



Department of
**Health, Social Services
and Public Safety**

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HOME ACCIDENT PREVENTION STRATEGY 2015 - 2025

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Minister's Foreword

In Northern Ireland in a typical week two people die as a result of home accidents. In addition to these deaths there are approximately 17,000 admissions to hospital each year as a result of unintentional injuries in general.

Accidents can cause pain, distress and suffering for the victim, their family and friends and even for the wider community. The repercussions of serious accidents can be felt for a long time and, in some cases, can cause life-changing pain, disability or death.

Home accidents can arise from many seemingly innocuous sources such as ill-fitting footwear or unsecured blind cords or from practices and behaviours such as not using appropriate lighting at night.

The vast majority of accidental injuries and deaths in the home are caused by falls but serious injuries and deaths can result from a wide range of accidents such as carbon monoxide poisoning, inhalation of smoke caused by fire, and blind cord strangulation, to name a few. These deaths and injuries can easily be prevented by being aware of the dangers and hazards that are present in the home environment and putting in place interventions to minimise the risks.

Statistics show that there are some groups in society who are especially vulnerable to accidents in the home and who suffer disproportionately because of them. These include babies and young children, particularly those under 5, people over 65, and those with greater social, economic and health disadvantage. This Strategy is concerned with the entire population of Northern Ireland but gives particular attention to these vulnerable groups.

In addition to the human costs, home accidents result in significant pressures and additional costs in health and social care. Preventable pressures and costs don't just arise in Emergency Departments; they affect a number of areas of care ranging from immediate post-emergency care in hospital, through rehabilitative care, to the

long-term care and support associated with acquired life-long disabilities. This in turn impacts on the overall capacity of the service to provide quality care.

The previous Home Accident Prevention Strategy 2004 – 2009 delivered many positive outcomes and made a significant contribution to reducing home accidents and deaths. This new strategy aims to build on that contribution. A comprehensive implementation plan to accompany the strategy will be developed by the Public Health Agency, in partnership with other central and local stakeholders. The partners, who are from a range of backgrounds including central and local government, statutory, private, and voluntary and community sectors, will play a key role in contributing to a reduction in the number of deaths and unintentional injuries occurring in the home. It is important that, given the current financial and resource constraints, there is a coordinated approach taken by all partners involved.

As Minister of Health I am committed to having in place a strategy which will help to reduce deaths and unintentional injuries in the home.

I would like to acknowledge and thank all those who contributed to the development of this strategy, including those from the voluntary and community sectors, from other Government Departments and from across the Health and Social Care family. I would like to particularly thank the Royal Society for the Prevention of Accidents (RoSPA), the Public Health Agency (PHA) and the Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG) for permission to use and reproduce invaluable statistics and data.

JIM WELLS

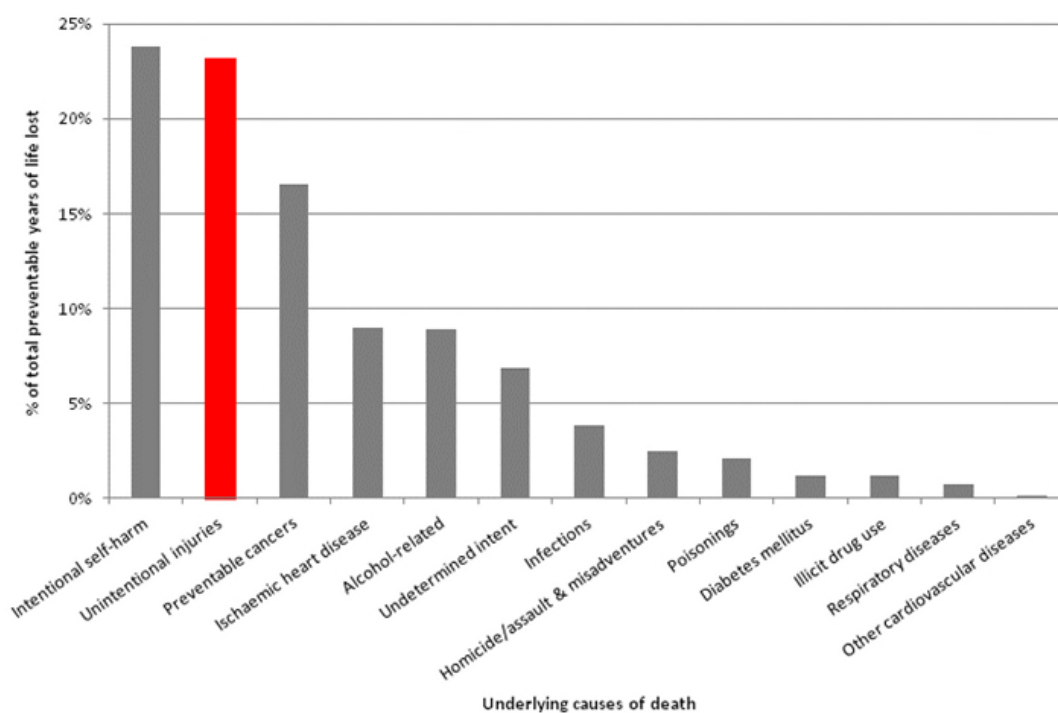
Minister of Health, Social Services and Public Safety

1. Why we need a home accident prevention strategy

Why do we need a home accident prevention strategy?

Accidents are the main cause of premature, preventable death for most of a person's life. The human cost of premature deaths can be expressed as **preventable years of life lost (PrYLLs)**. In Northern Ireland unintentional injuries in general (not just from accidents in the home) account for almost a quarter of PrYLLs¹. See Figure 1.

Figure 1: Preventable Years of Life Lost (PrYLLs) in NI in 2011 for people up to the age of 60



Source: RoSPA/Northern Ireland Statistics and Research Agency

PrYLLs are a dispassionate numerical measure, but for every person who dies as a result of an accident that need not have happened, the grief and life-long pain for the family and friends of the victims cannot be measured. Accidents can have a profound impact on the lives of those who are left behind.

¹ RoSPA Big Book of Accident Prevention NI, 2013.
<http://www.rospace.com/PublicHealth/big-book-ni.pdf>

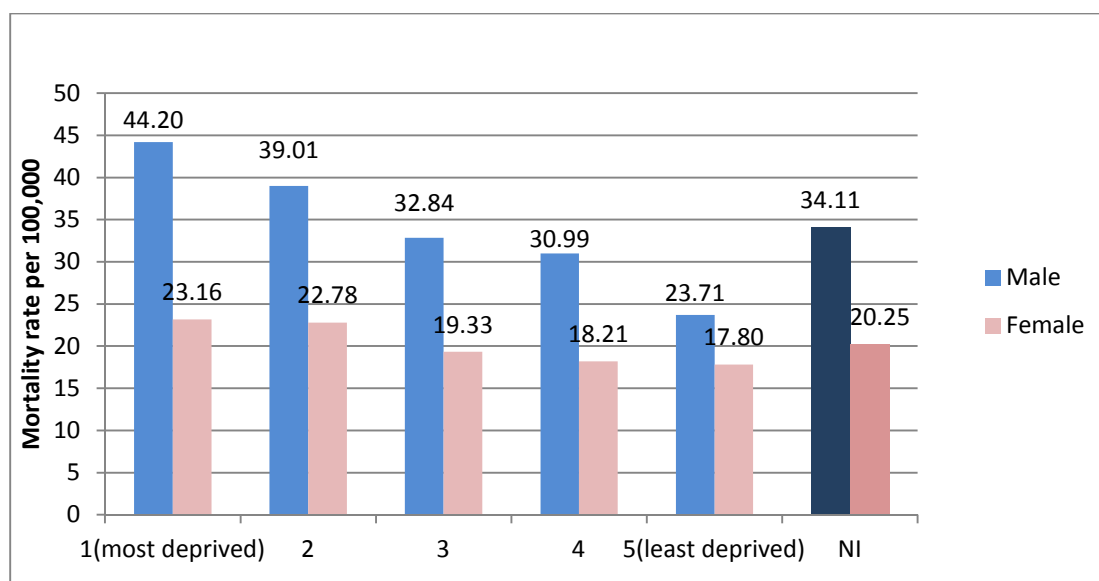
Accidents are often violent in nature, and non-fatal unintentional injuries cause pain, distress and suffering, and in many cases result in life-changing disabilities and chronic conditions. Accidents can also have a serious impact on emotional and mental health. Accidents can be traumatic with residual guilt, remorse and grief having a lasting effect on members of a family or community.

There are groups in society who are especially vulnerable: babies and young children and older people, particularly under-5s, over-65s and vulnerable groups suffer disproportionately from the unintentional injuries that result from home accidents.

The prevalence of unintentional injuries offends against our basic sense of social justice, as there is a strong correlation with poverty, deprivation and health inequalities.

Death rates due to unintentional injuries are higher in areas of increased deprivation with rates for males showing the sharpest deprivation gradient. See Figure 2.

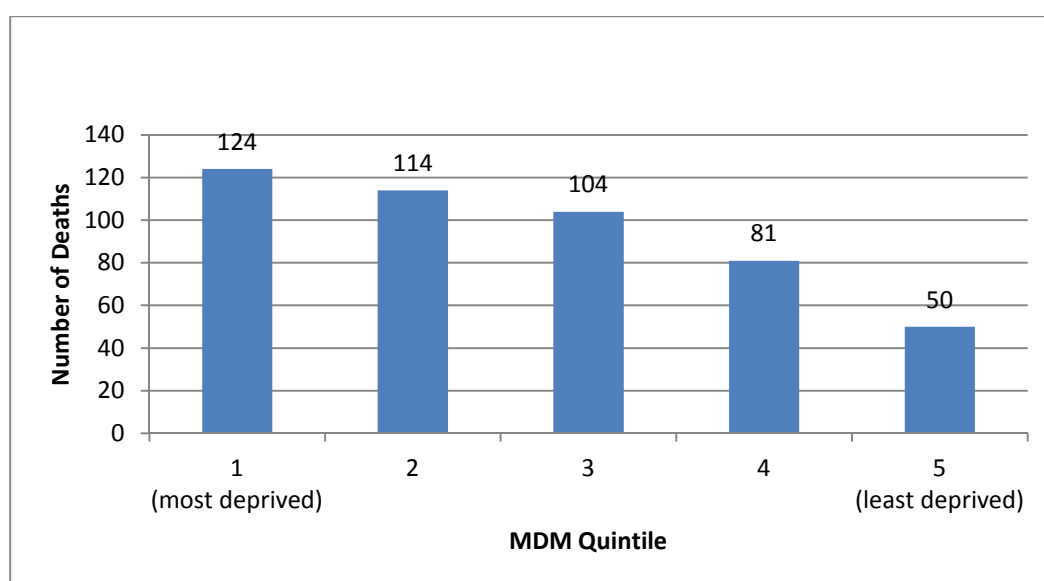
Figure 2: Annualised death rates per 100,000 due to unintentional injury by deprivation quintile and gender 2009 to 2011



Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

Analysis of the number of deaths from unintentional injury in those aged under 20 between 2001 and 2011 shows a deprivation gradient with highest numbers in the most deprived and lowest numbers in the least deprived quintiles (see figure 3). The impact of deprivation is particularly seen in children under 10 with four times as many children living in the most deprived quintile of Super Output Areas (SOAs) dying as a result of an unintentional injury compared with children under 10 living in the least deprived quintile.

Figure 3: Child and Young Person (0-19 yrs) unintentional injury deaths by deprivation quintile (2001 to 2011)



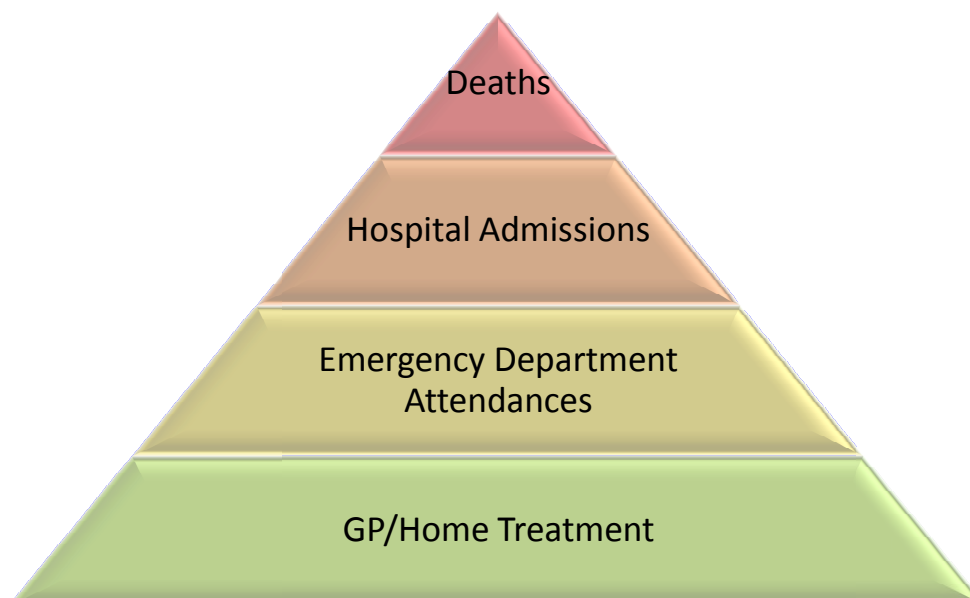
Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

The above data is in keeping with that observed elsewhere, with the Child Accident Prevention Trust (CAPT) reporting persistent and widening inequalities between socio-economic groups for childhood deaths from accidents (<http://www.makingthelink.net/topic-briefings/inequalities-and-deprivation>). Data from England and Wales has shown that children from the most disadvantaged backgrounds are 13 times more likely to die in accidents than children of parents in higher managerial and professional backgrounds².

² Edwards P et al. Deaths from injury in children and employment status in family: analysis of trends in class specific death rates, *BMJ*, 333: 119-121, 2007.

In addition to the human cost in terms of preventable deaths and suffering, accidents represent a significant avoidable burden on our health and social care system, a brake on our prosperity as a society, and a drain on public service resources. In Northern Ireland it is estimated that accidents in general cost society more than £4bn each year, with £650m of this burden being carried by the state³. This is a conservative estimate, as the full burden of accidents is unknown. Many injuries are treated at home or by pharmacists, GPs - including Out of Hours doctors - or by Minor Injuries Units and Emergency Departments, and, although they are not visible in the routine data that is captured at present, they still add to the burden on society. See Figure 4.

Figure 4: Accidental Injury Triangle



Source: Krug, E. (ed). (1999). Injury: A leading cause of the global burden of disease. WHO (World Health Organization Advisory Group). Geneva: WHO

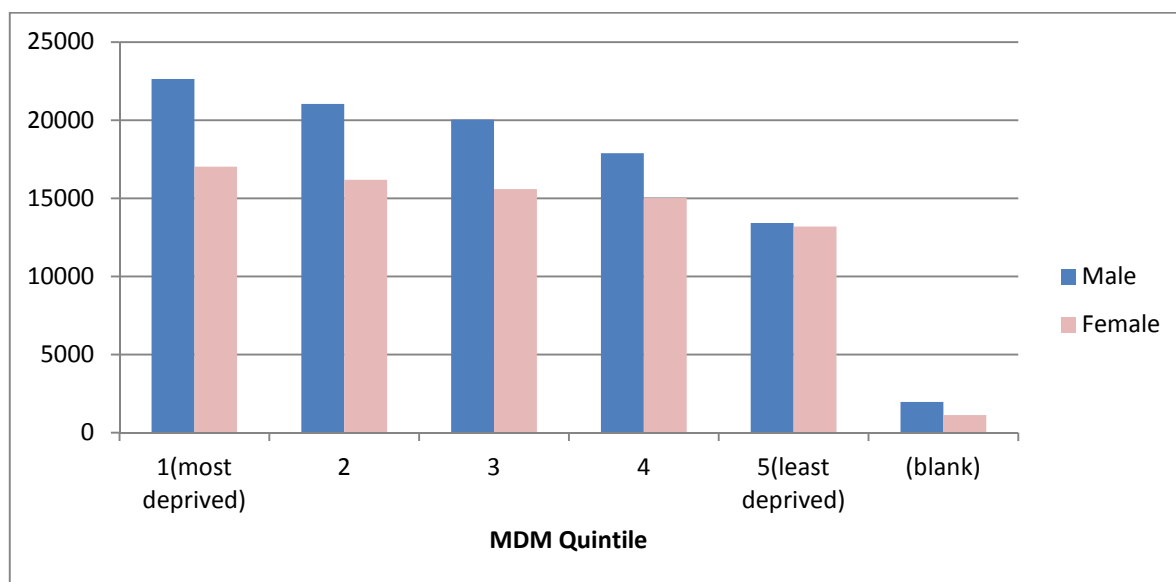
There are approximately 17,000⁴ admissions to hospital in Northern Ireland each year as a result of unintentional injuries.

³ RoSPA Big Book of Accident Prevention NI, 2013:
<http://www.rospa.com/PublicHealth/big-book-ni.pdf>

⁴ DHSSPS, Hospital Inpatient System.

Hospital admissions show a clear correlation with deprivation, particularly in males. Those from the most deprived quintile of wards (1) have much higher numbers of admissions than those in the least deprived quintile (5). See Figure 5.

Figure 5: Hospital unintentional injury admissions 2003 to 2012 by deprivation quintile

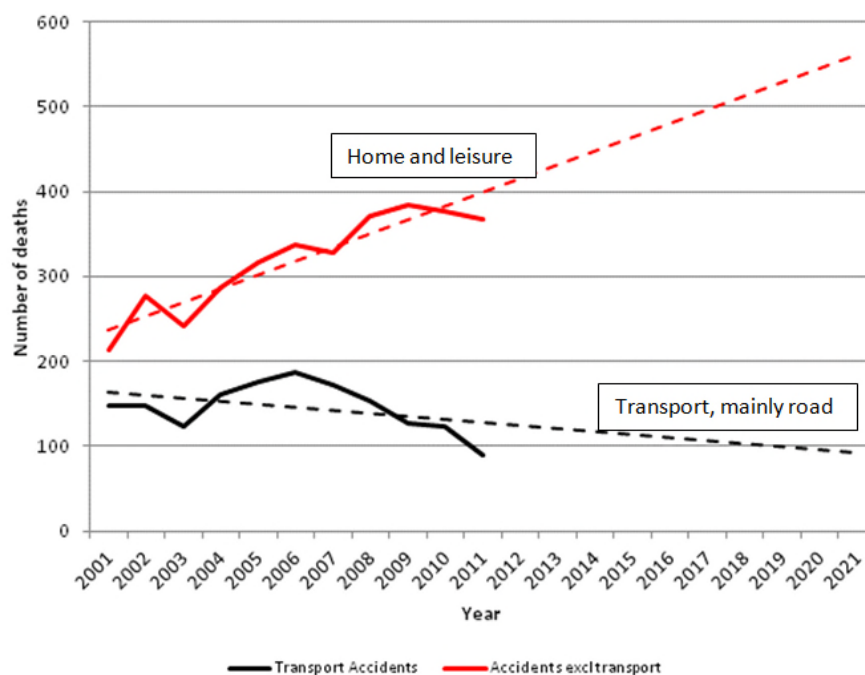


Source: DHSSPS

Why focus on accidents at home?

Accidents occur in different environments, most commonly in the home, on the roads and in other public spaces, in the workplace and while participating in sports and leisure activities. Over many years a wide range of interventions, such as legislation and public awareness campaigns, have helped to prevent a significant number of deaths and injuries from road traffic accidents and have made workplaces much safer than they once were. However, in the ten-year period 2001-2011 there was a steady increase in fatal home and leisure accidents. See Figure 6.

Figure 6: Extrapolation of accidental deaths, looking ahead 10 years in NI



Source: RoSPA Big Book of Accident Prevention Northern Ireland 2013

In the coming decade work will continue to help further reduce road deaths and injuries through delivery of the Department of Environment’s Road Safety Strategy and in the workplace under the Health and Safety Executive’s Workplace Health Strategy. The Home Accident Prevention Strategy is not intended to duplicate accident prevention work in other environments.

Why a strategy?

There are many organisations in the statutory, voluntary & community and private sectors that have done invaluable work to make the home environment safer. This strategy sets an agreed strategic direction and is intended to achieve further progress through closer and more effective coordination and information-sharing between the agencies concerned.

This strategy should not be seen in isolation; it is intended to complement a wide range of strategies and policies such as:

- the new public health strategic framework *Making Life Better – A Whole System Strategic Framework for Public Health 2013-2023*

- (<http://www.dhsspsni.gov.uk/mlb-strategic-framework-2013-2023.pdf>);
- Transforming Your Care (<http://www.transformingyourcare.hscni.net/>);
 - National Osteoporosis Society Strategic Plan 2013 - 2017 Building Stronger Bones (<http://www.nos.org.uk/Document.doc?id=1289>);
 - Active Ageing (<http://www.ofmdfmi.gov.uk/active-ageing-strategy-2014-2020-consultation.pdf>);
 - *Healthy Child, Healthy Future*, May 2010 (<http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf>); and
 - recommendations from the European Child Safety Alliance (<http://www.childsafetyeurope.org/>).

Home Accident Prevention Strategy and Action Plan 2004-2009

The first Home Accident Prevention Strategy and Action Plan 2004 – 2009 (<http://www.dhsspsni.gov.uk/eqia-haps04.pdf>) was published in November 2004.

The Strategy identified four key areas for action:

- Policy Development
- Improving Awareness
- Improving Training and
- Accident Information.

The actions required concerted collaborative actions from a number of Northern Ireland Civil Service Departments and Health and Social Care Boards, Trusts and agencies including the non-statutory sector.

A review to assess the impact of the 2004 – 2009 Strategy (http://www.dhsspsni.gov.uk/review_of_the_home_accident_prevention_strategy_2011.pdf) concluded that significant progress had been made, with the majority of the Strategy's actions being achieved. Many of the programmes and pilots were extended and rolled out. Other pilots and initiatives demonstrate good practice and have the potential for regional implementation.

The review noted that actions on accident information had not been addressed, i.e. to agree a minimum dataset, and to develop a central service for the collection,

analysis and dissemination of home accident data. The standardisation of home accident data, recording and collection is particularly important to acquire accurate baseline data.

The targets in the 2004 strategy were developed to help achieve targets in the public health strategy, *Investing for Health* and to measure the overall success of the strategy in reducing the number of accidental deaths and injuries in the home. The review report concluded that there had been considerable progress made towards reducing the number of accidental injuries in the home over the duration of the strategy, but that there had not been a corresponding reduction in the number of accidental deaths. Falls prevention continues to be a challenge, with falls in the home being a leading cause of accidental death.

The review report concluded that key challenges remained and that there was still a need to prioritise home accident prevention. It recommended that a new 10-year strategy should be developed to set the regional strategic policy for home accident prevention to reduce the number of accidental deaths and injuries in the home.

Values and principles

The values and principles that inform this strategy are as set out in *Making Life Better* and are set out in Figure 7.

Figure 7: Values as set out in *Making Life Better*

<p>Social justice, equity and inclusion</p>	<p>All citizens should have the right to the highest attainable standard of health.</p>
<p>Engagement and empowerment</p>	<p>Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.</p>
<p>Collaboration</p>	<p>Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.</p>
<p>Evidence-informed</p>	<p>Actions should be informed by the best available evidence and should be subject to evaluation.</p>
<p>Addressing local need</p>	<p>Action should be focused on individuals, families and communities in their social and economic context.</p>

Source: DHSSPS

2. Strategic direction

Vision

The vision for the Home Accident Prevention Strategy 2015 – 2025 is:

that the population of Northern Ireland has the best chance of living safely in the home environment where there is negligible risk of unintentional injury.

Strategic aim

The strategic aim is:

to minimise injuries and deaths caused by home accidents, particularly for those who are most at risk.

Objectives

The partners in the strategy will seek to realise the vision and achieve the strategic aim by pursuing the following objectives.

1. Empower people to better understand the risks and make safe choices to ensure a safe home with negligible risk of unintentional injury.
2. Promote safer home environments.
3. Promote and facilitate effective training, skills and knowledge in home accident prevention across all relevant organisations and groups.
4. Improve the evidence base.

Scope of the strategy

For the purposes of this strategy “home” is defined as:

any primary residence including a house, apartment, farmhouse, caravan, together with its outbuildings, garden, yard, driveway, path, steps and

boundaries or common areas, e.g. lifts, lobbies, corridors and stairwells. It need not be the home of the injured person.

In this context “home” does not refer to residential institutions such as nursing homes or prisons, or temporary accommodation such as a hotel, boarding house or hospital. These categories of residential settings are governed by regulations to manage the environmental risks and, to some extent, behavioural risks. Nursing homes, specifically, afford a greater degree of supervision than is available to many older people who live alone in their own homes. This supervision is significant both for preventing accidents and for responding quickly to accidents. The safety of residents is a core consideration in the inspection of these settings by the Regulation and Quality Improvement Authority (RQIA) and other agencies.

<http://www.rqia.org.uk/publications/legislation.cfm>

Notwithstanding the differences between domestic settings and those residential settings that are not within the scope of the strategy, it is expected that some of the measures that will implement the strategy will be applicable in residential settings.

It is acknowledged that there is no clear boundary between a farm as a home and a farm as a workplace. This strategy relates to the farmhouse as a home. The Health and Safety Executive in Northern Ireland leads in respect of farm safety.

<http://farmsafe.hseni.gov.uk/>

Priority groups

Most home accidents can be prevented by identifying their causes and removing these, or reducing people’s exposure to them. The environments in which people live do much to determine injury risks and opportunities for injury prevention.

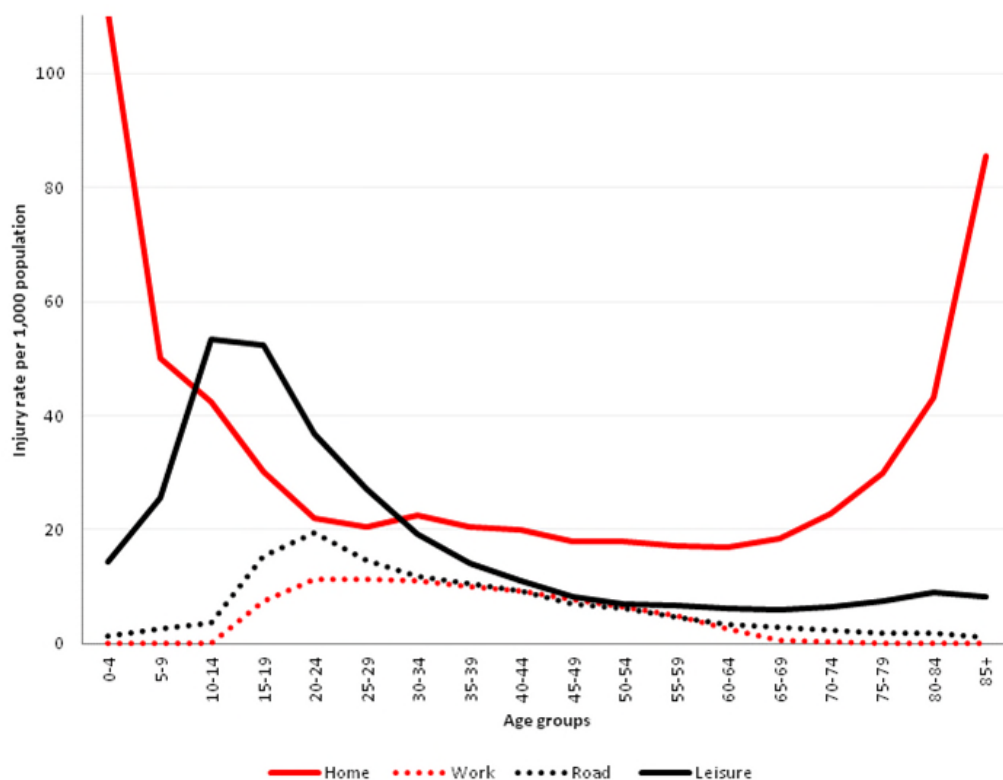
This strategy is aimed at the entire population of Northern Ireland as accidents can and do affect everyone. However there are groups of people who are more likely to have accidents and more likely to suffer long-term effects as a consequence of an accident. The focus of this strategy is on babies and children under 5, people over 65 and other vulnerable groups, however it is recognised that the risk of having an

accident can increase depending on a range of circumstances including living alone, mental, physical or sensory impairment, illness, multiple medications or other types of vulnerability.

In addition to the priority groups, a population approach is also needed to improve home safety awareness and reach those responsible for providing care for priority vulnerable groups i.e. parents, guardians, foster parents, families, carers and communities in general.

Figure 8 demonstrates the increased rate of accidents among young children and older people reported to Emergency Departments.

Figure 8: Unintentional injury rates by age by age and location



Source: RoSPA

Babies and children under 5

More than any other group, under-5s depend on others for their safety as they become able to move and explore their home environment before they gain knowledge and understanding of hazards and the skills to respond to them.

Preventing injuries among babies and young children depends on creating safer products and home environments for them and on influencing those who care for them. Adults are the people responsible for the safety of babies and young children in the home, as parents or in other capacities, and they can do much to provide safe environments and model safety and risk management behaviour.

Figure 9 shows data collected through 5,416 home safety checks carried out between April 2012 and March 2014 in Northern Ireland. Although the service is targeted towards families with babies and children under 5, the data may contain families with children under 18 who have disabilities.

Children
<ul style="list-style-type: none">• 8% had an accident in the 12 months before their check.• 68% were falls.• 27% visited their GP.• 44% went to hospital.• 74% did not have stair gates.• There was a high percentage of concern regarding burns/scalds and medicines management.

Figure 9: Data from checks carried out by Home Safety Officers

Source: Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG)

People over 65

The population of Northern Ireland is getting older and the number of older people will continue to increase. There are now 266,000 people aged over 65 years living in Northern Ireland (15% of the population). This has increased over the last 20 years by 60,000 and is forecast to double again by 2051. The biggest increase has been in people aged 85 years and over, a group that has doubled in size in the last 20 years and which is set to quadruple by 2051⁵. Older adults are more vulnerable to home accidents due to many of the effects of the ageing process including medical

⁵ Source: Director of Public Health Annual Report 2012/NISRA

conditions, impaired mobility and gait, increased sedentary behaviour, fear of falling, impaired cognition, visual impairment and foot problems. The impact of home accidents tends to be high, as older adults have lower recuperative capacity and injuries impact upon their bodies more severely such as bones fracturing more easily and scalds to the skin happening more quickly.

An ageing population is a significant achievement, reflecting advances in health and quality of life. A key challenge will be to enable older people to remain in good health for as long as possible.

Figure 10 shows data collected through 6,048 checks carried out by Home Safety Officers between April 2012 and March 2014. Although the service is targeted at people over 65, it does not exclusively cover this age group and includes vulnerable adults.

Figure 10: Data from checks carried out by Home Safety Officers

Older People
<ul style="list-style-type: none">• 25% had a home accident in the 12 months before their check.• 94% of these were falls.• 35% visited their GP.• 45% visited hospital.• 23% did not have an adequate number of suitably located smoke detectors*.• Approx 66% homes that required audible carbon monoxide monitors did not have one.

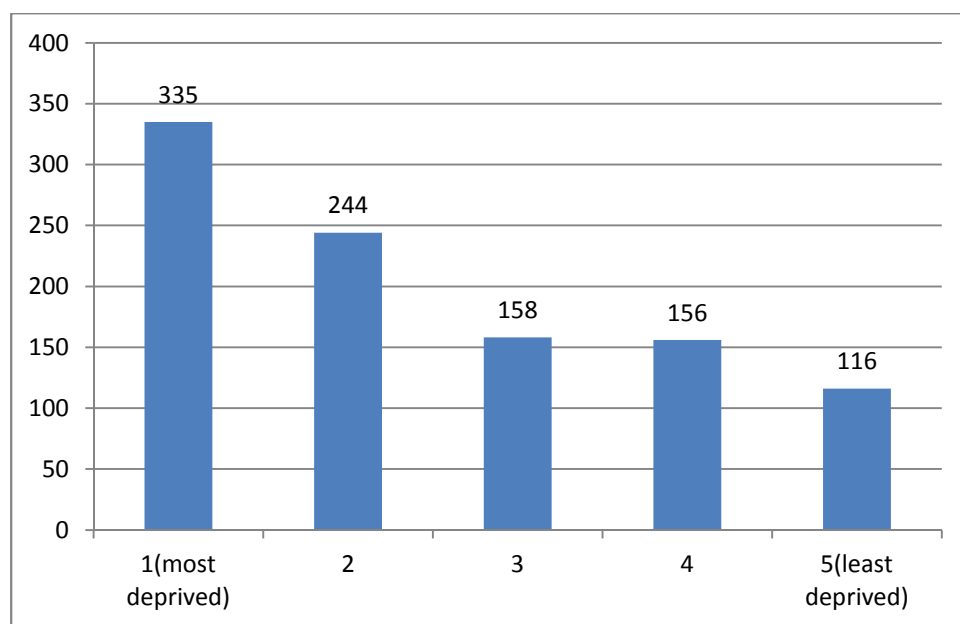
Source: Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG)

* An adequate number being at least one smoke detector per floor, and suitably located being situated on ceilings away from walls and light fittings.

Impact of deprivation

The number of deaths due to unintentional injuries in the home is considerably higher among those living in more deprived areas. See Figure 11.

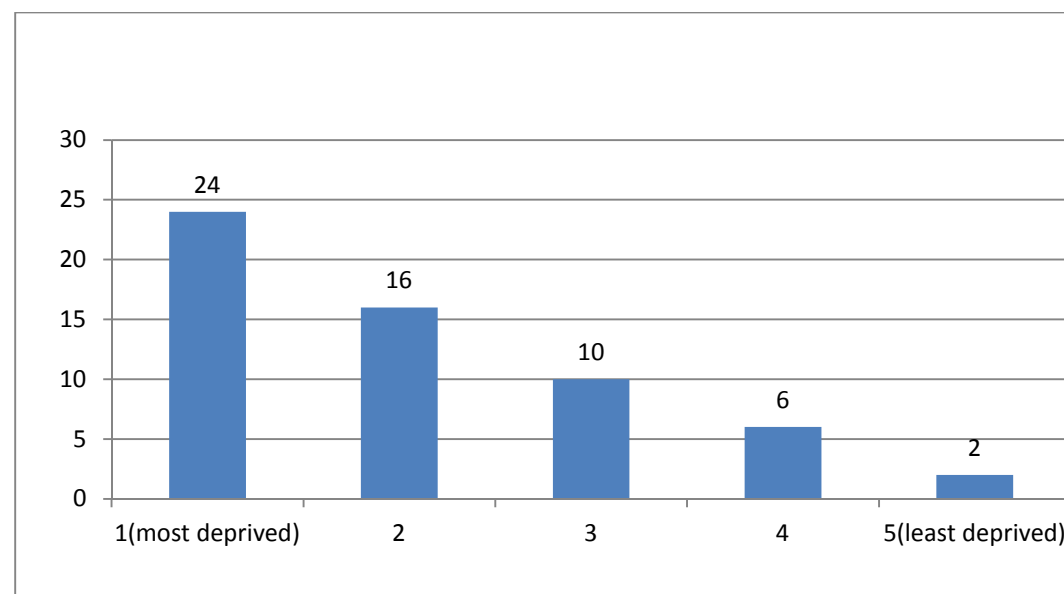
Figure 11: Total Northern Ireland home accidents by deprivation quintile (2001-2011)



Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

Between 2001 and 2011, 24 children and young people aged 0-19 years from the most deprived quintile of Super Output Areas (local geographical units used for the Census) died as the result of an unintentional injury in the home, compared with two children and young people aged 0-19 years living in the least deprived quintile. See Figure 12.

Figure 12: Child and Young Person home accident deaths by deprivation quintile (2001-2011)



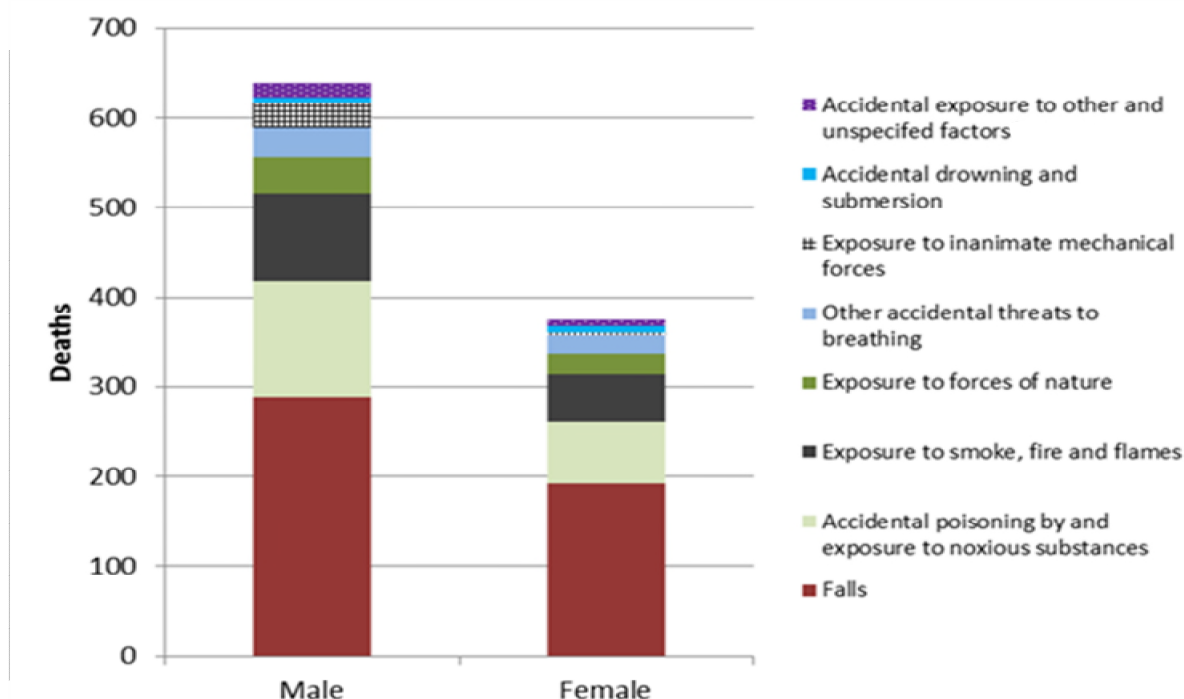
Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

Types of home accident

Accident trends vary and the type and frequency of accident suffered can be influenced by a range of factors such as weather, time of the year, demographics, lifestyle and behavioural choices (eg. use of candles, substance misuse, climbing on a stool to change a light bulb), economic factors that can affect the types of products we buy, including home safety aids, as well as services we use or do not use to maintain appliances. Regardless of these factors, the basics of accident prevention, i.e. awareness, supervision, risk assessment, hazard identification and reduction, remain the same.

Falls are the major cause of unintentional injury and death occurring in the home accounting for 480 deaths (288 male; 192 female) between 2001 and 2011, equating to just under half (47%) of all unintentional injury and deaths at home. See Figure 13.

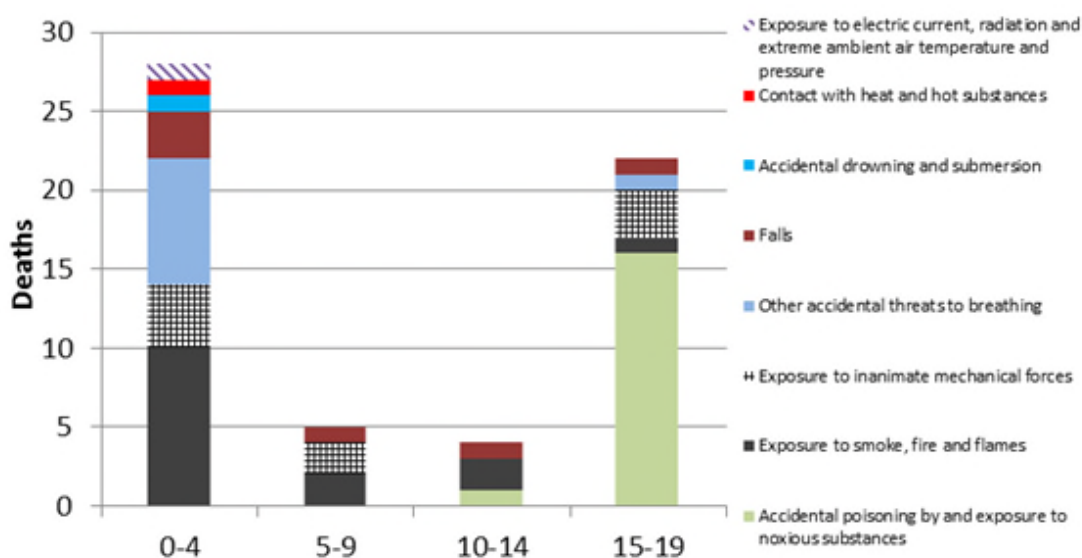
Figure 13: Unintentional Injury Deaths Occurring at Home 2001-2011



Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

The numbers and causes of deaths from unintentional injury in children and young people that occur at home vary substantially by age. In young people aged 15-19 accidental poisoning is the main cause of death. Of the 17 accidental poisoning deaths in those aged 10-19, nine were due to carbon monoxide (CO) poisoning. See Figure 14.

Figure 14: Unintentional Injury Deaths Occurring at Home in Children and Young People 2001-2011



Source: PHA analysis of deaths data from The General Register Office for Northern Ireland

Within the lifetime of this strategy, it is intended that the focus should include:

- falls;
- poisonings;
- smoke, fires and flames;
- strangulation, choking and drowning, and
- burns and scalds.

Falls

Falls are a significant and growing public health issue in an ageing population. The risk of falling in the home increases with age. Falls also account for the majority of non-fatal accidents in babies and children under 5.

For children, most falls involve tripping over on the same level. However, the most serious consequences result from falls between two levels, such as falling out of a pram or highchair or falling from a bed. The worst injuries are sustained when a child falls from a great height, such as falling down stairs or from a balcony or window, or when the child lands on something hard, sharp or hot.⁶

For those over 65, a substantial number of falls are due to unspecified reasons and occur whilst moving about on one level. This may reflect instability associated with impaired general health. The cause of a fall is often multi-factorial, involving both environmental hazards and an underlying medical condition. In the case of poor bone health and osteoporosis, a fall is much more likely to result in a fracture even where the impact of the fall is minimal. Loss of strength, balance and gait, decline in vision, mental health problems and deficiencies in the diet are all contributory factors. Although prescription medicines are seldom the sole cause of falls, they can be a major risk factor, as can dehydration.

Falls account for 71% of all fatal accidents to those aged 65 and over.⁷ Recurrent falls are associated with increased mortality, increased rates of hospitalisation, and higher rates of institutionalisation.⁸ Studies have shown that one third of people aged over 65 in the general population have one fall per year, with 40–60% of these falls causing injury⁹. 50% of people who have suffered a hip fracture can no longer live independently. Fear of falling again reduces quality of life and wellbeing. Even if a fall does not result in serious injury the loss of confidence can lead to an individual restricting their activity and indeed this can lead to further falls. Based on costs from 2009/10, the South Eastern HSC Trust *Falls and Osteoporosis Strategy* estimated

⁶ RoSPA:

<http://www.rospa.com/homesafety/adviceandinformation/childsafety/accidents-to-children.aspx>

⁷ RoSPA. 30 March 2012:

www.rospa.com/homesafety/adviceandinformation/olderpeople/accidents.aspx

⁸ Physiotherapy works: Fragility fractures and falls. Chartered Society of Physiotherapists. October 2014: <http://www.csp.org.uk/publications/physiotherapy-works-falls-frailty>

⁹ Director of Public Health Annual Report 2012:

http://www.publichealth.hscni.net/sites/default/files/DPH_Report_05_13_0.pdf

that for every hip fracture avoided, approximately £10,170 could be saved¹⁰. This is a conservative estimate. The full direct costs to health and social care that are associated with an accidental injury can include, in addition to the cost of immediate treatment, the cost of medium-term care and rehabilitation and, in cases of life-changing injuries, the cost of long-term care and support. Costs are incurred in other public services; there are costs to society from loss of economic activity, and there are also the financial costs that may be borne by someone who is unable to work.

There are already a number of programmes aimed at falls prevention, and focus will remain on trying to reduce the number of falls.

Figure 15 shows data captured relating to falls in the home, during home safety visits between April 2012 and April 2014.

¹⁰ Director of Public Health Annual Report 2012:
http://www.publichealth.hscni.net/sites/default/files/DPH_Report_05_13_0.pdf

Figure 15: Data from checks carried out by Home Safety Officers

Children or Young People	Older People
<ul style="list-style-type: none"> • 36% of accidents reported were falls at height, the majority of which occurred in the porch/hall/stairs. • 74% of homes did not have stair gates. • In 68% of homes which had stair gates, the gates were inadequate i.e. inadequate number/ not securely fitted/not safely located. • Only 8% of homes had an adequate number of securely fitted and safely located stair gates. • 46% of homes did not keep furniture away from windows to prevent children climbing up to reach them in the living room. • 23% of homes did not keep furniture away from windows to prevent children climbing up to reach them in the bedroom. • 29% of homes did not keep furniture away from windows to prevent children climbing up to reach them in other areas of the house. • 32% of all accidents were falls on the level and these occurred most commonly in the living room. 	<ul style="list-style-type: none"> • 94% of home accidents reported were falls. • 33% of accidents occurred outside or at the garage. • 16% occurred in the porch/hall/ stairs. • 16% occurred in the living area. • 35% of accidents occurred in winter. • 65% of older people took more than 4 types of medication per day. • 33% experienced dizziness or light heads. • 40% had difficulty getting into or out of the bath or shower. • 28% had difficulty getting on or off the toilet. • 61% had difficulty reaching, bending or putting on shoes. • 17% could not manage the steps outside their home. • 18% had difficulty using the clothes line. • In 13% of homes with stairs, the stairs were not free of obstruction.

Source: Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG)

Poisonings

Medicines and carbon monoxide are significant causes of accidental poisoning of people over 65. Information about medicines gathered during home safety checks is included in Figure 16.

Exposure to carbon monoxide by any fossil fuel-burning appliance that is not properly installed or regularly serviced can lead to death or illness. The *Power NI Carbon Monoxide Report 2011* showed that 69% of their customers said they had not undertaken the recommended annual boiler check¹¹.

According to the *Annual Report of the Registrar General 2009*, since 2001, 72% of all deaths by carbon monoxide poisoning in Northern Ireland have occurred in urban areas. Of these deaths, 37% occurred in Greater Belfast, which is in proportion to population size.

The Health and Safety Executive NI (HSENI) have lead responsibility for carbon monoxide safety, and work in partnership with a range of other accident prevention agencies and DHSSPS to raise awareness of the dangers of carbon monoxide.

In babies and young children, most poisoning accidents involve household products, carbon monoxide, medicines and cosmetics. Young children like putting things in their mouths to see what they taste like without realising they may be harmful. They also find clever ways to climb up to reach things as they are often very curious and like to explore.

Liquitab detergents are a common alternative to traditional powder, liquid or tablet style detergents used in washing machines and dishwashers. Young children have been injured after biting into or placing these brightly coloured liquitabs in their mouths, after mistaking them for sweets. Eye injuries and chemical burns have also resulted from skin contact with liquitabs.

¹¹ RoSPA Big Book of Accident Prevention NI, 2013:
<http://www.rospace.com/PublicHealth/big-book-ni.pdf>

Research carried out by the Royal Belfast Hospital for Sick Children from 1 January 2012 to 31 December 2013 showed that ingestion of liquitabs accounted for 14.5 per cent of all non-medicinal ingestions in Emergency Departments, with 2-3 year-olds being the most common age group affected. Two-thirds of the accidents happened during unsupervised play¹².

Potential hazards are constantly emerging, for example, the brightly coloured liquid contained in e-cigarette refills can also be attractive to children.

Figure 16 shows data captured, relating to poisonings in the home, during home safety checks between April 2012 and April 2014.

Figure 16: Data from checks carried out by Home Safety Officers.

Children or Young People	Older People
<ul style="list-style-type: none"> • 27% of homes with children under 5 used plug-in air fresheners. • 40% did not store medication, alcohol and chemicals safely out of sight and reach of children in the kitchen. • 32% did not store medicines, cleaning chemicals and cosmetics out of sight and reach of children in the bathroom. 	<ul style="list-style-type: none"> • 65% of older people were on more than four different types of medication per day. • 7% had difficulty reading labels on their medication. • 9% had difficulty collecting or handling their medication. • 10% of older people had difficulty remembering when to take their medication. • 13% did not dispose of out-of-date medication or medication not prescribed for them.

Source: Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG)

¹² RoSPA 17 December 2014: <http://www.rospa.com/news/releases/detail/?id=1358>

Smoke, fires and flames

The majority of deaths and serious injuries caused by house fires are the result of exposure to smoke and toxic gases produced by the fire, rather than exposure to heat and flames. Carbon monoxide poisoning is the main cause of death following smoke inhalation. Smoke also obscures the vision of those trapped by fire, decreasing their ability to escape to a place of safety.

From 1 January 2013 to 31 December 2014, 17 people died in accidental house fires in Northern Ireland. Six were over 65 years old. Poor mobility, sensory impairment, poor sense of smell and a reduced tolerance of smoke and burns contribute to fatalities. Major sources of ignition include cookers, smoking materials, electric fires and heaters, candles, and open fires.

Figure 17 shows data captured relating to injuries as a result of smoke, fire and flames in the home, during home safety checks between April 2012 and April 2014.

Figure 17: Data from checks carried out by Home Safety Officers.

Children or Young People	Older People
<ul style="list-style-type: none"> • 5% of homes with children under 5 did not have smoke detectors. • Of those that did, 7% did not have an adequate number and 4% were not suitably located. • 28% of homes did not test smoke detectors regularly. • 8% of smoke detectors were not working. • 51% of homes with children under 5 did not have a fire escape plan. • In 31% of homes someone smoked within the home. • 69% burned candles, including for emergency use. • 22% did not switch off or unplug appliances and heaters at night. • 24% did not close all doors at night. • 36% used chip pans, frying pans or grill pans. • In 6% of homes electric blankets were used. • 14% of electric blankets used were more than 10 years old. 	<ul style="list-style-type: none"> • 23% of homes did not have a sufficient number and/or suitably located smoke detectors. • In 28% of homes the smoke detectors were not tested regularly and/or were not working. • 46% did not have a fire escape plan. • In 17% of homes someone smoked within the home. • 42% burned candles, including for emergency use. • 20% did not switch off or unplug appliances and heaters. • 19% did not close all doors at night. • 56% used chip pans, frying pans or grill pans. • In 33% of homes electric blankets were used. • 20% of electric blankets used were more than 10 years old.

Source: Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG)

Strangulation, choking and drowning

Babies and small children are most at risk from choking because they examine things around them by putting them in their mouths. Such accidents are particularly distressing and completely preventable. Data captured during home safety checks at homes with children under 5 showed that 76% of homes did not keep blind cords out of reach in the living area, 68% did not keep blind cords out of reach in the bedroom, and 64% did not keep blind cords out of reach in other areas of the house.

In September 2013, the four UK Chief Medical Officers agreed to establish a UK group, led by the Chief Medical Officer for Northern Ireland, Dr Michael McBride, and comprising membership from the UK's four public health agencies, RoSPA and the British Blind and Shutter Association (BBSA), with the aim of exploring the scope for collaborative working to reduce blind cord and chain accidents and deaths. The group provided a report and recommendations to the UK Chief Medical Officer Group. The Public Health Agency, Health and Social Care Trusts, District Councils, RoSPA and home accident prevention groups continue to promote awareness of the dangers of blind cords and chains.

Babies and small children are most at risk from choking because they examine things around them by putting them in their mouths. Children can swallow, inhale or choke on items such as food, drink, toys and other small items. Home safety checks found that 12% of homes did not store small items such as coins, screws or jewellery out of reach of children.

Nappy sacks, used to dispose of soiled nappies, can also pose a suffocation risk to babies and young children. Parents and carers are generally aware of the dangers posed by plastic bags, but may not appreciate that nappy sacks pose similar risks. Home safety checks found that 36% of homes did not store plastic bags out of children's reach.

Babies can drown in as little as 2 inches (5cm) of water and it is important that they are never left alone for a moment, even if there is an older brother or sister with

them.¹³ Childhood drowning in the home has been associated with baths, fish tanks, water butts, garden ponds and paddling pools.¹⁴

Burns and scalds

For older people the rate of risk for severe accidents involving burns and scalds is lower than other age groups. However, older people are at the highest risk for fatal injuries from burns and scalds - four to five times greater than the population as a whole. Pre-existing conditions often contribute to their deaths. The main source of heat includes radiators, electric fires and cookers, with many receiving scald injuries involving the use of kettles.¹⁵ Older people tend to have thinner skin which may cause burns and scalds to penetrate deeper¹⁶ and cause more severe injuries. They also tend to have reduced recuperative ability.

Hot drinks cause most scalds to children under the age of five. A child's skin is much more sensitive than an adult's and a hot drink can still scald a child 15 minutes after being made. During home safety checks Home Safety Officers had concerns about hot drinks in 26% of homes. Young children are also very vulnerable to sunburn.

Many of the children who go to Emergency Departments with a burn or a scald are referred on for further hospital treatment. Recovery may be long and painful and many are left with permanent scarring. Hot bathwater is responsible for the highest number of fatal and severe scalding injuries among young children.

Children can also suffer burns after contact with open fires, cookers, irons, curling tongs and hair straighteners, cigarettes, matches, cigarette lighters and many other hot surfaces.¹⁷ In 10% of homes, Home Safety Officers had concerns about irons

¹³ HSCNI Birth to Five Book: <http://www.publichealth.hscni.net/publications/birth-five>

¹⁴ ROSPA: www.rospa.com/leisuresafety/Info/WaterSafety/statistics/child-drownings-2005.pdf

¹⁵ RoSPA. 30 March 2012:

www.rospa.com/homesafety/adviceandinformation/olderpeople/accidents.aspx

¹⁶ Hot water burns like fire campaign: <http://www.hotwaterburns.org/#!/later-life/c2494>

¹⁷ RoSPA:

<http://www.rospa.com/homesafety/adviceandinformation/childsafety/accidents-to-children.aspx#scalds>

and in 36% of homes Home Safety Officers had concerns about hair straighteners, tongs etc.

Objectives and strategic priorities

For each of the four strategy objectives there will be a set of strategic priorities which in turn will guide specific actions.

Objective 1: Empowering people

- Raise awareness of:
 - the scale and impact of home accidents;
 - the causes of home accidents and how to prevent them, and
 - the risk factors for under-5s and over-65s.
- Support and deliver effective preventative measures to reduce home accidents.
- Seek to influence behavioural change to reduce accidents.
- Promote personal responsibility for preventing unintentional injuries in the home.
- Encourage and promote awareness of product safety when making purchasing decisions and the importance of responding to publicised product recalls associated with consumer goods.

Objective 2: Safer home environment

- Deliver, support and promote home safety assessment schemes.
- Promote safer built environments.
- Provide home accident prevention equipment.

Objective 3: Training, skills and knowledge

- Support training and awareness programmes for people who come into contact with target groups.
- Support continuous professional development for those involved in the delivery of home accident prevention.

- Seek to increase the number and type of organisations promoting and trained in accident prevention work (public, private, commercial, voluntary & community).

Objective 4: Improve evidence base

- Enhance the capacity of information systems to capture and provide key data on:
 - the potential for home accidents;
 - injuries and deaths that have resulted from home accidents;
 - patient outcomes following injuries from home accidents; and
 - injured person's socio-economic background.
- Evaluate the Home Safety Assessment Scheme.
- Clearly define the roles of organisations in gathering and sharing information, including qualitative information.
- Support the development of appropriate systems to comprehensively capture information in relation to home accidents.
- Make formal links with the Injury Observatory for Britain and Ireland.
- Share and learn from best practice elsewhere.

3. Making it happen

Pursuing the objectives

The aim and objectives of this strategy can be achieved if there is a coordinated approach which ensures effective partnership working between Government departments, statutory, private, and voluntary & community sectors. If the four objectives identified in Chapter 2, are comprehensively realised, the ultimate goal of the population of Northern Ireland having the best chance of living in a safe home environment where there is negligible risk of unintentional injury will be within reach.

Data collection

The reason to collect information on injuries is to act as a catalyst for prevention. While various techniques currently exist to capture data, including digital pen and tablet-captured data from the District Council-led home safety check schemes and some accident and emergency data, significant further work needs to be done in order to capture information in a uniform and useful format.

Action plan

An action plan to accompany the strategy will be developed by the Public Health Agency in partnership with key stakeholders. If the objectives are to be met, it is essential that structures are in place to oversee the programme of action. The plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

Managing the plan

The Public Health Agency will be responsible for implementation and evaluation, with the assistance of a multi-agency implementation group to oversee and drive forward the actions outlined in the plan. The group will develop a rolling action plan and will report progress to the Department on an annual basis. This will be made available on the Departmental website.

Resources

A number of agencies currently dedicate significant funding and resources to home accident prevention. Implementation will require further effective use of existing resources across partner agencies, with alignment against key strategic priorities.

Implementation will also make good use of new funding opportunities, alongside the development of innovative approaches to achieve the objectives of the strategy.

Review

The action plan will be reviewed after one year to assess progress against objectives and targets, and to inform the roll-forward of the new action plan. Thereafter reviews will be conducted every three years.

Accident prevention: roles and responsibilities

The implementation of an action plan requires input from a variety of organisations, agencies and individuals ranging from Government Departments, Health and Social Services and local councils, to the voluntary sector and local communities.

The Department of Health, Social Services & Public Safety (DHSSPS) is responsible for the health and wellbeing of the population and therefore has overall responsibility for the formulation and the impact of the strategy and action plan.

In the longer term, DHSSPS will monitor the impact of the strategy and the action plan.

The Public Health Agency (PHA) is the major regional organisation for health protection and health and social wellbeing improvement. The PHA's role commits to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing. It is a multi-disciplinary, multi-professional body with a strong regional and local presence.

In fulfilling the mandate to protect public health, improve public health and social wellbeing, and reduce inequalities in health and social wellbeing, the PHA works within an operational framework of three areas: Public Health, Nursing and Allied Health Professionals, and Operations.

The PHA will be responsible for the development and implementation of the Home Accident Prevention Action Plan at regional and local level.

Health and Social Care Trusts are the main providers of health and social care services to the population of Northern Ireland. The work of the Trusts is guided by a wide range of policy development, from local evidence through to national policies, governing how care will be organised, delivered and managed. This extends to health and wellbeing which is an integral part of the care and services provided by Trust staff and which is delivered to local communities through health improvement and community development plans. Trusts work in partnership with DHSSPS and the Public Health Agency as well as many other statutory, commercial and community and voluntary organisations. In doing so Trusts play an active role in realising the aims of the strategy and action plan through responsibility for development and implementation at a local level.

Health and Social Care Board (HSCB) seeks to develop health and social care services across Northern Ireland. The role of the Health and Social Care Board is broadly contained in three functions:

- to commission a comprehensive range of modern and effective health and social services for the 1.8¹⁸ million people who live in Northern Ireland;
- to work with the Health and Social Care Trusts that directly provide services to people to ensure that these meet their needs, and
- to deploy and manage its annual funding to ensure that all services are safe and sustainable.

¹⁸ NISRA Census 2011

The Northern Ireland Fire & Rescue Service (NIFRS) seeks to deliver a fire and rescue service and work in partnership with others to ensure the safety and wellbeing of the community. NIFRS responds to fires, road traffic collisions and other specialist rescue incidents and provides community safety education and advice.

Department of Education's (DE) primary duty is to promote the education of the people of Northern Ireland and to ensure the effective implementation of education policy. DE's main statutory areas of responsibility are 0-4 provision, primary, post-primary and special education and the youth service.

District Councils have many statutory functions bearing directly on health and quality of life. Environmental Health departments cover food safety, standards and nutrition; health and safety; public health and housing; environmental protection; and ensuring product safety through the enforcement of consumer safety legislation. Building Control departments have responsibility for compliance with housing standards and Leisure Services provide activities linking to accident prevention. Councils also employ Home Safety Officers to deliver home safety check schemes, deliver Safe and Well projects, and support local Home Accident Prevention (HAP) groups. All these functions can specifically impact on the prevention of home accidents.

Home Accident Prevention Northern Ireland (HAPNI) is a voluntary network which aims to prevent all kinds of accidents that occur in and around the home. The HAP groups provide a local forum of employer-supported and traditional volunteers, and work in partnership with many of the other key stakeholders responsible for accident prevention including District Councils, Trusts, NIFRS and NIHE.

Health and Safety Executive for Northern Ireland (HSENI) is the lead body responsible for the promotion and enforcement of health and safety at work standards in Northern Ireland. The HSENI mission statement is "To ensure that risks to people's health and safety arising from work activities are effectively controlled".

HSENI is currently the chair of the Carbon Monoxide Safety Group for Northern Ireland and as such is fully committed to raising awareness of the risks associated with carbon monoxide to the public. HSENI lead on farm safety where farms are seen as the workplace.

Northern Ireland Housing Executive (NIHE) works with local communities and other agencies in the public, private and voluntary sectors to tackle issues that affect quality of life for the entire population including:

- the physical and social regeneration of local neighbourhoods;
- community safety and reductions in anti-social behaviour, and
- good community relations.

An Munia Tober is a community voluntary group that aims to provide support to Traveller families including personal development, toybox projects for pre-schoolers, after-schools projects, youth programmes and alternative education programmes. They also provide support for Travellers on health, housing, education, training and development.

The Royal Society for the Prevention of Accidents (RoSPA) promotes safety and the prevention of accidents at work, at leisure, on the road, in the home and through safety education. In Northern Ireland RoSPA receives funding from DHSSPS to deliver up-to-date, researched information, training and support services on all aspects of home safety. RoSPA also acts as a point of contact on issues relating to road safety and workplace safety in Northern Ireland, signposting these to the relevant departments within RoSPA UK.

Northern Ireland Home Safety Check Scheme Steering Group (NIHSCSSG) is a multiagency group made up of regional managers/co-ordinators of council-led home safety check schemes, and representatives from PHA, RoSPA, NIFRS and others engaged in the delivery of home safety checks. The group aims to provide a consistent approach to home safety checks, sharing best practice, and capturing Northern Ireland data.

Appendix: Drafting Group membership

Department of Health, Social Services and Public Safety

Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Public Health Agency

12-22 Linenhall Street
Belfast
BT2 8BS

Southern Health and Social Care Trust

Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Western Health and Social Care Trust

Altnagelvin Area Hospital
Glenshane Road
Londonderry
BT47 6SB

Health and Social Care Board

12-22 Linenhall Street
Belfast
BT2 8BS

Northern Ireland Fire and Rescue Service

1 Seymour Street
Lisburn
BT27 4SX

Royal Society for the Prevention of Accidents

Ground Floor
3 Orchard Close
Newpark Industrial Estate
Antrim, BT1 2RZ

Eastern Group Environmental Health Committee (EGEHC)

Civic and Administrative Offices
1 Bradford Court
Upper Galwally
Belfast
BT8 6RB

Department of Education

Rathgael House
Balloo Road
Rathgill
Bangor
BT19 7PR

Health and Safety Executive

83 Ladas Drive
Belfast
BT6 9FR

Home Accident Prevention Northern Ireland

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Northern Ireland Housing Executive

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