

in relation to the frequency and severity of injury within their communities.

To develop and maintain effective injury prevention partnerships, it is essential for the Aboriginal communities and all other stakeholders to be equally involved throughout the process. Local Aboriginal communities will have ultimate control over the scope and future of any initiatives or partnerships, which must be built on openness, trust, commitment, and sustainability.

Since the publication of the *Mid North Coast Aboriginal Injury Surveillance Project Report*, the project has successfully developed an inter-sectoral working party for the purpose of putting the recommendations of the report into action. The current priority for the working party is the development and implementation of an Aboriginal Injury Prevention Better Practice Model.

Copies of the *Mid North Coast Aboriginal Injury Surveillance Project Report: Pride, Respect and Responsibility* can be downloaded from the NSW Department of Health's Web site at www.health.nsw.gov.au/public-health/health-promotion/improve/injuryprev/pdf/abinjurncoast.htm.

REFERENCES

1. Gladman D, Hunter E, McDermott R, Merritt T, Tulip F. *Study of Injury in Five Cape York Communities*. Adelaide: AIHW National Injury Surveillance Unit, 1997.
2. Mid North Coast Aboriginal Health Partnership. *Mid North Coast Aboriginal Injury Surveillance Project Report: Pride, Respect and Responsibility*. Port Macquarie: Mid North Coast Aboriginal Health Partnership, 2001. ☒

CHILD DEATHS AND INJURIES IN DRIVEWAYS

Rebecca Mitchell

*Injury Prevention and Policy Unit
NSW Department of Health*

The Commission for Children and Young People's *NSW Child Death Review Team 1998–99 Report* found that, between 1996 and 1999, 17 children died after being reversed-over in home driveways in NSW.¹ The number of children injured in this way was much higher.¹ For example, between 1996 and 1998, 32 severely-injured children were admitted to the New Children's Hospital at Westmead alone, after being reversed-over in home driveways.¹

A review by the Motor Accidents Authority of NSW (MAA) suggests that child deaths and injuries in driveways are best tackled through a range of preventive measures.² The review, which responds to the *NSW Child Death Review Team 1998–99 Report*, calls for a mixture of prevention strategies, including: public education, new vehicle design, and building planning reforms.

The majority of casualties are children under two years of age; the injury was most likely to occur in the driveway of the family home or of other homes in the neighbourhood; and the vehicles involved were large, such as four-wheel drives or commercial vehicles.²

The recommendations of the MAA review include:

- encouraging government, community, and private sector organisations to incorporate driveway safety material into their existing programs;
- encouraging the use of lenses and mirrors that facilitate a view of the area immediately behind motor vehicles, especially large vehicles;

- researching the effectiveness and availability of electronic sensing devices for installation on the rear of motor vehicles;
- consulting with the Australian Building Codes Board to look at standards for the construction of driveways;
- furthering research into incidence figures and other related issues.

The MAA review was developed using the services of a broadly-based committee that included Kidsafe NSW, the NSW Roads and Traffic Authority, the NSW Department of Health, the New Children's Hospital, the NRMA, the Institute of Early Childhood, and the NSW Commission for Children and Young People.

A copy of *Child Deaths and Injuries in Driveways: Response to the Recommendations of the NSW Child Death Review Team 1998–99 Report* can be downloaded from the Motor Accidents Authority of NSW Web site at www.maa.nsw.gov.au/pdf/ChildFatalities.pdf.

REFERENCES

1. NSW Child Death Review Team. *NSW Child Death Review Team 1998–99 Report*. Sydney: Commission for Children and Young People, 2000.
2. Henderson M. *Child Deaths and Injuries in Driveways: Response to the Recommendations of the Child Death Review Team 1998–99 Report*. Sydney: Motor Accidents Authority of NSW, 2000. ☒