

July 2005 to June 2006 *Injury Surveillance Annual Report*



With the support of:



In conjunction with:



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We also acknowledge the Department of Health, Western Australia for its ongoing financial support.

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In conjunction with:

Kidsafe WA

The data is collected and analysed at Princess Margaret Hospital on a quarterly basis and provided to Kidsafe WA to prepare quarterly WA Childhood Injury Surveillance Bulletins on selected injury issues.

During 2005 to 2006 the following WA Childhood Injury Surveillance Bulletins were prepared by Kidsafe WA in conjunction with Princess Margaret Hospital and made available through the Kidsafe WA website www.kidsafewa.com.au

- July 2007 - Childhood Injury Surveillance in WA: Beginnings and Now
- October 2007 - Falls in Focus: How do children fall?
- January 2007 - Unintentional Injuries to Aboriginal and Torres Strait Islander Children
- April 2007 - Poisoning: Medicines can be poisons too

1. EXECUTIVE SUMMARY

Princess Margaret Hospital for Children (PMH) as the tertiary paediatric centre for Western Australia, remains the major referral source for injured children. This is the first annual report using the revised Injury Surveillance codes.

The financial year 2005/06 saw 47,104 children present to the emergency department, of these 11,344 (24%) after suffering an injury. This represents a 6.7% increase when compared with the previous financial year. The injury rate was slightly below the long-term average, 25% of total presentations, but represented a significant 8.1% increase in actual injury presentations from the previous financial year. The male to female injury ratio, 3 to 2 respectively, is the same as the long term ratio. The pre-school age group dominated injury presentations, representing 40% of the total injuries seen at PMH. During this financial year the greatest presentation numbers (35%) occurred in the early evening period of 5 to 8pm, with this being delayed 30 minutes on weekends. The peak period was 1 hour later in the summer, than in winter due to the later sunset.

The majority of injured children presenting to PMH reside within the Metropolitan area of Perth (93%) and are not of Aboriginal background (94.5%). The overall rate of aboriginal presentation (5%) was above their general population percentage (4%), however a significantly higher percentage of rural children were of Aboriginal descent (16%). The majority of injuries occur in or around the child's home (59%). The school and surrounds were the next likely place for injury, though with a decline in numbers during school holidays. Falls remain the dominant cause (43%) followed by being hit by or hitting an object (21%). The overall rate of admission following an injury was 20%, however was nearly 52% for those presenting from a rural region.

A brief analysis of injury trends is featured within this report. There are two clearly identified seasonal cycles related to injury presentations to PMH, an annual cycle with a winter peak and a weekly cycle with a peak on Sunday. The analysis of data by cause of injury identified clear seasonality of presentations amongst burn, bicycle and fall related injuries.

In conclusion, the financial year 2005/06 has seen an increase in total emergency and injury presentations, but a reduction in the admission rate. The unexpected cooler and drier weather experienced during the last quarter of the year resulted in an increase in almost all injury classifications. In particular, an outdoor activity like bike riding, skateboarding and rollerblading, together with poisoning and burns.

2. INTRODUCTION

Princess Margaret Hospital for Children (PMH) is the only tertiary paediatric centre for Western Australia and is thus the reference centre for paediatric illness and injury for the state. Although the catchment zone may potentially be the entire state, it does not see all children requiring hospital treatment in any given year. Many will be treated appropriately at regional hospitals and medical centres. On average, approximately 44,000 children present to PMH seeking medical assistance from the hospital's emergency department each year. The majority of these children will be under 6 years of age.

Injury surveillance is a systematic data collection related to all children presenting to the emergency department with an injury. A modified version of the International Classification of External Causes of Injury (ICECI), version 1.1a is currently used to code injury presentations. The ICECI is a member of the World Health Organisation's (WHO) Family of International Classifications. The five major data elements collected are: cause, human intent, location of injury, activity and injury factor. This report is based on data extracted from these injury surveillance data fields.

The PMH emergency department uses the Emergency Department Information System (EDIS) version 9.31.000.01, a computer-based database, to record and collate all patient details of children presenting to the hospital's emergency department. This is a real time electronic database used to record and manage patient data. The system has been in operation since January 1998 and is subject to quality assurance checking to ensure data accuracy and integrity. Access to EDIS is via remote terminals within the emergency department, the database being networked

3. METHOD OF DATA COLLECTION

A triage nurse initially assesses the children presenting to the emergency department of PMH. All clinical information and basic demographic details are recorded together with the child's triage code, an indication of the level of "emergency", based upon their reason for presentation. Those children presenting due to injury then have injury surveillance data taken, based on the following fields: date, time and cause of injury, intent of injury, place of injury, activity when injured and any appropriate injury factor. One full-time Injury Surveillance Officer is employed at PMH to monitor and analyse the injury data.

3.1 DATA ACCURACY AND COMPLETENESS

PMH is committed to the provision of quality data for health professionals and other interested parties. Daily validation of injury data fields is undertaken by the Injury Surveillance Officer to ensure the accuracy of data. This involves the checking for null or missing data fields and identifying any misclassification of data.

3.2 LIMITATIONS

The data contained in this report represents the paediatric population that presents to PMH and as such comparisons made on a state or other basis must be done so with due care. The data used for this report is reliant on the accuracy of those entering data within EDIS. As such, it may be subject to coding bias and associated skewing of injury data. Finally there is scope for inadequate or under reporting of injury data.

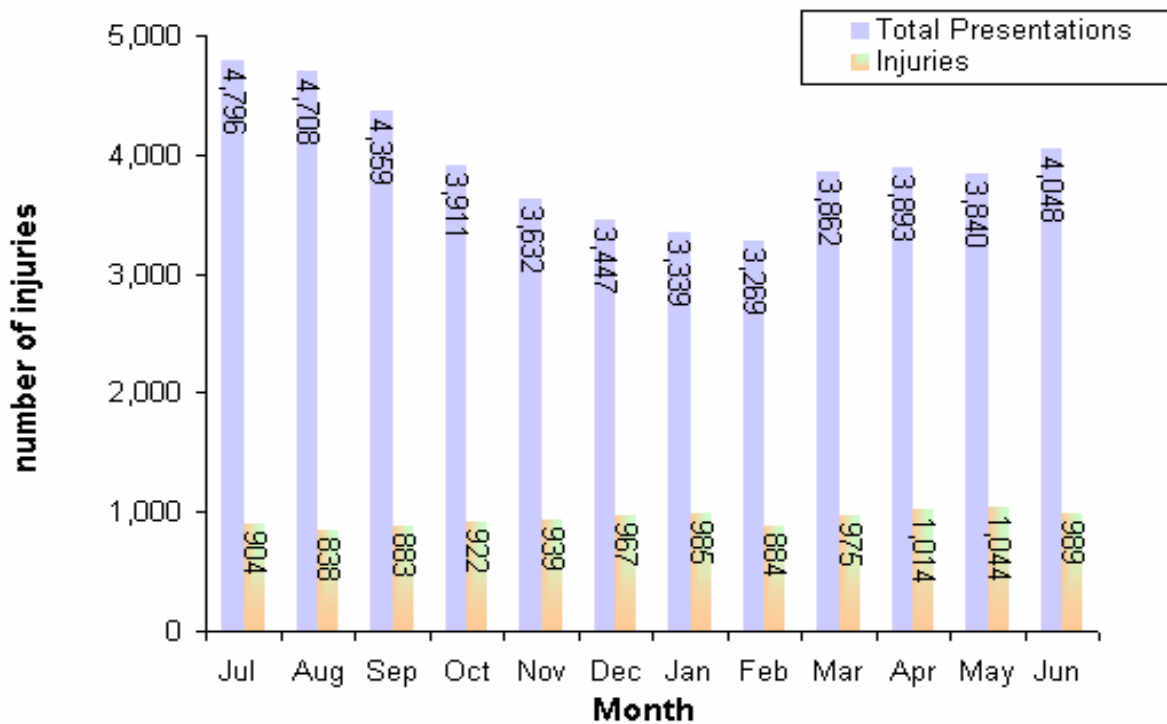
4. DEMOGRAPHIC DATA

4.1 TOTAL EMERGENCY DEPARTMENT PRESENTATIONS DUE TO INJURY, JULY 2005 TO JUNE 2006

The financial year saw a total of 47,104 presentations to the emergency department of PMH, with figure 4.1 displaying the monthly breakdowns. This represents a 6.7% increase from the presentations seen during the previous financial year. The yearly cycle experienced within the emergency department is clearly evident in figure 4.1, with late winter peak and late summer trough.

Injury presentations for the year, 11,344 (24%) were below the long-term average of 25% of total presentations but a significant 8.1% increase in overall injury numbers when compared with the previous financial year. The monthly percentage of injury presentations (figure 4.1) shows no obvious seasonal cycle. However a yearly cycle is noted when injury presentations are viewed as a percentage of total monthly presentations, with a summer peak of 29.5% and a winter trough of 17.7%.

Figure 4.1 Number of ED presentations July 05 – June 06

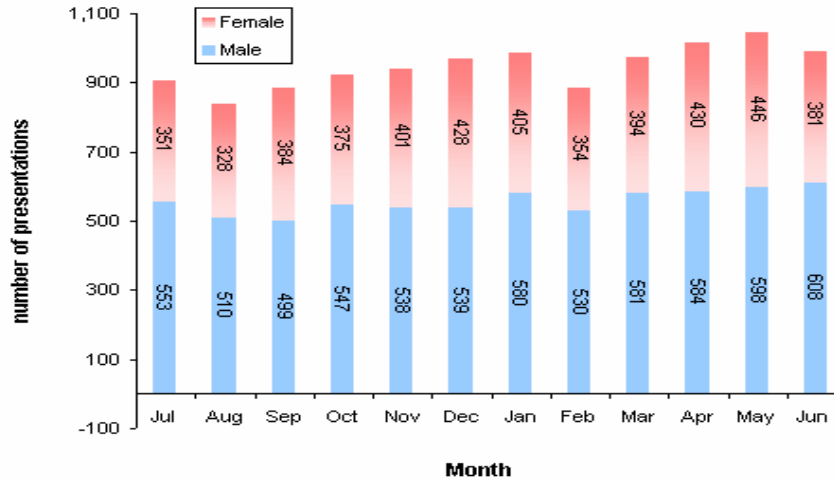


4.2 AGE AND SEX DISTRIBUTION

Male: 25.6% Of Total Male Admissions: (26,085)

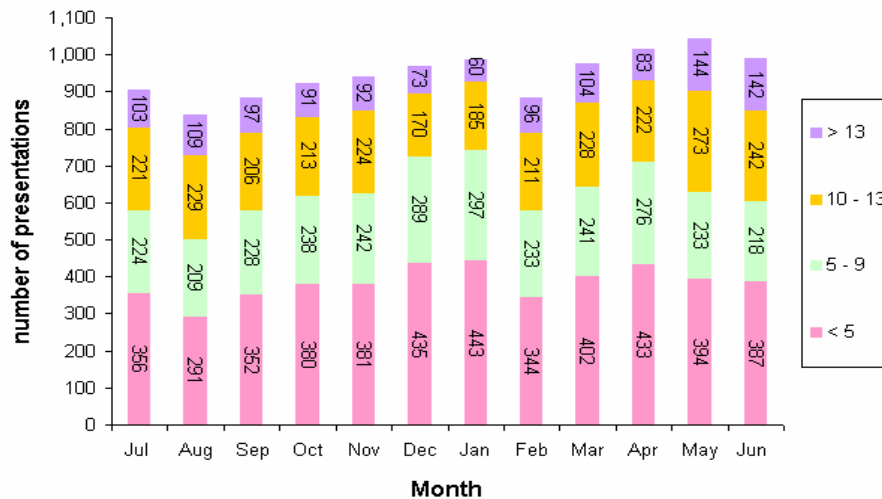
Female: 22.3% Of Total Female Admissions: (21,019)

Figure 4.2.1 Sex Distribution July 05 – June 06



During this report period, males represented 58.8% of injury presentations (n=6,667) and females 41.2% (n=4,677). Figure 4.2.1 displays the monthly breakdown of presentations. This is consistent with known injury rates between the sexes. The gender ratio varies little throughout the year, with the highest proportion of females presenting in December and males presenting in June.

Figure 4.2.2 Age Distribution July 05 – June 06



The pre-school age group, those under 5 years of age, remained the dominant group representing 40% (n=4,598) of total injury presentations to PMH. Those under 10 years of age represented 66% of total injury presentations. Figure 4.2.2 displays the monthly breakdown by age groupings. Those under 10 years of age have a peak presentation in summer, with the older children peaking in winter months. The males dominated injury presentations in all age groups. Teenagers represent a smaller percentage (10%) due to the predictable trailing off to adult medical centres.

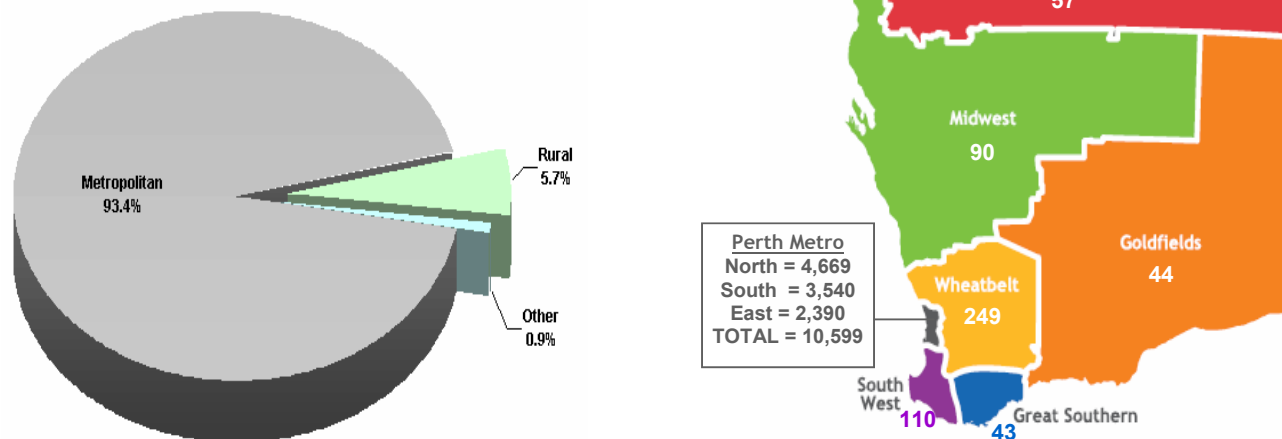
4.3 AREA OF RESIDENCE

Metro: (n = 10,600)

Rural/Remote: (n = 644)

Other: (n = 100)

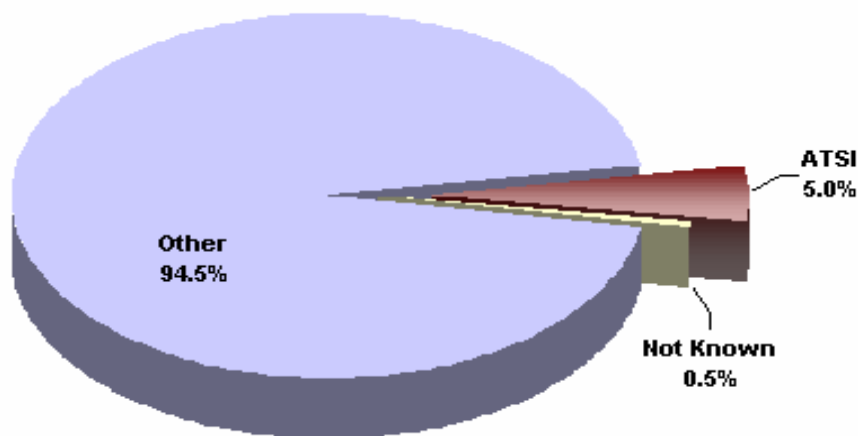
Figure 4.3 Area of residence (Based on home postcode)



Children with a Perth metropolitan residential postcode represent the majority (93%) of the injured children seen by the emergency department, as displayed in figure 4.3. There is no significant difference between the sexes between metropolitan and rural children, a higher percentage of primary school age children presented from rural regions.

4.4 ABORIGINALITY

Figure 4.4 Aboriginality

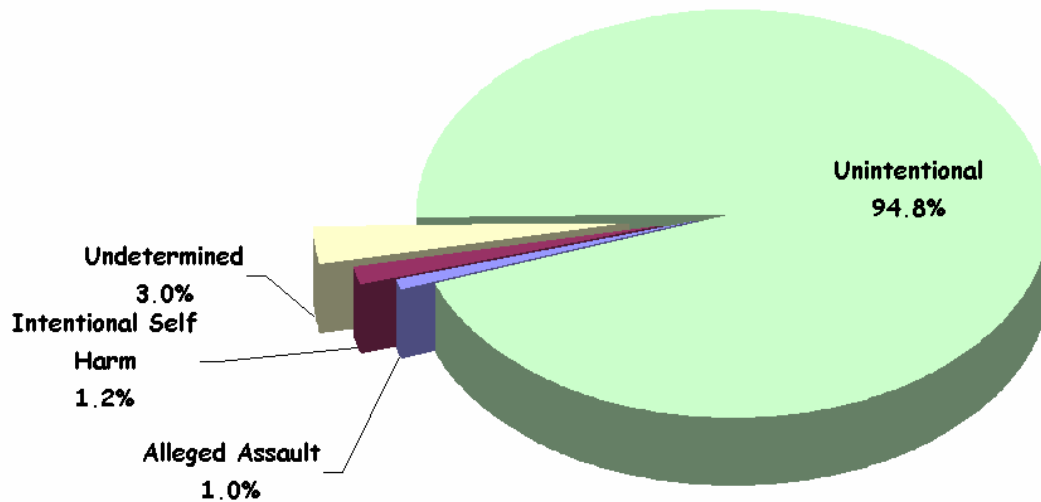


Children of Aboriginal or Torres Strait Island decent represented 5% of children attending the emergency department during the second quarter of 2006. There were no significant gender or age grouping differences between Aboriginal and non-aboriginal children, however 19% of presentations from a rural region were of Aboriginal descent. A significant 18% of assault injuries and 22% of intentional self harm injuries (2 in 3 females) occurred to Aboriginal children.

5. INJURY DATA

5.1 INJURY INTENT

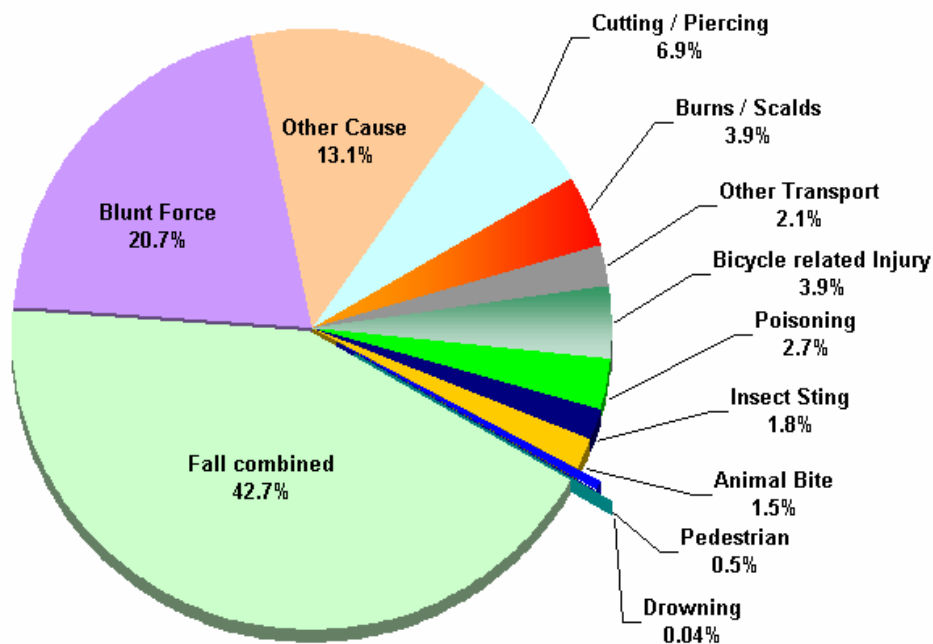
Figure 5.1 Injury Presentation by Human Intent



The great majority (95%) of injury is unintentional, with intentional and assault injuries more prominent in the older age groupings. It is noted that females represented 85% of intentional injury presentations.

5.2 MAIN CAUSE OF INJURY

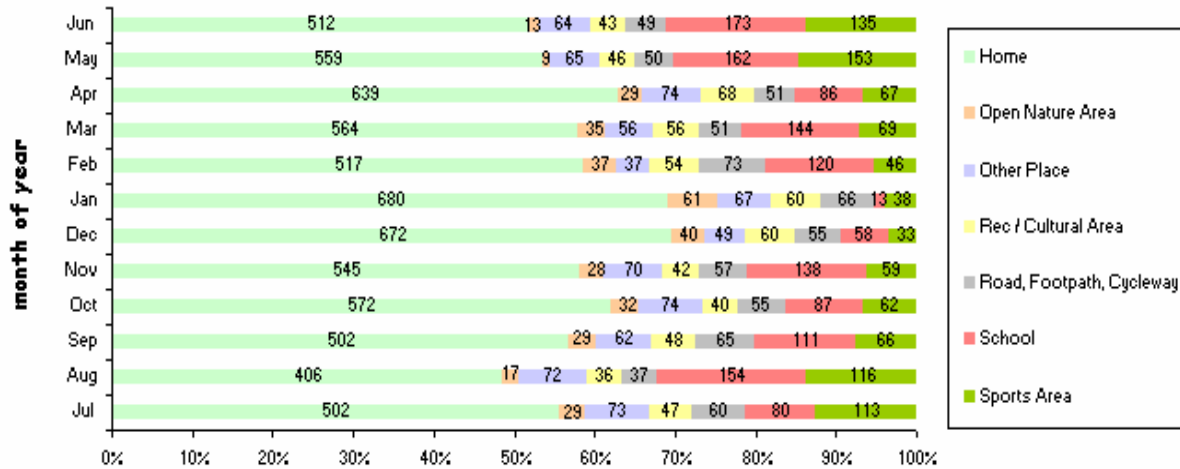
Figure 5.2 Main cause of injury



During the past financial year, falls were the dominant cause of injury, a direct correlation with the majority of presentations being in the under 5 age group. Burn injuries may only comprise 4% of injury presentations, but result in the greatest period of hospitalisation.

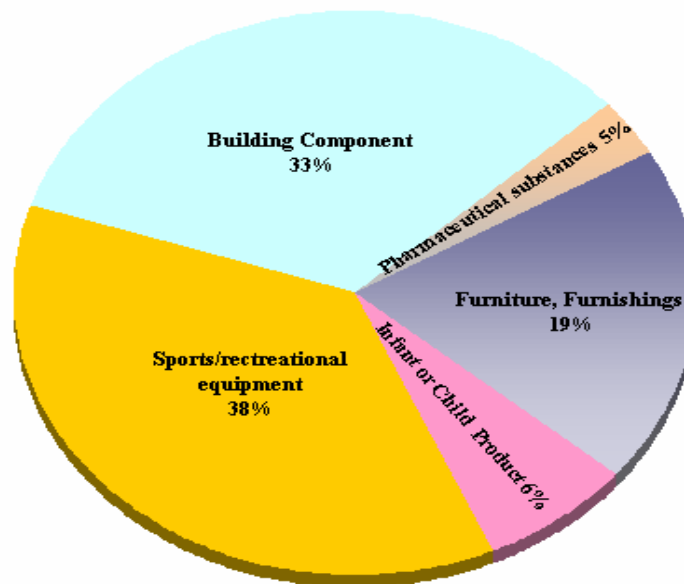
5.3 PLACE OF INJURY

Figure 5.3 Place of Injury



Children presenting to PMH are most commonly injured in the home or its surrounds (n=6,670) as displayed in figure 5.3. This continues a trend noted during 2005. The school / daycare centres and sporting areas (n=2,283) were the next most common. The males were the more commonly injured at each location. As the children age, injuries increasingly occur outside the home environment. The pattern of home injuries appears to follow the seasonal nature of presentation, with a summer peak and winter trough in injuries.

Figure 5.4 Injury Factor

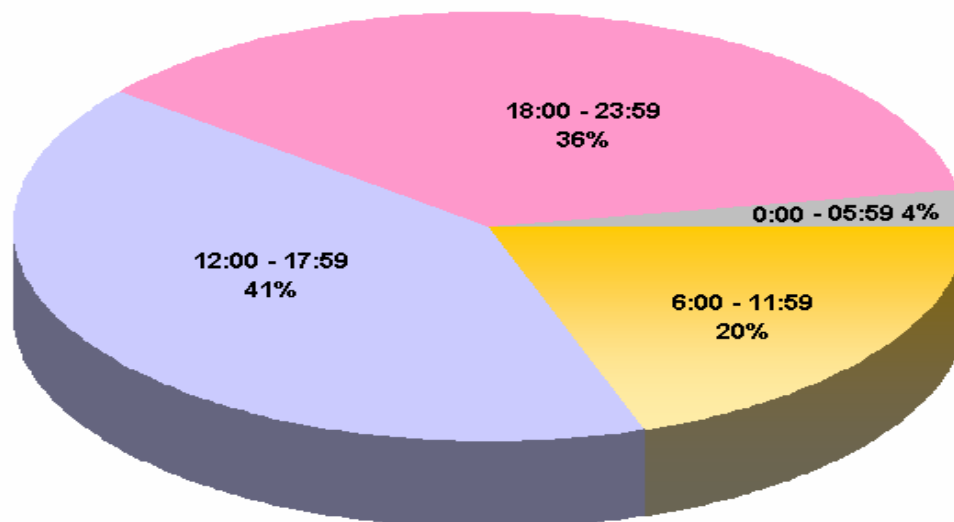


It must be noted that nearly half of all injury presentations (48%) did not have an associated injury factor recorded. Figure 5.4 displays those injury factors recorded. Sporting or recreational equipment (38%) were the common injury factors. Nearly 1 in 5 injuries are associated household items such as furniture, beds or tables. These results correlate with the home and sporting field being the most common locations of injury.

6.0 ASSESSMENT AND TREATMENT DATA

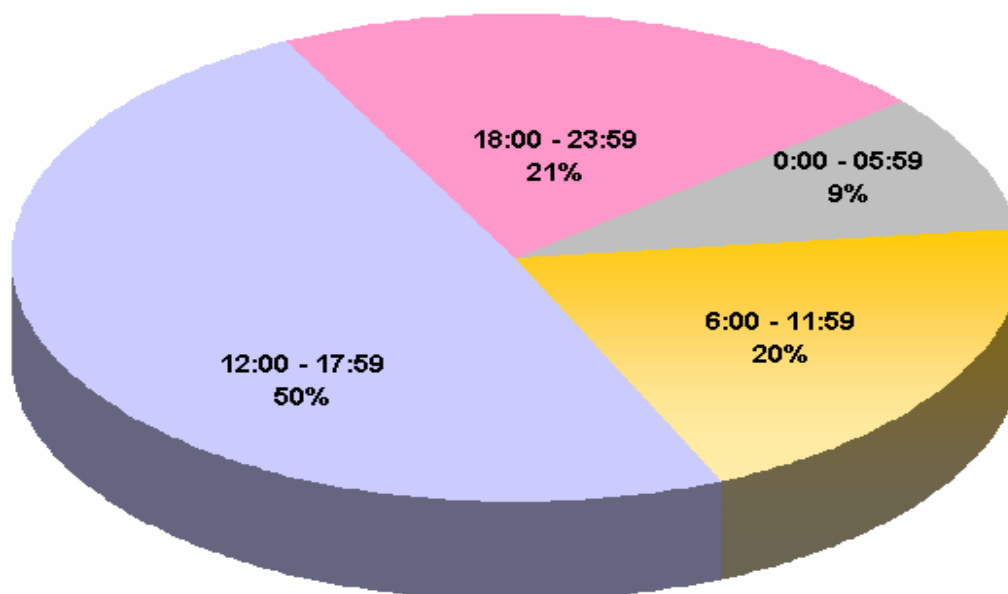
6.1 TIME FACTORS

Figure 6.1.1 Time of presentation



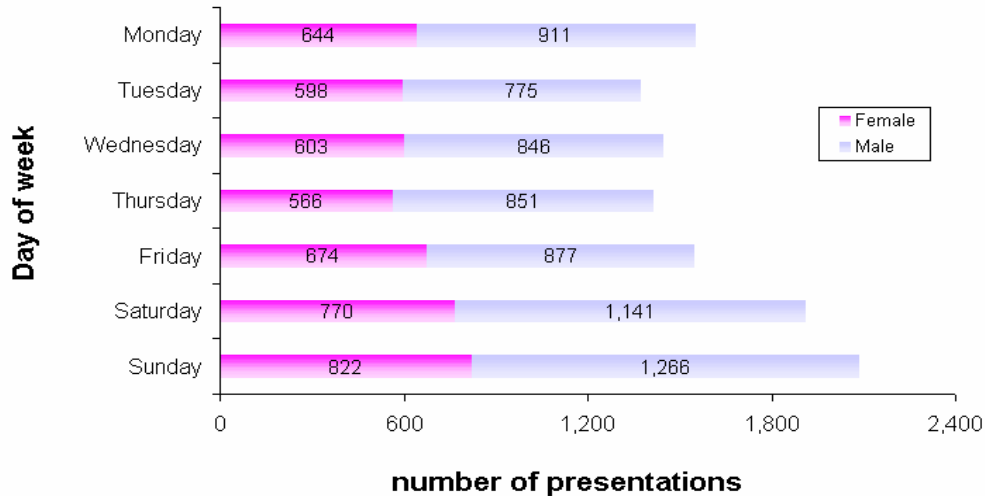
The majority of injured children present after midday each day, as displayed in figure 6.1.1, with 61% arriving between noon and midnight, with a peak period between 5 and 9pm (35%). Of the children presenting to PMH after an injury, 52% from a metropolitan region arrived within 2 hours compared with 21% of rural children. As displayed in figure 6.1.2, 50% of injuries occur between noon and 6pm with a peak period between 4 and 8pm. This correlates with the time period after school and before an evening meal. A comparison between the two time graphs displays the time lag between time of injury and presentation. Many children from rural regions arrive after 10pm, due to the longer transportation time.

Figure 6.1.2 Time of injury



6.2 DAY OF ATTENDANCE

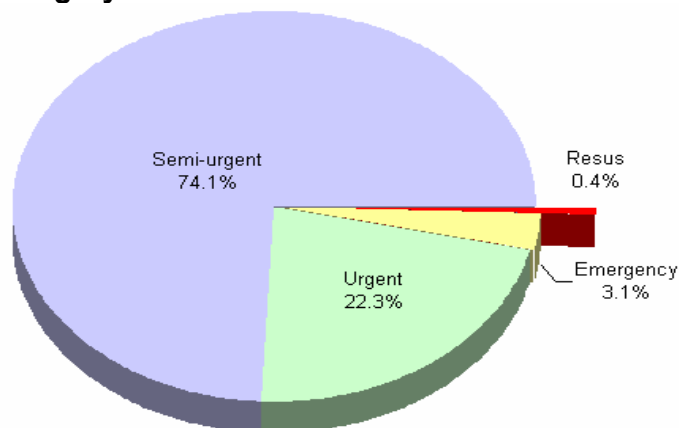
Figure 6.2 Day of attendance



The weekend saw the highest presentations during the year (35%), with a peak on Sundays and a trough on Tuesday each week. The male/female ration approached the historical 3:2 ratio on each day during this quarter.

6.3 TRIAGE CATEGORY

Figure 6.3 Triage category



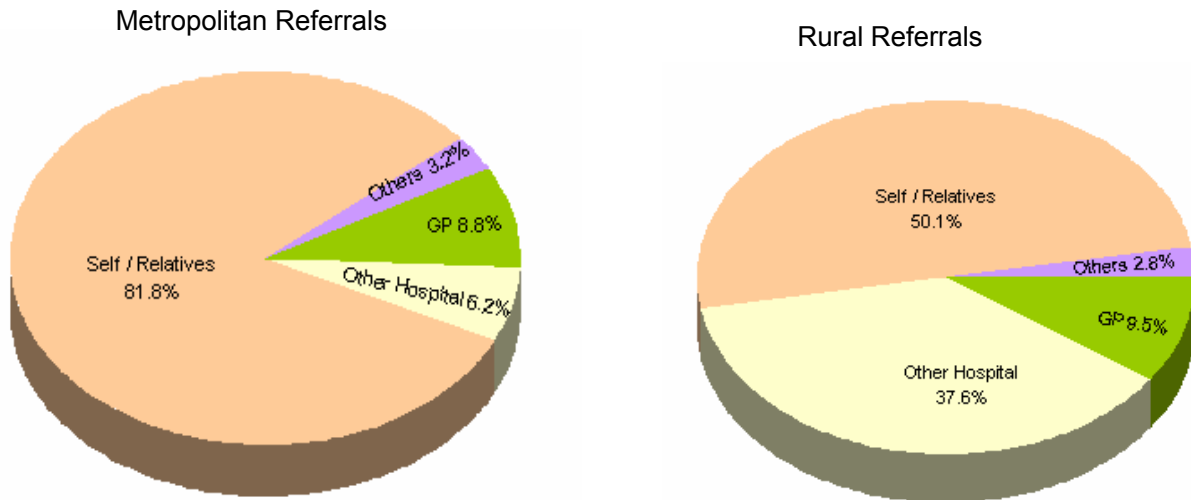
The majority of children (96.4%) are given a triage category of either semi-urgent or urgent, as displayed in figure 6.3. These are injuries deemed to require medical attention within 1 hour of being triaged. There was no identified difference between the sexes or age grouping with reference to triage code. The triage category (code), is a reflection upon a child's urgency for medical intervention, as shown in table 1.

Table 1: Triage categories

Category	Seen within (mins)
Resus (1)	0
Emergency (2)	10
Urgent (3)	30
Semi-Urgent (4)	60
Non-Urgent (5)	120

6.4 SOURCE OF REFERRAL

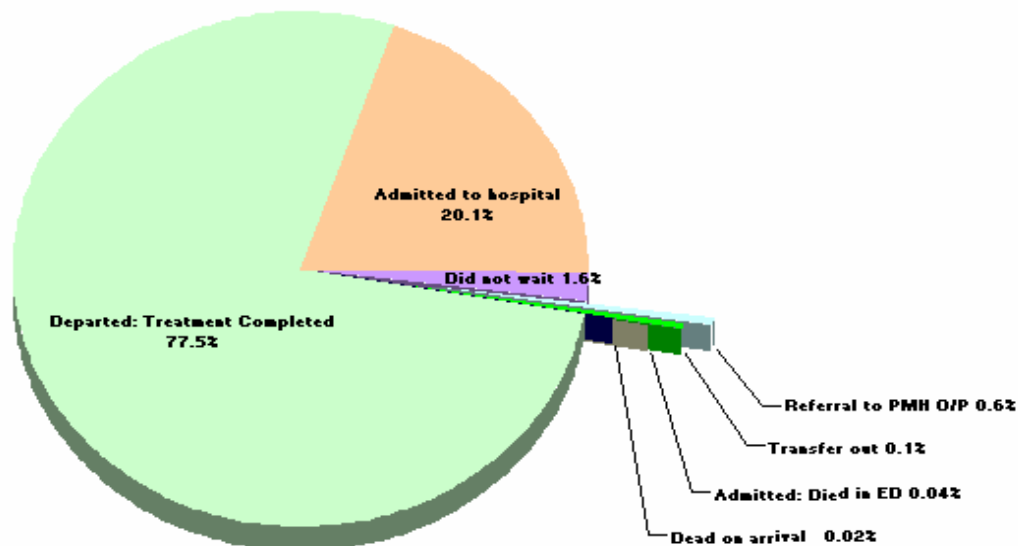
Figure 6.4 Source of referral



The vast majority of children (80%) present without referral from another medical source, with a further 17% having been reviewed by either their local GP or another hospital. A significantly higher proportion of rural children present to PMH after medical review as displayed in Figure 6.4. Similarly, 82% of metropolitan children present directly to the emergency, compared with 50% for those living in rural areas.

6.5 OUTCOME OF ATTENDANCE

Figure 6.5 Outcome of attendance

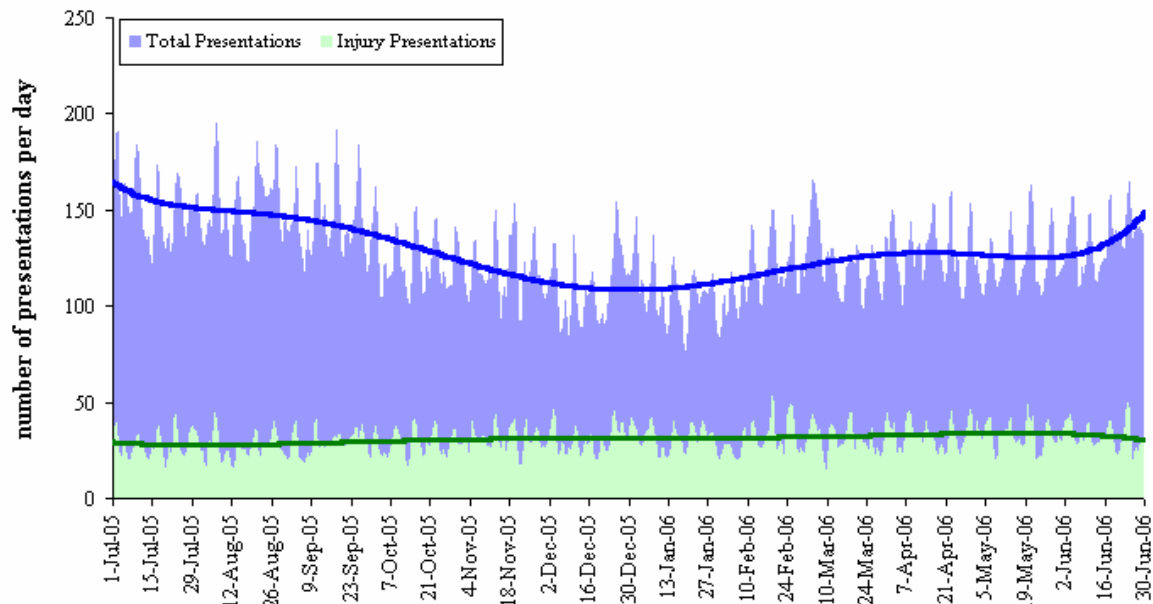


In the majority of cases (98%) children receive treatment for their injuries within the emergency department. Of these, nearly 4 in 5 were subsequently discharged home after their treatment, with a further 20% admitted to PMH or transfer to another hospital.

There was a significant difference in the admission rate between children from rural and metropolitan regions. Rural children were nearly 3 times more likely to be admitted to PMH following an injury presentation than those from the metropolitan region, but rarely left before having their injury treated.

7. TIME SERIES ANALYSIS

Figure 7.1 Daily Total Emergency Presentations v Injury Presentations



The daily number of children presenting to PMH changes each day. An analysis of the daily total ED and injury presentations, as displayed in figure 7.1, indicates the presence of two seasonal patterns. An annual cycle, indicated by the trend line, with a peak in the winter months and weekly cycle with a Sunday peak. It is intriguing to note that a weekly cycle is identifiable in the injury presentation rates, though not an annual one, indicated by the “flat” trend line. During the past financial year the weekly injury numbers remained relatively static, but varied in comparison to total ED presentations.

Figure 7.2 Cause of Injury by month

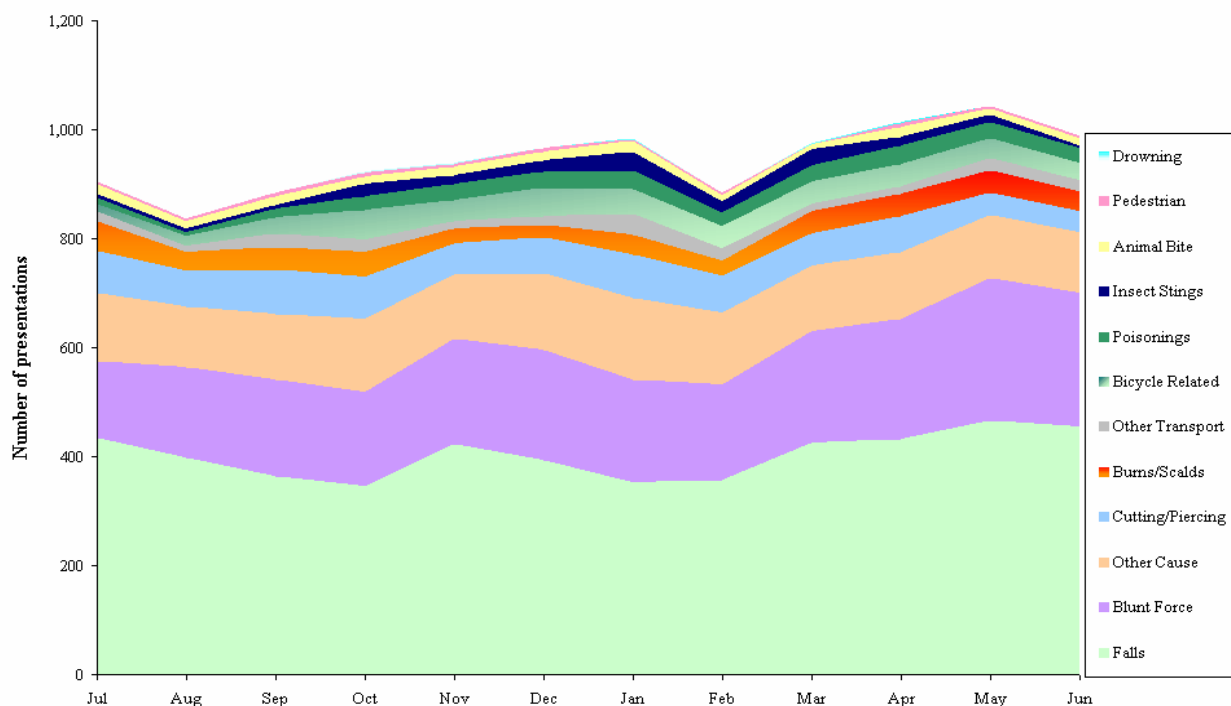


Figure 7.2 displays the monthly variation in cause of injury for the financial year. Clearly falls result in the majority of injury presentations throughout the year. When these falls are divided by type, figure 7.3, underlying seasonal patterns immerge.

Falls from the same level were more common in the winter months, with the inclement weather leading to play within the house. Falls from a height greater than 1 metre did not experience a significant variation throughout the financial year. Burn or scald injuries have a very seasonal pattern, with a winter peak and summer low. This injury cycle occurs for burns resulting from hot liquids and touching a hot object. Figure 7.4 displays the monthly presentations resulting from falls from bicycles and rollerblades, skateboards, etc (wheeled pedestrian). In contrast to other injury causes, these have a summer peak

Figure 7.3 Bicycle / Wheeled Pedestrian Injuries

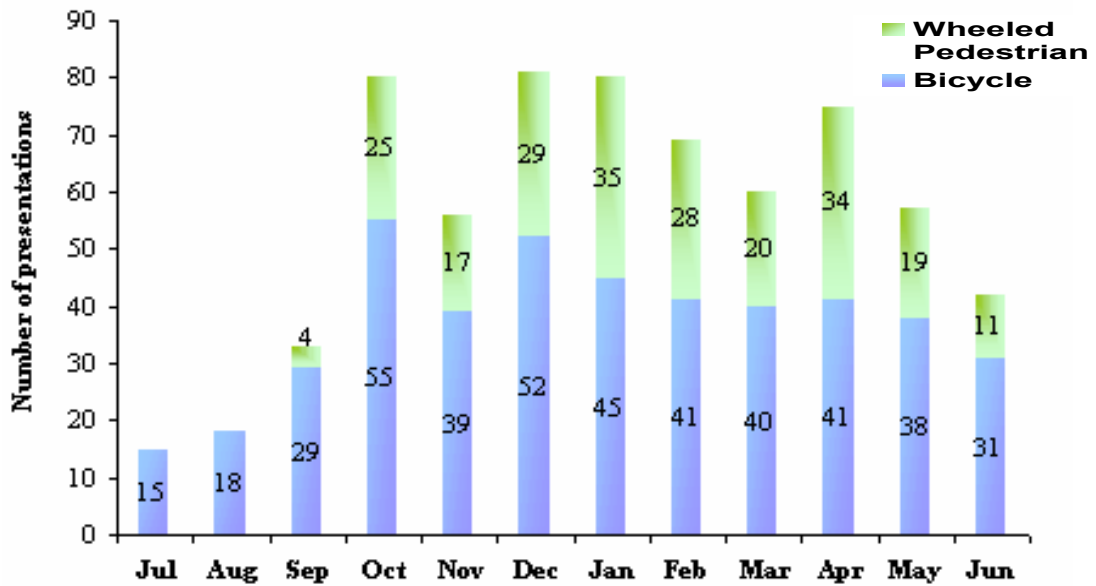
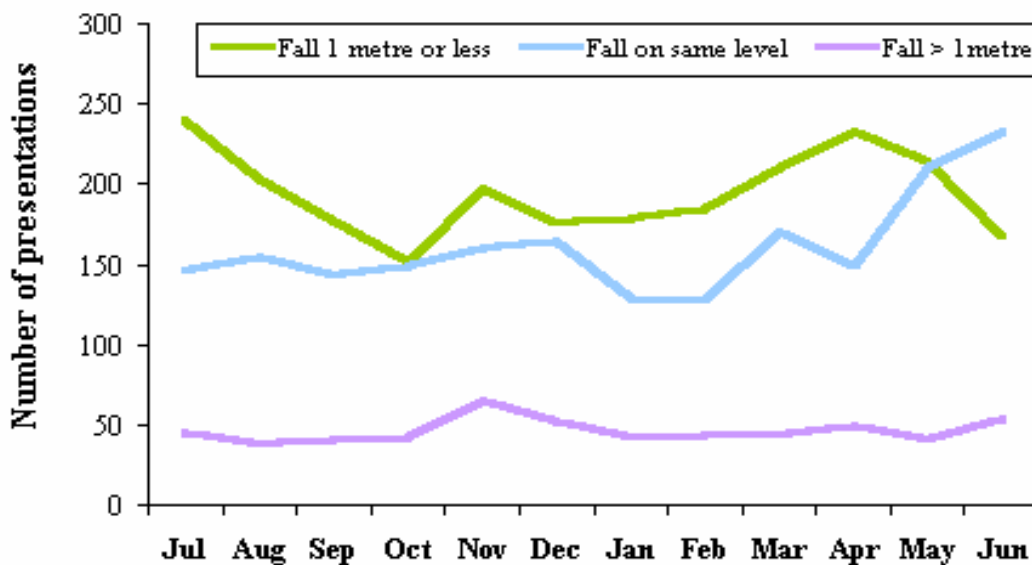


Figure 7.4 Falls related Injuries



The time a child presents to the ED is influenced by many factors. These include the nature and time of injury, distance to travel and method of transport available. An analysis of the time of presentation indicates little the time of the year only impacts upon presentation time during the peak of summer, with a higher than average number of presentations between midnight and 6am.

Figure 7.4.1 Time of Presentations

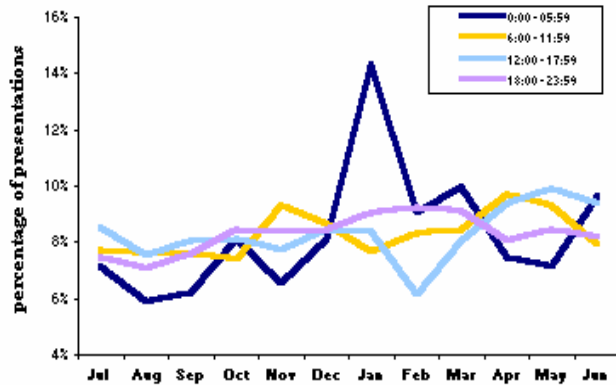
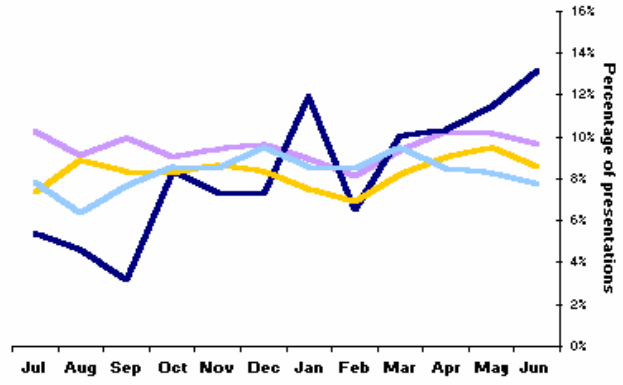
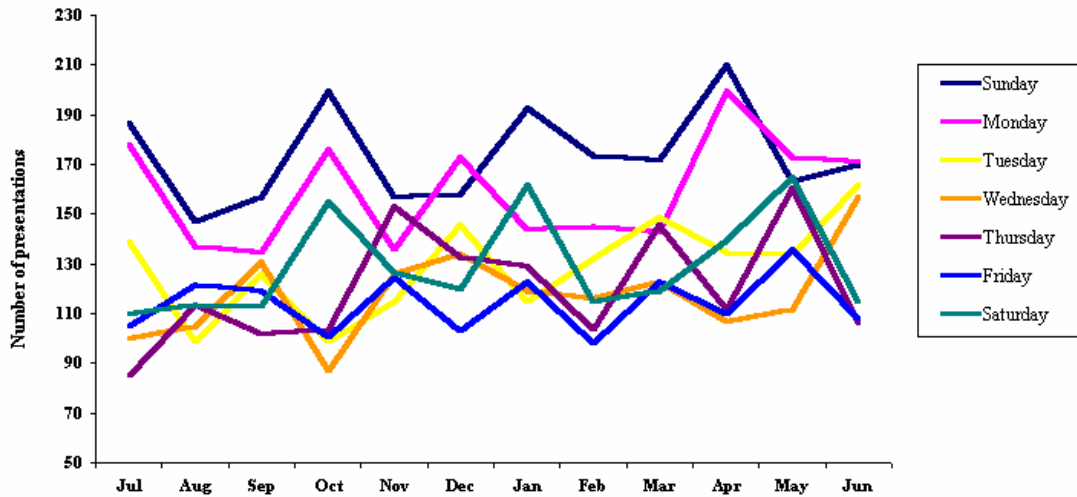


Figure 7.4.2 Time of Injury



Similar to the time of day, the day of admission does impact upon the number of injury presentations seen within the ED department. Weekend days see the highest numbers each week of the year due to a number of influencing factors. These include increased activity by children, particularly sporting related and reduction in access to general practitioners. Figure 7.6 displays no overall day related trend, but does indicate presentation peaks that approximately correlate to school holidays.

Figure 7.6 Day of presentation



8. DISCUSSION

The collection of injury data plays a vital role in the development of strategies to prevent or minimise childhood injury. It relies on an efficient and reliable computer system and the co-operation of nursing, clerical and medical staff within the emergency department or PMH. Through the analysis of this collected data, injury trends and changes can be noted as well as the effectiveness (or not) of injury prevention programs.

The last financial year saw the highest number of total and injury presentations recorded on the EDIS system. This report has enabled a brief analysis of the seasonal nature of presentations to the emergency department of PMH. Injuries from burns, bicycles and skateboards clearly have a cyclical pattern of presentation. Despite the 7% increase in children presenting, these underlying cycles appear to have not altered. However despite this increase, the overall admission rate declined 1% following an injury. The male to female gender ratio equated the 3 to 2 long-term average, a fact that all injury campaign designers should keep in mind. Whilst total number of injuries increased there was no significant increase in a specific cause of injury. Presentations following a burn or scald remain somewhat static in number, a fact that should be of concern. This type of injury often results in longer lengths of hospitalisation than other causes of injury, but can be considered one of the most preventable injuries.

The majority children present to the emergency department after an unintentional injury and are discharged home following treatment. This financial year saw 4 deaths within the emergency department related to an injury, the highest number since 1999.

9. FUTURE (RECOMMENDATIONS)

This financial year saw a number of significant changes to the injury surveillance data collection at PMH. The introduction of a definitive ability to collect safety equipment usage was the most significant. All sporting and recreational activities will now have appropriate safety equipment usage, or not, recorded. This will assist in the structuring of specific and appropriate campaigns aimed at injury reduction.

This report contained a feature on the factors that are associated with a child presenting following an injury. This, together with the new data field recording any sporting activity, enables a far more comprehensive view of childhood injuries to be attained. This data on how children are injured should enable appropriate safety campaigns to be better targeted. The injury factor data divided by age clearly indicates how these campaigns need to be age specific. The overall aim should be the reduction in severity of childhood injuries.

June saw the introduction of definitive data fields for safety equipment (helmets, seatbelts, mouthguards, etc) related to a variety of sporting and recreational activities. This type of data should further enhance the targeting of safety programs.

10. SUMMARY OF WA CHILDHOOD INJURY SURVEILLANCE BULLETINS FROM 2005-2006

10.1 July 2005 Bulletin

Childhood Injury Surveillance in WA: Beginnings and Now

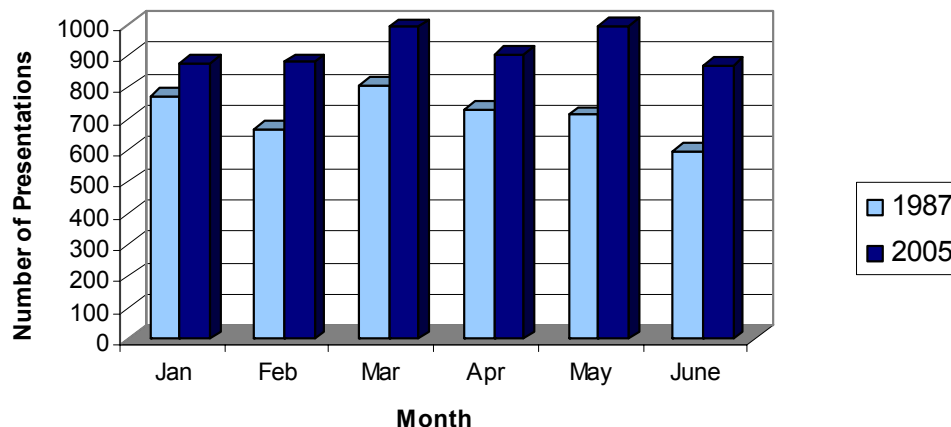
Introduction

- The West Australian Division of the Child Accident Prevention Foundation of Australia (Kidsafe WA) introduced Injury Surveillance data collection at Princess Margaret Hospital (PMH) in July 1986.
- The Injury Surveillance system was designed to provide timely clues as to the nature and causes of injuries primarily for use to develop injury prevention interventions.
- The first calendar year report was available at the end of 1987.
- In 1997 the Department of Health (DOH) and PMH became responsible for producing reports on patterns of childhood injury in Western Australia.
- A new system for collecting Injury Surveillance data at PMH was implemented in July 2004.
- This edition of the WA Childhood Injury Surveillance Bulletin compares 1987 data against 2005 data.

Summary

- In July 2004, Injury Surveillance at PMH was adjusted to match the coding used in other Perth Metropolitan Hospital Emergency Departments.
- The combined first two quarterly data reports available from PMH are for January to June 2005.
- January to June 2005, 5,524 children presented at PMH Emergency Department as a result of injury.
- During 1987, 7,573 children were recorded by the ISS as attending the Accident & Emergency Department (A&E) for the first time on account of injury, 4,285 between January and June 1987.
- For the purpose of this Bulletin, only January to June 1987 data has been used for comparison.
- There are limitations in the comparison due to changes in the coding of data collected.

Figure 1: Number of Emergency Department Presentations at PMH, January to June 1987 & 2005



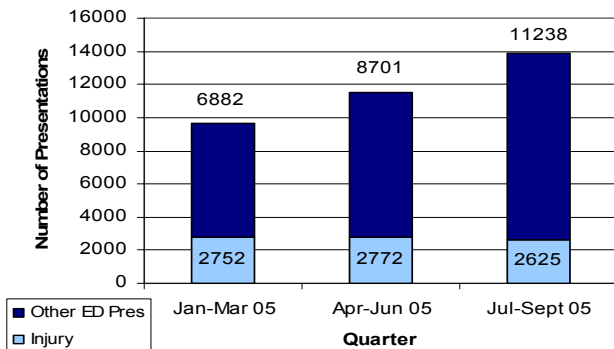
10.2 October 2005 Bulletin

Falls in Focus: How do children Fall?

Childhood Injury Presentations: July to September 2005

- There were 13,863 presentations to Princess Margaret Hospital Emergency Department (PMH ED) from July to September 2005.
- Injury presentations accounted for 19% of the total number of PMH ED presentations.
- The leading cause of injury presentations to PMH ED from July to September was Falls (45.4%, n=1,175).
- So far this year (January to September 2005) there have been 8,149 injury presentations to PMH ED (See graph below).

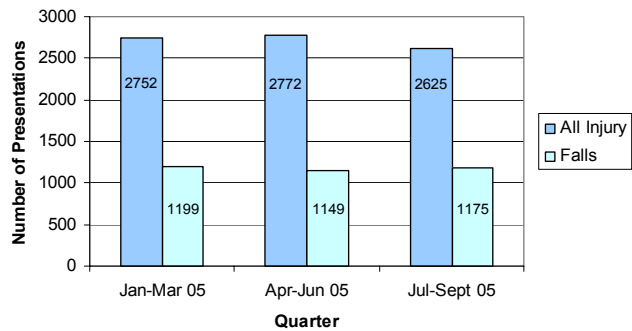
Total PMH ED Presentations Jan to Sept 2005



Introduction – Falls in Focus

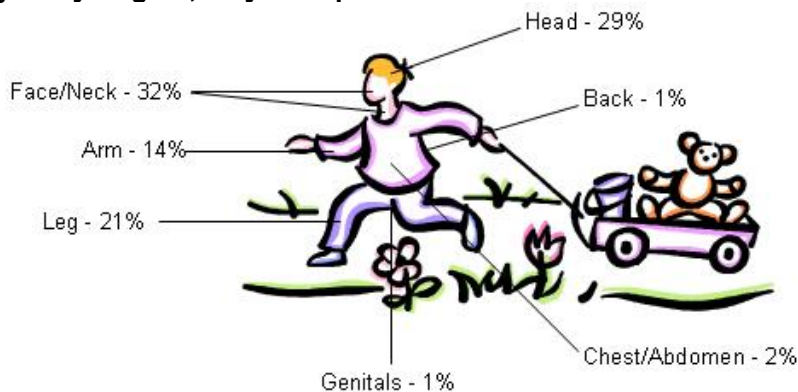
- There were 1,175 fall related injury presentations to PMH ED between July and September 2005.

Comparison of Injury and Fall Presentations, PMH ED Jan to Sept 2005



- Children aged 1 and 2 years of age accounted for the highest number of fall injuries (1: n=130; 2: n=112).
- The majority of falls were falls from less than 1 metre high.
- Falls accounted for 8.6% of the Total Emergency Department Presentations from July to September 2005.
- Aboriginal children accounted for just 3% of all fall-related injury presentations to PMH ED.

Percentage of Princess Margaret Hospital Emergency Department Fall related Injury Presentations by Body Region, July to September 2005



10.3 January 2006 Bulletin

Unintentional Injuries to Aboriginal and Torres Strait Islander Children

Childhood Injury Presentations: October to December 2005

- There were a total of 10,990 presentations for all causes to Princess Margaret Hospital Emergency Department (PMH ED) from October to December 2005 (See graph below).
- Injury presentations accounted for 26% (n=2,828) of the total number of all PMH ED presentations.
- The leading cause of injury presentations to PMH ED from October to December continued to be Falls (41.1%, n=1,163).
- Children of Aboriginal or Torres Strait Islander descent accounted for 4.7% of all injury presentations from October to December 2005.
- Unintentional injury presentations accounted for 96% of all injury presentations with intentional/assault injuries (4%) more prominent in the older age groups.
- The home remains the most common location for injuries to occur (63%) and this quarter (Oct-Dec 2005) had the highest percentage of injuries occurring in the home.
- For the calendar year 2005, injuries accounted for 24% (n=10,977) of the total number of all PMH ED presentations.

Total PMH ED Presentations Jan to Dec 2005

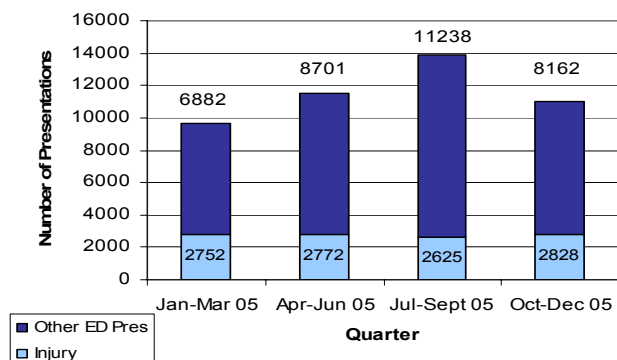


Photo from www.virgina.edu

Summer Injury Snapshot – Drowning

- There were 93 drowning/immersion presentations to Princess Margaret Hospital ED from 2001 to 2005.
- 6.4% of these Immersions were dead on arrival or died in the ED.
- 79% of Immersion cases occurred in the Home. Of those injuries where a particular location was specified the top 3 locations were:
 - Home Swimming Pool: n=41
 - Home Bathroom: n=15
 - Home Yard/Garden: n=11
- Over the past five years the number of drowning presentations was lowest in 2005 (n=10).

Introduction – Indigenous Children

- 512 Aboriginal and Torres Strait Islander (ATSI) children presented at PMH ED in 2005 for injuries.
- ATSI children aged 1 (n=52), 2 (n=57) & 14 (n=41) years of age accounted for the highest number of injury presentation.
- The most common injury was from “Other Blunt force (n=104) closely followed by falls from less than 1 metre high (n=88).
- ATSI children accounted for 4.6% of the total Emergency Department Injury Presentations in 2005.

10.4 April 2006 Bulletin

Poisoning: Medicines can be poisons too

Quarterly Summary: Jan to Mar 2006

- There were 10,470 presentations to Princess Margaret Hospital Emergency Department (PMH ED) from January to March 2006.
- Injury presentations accounted for 27% (n=2,844) of the total number of PMH ED presentations.
- Injury presentations for January to March 2006 (27%) were higher than the long-term average of 25% of total presentations and 3% higher than the first quarter last year.
- The pre-school age group (those under 5 years of age) remained the dominant group representing 42% (n=1,189) of total injury presentations to PMH.
- Falls remained the leading cause (39.9%) of injury presentations to PMH ED in January to March 2006.
- In the past 12 months (April 2005 to March 2006) there have been 11,072 injury presentations to PMH ED (See graph below).



Introduction – Childhood Poisoning (January to March 2006)

- There were 92 poisoning related injury presentations to PMH ED between January and March 2006. This is almost half the total number of poisoning presentations to PMH ED in all of 2005 (n=219).
- For all PMH ED poisoning presentations (children under 15 years of age) 55% occur in children under 5 years of age.
- Children aged 1 and 2 years of age accounted for the highest number of poisoning injuries (1: n=18; 2: n=20).
- More females (n=58) presented at PMH ED for poisoning in January to March 2006 than males (n=34).
- The majority of poisoning presentations were poisonings from pharmaceutical substances (Jan to March 2006 - 49%).
- Poisoning presentations accounted for 0.8% of the Total PMH ED Presentations and 3% of the Injury PMH ED Presentations for January to March 2006.
- Aboriginal children accounted for 8% of all poisoning-related injury presentations to PMH ED in Jan-March 2006.

Total PMH ED Presentations Jan 2005 to March 2006 (Current Quarter Bold)

