



# KIPRC

*Kentucky Injury Prevention  
and Research Center  
2006-2008*

# Kentucky Injury Prevention and Research Center

## Who We Are

The Kentucky Injury Prevention and Research Center (KIPRC) is a partnership between the Kentucky Department for Public Health and the University of Kentucky's College of Public Health that combines academic investigation with practical public health initiatives.

## What We Do

Our purpose is to decrease the burden of injury in the Commonwealth. Our partnership, grounded in a belief that most injuries are preventable, cultivates a collaborative approach to problem solving. KIPRC works to reduce injury through education, policy initiatives, public health programming, surveillance, risk factor analysis, direct interventions, and evaluation.



# Greetings from the Director

Welcome to the Kentucky Injury Prevention and Research Center's Annual Report website. We report our activities with both pride and humility: pride in our continued progress to make Kentucky a safer place to live and work, and humility as we contemplate the scope of tasks yet to be accomplished.

Our progress is due to the tireless efforts of our project managers: Dr. Terry Bunn in occupational safety and health, Robert McCool in fire prevention and community safety programs, Dr. Susan Pollack in pediatric and adolescent injury prevention, Michael Singleton in several areas of surveillance and prevention capacity improvement, and Dr. Sabrina Walsh for the Kentucky Violent Death Reporting System. KIPRC is fortunate to have such talented and dedicated leadership, as well as the support of over a dozen skilled specialists in areas ranging from field investigation to community outreach to biostatistics.

We could not work effectively—in fact, we might not be able to function at all—without the collaboration of our many partner agencies and organizations. The colleagues upon whom we rely are noted in the reports of each program area. The Kentucky Department for Public Health, an agency with vast statewide reach and wide-ranging expertise, is not only an indispensable partner but functionally engaged with KIPRC's leadership and direction.

The 2008 General Assembly session included enactment of two critical pieces of legislation: a law requiring the use of booster seats for children who have outgrown car seats but are too small to be protected by safety belts, and authorizing legislation for the development of a statewide trauma system. The enactment of primary safety belt legislation in the 2006 legislative session has been associated

with a double-digit percentage drop in the state's motor vehicle fatality count. While we celebrate these steps toward a safer Kentucky, we continue policy-related work and research to make safety-related laws both more effective and more enforceable.

We call on all current and prospective partners to bring your needs to our attention so that we can better target our work towards the achievement of our shared goals. Our vision is simply stated:

**A safer Kentucky—it's no accident!**

**Julia F. Costich, Director**



# Fatality Assessment and Control Evaluation Program

## FACE



The Kentucky FACE program is a fatal occupational injury surveillance program awarded to the Kentucky Department for Public Health and the Kentucky Injury Prevention Center by the National Institute for Occupational Safety and Health. The purpose of the FACE program is to conduct in-state surveillance of fatal occupational injuries and to perform on-site evaluations of worker fatalities. National targets for evaluations include worker deaths among youth workers, immigrant workers, workers in highway work zones, and workers using machinery. Additionally, fatalities among drivers of semi trucks and dump trucks, and construction industry fatalities are state-specific priorities for on-site evaluations.

The evaluation reports (all personal identifiers removed) describe the fatal incident in detail, including events before, during and after the fatality occurred. Analysis of the incident leads to prevention recommendations and strategies that address organizational, behavioral, environmental and engineering controls. Evaluation reports are disseminated to employers and employees in similar industries and occupations with the goal of preventing future work fatalities.

In 2007, the Kentucky FACE Program recorded 109 worker deaths, decreased from 136 worker deaths recorded in the year 2006. The leading industries where the fatalities occurred were in the transportation and warehousing industry (26%), and the construction and agriculture, forestry, fishing, and hunting industries (15% each). The primary cause of worker death was due to motor vehicle collisions (32%), falls (15%), and machinery (13%).

# FACE

## Recent Publications

- Slavova, S., Bunn, T., Pavlov, D., Kryscio, R.J. 2007. Surveillance of occupational drivers using k nearest neighbor methods on the line. Proceedings of the Joint Statistical Meetings. 2631-2634.
- Bunn TL, Slavova S, Bathke, A. 2007. Data Linkage of Inpatient Hospitalization and Workers' Claims Data Sets to Characterize Occupational Falls. J KY Med Assoc. 105: 313-320.
- Bunn TL, Slavova, S, Hall, L. 2008. Narrative Text Analysis of Kentucky Tractor Fatality Reports. Accid. Anal. Prev. 40(2):419-25.

# Kentucky Occupational Safety and Health Surveillance Program

## KOSHS



The National Institute for Occupational Safety and Health awarded the Kentucky Department for Public Health and the University of Kentucky the KOSHS program, which has been funded since the year 2005. Fifteen states conduct surveillance of nineteen indicators of occupational injuries and illnesses. Since falls and motor vehicle collisions are the leading causes of occupational injuries, Kentucky has included state-specific indicators for these types of injuries.

The analysis of these indicators for Kentucky shows that Kentucky's nonfatal work-related injury and illness rate decreased by 64% since 1997 but was still 20% above the national rate in the year 2006. Rates are also elevated for work-related fatalities, musculoskeletal diseases, pneumoconiosis, pesticide-associated injuries, and adult blood lead levels compared to national rates.

A statewide occupational injury prevention consortium was established in 2006 to develop a statewide occupational injury prevention strategic plan and to establish priorities for the state to reduce the burden of occupational injuries and illnesses. One area identified by the consortium for action was the inability to reach new and small businesses with safety information and to promote the benefits of a worker safety program. A presentation is currently being developed in web-based and power-point formats targeted to both new and established businesses to convince companies that they need to have an effective applicable worker safety program to reduce total company costs and prevent worker injuries.

# KOSHS

## **Recent Publications**

Bunn TL, Slavova S, Spiller HA, Colvin J, Bathke A, Nicholson VJ. 2008. The effect of poison control center consultation on accidental poisoning in-patient hospitalizations with preexisting medical conditions. *J Toxicol Environ Health A*. 71(4):283-8.

Nicholson VJ, Bunn TL, Costich JF. 2008. Disparities in work-related injuries associated with worker compensation coverage status. *Am J Ind Med*. 51

# Drug Endangered Child Training Network

Children who are living in families and in communities with high rates of substance abuse can benefit from a community team response that is based on evidence, best practice, and cooperation of all groups to rescue, shelter, defend, and protect children and to enhance their opportunities for health, education and lifelong well-being.

The Drug Endangered Child (DEC) Training Network seeks to meet the training needs of professionals who help break the cycle of parents who are involved in the manufacture, use, and trafficking of illicit substances and the children who are physically, sexually, or emotionally injured by the choices drug affected parents make.

The goals of the Drug Endangered Child (DEC) Training Network are as follows:

- Increase access to affordable, reliable training information to professionals who work in law enforcement, child protection, education, mental health, and the health field.
- Local medical and law enforcement personnel will identify, rescue, shelter and defend drug endangered children.
- Children who are identified as drug endangered will receive crisis care through proper implementation of the National Medical Protocol for Drug Endangered Children ([www.nationaldec.org](http://www.nationaldec.org)).
- Create a network of professionals who share information and experiences to improve the lives of recovering persons and their children who are emotionally or physically injured because of addiction to drugs.

Community professionals will have access to the most current information related to diagnosis, evaluation, treatment and care of drug endangered children.

The outcomes of a DEC Team may include:

- Physical and emotional protection of children.
- Breaking the cycle of child abuse.
- Protection of exposed child's health.
- Establishment of community protocol through cooperation, sharing of information, and case coordination
- Restoration of family.

Facilitating communication between various agencies.

## Trauma Systems and the Kentucky Trauma Registry

KIPRC has been an active participant in trauma system development and traumatic injury surveillance for over a decade. The most recent edition of the Kentucky Trauma Registry Report, covering patients cared for in the state's trauma centers from 1995 through 2006, is available at (<http://www.kiprc.uky.edu/PDFFiles/traumaAnn06.pdf>).

The findings from the Kentucky Trauma Registry Report for 1995-2006 are based on injuries seen by the trauma services at the state's Level I facilities, the University of Kentucky Hospital and the University of Louisville Hospital, as well as Kosair Children's Hospital and the state's Level III facilities. The latter category formerly included the Regional Medical Center at Madisonville, but RMC abandoned its verified status in 2006. Thus, the only remaining Level III facility in 2008 is Taylor County Hospital, and its caseload is substantially different from those of the academic health centers. For the purposes of the current trauma registry report, only the Level I and Kosair data are analyzed. When the complement of facilities in Levels II-IV increases, their data will be reintegrated into the report.

A broad overview of trauma registry findings yields results that would not surprise those familiar with injury patterns in relatively rural states with limited minority populations. The large majority of trauma patients are white males in early- to mid-adult years, and the most common cause of traumatic injury is a motor vehicle crash. Other common causes of trauma are falls and attempted homicide. While suicide deaths are three times as common as homicide deaths in Kentucky, suicide is much less common in the trauma registry because poisoning (i.e., drug overdose), a common mechanism of suicide, is not typically included in the definition of trauma as it is in the definition of injury.

Areas of current concern in trauma include ATV injuries, particularly among children and young teens, and traumatic brain injuries associated with such factors as failure to wear a helmet or, in the



# Trauma Systems and the Kentucky Trauma Registry

case of returning military, exposure to intense explosive blasts.

Kentucky's trauma system development is entering an exciting phase of unprecedented interest and official status. The 2008 General Assembly enacted legislation (codified at KRS 211.490-.496) that authorized the establishment of a state trauma system, although no funding was appropriated for its support. The state Committee on Trauma, convened by the state chapter of the American College of Surgeons, has served as the vehicle for trauma system advocacy, working closely with the Kentucky Hospital Association and the Kentucky Department for Public Health.

In addition to the newly achieved official status for the state trauma system, recent months have seen expressions of interest in trauma system participation by a wide range of facilities across the state, including federally-designated Critical Access Hospitals seeking Level IV designation as well as larger regional facilities aiming for Level III or Level II verification under American College of Surgeons guidelines.

Funding is being sought to support these initiatives and KIPRC will continue its pivotal role as trauma registry compiler and data analyst. In addition, if the trauma system funding (under review as of July 2008) becomes available, KIPRC will provide and coordinate injury prevention services and outreach in the context of the statewide trauma system.



# Kentucky Violent Death Reporting System

Sabrina Walsh, DrPH; Li Liu, PhD Candidate

Recognized by the Centers for Disease Control and Prevention (CDC), violence is a nationwide health problem that results in over 50,000 homicides and suicides each year. In order to better understand why violent deaths occur, the CDC has developed the National Violent Death Reporting System (NVDRS), a nationwide state-based surveillance system designed to track trends and characteristics of violent deaths with the goal of reducing these deaths.

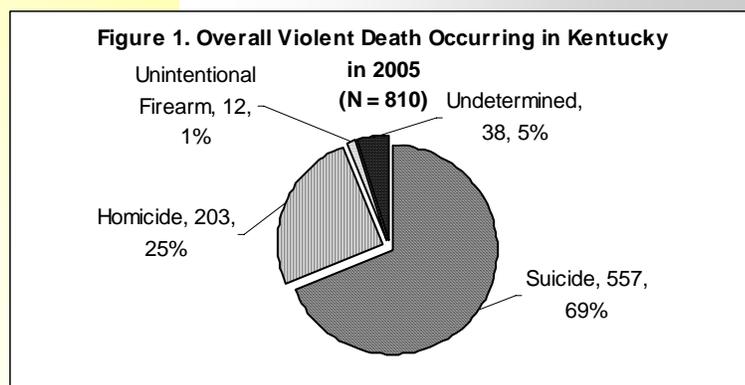
In anticipation of becoming part of the CDC's NVDRS, and with the financial support of the Kentucky Department for Public Health, a statewide Violent Death Reporting System for Kentucky was initiated in January 2002. Kentucky joined the NVDRS in 2005 as one of 17 funded states. All participating states are required to collect information about violent deaths from the following investigating agencies: police departments, coroners, medical examiners, forensic crime laboratories and toxicology laboratories.

In 2005, 810 violent deaths occurred in Kentucky; suicide was the most common cause of violent death with an almost 3 to 1 ratio over homicide (Figure 1).<sup>x</sup>

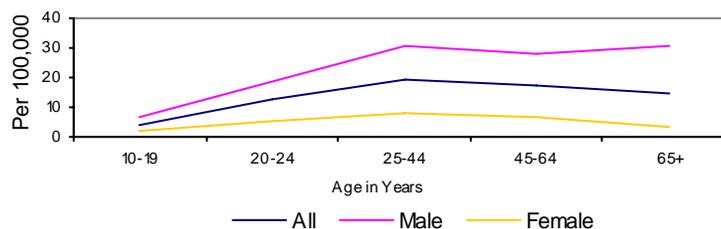
## Suicide

Of the 557 suicides 451 (81%) were men; decedents were between the ages of 35-59 in over half of suicides. Of the 375 (68%) firearm related suicides, 320 (85%) were men, and 363 (97%) were white.

Figure 2 shows a higher rate of suicide in men increasing with age while



**Figure 2. Occurrent Suicide Ratios by Gender and Age, KVDRS, 2005**



# Kentucky Violent Death Reporting System

in women there is a smoother distribution decreasing in later years. While the majority of suicides involved a firearm, poisoning was a more common cause of suicide in women than in men (26% and 8%), hanging was more common in minors versus adults (31% and 17%) and in nonwhites versus whites (27% and 17%).

A case history was recorded by the coroner and available to the KVDRS in 78% of suicides. \*Current depressed mood (55%), current mental health problem (52%), and current treatment for mental health (52%) comprise the top three circumstances surrounding a suicide. In 29% of suicides the coroner noted an intimate partner problem as a contributing factor. In 44% of those cases, the decedent's partner was in the process of leaving, breaking up, separating, divorcing, or a divorce recently finalized—87% were men who died by suicide.

## Homicides

There were 203 recorded homicides in Kentucky in 2005 (including legal intervention: a death when the decedent was killed by a police officer or other peace officer). In contrast to suicides, in which most victims were white non-Hispanic, there were more homicides among black males than other race/ethnicity groups.

When cases involving intimate partner-violence and/or jealousy/lovers triangle were identified more deaths occurred in white individuals (27%) than in black individuals (6%). Where drug trading was noted, more deaths occurred in blacks (16%) than non-white Hispanics (7%).

Firearms were identified as the most common mechanism of death in homicides (74%). Male and female victims had similar causes of death, although women were victims of strangulation/suffocation more often than men. Sharp instruments were more often used in homicides of victims with no high school diploma.

A case history was recorded and collected for 76% of the 2005 homicide cases. Circumstances surrounding male victims of homicide were most often precipitated by another crime and/or involve argument, abuse or conflict (83%

# Kentucky Violent Death Reporting System

of cases). Of the female homicides 36% were intimate partner violence-related compared to 6% of male homicides.

In addition to the circumstances surrounding a homicide, data were collected on the relationships of victims to suspects. There were 231 different victim-suspect relationships that characterized the 192 homicide victims. In over half of the incidents, the suspect was known to the victim; only 10% involve a stranger.

If you would like more information about the KVDRS project, a copy of the 2005 annual report, or other publications, please contact the KVDRS offices at 859-323-8591.

## Acknowledgements

This report was supported by Grant Number 424128 (National Violent Death Reporting System) from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Additional information on the NVDRS can be found at <http://www.cdc.gov/ncipc/profiles/nvdrs/facts.htm>

× Ratios are based on all deaths from violence that occurred in Kentucky divided by the population for 2005

\* More than one circumstance may apply to an individual case

## **Crash Outcome Data Evaluation System**

Kentucky's Crash Outcome Data Evaluation System (CODES) is funded by the National Highway Safety Administration (NHTSA) for the purpose of linking state motor vehicle traffic crash report databases to administratively unrelated databases that contain medical and economic information pertaining to persons involved in crashes. This linked database enables us to discover relationships between crash characteristics and injury outcomes for persons hospitalized as a result of motor vehicle crashes, and to assess the inpatient acute care charges associated with their treatment. To date we have linked crash report and hospital inpatient databases for 2000 to 2004.

In 2007 we published a fact sheet that demonstrated the differences in outcomes for crash-involved children ages 4 to 8 who were restrained in a safety seat compared to those who were restrained in an adult lap/shoulder belt. The children in safety seats had consistently better outcomes: fewer and less severe injuries, fewer days spend in the hospital, and lower hospital charges. Advocates presented the results at the 2008 General Assembly, during which booster seat legislation was finally passed after several previous attempts.

# Integrated Core Injury Prevention and Control Project (ICIPC)

Through a diverse coalition called the Kentucky Safety and Prevention Alignment Network (KSPAN), this project is working to improve Kentucky's core capacity to perform injury surveillance and epidemiology, and to implement and evaluate evidence-based injury prevention and control programs. Highlights for 2008 included the following.

## **Senior falls symposium**

We held a symposium on the issue of falls and fall prevention for older adults (age 65 and over). A committee has been formed to consider established research on fall risk factors and effective interventions, as well as existing fall prevention efforts within the state, and to design a coordinated fall prevention program for older adults. We're working with a consultant to draft enabling legislation and identify possible funding sources. Our goal is to introduce the legislation in the 2009 or 2010 session.

## **Safe Communities America**

In order to assist local communities in developing capacity for injury and violence prevention, we are partnering with Kentucky's National Safety Council office to implement the Safe Communities American program in Kentucky. Our goal is to provide training, technical assistance, and other forms of support to communities that have achieved the SCA designation, and to assist communities that have not yet been designated but are interested in working towards that goal.

## **First quarter 2008 statewide ED data expected in August**

We worked with Kentucky Hospital Association, the Kentucky Office of Health Policy, and the Kentucky Transportation Cabinet to secure funding to support the collection of data from emergency departments across Kentucky for 2008. This is a significant step forward in improving our Kentucky's injury surveillance infrastructure.

## **KSPAN web site**

We published our new web site at <http://www.kspan.uky.edu/>.

# **Central Nervous System Injury Surveillance Project**

The Central Nervous System Injury (CNSI) Surveillance Project is funded by the Kentucky Traumatic Brain Injury Trust Fund Board. Its purpose is to track cases of traumatic brain injury, spinal cord injury, and acquired brain injury as defined by the Centers for Disease Control and Prevention (CDC) and the Kentucky Revised Statutes (KRS 211.470). Cases are taken from the Kentucky Hospital Discharge Database (HDD) and the National Center for Health Statistics' annual Multiple Cause of Death (MCOB) files. These three sources are linked to resolve double-counting of cases.

The eighth annual CNSI report, which summarizes injuries that occurred between 2000 and 2005, was completed in July 2008.

# **Residential Fire Injury Prevention Project**

The Residential Fire Injury Prevention Project (RFIP) funds and oversees cooperative projects with local partner agencies—primarily fire departments—to install smoke alarms in homes that do not have them and to teach the residents of those homes how to maintain their smoke alarms, as well as how to escape from their home if a smoke alarm sounds. Local projects also include a community-wide fire safety awareness and fire prevention education component. The project, which is also known as the Smoke Alarm Installation and Fire Education (SAIFE) project is funded by CDC's National Center for Injury Prevention and Control (NCIPC).

The project began in 1998 with a three-year pilot program that focused on counties with unusually high rates of fire-related deaths and injuries. The success of the initial project helped Kentucky win a five-year implementation project in 2001. The second project included a number of changes and improvements based upon lessons learned from the initial project, including a transition to working with individual local agencies rather than solely with county-wide projects. The second project was as successful as the first, and Kentucky was awarded a third project through a highly competitive application process in 2006.

Local organizations such as fire departments, public health departments, and non-profit organizations submit applications for project funding each summer. Applications are reviewed by a 15-member committee composed of professionals from the fire service, public health, and other public safety organizations. The project funds four to eight local projects per year. The number funded depends primarily upon the size and cost of the individual projects. Each applicant that is funded becomes the lead local agency for their project and appoints a coordinator who oversees the local project and coordinates with the KIPRC staff.

The local agency receives long life lithium battery-powered smoke alarms, fire safety education materials, and compensation for data collection. Local personnel provide the labor to identify and enroll households without working smoke alarms, install alarms in those homes, and provide fire safety education to both recipients of smoke alarms and the community at large. Local personnel also collect evaluation data for the project.

# Residential Fire Injury Prevention Project

Since the project began in 1998, we have installed more than 22,300 smoke alarms in over 9,300 households and provided fire safety information and education to hundreds of thousands of Kentuckians. More importantly, we have documented cases in which 76 individuals were able to escape from a fire in their home after being warned of the fire by a project-installed smoke alarm. We can't be certain that some of these people would not have escaped even without the alarm, but it's obvious that we are saving lives. We are also saving property; early warnings from smoke alarms usually lead to early notification of the fire department, and in several cases the fire was extinguished before it was able to spread and destroy the structure. The value of the property saved alone is enough to offset most of the cost of the project.

As of September 30, 2008 we have served communities in 34 counties. The FY 2009 projects will add two new counties to that list. By the time the current project ends in 2011, we hope to have served communities in at least one third of Kentucky's counties.

In addition to their primary role of coordinating the SAIFE project at the state level, conducting training and providing technical support for local project personnel, and project reporting, the KIPRC staff assigned to the project also take an active role in other fire safety programs. Two staff members are members of the management team working to implement the Risk Watch® fire safety and injury prevention curriculum in Kentucky schools. Staff members also work with the Kentucky Fire Marshal's Office, the Kentucky Firefighters' Association, the Kentucky Commission on Fire Protection, Personnel, Standards and Education, and other state and local agencies to support fire prevention programs throughout the Commonwealth.

## State Injury Prevention Program

The State Injury Prevention Program (SIPP) provides general injury prevention information and education to members of the public and to local officials and organizations. Program staff members also provide assistance, technical advice and consultations to local health departments and other organizations involved in the provision of community-level injury prevention services. Key topic areas include motor vehicle occupant safety, with a particular focus on child restraints, all-terrain vehicle (ATV) safety, and safety at home.

The three staff members assigned to the program also operate the SAIFE project. This limits the time that they have available for direct contact with members of the public. While program staff members do provide safety education directly to members of the public at health and safety fairs, through community classes, and at other public events, they focus primarily on supporting local organizations by providing information, training and technical assistance. Some of the services provided by the program include child passenger safety and occupant protection training, assistance with program and evaluation design, and even grant-writing advice.

SIPP provides injury prevention information and training to public safety agencies such as fire departments, rescue squads, law enforcement agencies, and emergency medical services agencies, both independently and in cooperation with state-level public safety training agencies. Staff members also work with local safety coalitions, SAFE KIDS organizations, and other community groups within their service regions. The goal of SIPP is to help bring injury prevention and safety programs to the community level by supporting local organizations that are working to improve safety in their communities.



## Community Partnerships

An increasing number of state and federal programs require the involvement of locally-based coalitions to combat major public health issues, and not surprisingly, there are a growing number of health and safety coalitions. The training that we provide gives groups a solid set of skills to build upon that is rooted in local community issues and solutions. The project has allowed staff to refine and improve our capacity building training and increase KIPRC and the College of Public Health's visibility among health and safety groups in the state, health departments and non-profits.



As a continuation in 2006 of the Centers for Disease Control funded project Community Partnerships, the project began consulting with various health and safety coalitions in the state about their training needs. The revised core components for a one day training are: Healthy County Visioning and Values, strategic planning, membership and volunteer recruitment and fundraising, and framing the message. For two day trainings the following is included in with the primary core components: mission development, goal setting, evaluation for coalitions, and roles of members, leaders, experts and staff. Each component continues to build on the previous exercise. At the end of the first day, participants have a project that they can immediately begin to implement. The Healthy County Visioning and Values is an exercise that asks people to think about the good things about their county, what they like and value. Family, faith, public services, libraries, and natural beauty are frequently listed. Then people are asked to think of the things that are missing. Lack of access to clean drinking water, proper health care, adequate housing stock, and activities for youth are frequently on the list. Participants are asked to rank from this list the things that they think most important. The most popular theme across coalitions was to create activities for rural youth, specifically create skateboard parks. One coalition had a volunteer who committed to lead the project and broker the acquisition of land. The county government stepped in to help fundraise and add the project to the Park and Recreation Department. The local project sponsor would bring in



# Community Partnerships

teens to serve on the project board of directors with other county stakeholders. At the end of the training, they had a timeline and a list of the different agencies and stakeholders who would need to be involved.

The next stage of the core component exercises work through training on how to frame a coalition's message in order to better recruit volunteers.

The group ends the exercise with a list of recruiting targets from the community. The last core component is an exercise to work through fundraising ideas and brainstorm local avenues of fundraising. The second day of a two day training begins with a review of the previous day, an in depth look at the coalition's mission and development of one if needed, goal setting, building in participatory evaluations for coalitions, and clarifying the coalition roles and responsibilities of members, leaders, experts and staff.

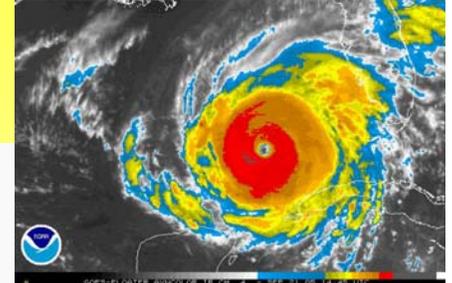
In 2006-2007, Community Partners held seven on-site coalition capacity building trainings in Western Kentucky, Magoffin, Pike, Laurel, Perry, and Bath Counties. Participants represented health and safety coalitions and faith-based groups from twelve separate counties. The project consulted one-on-one with three other county coalitions, the Lexington-Fayette County Health Department's Diabetes Coalition, Bath, and Perry County's Operation Unite coalitions. Training materials were refined to reflect the suggestions and evaluations of the participant groups.



# Preparedness

What types of emergencies are most likely to affect Kentucky?

Strong storms can bring massive amounts of damage by wind, flooding, and ice. Wrecks involving hazardous materials along transportation routes can result in the release of chemical or radiological agents. Earthquakes can disrupt power, oil, and gas lines. Medical experts warn that especially virulent strains of influenza can have devastating effects on any population not adequately prepared.



How can Kentuckians prepare themselves for emergencies?



Not everyone is harmed during a critical event, but it makes sense to be prepared. It is after the event has happened that most injuries are sustained. Cleaning up after storms, fallen power lines, high water, and toxic fumes present the primary opportunity for injury and death. Injury experts are researching the injury patterns and triage efforts in the aftermath of emergencies in order to prevent injury and more quickly treat injuries that occur.

If you are interested in learning more or becoming involved in emergency preparedness in your community you can access the Department of Public Health Kentucky Outreach and Information Network at <http://chfs.ky.gov/dph/epi/preparedness/KOIN.htm>.

Not all emergencies are sudden. Researchers are beginning to investigate the short, medium and long term health, medical, and injury issues caused by climate change, high energy prices, and population. KIPRC has joined with the Johns Hopkins Center for Emergency Preparedness to help plan an academic conference exploring these topics and the role of public health. For more information, please contact Genia McKee at (859) 323-0298.



# **Pediatric and Adolescent Injury Prevention Program PAIPP**

KIPRC/PAIPP have for several years provided a home for a multidisciplinary Kentucky Booster Seat Coalition, strengthened this year by the additional efforts of the state Coroners' Association and 2<sup>nd</sup> year University of Kentucky medical students. The highlight of our year was the passage of the Booster Bill after 7 years of trying, and our new ability to better protect those children ages 4-7 from motor vehicle crash related injuries and death. At the Kentucky Lifesavers Conference in spring 2008, the Coalition recognized the efforts of key legislators who had sponsored the booster bills on both sides of the legislature. The Coalition will continue to be involved in educational efforts to implement the Bill.

Ongoing work with DPH/MCH for more than the past decade focuses on three areas: child fatality review (CFR), injury prevention education and support for local health departments and other professionals who work with children, and leadership of the state Safe Kids Coalition.

PAIPP works with MCH to provide leadership for the state CFR team, to provide technical assistance to county CFR teams and their health department and coroner members especially in their efforts to implement and maintain CFR, and assist DPH with the annual legislatively mandated CFR report. Major efforts in the past year have included review of all fire, ATV and drowning deaths, efforts to increase EMS presence and to increase medical review of both injury and natural deaths, ensuring that national developments and new scientific literature relevant to CFR are brought to the team, and early efforts to develop a linkage of pediatricians involved in CFR within the state.

Requests for assistance from local health departments have centered this year on child passenger safety and safe sleeping. State- level CPS experts have worked together to begin to develop a more proactive planning process for supporting existing CPS techs and extending education to health departments and counties where it is most needed and has been least available. PAIPP maintained a presence at all major state-level conferences involving nurses, trauma personnel, early childhood and child care leaders, foster care and social work professionals, children with special health care needs and the families and agencies that support them to provide injury prevention education and materials.

SAFE KIDS activities include safe sleeping, drowning and fire prevention, but

## PAIPP

the primary emphasis is on child passenger safety as the leading cause of Kentucky pediatric death above age 1. Much of that work is done in partnership with the state Governor's Highway Safety Program/Louisville-Jefferson County Safe Kids. Throughout 2007-8 we assisted rural Safe Kids counties in their first-ever experience of running their own CPS programs. State Farm Insurance helped us kick off the grand opening of a new Pulaski County Safe Kids chapter in May, 2008. In the spring of 2008 we coordinated the successful applications of the state and 4 county chapters to receive \$17,000 of funding for the 2008-9 Buckle Up program.

The Injury Free Coalition for Kids of Lexington at Kentucky Children's Hospital is based at KIPRC and had initial funding from Robert Wood Johnson Foundation. After that funding was redirected to obesity issues, Injury Free had the distinction of writing a state grant to provide injury prevention services for children with special needs and the staff who care for them which was approved and initially funded in full in the fall of 2007, before falling victim to budget crises. Injury Free continues to work with the community of families of children with special needs and those who serve them in health and social services. We are proud that one of our staff, who is already a nationally certified CPS tech, successfully completed training at Riley Children's Hospital in fall 2007 to become one of 5 people in the state of Kentucky with certification as a special needs CPS tech. We have been working with in-hospital services to develop their CPS capacity. Injury Free continues to work with the Lexington Fire Department on a home fire inspection/smoke detector installation program which was designed to permit access for all residents without identification of immigration or rental status, and which has been credited with saving the life of one elderly woman in a kitchen fire. We continue to focus our efforts on the two communities with whom we have built playgrounds. We continue to provide injury education for child care professionals and Hispanic lay health workers (Promotoras), to partner with social services in their "40505" project for the prevention of child abuse and to bring unintentional injury prevention to that community as well.

Additional academic efforts of PAIPP include participation in the Institute of Medicine review of the National Institute for Occupational Safety and Health Agriculture, Forestry and Fishing Program.

# Consumer Product Safety Program

## ACTIVITY OVERVIEW

The KIPRC Consumer Product Safety Program was initiated in December, 2007 to limit consumer's exposure to unsafe products primarily through increasing consumer awareness of recalls and promotion of safe practices in the use of consumer products. In its first half-year of existence, the program conducted 25 displays and presentations in 12 counties. Many of these events centered on nursery equipment safety, sleep safety for infants, and recalls of nursery equipment. Six of these presented information about nursery safety, sleep safety and SIDS avoidance to participants in countywide Baby Safety Showers for new and expectant mothers. Three of these events were presentations to high school parenting and child development classes. Seven displays were offered at statewide professional conferences including those for foster parents, grandparents as caregivers and coroners. Latino outreach included presentations in two counties as part of a "*Promotores*" program to develop lay health and safety consultants in predominantly Hispanic neighborhoods. Mailings included swimming safety information in May and Simplicity Bassinet recall information. Both went to county Health Educators and the Bassinet recall was sent to the Division of Child Care.

## HAZARDS WITH UNSAFE PRODUCTS

Exposure to unsafe products generally occurs in one of (two) ways:

- 1) Use of products manufactured before current safety standards were developed.

A classic illustration may be found in the continued use of a "family heirloom" baby crib built before the hazards of entrapment with suffocation or strangulation were addressed in 1973. At one time, as many as 35 deaths a year were attributed to use of cribs that did not meet modern design specifications.

Some of us may own one of the 12 million cedar chests manufactured between 1912 and 1987 that have been recalled for repair by one company because they have latches that cannot be released from the inside, resulting in the suffocation deaths of at least 7 children. Others may still be using that favorite hair dryer manufactured before immersion protection devices were required in 1991, or an infant walker purchased for an older sibling before stair brakes were required in 1998.

# Consumer Product Safety

## 2) Use of recalled products that have not been repaired.

Cooperation between manufacturers and the U. S. Consumer Product Safety Commission have made the process for withdrawing a recalled product from the retail stream very efficient. Influencing consumers to take appropriate action for recalled products in their possession is more problematic. For instance, nearly 800,000 toasters sold under 8 brand names and 145,000 coffee makers were recalled because of fire hazards during the first 9 months of 2008. Has the gentle reader checked his kitchen appliances lately?

Why do we as consumers not respond to recalls? Perhaps we don't learn about them through conventional channels, don't know how to identify the product, or just don't perceive that the issue is important or that we have time to address it. It happens that one of the most efficient means for learning of a product recall is to register purchases through use of the "Product Registration Card" or the manufacturer's website. Also, consumers can visit the Consumer Product Safety Commission website and sign up to receive recall notifications by e-mail.

The Product Safety Program seeks to improve consumer awareness of product hazards by networking recall and safety information with other public and private agencies, direct consumer education services through presentations at Baby Safety Showers and other safety related events and periodic checks of retailers to ensure that recall instructions have been followed.

**KIPRC'S VISION:****National recognition as a leading applied injury research center.****KIPRC'S MISSION:****To reduce the rate of injuries and related death and disability.****EDUCATION/AWARENESS****Goal:** To increase knowledge and awareness of the injury problem in Kentucky and to impart skills and strategies to reduce this problem.**Enabling Strategies:**

Data Dissemination, Training, Consulting, Internships, Injury Prevention Courses.

**Effectiveness Indicators:**

Working relationships with new groups.

Collaborative grant proposals.

Peer-reviewed publications.

College of Public Health course and curriculum development.

Student involvement, Continuing education.

**Goal:** To increase KIPRC's recognition and visibility as an injury prevention leader.**Enabling Strategies:**

Market name awareness and content.

Publicize accomplishments.

Expand network.

**Goal:** To establish and maintain effective leadership and process.**Enabling Strategies:**

Increase staff support.

Increase stable funding.

Continuous quality improvement.

**Goal:** To impact injury legislation.**Enabling Strategies:**

Stabilize funding.

Support mandatory data reporting.

Support booster seat legislation.

Modify existing graduated driver's licensing.

Support primary enforcement of seat belt use.

**RESEARCH****Goal:** To increase the quality and quantity of KIPRC research.**Enabling Strategies:**

Expand funding.

Publish peer-reviewed articles and present findings at professional conferences.

Attract, develop and retain high quality researchers.

**Goal:** To implement new and improve existing community-based intervention programs.**Enabling Strategies:**

Assess needs.

Build relationships with community.

Pursue funding.

Identify and implement intervention.

Evaluate the intervention.

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