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Roundtable forum on burns prevention

House of Representatives
Standing Committee on Health and Ageing

July 2010
Canberra

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Foreword

It gives me great pleasure to present the Committee's report of the roundtable forum on burns prevention in Australia.

Subsequent to receiving a briefing from Professor Fiona Wood OAM and Mr Julian Burton, on behalf of the Julian Burton Burns Trust, the Committee determined to hold a public roundtable forum to gather opinions and views about the state of burns prevention activities in Australia. The roundtable forum was held in Canberra on 1 February 2010, and the Committee heard that it was the first time that all the relevant stakeholders had been gathered in a room at the same time to discuss burns prevention activities.

The Committee has made a number of recommendations that it hopes will reduce the fragmentation of information and support services, improve our prevention activities and result in better quality care and support of burns survivors in Australia.

I would like to take this opportunity to thank my Committee colleagues for their contribution to the report, as well as the witnesses who travelled to Canberra to speak with the Committee and people who made submissions to the inquiry.

The Committee would like to express its particular thanks to the burns survivors and their families who came to Canberra and shared their experiences with the Committee. The report is richer for your contribution.

Steve Georganas MP
Chair

Membership of the Committee

Chair	Mr Steve Georganas MP	
Deputy Chair	Mr Steve Irons MP	
Members	Mr James Bidgood MP *(to 22/10/09)*	Mrs Catherine King MP
	The Hon Bronwyn Bishop MP *(from 3/2/10)*	Mrs Margaret May MP *(to 3/2/10)*
	Mr Mark Coulton MP *(to 3/2/10)*	Mr Shayne Neumann MP *(from 11/2/10)*
	Mrs Joanna Gash MP	Ms Amanda Rishworth MP
	Ms Jill Hall MP	Dr Andrew Southcott MP *(from 3/2/10)*
	Mrs Julia Irwin MP	

Committee Secretariat

Secretary	Ms Sharon Bryant *(from 27/4/2010*
	Mr James Catchpole *(to 23/4/2010)*
Inquiry Secretary	Ms Penny Wijnberg
Administrative Officers	Mrs Jazmine Rakic
	Mr Shaun Rowe

Terms of reference

That the Standing Committee on Health and Ageing, after reviewing the 2008-2009 annual report of the Department of Health and Ageing and pursuant to Standing Order 215(c), hold a public roundtable forum on burns prevention, conduct associated inspections and report to the House of Representatives.

List of abbreviations

AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
ANZBA	Australian and New Zealand Burns Association
COTA	Council on the Ageing
DoHA	Department of Health and Ageing
NEHIPC	National E-Health and Information Principal Committee
NHISSC	National Health Information Standards and Statistics Committee
NISU	National Injury Surveillance Unit
NSW	New South Wales
TBSA	Total Body Surface Area
the committee	House of Representatives Standing Committee on Health and Ageing
WHO	World Health Organisation

List of recommendations

3 Can we improve?

Recommendation 1

That the Department of Health and Ageing consider burn injuries as part of any new *National Injury Prevention and Safety Promotion Plan 2004 – 2014*.

Recommendation 2

The committee recommends that the Department of Health and Ageing develop a National Burn Injury Prevention Plan which can be used to co-ordinate burn prevention activities within Australia.

Recommendation 3

That the Minister for Health and Ageing facilitate the ongoing development of the Australian and New Zealand Burn Association Burns Registry.

Recommendation 4

That the Minister for Health and Ageing engage with the Australian and New Zealand Burn Association in the development of the E-Health system to ensure that datasets on burns incidence and treatments are collected.

Recommendation 5

That the Minister for Health and Ageing ensure that improved data collection of the extent of burn injuries in Australia be evaluated to ensure that policies aimed at reducing burn injuries are effective and accountable, and that survivors are receiving the best possible treatment.

Recommendation 6

That the Minister for Health and Ageing promote targeted national burns prevention safety campaigns to at risk groups including workers, young, older and Indigenous populations.

Recommendation 7

That the Federal Government implement age appropriate and targeted burns education campaigns to all levels of the Australian population including school children, indigenous groups, new parents and the elderly.

Recommendation 8

That the Minister for Health and Ageing in conjunction with the Minister for Housing and relevant state and territory housing Ministers apply nationally consistent regulations to limit the maximum temperature of water flowing from taps in home hot water systems.

Recommendation 9

That the Australian Government co-ordinated by the Department of Health and Ageing investigate all regulatory options which would reduce the risk of burn injuries in Australia.

Recommendation 10

That the Minister for Health and Ageing work with various support groups to implement an accreditation scheme for burns survivor networks in order to reduce fragmentation of information and support services within the health system and assist burns survivors to access the care and support that they need.

Recommendation 11

The committee recommends that the Minister for Health and Ageing support the implementation of a Burns Care Nurse training and accreditation program similar to that offered for Breast Care Nurses.

Recommendation 12

The committee recommends that the Federal Government investigate ways to ensure that more Australians benefit from first aid training.

1

Introduction

1.1 In November 2009, the House of Representatives Standing Committee on Health and Ageing (the committee) received a private briefing from Mr Julian Burton and Professor Fiona Wood OAM on behalf of the Julian Burton Burns Trust. Professor Wood, Director of the Royal Perth Hospital Burns Unit, indicated to the committee that she believed burn injuries should be considered a chronic disease due to the long-term social and health impacts that burn injuries have on the individual, their family and the Australian society as a whole. She argued that more work needed to be done to prevent burn injuries from occurring.

1.2 The committee resolved to hold a public roundtable forum on burns prevention in Australia to better inform itself of the impact of burn injuries on individuals and society, as well as ways to minimise or prevent burn injuries in the first place.

1.3 The committee determined that a public roundtable forum would be the best manner in which to conduct this inquiry. This forum would afford an opportunity to gather interested individuals to discuss the issues and recommend potential solutions.

The roundtable

Parameters of the report

1.4 This report of the public roundtable forum draws together the evidence received at the public roundtable, and in the written submissions, to reach conclusions about the need to prevent and minimise burn injury in Australia.

1.5 Chapter two details the extent of burn injuries in Australia including a definition of burn injuries and the cost of burn injuries to the health system. Chapter three contains the committee's discussion and conclusions and is structured around the following four themes:

- lack of a national burn injury prevention plan;
- inadequacies in information and data;
- insufficient national prevention and education campaigns; and
- complexity of the care and support that is provided to burns survivors.

Conduct of the roundtable

1.6 The public roundtable was focused on two discussion topics; firstly, the impact of burn injuries on the individual, the family and the health system; and secondly, ways to prevent or minimise burn injuries. The discussions sought to consider the social and financial costs of burn injuries on Australians and the health system and explore ways that these costs could be minimised.

1.7 The committee selected a number of organisations which would give a broad range of views and represent diverse interest groups including burns survivors, medical practitioners, burns support networks and first aid providers. The participants in the public roundtable discussion, which was held in Canberra on Monday, 1 February 2010, were as follows:

- Australian and New Zealand Burn Association;
- Burns South Australia Aboriginal Burns Program;
- Council on the Ageing Seniors Voice;
- Australian Government Department of Health and Ageing;
- Julian Burton Burns Trust;
- KIDS Foundation;
- St John Ambulance Australia; and
- several individual burns survivors.

1.8 In addition to the public roundtable, the committee accepted as evidence four submissions, four supplementary submissions and one exhibit from interested persons or organisations. These are listed in Appendices B and C.

1.9 The committee also took the opportunity to visit the Burns Unit at Royal Perth Hospital on Monday, 15 February 2010. This enabled the committee to gain further insight into the complexity of treating and managing burns patients within the medical system. The committee thanks all the staff of the Burns Unit who took the time to show the committee around the facility.

1.10 The committee would also like to extend its thanks to all of the individuals and organisations that travelled to Canberra to participate in the public roundtable, or made submissions to the inquiry. The committee extends specific thanks to the burns survivors who gave a personal account of their experiences at the public roundtable. Their evidence has enabled a more in depth understanding of the imperative of preventing or minimising burn injuries in the first place.

2

The extent of burn injuries in Australia

What are burn injuries?

2.1 According to the World Health Organisation (WHO):

> A burn injury of the skin occurs when some or all the different layers of cells in the skin are destroyed by a hot liquid (scalds), a hot solid (contact burns), or a flame (flame burns). Injuries of the skin and other tissues due to ultraviolet/infrared radiation, radioactivity, electricity, or chemicals are also considered to be burns.[1]

2.2 The skin is the body's largest organ and is made up of three layers; the epidermis, the dermis and the subcutis. These layers work together to:

> … act as a waterproof, insulating shield, guarding the body against extremes of temperature, damaging sunlight, and harmful chemicals. It also exudes antibacterial substances that prevent infection and manufactures vitamin D for converting calcium into healthy bones. Skin additionally is a huge sensor packed with nerves for keeping the brain in touch with the outside world. At the same time, skin allows us free movement, proving itself an amazingly versatile organ.[2]

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1 World Health Organisation (WHO), *Facts about injuries: Burns*, accessed from http://www.ameriburn.org/WHO-ISBIBurnFactsheet.pdf on 19 February 2010.

2 National Geographic, *Skin*, accessed from http://science.nationalgeographic.com/science/health-and-human-body/human-body/skin-article.html on 19 February 2010.

2.3 A burn to the skin can be relatively minor or result in life threatening complications depending on the severity of the burn. Burns are categorised according to the extent of damage to the skin. There are three levels of burns:

- **Superficial** – (also known as first degree burns) cause damage to the first or top layer of skin. The burn site will be red and painful.
- **Partial thickness** – (also known as second degree burns) includes damage to the first or second skin layers. The burn site will be red, peeling, blistering and swelling with clear or yellow-coloured fluid leaking from the skin, and is very painful.
- **Full thickness** – (also known as third degree burns) involves damage to both the first and second layers, plus the underlying tissues, muscle, bone and organs. The burn site generally appears black or charred with white exposed fatty tissue or bone. The nerve endings are generally destroyed so there is little or no pain experienced at the site of the full thickness burn but surrounding partial thickness burns will be very painful.[3]

2.4 Another important classification for a burn injury is the total body surface area (TBSA) which is affected. Generally a burn to greater than 10 per cent TBSA is classified as a major burn.[4] The Australian and New Zealand Burn Association (ANZBA) recommends referral to a specialist burns unit based on the following criteria:

- burns greater than 10 per cent of TBSA;
- burns of special areas—face, hands, feet, genitalia, perineum, and major joints;
- full thickness burns greater than 5 per cent of TBSA;
- electrical burns;
- chemical burns;
- burns with an associated inhalation injury;
- circumferential burns of the limbs or chest;
- burns in the very young or very old;

3 Better Health Channel, *Fact sheet: Burns*, accessed from http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Burns on 19 February 2010.

4 Submission No. 1, Australian Government Department of Health and Ageing (DoHA), p 3.

- burns in people with pre-existing medical disorders that could complicate management, prolong recovery, or increase mortality; and
- burns with associated trauma.[5]

Who is affected?

2.5 According to research published by the Australian Institute for Health and Welfare (AIHW) National Injury Surveillance Unit (NISU) approximately 46,661 people were hospitalised as a result of a burn or scald related injury in the period 1999-00 to 2003-04.[6] Data for the ten year period from 1998-99 to 2007-08 shows that there were almost 74,000 hospital separations[7] where the principal diagnosis was a burn or burn injury.[8]

2.6 Young children, males and older people form a disproportionately large segment of the total number of Australians affected by burn injuries.[9] A submission to the inquiry stated that 10 per cent of annual admissions to the Burns Unit at the Royal Adelaide Hospital are the result of workplace injuries with burns being prevalent in the hospitality industry and large heavy industries.[10]

2.7 The committee heard concerns about the significantly high numbers of Aboriginal and Torres Strait Islander people affected by severe burn injury. Mr Kurt Towers from the Burns South Australia Aboriginal Burns Program told the committee that:

> … Aboriginal people do sustain 25 times the rates of severe burn injury of non-Aboriginal people. Between 2003 and 2008, Aboriginal children represented 73 per cent of the burn admissions of people with over 40 per cent of total burn surface

5 Australian and New Zealand Burn Association (ANZBA), *Criteria for specialised burns treatment*, accessed from http://www.anzba.org.au/index.php?option=com_content&view=article&id=51&Itemid=58 on 22 February 2010.

6 Submission No. 1, DoHA, p 5.

7 A hospital separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Admitted patients who receive same day procedures (for example, renal dialysis) are included in separation statistics. Source: Steering Committee for the Review of Government Service Provision, *Report on Government Services 2010*, Productivity Commission, p 10.3.

8 Singer, A., DoHA, Transcript, p 3.

9 Submission No. 1, DoHA, p 5.

10 Julian Burton Burns Trust, Submission 2.1, p 1.

> area. Burns are often more severe due to poor first aid response in the community or delayed referral to a burns centre.[11]

Do we know the true extent of burn injuries?

2.8 The committee heard compelling evidence from Professor Kimble, who appeared on behalf of St John Ambulance Australia, about the number of children that were affected by burns in Queensland in 2007. In that year 174 children under the age of 16 were admitted to hospital for 24 hours or more to receive treatment.

2.9 However, many witnesses raised concerns about the adequacy of relying on admissions data to determine the number of people who are affected by burn injuries. Professor Kimble stated that the Royal Children's Hospital treated 650 new burns patients in 2007 but only 74 of those were admitted to hospital for more than 24 hours. That means that only 11 per cent of burns patients were actually admitted. Professor Kimble added that if this rate of admission held for all 31 hospitals that treated children with burns in Queensland, then almost 1,500 children would have presented at hospital with new burns in 2007.[12]

2.10 If these figures reflect a trend across Australia, it could indicate that there is an underreporting of the extent of burn injuries in Australia, as hospital admission figures may significantly underestimate the number of people affected by burn injuries.

2.11 Mrs Petrys, on behalf of the Council on the Ageing (COTA) stated that her organisation believes that the data on the extent of burn injury amongst the older population is significantly under-represented.[13]

2.12 Concern about the inadequacy of the data was reiterated by the President of ANZBA, Mrs Sheila Kavanagh, who stated that:

> The other thing that we do not know is the true extent of injury across society. We see the high end, the high cost, but we do not see the smaller numbers who get smaller burns who are treated locally…[14]

2.13 In an attempt to get a clearer picture of the number of burns survivors who are treated locally, the committee sought additional information about the number of treatments or cost of treating burns survivors locally

11 Towers, K., Burns South Australia Aboriginal Burns Program, Transcript, p 11.

12 Kimble, R., St John Ambulance Australia, Transcript, p 11.

13 Petrys, D., Council on the Ageing (COTA), Transcript, p 6.

14 Kavanagh, S., ANZBA, Transcript, p 9.

through a General Practitioner. The Medicare Benefits Schedule data from the Department of Health and Ageing indicates that MBS number 30003,[15] which can be utilised by General Practitioners to treat burn injuries, was utilised 7,455 times nationwide at a cost of $207,626 in the 2007/2008 financial year. [16]

2.14 However, these MBS numbers may not provide a clear idea of the number of people who suffer from burn injuries in Australia.

> There are MBS items in relation to burns treatment, though most of it is more at the burns surgical end rather than the kinds of treatments that GPs were doing. I did ask for that data but, unfortunately, it has not become available in time.[17]

2.15 Issues relating to the need for better data gathering are discussed in detail in chapter three.

Causes of and treatments for burn injuries

2.16 There are a number of causes of burn injuries including:

- hot fluids such as food stuffs, oils and water;
- highly flammable materials;
- fires such as of motor vehicles, buildings, barbeques and bushfires;
- contact with hot objects or machinery;
- electrical current;
- explosions; and
- chemicals such as caustic acids, alkalis and hydrocarbons.[18]

2.17 The diversity of causes and differences in severity mean that there are a number of different treatments for burn injuries. These include cooling the burnt area with cold water, removing blisters and cleaning the burnt area, pain relief, application of specialised dressings, emergency and skin graft

15 MBS number 30003: LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation, accessed from http://www9.health.gov.au//mbs/search.cfm?q=30003&sopt=I on 07 July 2010.

16 Supplementary Submission No 1.1, DoHA.

17 Singer, A., DoHA, Transcript, p 38.

18 Submission No. 1, DoHA, p 2.

surgery and long-term rehabilitation treatment provided by psychologists, physiotherapists, dieticians and occupational therapists.[19]

Costs associated with burn injuries

Financial costs

2.18 The committee sought to understand the financial costs of treating a typical burns patient. Professor Maitz used an example of treating an adult with a burn injury to 50 per cent of the TBSA and that it was estimated it would cost more than $700 000 to treat this single patient.[20]

2.19 Evidence presented to the committee stated that in the 2007-08 financial year, the cost of burns and burn injury separations was $65 million.[21] However, Professor Maitz drew the committee's attention to data published by the British Burns Association that:

> … states that the true cost of a burn injury is hidden in one-third of the acute hospital cost and two-thirds in rehabilitation and loss of income. If we were to accept the cost of $65 million per year then that would be one-third of the true cost.[22]

2.20 A significant financial cost is accrued through the need for long-term ongoing rehabilitation including physiotherapy, massage and counselling. For example, Mr Julian Burton told the committee that he has massage and physiotherapy every fortnight to increase the flexibility of his skin.[23] However, this is not available to all patients, as Mrs Terri Scroggie, the mother of burns survivors, informed the committee:

> I cannot afford that for my daughters. I do not have the money to give the girls the massages that they need … I cannot afford the proper things to help her out – such as for her to be massaged – because it is not covered. I cannot give them what they need.[24]

2.21 The ongoing financial costs are compounded for families because it is often the case that some members of the family will have to leave their

19 Submission No. 1, DoHA, pp 3-4.
20 Maitz, P., Julian Burton Burns Trust, Transcript, p 6.
21 Singer, A., DoHA, Transcript, p 4.
22 Maitz, P., Julian Burton Burns Trust, Transcript, p 6.
23 Burton, J., Julian Burton Burns Trust, Transcript, p 17.
24 Scroggie, T., Private capacity, Transcript, p 18.

jobs, either as a result of their own burns or to care for burns survivors.[25] This means that the family income can decrease at the same time as treatment costs increase.

2.22 An important element of burn injury treatment that was presented to the committee is the consideration that burns are equivalent to a chronic disease. Treatment of burns is not a one off intervention. Surviving burn injuries involves a lifetime of ongoing treatment and rehabilitation.[26] It stands to reason that this lifelong treatment regimen incurs significant ongoing costs — beyond those of the first presentation and emergency treatment in hospital.

Social costs

2.23 However, this committee is not concerned simply with the significant financial cost of burn injuries — both to the health system and to the individuals and their families. Burn injury carries with it a significant social cost that impacts on the family, the survivor and the community.

2.24 The committee acknowledges the evidence of Mrs Terri Scroggie whose two children had suffered severe burn injuries. She emphasised:

> ... it is not just the ones who survive the burns but a whole unit of people who are affected. My parents have also been affected. They had to leave their jobs and their home to come and look after the other children.[27]

2.25 A significant social cost of burn injuries is the impact on the mental well-being of the burns survivor as well as the immediate family. The committee heard that burns are "emotionally shattering".[28] Mr Wayne Griffith, a burns survivor, told the committee that he withdrew after suffering his injury:

> I became very hermit-like and could not go out … If I had to do some shopping I would do it very early in the morning or very late at night so I did not have to meet people. I did not like people looking at me, because I had this second skin on.[29]

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25 Burton, J., Julian Burton Burns Trust, Transcript, p 19 and McCartney, N., KIDS Foundation, Transcript, p 21.

26 Burtons, J., Julian Burton Burns Trust, Transcript, pp 17-18.

27 Scroggie, T., Private capacity, Transcript, p 8.

28 Burton, J., Julian Burton Burns Trust, Trancript, p 8.

29 Griffith, W., Private capacity, Transcript, p 8.

2.26 And this psychological impact extends to the nurses and doctors who are treating burns patients too. Mrs Sheila Kavanagh from ANZBA told the committee that treating burns patients has a significant emotional impact on the nurses, therapists and clinicians.[30]

Conclusion

2.27 It is clear that the treatment of burn injuries involves a significant amount of expertise and ongoing care. Furthermore, burn injuries have an ongoing impact not only on the individual survivor but on their family, the health system and society as a whole. The committee agrees with the evidence of a number of witnesses at the public roundtable that more work must be done to prevent burn injuries in the first place. Ways to prevent or minimise burn injuries are discussed in greater detail in the next chapter.

30 Kavanagh, S., ANZBA, Transcript, p 9.

3

Can we improve?

3.1 Given the high costs of treating patients with burn injuries the committee supports the evidence presented to it at the public roundtable that more should be done to minimise the severity of burn injuries, when they do occur, or prevent them from occurring in the first place.

3.2 The committee was pleased to gather a number of organisations in the same room at the same time to discuss burn injury prevention. Moreover, the committee was surprised that this was the first time all the relevant stakeholders had been gathered in the same room at the same time.

3.3 The discussions with the participants at the roundtable highlighted some of the gaps that currently exist in burn injury prevention, and the committee has made recommendations in order to try and fill those gaps.

3.4 However, this is a report of the roundtable forum, and therefore the committee is guided by the evidence received orally at the forum and in written submissions. The committee anticipates that its recommendations will provide a useful guide to government in order to better target and implement burns prevention campaigns.

3.5 The areas where the committee has identified gaps in current policy with regards to burn injury prevention are as follows:

- lack of a national burn injury prevention plan;
- inadequacies in information and data;
- insufficient national prevention and education campaigns; and,

- complexity of the care and support that is provided to burns survivors.

National Injury Prevention Plan

3.6 The Department of Health and Ageing (DoHA) website provides a link to the *National Injury Prevention and Safety Promotion Plan 2004 – 2014*.[1] The stated goals of this plan are to achieve a positive safety culture in Australia and create safe environments.[2]

3.7 The committee argues that burn injury prevention must fall under the umbrella of injury prevention in Australia more broadly. The Committee understands, based on correspondence from DoHA, that there have been no discussions as yet about the future of the *National Injury Prevention and Safety Promotion Plan 2004 – 2014*.[3]

The committee considers central co-ordination of a national injury prevention plan to be an important responsibility of DoHA. Therefore the committee strongly urges DoHA to consider burn injuries as part of any new *National Injury Prevention and Safety Promotion Plan 2004 – 2014*.

Recommendation 1

That the Department of Health and Ageing consider burn injuries as part of any new *National Injury Prevention and Safety Promotion Plan 2004 – 2014*.

3.8 Nevertheless, the *National Injury Prevention and Safety Promotion Plan 2004 – 2014* does not explicitly mention the issue of burn injuries. The committee is aware that the World Health Organisation (WHO) released a *WHO plan for Burn Prevention and Care* in 2008.[4] The WHO plan acknowledges that burns are a major public health problem more so in low and middle income countries.

1 Accessed from http://www.nphp.gov.au/publications/sipp/nipspp.pdf on 7 July 2010.

2 Strategic Injury Prevention Partnership, *National Injury Prevention and Safety Promotion Plan*, 2005, p iii.

3 Supplementary Submission 1.3, Department of Health and Ageing (DoHA).

4 WHO plan for burn prevention and care, accessed from http://www.who.int/violence_injury_prevention/media/news/13_03_2008/en/index.html on 7 July 2010.

3.9 The committee acknowledges that the AUSBURNPLAN has been developed by DoHA to provide a planning and coordination response to an event that may result in mass trauma and multiple burns survivors.[5]

3.10 However, the AUSBURNPLAN, while a valuable and necessary public health document, does not focus on burn injury prevention activities.

3.11 Therefore, the committee believes that burns prevention activities in Australia would benefit from greater co-ordination. This greater co-ordination could be fostered through the development of a National Burn Injury Prevention Plan, which could be based on the WHO plan and incorporate activities in the following areas:

- advocacy;
- policy;
- data and measurement;
- research;
- prevention;
- treatment services; and
- capacity building.[6]

5 AUSBURNPLAN, accessed from http://www.health.gov.au/internet/main/publishing.nsf/Content/health-emergency-ausburn-cnt.htm on 9 July 2010.

6 WHO plan for burn prevention and care, p 11, accessed from http://www.who.int/violence_injury_prevention/media/news/13_03_2008/en/index.html on 07 July 2010.

Recommendation 2

The committee recommends that the Department of Health and Ageing develop a National Burn Injury Prevention Plan which can be used to co-ordinate burn prevention activities within Australia.

Information and data

Data

3.12 A number of witnesses raised concerns with the committee about the inadequacies of the data available on burn injuries. These concerns reflected two main issues:

- the potential under-representation of the current level of burn injuries amongst different sectors of the population;[7] and
- lack of knowledge about the success or failure of different interventions and treatment regimes.[8]

3.13 The committee heard a number of reasons why it was important to collect and analyse data on burn injuries and treatments including to:

- understand which treatment regime is most effective and has the best patient outcomes;[9]
- identify deficits in treatment options at different locations;[10]
- improve the targeting of education and prevention campaigns;[11] and
- estimate a more accurate baseline of burn injuries.[12]

3.14 An example of the positive role that data gathering can play was provided to the committee by Professor Peter Maitz. His unit identified a spike in the number of young children from an affluent part of Sydney suffering burns to their palms. Doctors were concerned that a specific socio-economic group was being affected by burns in much higher levels than

7 Petrys, D., Council on the Ageing (COTA), Transcript, p 6.
8 Cameron, P., Australian and New Zealand Burn Association (ANZBA), Transcript, p 7.
9 Cameron, P., ANZBA, Transcript, p 17.
10 Cameron, P., ANZBA, Transcript, p 17.
11 Kavanagh, S., ANZBA, Transcript, p 29.
12 Buza, Y., Stakeholder, Burns South Australia Aboriginal Burns Program, Transcript, p 29.

normal. Using the burns database, doctors were able to establish that these children were suffering from friction burns caused by exercise treadmills. This information was communicated to the legislative body, and within six months all new such treadmills were accompanied by appropriate warnings about the potential for friction burns.[13]

Committee comment

3.15 The committee agrees that good data and research should be used to underpin both our treatment regimes as well as to evaluate and monitor the success, or failure, of different prevention campaigns. Good quality data should be collected, evaluated and utilised to drive policy changes and monitor the effectiveness of those policy changes.

Monitoring system

3.16 The committee agrees that improved data collection is an essential element of improving Australia's response to burn injuries in Australia. The committee was gratified to hear that the Australian and New Zealand Burn Association (ANZBA) is developing a national burns database, with the support of the Julian Burton Burns Trust. This register is only relatively new, but ANZBA:

> ... are systematically collecting burns admission data from those units right across Australia and New Zealand. We [ANZBA] hope to build on that to look at both the prevention side and the circumstances of burns and the other side of it, as we were discussing before: the long-term effects of burns ... You cannot conduct any of these programs effectively without having systematically collected data to ensure that what you are doing is working and that you are not missing out on certain areas or groups.[14]

3.17 The committee questioned participants about the role for the Australian Institute of Health and Welfare (AIHW) in developing the datasets that are collected. Professor Cameron responded that:

> Although we work with the AIHW, the way the AIHW is set up it cannot do this sort of work. It actually has to come from the clinical units and be agreed by the clinicians as to how to interpret this data and use this data.[15]

13 Maitz, P., Julian Burton Burns Trust, Transcript, p 42.

14 Cameron, P., ANZBA, Transcript, p 37.

15 Cameron, P., ANZBA, Transcript, p 38.

3.18 The committee notes however that the AIHW houses the secretariat of the National Health Information Standards and Statistics Committee (NHISSC) which is a sub-committee of the National E-health and Information Principal Committee (NEHIPC). The NEHIPC reports to the Australian Health Ministers Advisory Council (AHMAC) and provides advice on needs and priorities for health information.[16]

> NHISSC is responsible for providing strategic advice on issues relating to health information standards; endorsing national information standards for the health sector and endorsing specifications for statistical collections of national health information.[17]

3.19 Mrs Sheila Kavanagh, from ANZBA, stated that improvements to data collection could occur through the proposed national E-Health system. The proposed national E-Health strategy will provide a framework to facilitate the sharing of electronic patient data between the Commonwealth, states, territories and the private health sector. The purpose is to ensure secure but efficient information interchange between health providers who are treating individual patients. Among other benefits, the adoption of the E-Health system will allow collection of better quality data sets on treatment effectiveness.[18]

3.20 Mrs Kavanagh expressed a desire for organisations, such as ANZBA, to be involved in the development of the E-Health system to ensure that this electronic record is used to systematically collect nationwide burns data.[19]

3.21 Professor Roy Kimble raised concerns that most hospitals are not funded to collect data for national databases. He stated that data collection was very important, and therefore funding needed to be provided to supply data.[20]

Committee comment

3.22 The committee agrees with the evidence presented to it at the public roundtable that there is a need to improve Australian burn injuries data

16 Australian Institute for Health and Welfare (AIHW), 2010, *Creating Nationally Consistent Health Information: engaging with the national health information committees*, Data linkages series no. 8. Cat. No. CSI. 8, Canberra, p 1.

17 AIHW, 2010, *Creating Nationally Consistent Health Information: engaging with the national health information committees*, Data linkages series no. 8. Cat. No. CSI. 8, Canberra, p 1.

18 See www.nehta.gove.au and www.health.gov.au/internet/main/publishing.nsf/content/national+Ehealth+strategy.

19 Kavanagh, S., ANZBA, Transcript, p 37.

20 Kimble, R., St John Ambulance Australia, Transcript, p 12.

collection and monitoring. This data can then be used to target education campaigns, assess the quality of care and develop best practice treatment models. The ANZBA burns registry and the development of E-Health presents a good opportunity to begin to collect data on burn injuries and treatments Australia-wide.

3.23 The committee recognises the importance of multi-disciplinary support for the treatment of burn injuries. The development of the ANZBA Burns Registry presents a useful opportunity to evaluate what care is provided across Australia, the strengths and weakness as well as the gaps in care. This can then be utilised to develop guidelines for the treatment of burns survivors, underpinned by empirical data about what services are or are not effective. The committee urges ANZBA to contact the NHISSC in order to ensure that the ANZBA Burns Registry meets Australian data development standards.

Recommendation 3

That the Minister for Health and Ageing facilitate the ongoing development of the Australian and New Zealand Burn Association Burns Registry.

Recommendation 4

That the Minister for Health and Ageing engage with the Australian and New Zealand Burn Association in the development of the E-Health system to ensure that datasets on burns incidence and treatments are collected.

Evaluation

3.24 Evaluation is essential to ensure the effectiveness of programs and interventions, and should be used to ensure that policies aimed at preventing burn injuries are having the appropriate outcome, and are targeted to the correct population groups.

> The important thing about any prevention campaign or educational campaign is targeting the right population. If you do

> not target the right population, you have really wasted your money.[21]

3.25 Improvements to data collection and monitoring should allow improved evaluation of policy changes, education campaigns and treatments for burn injuries:

> To get to that stage you have to actually have, again, standardised data collected across Australia in a way that allows you to know whether your campaign is working or not, whether you have targeted the right people, and whether you have spent the right amount of dollars for specific groups, whether it be Indigenous, rural, urban or whatever, because without that data you cannot mount an effective campaign.[22]

Committee comment

3.26 Evaluation should be embedded into programs and interventions to ensure that they are proving effective and are targeting the appropriate population groups.

3.27 In addition, different forms of treatment need to be evaluated in order to ensure that burns survivors are receiving the best possible care and support.

Recommendation 5

That the Minister for Health and Ageing ensure that improved data collection of the extent of burn injuries in Australia be evaluated to ensure that policies aimed at reducing burn injuries are effective and accountable, and that survivors are receiving the best possible treatment.

Research and development

3.28 The committee heard that Australia is a world leader in burn injury research, but that it is not communicating the lessons learnt to the broader community. According to Professor Kimble:

> ... when it comes to research into burns, Australia really does lead the world. For its size, Australia puts out more burns literature

21 Kimble, R., St John Ambulance Australia, Transcript, p 38.

22 Cameron, P., ANZBA, Transcript, p 29.

> than any other country in the world, on treatments and, especially, prevention. And, as I said before, Australia is definitely performing the majority of the work in first aid in the world. So we have all the evidence that we need. What we really need is money to get these messages out to and to educate the public, and I think that is where the discrepancy is. There is no shortage of enthusiasm from the research groups.[23]

3.29 However, there is a need for improved data collection, analysis and research more broadly. For example, the treatment offered at burns units may differ across Australia, but there is no systematic evaluation or research of which treatment is offering the best long-term success.

> Even in the burns community, the surgeons themselves are doing fantastic work but they do not know whether they are doing the right work. If you go to each state they are doing it slightly differently, using different forms of treatment. This is a terrible injury, with terrible outcomes, and we do not have any systematic way of knowing whether we are offering the best treatment around Australia.[24]

3.30 In addition, research needs to be undertaken to ensure that new and emerging technologies aimed at treating burn injuries are developed and incorporated into clinical practice.

Committee comment

3.31 The committee was gratified to hear that Australia is a world leader in burns research, and hopes that there is continued support in terms of funding for this important task.

3.32 In addition, the committee hopes that the recommendations in this section about the need to improve our data collection, monitoring and evaluation will allow Australia to continue to deliver cutting edge research and evaluation of burns treatment and burn injury prevention.

23 Kimble, R., St John Ambulance Australia, Transcript, p 48.

24 Cameron, P., ANZBA, Transcript, p 10.

Prevention

Education campaigns

3.33 As with most medical conditions, it is far better to prevent burns from occurring in the first place.

3.34 The committee heard about a child patient who has undergone 74 operations to release their scars and therefore accommodate their natural growth. Each surgery is accompanied by a long and painful rehabilitation process and is surgically and psychologically traumatic.[25] Surgeons indicated that this was not a unique example. Examples such as these highlight the claims that preventing burns will have an immediate and long lasting beneficial impact on the health and well-being of Australians.

3.35 The committee enquired about the role that education can play in preventing burn injuries from occurring in the first place. Professor Kimble stressed the importance of a targeted education campaign through providing the committee with an example of a successful education campaign that reduced burn injuries caused by campfires in Queensland.

3.36 As a result of an increase in burns to children's hands and feet caused by inappropriately dampened fires, surgeons developed leaflets explaining how to extinguish a fire safely and made them available through camping stores and at camp sites. This education campaign stopped campfire burns for 8 months after its completion. However, the injuries started to increase after the campaign ceased. The campaign could not be sustained because those running it were surgeons from burns units who undertook the necessary work in their spare time. Professor Kimble added that when this campaign was funded and provided through general television advertising it had had no impact on the incidence of burn injuries caused by campfires, demonstrating that these campaigns need to be targeted and sustained.[26]

3.37 Mrs Yvonne Buza, a stakeholder in the Burns South Australia Aboriginal Burns Prevention Program, also raised the need for campaigns to be targeted to Indigenous populations who have specific needs. For example, many communities do not have access to cold running water and there may be some traditional activities which increase the risk of burns and scalds. She reiterated the need for Indigenous communities to be engaged

25 Kimble, R., St John Ambulance Australia, Transcript, p 27.

26 Kimble, R., St John Ambulance Australia, Transcript, pp 38-39.

in the development of prevention campaigns to ensure that they are appropriately targeted.[27]

> It is great to get out and prevent but we need to have the data to tell us where to go. We can sit here and start to work collaboratively with governments—whether state or federal—but you have to be accountable for the funding. So the whole idea for us of a two-prong attack is to have the statistic information that we get from Peter, which gives us some guidance and direction as to our future campaigns—whether it is schools, community awareness campaigns et cetera. This gives us some credibility and some accountability with regard to where we are going to go from a financial point of view and also the social impact that we are making as well. I think it is imperative both from a prevention point of view and a treatment point of view.[28]

3.38 The ANZBA Burn Prevention Committee's submission stressed the need for any prevention programs to be evaluated.[29]

Committee comment

3.39 Any prevention and education campaigns will need to be targeted and evaluated. This again stresses the need for improvements to the information and data available on burns more generally, as discussed earlier in this chapter. Again the committee reiterates its recommendations regarding improving data collection, evaluation and monitoring.

Existing burns education campaigns

3.40 The committee sought to understand what education campaigns were already established in the community. Mr Julian Burton from the Julian Burton Burns Trust informed the committee about the BurnSafe program that his organisation is implementing. This and other education programs provided by the Burns Trust focuses on educating young children, the Aboriginal community, the elderly and on raising general community awareness about burns and appropriate first aid treatment, and encouraging behavioural and social change.[30]

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27 Buza, Y., Stakeholder, Burns South Australia Aboriginal Burns Prevention Program, Transcript, p 42.

28 Burton, J., Julian Burton Burns Trust, Transcript, p 37.

29 Submission No. 3, ANZBA Burn Prevention Committee, p 3.

30 Burton, J., Julian Burton Burns Trust, Transcript, pp 31-32.

3.41 Mrs Susie O'Neil from the KIDS Foundation explained that the KIDS Foundation programs recognised that children are effective educators and can drive behavioural change within the family. One of the programs that the KIDS Foundation has developed is the Safety Club, which is a student initiated program where students run the club and engage with the principal, teachers and parents. Independent evaluation of this program has found a decrease in injuries as a result of the Safety Club. She added that the KIDS Foundation has also developed educational materials aimed at pre-school children educating them about injury prevention. Mrs O'Neil stated that these programs were proving very successful.[31]

3.42 Submissions received by the committee also mentioned programs aimed at preventing burns in primary school aged children, and improving first aid literacy amongst adolescents and young adults. These programs are:

- Learn to Stop Burns; and
- Burns Dangers III.[32]

Committee comment

3.43 The committee argues that there is a role for the Federal Government to play in ensuring a coordinated Australia-wide targeted education campaign is developed. Given the varied causes of burns injuries, there are a number of areas where targeted campaigns to prevent burns would be beneficial, focusing on preventing burns in the household and workplace, as well as campaigns aimed at Indigenous populations and the elderly.

3.44 In addition the committee contends that these programs need to be evaluated in order to ensure their effectiveness over the long-term.

Recommendation 6

That the Minister for Health and Ageing promote targeted national burns prevention safety campaigns to at risk groups including workers, young, older and Indigenous populations.

31 O'Neill, S., KIDS Foundation, Transcript, p 35.

32 Submission No. 2, NSW Severe Burn Injury Service, pp 5-7.

Recommendation 7

That the Federal Government implement age appropriate and targeted burns education campaigns to all levels of the Australian population including school children, indigenous groups, new parents and the elderly.

Regulatory changes

Regulating hot water systems

3.45 Participants at the public roundtable suggested that in some cases regulatory changes could be made which would help reduce the incidence of burn injuries. For example, most witnesses agreed that the hot water in many Australian homes was heated to an unnecessarily high temperature, with some hot water systems registering temperatures of 80 and 90 degrees Celsius which can cause severe burns.[33]

3.46 Witnesses explained that there is a significant difference in the burns risk of water heated to 40 or 50 degrees Celsius. Water heated to 40 degrees is unable to burn but at 50 degrees Celsius can cause scalds. A number of surgeons raised concerns that, unlike Europe, hot water systems in Australia are not regulated to ensure that the maximum water temperature is limited to 40 degrees Celsius.

3.47 The committee enquired as to what are the current regulations governing hot water units in homes. Professor Kimble, from St John Ambulance Australia, indicated that he believed legislation had been introduced in Queensland and New South Wales (NSW) that limited the hot water of bathroom taps to 50 degrees Celsius, but that it only applied to new houses. Professor Kimble added that the regulation also applied to replacement hot water systems for older houses but added that the pace of change is incredibly slow.[34]

3.48 Professor Maitz, from the Julian Burton Burns Trust stated that water temperatures in Europe are limited by installing a cold and hot water mixing thermostat in the pipes before the water reaches the tap:

33 Kimble, R., St John Ambulance Australia, Transcript, p 15.

34 Kimble, R., St John Ambulance Australia, Transcript, p 14. See also Submission No. 3, ANZBA Burn Prevention Committee, p 5.

> I was told – I am not a plumber – that this is a relatively inexpensive way to do it.[35]

3.49 Mrs Debra Petrys, on behalf of the Council on the Ageing (COTA), stated that there are a number of home safety audits which are currently undertaken for older people. She added that perhaps hot water regulation, and checking of and/or installation of smoke alarms should be incorporated into these audits.[36]

Committee comment

3.50 As older people are a higher risk group for burn injuries, the committee thinks using the home safety audits to regulate hot water systems and check or install smoke alarms is a sensible suggestion.

3.51 Given that a number of burn injuries are caused by hot water scalds, there is value in ensuring that home hot water systems are temperature controlled to a maximum temperature that minimises the risk of burn injuries occurring. The committee supports further investigation of ways to cost effectively protect Australians from severe burns in their homes, by limiting the maximum temperature of water in home hot water systems.

Recommendation 8

That the Minister for Health and Ageing in conjunction with the Minister for Housing and relevant state and territory housing Ministers apply nationally consistent regulations to limit the maximum temperature of water flowing from taps in home hot water systems.

Other regulatory options

3.52 Professor Maitz raised another example of where regulatory action could be used to help prevent burn injuries. He stated that the self-extinguishing cigarette had been invented in Australia but, at the time of the hearing, was not mandated for cigarettes sold in Australia.[37] The committee notes, however, that from 23 March 2010 the importation and production of "high fire risk" cigarettes in Australia was prohibited.[38]

35 Maitz, P., Julian Burton Burns Trust, Transcript, p 14.

36 Petrys, D., COTA, Transcript, p 33.

37 Maitz, P., Julian Burton Burns Trust, Transcript, p 33.

38 See *Trade Practices (Consumer Products Safety Standard) (Reduced Fire Risk Cigarettes) Regulations 2006*, SLI 2000 No. 195.

3.53 Submissions to the inquiry, received after the public roundtable forum, raised the potential for legislative changes to occur regarding:

- hot water bottles;
- cigarette lighters;
- fireworks;
- hot irons;
- electrical switchboards;
- availability of flammable liquids; and
- flammable clothing for adults and children.[39]

Committee comment

3.54 The committee considers that all regulatory and legislative changes which will improve the safety of Australians and reduce the risk of burn injuries should be considered by relevant authorities.

Recommendation 9

That the Australian Government co-ordinated by the Department of Health and Ageing investigate all regulatory options which would reduce the risk of burn injuries in Australia.

Care and support

3.55 The committee heard that there are some changes which should be made to the way in which we treat burn injuries in Australia. Burns survivors stressed the need for multi-disciplinary ongoing support, both while in hospital and after discharge from hospital.[40] The range of support required includes ongoing psychological support, physiotherapy, dietitians, occupational health and therapy, and massage.

39 For details please see: Submission No. 2, New South Wales Statewide Burn Injury Service (NSW SBIS) and Submission No. 3, ANBA Burn Prevention Committee.

40 Griffith, W., Private capacity, Transcript, p 16; Scroggie, T., Private Capacity, Transcript, p 18; Burton, J., Julian Burton Burns Trust, Transcript, p 20.

3.56 A number of witnesses raised the need for psychological support to be provided to burns survivors, their families and carers, and fire fighters who often witness burn injuries occurring.[41]

3.57 Mr Wayne Griffith, a burns survivor from the 2005 Eyre Peninsula bushfires, commented that he felt secure while in the hospital, but then had to go home to nothing — because he had lost his wife in the fires. He added that it would have been useful to have access to a trauma psychiatrist while he was still recovering in hospital in order to enable him to build a relationship with the psychiatrist. Instead it took him three years, from when he was injured to seek the help of a psychiatrist, and that was only as a result of intervention by his family.[42]

3.58 Professor Maitz stressed the importance of post-hospital care. He stated that it is relatively simple to repair the immediate damage to patients, but far more difficult to ensure that they receive the ongoing support they need in order to fully re-integrate into society, and enable them to have a normal life.[43]

3.59 Mr Kurt Towers, from Burns South Australia Aboriginal Burns Program, reflected that a number of the associated support services required by burns survivors, such as physiotherapy and peer-support, are not available in rural and remote Indigenous communities. He stressed that those communities were still trying to manage the burns alone, and often could not access the additional support that is required.[44]

Committee comment

3.60 Earlier in this chapter the committee made recommendations regarding data gathering and research. The committee hopes that some of this research will be directed at evaluating the different treatment options available to burns survivors across Australia with a view to ensuring that all Australian burns survivors access world's best practise standards of care and support.

41 van Gerwen, S., St John Ambulance Australia, Transcript, p 12; Griffith, W., Private capacity Transcript, p 16; and Kimble, R., St John Ambulance Australia, Transcript, p 26.

42 Griffith, W., Private capacity, Transcript, p 16.

43 Maitz, P., Julian Burton Burns Trust, Transcript, p 15.

44 Towers, K., Burns South Australia Aboriginal Burns Program, Transcript, p 19.

Reduce fragmentation

Accreditation of survivor networks

3.61 Mrs Terri Scroggie raised concerns with the difficulty that patients and their families may have in finding and accessing support services once the patient is discharged from hospital:

> I would like to say that, when you are in hospital, you are safe; you are looked after and you know that you are going to get what you need. You are then shoved out not knowing anything or anyone and you are pretty much on your own.[45]

3.62 Mrs Kavanagh from ANZBA admitted that burns survivors and their families have to navigate a fragmented medical system in order to access the care and support that they may require.

> Historically, in Australia, the clinicians and burns units have been responsible for every facet of burn prevention, survivor support and clinical care delivery. This has started to change and we have seen support groups come to the fore. There is no doubt that there has been some resistance in some clinical groups, based on a lack of knowledge and a protectiveness of the clients to ensure that we do not refer them on to people we do not know and that we know what we are referring them on to. Support needs to come in many forms. Whether it be online, one-to one or group, everybody wants something different to support them. We have seen a huge development in that area. You have identified that we need some information sharing so that clinicians feel safe about referring their burns survivor and family into somebody else's care; clinicians feel very responsible for that. That is one of the barriers that is present and that we have to work on.[46]

3.63 In response to survivors stating that they felt they had little support out of hospital, one of the support organisations, the KIDS Foundation, raised the possibility of accreditation of support networks in order to enable doctors and associated clinicians to refer patients to accredited support programs.[47] Mrs Kavanagh, from ANZBA, indicated that information sharing needed to improve in order for patients to be aware of the support services available to them.[48]

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45 Scroggie, T., Private capacity, Transcript, p 15.

46 Kavanagh, S., ANZBA, Transcript, p 25.

47 Dunn, K., KIDS Foundation, Transcript, p 19.

48 Kavanagh, S., ANZBA, Transcript, p 25.

Committee comment

3.64 The committee agrees that accreditation, or similar, of support and burns survivor networks would have merit, and encourages ANZBA to work with the various burns survivor networks to progress this idea. This would enable burns survivors and their families to better access the variety of care and support that they need.

Recommendation 10

That the Minister for Health and Ageing work with various support groups to implement an accreditation scheme for burns survivor networks in order to reduce fragmentation of information and support services within the health system and assist burns survivors to access the care and support that they need.

Burns care nurses

3.65 Mrs Nerissa McCartney, who has provided long-term care for a burns survivor and now works for the KIDS Foundation, raised the idea of a 'Burns Care Nurse' similar to the 'Breast Care Nurse' for breast cancer patients. A Burns Care Nurse could make regular visits to the patient both while they are in hospital and then continue that support once the patient returns home. The nurse could make sure the burns survivor is managing and that they are getting appropriate support.[49]

3.66 Mrs Kavanagh from ANZBA responded that a Burns Care Nurse is a good idea especially because Breast Care Nurse training and accreditation has been very successful. However, she raised concerns about funding, stating that the majority of Breast Care Nurses are privately funded.[50]

3.67 The Committee notes that in the 2008/09 budget the Federal Government provided $12 million over four years to the McGrath Foundation to train and employ 30 additional Breast Care Nurses.[51]

49 McCartney, N., KIDS Foundation, Transcript, p 21.

50 Kavanagh, S., ANZBA, Transcript, p 25.

51 DoHA media release, accessed from http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2008-hmedia009.htm on 13 July 2010

Committee comment

3.68 The committee agrees with the proposal to develop an accredited training program for Burns Care Nurses similar to that available for Breast Care Nurses. These nurses will then be able to assist a burns survivor to appropriately access the complex treatment options available to them in a manner which suits the patient.

Recommendation 11

The committee recommends that the Minister for Health and Ageing support the implementation of a Burns Care Nurse training and accreditation program similar to that offered for Breast Care Nurses.

First aid training

3.69 The committee was interested in the benefits of first aid, and Mr Stephen van Gerwen from St John Ambulance Australia explained that cooling the burn as quickly as possible minimises the impact of the burn. He added that St John Ambulance Australia would like to see at least one person in every household trained in first aid, as this would assist in minimising burn injuries because a significant number occur in the home.[52]

3.70 Other witnesses supported the need for better first aid training amongst the Australian population. Professor Kimble, an expert advisor for St John Ambulance Australia provided recent data about the use of first aid in burn injury treatment in Brisbane:

> ... recent data from Brisbane ... shows that only 86 per cent of burns victims had first aid and only 12.1 per cent had what we would call ideal first aid. That means that 88 per cent had sub optimal or no first aid.[53]

Committee comment

3.71 The committee recognises the importance of appropriate first aid in minimising burn injuries. The committee supports calls for more Australians to be first aid trained, and thinks that improved fist aid literacy would have benefits beyond simply minimising burn injuries and would be beneficial for the Australian society as a whole.

52 Van Gerwen, S., St John Ambulance Australia, Transcript, p 28.

53 Kimble, R., St John Ambulance Australia, Transcript, p 28.

Recommendation 12

The committee recommends that the Federal Government investigate ways to ensure that more Australians benefit from first aid training.

Conclusion

3.72 The committee thinks that improvements to burn injury prevention can be made in a number of areas. Firstly, the federal government needs to ensure that it collects adequate and appropriate data on the incidence and severity of burn injuries in Australia.

3.73 This data is essential to underpin policy changes, prevention campaigns and care and support of burns survivors.

3.74 Many burns are preventable, and any prevention campaign needs to be targeted to appropriate groups, sustained and evaluated for its success.

3.75 Where burns cannot be prevented, evidence demonstrates that appropriate first aid can minimise the severity of the burn injury. The committee supports calls for more Australians to be first aid trained in order to equip members of society with the skills they may need when dealing with a burn injury.

3.76 In addition, there would be significant benefit in investigating ways that fragmentation of the medical system can be reduced in order for burns survivors to be able to access the relevant care and support that they may require.

Steve Georganas MP
Chair
July 2010

A

Appendix A – Roundtable Participants

Monday, 1 February 2010 - Canberra

Australian and New Zealand Burn Association

Professor Peter Cameron, Chair, ANZBA Registry Steering Committee

Mrs Shelia Mary Kavanagh, President

Burns South Australia Aboriginal Burns Program

Mr Kurt Towers, Manager, Aboriginal Burns Program

Mrs Yvonne Buza, CEO, Aboriginal Health Council of South Australia

Council on the Ageing Seniors Voice

Mrs Debra Petrys, General Manager, National Programs

Australian Government Department of Health and Ageing

Dr Andrew Singer, Principal Medical Adviser Acute Care

Julian Burton Burns Trust

Mr Julian Burton, CEO

Mr Wayne Griffith

Professor Peter Maitz, Board Member

Ms Terri Scroggie

Ms Jessica Scroggie

KIDS Foundation

Mrs Kellie Dunn, Founding Director

Mrs Nerissa McCartney, Program Co-ordinator Burn Survivor Network

Mrs Susie O'Neill, Founding Director

St John Ambulance Australia

Professor Roy Kimble, Medical Adviser

Mr Stephen van Gerwen, National Training Manager

B

Appendix B - Submissions

1. Australian Government Department of Health and Ageing
   - 1.1 – (Supplementary)
   - 1.2 – (Supplementary)
   - 1.3 – (Supplementary)
2. Julian Burton Burns Trust
   - 2.1 – (Supplementary)
3. NSW Statewide Burn Injury Service
4. Australian and New Zealand Burn Association Burns Prevention Committee

C

Appendix C - Exhibits

1 KIDS Foundation, *Burns Survivors Support Survey.*