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Home Safety—The Challenge to Public Health

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Home accidents are now a leading cause of death and injury particularly in young children and the elderly. For example, 3.1 million accidents occur in the home every year in the United Kingdom with no signs of diminishment. More effective systems of accident recording, monitoring, investigation, intercollaboration and education are urgently needed to redress this epidemic. More attention needs to be given to preventive safety design in architect training and adoption of home safety design standards and legislation. The major threat to public health which home accidents represent must not go unchallenged.

Deaths and injuries caused by accidents in the home present us with one of the biggest public health challenges of this country. Quarterly statistics by WHO in 1984 stated that accident injuries of all kinds now rank fifth among the leading causes of death; in the case of young children and the elderly it is often higher than for infectious diseases (WHO, 1984).

Unfortunately, data on home accidents are less readily available on a national basis than data on road accidents. The American National Electronic Injury Surveillance System (NEISS) was the first to collect data on home accidents, followed by the United Kingdom (UK) Home Accident Surveillance Scheme, (HASS), now being developed on an European Economic Community and Nordic Country Basis. HASS has been monitoring the UK general pattern of accidents in the home from information recorded at 20 hospital Accident and Emergency (A&E) Departments since 1976. According to their estimate 3.1 million accidents occur in the home every year in the UK. Of these, 5,500 are fatal and represent about 40% of all fatal accidents and a third of all accidents treated in hospital (DT1, 1989). This costs the National Health Service approximately £300 million each year. Young children have the highest risk of incurring a home accident: Over 200,000 accidents occur each year to children aged 0–4 years. The HASS statistics show that 25% of all home

accidents are to children aged 1–14 years and 40.7% to children aged 0–14 years. The cost of childhood accidents alone in the United Kingdom is greater than the cost of treating cancer for all age groups. However, in terms of overall numbers, over half of all home accidents occur to elderly persons over the age of 75 years. These are mainly injuries arising from falls many of which are fatal. Indeed elderly people are at far more at risk of incurring a fatal home accident than any other group.

The long term trend for *fatal* home accidents in the United Kingdom shows a steady improvement from some 7,500 deaths p.a. in 1966 to less than 5000 p.a. by 1987. However, this has been levelling out over the last few years and the progress of improvement now appears to have bottomed out (Barrow, 1987).

The trend in *nonfatal* accidents is less satisfactory. Here the number has stayed constant at around 2 million per annum throughout the 10 years of HASS (i.e., according to HASS), there has, "been no improvement at all in non-fatal accident rates over this time" (Barrow, 1987).

Policy makers and practitioners in the UK are therefore faced with a major health hazard which unlike other twentieth century ailments has reached epidemic proportions and shows no signs of diminishing. The tragedy is that these human deaths and resultant misery are in the main, entirely preventable. We already have detailed knowledge of causation and safety design measures which can limit both the incidence and severity of home accidents. What is needed is the political will and the resources to act upon this knowledge.

The World Health Organisation (WHO) strategy document "Health for all by the year 2000" makes specific reference to a number of targets for safety in the home and environment (WHO, 1986). For example, target number 10 states that by the year 2000, deaths from accidents in the European region should be reduced by at least 25%; target number 24 requires that all people in the region should have a better opportunity of living in houses and settlements which provide a healthy and *safe* environment. These targets thus provide an opportunity to re-examine existing policies, standards, legislation and attitudes towards accident limitation. This is especially important in the United Kingdom which has dismally failed to reduce accidents

over the last ten years or given home safety the priority and attention it clearly deserves.

In fairness though the problem may be no better outside the United Kingdom. The problem is making any meaningful comparisons since the extent and methods of collating home accident statistics (where they are monitored at all) varies considerably throughout the world. For example, a review of the problems of accidents in Europe by Jackson (1983) concluded that "home accidents have been under-researched and underestimated in importance compared to vehicle accidents". Jackson somewhat cynically concludes that the relative lack of concern over falls (which is the predominant cause of fatal and severe accidents) "may be associated with the fact that they do not cause much damage to property in comparison to the distress caused to people".

Conception of the Problem

The sorts of factors which distort comparative statistical analysis include interpretation of the term "home", e.g., whether this should be restricted to the shelter on the immediate environs, whether suicides are included as accidents or not, and how severity of accidents is recorded. (Many countries only keep statistics on fatalities and not serious injuries resulting from accidents.) The WHO defines an "accident" as an "unpremeditated event resulting in recognisable damage" (Backett, 1965). For recording purposes HASS define an accident "as an unintentional injury or suspended injury no matter how caused, except deliberately self-inflicted injuries/suspected suicides or injuries resulting from physical attacks by other persons, animals or insects" (DTI, 1986). The important word in this definition is "injury" since physical injury, disability, or mental impairment brings accidents within the WHO, definition of Health.

In some countries where the home is also the basis for cottage industries, home accident statistics may include injuries caused by occupational accidents. There are similar recording difficulties in counting accidents to people who live in and work in hotels, shops and farms.

A critique of the various data collection systems at present in use has been published by the OECD, but in general, national

data have not been collected over a long enough period of time or in enough countries to warrant any overall comment other than a general statement about the significance of falls as a cause of death and of poisoning in children as a reason for admission to hospital.

With regard to falls, intercountry variations are considerable: Bulgaria and Spain have low rates, Austria and France high ones (about four times the rate of the lowest countries), while the rate in Hungary has almost doubled in the nine years 1969–1978. By contrast, fires produce comparatively few deaths, with no sign of any significant changes over the years. Poisoning likewise is low, apart from in Finland which has a rate of 8.9 per 100,000 population which is twice as high as the next country, Bulgaria (Jackson, 1983).

Vulnerable Groups

Examination of accident returns show a fairly standard morbidity pattern by age and gender (Backett, 1965). Children (particularly boys) have a relatively high injury rate but a fairly low risk of death. Home accidents gradually rise to a slight peak in the toddler and 15–24 age groups, steady in middle age, and finally rise sharply in the elderly. Interestingly enough, the elderly suffer fewer accidents than children but more of the accidents end in serious injury or death. Females have a higher number of fatal home accidents than males, probably because they spend more time in the home, are often distracted by young children and may be subject to the often destabilizing effects of premenstrual tension.

A review of home accidents in children shows that the pattern of accidents also changes with the hazards of the environment and the stage of children development. Young babies are totally unable to protect themselves and rely entirely on adult guardians for their safety. Toddlers aged 2–5 years (who have the largest number of home accidents of any age-group) also are incapable of recognising dangers, are physically immature and yet at the same time are actively exploring their environment: consequently, they are at greater risk of minor accidents. For *babies*, the greatest hazards are to be found in the bedroom, kitchen, bathroom or any room where he or she is

unattended. Suffocation and falls are the most common types of accident. However, for children aged 2–5 years the places where accidents most frequently occur are the living room, kitchen, nursery and bedroom: falls, scalds, poisoning and burns predominate. For somewhat older children, the pattern of accidents is more varied with danger in the immediate vicinity of the home becoming more commonplace.

Home accidents can have very serious consequences for the elderly, such as invalidity, extended periods of medical care and even death. In addition, pathological factors, such as acute and chronic illnesses, compound the effects of accidents. The tendency of the elderly to tire easily, to be forgetful, absent-minded and fearful of modern surroundings and equipment increases environmental hazards (WHO, 1968). The side effects of medication for geriatric ailments or mental illness also interfere with normal reasoning abilities, thus increasing accident risks. Depression, lack of self-confidence or boredom also may disincline the elderly to take safety precautions.

Socioeconomic classification of accident victims has not been sufficiently refined to enable any accurate opinions to be formed. However, many surveys have shown a relationship between *poverty* and a high number of domestic accidents. Socially neglected families generally live in substandard housing that is often overcrowded, unduly cluttered with equipment and household belongings (because of limited storage space), or has inadequate cooking facilities, all of which are likely to play some part in home accidents. For instance, an information paper by the Building Research Establishment in England noted that a number of housing and social indicators are statistically correlated with fire incidence in dwellings. Research showed a higher incidence of fires in areas of nonowner-occupied and thus poorer areas (Chandler, 1980). Clearly, in poor housing, accidents are related to the higher number of hazards present and also perhaps to less understanding of hazard risks.

Low income also may contribute to home accidents, by reducing the amount of finance available to remedy an unsafe physical environment, or to buy safe but more expensive equipment and goods. Children of one-parent families also seem to have a higher number of accidents. Single parents generally

have less income, tend to live in poorer, less safe housing, and may be forced occasionally to leave children unsupervised.

Another important epidemiological factor in the etiology of home accidents concerns the *state of health* of the occupants. Recent studies of fatal accidents carried out by the Consumer Safety Unit of the Department of Trade in the United Kingdom (Poyner, 1980) suggest that many accidents in the home occur because of the physical and mental condition of the casualty and the characteristics of the social setting. Relevant factors include alcohol, drugs, mental and physically disabling illness, tiredness, stress and inadequate supervision of children. Very low intelligence also is correlated with increased accident liability, but other handicaps in the form of decreased sight, hearing, sense of smell, skeletal deformity and spasticity also make people more vulnerable to accidents. For example, arthritis and osteoporosis (particularly of the neck of the femur) make a fall that might not seriously injure a healthy limb more likely to result in a fracture. Also, the relative immobility of the arthritic lower limb makes tripping and falling more probable.

Immigrants and ethnic minorities also may be a special risk of home accidents because of poor understanding of electrical and mechanical appliances together with a generally poorer educational background or difficulties in adjusting to a different environment.

However, at a more complex level "home safety" means more than just death and injury limitation. It also includes other consequences of living in unhealthy housing or using household products which are unsafe or in some way hazardous to health. Many authorities have taken a very narrow view of home safety and have arbitrarily tried to prioritise some home safety features whilst ignoring others of equal importance. In other cases, there is confusion as to what constitutes 'health' and 'safety'.

A 'Holistic' home safety policy would take a much a wider view. Safety would certainly include the "accidental" ingestion of asbestos fibres from asbestos building materials or "accidental" inhalation of indoor air pollutants emitted from building products. From this perspective any distinction between "safety" and "health" is arbitrary and meaningless, 'Safety' must be seen as one aspect of any public health policy and not disconnected, as it often is, into some separate, remote entity.

Home Safety Policy

Effective home safety policies have several key components: *primary prevention* which is concerned with safety design of the home environment and consumer products used in the home; and *secondary prevention* including elements such as health education and accident monitoring.

Primary Prevention

Compliance with the WHO 'Health for All' targets would mean reducing the number of accidents caused by unsafe architectural features in the United Kingdom by 250,000 each year. This is not an unreasonable objective. For example, in the UK during 1984 there were 33,000 accidents attributable to the use of nonsafety glass in doors and windows (Tomalin, 1985). According to Sinnot "the elimination of glass in doors and the relocation or modification of windows so that they are unlikely to be contacted accidentally should be considered in a home safety glazing material in all glazed panels in doors, side panels and low level windows" (Sinnot, 1987). However, Sinnot believes that existing British Standard requirements (BS6262) for glass are "inadequate". In any case compliance with British Standards is not statutorily required by current Building Regulations.

In theory, the United Kingdom Building Regulations of 1986 have a number of requirements that directly or indirectly affect health and safety in new housing or conversions. However, the 1986 Regulations have been considerably diluted as part of the governments strategy of "lifting the bureaucratic burden" to builders and designers to increase consumer choice and to expose building construction standards to market forces. This is a short-sighted policy since it leaves the door open for consumer exploitation particularly by "cowboy builders" taking advantage of the ignorant or gullable who are usually unaware of correct safety design when buying or rehabilitating housing. This could follow the pattern of injuries caused by cheap and unsafe consumer goods where safety standards either do not exist or have been compromised by unscrupulous product manufacturers. However, in the main, the safety of consumer goods used in the home is governed by a wealth of consumer legislation including a number of regulations made under the

Consumer Protection Act 1961 and the Consumer Safety Act 1978. Unfortunately the same legal protection is not granted to consumers in relation to unsafe *housing design* features. Ideally Building Regulations should include a specific section on home safety which incorporates all preventive design measures.

Apart from legal controls there is considerable information available on home safety design through product and design standards, Codes of Practice's and other guidelines. There are a number of ways such guidelines can be implemented. Some agencies have produced design check lists for architects and designers when originating plans and specifications. One example is presented in a document entitled "Healthy Housing Guidelines" which the author has written for WHO (Ranson, 1988). The following requirements relate directly to home safety and can be used as a basis for policy formulation and implementation: (a) protection of neighbourhood against the hazards of vehicular traffic; (b) avoidance of unsafe conditions in the housing environment, in outbuildings and surroundings of the home; (c) protection against the risks and effects of falls; (d) provision of adequate facilities for enabling means of escape in case of fire and control and removal of conditions likely to cause or promote fire; (e) protection against burns and scalds (f) protection against asphyxiation or gas poisoning from faulty heating and cooking appliances and services; (g) protection against electrical shocks from defective appliances and services; (h) protection against bodily injuries from lacerations and similar injuries; (i) protection against poisoning from dangerous drugs, medicines and household chemicals; and (j) protection against poisoning from plants.

The Department of the Environment booklet "Safety in the Home" (DOE, 1971) and the Child Accident Prevention Trust book "Child Safety and Housing" (CAPT, 1986) also give detailed information on safety design measures in Housing. The problem is that home safety is not specifically included in architecture and planning training programmes. Architects and planners are thus often ignorant about home safety criteria. Clearly, whatever the drawbacks of legislative constraints, it is paramount that architects, planners and designers are fully conversant and involved in home safety design. This is probably the

most effective preventive device available. Public authorities could greatly facilitate this through training courses, scheme design working parties and standard design briefs, particularly, in the publicly owned housing sector where local authorities (as landlords) have a moral if not a statutory duty to protect the health, safety and welfare of its tenants. In the private sector, architects, builders, building societies and housing agencies may also need to be targeted in collaborative measures to improve understanding of home safety design.

The above measures mainly apply to *new* housing. However, one would expect to find most unsafe conditions in *existing* housing particularly older housing of poor initial design and/or in a state of poor repair. The range of safety issues here may relate to the structural safety of the shelter itself, or to fixtures, fittings, services and goods used within. Since it is generally poor and uneducated people who live in the most worse housing its not surprising that its in *existing* housing where most home accidents generally arise.

However, this raises the question of what we mean by the term "housing" or the "home" in relation to safety. There is no satisfactory way of defining the boundaries of the home and environment in terms of home safety and accident prevention but it is important to recognise that a distinction often exists and that this can affect accident monitoring and policy implementation. At its most basic level the "home" is defined as the basic structure for providing shelter against the elements and to serve as the focus of household life. However, people do not spend all of their time indoors. Children, for example, spend a lot of time *outside* the shelter during play.

My own view is that Home Safety must include the "residential environment" which has been described by WHO as "the physical structure that mankind uses for shelter and the environs of that structure including all necessary services, facilities, equipment and devices needed or described for the physical and social well-being of the family" (WHO, 1972). Clearly consumer products used inside or outside the home come within this definition. It will certainly mean including leisure activities, safety of play areas and pedestrian and road safety at least in the immediate surrounds of the home. It may also include water

safety. It is encouraging to note that the Commission of the European Communities have decided to include leisure accidents in the European Home and Leisure Accident Surveillance System (EHLASS) which will strengthen the existing HASS system in the United Kingdom regards the home as being synonymous with the house or shelter.

In terms of intervention and secondary prevention, in the United Kingdom, specific powers are given to local authorities to deal with dangerous structures under Building Acts and Public Health legislation. Environmental Health Officers also commonly use Housing and Public Health Acts to deal with housing in a state of disrepair or lacking basic amenities. It is a major omission of current housing legislation that home safety is not one of the items which can be taken into account when assessing whether housing is fit for human habitation or not. Nevertheless many safety design measures could come within the specific criteria for determining whether a house is unfit for human habitation under current legislation, for example: repair, stability, internal arrangement, natural lighting, ventilation, and facilities for preparation and cooking of food and for disposal of waste water.

In addition the Defective Premises Act 1972 makes landlords (who are responsible for maintenance or repair) liable to all persons who might reasonably be expected to be affected by defects in the state of the premises a duty to take reasonable care to see that these persons are reasonably safe from "personal injury" caused by a relevant defect.

Special legal provisions apply to *houses in multiple occupation* (HMO's) and *hostels*. These premises (particularly those providing bed and breakfast accommodation for the homeless) are potentially the most dangerous type of housing from the point of view of home safety. Viz: Bed and breakfast accommodation typically accommodates low income, single parent families (where children might be left unsupervised for long periods); serious overcrowding and poor state of repair makes it impossible for children to be safeguarded against accidents; risks of fires and fire deaths are higher in multioccupied housing. According to a survey by the DOE, 38% of HMO's had inadequate fire escapes and 16% were grossly over crowded. It is

estimated that 15,000 children are living in hostels in London alone.

A recent survey by the Health Visitors Association and SHELTER (a campaign group for the homeless) of bed and breakfast accommodation showed that home accidents were commonplace particularly to young children (Drennan, 1988). There might be a number of explanations for this. Research by Constantinides showed that there was a close correlation between the number of home accidents and socio-economic factors such as income and class (Constantinides, 1986). However, other factors, such as disrepair, overcrowding, lack of play facilities, inadequate cooking facilities are other relevant considerations which ought to be considered.

Home Safety Education

The second ingredient of a home safety policy is safety education. Given the view that home safety is just another branch of preventive medicine, (i.e., that it has a public health foundation) then it follows that home safety education is a branch of health education, although it may be administered separately from other health education initiatives.

In order to be effective, health education must be developed along three main lines: (a) raising individual competence and knowledge about health and illness and about prevention and coping with a given situation; (b) raising competence and knowledge in using the health care system and to understand its functions; and, (c) raising awareness about social, political and environmental factors that influence safety as an aspect of health.

There are several elements to achieving these objectives. Most of these revolve around targetting the right information to the right people and optimising the right communication vehicles to ensure that this is achieved.

Regarding targets, home safety education normally follows other health education initiatives in institutionalising "individual responsibility in making safety choices". This priority is totally misguided, because it tends to "preach to the converted" and can become a middle class institution. In any event, changes in lifestyles (rather than the environment in which these

lifestyles take place) are extremely difficult to achieve particularly in the very young and old. Nevertheless, in terms of risk behaviour there is no doubt that lifestyles can be hazardous to health. However, this is not because people choose to risk their health and safety by acting dangerously. In the main, safety costs money which many people simply do not have. Risk behaviour is sometimes the only way people can continue functioning or at least adapt to the unsatisfactory physical and social environment in which they live. Didactic styles of safety education only serve to enforce the powerlessness which poverty groups, ethnic minorities, single parent families, the chronically sick and the elderly already face. Unfortunately safety statistics show that it is precisely these groups which have the most accidents.

Safety education really needs to be applied to those in a position to change the physical environment in which hazardous lifestyles take place (e.g., the professions, the policy makers and the politicians). This really is the third aspect of health education: raising awareness about social, political and environmental factors which influence safety as an aspect of health. Some local authorities have taken up some of these issues through interprofessional health promotion teams and home safety committees.

Local authorities in the United Kingdom have generally failed to target Home Safety Education to those groups who would most benefit from it. Most have ignored social, cultural, economic and ethnic considerations in their safety campaigns. Education of professionals, such as Environmental Health Officers, GPs, Health Visitors, Midwives, District Nurses, Housing Officers etc., on home safety would probably be a much more effective approach than current initiatives. This could be supported by implementation of free home safety check schemes which some authorities have offered to home owners. In terms of vehicles of communication, local authorities have generally shown a lack of flair and imagination in getting their message across. Television, radio, video and press could be used far more effectively than they have so far and campaigns need to be constantly reinforced (i.e., publicity should empower change rather than order it in a prescriptive manner). Finally more

home safety education by inclusion of home safety in school curricula.

Accident Monitoring and Prevention

Home accidents are unique in that there is generally no legal requirement to announce them, or to monitor either their incidence, or the source of injury. According to Health and Safety Legislation in the United Kingdom accidents have to be recorded in an accident book and notified to the Enforcement Authority. Usually there is an investigation to establish causality following which secondary preventative action can be taken. However, this system does not apply to home accidents. The HASS system permits a certain amount of information of accidents to be collected at 20 chosen hospital A&E Departments. Most home accidents therefore simply go unrecorded. Effective collaboration between local authorities and health authorities and doctors would enable more systematic monitoring, investigation and in some cases intervention. In the USA (Haddon, 1973) has defined ten areas of intervention as follows: (a) prevent the creation of the hazard in the first place; (b) reduce the amount of hazard brought into being; (c) prevent the release of the hazard that already exists; (d) modify the rate of, or spatial distribution of, the hazard from its source; (e) separate in terms of time or space the hazard from the person or object to be protected; (f) separate the person from the hazard by a material barrier; (g) modify the relevant basic qualities of the hazard, and, (h) make the protectee more resistant to damage from the hazard, (i) to begin to counter damage done by hazards, (j) to stabilize, repair and rehabilitate the object of the damage.

However, these areas of intervention do not refer to the importance of finding out the facts before deciding on priorities and setting a policy, nor in measuring the results. According to Jackson, accident prevention can take place by (a) altering the human being by education and training, (b) by altering the agent so as to reduce its potential for harm, and (c) by environmental changes (Jackson, 1983). These three principles are common to most public health policies. The process, therefore, involves the following:

1. The collection of satisfactory data on the accident, the injury, the person(s) concerned, the agent and the environmental

and psychological circumstances. (This must include assessment of the severity of injury before priorities can be set by medical services).

2. An analysis of data to decide what factors are most readily modifiable. The role of health services here lies partly in the area of psychology and behavioural sciences, but also in the interrelationships with ergonomics and biomechanics.
3. The identification of those persons or bodies who should be responsible for modifying the person, the agent or the environment. These may be individuals, local authorities with responsibility for the environment, a national trade association, a national standards institution, an educational or voluntary organisation, or a government department - or a combination of any of these. The role of health services lies in co-operation and support rather than in initiation.
4. The implementation of appropriate policies by the appropriate authorities.
5. The assessment of the effectiveness, including cost-effectiveness and cost-benefit, of the measures taken. Here the wheel has come full circle as we are back to the question of measurement again and thus to the importance of the role of health services.

Intercollaboration and Intervention

It is appropriate to underline the importance of intercollaboration between agencies which have a direct or indirect interest in Home Safety and the need to adopt a corporate approach to Home Safety Policies. However, it is also important to involve non-Governmental Agencies and professionals in these discussions and of course the community itself. Effective community participation is an essential element to inter-collaboration in any home safety policy. For example, Tenants Associations and Advice agencies can be extremely useful sources of information on potential home safety hazards and effective liaison arrangements should be made between all those who routinely visit housing for home visits. Local Community Groups such as play school organisations, Help the Aged Organisations and Safety Groups can be particularly useful in getting the message across. The higher degree of consultation and co-operation achieved the

higher is the likely preventive action which is likely to be attained. Certain areas of France have established local groups and in the United Kingdom, local multi-disciplinary groups were established in connection with the "Play if Safe" campaign on children's accidents of all sorts. There have been several examples of successful programmes of home accidents on a local scale. For example, the "Children can't fly" programme in New York has succeeded in reducing the numbers of deaths from children falling out of apartment windows from 150 a year to 1 death only in 1981. This was done by the identification of the social background of the children involved and by the provision of free window bars. Two features are worthy of mention: firstly, that these measures were instituted only after purely educational methods had failed, and secondly, that the cost of the provision of the window bars was less than the cost would be for medical care of the children who would otherwise have fallen out of the windows.

National programmes and policies are mainly directed at the prevention of specific types of accidents or in special age groups such as children, or by the use of special methods such as education. In the United Kingdom the Royal Society for the Prevention of Accidents (RoSPA) has separate groups dealing with special spheres of interest such as road safety and home safety and uses the educational approach in the main. The Child Accident Prevention Trust (CAPT) is a very much younger and smaller body. It aims to be a scientific advisory body in all aspects of accident prevention in childhood, which often need different approaches from the prevention of accidents in adults by reason of the close interrelationship of children's accidents with child development.

It is impossible to mention all of the wide variety of national institutions that are involved in accident prevention, but would stress the importance of national bodies such as AFNOR in France, the British Standards Institution (BSI), the DIN in the Federal Republic of Germany, and the Danish Standards Institution in setting standards. *It is important to note that there has not been the same interest in providing standards relating to safety design and architectural features within the home and home environment.*

To be successful, home safety cannot and should not operate in total isolation from other service delivery agencies and the

community it is supposed to serve. Effective collaboration is the only practical way forward, particularly between the legislature and the various branches of the executive side of the government and voluntary bodies or organisations. One possible way of improving inter-sectoral collaboration is through a national accident prevention committee or council imposed on the appropriate government departments and the various voluntary bodies. This would be responsible for policy decisions in this field and it could conceivably be given some executive powers in order to initiate the action. In this way a national policy and plan can be developed and action taken.

Conclusion

The high number of deaths and injuries caused by accidents in the home presents us with one of the biggest public health challenges this century. However, the response of Government, Health Services and the professionals to Home Safety has been sporadic, low key and preoccupied with largely facile safety education initiatives. Design prevention, accident monitoring and investigation has usually been underrepresented in Home Safety policies. Local authorities, as democratically accountable institutions close to the community they serve, are in a unique position to promote health and safety in the home - not just as major public landlords but also as guardians of the public health.

It is argued that existing housing and building legislation needs to be strengthened to give local authorities executive powers to deal specifically with unsafe housing, despite cut-backs in health and local authorities, which are undoubtedly causing severe difficulties in extending preventive medicine. Nevertheless, the extant legislation could be used more effectively so that the abysmal progress made so far in reducing home accidents can be rectified.

Without a strong commitment to making home safety a reality the WHO "Health for all targets" aimed at reducing the number of home accidents by 25% by the year 2000 will not be achieved. The alternative is to subject this and future generations to a legacy of avoidable deaths, pain, injuries and disabilities. A major threat to public health such as this must not go unchallenged.

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