on Injury Prevention and Control. Two western Canadian centres are hosting the national conference—the British Columbia Injury Research and Prevention Unit and the Alberta Centre for Injury Control and Research. Themes will be road safety; occupational safety; intentional injuries; home, sport, and leisure safety; and post-injury control. *Further information:* www.med.ualberta.ca/acicr or www.bcricwh.bc.ca/bcirpu.

Injury 2000 Prevention and Management

19–25 November 2000, Canberra, Australia. *Further information:* Injury 2000 Prevention and Management, PO Box 1280, Milton, Queensland 4064, Australia (tel: +61 (0) 7 3858 5410; fax: +61 (0) 7 3858 5510; e-mail: injury2000@im.com.au).

10th International Conference on Safe Communities

21–23 May 2001, Anchorage, Alaska. This conference will focus on the opportunities in the new millennium for community based injury prevention programming. *Further information:* Diana Hudson, PO Box 210736, Anchorage, Alaska 99521, USA (tel: +1 907 929 3939, fax: +1 907 929 3940).

Nordic Safe Community Conference

21–24 August 2001, Denmark. *Further information:* Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

Honorary editors honoured

Not one but two of our honorary editors have been honoured. We are proud and delighted that Sue Baker has received the American Public Health Association Award for Excellence and Hugh Jackson will be the recipient of the James Spence Medal from the Royal College of Paediatrics and Child Health. In both cases these awards signify not only that the recipients' peers recognise their contributions to their respective disciplines, but also that the field of injury prevention is one worthy of such recognition, largely as a result of their efforts.

LETTERS TO THE EDITOR

Open invitation from the International Poverty and Health Network to all health professionals

EDITOR,—Always and everywhere, the challenge for all health professionals is to understand, from a position of relative comfort, the nature and extent of the problems faced by the poor, the marginalised, and the vulnerable.¹ Understanding, once even partially achieved, creates empathy and a responsibility to advocate for redress.

The International Poverty and Health Network (IPHN) was created in December 1997, following a series of conferences organised by the World Health Organisation (WHO). The aim of the network is to “integrate health into poverty eradication policies and strategies, promoting commu-

nity partnership and intersectoral action, as a means to achieve effective and sustainable results”. It was formed in response to the evidence of the persistent and growing burden of human suffering due to poverty and it invites others to join the endeavour.

Around 1.3 billion people live in absolute, grinding poverty on less than \$1 per day despite the overall substantial growth of the world economy which doubled over the 25 years before 1998 to reach \$24 trillion.² Of the 4.4 billion people in developing countries nearly 60% lack access to sanitation, a third have no access to clean water, and about 20% lack access to health care of any kind; a similar proportion do not have sufficient dietary energy and protein.

Economic disparities both within and between countries have grown and in about 100 countries incomes are lower in real terms than they were a decade or more ago.³ By 1995 the richest 20% of the world's population had 82 times the income of the poorest 20%. The world's 225 richest people have the combined wealth equivalent to the annual income of the poorest 2.5 billion people in the world (47% of the world's population).⁴ At the same time the world is facing a growing scarcity of essential renewable resources from deforestation, soil erosion, water depletion, declining fish stocks, lost biodiversity, and challenges such as climate change which are likely to impact particularly on poor, vulnerable populations.

Despite the overall dramatic increases in life expectancy which have occurred over the last century, health professionals should be concerned about growing inequalities in health and wealth.⁵ The precipitous decline in life expectancy in Eastern Europe, particularly in Russia, is a graphic example of how health may deteriorate as societies face sudden social and economic change accompanied by growing poverty. The gap in life expectancy between selected Western European countries and Russia has widened from about three years for men in 1970 to around 15 years in 1995; the figures for women show a widening from four to 10 years over the same period.⁶ This health crisis is centred particularly on adult mortality from chronic diseases and external causes, principally violence. The East Asian recession has been deep and severe, resulting in substantial falls in average per capita income in five countries, most notably in Indonesia, with likely effects on poverty and ill health.

Many African countries have total external debts that are more than 100% of their gross national product. Although there has been progress in cancelling debt, only 22 of the 52 countries needing substantial or total debt reduction will actually see their annual payments reduced after the agreements made at the Cologne summit.⁷ Therefore much still remains to be done, including monitoring how the World Bank and International Monetary Fund (IMF) propose to implement the debt reduction programme and ensuring that the economic policy reforms they recommend are focused on reducing poverty.

Even among generally prosperous, industrialised nations, in countries including Spain, Finland, Sweden, Denmark and the USA, there are many examples of growing socioeconomic inequalities in health over the last 20 years or so.⁸ In the UK, there has been a widening of the differential in all cause mortality between social class V (unskilled) and social class I (professional) from a twofold

difference in 1970–72 to almost a threefold difference in 1991–93.⁸

It is a matter of particular concern that the lives of so many children are blighted by poverty and robbed of their physical and mental potential.⁹ Even in the USA more than one in four children under the age of 12 have difficulties in obtaining all the food they need.

Ill health and poverty are mutually reinforcing and can generate a vicious cycle of deterioration and suffering. Ill health contributes directly to reduced productivity and, in some cases, to loss of employment. When it affects the principal earner in poor families it frequently has severe implications for economically dependent children, and other family members, who may no longer be able to nourish themselves adequately. By definition, poor people have very few reserves and may be forced to sell what assets they have, including land and livestock, or borrow at high interest rates, in order to deal with the immediate crisis precipitated by illness. Each option leaves them more vulnerable, less able to recover their former condition, and in greater danger of moving down the poverty spiral. In contrast, effective and accessible health services can protect the poor from spiralling into worsening economic problems with the onset of illness, and community based health care has the potential to make a major contribution to the building of social capital and to the strengthening of the community's own coping mechanisms.

In the 20th century development was all too often equated with economic growth, but the link between economic prosperity and health, a key component of human development, is not automatic. A recent World Bank study of the causes of declines in mortality between 1960 and 1990 suggested that gains in income contributed around 20% to male and female adult mortality and under 5 mortality rate reductions.¹⁰ The researchers indicated that educational level among women and the generation and utilisation of new knowledge were more important factors.

Poverty is a social construction with many dimensions including lack of basic education, inadequate housing, social exclusion, lack of employment, environmental degradation, and low income. Each of these diminishes opportunity, limits choices and undermines hope, and each poses a threat to health. Economic indicators focus primarily on income poverty, whereas health indicators provide a measure of the multidimensional nature of poverty. For this reason, health should be the pre-eminent measure of the success or otherwise of development policies in the next century. It is health, rather than economic, indicators which will demonstrate the importance of implementing policies across a range of sectors to slow the rate of depletion of renewable resources and, through the securing of human rights,¹¹ to capitalise on the potential of those who are currently unable to improve their quality of life.

Health professionals strive to understand the detail of their patients' experience of illness and distress. Where health is being undermined by poverty, this understanding becomes, as we share our patients' frustration and anger, part of a process of developing solidarity with disadvantaged individuals and communities. Once suffering is expressed, it becomes tangible and demands redress. This is one of the fundamental processes of medicine and healing; it applies no less to social injustice. If we simply hear the story of

suffering but make no move to work alongside the sufferer for redress, we abandon our task.

The IPHN is a worldwide network of people and organisations from the fields of health, business, non-governmental organisations, and government, who seek to influence policy to protect and improve the health of the world's poor, with particular emphasis on the poorest in all countries. The IPHN urges that a balance must be struck between social development and growth in per capita income; between the human and income dimensions of poverty; and between redistributive and market reforms. At the level of health, with particular focus on the needs of the poorest and most vulnerable, the aspiration is to achieve a balance between biomedical and social approaches; between community based health development and an appropriate response to the needs of individuals; between preventive, promotive and curative health care; and between physical and mental health.

Over the next few years IPHN supporters will strive to reduce the burden of ill health due to poverty in the following ways:

- Engaging in strategic discussions with international institutions such as the IMF, the World Bank, the WHO, and national governments to ensure that health is placed at the centre of development and that health impact assessments of all policies are undertaken.

- Promoting intersectoral action for health at the local, regional and national levels by working with sectors such as education, business, agriculture, and transport to develop and implement effective policies.

- Building the evidence base on effective interventions to reduce inequalities in health and how improved health can reduce poverty.

- Facilitating exchange of knowledge between health professionals in the north and south about effective ways of working.

- Ensuring that education programmes for health professionals include appropriate information on the impact of socioeconomic inequalities on health and what health professionals can do to reduce such inequalities.

- Encouraging health professionals to work with local communities to improve the health of the poorest.

- Monitoring trends in health inequalities and using the data to influence policy.

We invite others to join us in this endeavour.

For more information about the IPHN, please contact: International Poverty and Health Network, Health Link Worldwide, Cityside, 40 Adler Street London E1 1EE, UK (tel: +44 (0)207 539 1570, fax: +44 (0)207 539 1580, e-mail: (Roger Drew) drew.r@healthlink.org.uk) or International Poverty and Health Network, Community Health Cell, Society for Community Health and Awareness, Research and Action, No 326, 5th Main, 1st Block, Koramangala, Bangalore 560 034, India (e-mail: (Thelma Narayan) sochara@blr.vsnl.net.in at INET).

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Versions of this editorial are being published in many journals world wide.

Let's emphasize fire sprinklers as an injury prevention technology!

EDITOR,—The recent article by Lynne Warda *et al* did a generally excellent job of reviewing the literature on prevention of fire injuries.¹ Perhaps because the keywords did not include “sprinkler”,² the report completely neglected the tremendous value of automatic fire sprinkler systems in preventing deaths and injuries in house fires. The National Institute of Standards and Technology estimates that while smoke detectors alone can reduce the fire death rate by 52%, sprinklers alone could reduce deaths by 69% and the combination by 82%.³

Sprinklers protect people without requiring human action after a fire starts, and therefore go a major step beyond smoke detectors. Detectors can alert people to a fire, but fail to protect anyone who cannot easily escape without help—children, the elderly, the disabled, the intoxicated⁴—the very people who are at greatest risk of dying once a fire is initiated. Detectors do nothing directly to prevent flashover and unacceptable heat, visibility, and toxic smoke conditions. In contrast, fire sprinklers are designed to effectively extinguish fires and to prevent these life threatening conditions.

Although the great majority of fire deaths occur in residential properties, no epidemiologic research on the impact of sprinklers on morbidity and mortality in private housing has been published. During the years 1985–91, the National Fire Incident Reporting System received reports of 5171 non-arson

fires in homes with sprinklers and 126 240 non-arson fires in homes without sprinklers for the same fire departments. Preliminary results of research, which included validation of the outcomes and sprinkler status with the reporting fire departments, by Kay, one of the authors, indicate that the sprinklered homes had no fatal fires and 3.9 non-fatal injury fires per 1000 fires. In contrast, the non-sprinklered homes had 8.0 fatal fires and 36.7 non-fatal injury fires per 1000 fires.

In recent years, some jurisdictions in the United States have mandated sprinkler installation in new single family or multifamily housing. Yet many builders and homeowners are discouraged by myths and misconceptions, including a belief that sprinklers will "go off" by mistake and cause extensive water damage. In fact, sprinklers rarely activate accidentally and they sprinkle only rooms where there is fire. Not only do sprinklers improve life safety conditions by extinguishing a fire soon after onset, sprinkler discharges of 30 gallons/minute cause much less property damage than fire hoses at 300 plus gallons/minute.

Many people also think that sprinklers are too costly, but advances in quick response sprinkler technology have improved performance and reduced costs through the use of plastic pipe. The installation cost (\$1–1.50 per ft² of finished floor space) in a new house can be gradually recovered by reductions in insurance premiums.

Installation of automatic sprinkler systems in all new dwelling units and retrofitting in high hazard locations should be a high priority goal of the next decade.

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Argument for accident and emergency (A&E) collection flawed

EDITOR.—In a recent edition of *Injury Prevention*, Leonard and colleagues argue that the monitoring of recent changes in bicycle road safety policy in Scotland require "accurate measurement to generate robust findings" (p303).¹ Regrettably what they propose, "a national computerised data collection system for all A&E [accident and emergency] departments" (p304), will not meet their specification. This is primarily because there would be many cyclists who do not attend A&E who have injuries of similar anatomical or physiological severity to those that do attend. There is evidence that the probability of attendance at A&E depends on factors other than injury occurrence, including demographic and access factors such as distance from hospital.^{2–4} Equally important

is that delivery of A&E services may change within and across providers over time in response to changes in health service policy and practice.⁵

If Scotland wishes to monitor the impact of its transport policy on injury to bicyclists it needs an indicator which ideally meets the following criteria:

- (1) The indicator should reflect the occurrence of injury satisfying some case definition of anatomical or physiological damage;
- (2) The injury cases ascertained should be important in terms of incapacity, impairment, disability, quality of life, cost, and/or threat to life;
- (3) Cases should be completely ascertained from routinely or easily collected data;
- (4) The probability of a case being ascertained should be independent of social, and of health services supply and access factors.⁵

An indicator based on all attendances for injury at A&E departments will not satisfy these criteria. We have argued that, in the context of routinely collected data in England, a reliable indicator is one based on identifying cases of serious long bone fractures admitted to hospital.⁵ This indicator may be a useful starting point for the measurement of recent changes in bicycle road safety policy where, like in England and Wales, no direct measures of injury severity are routinely collected.

A national computerised data collection system for all A&E departments in Scotland is likely to be expensive. A better use of any additional resources would be to introduce severity coding of injury admissions, and to use an indicator based on serious injury cases to monitor the effect of this and other policy changes.

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Foam party risks

EDITOR.—Foam parties are becoming increasingly popular among young people. A male adolescent aged 16 years tried to leave a dance floor covered with several feet of party foam. Because of the slippery foam adhering to his shoes and the floor he fell and hit his head on a metal bar placed at the edge of the dance floor. He got up but he soon became somnolent and retrograde amnesia occurred. Because of the foam nobody could see the circumstances of the fall and he was taken



Figure 1 Computed tomogram two days after the accident showing right frontal intracerebral haematoma with perifocal edema, small right frontal subdural haemorrhage, and midline shift to the left.

outside to recover. Consequently his transport to an emergency department was delayed.

At admission a small skin bruise at the occiput was noted. Because of increasing headache and clinical signs of increased intracranial pressure he was referred to our hospital for further treatment the second day after the accident. Computed tomography at admission demonstrated a significant right frontal intracerebral haematoma with perifocal oedema, a small right frontal subdural haemorrhage, and a midline shift to the left (fig 1). He was monitored in the intensive care unit with an epidural intracranial pressure transducer. The initial recovery was uneventful and he was discharged home two weeks after the injury. However, he had lost smell and taste perception and his short term memory remained disturbed at follow up six months later.

Young people should be made aware that party foam sprayed on a dance floor creates a very slippery surface and the potential for accidents may be imperceptible to others when several feet of foam cover the floor. Foam parties can also cause significant chemical keratoconjunctivitis when the foam containing anionic tensioactives comes into contact with their eyes.^{1 2}

We therefore recommend that party foam should be used only when there is adequate supervision of the dance floor. The edges of the floor should be rounded and made of impact absorbing material. Party foam must not be sprayed onto the faces of people dancing.

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