



Institut de veille sanitaire

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## European Project

**Establishing a rapid response mechanism  
within the Injury prevention programme:  
a pilot study  
«Rapid alert»**

## Final report



This is the final report concerning the project:

**«Establishing a rapid response mechanism within the Injury prevention programme: a pilot study»**

which received European funding from the General Directorate for Health and Consumer Protection (DG SANCO), under convention SPC.2002281, as part of the 2002 Injury Prevention Programme 2002.

This project has been carried out under the supervision of the  
Institut de veille sanitaire (France)

With the following partners

in Europe:

The Sicher Institute Leben (Austria)

EDUCA-SANTE (Belgium)

National Institute of Public Health (Denmark)

Instituto Nacional de Saude (Portugal)

Swedish Consumer Agency (Sweden)

and within France:

Psytel

Commission de la sécurité des consommateurs (Consumer Safety Commission)

Direction générale de la consommation, de la concurrence

et de la répression des fraudes (General Directorate for Consumer Affairs, Competition and the Prevention of Fraud)

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# Summary

## Objectives of the project

The project «Establishing a rapid response mechanism within the Injury prevention programme: a pilot study», hereafter referred to as «Rapid alert», was introduced into the public health policy of the European Union, more specifically as part of «Establishing a rapid response mechanism» within the Injury Prevention Programme, IPP.

The objectives of this project, as they were initially defined in 2002, were as follows:

- To compile an inventory of the existing networks and partners in the field and to list any new function that could complement the existing tasks in order to respond to the specific needs of injury prevention. These new functions are not intended to replace the existing official notification networks, but to provide a mechanism for the rapid provision of complementary information for the purposes of epidemiology and prevention.
- To produce a pilot tool, such as a website for example, including: a list of addresses, a forum for questions, a database of the «high-risk situations» that have been identified and the actions undertaken, a forum for joint actions, etc.
- To describe a system that will notably make it possible to include the competent national authorities, consumer associations and the organisations responsible for standards.

This project was therefore intended to provide a high level of protection of the health and safety of consumers. This project has received funding from the European Union (DG SANCO). It was carried out under the supervision of the Institut de veille sanitaire (France), with the following European partners: The Sicher Institute Leben in Austria, EDUCA – SANTE in Belgium, Instituto Nacional de Saude in Portugal, National Institute of Public Health in Denmark, Swedish Consumer Agency in Sweden. Within France, the following bodies contributed to the work: the Commission for the Consumer Safety, the General Directorate for Consumer Affairs, Competition and the Prevention of Fraud, and Psytel.

## Summary of what has been achieved

Home and leisure accidents are numerous throughout the countries of the European Union; they are often avoidable and sometimes serious. They occur in the context of a very wide range of circumstances and activities, which mirror the wide variety of activities associated with life itself. Most of these accidents change little over time, their risk factors are stable, and it is possible to take a long-term approach to their prevention. However, the constantly changing living conditions also generate «new» accidents, linked to hitherto-unknown products, activities, or behaviours, or ones that were previously minority pursuits, and which have now become widespread. Some accidents that have not actually become more frequent or serious still seem to be «new», because more attention is paid to accidents nowadays, and this has resulted in greater measurement and awareness of their importance.

Consumer protection tends to focus on improving products (in order to avoid accidents as a result of using them), but there is obviously room for another approach that focuses on identifying all the causes that lead to accidents, not just the products involved, but also the circumstances in a more general sense. This more global approach is that used in public health prevention.

When «new» accidents occur, this calls for the introduction of a «notification and alerting system», similar to those that already exist in other field related to health. This concern, which is more often displayed with regard to infections, the environment or bioterrorism, has not really been developed so far at the European level, although it does form part of the «second pillar» of the 2003-2008 European Programme for Public Health. The work done in the context of this project has shown that in many countries this concern does already exist, and has led to attempts to find solutions: how should we organise the reporting of accidents that are «atypical» for one reason or another, how should things be organised so that they are followed-through in a satisfactory fashion, what strategies should we adopt with regard to information, investigation, etc. before an actual alert is issued?

## **The basis of an accident alert system:** *EASI, European Alert System on Injuries*

In attempting to establish the basis of a home and leisure accident alert system, the following factors have been taken into account:

- definitions of the terminology used (notification, alert, etc.) and of the procedures already in use in other health alert systems
- the existence of the RAPEX alert procedures that focus on protecting consumers when they use the products concerned
- the value of a down-to-earth and practical approach of a scientific nature, drawing on the national experience of the countries involved in the project.

The characteristics of «atypical» accidents that may be notified are described qualitatively. The main «criteria for notifications» that have been proposed are as follows:

- a large number of accidents occurring within a short period of time or the cumulative impact of a small number of recurring accidents over a longer period of time
- the seriousness of the accidents
- the novelty of a given type of accident
- the frequency with which consumers are exposed to the same circumstances
- the clear identification of a specific circumstance/product/behaviour
- a considerable increase in the occurrence of a known type of accident in specific circumstances and/or within specific populations.

These criteria may be cumulative. They are neither necessary nor sufficient, and a qualitative assessment is also called for. They may be applied to a given situation, and a given time and place or, on the contrary, used to monitor any trends related to time or geographical location.



A very simple approach has been adopted as the basis for the response to the cases reported:

Step 1: Notification of the case (or cases) in a Member State

Step 2: Validation of the notification at the level of the Member State; determination of the seriousness of the accident that has occurred and whether it is possible to respond; response within the Member State; circulation of the information throughout the EU.

Step 3: Compiling the notification report at EU level: search of the databases available for similar cases in the EU; search of the literature; circulation of the results within the EU; reaction at EU level.

Step 4: if appropriate, setting up and carrying out an ad hoc study; follow-up and conclusions; reaction at EU level.

A test website has been set up and has been running for five months involving the partners in the project. This *EASI* system, the *European Alert System on Injuries* has made it possible to validate the options listed above, to set up the kernel of practice and to organise how to handle the cases reported. This also provided a rough idea of how many reports can be expected. It made it possible to characterise the «atypical cases» that were reported, and to record the steps it was proposed to take following the accidents notified.

There is no doubt, following the performance of this test and the results obtained, that there is an unsatisfied need for a home and leisure accident alert system, and it should be developed using this flexible approach: using the Internet, combined with a scientific approach that it should be developed, without waiting for the legislation to be introduced.

## **Proposals for the routine introduction of EASI**

The practicalities of the routine introduction of EASI are quite straightforward:

- Constitute a group of scientific experts on a voluntary basis. The only condition for allowing these experts to take part in the alert system is that they must be professionally recognized in their own countries
- Adopt the procedure for making notifications, validation and management of notifications
- Update the address list of possible correspondents in each country who could contribute to validating the notifications or to providing scientific information. Make the public and medical profession aware that this network exists.
- Organise a full-scale test in the European Union in 2005 and 2006, using the current teams supported by the DG SANCO, based on the same principles as the test carried out in this study: notifications via the Internet, a scientific approach, initial validation at national level, etc.
- In the context of this test, to establish a schedule for how often the notifications are consulted and dealt with ,and also for sharing information about how the test is progressing
- draw the conclusions from this first generalisation in 2006. Compile the final specifications for routine introduction in the EU, using the appropriate methods, from 2007.

**Home and leisure accidents are a major public health problem. In the future it will become increasingly unacceptable for people to die or become seriously disabled as the result of an avoidable accident. These concerns are shared by all the countries within the European Union. Setting up the SAViC/EASI notification and alert system described here will contribute to protecting people, by clarifying the novelty, frequency and seriousness of the «atypical» accidents, or the trends in the circumstances under which they have happened. The European dimension is particularly valuable in this system, because they are often unusual events. Setting up ways of responding to these new accidents will make it possible to avoid them or to reduce their seriousness. Using the IDB database to identify the cases to be notified and to validate the cases notified could be particularly useful and would work in tandem with the implementation of EASI.**

# Introduction

## Objectives of the project

The «Pilot study for the introduction of a rapid injury prevention alert system» project, known as the «Rapid alert» programme, forms part of the public health policy of the European Union, and more specifically of the section “Establishing a rapid response mechanism” of the Injury Prevention Programme (IPP) [1].

This project had the following objectives :

- To compile an inventory of the existing networks and partners in the field, and to list any other functions that could complement existing actions, in order to respond to specific needs in the field of injury prevention. These new functions should not replace existing official notification systems, but provide a complementary rapid information mechanism for epidemiological and preventative purposes.
- To construct a pilot tool, a website for instance, including: a list of addresses, a forum for questions, a database of the “high-risk situations” identified and the measures taken, a space for joint efforts, etc.
- To describe the system that will make it possible to include, notably, the competent national authorities, the associations of consumers and the bodies responsible for standards.

This project was also intended to contribute to providing a high level of protection of the health and safety of consumers. This has received funding from the European Union (DG SANCO). It has been carried out under the supervision of the Institut de veille sanitaire (France), with the following European partners: The Sicher Institute Leben in Austria, EDUCA – SANTE in Belgium, Instituto Nacional de Saude in Portugal, National Institute of Public Health in Denmark, Swedish Consumer Agency in Sweden. Within France, the following organisations were involved in the work: the Commission for consumer safety, the General Directorate for Consumer Affairs, Competition and the Prevention of Fraud, and Psytel.

## Working methods

The project was carried out between April 2003 and January 2005 at the Institut de veille sanitaire, under the supervision of Bertrand Thélot, with the assistance of Marianne Perez who was the Project Assistant between April 2003 and June 2004, and of Emmanuelle Szego, which has contributed to the investigation and to the summaries of the literature between April and November 2003. The Psytel company (Marc Nectoux) was involved in all the phases of the project. The European partners in the project consisted of: Robert Bauer and Mathilde Sector from the Sicher Institute Leben in Austria, Alain Lévêque and Martine Bantuelle from EDUCA – SANTE in Belgium, Bjarne Laursen and Birthe Frimodt-Möller from the National Institute

of Public Health in Denmark, Baltazar Nunes and Joao Brandao from the Instituto Nacional de Saude in Portugal, Henrik Nordin and Stig Hakensson from the Swedish Consumer Agency in Sweden. In France, in addition to Psytel, the partners involved in the project were the Commission for consumer safety, represented by Françoise Briand, and the General Directorate for Consumer Affairs, Competition and the Prevention of Fraud, represented by Aline Peyronnet and Yannick Bailbled. These partners were asked to help in several ways: up to September 2003, by contributing bibliographical information about the systems for collecting home and leisure accidents in their countries; in October 2003 by attending a working meeting organised in Paris to fix the direction to be given to the project; up to December 2004, by e-mail and telephone contacts, to provide their criticisms and comments about the solutions proposed to institute a rapid response procedure at the European level; in May 2005 to carry out a critical rereading of the final report. Finally, some individuals contributed to the notification of accidents on the test accident alert website: Loïc Josseran, Bruno Fabres, Florence Suzan (InVS), and Philippe Meyer (hôpital Necker, Paris).

The project followed the steps scheduled:

**Step 1: Analysis of the existing alert systems**

Analysis of the alert systems that already exist in the field of accidents at the European level (RAPEX: rapid exchange of information about products that constitute a serious and immediate risk, PROSAFE: European Forum for the safety of Products, etc.), and the national alert mechanisms used in the States which were partners in the project.

**Step 2: Analysis of the additional functions required to institute an alert system for home and leisure accidents**

Working with national experts in the States involved in the project, determination of the new functions that it would be useful or necessary to envisage introducing, and the bodies required to implement this new specific alert system for the prevention of home and leisure accidents.

**Step 3: Development of a pilot tool**

In view of the existing facilities and specific needs with regard to alerts concerning the prevention of home and leisure accidents, proposal for the development of a pilot tool corresponding to the conditions already defined. Compiling the specifications and developing the pilot tool.

**Step 4: Testing and assessment of the pilot tool**

The tool is tested by all the partners involve din the project. Collection of the cases corresponding to an alert system. Assessment of the qualitative and quantitative aspects of the tool and the test procedure for collecting cases. Analysis of whether it is opportune to extend the alert system for home and leisure accidents and/or to introduce a permanent system.

**Step 5: Writing and dissemination of the final report**

# **Current situation: monitoring and alerts in the field of home and leisure accidents**

## **Monitoring home and leisure accidents**

Home and leisure accidents (HLAs) constitute a major public health problem. They are a major cause of death, in both developed and developing countries, and many of these deaths seem to be avoidable [2-4]. This situation began to be recognized in the 1970s in Europe, which led to the introduction of the Ehllass system (*European Home and Leisure Accident Surveillance System*) in the 1980s. This later became the IDB (*Injury Data Base*) system [5]. Surveys of accidents began to take shape in some countries (Austria, France, Greece, Netherlands, ...), with data being collected by the Emergency Departments of some hospitals. In other countries (Germany, Spain, Luxemburg, ...) transverse surveys were carried out amongst the general population, at varying intervals. For many years, this data collection was subsidized by the European Union. These surveys produced descriptive statistics, which, despite their lack of uniformity, were sufficiently convergent to confirm the high levels of mortality and morbidity attributable to home and leisure accidents. The main causes of accidents were quantified, and the avoidability of many accidents was recognized. In many cases, these findings led to actions to provide prevention, information, awareness, and regulations intended to reduce the incidence of accidents (primary prevention) or their consequences (secondary and tertiary prevention).

The emergence, since the 1980s, of this awareness of the consequences for health of the occurrence of home and leisure accidents, was accompanied by the organisation of a network of European experts involved in prevention and epidemiological monitoring in this field. Since 2003, this network, which is known as the Injury Prevention Network, IPN, was actively involved in the Injury Prevention Programme, IPP, between 1999 and 2002 () [1], and subsequently in the programme of community action in the field of public health (2003-2008) [6]. It has resulted in the pooling of experience, the development of common nomenclatures, the introduction of projects concerned with specific topics, etc. The work reported here was planned and funded as an IPP project.

The recognition that home and leisure accidents are a major cause of morbidity and mortality has therefore made some progress. During his or her life, every European citizen can expect to be confronted by a home and leisure accident. The descriptive surveys described above have identified the main trends associated with these accidents: falls make up more than half of these accidents; the most serious accidents consist of burns; children and the elderly are the most vulnerable groups, although all age groups are affected; the cost of dealing with these accidents can account for as much as one tenth of expenditure on health, and the social impact of accidents is considerable.

## **Home and leisure accidents: an alert system in addition to monitoring?**

In addition to these main trends, we also know that the risk of some accidents changes over time. On the one hand, every year brings new types of accidents and new circumstances under which they occur. And on the other, some existing types of accidents will display new characteristics: innovation means that they may sometimes suddenly become more common, start to happen in previously unknown circumstances, or affect populations that had previously been unaffected. It is not yet possible to find out how important these changes are objectively, because these «new» accidents, regardless of what makes them «new», are not being monitored, let alone subjected to systematic analysis.

**The main objective of this project was to find out which system should be introduced to detect the occurrence of «new» accidents (accidents hitherto unknown, or accidents of which the circumstances and incidence have suddenly changed to a considerably extent), to describe them, to identify the risk factors, how to manage and prevent them.**

The similarity of the situation throughout European and the fact that the occurrence of a new accident is often a rare event mean that this work logically has a European dimension. The rapidly changing environment, the increase in exchanges of people and merchandise, the introduction of new products, the development of new patterns of behaviour resulting in new risks are generally the same throughout the countries of the European Union. The lack of success of some attempts to set up national alert systems in some countries also justifies a Europe-wide approach. Finally, the fact that there is already an alert system functioning at the European level that is restricted to product safety (see below, the RAPEX system) has also led to an general reflection throughout Europe about what should be done about «new» accidents.

In attempting to identify a «new» accident, to do so at an early stage, and then implementing the monitoring and controls required to prevent such accidents, implies a perspective of notifications and alerts. We will have to define what we mean by an alert in the case of home and leisure accidents. There are several steps before we get to the actual alert phase itself. The numerous «alert systems» that exist, in the field of health or other fields, provide concrete examples of the organisation and procedures that need to be implemented for targeted actions. The fact that these systems have been around for some time, their scale and the experience they have provided will all be helpful in designing and constructing a specific system for home and leisure accidents.

In the context of this project, we have therefore attempted to answer the following questions :

- is there any place for a European rapid alert network in the field of home and leisure accidents ?
- how would such an alert system work: objectives, procedures, mechanism, means?
- what sorts of accidents could usefully have been reported via such a system in the recent past?

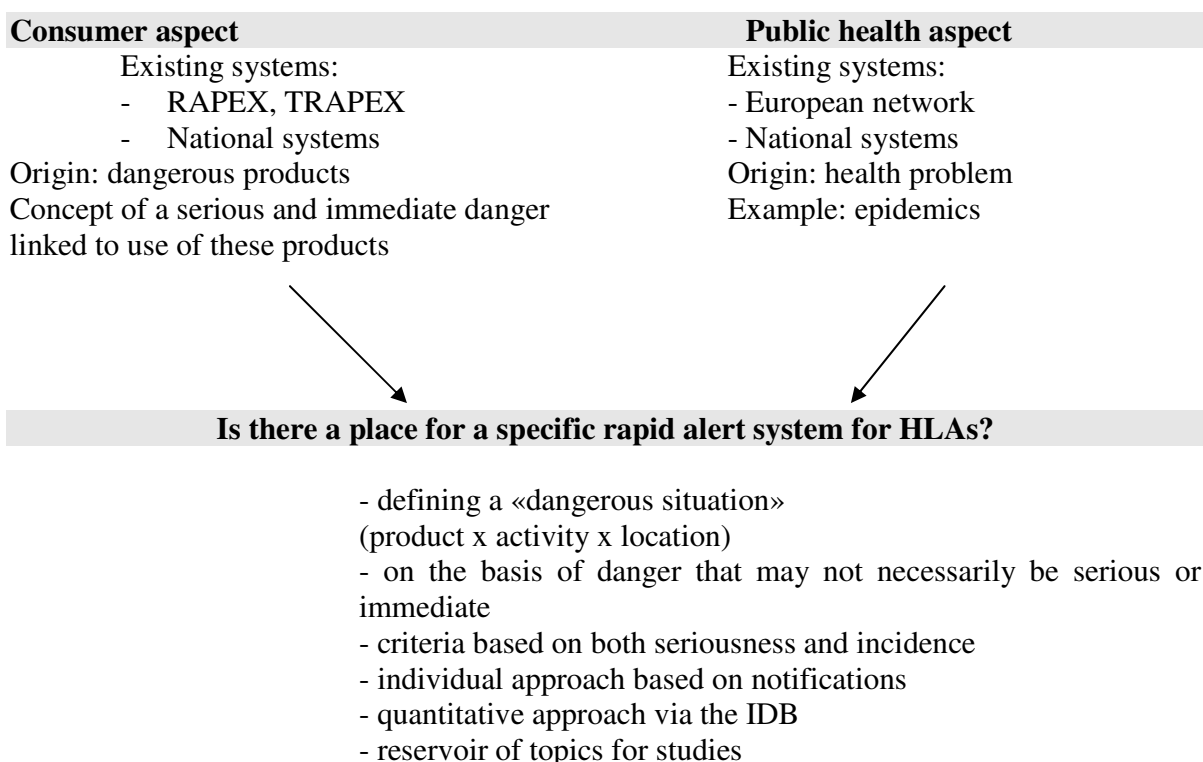
To fuel this task, we have collected information about existing alert systems, mainly in the fields of public health and consumer protection, in Europe, and that have some link with home and leisure accidents. To provide a concrete answer to the final question, a test site for the

collection of accidents «notified» as being «new» was set up, and has been used by the partners involved in the project for some months.

The existence of alert systems in the field of consumer protection had a major influence on how we went about the task. The procedures for an intervention at the European level when an accident has occurred or could occur as the result of using a product are based on long-established solid legislation that has recently been updated. These procedures have been in force for many years and make little use of epidemiology. The health of consumers, despite being an essential objective of these systems, is not the gateway: the alert is triggered by the product. It was therefore accepted from the outset that setting up a new accident alert system would be able to benefit from this experience and would not seek to change it.

On the other hand, there have been health-related alert systems for many years, notably in the field of infectious diseases. They have characteristics that in some ways run contrary to those of the systems described above: initial concern about health, the major contribution of epidemiology to implementing the system. The experience obtained with these systems should also directly benefit thinking about how to set up an alert system in the field of home and leisure accidents.

The diagram below summarizes the differences between the two existing approaches:



## **The types of accidental causes that have given rise to the alert**

It is possible to identify the accidents in which the following are directly implicated:

- products (whether manufactured or not),
- behaviour
- environmental causes (such as heatstroke)
- activities (e.g. sport)

The great majority of home and leisure accidents (HLAs) are linked to the use of a product (4 out of 5). However, it is relatively rare for the product to be the sole cause of the accident (in fewer than 1 in 5 cases). In most cases, the way the product is used, behaviour, etc. are also involved.

In addition, accidents directly linked to the activity account for about one third of the main causes of accidents. Sports lead to accidents (1 out of 6), regardless of whether they takes place at school or elsewhere (football, rugby, judo, basketball, etc.). The other activities that generate accidents include DIY, games, hobbies and other domestic activities.

The cause of the accident is often multifactorial, and it may result from a complicated process. There is a lot of interaction between the various different causes, notably with regard to behavioural causes and products: it is often the way a consumer uses a product that is dangerous rather than the product itself.

The alert systems that focus on "products" are mainly concerned with manufactured products and foodstuffs, and only to a lesser extent with behaviour. Products that are neither manufactured nor foodstuffs, causes linked to activities and environmental causes, which are responsible for quite a sizeable proportion of accidents, are left out of the alert scenario

**Our working hypothesis has been that the existing alert systems with a «product» gateway have their shortcomings, and so there is therefore room for an alert system focussing on «HLAs», regardless of how the accident occurred.**



# Existing alert provisions

## Existing rapid alert systems– consumer-orientated component

### The RAPEX system

#### Working principles

The system for the rapid exchange of information (RAPEX, *Rapid Exchange of Information on Dangers Arising from the Use of Dangerous Products*) was set up within the European Community in 1984 (decision 84/133/EEC), and its main objective was to contribute to the safety of consumers and to protecting their health, by setting up an organised system for the exchange of information about products that are potentially dangerous for human health and safety [7, 8]. This system has been maintained by various subsequent decisions, and was finally included in the Directive on the General Safety of Products (DGSP) of 1992, which was revised and strengthened in 2001 [9 - 11]

The system stipulates that any Member State that introduces urgent measures to prevent, restrict or impose certain conditions on the marketing of a product due to the serious and immediate danger that this product poses for the health and safety of consumers, must inform the Commission of this without delay.

The products involved are those intended for consumers, supplied in a commercial context, whether sold or supplied free of charge, and whether they are new, second-hand or reconditioned. In contrast, the system does not apply to pharmaceutical products, animals, and products of animal origin or to situations of radiological emergency, which are subject to parallel notification procedures.

This rapid exchange system comes into play when a product demonstrates a serious and immediate risk for the health and safety of consumers. This risk is assessed on a case-by-case basis by the national authorities. When a serious and immediate risk is detected, as far as possible and appropriate the national authority consults the producer or the distributor in order to obtain information about the product and the nature of the danger. This should make it possible to take measures that will ensure consumer protection whilst interfering as little as possible with business.

When a Member State takes measures to eliminate a risk of which the effects may extend beyond its territory, they must immediately inform the Commission. The information must be sent to the Commission in writing and as soon as possible. It contains information:

- making it possible to identify the product, in particular its nature and its characteristics;
- describing the nature and importance of the dangers involved;
- about the measures that the Member State has adopted;
- about the marketing chain.

The Commission checks this information and transmits it to the other Member States who, in their turn, immediately communicate the measures taken. The Commission may also contact the authorities in the country thought to be the country of origin in order to have some pertinent checks carried out. In exceptional cases, the Commission may open an investigation in order to complete the information received or to convene the emergency committee competent with regard to product safety.

The Commission must try to manage the system in such as way as to:

- avoid any duplication in the processing of the notifications;
- making maximum use of its facilities and skills;
- ensure that the services concerned are fully informed;
- ensure that the various committees work as a team.

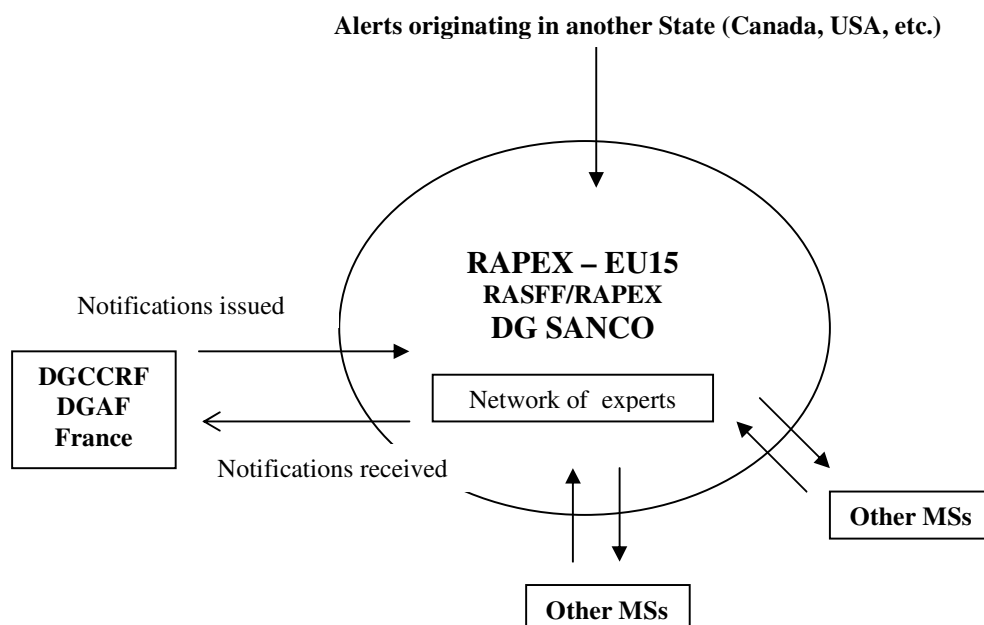
If a Member State that has taken an emergency measure wishes to alter its regulations by introducing technical specifications, it must notify the Commission.

The rapid information exchange system currently has two communication networks:

- a foodstuffs network
- a network for non-food products.

The list of the points of contact and the civil servants in charge of these networks is circulated only to the members of the networks concerned.

Access to RAPEX is open to candidate countries, third countries and to international organisations, in the context of existing agreements between the Community and these countries or organisations, as specified in these agreements.



The «experts in the field» who are professionally involved in enforcing community legislation for consumer protection and market control for products have constituted a « forum », known as PROSAFE (*product safety enforcement forum for Europe*) [13] since 1991. The objectives of this forum are to promote the tightening up of effective legislation and its enforcement in Europe. In, particular, they are intended to provide a forum for the gathering and pooling information and procedures, exchanges of ideas and experience about how best to achieve these objectives, proposals for practical improvements of these problems, etc.

## **The TRAPEX system**

The TRAPEX system (*Transitional Rapid Exchange of Information on Danger Arising from the Use of Dangerous Products*) is a market surveillance network set up in the countries of Eastern and Central Europe and the Candidate countries [13]. The system originated at a meeting of the Centre de Droit de la Consommation (CDC) (Centre for Consumer Law) at Louvain-La-Neuve (Belgium) in March 1999, when the representatives of nine countries of Eastern and Central Europe (Bulgaria, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, plus Slovenia as an observer) signed an agreement defining the main lines of how this cooperative system was going to work. The secretariat of the TRAPEX system is located in Hungary at the *General Inspectorate for Consumer Protection* (GICP). The system really began its work in May 1999. The first six months were viewed as an experimental phase. At first, it was necessary to establish the legal and institutional bases of the system, which is essential in order to introduce effective market surveillance, i.e. to identify any dangerous products, to assess the risks associated with them and to take the appropriate measures. In 2000, the Czech Republic joined the TRAPEX system, and then in 2001 it was the turn of Cyprus and Malta to do so. Then Slovenia became a full member, and so TRAPEX now includes 12 States. The members of the system meet once a year to look at how the system has worked and to exchange useful information and opinions.

The aims of the TRAPEX system are to detect and circulate information about food and non-food products that are dangerous for the health and/or safety of consumers and to promote cooperation between the authorities of these countries. To some extent this corresponds to the RAPEX system for these countries. The participating countries receive information about products representing a «serious and immediate danger» for consumers when this product appears on the market in another country that is a member of the system. This country can then introduce any measures it sees fit to protect consumers against the danger, the aim obviously being to take the most appropriate measures as soon as possible.

Over 90 notifications were circulated in 2000, and in 29 cases the authorities in partner countries answered that they had found that the product in question was available on their own market. The number of notifications rose to 152 in 2001, 142 of which concerned industrial products and 10 food products .

# The national systems

## Notifications in France

This primarily involves implementing the RAPEX system in France. Notification forms are completed by the Departmental Directorates for Consumer Affairs, Competition and the Prevention of Fraud (DDCCRF) and sent to the General Directorate for Consumer Affairs, Competition and the Prevention of Fraud (DGCCRF). These Directorates depend on the Ministry of the Economy and Finance (small and medium-sized businesses), which in France is the Ministry responsible for implementing the RAPEX system ([14] and Annex VIII). Only a few forms trigger a RAPEX report. There can be various reasons delaying a RAPEX report or for not reporting an event at all:

- If the product is only distributed locally, within France, any incidents linked to it are not reported in RAPEX
- If the product is manufactured in another EU country, it is preferable to start by informing the country concerned, because this is how the most information can be obtained, particularly about the distribution circuits and points of entry into other States
- A relatively subjective assessment is made of its degree of severity, reproducibility and whether it could have been avoided, the « avoidability » of the accident, before submitting a RAPEX report
- For a RAPEX report to be made, the product must have been subjected within the country to a « restrictive measure »
- If a chain of shops withdraws a product in France, and they are definitely going to do the same at their other outlets in other Member States, then no RAPEX report is made.

Notification in the RAPEX system is therefore not automatic. It follows a global assessment of the situation at the national level. It only occurs when there is a potentially considerable risk and it is thought that the information circulated would be «helpful» to the authorities in the other Member States.

Thousands of product seizures take place every year, but the DGCCRF does not notify many of them. The level of the risk is assessed, as is whether the product is marketed in other Member States, etc. The DGCCRF can act on the basis of a single report, which is not the case in all the other Member States. Safety requirements differ in Member States in Northern and Southern Europe.

The sources of notifications to the DGCCRF can be very diverse: consumers, media, distributors, possibly even competitors, etc. When a notification arrives from another country, it can be very useful to know how the product gets into France (via which network of importers etc.) so as to be able to proceed to a withdrawal if necessary. This information ought to be included in all notifications. However it isn't, and the vagueness of a notification can sometimes make it very difficult, to identify the trading circuit, and thus to identify the product. Precise identification of the product is essential (a photo helps). Accurate references must be available. The traceability of the product is very important. It must be possible to indicate where the product enters the various Member States. It isn't possible to «go fishing»

for poorly identified products or ones of which the trade circuits are not known (one has to turn to the federations of importers or distributors).

In France, there is no specific assessment authority for non-food products (to correspond to the AFFSA, the French Agency for the Health Safety of Foods, for food products). This task often falls to the DGCCRF. Test Laboratories, such as the National Tests laboratory (LNE) act in order to answer very specific questions indicated in detailed specifications: does the product match the reference provided? The cause of the accident is often a combination of behaviour/product components. We need to find out where the cursor lies between these two components.

#### Examples of possible or actual RAPEX reports

- The «yoyo with an elastic cord»: this product is not dangerous if it is used vertically (like a traditional yoyo). If it is used horizontally, like a catapult, there is a risk that the cord may wind itself round the user's neck. This can lead to strangulation and thus to suffocation (several cases have been reported). This product has been banned.

- The «bath seat for babies with a suction pad»: this is also a behaviour-based alert. The accident happened because the adult left the bathroom for a few minutes (there have been several cases of drowning). The measures envisaged are to fit a cord that would link the baby to the person bathing them. This fitting is currently under investigation. It would only be used by people who realise the danger, but it also has the advantage of pointing out this potential danger to everyone, of making the «dangerousness» of using this bath seat clear. The warning can be heightened by product labelling.

- A «very slightly radioactive watch»: in this case the danger results from prolonged use of a product (there is no «immediate» danger).

- The «nappy-changing table suspended from a frame»: accidents have been reported with this product. The DGCCRF took a sample from the supplier for testing. This test did not demonstrate the danger. Nevertheless the DGCCRF asked for changes to be made to the suspension device.

- the case of easy-opening cans: several consumers received severe cuts while opening the can (a danger inherent in the product or just clumsiness of the user?).

- the case of Indian peppers: the red dye used in some small Indian peppers is a banned carcinogenic substance. Should this be reported in RAPEX? There is no immediate danger, but they can be dangerous after repeated consumption. In the end, France did notify this case in RAPEX.

- the case of the Chinese candies/sweets: small gelatin sweets (konjac) that have to be sucked. Consumers unfamiliar with them can block their airways. Fatalities have been reported in Canada. After viscosity tests had been performed, these sweets were banned in France.

- the case of an underwater gun: a violent discharge of compressed air occurred while the consumer was examining it and unscrewing it close to his face, leading to the loss of an eye.

- the case of a liquid soap packaged in aerosol form : the excessive pressure of the spray led to ocular irritations.

These latter examples show that the behaviour of the user is an important variable in the occurrence of an accident, even though this can be viewed as still being a «normal» use (a concept calling for discussion) of the product.

#### The range of possible measure

A distinction has to be made between amicable measures and coercive measure, and also between measures concerning products that are subject to a legal framework, and those that are not. Quite a lot of products are not subject to any legislation. Some examples of products with no legal framework include: suction pad of a car sunshade (this is not a toy), vegetable slicers, luminous wands, etc. There are no specific standards or directives for these products. Reference is made to European directives with new approaches (e.g. «toys», «machine tools», «electrical products»). In the field of child-care products, national legislation does exist, but no European harmonisation. There is however a «general obligation for safety ».

#### Amicable measures

- Voluntary withdrawal: prohibition of sale
- Recall: usage ban. These are the most severe measures. They can be done via the media and/or by direct intervention involving the distributors or manufacturers (a withdrawal may take place without a recall, but not vice versa)
- Request for a modification of the product or the labelling, or of the consumer information
- Action with no effect on the product (particularly in the case of foodstuffs): check for foreign bodies (such as pieces of glass), modification of a production line, etc.

#### Coercive measures

- Withdrawal involving an administrative order: this is very rare, a withdrawal remains in force for one year. It can be renewed (as in the example of «laser pointers»).

#### Theoretical points

The DGCCRF always first tries to reach an agreement with the manufacturer and/or importers. Amicable procedures are by far preferred. The authorities' first concern is consumer safety, but they are also careful not to damage the Manufacturer's interests unnecessarily. If the product is not subject to any specific legislation (national or European) the «general obligation for safety» can be invoked. In this case, the DGCCRF sends a «warning» to the manufacturer and asks for a modification of the product. If their response is not satisfactory, the authorities may proceed to an administrative order. Many new products fall outside the legislative framework, which did not foresee their existence. Risks change over time. Standards, which are guidelines for Manufacturers rather than being an obligation, must constantly be updated. However, they can be made obligatory. There may also be a «permanent legislation» for some categories of product (e.g.: weapons). In this case, the actions follow a special procedure that, amongst other things, requires the Commission for Consumer Safety and the other Member States to be consulted.

The new European Directive «General safety of products», which was integrated into French law on 15/JAN/2004 [8], obliges the manufacturer to inform the public authorities about any safety problems associated with products. This makes notification mandatory. The obligation applies to all consumer products apart from those that are already subject to specific legislation. We do not know how many notifications this new provision is going to generate. The DGCCRF is planning to handle these notifications at the regional level

#### The responses to RAPEX

After each notification, the Commission asks what response has been made. A reply must be forthcoming within 6 weeks. Various different types of response are possible:

- No action has been taken because the danger does not seem to be obvious
- A procedure involving product research has been undertaken
- The search for information about the product is part of a more global investigation (e.g. cyclical investigations of products linked to «Vacations/Holidays», «Halloween», «Mardi gras», «toys», etc.)
- A specific action has been undertaken (product sampling, test, risk assessment, etc.).

#### Reports to the Consumer Safety Commission in France:

France also has an unusual method of reporting cases that may involve a defective product. The Consumer Safety Commission (CSC) is an independent Administrative Authority, which can be contacted or can itself decide to investigate cases outside any predetermined framework at the French or European level ([15], Annex VI). Like the DGCCRF, the CSC has no legislative power, and in some ways its work complements that of the DGCCRF. It compiles its cases on the basis of any information that could help to elucidate the causes, circumstances, etc. of the occurrence of an accident and the means of preventing it in the future. It issues opinions, which do not have executive force, but which provide irreplaceable information for improving safety and accident prevention.

#### **How the RAPEX system works in partner countries**

The countries that are partners in the present project (Austria, Belgium, Denmark, Portugal, Sweden) have been able to provide a detailed description of the types of organisations and responses that each of them uses to ensure consumer safety relating to the use of products, in accordance with European directives, and notably by means of the RAPEX system. Annex III provides details about these different situations, in the minutes of the meeting held in Paris on 23-23 October 2003.

First of all, these exchanges have made it possible to appreciate the diversity of how these administrative procedures are organised in the different countries in order to comply with the requirements of the European Directives. What also emerged was the degree of consensus, based on the fact that question about consumer safety had to be answered. This is a field which has made progress in Europe, based on the existence of texts (Directives), and on the fact that practice and methods are fairly advanced, at least in the five countries that are partners of France in this project.

However, beyond this, some unexpected facts also emerged from these exchanges, and from the analysis of the situations in France and in the other countries that were partners in this project. The way some of the cases reported to the DGSP were processed did not allow sufficiently for the influence of behaviour or other usage-related components in addition to the «product» itself. In this respect, the procedures did not anticipate much recourse to epidemiological studies. In the context of a response that had to be «rapid», or even immediate, there is not always any place for longer studies or those involving anything more than simply collecting readily available information. Indeed, some questions are not answered by the current notification system and/or by the procedures for handling them. Furthermore, all the experts confirmed that some reports of home and leisure accidents could not be included in the current framework for reporting stipulated by the DGSP, simply because the DGSP does not allow them to be included (no serious or immediate danger, no product involved, etc.).



## **The existing rapid alert systems – health-oriented component**

As we have already pointed out, many health sectors have set up alert systems. This is true not only in the obvious the field of infectious diseases, but also in other areas, such as health threats linked to the environment, alerts linked to bio-terrorist threats and others.

The ability to issue an alert, or more generally, to take into account threats to health is a subject of explicit concern to the European Union. The decision of 23 September 2002 to adopt a programme of community action in the field of public health (2003-2008) [6] distinguishes between three «pillars», three levels of intervention, and the second of these pillars is to be able to respond to threats to health. In this sense, even though the present project, which was accepted by DG SANCO as part of the IPP programme that depends on the programme of action for 1999-2003 [5] was a trail blazer, we can view it as being fully part of the second pillar of the 2003-2008 programme, even though this programme does not explicitly mention home and leisure accidents as potential subjects for alerts.

The value for this project, of these studies which sometimes date back quite some way, is that the methods, procedures, and skills are often quite advanced in these areas, and we can draw on them directly when considering how to set up an alert system for home and leisure accidents. This paragraph should therefore be seen in this light.

### **Infectious diseases**

**It is above all infectious diseases** that come to mind when health alerts are mentioned. Among the recent documents published just before the European Centre for Epidemiological Surveillance was set up in Stockholm, we can mention the conclusions of the feasibility study «An EU rapid response mechanism and capacity for threats to public health» [16]. Within France, many documents stipulate the definitions and procedures to be implemented if a notification is made that could lead to an alert in the field of infectious diseases; see for instance [17, 18].

The community network for the surveillance of transmissible diseases was set up in 1999 (decision 2119/98/EEC), and it is based on an early warning and reaction system (EWRS, Early Warning Reaction System) that has been operational since January 2000. This system has the task of alerting the public health authorities of the States that are members and the Commission that foci of infectious diseases are present that go beyond the national scale and that are likely to call for coordinated action at the level of the Community. Depending on the situation, the Commission and the Member States agree what measures are appropriate and whether to implement them in an individual or combined manner. The EWRS system is a telematic system of liaison between the competent authorities of the Member States and the Commission. It provides an immediate exchange of views with regard to assessing the risks and how best to handle them, which is crucial for taking the proper steps to protect public health.

The events to be notified as part of the early warning and reaction network are as follows:

- Outbreaks of transmissible diseases extending to more than one Member State of the Community
- The concentration in space or time of diseases, if similar pathogens are a possible cause of the phenomenon and if there is a risk that it could be propagated between Member States within the Community
- The concentration in space or time of cases of similar diseases outside the Community, if pathogens are a possible cause of the phenomenon and if there is a risk of propagation in the Community
- The appearance or recurrence of a transmissible disease or of an infective agent that could require coordinated community action at the appropriate time to bring it under control.

The procedures of information, consultation and cooperation are activated at various different levels:

**- First level of activation: exchange of information**

When the information gathered in one or more Member State or from other authorized sources suggests that an event is likely, the competent authority responsible for protecting public health in each Member State without delay informs, via the intermediary of the network, the corresponding authorities and the Commission about the circumstances and background. As soon as this information has been received the competent authorities of the Member States concerned indicate whether they consider that other Member States should implement measures or whether coordinated community actions are called for with the assistance of the Commission. The Commission and the Member States concerned ensure that there is a permanent and rapid exchange of the information that they receive and keep the other Member States informed. The competent health authorities of the Member State(s) concerned immediately carry out a joint assessment of the information obtained with the bodies and/or authorities in order to confirm whether there is an event that constitutes a threat to public health. The Commission can decide to call an extraordinary meeting of the network committee or the experts appointed to ensure the transparency and effectiveness of any steps taken

**- Second level of activation: potential threat**

Verification and assessment in order to find out whether the threat to public health is real or probable, technical assistance is provided for any further investigation in the Member States, in the form of epidemiological expertise in the field, laboratory facilities, and other types of expertise, in particular of a clinical nature. The Community can provide this assistance on condition that the Member State concerned asks for it. If the final assessment of the risk concludes that there is no threat to public health, and that no action is called for or that only a local action is called for, the health authorities of each of the Member States involved immediately inform their European counterparts and the Commission of the nature and scope of the measures that it/they have taken or intend to take. If other Member States or the Commission do not formulate any objections within a period of three days, no further action is required from the early warning and reaction alert system (deactivation).

**- Third level of activation: confirmed threat**

Coordination of the measures taken: if an event is confirmed as being a threat to public health, the competent health authorities of the Member States concerned inform the other Member States and the Commission without delay about the progress made and the outcome of the measures taken. The Member States and the Commission coordinate any further measures to

be taken at the Community level. The Commission supports the Member States to coordinate their efforts to cope with the threat to public health and to ensure the protection of the population. The system is deactivated after agreement has been obtained from the Member States concerned, who inform the other Member States and the Commission.

**- Information intended for the general public and the professions concerned**

If an event occurs, the Member States promptly make appropriate information available to the professionals concerned and to the general public, and inform them about the measures taken. The Commission and the Member States inform the professionals concerned and the general public about any steps that have been agreed at Community level and inform them immediately the threat to public health is over.

## **Clusters**

Outside the field of infectious diseases, we should mention the «Guidelines for Investigating Clusters of Health Events» published by the MMWR (Morbidity and Mortality Weekly Report) in 1990, which mentions injuries as being within its remit in addition to chronic diseases and problems during childbirth [19]. An interesting thesis written in Quebec («Protocole d'investigation des agrégats de nature non infectieuse» [20]), proposes steps to be taken to investigate clusters of a non-infectious nature. These studies were revised and applied very concretely in 2000-2002 to analyse a cluster of cancers in a school in the Paris area of France [21, 22].

The methodology proposed for investigating clusters of a non-infectious nature in [20] is described for an environmental exposure. It starts with a step to confirm that there is indeed a cluster, i.e. an unusually great number of occurrences of a health problem in a defined space/time.

**- Step 1: To assess the complaint**

At the end of this step, it will be possible to find out whether there is a problem that leads to the suspicion that there is a cluster or undue environmental exposure. This objective could be achieved rapidly, depending on the nature of the information gathered. This step is often easy and can easily be carried out by a small public health team.

a) To receive the notification and collect the basic information. The public health authorities must anticipate a mechanism for receiving and assessing any reports of clusters of diseases that could have a negative impact on public health. This mechanism will make it possible to collect information in a uniform manner.

b) Provide the follow-up with the person who has made the report.

c) Establish a definition of the cases. The cases must be checked one by one and subsequently a definition provided that is as accurate as possible and based on the symptoms of the illness. The localisation of the cases, their demographic characteristics and the period of time involved are all essential aspects in the assessment of cases. It will then be possible find out whether they are indeed similar cases or different; and if they are similar, to state how many cases have occurred.

d) To carry out a summary investigation of the environment. Often the population already has an idea about the suspected environmental exposure. An attempt must be made to find out whether the effects experienced are subjective or objective. Is the exposure occupational, domestic, local, regional, new or long-standing? Does it involve a new source of pollution or a

long-established one that people are perceiving as harmful to health? Are there any environmental surveillance data readily available? What is the value of the information obtained about the suspect exposure?

e) To collect and analyse all the pertinent facts. Examination of the data should make it possible to find out whether there are enough cases to lead to a suspicion that there is a cluster or that an environmental exposure is assumed to have harmful effects for health.

Conclusion of the step: at the end of this first step, criteria have to be applied to decide whether to continue or to discontinue the process. These criteria concern:

- the rarity of the event
- the nature of the exposure
- the specificity and the severity of the problem
- the suspicion of any excess
- the concern amongst the population
- the potential effects of inaction if nothing is done
- the political pressure

If the decision taken is to stop the process, then a report must be written and the person who originally reported the information to tell him/her what the public health authorities have concluded.

If the decision is to continue the process, then we go on to step 2.

### **- Step 2: To validate the cases and the environmental exposure**

After a quick analysis, the first step having shown that there could be a problem involving a cluster of unacceptable environmental contamination of the population, what has to be done is to check the data in detail to find out whether, after scrutinizing the data, the conclusion is reached that there is a problem requiring further investigation. There is therefore a reasonable doubt that must be checked. The purpose of this step is to go further, and provide more evidence of the suspected cluster or environmental exposure that has repercussions on health so as to be able to formulate a hypothesis.

a) Validate the cases: identify the files to be consulted; ensure confidentiality; check the files; analyse the cases using appropriate statistical methods.

b) Validate the environmental exposure: to identify the types of contaminants emitted by the suspected source; to identify the population exposed and the route and period of exposure; to specify the environmental surveillance; review the literature.

c) Assess the epidemiological and environmental data obtained.

After this step, there should already be some epidemiological and environmental observations. If there is an excess and this can be logically accounted for, the investigation can stop. If it cannot be explained, it may be necessary to go on to the next step.

d) Consult the «advisory Committee», which, in the context of public health, makes it possible to obtain the opinions of different people who may be implicated in different ways in the problem. This also makes it possible to envisage problems that have not been suspected and are not always of a scientific nature. This is not therefore a scientific committee made up entirely of experts.

Conclusion of the step: some criteria are used before going onto the next step. After reviewing the criteria of the first step, further criteria are added. These concern:

- the likelihood of a large cluster
- a well-documented exposure
- a population facing significant exposure

- the plausibility of the exposure-symptoms link.

### **Step 3: Detailed survey**

The epidemiological objective of this step is to make sure that the hypothesis of the supposed cluster stands up to a rigorous analysis of all the cases investigated. From the environmental standpoint, it is necessary to assess the impact on health and decide whether there is a possible link between the cluster and the suspected environmental cause.

a) To confirm the excess by an exhaustive search for cases and to analyse them: constitute a research team; review the definition of cases; devise a strategy for identifying all cases; obtain comparative data; carry out statistical analyses; compile a questionnaire and analyse the cases.

b) Determine the extent of the link between the effect and the hypothetical agent: once the population most at risk (the people facing greatest exposure) has been identified, answers must be obtained to the following questions: will the population concerned accept the biological assessment? Will it be possible to assess the health effects? Can one assume the degree of the link between the effect on health and the hypothetical agent?

Until it is possible to answer this question, if it is clear that the exposure is really harmful, the necessary measures must be taken to ensure that the population is not exposed to contaminants that could have a serious effect on health.

Conclusion of the step: the data analysis could make it possible to answer several questions:

- is there a cluster?
- even if there is no confirmed cluster, does the number of cases justify a prospective investigation?
- has some rare exposure been found to be common to most of the cases?
- is the suspected environmental exposure linked to the suspected cluster and could it be harmful for the health of citizens?

If the answer to all these questions is negative, then the epidemiological and environmental aspects of the survey are finished. If we decide to go further, there are two possible avenues to pursue: institute targeted surveillance or carry out a more detailed study.

### **End of the investigation**

At the end of the investigation, it is necessary: to write a report, have it validated and communicate the findings to the public by the appropriate means.

## **Other aspects of alert systems**

Other approaches to alert systems have emerged recently, in the USA after the terrorist attacks of 9-11, from the angle: what information should be collected and «kept up on one's sleeve» ready to use when a serious event threatening the health of the population occurs, and which may be an event of which the origin, scope, frequency or signs may all be entirely unknown – and which could, for instance, be linked to a terrorist attack. Quite a volume of literature has been published on this topic since 2001.

Nearer to home, reflection of this type took place in France after the heat-wave of the summer of 2003, which led to nearly 15,000 deaths over a few weeks, mainly amongst the elderly. A strategy for issuing an alert based on «urgent data with little specificity» (DPSU) was

developed, which is based on the data for the workload of the emergency services that are not designed to make it easy to identify «atypical features» in the workload that could correspond to the phenomenon we are looking for [23, 24]. In this case, which differs from the notifications described in the foregoing paragraphs are the methods of reporting the «atypical» event: the observation of an unusual change, according to criteria established in advance. The subsequent procedure varies somewhat: the report must be checked and validated, and its significance determined and, if appropriate, an alert report is launched, investigations carried out, and the information circulated, etc.

The sources of inspiration for this report include the wide-scale reflection that was started in 2004 by the Institut de Veille Sanitaire, which was intended to boost the coherence of the health alert systems in France, and in particular to decide how responsibilities would be shared at the local, regional and national levels [25].

# Developing and testing a pilot tool

## Conditions for introducing an alert system

### Objectives, definitions, procedures, organisation

The European Alert System on Injuries (EASI or SAViC) should contribute to the safety of citizens and the protection of their health.

It is intended to prevent home and leisure accidents that have been notified as «atypical». This characteristic resides in the fact that the accident is new, more serious or more frequent, and that these characteristics are real or perceived to be real. An atypical accident in this sense is likely to be reported in an appropriate database. These accidents may be genuinely new, for instance accidents linked to a new sport. However accidents that were already known may also be notified because they have become more common over a short period of time, or the identification of behaviour patterns that trigger them or of groups in which they occur more frequently, etc.

Cases can be collected in various manners, including on an *ad hoc* basis from reports obtained from health-care professionals, from the public, who have access to the notification channels: telephone, fax, Internet. The case of home and leisure accidents does not differ in any way from other fields involving notifications and alerts.

This notification is circulated to people whose work makes them the right people to deal with the situation, i.e. to implement the scheduled procedures of verification, confirmation, investigation, information, etc. common to all alert systems. A Committee of experts EASI/SAViC should therefore be set up. The experts could be chosen by a consensus at the national level with the assistance of scientific correspondents within the IPN network (*Injury Prevention Network*). They must be able to respond to notifications received from other Member States, and to circulate these notifications within their own country.

The steps of the procedure for managing a notification could be based on those used in other fields. There is some parallel between the steps involved in managing a notification at the national level and at that of the European Union. The switch to a real «alert » will doubtless remain a rather unusual event within Europe, to judge from the few cases in the RAPEX system (a few cases per year). In addition, there is currently no administrative framework at the European level for an alert of this type (whereas such a framework does exist for RAPEX).

The following series of steps can be proposed:

**Step 1: Notifications of the case (or cases) in a Member State**

- Receive the notification.
- => Has the notification received been validated?

**Step 2: Validation of the notification within the Member State**

- Validate the case or cases
- Determine the seriousness of the accident that has occurred
- Decide what can be done
- React within the Member State
- Circulate the information within the EU via the SAViC/EASI Committee of experts.
- => Is there any need for further investigations within the Member State or within the EU?

**Step 3: Compiling the file corresponding to the notification at the EU level**

- Identify any similar cases within the EU on the basis of the available databases
- Search of the literature
- Circulate the findings throughout the EU via the SAViC/EASI Committee of experts
- Reaction at the EU level.
- => Is there any need for an *ad hoc* study?

**Step 4: Performance of an ad hoc study**

- Setting up an ad hoc study
- Monitoring of the ad hoc study
- Conclusions of the ad hoc study
- Reaction at EU level.

This procedure can be adapted to suit the conditions under which it is being implemented and the categories of accidents. It includes informing the representatives of the RAPEX system, at the national level of the State within which the initial case was reported. The addresses of the «useful» correspondents and those to be informed within each of the Member States involved in the system would have to be available.

The following main «criteria for notification» can be proposed:

- a large number of accidents occur within a short period of time, or the cumulative impact of a small number of recurring accidents over a longer period of time
- the severity of the accidents
- the novelty of the type of accident
- the frequency with which consumers are exposed to the same circumstances
- the clear identification of a specific circumstance/product/behaviour
- a considerable increase in the occurrence of a known type of accident in specific circumstances and/or within specific populations.

These criteria can be cumulative. They are neither necessary nor sufficient, and a qualitative assessment is also called for. They may be applied to a given situation, and a given time and place or, on the contrary, used to monitor any differences related to time or geographical location. They include the criteria taken into account in the context of compliance with the Directive concerning the general safety of products (DGSP, see for example [26]).



These criteria can be proposed to the people or bodies able to circulate a notification and can also be used by experts responsible for confirming and validating the notification transmitted to them.

The notifications can be generated by individuals, whether professionally involved in health or not, or from public- or private-sector groups or associations. The systematic use of existing databases in the case of home and leisure accidents can also generate notifications. In October 2003, Denmark (see Annex III) applied processing procedures for application to routinely-collected data, to compare the results for different periods and to deduce whether there have been any atypical features concerning the frequency, or seriousness, etc. of the accidents, or the socio-demographic characteristics of the people involved in the accidents. A procedure has been developed in the context of this project to identify accidents that in one way or another can be viewed as being atypical from the EPAC database (Enquête permanente sur les accidents de la vie courante [27, 28], the French contribution to the IDB system [5]). Similar studies can be carried out using the national databases of other countries, either to report new cases or to document cases reported elsewhere in Europe. The cases reported to the EASI system between June and October 2004 via the test website (see the following paragraphs and Annex V), included three trampoline accidents (in Denmark, Sweden and France). An analysis of the trampoline accident included in the EPAC database made it possible to provide further details about these accidents (Annex VI).

## Setting up a test website

It has been shown above that the conditions under which unexpected or atypical home and leisure accidents occur have not been subjected to any analysis, at least if the presence or use of a product was not in the forefront of the accident. We do not even know the basic facts about these accidents (description, frequency, location). There is therefore clearly a need to set up an appropriate system for these situations, in order to provide ourselves with the means to prevent these «new accidents», in the sense specified above. It is also necessary that such a system, which is similar to the notification and alert systems that exist in other areas of health care, can both interact with the existing systems for RAPEX-type accidents, and also be flexible to set up and use.

These arguments in favour of flexibility of use and access have led people to envisage the use of a specific website. This lay behind the development of an HLA alert test website in the context of this project. This module had the following aims:

- to provide a short description of the aims and the context of the project
- to provide the basic definitions of the EASI system
- to provide examples of possible notifications
- to provide the procedure that would make it possible to report a case in the context of the test procedure
- to provide a website where the notifications received can be consulted.

There are two versions of the module: one is in French and the other in English. It is accessible at the following address: <http://www.dsi.univ-paris5.fr/AcVC/>. It can also be accessed by going to the InVS website: <http://www.invs.sante.fr>, and then clicking on «surveillance», and then on «accidents de la vie courante».

The content of the website is shown in Annex IV. It consists of: a home page «Setting up a rapid reaction mechanism in the field of injury prevention: a pilot study – Test phase», and several modules:

- Aims and context
- The problem
- Other definitions concerning the EASI system (European Alert System on Injuries)
- Examples of situations that have led to accidents that could be notified
- Notifications.

In the Notifications module, instructions are given on how to make a notification: complete the EASI notification form (European Alert System on Injuries), in Word format, and send it to the Project Manager. The form will be integrated into the other forms, if necessary after being completed. The trial period of this test site lasted for five months, from June to October 2004.

The notification form is shown in Annex IV. It is very simple and consists of 3 sections:

1 – One section concerning the characteristics of the accident: the period or date when the «atypical» accident that gave rise to the notification occurred; description of the product involved; the number of cases during the period; other factors involved; activity at the time of the accident; location of the accident; mechanism underlying the accident and its consequences; the contribution, if any, of behaviour in producing the accident; other information about the lesion, the part of the body injured, any particular features that make this accident atypical, the social profile of the people involved.

2 – What the person making the notification thinks it would be appropriate to do after this accident, in the form of multiple-choice questions: set up an investigation; look for similar accidents that have happened recently or in the vicinity, or elsewhere; set up an epidemiological study of this type of accident; inform health professionals, the health authorities, other authorities, the press and the media, the general public etc. that this accident has happened.

3 – The contact details of the person making the notification

In practical terms, each of the partners at the European and French level, has been able to report a few cases of accidents, that they considered atypical, between June and October 2004, by sending this completed form to the InVS.

## Cases notified: number, nature, proposed follow-up

### Number of accidents notified during the test

In the five months between June and October 2004, 31 cases of home and leisure accidents were reported by the partners involved in the project: Austria: cases 1 and 2; Belgium: cases 3 to 7; Denmark 8 to 11; Portugal: 12 to 16; Sweden: 17, 18; France: 19 to 31 (InVS 19 to 25, DGCCRF: 26 and 27, CSC: 28 to 30, hôpital Necker in Paris: 31). The corresponding forms are included in Annex V. The list of the names given to these accidents, decided by the person making the notification, is as follows:

- 1 - Gasoline bottle
- 2 - Paraglider
- 3 - Beetroot
- 4 - Horses
- 5 - Tractor
- 6 - Tram rail
- 7 - Cuistax
- 8 - Fall
- 9 - Electrical appliances
- 10 - Trampoline
- 11 - Correction fluid
- 12 - Fish: *Trachinus draco* (Greater weever)
- 13 - Sea medusas
- 14 - Glass doors
- 15 - Mixers
- 16 - Baby walkers
- 17 - Snowblade bindings
- 18 - Trampoline
- 19 - Go-Kart
- 20 - Piercing ring
- 21 - Basketball
- 22 - Trampoline
- 23 - Bee and wasp stings
- 24 - Allergy to artemisia
- 25 - Choked by hair (*cheveu étrangleur*)
- 26 - Lens effect
- 27 - Body - Fly
- 28 - Aquarium heating system
- 29 - Nappy-changing table
- 30 - Snow escalator
- 31 - Falling through a window

Thirty-one notifications may seem to be rather a lot, given that they were collected over a short period of time, that a small number of bodies were asked to provide cases and that cases were reported on a voluntary basis. Trampoline accidents were reported three times in three different

countries, which has led us to carry out an analysis of these accidents in the EPAC database (see Annex VI). One or more products were often involved in these accidents. In all the cases, the notification reported multiple components at the origin of the accident. The most interesting analyses that can be carried out on the basis of these notifications are, on the one hand, the reasons for which they were considered to be sufficiently atypical to have to be reported and, on the other, the suggestions of «what to do » made by the people making the notification.

## **Characterisation of the atypical nature: why was the accident notified?**

Classification of notifications:

- based on the reported or potential seriousness (serious sequelae: death, sequelae, hospitalisation, in particular amongst vulnerable people):
  - o forms: 1, 5, 6, 8, 9, 15, 17, 19, 23, 25, 26, 27, 28, 29, 30, 31
- based on the reported and/or assumed frequency:
  - o forms 10+18+22, 14, 16, 17, 21, 23, 24, 31
- based on its novelty (accident never, rarely or insufficiently often reported previously, unexpected, occurring to people who are not protected or were unaware of the danger):
  - o forms 2, 3, 4, 5, 6, 7, 11, 15, 17, 19, 20, 25, 26, 27, 28, 29, 30
- based on an increase of a previously known phenomenon:
  - o forms 12, 13, 15, 23, 24, 31.

The distinctions made above are subjective, they result mainly from the information provided in the notification forms. They also depend on the country where the accident occurred, in which the situation of knowledge about the accident notified may differ from that in other countries. For example, accidents with baby-walkers (form 16) notified by Portugal have led in recent years to a warning in France from the Commission for Consumer Safety. As such, they would not therefore have led to a notification in France unless, for example, their number had increased suddenly. In contrast, the fact that these accidents have been studied in France may contribute to preventing them in Portugal. This is something useful that the EASI network can do, by simply circulating information.

The novelty of the cases is often a reason for their being notified. This implies that the accidents in question are rare, or at least that they have so far remained sufficiently unnoticed to appear to be «new». The notification and circulation of information at the level of the European Union contribute directly to the first recognition of the importance of these accidents. Examples: before this test, it would be difficult to imagine finding three accidents linked to a trampoline. One fatal piercing accident was recorded in France in 2004 (piercing followed by septicaemia and then by death): piercing may be becoming a risky activity? From a quantitative standpoint, the notifications via the EASI network provide the beginnings of a reply. Another example: in the early years of the 21st century in France, two people did bungee jumps under very special conditions, since they shared an elastic tether intended for a single person. The outcome was one dead and one survivor with very serious injuries. Did this accident, which was mainly attributable to the irresponsible behaviour of the people involved,

have any precedent? A notification network could have answered this question at the European level.

Many previously known accidents have undergone a considerable and/or unexpected increase. This could result from environmental or climatic changes or from changes in behaviour. Forms 12 (jelly fish), 13 (fish), 23 (wasp/bee stings), 24 (allergy to artemisia) correspond to injuries caused by animals or plants, and their numbers and aggressiveness towards human beings vary from one year to another. There was a particularly large number of wasp/bee stings in 2004 in France; it was suggested that this was a delayed outcome of the heatwave during the summer of 2003: there were more hornets and wasps in 2004 because the preceding summer had been very hot. It would have been easier to test this hypothesis if information about the number of stings in 2004 had been available from surrounding countries.

## **What to do after a notification has been made?**

The suggestions of what to do after accidents notified in the context of the test can be divided into the following categories:

- 1 – Set up a detailed investigation of this accident
- 2 – Look for similar accidents that have occurred recently in the vicinity
- 3 - Look for similar accidents that have occurred recently elsewhere
- 4 – Carry out a search of the literature for this type of accident
- 5 – Set up a specific epidemiological study of this type of accident
- 6 – Circulate the information that this accident has occurred to:
  - 1 – Health professionals
  - 2 – The health authorities
  - 3 – Other public authorities
  - 4 - The press and the media
  - 5 - The general public
  - 6 – Others (give details)
- 7 - Autres suggestions.

The results are summarized in the table below, in which the last two types of answers have been combined under the heading «Other information», with the following notes.

Note 1 (form 4: horse): inform the owner of the horse.

Note 2 (form 18: trampoline, Sweden): inform trampoline retailers.

Note 3 (form 19: go-kart): investigate the seriousness of karting accidents.

Note 4 (form 24: allergy to artemisia): warn people who know that they are allergic to artemisia

Note 5 (form 25: *cheveu étrangleur* - choked by hair?): inform midwives and maternity units

Note 6 (form 28: aquarium heating system): inform the authorities in charge of regulations and standards; inform shops selling aquaria.

Note 7 (form 29: nappy-changing tables): inform the manufacturers and distributors; schedule a modification of the product.

Note 8 (form 31: falling out of a window): inform the health professionals and local elected representatives; introduce regulations and standards for these windows.

**SAVIC/EASI System - Test: 31 accidents June - October 2004**  
**What do you think should be done now that this accident has been reported?**

Form n°	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
Country	A	A	B	B	B	B	B	DK	DK	DK	DK	P	P	P	P	P	S	S	F	F	F	F	F	F	F	F	F	F	F	F	F	31	
Proposed actions:																																	
1 - investigation of the accident									X	X				X													X	X		X	X	X	8
2 – search for similar, recent accidents occurring in the vicinity			X			X	X				X	X	X				X						X								X		9
3 - search for similar, recent accidents occurring elsewhere			X		X	X	X	X	X	X	X						X			X			X			X	X			X	X	15	
4 – search of the literature																		X		X	X	X	X	X		X	X	X		X	X	11	
5 – set up an epidemiological study														X	X				X		X							X	X	X	X	8	
<b>6 – inform:</b>																																	
1: health professionals					X								X										X	X	X					X		6	
2: the health authorities																			X			X	X						X	X	5		
3: other authorities			X				X													X		X	X							X		6	
4: the press and media					X			X	X	X		X			X		X	X	X			X	X	X			X	X		X		14	
5: the general public			X	X	X	X			X	X							X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	18
<b>Other information or actions (see notes)</b>																		2		3					4	5		6	7	8	8		

Other details:

Form 17 (snowblades): a specific action was undertaken in 2004 concerning way snowblade accidents are classified and then coded in Denmark. This means that it will now be possible to identify and investigate these accidents in the IDB entries from Denmark in 2005.

Form 23 (wasp/bee skins): the French health authorities compiled and released a press communiqué on 20 August 2004, when the numbers of stings increased. A summary was written in the first half of 2005 [29].

Form 24 (allergy to artemisia): as in the previous case, an investigation led to a report on allergies to artemisia and to a press release from the French health authorities [30].

Form 31 (falling out of a window): the specific investigation of exfenestrations, requested after the notification in Summer 2004, is currently being carried out in the Paris region for 2005 by the InVS and the hôpital Necker.

Overall, what could be termed the «first level of investigation» is specified in one half of cases: carry out a search of the literature based on the case reported (requested in 11 cases) and try to find out whether similar accidents have occurred elsewhere (15 cases) or in proximity (9 cases). An investigation of the accident was suggested in 8 cases, as well as the more onerous procedure of setting up an epidemiological study.

Information of the general public was requested in 18 cases, and that of the media in 14 (these two items overlap). Information of specific groups was requested: health authorities, other authorities, health professionals.

This small number of cases cannot claim to describe what «should» or even «can» be done in operating an accident alert system for home and leisure accidents when the gateway is less via the product than via a type of behaviour. However, it is remarkable that so many cases were reported over so short a time. There are certainly considerable differences between countries with regard to culture, and progress in understanding accidents, and in the role the health authorities are likely to play in this field. There are also a lot of points in common: «atypical» accidents of the same type, seriousness and scope occur in several countries simultaneously (consequence of common lifestyles and behaviour patterns throughout Europe?). There is a remarkable similarity between approaches and reaction. From the standpoint of the central theme of this project, there was absolutely no doubt, in view of the way this test proceeded and its findings, that there is a gap waiting for an accident alert system for home and leisure accidents, which is flexible involving both the Internet and a scientific approach, even before the legislation, which must be developed, actually appears.





# Conclusions

## Room for an accident alert system

Home and leisure accidents are numerous in all the countries of the European Union ; they are often avoidable and sometimes serious. They occur under very varied circumstances and during very varied activities, mirroring the range of activities that characterise life itself. Most of these accidents change little over time, their risk factors are stable, their prevention can be organised over the long-term. However, living conditions that are constantly changing lead to «new» accidents, linked to hitherto unknown products, activities, or behaviour patterns, or ones that were previously uncommon and which one day start to become common. The fact that more attention is paid to accidents today than in the past also leads to greater awareness and a better perception of their extent: without actually changing in number or seriousness, some accidents can also seem to be «new» in this sense.

The alert systems that exist to date (RAPEX type) are firmly established in the countries of the European Union. They are based on European Directives and national legislation, undertaken with the general objective of consumer protection and safety with regard to the products that they may use. This «product-based» approach is valuable and indispensable. It may not be the only pertinent approach: accidents that occur while a product is being used may be due (to a limited extent, considerably or even exclusively) to behaviour, to the way the product is used, rather than to the product itself. It always involves protecting the «consumer», but the perspective changes when it is the circumstances that predominate in triggering the accident, and not the product itself. Furthermore, some accidents can also occur without any product being used (when behaviour alone is involved, for instance in some types of sport).

Whereas consumer protection tends to focus on improving products (with the aim of preventing future accidents), there is obviously room for an approach that focuses on discovering the causes that lead to accidents, both the products and circumstances in the widest sense, to prevent their occurrence. This more global perspective is the same as that used in prevention in the field of public health.

When «new» accidents occur it is therefore appropriate to introduce a «notification and alert system», like those that exist in the field of health. This concern, which is more common in the fields of infectious disease, the environment or of bioterrorism, has not really been developed at the European level so far, even though it does form part of «the second pillar» of the European public health programme for 2003-2008. The work done in the context of this project has shown that in many countries this concern already exists, and there have been attempts to find solutions: how can we organise the notification of accidents that are «atypical» in one way or another, how can we organise ourselves in order to follow up their management through to the end, what strategy of information, investigation, etc. should be implemented until an actual alert is issued?

## The bases of an accident alert system: EASI

The available information about health alerts has been used as the basis of this work: the same definitions of terms (notification, alert, etc.) that need to be adopted for home and leisure accidents; the existing procedures for use in the context of an alert corresponding to an infectious disease, or to an environmental cause, suspected clusters, etc. have been drawn upon and transposed into the context of this project.

The reflection has taken into account the existence of the RAPIEX alert procedures: another alert system for accidents can only be envisaged as an add-on to this system.

A primarily concrete and practical approach has been adopted, in order to yield simple proposals, based on national experience in the countries involved in the project.

The characteristics of «atypical» accidents that can in principle lead to a notification, have been described qualitatively.

The main «criteria for notifications» that have been proposed are as follows:

- a large number of accidents occurring within a short period of time or the cumulative impact of a small number of recurring accidents over a longer period of time
- the seriousness of the accidents
- the novelty of a given type of accident
- the frequency with which consumers are exposed to the same circumstances
- the clear identification of a specific circumstance/product/behaviour
- a considerable increase in the incidence of a known type of accident in specific circumstances and/or within specific populations.

These criteria may be cumulative. They are neither necessary nor sufficient, and a qualitative assessment is also called for. They may be applied to a given situation, and a given time and place or, on the contrary, used to monitor any trends related to time or geographical location.

A very simple approach has been adopted as the basis for the response to the cases reported:

Step 1: Notification of the case (or cases) in a member State

- Reception of the notification

=> Is the notification valid?

Step 2: Validation of the notification at the level of the Member State;

- Validate the case(s)

- Determine the seriousness of the accident that has occurred

- Determine the ability to react

- React within the Member State

- Circulate the information within the EU via the SAViC/EASI Committee of experts.

- o Is there any need for further investigations within the Member State or within the EU

Step 3: Compiling the notification report at EU level:

- Search for similar cases in the EU in the databases available; search of the literature;

- Circulate the findings within the EU; via the SAViC/EASI Committee of experts

- Reaction at EU level.

- o Is there any need for a complementary ad hoc study?

#### Step 4: Performance of an ad hoc study

- Setting up an ad hoc study
- Follow-up of the ad hoc study
- Conclusions of the ad hoc study
- Reaction at EU level.

A test website was up and running for five months between the partners involved in the project. This EASI system (European Alert System on Injuries) or SAViC (*System européen d'Alert sur les accidents de la Vie Courante*), has made it possible to validate the above options, and to introduce the kernel of the practice and organisation of how to manage the cases notified. It has also provided an initial idea of how many notifications can be expected: 31 cases of atypical accidents, within five months, during this test limited to the partners involved in the project in five Member States. With the participation of all the Member States and publicity about the fact that the system exists targeted on all potential partners, we can expect considerably more than 100 notifications per annum as a minimum baseline.

The nature of the atypical nature at the origin of the notification was as follows:

Classification of notifications:

- based on the reported or potential seriousness (serious sequelae such as death, sequelae, hospitalisation, in particular in vulnerable people): 16 reports (more than one half of the cases)
- based on the reported and/or assumed frequency: 10 reports (including three of the same type of accident)
- based on its novelty (accident never, rarely or insufficiently often reported previously, unexpected, occurring to people who are not protected or unaware of the danger: 17 reports (more than one half of the cases)
- based on an increase in a previously known phenomenon: 6 reports.

This subjective classification is based mainly on the information included on the notification forms. It also depends on the country where the accident was reported, and in which the situation of what is known about the accident reported may be different from that in other countries. The novelty of the cases is often the reason for their notification. This means that the accidents in question are rare, or at least that they have hitherto remained sufficiently unnoticed to appear to be «new». The notification and the circulation of information at EU level contribute directly to an initial recognition of the importance of these accidents. Many accidents that were already known have undergone major and/or unexpected increases. They may depend on environmental or climatic changes or changes in behaviour.

The «suggestions for action» after accidents notified in the test fall into the following categories:

- a «first level of investigation» was specified in half the cases: carrying out a search of the literature based on the case notified (requested in 11 cases) and trying to find out whether similar accidents have occurred elsewhere (15 times) or in the vicinity (9 cases).
- An investigation of the accident was suggested 8 times; as well as the onerous measure of setting up an epidemiological study.
- Informing the general public was requested in 18 cases, and informing the media 14 times (these two items overlap). Informing specific groups (health authorities, other authorities, health professionals) was also requested.

It is remarkable that so many cases were reported in so short a time. There were far more common points than national differences in the «alert» approaches. The similarities of the approaches and reactions are very remarkable. **These is no doubt, following the performance of this test and the results obtained, that there is an unsatisfied need for a home and leisure accident alert system, and it should be developed using this flexible approach: using the Internet, combined with a scientific approach, without waiting for legislation to be introduced.**

## **Proposals for the introduction of EASI on a routine basis**

The practicalities of introducing EASI on a routine basis are quite straightforward:

- Constitute a group of scientific experts on a voluntary basis. The only condition for allowing these experts to take part in the alert system is that they must be recognized professionals in their own countries.
- Adopt the procedure for making notifications, validation and management of notifications
- Update the address list of possible correspondents in each country who could contribute to validating the notifications or the scientific information to be made available to the general public or health professionals. These may be scientists involved in public health or epidemiology (as at the InVS in France); administrators involved in consumer protection (such as the DGCRF or the CSC in France); professions responsible for prevention in the public or private sectors. The bodies involved vary from country to country. The experts of the IPN injury prevention network could be used for this task.
- Organise a full-scale test in the European Union in 2005 and 2006, using the current teams supported by the DG SANCO, based on the same principles as the test carried out in this study: notifications via Internet, scientific approach, initial validation at national level, etc., The current teams (InVS, Pystel) could start this work with support from DG SANCO.
- In the context of this test, institute a schedule for how often the notifications should be consulted and dealt with (once a day?), and also for sharing information about how the test is progressing (a teleconference every three months?).
- Draw the conclusions from this first generalisation in 2006. Compile the final specifications for routine introduction in the EU, using appropriate methods, from 2007.

**Home and leisure accidents are a major public health problem. In the future it will become increasingly unacceptable for people to die or become seriously disabled as the result of an avoidable accident. These concerns are shared by all the countries within the European Union. Setting up the SAViC/EASI notification and alert system described here will contribute to protecting people, by making «atypical» accidents better understood with regard to their novelty, their frequency, their seriousness, or the trends in the circumstances under which they happen. The European dimension is particularly valuable in this system, because they are often unusual events. Setting up ways of responding to these new accidents will make it possible to avoid them or to reduce their seriousness. Using the IDB database to identify the cases to be notified and to validate the cases notified could be particularly useful and would work in tandem with the implementation of EASI.**

# Appendices



# Appendix I

## Acronyms, abbreviations, definitions

AcVC :	accident de la vie courante
AFFSA :	Agence française de sécurité sanitaire des aliments
CDC :	Centre de Droit de la Consommation
CSC :	Commission de la sécurité des consommateurs
DDCCRF :	Direction départementale de la consommation, de la concurrence et de la répression des fraudes
DGCCRF :	Direction générale de la consommation, de la concurrence et de la répression des fraudes
DG SANCO :	Direction Générale Santé et Protection du Consommateur
DGSP :	Directive relative à la sécurité générale des produits
DPSU :	Données peu spécifiques d'urgence
<i>EASI:</i>	<i>European Alert System on Injuries</i>
<i>Ehlass:</i>	<i>European Home and Leisure Surveillance Accident System</i>
EPAC :	Enquête Permanente sur les Accidents de la vie Courante
<i>EWRS:</i>	<i>Early Warning Reaction System</i>
<i>GICP:</i>	<i>General Inspectorate for Consumer Protection (Hongrie)</i>
<i>GPSD :</i>	<i>General Product Safety Directive</i>
<i>HLA:</i>	<i>Home and Leisure Accident</i>
<i>ICECI:</i>	<i>International Classification of External Causes of Injuries</i>
<i>IDB:</i>	<i>Injury Data Base</i>
InVS :	Institut de veille sanitaire
<i>IPN:</i>	<i>Injury Prevention Network</i>
<i>IPP:</i>	<i>Injury Prevention Programme (Programme de prévention des blessures)</i>
<i>ISS:</i>	<i>Injury Surveillance System (Système de surveillance des traumatismes)</i>
LNE :	Laboratoire national d'essais
<i>MMWR:</i>	<i>Morbidity and Mortality Weekly Report</i>
<i>NIPH :</i>	<i>National Institute of Public Health (Danemark)</i>
OMS :	Organisation mondiale de la santé
<i>PROSAFE:</i>	<i>product safety enforcement forum for Europe.</i>
<i>RAPEX:</i>	<i>Rapid Exchange of Information on Dangers Arising from the Use of Dangerous Products</i>
SAViC :	Système européen d'Alerte sur les accidents de la Vie Courante
SI :	Système d'Information
<i>TRAPEX:</i>	<i>Transitional Rapid Exchange of Information on Dangers Arising from the Use of Dangerous Products</i>
UE :	Union européenne
<i>WHO:</i>	<i>World Health Organization</i>

### Pays européens :

Autriche : A ; Belgique : B ; Allemagne : D ; Danemark : DK ; Espagne : E ; France : F ; Grèce : EL ; Luxembourg : L ; Pays-Bas : NL ; Portugal : P ; Suède : S

# Some definitions

(inspirées de [17])

**Alerte** : toute information faisant état d'une possible menace (danger ou risque) pour la santé publique pouvant nécessiter une réponse ou une action de la part des destinataires avec un degré d'urgence éventuellement précisé. Elle peut correspondre à une situation d'exposition à un agent (danger) ou de survenue de cas (cas groupés ou épidémies) ou d'événements de santé inhabituels (létalité levée, formes inhabituelles, ...)

La distinction entre signal et alerte est nécessaire dans un objectif de gestion et de hiérarchisation de l'information disponible.

Un **signal** est une information qui peut révéler une situation d'alerte mais dont le niveau de précision est insuffisant pour porter un jugement sur la réalité de la menace. Un signal nécessite d'être validé, confirmé, complété ou simplement noté lors d'une phase exploratoire. Suite à cette phase exploratoire, le signal pourra être transformé en alerte, donner lieu à une surveillance pour détecter d'autres signaux similaires, être simplement noté ou être infirmé car il correspond à un « faux positif ». Le passage du signal à l'alerte nécessite un jugement qui est porté sur des faits documentés après une phase d'expertise.

**L'alerte** correspond à une situation pour laquelle un jugement a été porté, suite à une expertise sur le fait que l'évènement ayant fait l'objet du signal menace potentiellement la santé publique. Il est possible de passer directement à l'alerte si le signal est suffisamment explicite (exemple : franchissement d'un seuil, nombreux cas confirmés, ...).

**Cluster** (ou **agrégat**) : regroupement temporo-spatial de cas d'une maladie sans que l'on puisse juger du caractère anormal par rapport à l'incidence moyenne.

**Cas groupés** : regroupement temporo-spatial d'une maladie ou d'un syndrome jugé comme supérieur à ce que l'on attend (*outbreak* des anglo-saxons).

**Epidémie** : situation de cas groupés d'une ampleur plus importante (touchant par exemple une région ou l'ensemble du territoire). Le terme d'épidémie est le plus souvent employé dans le domaine infectieux.

**Investigation** : mise en oeuvre d'une étude spécifique dont le but le plus souvent de permettre l'identification des mesures de contrôle et de prévention les mieux adaptées. Elle fait suite à l'analyse du signal (du signalement) qui a permis de conclure qu'il y avait une situation d'alerte. L'investigation est le plus souvent multidisciplinaire et nécessite une coordination de partenaires multiples. Il pourra s'agir d'une analyse de risque (définition du danger, évaluation de l'exposition et des risques de diffusion, ...) ou d'une expertise (synthèse des connaissances pour proposer des options de gestion aux décideurs).



# Appendix II

## List of partners

Institut de veille sanitaire (France)  
Bertrand Thélot, Marianne Perez, Emmanuelle Szego

Institut Sicher Leben (Autriche)  
Robert Bauer, Mathilde Sector

EDUCA-SANTE (Belgique)  
Alain Lévêque, Martine Bantuelle

National Institute of Public Health (Danemark)  
Bjarne Laursen, Birthe Frimodt-Möller

Instituto Nacional de Saude (Portugal)  
Baltazar Nunes, Joao Brandao

Swedish Consumer Agency (Suède)  
Henrik Nordin, Stig Hakansson

Psytel (France)  
Marc Nectoux

Commission de la sécurité des consommateurs (France)  
Françoise Briand

Direction générale de la consommation, de la concurrence et de la répression des fraudes (France)  
Aline Peyronnet, Yannick Bailbled

## Timetable of tasks

### **Etape 1 : Analyse des mécanismes d’alerte rapide existants**

- **Mise en place en avril 2003 de l’équipe de travail et de la répartition des travaux :**
  - INSTITUT SICHER LEBEN - Autriche
  - EDUCA-SANTE – Belgique
  - NATIONAL INSTITUTE OF PUBLIC HEALTH - Danemark
  - MINISTERIO DA SAUDE - INSTITUTO NACIONAL DE SAUDE - Portugal
  - SWEDISH CONSUMER INSTITUTE - Suède
  - PSYTEL - France
  - Commission de la sécurité des consommateurs (CSC) - France
  - Direction générale de la consommation, de la concurrence et de la Répression des Fraudes (DGCCRF) – France

- Avril 2003 : Prise de connaissance du contexte de l'étude et des objectifs.
- Avril 2003 : Organisation du projet : calendrier, tâches, acteurs et jours-hommes. Envoi des contrats de partenariat.
- Mai - Juin 2003 : Etude documentaire et bibliographique sur les systèmes d'alerte en France.
- Juin 2003 : Prise de contact avec les responsables de ces systèmes pour des compléments d'information.
- Juin – Juillet 2003 : Etude documentaire et bibliographique sur les systèmes d'alerte européens. Contacts par mail avec les équipes européennes.

## **Etape 2 : Analyse des fonctionnalités complémentaires nécessaires au nouveau système**

- Juin 2003 : projet de plan pour le rapport intermédiaire.
- 02/07/2003 : réunion à la DGCCRF. Rédaction du CR et des éléments de réflexion.
- 04/07/2003 : réunion à la CSC. Rédaction du CR et des éléments de réflexion.
- 15 et 16/07/2003 : participation à la réunion de l'IPP Network. Présentation du projet.
- 24/07/2003 : rédaction du document : « Réflexion sur le fonctionnement du système d'alerte SIRAC (Système d'Information et de Réaction aux Accidents de la vie Courante) ».
- Août 2003 : rédaction du projet d'agenda pour le meeting du 23 et 24 Octobre 2003 à Paris.
- Septembre/octobre 2003 : Préparation du meeting de Paris. Documents à envoyer, rédaction de documents spécifiques et de transparents PowerPoint, organisation de la réunion.
- 16/09/2003 : rédaction du document « Exemples de cas pouvant faire l'objet d'une alerte SIRAC ».
- 15/10/2003 : réunion à la DGCCRF. Rédaction du CR.
- 16/10/2003 : rédaction du document « Position du problème ».
- **Réunion des 23 et 24 octobre 2003 à Paris. Voir programme en annexe.**
- Fin octobre 2003 : rédaction du rapport intermédiaire destiné à la Commission.

### **➔ Remise du rapport intermédiaire à la Commission (31 octobre 2003)**

- Début novembre 2003 : rédaction des minutes du meeting de Paris.
- 11 et 12/12/2003 : participation à la réunion du « Working Party Injuries » à Luxembourg.

## **Etape 3 : Développement d'un outil pilote**

- Février 2004 : étude de cas pour le système d'alerte à partir du texte libre EPAC 2002.
- Février 2004 : rédaction du projet de fiche simplifiée de signalement.
- Février 2004 : rédaction du document : « Définitions complémentaires pour EASI (European Alert System for Injuries) ».
- Mars 2004 : développement et mise en place de la partie Internet de l'Alerte rapide « EASI » sur le site AcVC de l'InVS (Contexte, Problématique, Définitions, Exemples de cas, Critères de signalement, Fiche de signalement). Validation le 2 avril 2004.
- Avril 2004 : préparation et participation au meeting de Luxembourg les 28 et 29 avril 2004 « Working Party on Accidents Injuries ».
- Mai 2004 : correction du site Internet, mise en place du site en français et en anglais.

## **Etape 4 : Test et évaluation de l'outil pilote**

- **04/06/2004 : sites SAViC / EASI disponibles pour le signalement des cas – Envoi du mail d'ouverture aux partenaires du projet.**
- Juin 2004 : mise au point d'une procédure de recherche de cas à signaler dans les fichiers EPAC à partir du texte libre.
- 01/07/2004 : document « Procédure de recherche de cas à signaler dans les fichiers EPAC 2004 à partir du texte libre » (avec les fichiers correspondants).
- 20/07/2004 : version améliorée du document précédent incluant les critères de fréquence et de gravité (dont décès) et une sortie du dictionnaire en tableau Excel.
- Juillet 2004 : mise en ligne des fiches de signalement de cas SAViC (DK et F).
- Août 2004 : relance des partenaires européens du projet pour fourniture des signalements.
- Septembre 2004 : relance et chargements des nouvelles fiches de signalement.
- 07/10/2004 : dictionnaire + vecteurs de faits établis à partir du texte libre des nouveaux fichiers EPAC 2004 (15 fichiers) avec le fichier Excel correspondant pour trouver de nouveaux cas de signalement.
- Octobre 2004 : Relance pour de nouvelles fiches de signalement, préparation de la réunion téléphonique du 10 novembre (Voir les fiches de signalement en Annexe).
- Novembre 2004 : Etude approfondie d'un signalement : les accidents de trampoline. Document « Eléments pour le traitement d'un signalement dans EASI : les accidents de trampoline ».
- **10/11/2004 : réunion téléphonique avec les partenaires européens et Psytel pour la finalisation des positions sur l'organisation du système de réaction rapide, et le bilan de mise en place de l'outil pilote.**

## **Etape 5 : Rapport final**

- 30/11/2004 : Remise du rapport d'activité de Psytel à l'InVS.
- décembre 2004 – mai 2005 : rédaction du rapport final du projet.

### **➔ Remise du rapport final à la Commission (31 mai 2005)**

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#### **Réunions de suivi de projet de l'équipe française à l'InVS (généralement le mercredi matin tous les 15 jours) avec :**

B. Thélot – InVS et M. Nectoux – Psytel pour toutes les réunions,  
M. Pérez - InVS, E. Szego - Psytel, M. Darlot - Psytel pour certaines d'entre elles.

**➔ pour l'année 2003 :** 23/04, 07/05, 21/05, 04/06, 18/06, 02/07, 09/07, 24/07, 07/08, 03/09, 11/09, 17/09, 26/09, 09/10, 16/10, 29/10 (Tél.), 20/11 (Tél.)

**➔ pour l'année 2004 :** 07/01, 21/01, 04/02, 25/02, 10/03, 24/03, 02/04, 26/04, 13/05, 02/06, 14/06, 28/06, 06/07, 21/07, 20/08, 08/09, 07/10, 10/11, 29/11, 15/12



# Appendix III

## Meeting on 23-24 October 2003

### Schedule

**Project « 2002/IPP - Rapid alert »**  
**“Establishing a rapid response mechanism within the Injury prevention programme : a pilot study”**

### First Meeting

Paris, 23<sup>rd</sup> and 24<sup>th</sup> of October 2003

Location : Vacassy, Room ED-1

Institut de Veille Sanitaire

### Agenda

#### 23<sup>rd</sup> of October 2003

- 12h 30      Welcome  
*Bertrand Thélot - InVS*  
Lunch in CESES Room
- 14h00 - 14h30 Presentation of the InVS  
*Bertrand Thélot - InVS*
- 14h30 - 15h15 Project Status  
*Marianne Perez - InVS*  
- Team  
- Overview of the project  
- Timetable  
- Tasks  
- Review of the literature  
- The present state of affairs  
Discussion: *All participants*
- 15h15-16h30 Alert Systems for Consumer Products in France  
*Yannick Bailbled - DGCCRF*
- 16h30 – 18h    Alert systems in each EU partner country  
Presentation by country: *Each partner*
- 20h            Suggested dinner: Aux Tables de la Fontaine 2 r . des Trois Bornes – 75011 Paris

#### 24<sup>th</sup> of October 2003

- 9h30            Summary of the previous day  
*Marianne Perez - InVS*
- 9h45 – 10h30 Alert system in each EU partner country (continued)  
Presentation by country : *Each partner*

- 10h30 – 11h Alert systems in other areas  
Public health area: Cluster, infectious diseases  
Other areas: Environmental, heat wave  
*Bertrand Thélot –InVS*
- 11h - 12h30 Discussion about a possible alert system for HLIs  
*All participants*  
- Case studies  
- Possible alert mechanism  
- Technical aspect for test  
- Running a test
- 12h30 - 14h Lunch in the Salle des Plâtres
- 14h - 15h Structure of the final report  
*Marc Nectoux – Psytel*
- 15h - 15h30 Next steps of the project  
*Bertrand Thélot – InVS*
- 15h30 - 16h Any other business  
**Conclusions**

If you have any questions, please contact: Marianne Perez – InVS – m.perez@invs.sante.fr  
Tel : +33 1 55 12 53 20

### List of participants

Name	Institute	Country
Bjarne Laursen	National Institute of Public Health (Denemark)	DK
Baltazar Nunes	Ministerio da Saude (Portugal)	P
Robert Bauer	Institute Sicher Leben (Austria)	A
Henrik Nordin	Swedish Consumer Agency (Sweden)	S
Alain Levêque	Educa-Santé (Belgium)	B
Francoise Briand	Commission de Sécurité des Consommateurs	F
Aline Peyronnet	DGCCRF	F
Yannick Bailbled	DGCCRF	F
Bertrand Thélot	Institut de Veille Sanitaire	F
Marianne Perez	Institut de Veille Sanitaire	F
Emmanuelle Szego	Psytel	F
Marc Nectoux	Psytel	F



**Project « 2002/IPP - Rapid alert »**  
**“Establishing a rapid response mechanism within the Injury prevention programme : a pilot study”**

**First Meeting**

Paris, 23<sup>rd</sup> and 24<sup>th</sup> of October 2003

Location : Vacassy, Room ED-1

Institut de Veille Sanitaire

**Minutes – 07.01.2004**

**Participants:**

Alain Levêque (AL): EducaSanté, Belgium  
Aline Peyronnet (AP): DGCCRF, France  
Bjarne Laursen (BL): National Institute of Public Health, Denmark  
Baltazar Nunes (BN): ONSA, Portugal  
Bertrand Thélot (BT): InVS, France  
Emmanuelle Szego (ES): PSYTEL, France  
Henrik Nordin (HN): Swedish Consumer Agency, Sweden  
Marc Nectoux (MN): PSYTEL, France  
Marianne Perez (MP): InVS, France  
Robert Bauer (RB): Sicher Leben, Austria

BT welcomes the participants to the meeting and gives a brief overview of the Institut de Veille Sanitaire (InVS) and its functioning.

**Rules of the meeting**

Because of the multinational and multilingual character of this project, BT emphasizes the necessity of taking the time to make sure that all the participants understand what is said both linguistically (use of interpreters) and in terms of the project content.

**Goals of the project**

**Aim**

To establish the characteristics of an alert mechanism in the field of injuries which is related to and complements existing alert systems which are more “product-oriented.”

**Preliminary remarks**

Is there a place for an alert system for injuries?

RB states that at the very least EHLASS data can be used to document signals, even if it is not an alert system. RAPEX offers a good system (covers 99% of cases), but only for injuries in which the main responsibility lies on the product.

BN comments that while all emergency departments in Portugal participating in the EHLASS programme are asked to report strange or exceptional cases of injuries to ONSA, not a single report has been filed until now, despite the fact that they know from other sources that there have been such cases (ex.: women getting their hair caught in mixers and being scalped).

BL explains that in Denmark there is already an accident signalling system in which data on products, locations and age groups are crossed to see if there is an increase in frequency of certain cases. This data crossing is done once a year and information is distributed publicly.

HN cautions that he has a different point of view as he works for a consumer agency which uses EHLASS data, but is not responsible for collecting it. He notes that in Sweden the data is nearly exhaustive.

### **Alert systems in partner countries**

#### **Portugal**

Like in all European countries, Portugal has the product-oriented system of RAPEX which is coordinated by the Consumer Directorate.

However, Portugal has SARA (*Sistema de Alerta e Resposta Adequada*—alert system and appropriate reaction) which is a computer information system coordinated by the General Directorate of Health. Once it is completely operational, it will comprise of 300 public health regional agencies. SARA will allow for early detection of cases leading to rapid control and acquisition and dissemination of knowledge. Within SARA there is a subsystem for detection of SARS and meningitis.

In parallel, there is a general practitioner sentinel surveillance system for influenza detection which must submit weekly reports to ONSA of influenza-like symptoms among their patients.

Furthermore, Portugal has put in place a Heat Wave Surveillance System which consolidates data from the meteorology centre and ONSA and then sends information through SARA and the National Service of Civil Protection. This system runs from mid-May to the end of September every year.

#### **Austria**

Austria also has a functioning RAPEX system which issues little information on injuries. It would be favourable, however, to use EHLASS data for an injury alert system. RB reminds the participants that as of January 1, 2004 the DG SANCO's main directives will deal not only with products, but also with services, thus enlarging their sphere of influence.

#### **Belgium**

AL describes the RAPEX system in Belgium, noting that it is fraught with inter-regional and inter-communal administrative problems. There are no other systems in Belgium related to injury alerts. In other fields, there exist ozone pollution, food safety, and infectious disease alert systems.

#### **Denmark**

The functioning of RAPEX in Denmark works the same way as in most other countries. There is also a food safety alert system which catalogues 1500 signals per year, very few of which are confirmed.

Denmark has a registry of infectious diseases which has been in operation since the 17<sup>th</sup> century. There is a list of diseases which all doctors must (and do) report on and the results are published in a weekly news bulletin.

Other alert systems that exist in Denmark: resistant bacteria (DANMAP), new drug early warning system, nuclear accidents, bio terrorism and air pollution.

#### **Sweden**

HN states that he had trouble contacting experts on injury alert systems, as the Swedish Consumer Agency focuses on products and administers RAPEX. HN gives an example of a case in which RAPEX could be used to detect or alert on potential injuries and accidents. There was a defective pram on the market whose handles broke. Two cases were reported in which the handles broke while the parent was going down stairs with the pram. In one case the baby in the pram was slightly injured and in the other not at all.



## **Consumer alert system in France**

AP presented the role of the DGCCRF (Directorate General for consumption, competition and the suppression of fraud). The DGCCRF acts in the fields of competition (in which there is little demand) and consumption, specifically on food and other products and services.

She notes that they have quite a bit of power because their actions can lead to judicial proceedings and legal measures. Furthermore, it is an agency that has been around for a long time and is well known by the public. The DGCCRF has had alert systems for many years, but they were only formalized in 1999.

Definition of an alert: information whose absence could have a negative impact on the health or safety of the population.

Sources of signals: RAPEX, consumer complaints, consumer associations, professionals (companies), police departments, Consumer Safety Commission (CSC), regional administrations, media.

Procedure: as soon as signal arrives, a file is begun. Background check to make sure that if measures need to be taken, they already have been, or will be. Summary evaluation of the risk (is it real? serious? reproducible?), dissemination of the information.

Question: Are measures actually taken?

More and more are taken preventively by companies. If a company's action is insufficient, only then does DGCCRF intervene. Can lead to additional labelling, legal proceedings, banning import of product, taking product off market, product recall and information to consumers or destruction of product.

Advantages in France: centralized state, food and non-food alert systems, legal measures allow for action.

Weaknesses: DGCCRF doesn't want to be first in line of responsibility, coordination by different administrations, procedure can very quickly become judicial which leads to difficulty in obtaining or distributing information, sometimes excessive measures are suggested.

Example: the CSC noted that there are drownings of children who are left alone in bath seats and bath rings. CSC wants these products removed from the market. But DGCCRF notes that there are also drownings of children left alone in bath tubs without seats or rings. Behaviour more to blame than product. Problem is that consumers think that seats and rings are secure products, so their attitude leads to more risky behaviour. Measures suggested by DGCCRF: more information, better labelling, but not banning product.

## **Discussion**

AL: What is the point of putting in place an injury alert system? For signalling? EHLASS already can be used for signalling and to do retrospective studies. Perhaps new system would react more quickly, but would need surveillance team 24 hours a day, 7 days a week.

RB: Need to specify areas of interest and not try to alert on everything. Need to increase severity. Maybe system needs to be extended to all injuries (i.e. include violence and not just HLIs).

AP: DGCCRF's system works for purely product cases in which there is a lead signal phase, an alert phase and a measures-taken phase. For cases which are not purely product oriented, after the alert phase nothing really happens and the case falls off the radar.

MN: With EHLASS, very precise coding of injuries and products involved in injuries not possible.

AP: Qualitative information is necessary. Often there are false signals or information which is not precise.

AL: Injuries are not/ should not be the only point of entry into alert system. In HN's pram example, the handle could have broken and not resulted in an injury the first two times, but the case still ought to be signalled. There ought to be a way to take into account circumstances without them having necessarily resulted in an injury.

MN: Examples of injuries involving non-manufactured goods: increase in dog bites noted, but no place to report the information, same with increase in collisions between snow-boarders and skiers. Causes of injury related to activity, environment, quantity or behaviour, not equipment/ product.

AL: Still has doubts about injury alert system. What are the priorities for public health? For dog bites and bicycle accidents, we already have well documented information. No point in collecting more epidemiological data. Lack of political will. Instead governments ought to subsidize bicycle helmets to help prevent bike injuries. But can EHLASS identify new problems? Would like to have data from other countries available so as to be able to pressure/ lobby own government.

MN: Need to sensitize EHLASS coding teams

HN: It is essential to try to develop EHLASS as an alert system, considering it is expected to function as such. Making use of EHLASS would reinforce idea at the European and national levels that the system is necessary.

## **Conclusion**

### **Main points**

The majority of participants agree that there is a place for a specific development in HLI signalling: developing procedures, reactive capacities, use of routine data collection and available results, putting in place specific data collection. AL, however, underlines the difficulties of putting this in place in some countries, i.e. Belgium, because it is not perceived as a public health priority.

The following seem necessary for the proper functioning of such a system :

- Clearly define the magnitude of its potential action and its relationship to RAPEX
- Ensure better statistical use of data in view of an injury alert system. Some atypical cases ought to be visualised through quantitative abnormalities (more injuries, more severe, more concentrated period of time, etc.). Some cases ought to be visualised through qualitative abnormalities (one particular case of injury never previously identified, or in never previously recognized circumstances).
- Put in place a light and flexible operating procedure which is not taxing in terms of workload and can be taken on by existing teams
- Maximize the use of the data collected through ISS and availability in the IDB
- Develop an automated statistical tool (such as data mining), like the ones in DK and in FR, which would be able to produce or validate alert signals.
- Take as an example the procedures and tools developed in the framework of the food alert systems
- Take into account the extension of the DG SANCO's directives to services, and not just products.
- Create a newsgroup on pilot website to post information on new injuries. Newsgroup could act as signalling centre. This could be proposed as a task of the EIPN secretariat

### **Work plan**

- By the end of February, we would like to have a complete collection of documents on the different types of alert systems in each partner country. We are soliciting each partner for more information.

- The partners are encouraged to forward any more information that may be gathered about alert systems within their own countries.

- In the coming months, the French team will propose a pilot tool for collecting signals potentially leading to an injury alert. The partners will then be asked to give feedback on the proposed signalling and alert system.

### **Next meeting**

We foresee a meeting in June or July 2004, after the Vienna conference on injuries and compatible with the various participants' constraints.

Attachments : Power point presentations on alert systems

# Appendix IV

## Content of the test accident alert website

Site accessible à l'adresse: <http://www.dsi.univ-paris5.fr/AcVC/>, ou en se connectant sur le site de l'InVS : <http://www.inves.sante.fr> ; puis cliquer sur surveillance, puis cliquer sur « accidents de la vie courante ».

*Ce site a été ouvert à la saisie de cas entre juin et octobre 2004.*

Etude pour la Commission européenne  
Direction Générale Santé et protection du consommateur (DG SANCO)

### Etablissement d'un mécanisme de réaction rapide dans le domaine de la prévention des blessures : une étude pilote

#### Phase test

- [Buts et contexte](#)
- [Problématique](#)
- [Définitions concernant le système SAViC \(Système d'alerte sur les Accidents de la Vie Courante\)](#)
- [Exemples de cas pouvant être signalés dans SAViC](#)
- [Comment signaler un cas : accédez à la fiche de signalement](#)
- [Signalements reçus](#)

**Ce projet est développé sous la responsabilité de l'Institut de veille sanitaire, Département des maladies chroniques et traumatismes :**

Bertrand Thélot  
Marianne Perez

**Ce projet a bénéficié de la collaboration de :**

Marc Nectoux - Psytel (France)  
Robert Bauer - Institut Sicher Leben (Autriche)  
Bjarne Laursen - National Institute of Public Health (Danemark)  
Alain Lévêque - Educa-Santé (Belgique)  
Henrik Nordin - Swedish Consumer Agency (Suède)  
Baltazar Nunes - Instituto da Saude (Portugal)  
Yannick Baillbled, Aline Peyronnet - DGCCRF (France)  
Françoise Briand - CSC (France)  
Emmanuelle Szego - Psytel (France)  
Jean-Pierre Darlot - Psytel (France)

Document mis à jour le 25 octobre 2004

## Buts et contexte

Chaque citoyen européen, au cours de sa vie, a été ou sera confronté à un accident de la vie courante. Les accidents de la vie courante représentent un risque majeur pour la santé humaine, bien que cela soit encore peu pris en compte dans les préoccupations de santé publique.

Les grandes tendances liées à ces accidents sont bien identifiées : les chutes constituent plus de 50% du total de ces accidents, les accidents les plus graves sont les brûlures, les enfants et les personnes âgées constituent les catégories les plus vulnérables.

Le coût et la charge sociale des accidents de la vie courante est considérable : coûts directs et indirects liés aux soins, prise en charge, séquelles, etc.

Chaque année de nouveaux types d'accidents, de nouvelles circonstances accidentelles apparaissent sans se préoccuper évidemment des frontières nationales. L'évolution rapide de l'environnement, l'accroissement des échanges humains et marchands, l'introduction constante, non seulement de nouveaux produits, mais aussi de nouveaux comportements et de nouvelles conduites induisent de nouveaux risques.

Cependant il n'y a pas de système européen spécifique qui donnerait la possibilité de signaler ces nouveaux accidents à l'ensemble des membres de la communauté des intervenants susceptibles de mettre en oeuvre les actions efficaces et pertinentes.

En effet l'identification précoce, le suivi et le contrôle des nouveaux types d'accidents sont un élément important d'une politique efficace de prévention.

La Direction Générale Santé et protection des consommateurs (DG SANCO) subventionne cette étude de faisabilité : " Etablissement d'un mécanisme de réaction rapide dans le domaine des blessures. "

Les objectifs de ce projet sont de répondre aux questions suivantes :

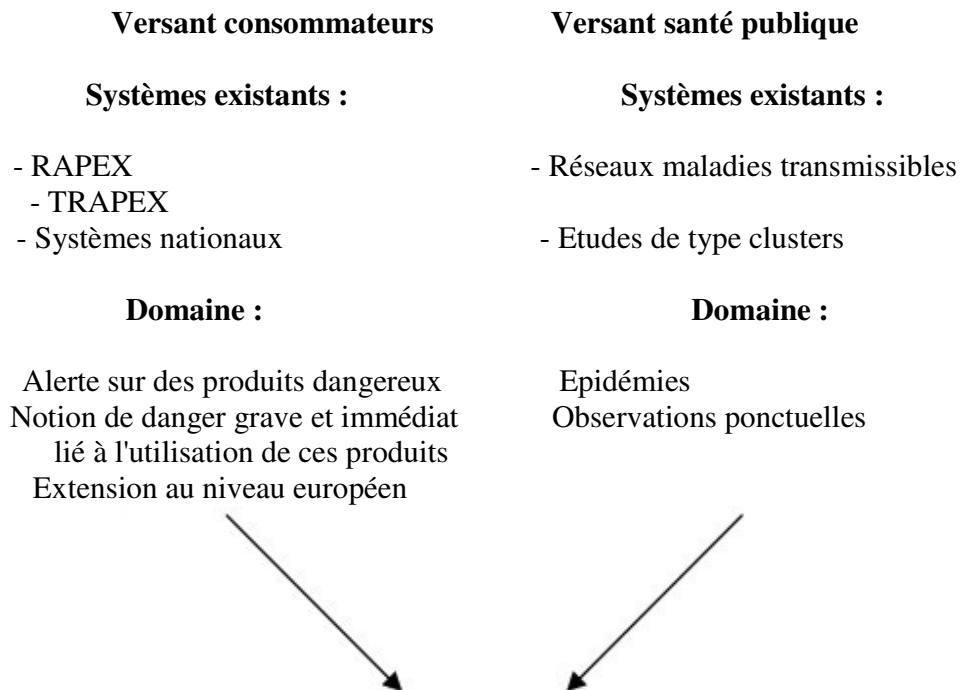
- Quels sont les systèmes d'alerte existants, essentiellement dans les domaines de la santé publique et de la protection des consommateurs en Europe ?
- Quels sont les types d'accidents récemment survenus qu'il aurait été utile de signaler dans un tel système ?
- Quelles sont les caractéristiques requises de mise en oeuvre d'un système d'alerte consacré aux nouveaux accidents de la vie courante ?
- Dans quelles conditions d'organisation et de coût ce système pourrait-il être mis en place ?
- En définitive, y a-t-il une place pour un réseau d'alerte dans le domaine des accidents de la vie courante en Europe ?

Pour étudier ce Système d'Alerte sur les Accidents de la Vie Courante en Europe (SAViC) (*European Alert System on home and leisure Injuries - EASI*), un outil de signalement, actuellement en phase de test (printemps 2004), est implanté sur ce site internet.

**Il est ouvert à toute personne désirant faire un signalement à partir de juin 2004.**

## Problématique

La problématique du projet " Etude pilote pur l'établissement d'un mécanisme d'alerte rapide dans le domaine de la prévention des blessures " est résumée dans le schéma suivant :



### Quelle place pour un système d'alerte rapide spécifique " accidents de la vie courante "

- définissant une " situation dangereuse " (produit x activité x lieu)
  - à partir d'un danger pas uniquement grave et immédiat
- critères fondés à la fois sur la sévérité, la fréquence et la singularité
  - approche ponctuelle par signalement
- approche quantitative par la base européenne Injury Database (IDB) ou d'autres bases de connaissances

### Une typologie des causes accidentelles contribue-t-elle de définir une place pour un système d'alerte spécifique ?

Si l'on veut caractériser les causes d'accidents, on peut distinguer les accidents où sont directement impliqués :

- des produits (manufacturés ou non),
- des comportements de consommateurs
- des causes environnementales (ex : coups de chaleur)
- des activités (ex : sports)
- La grande majorité des accidents de la vie courante (AcVC) est liée à l'utilisation d'un produit (4 fois sur 5). Toutefois il est relativement rare que le produit soit **seul** en cause dans la

survenue de l'accident (moins de 1 fois sur 5). Interviennent le plus souvent les manières d'utiliser les produits, les comportements, etc.

- Par ailleurs les accidents directement liés à l'activité représentent près du tiers des causes principales d'accident . L'activité sportive est à l'origine d'accidents (1 fois sur 6), qu'elle soit pratiquée à l'école ou non (football, rugby, judo, basket, etc.). Dans les autres activités générant des accidents, on trouve le bricolage, les jeux et loisirs et les autres activités domestiques.

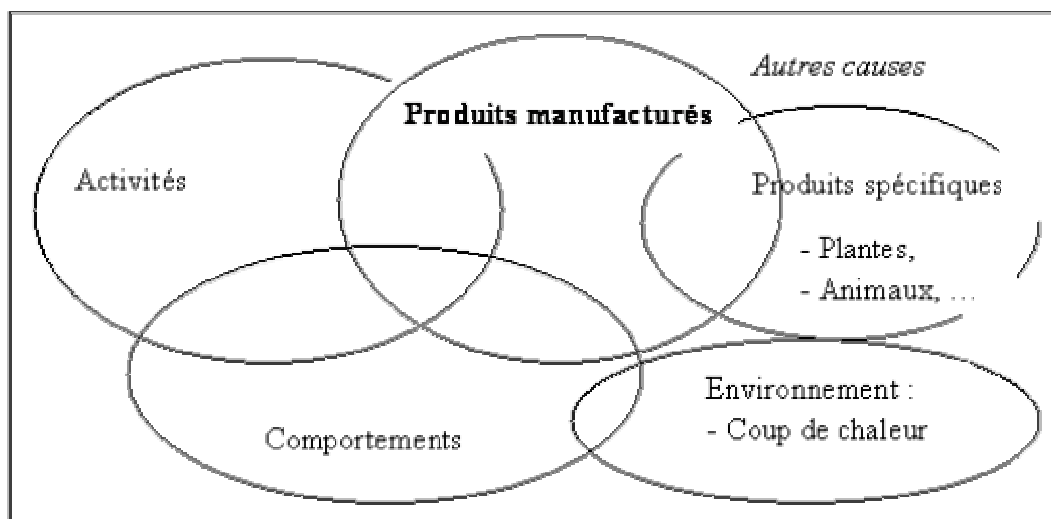
- La cause de l'accident est souvent multifactorielle et peut relever d'un processus complexe. L'expérience montre qu'il y a une forte imbrication des différentes causes, notamment en ce qui concerne les causes comportementales et les produits : c'est souvent la manière dont un consommateur utilise un produit qui se révèle dangereuse plus que le produit lui-même.

- Dans la typologie ci-dessous, les systèmes d'alerte orientés " produits " concernent surtout les produits manufacturés et alimentaires et, accessoirement, les comportements. Ils laissent hors du champ de l'alerte, les produits ni manufacturés ni alimentaires, les causes liées aux activités et les causes environnementales, c'est-à-dire une bonne partie des causes d'accidents.

**-> L'hypothèse est retenue qu'il existe un manque dans les systèmes d'alerte existants et donc une place pour un système d'alerte spécifique orienté " AcVC ". Cette hypothèse est examinée et développée au cours du projet.**

### Causes des accidents

Signalement SAViC possible pour des causes d'accidents se situant dans les zones entourées du schéma hors produits manufacturés :



## **Définitions complémentaires concernant le système SAViC (Système d'alerte pour les Accidents de la Vie Courante)**

### **- Objectif :**

Contribuer à la sécurité des citoyens et à la protection de leur santé par la mise en place d'un système européen d'information et de réaction sur les situations dangereuses de la vie courante (SAViC).

### **- Ce que ne sera pas le SAViC :**

- Un réseau concurrent du système européen RAPEX.
- Un réseau doté d'une autorité administrative propre.
- Un réseau impliquant des ressources humaines et techniques considérables.

### **- Ce que serait le SAViC :**

- Un système de signalement nourri par le réseau européen des experts sur les traumatismes.
- Un réseau complémentaire de RAPEX.
- Un système " léger ", constitué de :
  - carnets d'adresses, d'experts
  - un site Internet de test et dans l'avenir une articulation possible avec le site de la Commission Européenne
- Des générateurs d'informations : les services d'urgences des hôpitaux (réseau EPAC en France), les membres du Réseau de Prévention des Blessures, les autres intervenants d'urgences : médecins de ville, sécurité civile, associations, particuliers...
- Des analyseurs du signalement : un sous-groupe d'experts chargé de répondre avec niveau de réactivité à définir (en heures / en jours).
- Une procédure à mettre en œuvre suivant le nombre de signalements et pouvant aller jusqu'à la mise en place d'études spécifiques (collection de cas, analyse leur validité scientifique).

### **- Les critères de signalement d'un cas dans SAViC :**

- **Effectif** : nombre important de cas de traumatisme sur une courte période ou effet cumulé d'un nombre faible mais répétitif de traumatismes sur une période plus longue
- **ou/et gravité** des traumatismes considérés
- **ou/et nouveauté** du type de traumatisme
- **ou/et augmentation importante** d'un type connu de traumatismes
- **ou/et type d'AcVC** faisant l'objet d'une attention particulière du moment (" air du temps ")
- **dans tous les cas : identification suffisamment claire de la cause accidentelle (circonstance/produit/comportement/activité/lieu) pour déterminer qu'elle appartient au champ du système SAViC.**

## Exemples de situation ayant entraîné des accidents pouvant faire l'objet d'un signalement

### Accidents mettant en jeu des activités et/ou des comportements particuliers :

**Football :** Dans un hôpital donné, accumulation d'un nombre important d'accidents lors de matchs de football dans le cadre d'activités extra scolaires. Signalement lié à un comportement (violence scolaire / violence sportive) dans le cadre d'une activité.

**Collisions avec des pratiquants de roller :** Les codeurs constatent un nombre important d'accidents dus à des collisions entre piétons et pratiquants du roller.

**Accidents de chasse :** Signalement de l'augmentation du nombre d'accidents de chasse extrêmement graves.

**Imprégnation alcoolique :** Un centre de codage remarque un grand nombre d'accidents dus à l'imprégnation alcoolique et le signale dans le système.

**Cours de récréation :** Nombreuses chutes et contusions à la suite de bousculades dans les cours de récréation.

**Nouveaux sports :** Apparition de nombreux accidents liés à de nouvelles pratiques sportives ex : flysurf, windsurf, canyoning, bodyboard, etc.

### Accidents survenus en lien avec des produits non manufacturés et/ou des éléments environnementaux ou météorologiques :

**Morsures de chien :** Recrudescence des morsures dues à des races de chien en augmentation rapide et récente.

**Piqûre due à des méduses** dans une zone de baignade habituellement dépourvue de méduses.

**Allergies à une piqûre d'insecte :** Un centre signale une dizaine d'allergie à des piqûres de guêpe.

**Urticaires généralisés suite au contact avec une plante spécifique :** Un centre signale une dizaine d'urticaires liés au contact avec une plante.

**Indisposition due à l'ingestion d'eau de mer** lors d'une baignade (contamination par algues, polluants, autre...)

**Choc contre une gouttière** d'immeuble pourtant construite de manière réglementaire.

## Signalements

Pour un signalement SAViC (Système d'alerte sur les Accidents de la Vie Courante), remplir le document Word : [Fiche simplifiée de signalement SAViC](#), ci-dessous.

Renvoyer, en pièce jointe d'email, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

Période d'essai : à partir du 01/06/2004

Vous pouvez obtenir des informations sur les cas collectés sur le site Internet :

<http://invs.sante.fr>

Puis cliquer sur :

« surveillance », « accidents de la vie courante », « alerte rapide SAViC »



## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'email, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:b.thelot@invs.sante.fr) :  
b.thelot@invs.sante.fr

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) :
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :
  
- **Nombre de cas** durant cette période ou à cette date :
- **Autres éléments** en cause (environnement, météorologie, autre) :
  
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :
  
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :
  
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :
  
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

**Autres informations pertinentes :**

- Lésion :
- Partie lésée :
- Gravité :
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

# Appendix V

## Reporting cases via the SAViC / EASI test website

### Autriche

- 1 - *Gasoline bottle*
- 2 - *Paraglider*

### Belgique

- 3 - *Betterave*
- 4 - *Chevaux*
- 5 - *Tracteur*
- 6 - *Rail de tram*
- 7 - *Cuistax*

### Danemark

- 8 - *Chute*
- 9 - *Electric appliances*
- 10 - *Trampoline*
- 11 - *Correction fluid*

### Portugal

- 12 - *Fish : Trachinus draco (Greater weever)*
- 13 - *Sea medusas*
- 14 - *Glass doors*
- 15 - *Mixers*
- 16 - *Baby walkers*

### Suède

- 17 - *Snowblades bindings*
- 18 - *Trampoline*

### France

- 19 - *Kart*
- 20 - *Anneau de piercing*
- 21 - *Jeu de basket*
- 22 - *Trampoline*
- 23 - *Piqûres d'hyménoptères*
- 24 - *Allergie à l'ambroisie*
- 25 - *Cheveu étrangleur*
- 26 - *Effet loupe*
- 27 - *Body - Fly*
- 28 - *Chauffage pour aquarium*
- 29 - *Commode à langer*
- 30 - *Tapis roulant de neige*
- 31 - *Défenestration*

## **Rapid Alert Project - EASI**

### **Test phase**

Once filled, send this card by E-mail (as an attached document) to the project-leader: [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### **EASI card for signalling (v2)**

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### **Gasoline bottle**

- **Period or date** of occurrence (dd/mm/yyyy): 2003
- **Description of the involved product**, if any (manufactured or not):  
Gasoline bottle, match, open flame
- **Number of cases** during this period / date: 1 case in 2003 of an 8 year old boy , who burned his finger while playing with trying to light a candle with a match
- **Other involved elements** (environment, meteorology, etc.):
- **Activity**: What was doing the victim when the injury occurred? He was walking outside
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): Outside, near the garage
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.): Boy living next door playing with matches, threw a lighted match into the neighbour's garage, which caused the gasoline bottle outline to explode.
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around: neighbour boy is at fault, careless, did not realize the consequence of his action

**Other reliable information:**

- Lesions: multiple body parts burned
- Part of body injured:
- Severity:
- Other atypical elements:
- Social profile of the injured person(s):
- Other (specify): 82 days in the hospital

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The media:
  - The public:
  - Other (specify):

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you:**

Mathilde Sector, [mathilde.sector@sicherleben.at](mailto:mathilde.sector@sicherleben.at)

## **Rapid Alert Project - EASI**

### **Test phase**

Once filled, send this card by E-mail (as an attached document) to the project-leader: [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### **EASI card for signalling (v2)**

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

### **Paraglider**

- **Period or date** of occurrence (dd/mm/yyyy):
- **Description of the involved product**, if any (manufactured or not): Paraglider
- **Number of cases** during this period / date: 7 in 2003
- **Other involved elements** (environment, meteorology, etc.): in 2 cases the weather was the reason for the injury, otherwise due to not concentrating / stress / fatigue
- **Activity**: What was doing the victim when the injury occurred?  
Sport - paragliding
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): in the air, outdoors
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.): fall  
Fall from a big height – 2 cases by landing / 1 case the person tried to photograph his house from above and fell / 1 case by takeoff, etc.
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around:  
1 case a strong wind caused him to crash and fall

**Other reliable information:**

- Lesions: fracture in 6 cases, sprain in 1 case
- Part of body injured: ankle, elbow, lower spine, upper spine, pelvis, arm
- Severity: range, longest 21 days
- Other atypical elements: increasing number of paragliding in Austria
- Social profile of the injured person(s):
- Other (specify): 1 case female, 6 males, ages 20 to 50 (willing to take risks)

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The media:
  - The public:
  - Other (specify):

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you:**

Mathilde Sector, [mathilde.sector@sicherleben.at](mailto:mathilde.sector@sicherleben.at)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Betterave

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : octobre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) : betterave
- **Nombre de cas** durant cette période ou à cette date : 1
- **Autres éléments** en cause (environnement, météorologie, autre) : camion transportant des betteraves
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : piéton sur un trottoir
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : sur la voie publique
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : un betterave (+/- 1,5kg) est tombée d'un camion de transport et a percuté le membre supérieur gauche du piéton ; contusion importante du bras gauche
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : camion non couvert d'un filet de protection, virage.



**Autres informations pertinentes :**

- Lésion : contusion
- Partie lésée : bras gauche
- Gravité : modérée
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité : **X**
- Rechercher des accidents semblables survenus récemment en d'autres lieux : **X**
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques : **X**
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**  
[alain.leveque@ulb.ac.be](mailto:alain.leveque@ulb.ac.be)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Chevaux

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : mai 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :
  
- **Nombre de cas** durant cette période ou à cette date : 3
- **Autres éléments** en cause (environnement, météorologie, autre) : chevaux
  
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : nourrissaient les chevaux
  
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : dans les box à chevaux
  
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : adolescents pratiquant de l'équitation, mordus lors de l'entretien du cheval
  
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : nouveau cheval dans le cercle équestre ; comportements d'imprudence face à la méconnaissance de ce nouvel arrivé.

**Autres informations pertinentes :**

- Lésion : morsures superficielles
- Partie lésée : 1) bas du dos ; 2) main gauche ; 3) épaule
- Gravité : modérée
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public : x (qui fréquente le lieu)
  - Autre (préciser) : x (le propriétaire )

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**  
[alain.leveque@ulb.ac.be](mailto:alain.leveque@ulb.ac.be)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Tracteur

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : janvier 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) : prise de force motrice du tracteur
- **Nombre de cas** durant cette période ou à cette date : 1
- **Autres éléments** en cause (environnement, météorologie, autre) : la personne traumatisée portait un pantalon large
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : activités de bûcheronnage « amateur »
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : dans une coupe de bois (forêt)
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : la personne travaillait à l'arrière du tracteur et le pantalon a été happé par la prise de force motrice insuffisamment protégées.
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : non protection de la prise de force motrice ; port de vêtement inadaptés

**Autres informations pertinentes :**

- Lésion : rupture tendon d'achille, fracture cheville
- Partie lésée : cheville gauche
- Gravité : fracture et rupture ligamentaire
- Eléments singuliers qui rendent cet accident atypique : les professionnels utilisent du matériel sécurisé. Mais les « amateurs » et bricoleurs utilisent souvent du vieux matériel échappant à tout contrôle de sécurité.
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**  
[Alain.leveque@ulb.ac.be](mailto:Alain.leveque@ulb.ac.be)

## Projet Alerte Rapide - SAViC Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Rail de tram

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : été 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :
- **Nombre de cas** durant cette période ou à cette date : un seul connu
- **Autres éléments** en cause (environnement, météorologie, autre) : rail de tram
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : il roulait à vélo
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : sur la voie publique (mais sur site propre de tram et sans l'implication d'un tiers)
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : roue du vélo coincée dans les rails du tram, chute avec contusions et éraflures .
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : le fait d'emprunter le site propre d'un transport en commun avec les risques que cela comporte.

**Autres informations pertinentes :**

- Lésion : contusions multiples
- Partie lésée : membres sup et inf
- Gravité : modérée
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité : X
- Rechercher des accidents semblables survenus récemment en d'autres lieux : X
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public : X sur le danger que représente ce comportement
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**  
[Alain.leveque@ulb.ac.be](mailto:Alain.leveque@ulb.ac.be)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Cuistax

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : été 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) : cuistax à quatre roues / 4 places
- **Nombre de cas** durant cette période ou à cette date : 2 connus mais probablement d'autres en cette saison.
- **Autres éléments** en cause (environnement, météorologie, autre) : site touristique, densité popul ++
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : cuistax avec des amis
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : sur une digue de mer
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : manœuvre d'évitement d'un enfant et le cuistax s'est retourné.
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : la pratique de cette activité de loisir bien que règlementée, pose des problèmes lorsqu'il y a affluence sur les sites touristiques.



**Autres informations pertinentes :**

- Lésion : contusion cuir chevelu, entorse poignet
- Partie lésée : tête, poignet G
- Gravité : moyenne
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :** il serait souhaitable d'insister sur l'aspect dangereux de ses engins notamment lorsque la densité de population devient importante (période estivale) ; campagne d'affichage chez les loueurs de matériel.

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

[alain.leveque@ulb.ac.be](mailto:alain.leveque@ulb.ac.be)

## Rapid Alert Project - EASI Test phase

Once filled, send this card by E-mail (as an attached document) to the project-leader : [Dr Bertrand Thélot](mailto:bertrand.thelot@univ-lyon1.fr).

### EASI card for signalling

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### Chute

- **Date** of occurrence (dd/mm/yyyy): Chute/garden combination, increase from 3 cases in 1998 to 17 cases in 2003.
- **Description of the involved product**, if any (manufactured or not): **Chute**
- **Other** involved **elements** (environment, meteorology, etc.): **None**
- **Activity**: What was doing the victim when the injury occurred? **Playing**
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): **Garden**
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : **Especially falls from lesser or greater height, and contact with static object**
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around : **No particular behaviour**

**Other reliable information :**

- Lesions: **Contusion, bruise (51 %), fracture (25 %)**
- Part of body injured: **Many different**
- Severity: 4% admitted, but a large amount of fractures.
- Other atypical elements: **none**
- Other:

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you:**

Bjarne Laursen, National Institute of Public Health, Denmark  
Svanemøllevej 25, DK-2100 Copenhagen Ø

Phone: +45 3920 7777, fax: +45 3920 8010, email: bla@niph.dk

## Rapid Alert Project - EASI Test phase

Once filled, send this card by E-mail (as an attached document) to the project-leader : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### EASI card for signalling

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### Electric appliances

- **Date** of occurrence (dd/mm/yyyy) : 1998-2003 (increase from 23 to 61 accidents)
- **Description of the involved product**, if any (manufactured or not) : **Different electric appliances, lamps, leads, sockets, plugs**
- **Other involved elements** (environment, meteorology, etc.) : **Wet environment often occur in these accidents**
- **Activity**: What was doing the victim when the injury occurred? **Play, hobby, leisure activities (44%), unpaid work (38%)**
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): **Living rooms (33%), kitchen (11%), indoors/other, unspecified (20%), school (9%)**
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : **Contact with electric current**
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around :

**Other reliable information:**

- Lesions: **Electrocution (79%), burns (11%).**
- Part of body injured: **Whole body (76%), fingers (7%), hand (6%)**
- Severity: 24% admitted, however mostly only one day for observation.
- Other atypical elements:
- Other:

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:

**Other suggested actions:**

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Svanemøllevej 25, DK-2100 Copenhagen Ø

Phone: +45 3920 7777, fax: +45 3920 8010, email: bla@niph.dk

## Rapid Alert Project - EASI Test phase

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### EASI card for signalling

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications :

#### Trampoline

- **Date** of occurrence (dd/mm/yyyy) : 1998-2003
- **Description of the involved product**, if any (manufactured or not) : **Trampoline in gardens**
- **Other** involved **elements** (environment, meteorology, etc.) :
- **Activity**: What was doing the victim when the injury occurred ? : Playing
- **Location**: Where did the HLI occur ? (Inside home, in which part ? Outside home, etc.) : **Garden (per definition)**
- **Mechanism**: Which mechanism is at the origin of the injury ? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : **Fall (51%), overexertion (33%), contact with static object (7%), contact with person (7%)**
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around :

**Other reliable information:**

- Lesions : **Distorsion, sprain (36%), contusion, bruise (27%), fracture (27%)**
- Part of body injured : **Ankle (29%), elbow (11%), many other**
- Severity : **Relatively severe, 10% are admitted**
- Other atypical elements :
- Other :

**2. What would you suggest to do following this declaration (several answers allowed) ? :**

- Organizing a specific investigation of this injury :
- Collecting information about the recent injuries of the same type in the region :
- Collecting information about the injuries of the same type in other places :
- Making a bibliography :
- Organizing a specific survey on this type of injury :
- Organizing an information about that injury for :
  - Health professionals :
  - Health authorities :
  - Other public authorities :
  - The medias :
  - The public :

**Other suggested actions :**

**3. Please let us your name/address/fax/phone, so we may contact you :**

Bjarne Laursen, National Institute of Public Health, Denmark  
Svanemøllevej 25, DK-2100 Copenhagen Ø

Phone: +45 3920 7777, fax: +45 3920 8010, email: bla@niph.dk

## Rapid Alert Project - EASI Test phase

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### EASI card for signalling

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications :

#### Correction fluid

- **Date** of occurrence (dd/mm/yyyy) : march and november 2003 ( 2 cases)
- **Description of the involved product**, if any (manufactured or not) : **Correction fluid**
- **Other** involved **elements** (environment, meteorology, etc.) :
- **Activity** : What was doing the victim when the injury occurred ? : **unpaid work**
- **Location** : Where did the HLI occur ? (Inside home, in which part ? Outside home, etc.) : **Residential area (unspecified)**
- **Mechanism** : Which mechanism is at the origin of the injury ? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : **The bottle with correction fluid exploded, and the fluid caused irritation of the eyes and face**
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around :



**Other reliable information :**

- Lesions : **Corrosion**
- Part of body injured : **Eye / head, other**
- Severity : **Seems not to be so severe.**
- Other atypical elements :
- Other : Explosion of this kind has not been seen before 2003. Maybe it is a new more dangerous product?

**2. What would you suggest to do following this declaration (several answers allowed) ? :**

- Organizing a specific investigation of this injury :
- Collecting information about the recent injuries of the same type in the region :
- Collecting information about the injuries of the same type in other places :
- Making a bibliography :
- Organizing a specific survey on this type of injury :
- Organizing an information about that injury for :
  - Health professionals :
  - Health authorities :
  - Other public authorities :
  - The medias :
  - The public :

**Other suggested actions :**

**3. Please let us your name/address/fax/phone, so we may contact you :**

Bjarne Laursen, National Institute of Public Health, Denmark  
Svanemøllevvej 25, DK-2100 Copenhagen Ø  
Phone: +45 3920 7777, fax: +45 3920 8010, email: bla@niph.dk

## Rapid Alert Project - EASI Test phase

Once filled, send this card by E-mail (as an attached document) to the project-leader : [Dr Bertrand Thélot](mailto:bertrand.thelot@univ-lorraine.fr).

### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### **Fish: *Trachinus draco* (Greater weever)**

- **Period or date** of occurrence (01/01/2002-09/08/2004) :
- **Description of the involved product**, if any (manufactured or not) : Fish: *Trachinus draco* (Greater weever)
- **Number of cases** during this period / date : 25
- **Other involved elements** (environment, meteorology, etc.):
  
- **Activity**: What was doing the victim when the injury occurred? 'leisure at beach (walking in/by the water) and handling fish to cook (one case)
  
- **Location**: Where did the HLI occur ? (Inside home, in which part? Outside home, etc.) : Coastal beach and at home (one case)
  
- **Mechanism**: Which mechanism is at the origin of the injury ? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : Poisonous sting
  
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around : non available

**Other reliable information:**

- Lesions: Painful inflammation (intoxication)
- Part of body injured: members
- Severity: not available
- Other atypical elements: none in particular
- Social profile of the injured person(s) all
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed) ? :**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region :
- Collecting information about the injuries of the same type in other places :
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify):

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you :** João Brandão/Baltazar Nunes, **Observatório Nacional de Saúde**, Instituto Nacional de Saúde Dr. Ricardo Jorge, Av. Padre Cruz 1649-016 Lisboa, Tel: (+351) 217.526.453, Fax: (+351) 217.526.499 [www.onsa.pt](http://www.onsa.pt)

## Rapid Alert Project - EASI Test phase

Once filled, send this card by E-mail (as an attached document) to the project-leader : [Dr Bertrand Thélot](mailto:bertrand.thelot@cea.fr).

### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### Sea medusas

- **Period or date** of occurrence (01/01/2002-09/08/2004):
- **Description of the involved product**, if any (manufactured or not): Sea medusas
- **Number of cases** during this period / date: 1
- **Other involved elements** (environment, meteorology, etc.):
- **Activity**: What was doing the victim when the injury occurred ? : 'swimming
- **Location**: Where did the HLI occur ? (Inside home, in which part ? Outside home, etc.) : Coastal beach
- **Mechanism**: Which mechanism is at the origin of the injury ? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : burn
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around : Male, 24 y/o

**Other reliable information:**

- Lesions: Painful inflammation (intoxication)
- Part of body injured: thorax
- Severity: not available
- Other atypical elements: none in particular
- Social profile of the injured person(s) none available
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify):

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you :** João Brandão/Baltazar Nunes, **Observatório Nacional de Saúde**, Instituto Nacional de Saúde Dr. Ricardo Jorge, Av. Padre Cruz 1649-016 Lisboa, Tel: (+351) 217.526.453, Fax: (+351) 217.526.499 www.onsa.pt

## **Rapid Alert Project - EASI Test phase**

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### **EASI card for signalling (v2)**

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### **Glass doors**

- **Period or date** of occurrence (01/01/2002-09/07/2004) :
- **Description of the involved product**, if any (manufactured or not) : glass doors
- **Number of cases** during this period / date : 22
- **Other involved elements** (environment, meteorology, etc.):
- **Activity**: What was doing the victim when the injury occurred? : walking/running and/or playing
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.) : Home, Institutions and Shopping centres
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : cuts and bruises
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around : non available

**Other reliable information:**

- Lesions: open wounds or bruises
- Part of body injured: head or members
- Severity: not available
- Other atypical elements: none in particular
- Social profile of the injured person(s): both genders mainly children and teenagers
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify) :

**Other suggested actions :**

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## Rapid Alert Project - EASI Test phase

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### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications :

#### Mixers

- **Period or date** of occurrence (01/01/2002-09/07/2004):
- **Description of the involved product**, if any (manufactured or not): mixers
  
- **Number of cases** during this period / date: 2
- **Other involved elements** (environment, meteorology, etc.): Hair
  
- **Activity**: What was doing the victim when the injury occurred? : cooking
  
- **Location**: Where did the HLI occur ? (Inside home, in which part? Outside home, etc.) : kitchen
  
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : hair is enrolled by mixer till ripped off with or without scalp along
  
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around: non available



**Other reliable information:**

- Lesions: open wounds
- Part of body injured: head
- Severity: not available
- Other atypical elements: none in particular
- Social profile of the injured person(s): females age 6 and 21
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region :
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify):

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you :** João Brandão/Baltazar Nunes, **Observatório Nacional de Saúde**, Instituto Nacional de Saúde Dr. Ricardo Jorge, Av. Padre Cruz 1649-016 Lisboa, Tel: (+351) 217.526.453, Fax: (+351) 217.526.499 [www.onsa.pt](http://www.onsa.pt)

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### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

#### **Baby walkers**

- **Period or date** of occurrence (01/01/2002-09/07/2004):
- **Description of the involved product**, if any (manufactured or not): Baby walkers
  
- **Number of cases** during this period / date: 47
- **Other involved elements** (environment, meteorology, etc.): Stairs or not
  
- **Activity**: What was doing the victim when the injury occurred ? 'walking'
  
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): Home mainly
  
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : fall and/or hit ground or furniture and some burns
  
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around: non available

**Other reliable information:**

- Lesions: Concussions and cuts and some burns
- Part of body injured: mainly head, some members
- Severity: not available
- Other atypical elements: none in particular
- Social profile of the injured person(s): baby, both gender ages 1-4 yo
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify):

**Other suggested actions:**

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### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications :

#### Snowblades bindings

- **Period or date** of occurrence (dd/mm/yyyy): Winter season 2004
- **Description of the involved product**, if any (manufactured or not): Snowblades, skiblades or ski boards with non-release bindings. Short (<1 m) ski for downhill or trick skiing, bent upwards at both ends, making it possible to go backwards as well as forwards, or spin between directions. The non-release bindings can be used with different types of boots: traditional alpine boots, specific snowblade boots or hardshell snowboard or mountaineering boots.
- **Number of cases** during this period / date: Unknown. The Swedish Consumer Agency has received a notice from the county council of Dalarna of an increased number of injuries due to the appearance on a larger scale of the product in ski resorts in Dalarna during the past season. No statistical data to verify or disprove the increase is available, and the Agency has not had the opportunity to assess the risks involved with the non-release bindings used. This signalling is made to draw the attention of others to a possible risk.
- **Other involved elements** (environment, meteorology, etc.): Surface conditions in ski slopes and other prepared areas for downhill or trick skiing.
- **Activity**: What was doing the victim when the injury occurred?: Downhill or trick skiing.
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): Ski slopes and other prepared areas for downhill or trick skiing
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.): Primarily bending or twisting forces to the lower extremities in connection with falls, due to the use of non-release bindings
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around:

**Other reliable information:**

- Lesions: Distorsions, fractures
- Part of body injured: Lower extremities
- Severity:
- Other atypical elements: Possible reappearance in a new product of a risk which has been largely eliminated in traditional downhill skiing through the introduction and development of release bindings.
- Social profile of the injured person(s):
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed)?**

- Organizing a specific investigation of this injury:

- Collecting information about the recent injuries of the same type in the region:

The county council of Dalarna has include snowblades in the classification of sports in their injury registration, which is more summary than the EHLASS registration, but should be able to provide some information after the 2005 season.

- Collecting information about the injuries of the same type in other places:

- Making a bibliography:

- Organizing a specific survey on this type of injury:

- Organizing an information about that injury for:

- Health professionals:
- Health authorities:
- Other public authorities:
- The medias:
- The public:
- Other (specify):

**Other suggested actions: Include snowblades/ski boards in the EHLASS classifications of Product and Sport**

3. Please let us your name/address/fax/phone, so we may contact you:  
Henrik Nordin, Swedish Consumer Agency, SE-118 87 Stockholm, Sweden.  
Telephone: +46 8 429 0546 E-mail: [henrik.nordin@konsumentverket.se](mailto:henrik.nordin@konsumentverket.se)

## Rapid Alert Project - EASI Test phase

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### EASI card for signalling (v2)

1. An unusual / particular Home and Leisure Injury came to your knowledge. Your feeling is that it has to be registered in the EASI system because it is new, or because it appeared more frequent recently than usual, or more serious, etc. Please note below its specifications:

### Trampoline

- **Period or date** of occurrence (dd/mm/yyyy): Summer season 2004
- **Description of the involved product**, if any (manufactured or not): Trampoline sold for use in domestic gardens.
- **Number of cases** during this period / date: In the Skaraborg area, with about 260,000 inhabitants, 58 cases were registered for all of 2003, when registration for 2004 had reached cases happening in July, 62 cases had already been registered.
- **Other involved elements** (environment, meteorology, etc.):
- **Activity**: What was doing the victim when the injury occurred? : Trampoline jumping
- **Location**: Where did the HLI occur ? (Inside home, in which part? Outside home, etc.) : Mainly in domestic gardens
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.) : Falls from trampoline, failed jumps or landings, causing strains or impacts mainly to lower extremities
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around :

**Other reliable information:**

- Lesions: Mainly distortions, fractures and contusions
- Part of body injured: Lower extremities (foot distortions most common), upper extremities (fractures to the lower arm fairly common)
- Severity:
- Other atypical elements: Greatly increased use of product in recent years
- Social profile of the injured person(s): Mainly children and young persons
- Other (specify):

**2. What would you suggest to do following this declaration (several answers allowed) ? :**

- Organizing a specific investigation of this injury:
- Collecting information about the recent injuries of the same type in the region:
- Collecting information about the injuries of the same type in other places:
- Making a bibliography:
- Organizing a specific survey on this type of injury:
- Organizing an information about that injury for:
  - Health professionals:
  - Health authorities:
  - Other public authorities:
  - The medias:
  - The public:
  - Other (specify):   
Trampoline retailers

**Other suggested actions:**

**3. Please let us your name/address/fax/phone, so we may contact you :**

Henrik Nordin, Swedish Consumer Agency, SE-118 87 Stockholm, Sweden.  
Telephone: +46 8 429 0546 E-mail: [henrik.nordin@konsumentverket.se](mailto:henrik.nordin@konsumentverket.se)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Kart

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : 1<sup>er</sup> trimestre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Kart
- **Nombre de cas** durant cette période ou à cette date :  
6 accidents
- **Autres éléments** en cause (environnement, météorologie, autre) :
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Sport, course de karts
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  
Piste de course
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  
Choc, accident
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :  
Intrinsèque à la pratique du karting



**Autres informations pertinentes :**

- Lésion :
- Partie lésée :
- Gravité :
- Eléments singuliers qui rendent cet accident atypique :  
    Activité dangereuse en soi
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :  Investigation de la gravité

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Bertrand Thélot, Marc Nectoux, [b.thelot@invs.sante.fr](mailto:b.thelot@invs.sante.fr), [nectoux@dsi.univ-paris5.fr](mailto:nectoux@dsi.univ-paris5.fr)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Anneau de piercing

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : 1<sup>er</sup> trimestre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Anneau de piercing
- **Nombre de cas** durant cette période ou à cette date :  
2 accidents
- **Autres éléments** en cause (environnement, météorologie, autre) :
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  
Piercing coincé au niveau de l'ombilic  
A avalé son piercing de langue en mangeant
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

#### Autres informations pertinentes :

- Lésion :
- Partie lésée :

- Gravité :
- Éléments singuliers qui rendent cet accident atypique :  
Atypie et rareté
- Profil social des personnes impliquées :
- Autres (préciser) :

## 2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

## 3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :

Bertrand Thélot, Marc Nectoux, [b.thelot@invs.sante.fr](mailto:b.thelot@invs.sante.fr), [nectoux@dsi.univ-paris5.fr](mailto:nectoux@dsi.univ-paris5.fr)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Jeu de basket

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : 1<sup>er</sup> trimestre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  

Le ballon de basket est en cause dans 1/3 des accidents
- **Nombre de cas** durant cette période ou à cette date :  

165 accidents sur 13821 recours aux urgences
- **Autres éléments** en cause (environnement, météorologie, autre) :
  
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  

Sport, basket
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  

Salle de sport, terrain de sport
  
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  

Chute ou mauvaise réception pour 1/3 des cas
  
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

**Autres informations pertinentes :**

- Lésion :
- Partie lésée :
- Gravité :
- Eléments singuliers qui rendent cet accident atypique :  
Grande fréquence
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

Campagne de prévention

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Bertrand Thélot, Marc Nectoux, [b.thelot@invs.sante.fr](mailto:b.thelot@invs.sante.fr), [nectoux@dsi.univ-paris5.fr](mailto:nectoux@dsi.univ-paris5.fr)

## Projet Alerte Rapide - SAViC Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Trampoline

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : 1<sup>er</sup> trimestre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Trampoline
- **Nombre de cas** durant cette période ou à cette date :  
10 accidents sur 13821 recours aux urgences
- **Autres éléments** en cause (environnement, météorologie, autre) :
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Faisait du trampoline dans 9 cas sur 10
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  
Chute, mauvaise réception ou torsion
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :  
Le fait de faire du trampoline

**Autres informations pertinentes :**

- Lésion : torsion, contusion
- Partie lésée : jambe, dos, pied, genou ou bras
- Gravité :
- Eléments singuliers qui rendent cet accident atypique :  
Fréquence
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport et de la sécurité (DGCCRF)
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Bertrand Thélot, Marc Nectoux, [b.thelot@invs.sante.fr](mailto:b.thelot@invs.sante.fr), [nectoux@dsi.univ-paris5.fr](mailto:nectoux@dsi.univ-paris5.fr)

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Piqûres d'hyménoptères

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : juillet / août 2004

- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Piqûres d'hyménoptères (guêpes et frelons)

- **Nombre de cas** durant cette période ou à cette date :

Nombre total indéterminé, en revanche recours aux services d'urgences et au Samu important pour ce motif et sans précédent.

Des informations non vérifiables (sur déclarations) faisaient état d'augmentations des nombres de piqûres de 20 à 30% et plus par rapport à un été habituel.

- **Autres éléments** en cause (environnement, météorologie, autre) :

Eléments explicatifs proposées : un été 2003 très chaud, donc beaucoup de larves ; un hiver 2004 peu froid donc peu de larves détruites ; un printemps sec non humide, donc pas les moisissures qui contribuent habituellement à la destruction des larves.

Au total donc : l'augmentation des piqûres serait due à l'augmentation des hyménoptères susceptibles de piquer.

- **Activité** : Que faisait l'accidenté au moment de l'accident ? :

- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :

Phénomène observé sur l'ensemble du territoire national

- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

Pas de notion de comportement à risque relevé.



**Autres informations pertinentes :**

- Lésion :

- Partie lésée :

- Gravité : il y aurait eu une gravité plus importante que les étés habituels. L'explication tiendrait au fait que, puisqu'il y a eu plus de piqûres, il y aurait eu plus de personnes sensibles et/ou fragiles piquées. Non vérifié.

- Eléments singuliers qui rendent cet accident atypique :

- Profil social des personnes impliquées :

- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :

- Rechercher des accidents semblables survenus récemment à proximité :

- Rechercher des accidents semblables survenus récemment en d'autres lieux :

La recherche de cas a été menée sur l'ensemble du territoire national.

- Effectuer une recherche bibliographique sur ce type d'accident :

La bibliographie a été faite.

- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :

- Informer de la survenue de cet accident :

- Les professionnels de santé :

- Les autorités sanitaires :

- D'autres autorités publiques :

- La presse et les médias :

- Le public :

- Autre (préciser) :

**Autres actions souhaitées :**

Remarque : fin de la préoccupation sur ce sujet avec la fin de l'été.

Pas d'action prévue pour l'année prochaine.

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Loïc Josseran, Institut de veille sanitaire, cellule de coordination des alertes, 12 rue du val d'Osne, 94415 Saint Maurice cedex, France. + 33 1 41 79 68 48, [l.josseran@invs.sante.fr](mailto:l.josseran@invs.sante.fr)

Fiche remplie le 25 octobre 2004

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Allergie à l'ambroisie

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) :  
27 août 2004, alerte lancée par le Réseau National de Surveillance Aérobiologique concernant, pour les jours suivants, une forte présence de pollens d'ambroisie dans l'air, dans la région lyonnaise – vallée du Rhône – vallée de la Saône (région de prolifération de la plante), et des risques accrus d'allergies.
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Pollens d'ambroisie, fortement allergéniques (la période de pollinisation de la plante s'étale de fin août à fin septembre).
- **Nombre de cas** durant cette période ou à cette date :

Indéterminé. Sur la région lyonnaise, une étude de prévalence menée en 1999 évoque un taux de manifestations allergiques à l'ambroisie d'environ 8 à 12 % de la population dans les zones les plus infestées par la plante.

- **Autres éléments** en cause (environnement, météorologie, autre) :  
Week-end de grands déplacements sur l'axe sud-nord pour les vacanciers et une forte concentration de population sur les routes à ces dates.
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Risque de développer une rhinite allergique après être passé à travers la région de prolifération de l'ambroisie (fenêtre ouverte des véhicules, séjour, habitants).
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur) :  
Région de prolifération de l'ambroisie.
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :

Expositions aux pollens en circulation dans l'air, développement de symptôme de type rhinite allergique.

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

**Autres informations pertinentes :**

- Lésion :
- Partie lésée :
- Gravité :
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :  (personnes se sachant allergiques à l'ambroisie)

**Autres actions souhaitées :**

Comment l'alerte a été déclenchée en 2004 :

- chaque année depuis 3/4 ans, la DGS, sous l'impulsion de la Drass Rhône-Alpes, fait un communiqué de presse en août afin d'informer la population de l'existence du risque allergique à l'ambroisie dans la région de prolifération de la plante (pas d'évaluation de sa portée) ;
- en 2004, cette information n'a pas été faite ;
- le RNSA est en mesure de prévoir quelques jours à l'avance le déclenchement de la pollinisation des plantes (en particulier pour celles dont les pollens sont allergisants), sur la base de connaissances botaniques et des facteurs météorologiques, ainsi qu le niveau de risque allergique (échelle de 1 à 5). Le RNSA avait donc prévu un épisode de pollinisation de l'ambroisie pour les jours suivant le 27 août 2004. C'est ce qui l'a amené à émettre un bulletin d'alerte sous la forme : 1/ d'un communiqué de presse à l'AFP, 2/ d'une information à l'InVS ;
- en raison du fort risque allergique, l'InVS (DSE) n'a pas souhaité garder l'information pour lui et a lancé également un communiqué de presse national, lequel était le lendemain relayé au niveau de la préfecture de Rhône-Alpes.

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Bruno Fabres, Cire Rhône-Alpes, 04 72 34 31 15

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Cheveu étrangleur

- **Période ou date** de survenue de l'accident (25/10/04) :
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :

Cheveux de la mère

- **Nombre de cas** durant cette période ou à cette date : 1
- **Autres éléments** en cause (environnement, météorologie, autre) :
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Il (ou plutôt elle) se faisait changer sa couche

- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  
A la maison, dans la chambre du bébé

- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :

Lors d'un change, un cheveu de la mère est tombé et s'est enroulé autour de 2 doigts de pieds du bébé (2° et 3° orteils du pied gauche). Le jeudi 21, la mère s'est aperçue que les 2° et 3° orteils du pied gauche étaient boursoufflés et collés l'un à l'autre, sans rougeur ni chaleur. La mère a pensé qu'il s'agissait d'une particularité anatomique. Le lundi 25 octobre au soir, lors du bain du bébé, les 2 orteils en question sont apparus rouge violacés, chauds, gonflés avec, au dessous de la boursoufflure, une incision assez profonde d'un millimètre environ. Le bébé a été amené aux urgences pédiatriques où le diagnostic de « cheveu étrangleur » a été porté rapidement. Le chirurgien a retrouvé le cheveu qu'il a coupé. Les doigts de pied se sont recolorés dans les heures qui ont suivies.

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :  
La mère ne noue pas ses cheveux lors du change du bébé

**Autres informations pertinentes :**

- Lésion :
- Partie lésée : 2° et 3° orteils du pied gauche
- Gravité : pas de séquelle dans ce cas mais il y aurait pu en avoir si le bébé n'avait pas été amené aux urgences le soir même, les complications pouvant aller jusqu'à l'amputation des doigts de pied.
- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées : pas de profil particulier
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident : non
- Rechercher des accidents semblables survenus récemment à proximité : non
- Rechercher des accidents semblables survenus récemment en d'autres lieux : non
- Effectuer une recherche bibliographique sur ce type d'accident : oui
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident : non
- Informer de la survenue de cet accident :
  - Les professionnels de santé : oui
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public : oui
  - Autre (préciser) : sage-femme, service de maternité

**Autres actions souhaitées :**

Je pense qu'une information est nécessaire dans les services de maternité pour les mères qui ont les cheveux mi-longs ou longs, en recommandant de nouer ses cheveux lors du change et du bain des bébés. Ce syndrome ne touche que les nourrissons de quelques mois et peut avoir des conséquences graves, les cheveux pouvant également s'enrouler autour des testicules des bébés garçons

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**  
Florence Suzan, DMCT, InVS, 01 55 12 53 09, f.suzan@invs.sante.fr

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### Effet loupe

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : août 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) : 2 cas :
  - bocal sphérique pour poissons rouges
  - Broc d'eau en verre
- **Nombre de cas** durant cette période ou à cette date : 01
- **Autres éléments** en cause (environnement, météorologie, autre) : exposition au soleil d'un bocal rempli d'eau placé dans un environnement sensible à la chaleur (dessus de meuble, revêtement, nappe etc.).
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : sans objet
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : domicile - salon (proximité baie vitrée)
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : effet loupe produit par la présence d'eau dans un récipient dont la forme favorise l'amplification de la chaleur produit par le rayonnement solaire et, partant, l'échauffement de la surface du meuble qui se trouve en contact direct avec le bocal.
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : sans objet

**Autres informations pertinentes :**

- Lésion :
- Partie lésée :
- Gravité : le risque extrême est l'incendie dès lors que le bocal échappe à toute vigilance.
- Eléments singuliers qui rendent cet accident atypique : combinaison de la forme du récipient et de l'action du rayonnement solaire (effet loupe).
- Profil social des personnes impliquées :
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident : **X**
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux : **X**
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident : **oui**, si nous pressentons une fréquence suffisante.
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :  X si le nombre de cas connus le justifie, notamment au moment de l'achat.
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

DGCCRF

M. yannick Bailbled

Fax : 01.44.87.24.86

Mél : yannick.bailbled@dgccrf.finances.gouv.fr

## **Projet Alerte Rapide - SAViC**

### **Phase test**

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### **Fiche de signalement (v2)**

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

#### **Body – Fly**

- **Période ou date** de survenue de l'accident (jj/mm/aaaa) : octobre 2004
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :
  - Simulateur de vol libre accessible par tous dans le cadre d'une activité ludique (type foire)
- **Nombre de cas** durant cette période ou à cette date : 01
- **Autres éléments** en cause (environnement, météorologie, autre) : inexpérimentation de l'utilisateur
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : utilisait l'appareil
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : sans objet

**Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) : l'utilisateur muni d'une combinaison spéciale évolue dans un volume formé par une structure gonflable sous l'effet d'une puissante soufflerie et ses déplacements sont commandés par ses propres mouvements. (voir clichés photographiques).

Au cas particulier, la victime est retombée brutalement, tête la première, sur la base de la structure gonflable apparemment pas suffisamment souple pour amortir le choc.

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : probablement un mouvement non maîtrisé. Les mouvements des bras et jambes conditionnent l'évolution dans l'air.

#### **Autres informations pertinentes :**

- Lésion : la victime risque la tétraplégie
- Partie lésée :
- Gravité :



- Eléments singuliers qui rendent cet accident atypique :
- Profil social des personnes impliquées :
- Autres (préciser) :

## 2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :

- Mettre en place une investigation approfondie de cet accident : X
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux : X
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident : oui, si  
nous pressentons une fréquence suffisante.
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :  si le nombre de cas connus le justifie,
  - Autre (préciser) :

### Autres actions souhaitées :

Améliorer l'information sur le lieu d'utilisation

## 3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :

DGCCRF

M. Yannick Bailbled - Fax : 01.44.87.24.86 - Mél : yannick.bailbled@dgccrf.finances.gouv.fr

## Projet Alerte Rapide - SAViC

### Phase test

#### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Chauffage pour aquarium

- **Période ou date** de survenue de l'accident (02/02/2004)
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
  
Dispositif de chauffage pour aquarium  
(une résistance à l'intérieur d'un tube pirex)
- **Nombre de cas** durant cette période ou à cette date :  
  
2
- **Autres éléments** en cause (environnement, météorologie, autre) :  
Eau légèrement saline
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Nettoyage de l'aquarium
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  
Domicile
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  
  
Lors du nettoyage de l'aquarium, le tube a été choqué, s'est brisé, contact avec la résistance non blindée – Electrisation
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :  
  
Fragilité du matériel plutôt que comportement de l'accidenté.

**Autres informations pertinentes :**

- Lésion : Tétanie locale
- Partie lésée :
- Gravité : Potentiellement électrocution
- Eléments singuliers qui rendent cet accident atypique :  
Méconnaissance du risque – confiance dans le matériel
- Profil social des personnes impliquées : Indifférent
- Autres (préciser) :  
Danger accentué si le nettoyage est confié à un enfant  
Développement de ce type de matériel bas de gamme offert en cadeau

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
  
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :  Investigation de la gravité
  - Autorités de réglementation et/ou normalisation
  - Les magasins de vente

Commission de la sécurité des consommateurs.  
Cité Martignac, 111 rue de Grenelle – 75353 Paris 07 SP

## Projet Alerte Rapide - SAViC

### Phase test

#### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Commode à langer

- **Période ou date** de survenue de l'accident (25/10/2003)
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
Une commode de 3 tiroirs dont le plateau (amovible) sert de plan à langer
- **Nombre de cas** durant cette période ou à cette date :  
3 dont 1 mortel

**Autres éléments** en cause (environnement, météorologie, autre) :

- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  
Recherche d'objets dans le tiroir du bas et appui sur le second tiroir
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  
chambre au domicile
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  
Basculement de la commode, glissement du tiroir du haut qui a brisé les vertèbres cervicales

L'enfant a été entraîné dans une trappe à l'extrémité du tapis qui aurait dû être fermée. L'enfant a été broyée dans le mécanisme.

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :

Comportement de l'enfant raisonnablement prévisible

**Autres informations pertinentes :**

- Lésion : fracture
- Partie lésée : vertèbres cervicales
- Gravité : mortelle
- Eléments singuliers qui rendent cet accident atypique :

Le fait qu'un meuble ordinaire soit à l'origine d'un accident mortel

- Profil social des personnes impliquées :  
Classes moyennes
- Autres (préciser) :

## 2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :  Investigation de la gravité  
Les industriels et les distributeurs

**Autres actions souhaitées :**  
Modification du produit

Commission de la sécurité des consommateurs.  
Cité Martignac, 111 rue de Grenelle – 75353 Paris 07 SP

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](mailto:Dr.Bertrand.Thélot).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Tapis roulants de neige

- **Période ou date** de survenue de l'accident (14 fév. 2004)
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  

Tapis roulant en kit d'une station de sports d'hiver pour faciliter les déplacements.
- **Nombre de cas** durant cette période ou à cette date :  

2 cas (2003) en France - 4 cas en Autriche
- **Autres éléments** en cause (environnement, météorologie, autre) :
- **Activité** : Que faisait l'accidenté au moment de l'accident ? :  

ont emprunté ce trottoir roulant
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) :  

A l'extérieur des stations de sports d'hiver (Val Cenis)
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :  

L'enfant a été entraîné dans une trappe à l'extrémité du tapis qui aurait dû être fermée. L'enfant a été broyée dans le mécanisme.
- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident : aucun

**Autres informations pertinentes :**

- Lésion : multi fractures, écrasement de la cage thoracique
- Partie lésée :
- Gravité : mortelle
- Eléments singuliers qui rendent cet accident atypique :

Le fait d'accompagner les enfants ne permet pas de prévenir ce type d'accident.

- Profil social des personnes impliquées : Indifférent
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :  Professionnels du sport
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :  Investigation de la gravité  
Les professionnels et les élus des collectivités locales

**Autres actions souhaitées :**

Réglementation et normalisation des installations

Commission de la sécurité des consommateurs.  
Cité Martignac, 111 rue de Grenelle – 75353 Paris 07 SP

## Projet Alerte Rapide - SAViC

### Phase test

Renvoyer, en pièce jointe d'eMail, ce document une fois complété au chef du projet : [Dr Bertrand Thélot](#).

### Fiche de signalement (v2)

1. Un accident de la vie courante atypique est survenu. Du fait de sa nouveauté, de son caractère inhabituel, de sa fréquence, de sa gravité, etc. vous souhaitez le signaler dans SAViC. Indiquez ses caractéristiques :

### Défenestration

- **Période ou date** de survenue de l'accident : *Printemps et été,*
- **Description du produit** en cause, s'il y a lieu (manufacturé ou non) :  
*Fenêtres, balcons, terrasses*
- **Nombre de cas** durant cette période ou à cette date :  
*Environ 70 par an chez les moins de 6 ans en région Ile-de-France*
- **Autres éléments** en cause (environnement, météorologie, autre) :  
*Journées ensoleillées et chaudes, souvent alternance pluie / soleil*
- **Activité** : Que faisait l'accidenté au moment de l'accident ? : *Activité quotidienne*
- **Lieu** : Où a eu lieu l'accident ? (dans la maison, dans quelle pièce, à l'extérieur ?) : *Dans la maison, chambre d'enfant, salon*
- **Mécanisme** : Comment est survenu l'accident ? Détailler la suite des événements et à quoi ils ont abouti (chute, écrasement, brûlure, coupure, etc.) :

*Défaut de surveillance de l'enfant, même très court, devant une fenêtre ouverte non protégée ou sur un balcon ou terrasse, chute*

- **Préciser**, si possible, quelle part du comportement de l'accidenté et/ou de son entourage a pu jouer un rôle dans la survenue de l'accident :  
*Défaut de surveillance très court, méconnaissance du risque, fenêtre accessible à un enfant du fait du stockage d'objets devant cette fenêtre ou une balustrade de balcon (coffre à jouet, lit, radiateur)*



**Autres informations pertinentes :**

- Lésion : *Préférentiellement traumatisme crânien*
- Partie lésée :
- Gravité : *Proportionnelle à la hauteur de la chute, mortalité proche de 10%*
  - Eléments singuliers qui rendent cet accident atypique :  
*Implique préférentiellement des enfants de moins de 6 ans*
  - Profil social des personnes impliquées :  
*Proportion importante de parents d'origine africaine*
- Autres (préciser) :

**2. Quelle conduite à tenir vous paraît souhaitable à la suite du signalement de cet accident (plusieurs réponses possibles) ? :**

- Mettre en place une investigation approfondie de cet accident :
- Rechercher des accidents semblables survenus récemment à proximité :
- Rechercher des accidents semblables survenus récemment en d'autres lieux :
- Effectuer une recherche bibliographique sur ce type d'accident :
- Mettre en place une étude épidémiologique spécifique sur ce type d'accident :
- Informer de la survenue de cet accident :
  - Les professionnels de santé :
  - Les autorités sanitaires :
  - D'autres autorités publiques :
  - La presse et les médias :
  - Le public :
  - Autre (préciser) :

**Autres actions souhaitées :**

**3. Pour nous permettre de vous contacter, merci de laisser vos coordonnées :**

Philippe Meyer - Hopital Necker Enfants Malades  
149 rue de Sèvres - 75015 Paris, 01 44 49 41 83 ; 01 44 49 40 00 Bip 305 ; 06 11 76 18 69  
philippe.meyer@nck.ap-hop-paris.fr



# Appendix VI

## Investigation of trampoline accidents

Eléments pour le traitement d'un signalement SAViC/EASI

### 1. Contexte :

Dans le système SAViC/EASI, 3 signalements ont été transmis concernant les trampolines :

- un signalement du Danemark (National Institute of Public Health) :  
« *Trampoline in gardens* »
- un signalement de la Suède (Swedish Consumer Agency) :  
« *Trampoline sold for use in domestic gardens* »
- un signalement français de l'InVS, à partir de la base française EPAC :  
« *Trampoline* »

Face à ces signalements les actions entreprises ont été les suivantes :

- ➔ **recherche bibliographique**
- ➔ **recherche de cas similaires dans la base française EPAC**
- ➔ **recherche de cas similaires dans la base européenne IDB**

### 2. Recherche de cas similaires dans la base EPAC France :

#### Fréquence :

L'interrogation de la base française EPAC (version française du système de collecte IDB) pour les années 2000, 2001 et 2002, a été effectuée en sélectionnant les cas sur les variables : « Produit impliqué dans l'accident » ou « Produit ayant causé la lésion » ou dans le texte libre « TRAMPOLINE ». Les codes produits retenus ont été :

Code produit « 52140 » = mini-trampoline ou

Code produit « 52190 » = trampoline

➔ Résultat : 287 accidents sur 101 226 cas présents dans la base EPAC entre 2000 et 2001

Il s'agit donc d'un accident « non rare ».

#### Caractéristiques principales :

Ces accidents concernent très majoritairement des enfants des deux sexes entre 5 et 14 ans (70,4 %). Le mécanisme accidentel est la chute (64,5 %) ou « l'effort physique » (22,0 %). Ces accidents ont lieu sur un terrain de sport (63,1 %) ou à l'école (26,8 %), mais peu dans la sphère domestique (3,8 %). Un peu moins de la moitié de ces accidents se déroulent lors des activités scolaires (41,8 %). Ils produisent des contusions (58,5 %), des entorses (19,5 %) ou des fractures (14,6 %) des membres inférieurs (46,0 % - genou, cheville, pied).

#### Gravité :

- Taux d'hospitalisation : 21 hospitalisations / 287 = 7,3 %

- La durée moyenne de séjour : 2,1 jours (< à la moyenne globale -5 jours)

➔ Ces accidents sont donc globalement peu graves (moins graves que la moyenne)

Le texte libre n'apporte pas d'informations complémentaires sur les circonstances de ces accidents. Aucun texte ne met en cause directement le produit lui-même.

### Conclusions provisoires :

La pratique du trampoline semble relativement « à risque », bien que les accidents soient peu graves. On distingue la pratique scolaire (accident de sport à l'école) de la pratique lors des activités de loisirs. Actions de prévention envisageables :

→ une action d'information auprès du personnel d'encadrement (centre de loisirs et professeur de gymnastique).

→ un renforcement des dispositifs anti-choc sur les produits eux-mêmes ??

### 3. Recherche de cas similaires dans la base européenne IDB :

#### Fréquence :

La base européenne IDB a été interrogée pour les années 2000 et 2001 (les fichiers 2002 et au-delà n'étaient pas disponibles). Pour sélectionner l'ensemble des accidents de trampoline, trois requêtes différentes ont été effectuées :

Requête n°1 :

- « Date of attendance » = **2000, 2001, 2002**
- « Sport » = **Trampoline**

Requête n°2 :

- « Date of attendance » = **2000, 2001, 2002**
- « Product causing the injury » = **Mini-trampoline or Trampoline**

Requête n°3 :

- « Date of attendance » = **2000, 2001, 2002**
- « Product involved in the accident » = **Mini-trampoline or Trampoline**

Puis, les doublons ont été éliminés, pour constituer un fichier unique concernant les accidents de trampoline. La répartition des cas présents est la suivante (avec le nombre total de cas par fichier) :

<b>Trampoline</b>	<b>2000</b>	<b>2001</b>	<b>Total</b>	<b>sur 10 000 cas</b>
Autriche	11 (8622)	15 (11191)	<b>26</b> (19813)	<b>13,1 cas</b>
France*	98 (48080)	117 (41470)	<b>215</b> (89550)	<b>24,0 cas</b>
Grèce	14 (33111)	17 (35529)	<b>31</b> (68640)	<b>4,5 cas</b>
Suède	30 (27141)	0 (0)	<b>30</b> (27141)	<b>11,1 cas</b>
<b>Total</b>	<b>153</b>	<b>149</b>	<b>302</b> (205144)	<b>14,7 cas</b>

\* : On trouve moins de cas pour les données françaises dans IDB que dans EPAC car dans EPAC on a pu interroger aussi sur le texte libre.

**La France a un nombre de cas relatif plus important que les autres pays qui ont des cas similaires.** Les cas des autres pays ont des caractéristiques statistiques proches des cas français sur l'ensemble des variables.

### 4. Réflexions sur l'utilisation de la base IDB :

**Sur les fichiers présents :** en consultant les fichiers présents dans IDB au 04/11/2004, on constate que l'on dispose des fichiers nationaux suivant :

- pour l'année 2000 : A, D\*, E\*,F, EL, L, NL, S
- pour l'année 2001 : A, E\*,F, EL, NL
- pour l'année 2002 et au-delà : pas de fichiers

\* : recueil par enquête sans information sur les produits

**Sur l'interrogation de la base :** on aurait souhaité pouvoir interroger la base en utilisant des « OU » logiques, pour formuler une demande du type :

- « Sport » = Trampoline OU
- « Produit ayant causé la lésion » = Trampoline OU
- « Produit impliqué dans l'accident » = Trampoline

**Sur les données disponibles :**

- On aurait souhaité avoir des données européennes plus récentes (2002 et 2003)
- La variable « Sport » n'est pas utilisée dans tous les pays
- Les pratiques de codage ne sont pas homogènes en ce qui concerne, par exemple, les variables « Produit » (pas d'accidents de trampoline pour NL ??)

**Conclusions provisoires :**

→ L'étude des données IDB disponibles (302 cas) montre que ce ne sont pas tant les accidents de trampoline dans la sphère domestique (jardin : 9, maison et alentours : 2) qui sont nombreux que les accidents de trampoline dans les zones scolaires et de loisirs.

→ La France semble présenter un nombre relatif plus important de ce type d'accidents. Il serait intéressant de comparer les produits utilisés dans les différents pays, ainsi que les normes de sécurité appliquées lors des activités sportives scolaires.

→ Il reste un effort important pour rendre la base IDB plus informative pour ce type d'étude : mise à disposition plus rapide des fichiers nationaux, homogénéisation des pratiques de codage, utilisation d'un texte libre normalisé et monolingue, etc.



# Appendix VII

## Contributions of the partners

(Extracts)

### Austria

*Robert Bauer, Malthide Sector, décembre 2004*  
*Institute Sicherleben*

Partner Report on the European Union's Injury Prevention Programme 2002, the Directorate General for Health and Consumer Protection (DG SANCO) project entitled:

“Establishing a Rapid Response Mechanism within the Injury Prevention Programme: A Pilot Study.” (also known as “Rapid Response”)

**Partner Country:**Austria

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#### **Part 1: Rapid alert system in Austria**

RAPEX Austria is the rapid alert system for product safety in Austria, based on the European Commission RAPEX procedure as foreseen in directive 92/59/EEC on general product safety.

The contact point for RAPEX in Austria is:

Bundesministerium für soziale Sicherheit, Generationen und Konsumentenschutz - Abt. III/2-Produktsicherheit, Radetzkystraße 2, 1031 Wien, Fax (01) 715 58 31, [produktsicherheit@bmj.gv.at](mailto:produktsicherheit@bmj.gv.at)

There is no public inventory of notifications, but all RAPEX notifications originating from Austria are included in the EU-level inventory (available on a weekly basis on the EC website).

IDB Austria serves as a potential source for notifications to the Consumer Safety Authority by medical services staff and/or costumers. So far, however, no eventual notification have originated from EHLASS Austria.

An issue brought up by the administrators of this system is that it is hard to do follow-up on these cases due to the lack of details given at times and confidentiality of the case reporting. Often, the person involved in the injury with a product blames his/her behaviour and not the product.

The following aspects are governed by law in Austria, with obligation of notification for explicitly listed diseases and conditions:

Infectious and transmitted diseases diseases: Meldepflichtige übertragbare Krankheiten in Österreich. I) Meldepflichten nach Epidemiegesetz 1950, BGBl. Nr. 186/1950 idgF, und der Verordnung betreffend anzeigepflichtige übertragbare Krankheiten, BGBl. II Nr. 456/2001 in der Fassung BGBl II Nr. 210a/2003:

Veterinary Safety: Anzeigepflicht gemäß § 16 Tierseuchengesetz vom 6. August 1909, RGBL. Nr. 177, zuletzt geändert durch BGBl. I Nr. 96/2002:

Food Safety: Codex Alimentarius: The Codex Alimentarius Commission was created in 1963 by FAO and WHO to develop food standards, guidelines and related texts such as codes of practice under the Joint FAO/WHO Food Standards Programme. The main purposes of this Programme are protecting health of the consumers and ensuring fair trade practices in the food trade, and promoting coordination of all food standards work undertaken by international governmental and non-governmental organizations (<http://www.codexalimentarius.net/>)

In general, notification is done by medical services staff to the Ministry of Health ([buergerservice@bmgf.gv.at](mailto:buergerservice@bmgf.gv.at)):  
Bundesministerium für Gesundheit und Frauen, Radetzkystrasse 2 1030 Wien  
Tel.+43-1/71100-0 Fax +43-1/711 00-14300

## Part 2: Atypical events leading to injury in Austria

The following cases were highlighted as atypical in the Austrian IDB data analysis pilot for identifying cases for EASI:

### A. Gasoline bottle

- **Period or date** of occurrence (dd/mm/yyyy): 2003
- **Description of the involved product**, if any (manufactured or not):  
Gasoline bottle, match, open flame
- **Number of cases** during this period / date: 1 case in 2003 of an 8 year old boy , who burned his finger while playing with trying to light a candle with a match
- **Other involved elements** (environment, meteorology, etc.):
- **Activity**: What was doing the victim when the injury occurred? He was walking outside
- **Location**: Where did the HLI occur? (Inside home, in which part? Outside home, etc.): Outside, near the garage
- **Mechanism**: Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.):  
Boy living next door playing with matches, threw a lighted match into the neighbour's garage, which caused the gasoline bottle to explode and injure the neighbor.
- If possible, **Give further details** of the behaviour of the injured person and / or of the people around: neighbour boy is at fault, careless, did not realize the consequence of his action.

### Other reliable information:

- Lesions: multiple body parts burned
- Part of body injured:
- Severity:
- Other atypical elements:
- Social profile of the injured person(s):
- Other (specify): 82 days in the hospital

### What would you suggest to do following this declaration (several answers allowed)?

Provide burn safety resources to schools in Austria so that children are taught about the dangers of playing with fire, and mention this particular case as an example.

### B. Paraglider

- **Period or date** of occurrence (dd/mm/yyyy): 2003
- **Description of the involved product**, if any (manufactured or not): Paraglider
- **Number of cases** during this period / date: 7 in 2003
- **Other involved elements** (environment, meteorology, etc.): in 2 cases the weather was the reason for the injury, otherwise due to not concentrating / stress / fatigue



- **Activity:** What was doing the victim when the injury occurred?

Sport - paragliding

- **Location:** Where did the HLI occur? (Inside home, in which part? Outside home, etc.): in the air, outdoors

- **Mechanism:** Which mechanism is at the origin of the injury? Give some details on the succession of events and how they led to the injury (fall, crash, burn, cut, etc.): fall  
Fall from a big height – 2 cases by landing / 1 case the person tried to photograph his house from above and fell / 1 case by takeoff, etc.

- If possible, **Give further details** of the behaviour of the injured person and / or of the people around:

- a strong wind caused him to crash and fall

**Other reliable information:**

- Lesions: fracture in 6 cases, sprain in 1 case

- Part of body injured: ankle, elbow, lower spine, upper spine, pelvis, arm

- Severity: range, longest 21 days

- Other atypical elements: increasing number of paragliding in Austria

- Social profile of the injured person(s):

- Other (specify): 1 case female, 6 males, ages 20 to 50 (willing to take risks)

**What would you suggest to do following this declaration (several answers allowed)?**

Alert companies that offer paragliding that safety instructions need to be improved and discussed more intensively with their clients. Provide these companies with such case studies for them to use in educating clients.

**Part 3: Utility of a European Alert System**

We believe that a rapid response mechanism for service-related home and leisure accidents is a very useful application of the IDB data collection system in Europe. With very little extra costs, it would be possible to integrate such a system into the mainframe and thereby have a clear European added-value to the system. The proposal is to have a message board integrated into the IDB system, for national data administrators in each Member State to have the possibility to post a message concerning an atypical case. This message would be transmitted electronically to all national data administrators in Europe, and they can then investigate whether such similar cases exist in their own country. Such a system is needed in addition to RAPEX, which functions only for product-related cases.

A role model organization to follow would be the Consumer Product Safety Commission (CPSC) in the United States. This organization is charged with protecting the public from unreasonable risks of serious injury or death from more than 15,000 types of consumer products under the agency's jurisdiction.

In the United States deaths, injuries and property damage from consumer product incidents cost the nation more than \$700 billion annually. The CPSC is committed to protecting consumers and families from products that pose a fire, electrical, chemical, or mechanical hazard or can injure children. The CPSC works to ensure the safety of consumer products - such as toys, cribs, power tools, cigarette lighters, and household chemicals - contributed significantly to the 30 percent decline in the rate of deaths and injuries associated with consumer products over the past 30 years, which has legal authority to fine producers of dangerous products. Without this authority, not much can be done.

On-line forms can be filled in online to report an injury or to file a complaint about an unsafe product, and this data is investigated daily and product recalls are posted daily. Consumers are informed of dangerous products via newsletter and CPSC publications.

Such an agency is needed in Europe in order for researchers to be able to provide concrete data and cost measures to policy makers, as well as perform recalls/fines, in order to keep the citizens of Europe safe.

# Belgium

*Alain Lévêque, décembre 2004*

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## **1. Organisation actuelle des autorités administratives pour la mise en évidence de nouveaux types d'Accidents de la vie courante (AVC)**

- Rappel introductif

En Belgique, la documentation des traumatismes tant d'un point de vue quantitatif que d'un point de vue qualitatif pose de gros problèmes. Depuis la fin des projets EHLASS, il n'y a plus de données collectées en routine dans les structures hospitalières. Seuls les accidents de la voie publique et les accidents survenus dans le cadre du travail font l'objet d'un relevé plutôt exhaustif impliquant d'autres acteurs que les hôpitaux. Mais en ce qui concerne les AVC, un réel problème se pose actuellement en Belgique. Il apparaît donc clair que le développement d'un système permettant la mise en évidence de « nouveaux types de traumatismes » n'est pas à l'agenda des autorités sanitaires.

- AVC lié à des Produits

Comme dans la plupart des pays européens, le système RAPEX permet de mettre en évidence des AVC en lien direct avec des PRODUITS ; la porte d'entrée dans le système est donc clairement le produit. La gestion de ce système a été décrite dans les documents de l'atelier Paris 2003.

Ce système ne peut évidemment pas répondre à l'objectif de mise en évidence de nouveaux types d'AVC non liés à des produits !

- Surveillance épidémiologique des AVC et notification des « alertes »

La mise au point faite en introduction doit être relativement tempérée depuis le 1 octobre 2003. En effet, à cette date, l'ensemble des structures hospitalières disposant d'un service d'urgence doit compléter un support de collecte de données concernant les activités de ces services. Des informations sont notamment collectées sur le motif de la visite aux urgences (maladie, accident, suicide, ...) mais malheureusement, aucune question, aucun item ne permet de caractériser les types d'accidents ni les circonstances de survenue. Ce type de collecte ne peut donc en l'état, permettre la mise en évidence de nouveaux types d'AVC.

Le Ministère fédéral de la Santé reste un acteur incontournable dans la prise de décision par rapport à une éventuelle notification de « nouveaux types d'AVC ».

De plus, les autorités communautaires (Ministres communautaires ayant la Santé dans leurs attributions) sont également concernées car la prévention des problèmes de santé fait partie de leurs compétences.

- Autres acteurs publics ou privés impliqués dans la prévention des AVC

Les mutuelles de santé : ces associations sont impliquées notamment dans les procédures de remboursement des prestations de santé. Elles disposent donc d'informations sur les AVC. Bon nombre d'entre elles s'impliquent également dans des actions de prévention des traumatismes (campagnes d'information, ...). Elles pourraient être un bon relais vers leurs abonnés.

Des Associations : les deux plus importantes sont :

EDUCA SANTE qui travaille dans le domaine de la prévention des AVC depuis plus de 20 ans.

CRIOC : organisme de défense des consommateurs, qui a été notamment chargé du projet EHLASS pendant un certain nombre d'années

Les médecins de première ligne (médecins généralistes privés, maisons médicales) : ils sont souvent les premiers contacts lors d'AVC et donc source potentielle très importante d'informations sur les accidents et leurs circonstances. Ces informations viendraient très utilement compléter celles qui seraient collectées dans les services d'urgence. Ces médecins généralistes sont également impliqués dans les activités de prévention ; ils le sont en fonction d'intérêts particuliers et non dans le cadre de programmes de prévention structurés.

Les compagnies d'assurance sont, pour certains types d'AVC, impliqués dans la collecte de données mais ces dernières ne sont pas disponibles.

## 2. Exemples d'AcVC atypiques

[...]. Note : voir fiches en annexe.

## 3. Point de vue sur la nécessité / utilité d'un système d'alerte

Comme j'ai eu l'occasion de le dire lors de notre atelier de travail à Paris en 2003, la situation belge est particulière dans la mesure où les informations « basics » concernant les AcVC ne sont plus collectées au niveau des structures hospitalières. Seul le système RAPEX permet de collecter quelques informations sur les « AcVC nouveaux » en lien avec des « produits ». Ce système est évidemment trop spécialisé sur le produit et passe forcément à côté d'autres AcVC.

Difficile donc de justifier ou d'obtenir un soutien pour appuyer le développement d'un système d'alerte sur les nouveaux types d'AcVC alors que les informations de base ne sont pas suffisamment disponibles.

Pourtant, dans la philosophie de ce qui a été proposé lors de l'atelier de Paris et lors de la discussion de novembre 2004, on pourrait malgré tout envisager le développement, en collaboration avec les autres pays européens, d'un « réseau de vigilance » utilisant les nouvelles technologies de la communication, de faible coût et ne recherchant pas l'exhaustivité mais plutôt la conjonction de constats d'AcVC « particuliers » dans les pays européens.

Cet outil devrait être développé dans le sens de ce qui a été testé c'est-à-dire un site web clair et léger, permettant, sans perte de temps avec une navigation difficile, de compléter « on line » un questionnaire (dont les items de la phase test devraient être retravaillés).

Ce questionnaire devrait permettre la déclaration d'AcVC « particuliers ». Le caractère particulier n'est pas toujours évident à faire ressortir et il va dépendre du profil de celui qui notifie. En effet, si ce sont par exemple des médecins privés qui ont à le notifier, ils peuvent en relever le caractère particulier (selon eux) mais la notion de fréquence particulière ou d'augmentation de fréquence est, à leur niveau, difficile à prendre en compte. Ce questionnaire devra bien sûr être en accord avec les prescrits légaux nationaux concernant le respect de la vie privée.

Je pense que la fiche de collecte actuelle devrait être retravailler notamment dans la formulation des items ; je sais que la façon de la construire dépend notamment de « qui aura à la compléter » mais je crois que l'on gagnerait à « fermer plus d'items » sur base de l'expérience acquise avec les fiches qui ont été complétées durant la phase test.

Il faudrait aussi que cette fiche puisse être envoyée « en direct » et qu'un accusé de réception soit automatiquement envoyé.

La grande question est évidemment de savoir à qui cette fiche doit être envoyée ??

On aborde là les spécificités nationales. A mon avis, il faudrait que chaque acteur de ce projet discute avec ses autorités nationales pour savoir qui pourrait jouer un rôle centralisateur par rapport à ce système d'alerte. Mais cette mission dépasse le cadre de ce projet « Rapid Alert ».

Au-delà d'une notification à un « **point focal national** », il serait important de prévoir une notification à un niveau européen (c'est pour moi une des richesses possible de ce réseau d'alerte). Mais encore une fois : qui ? Comment rediffuser l'info à tous les pays ? ...

### Quelles seraient les personnes possiblement impliquées dans la collecte ?

En Belgique, ce sont évidemment les prestataires de soins en contact direct avec les cas qui sont les mieux placés : les services d'urgence des hôpitaux mais également les médecins de première ligne.

### Quelles seraient les procédures de « réactions » par rapport à des notifications de nouveaux types d'AcVC ?

On aborde ici aussi un domaine où les spécificités nationales priment. Des systèmes existent en ce qui concerne d'autres types de problèmes de santé (épidémie, contamination alimentaire,...) ; ils pourraient être utilisés pour cette nouvelle thématique.

### Comment faciliter l'implantation du système :

- Recommandation européenne
- Campagnes de sensibilisation nationales auprès des acteurs ciblés (hôpitaux, médecins, ...),
- Incentives ???

# Denmark

*Bjarne Laursen, 29 novembre 2004*

*National Institute of Public Health - Svanemøllevej 25 – Denmark - bla@niph.dk*

## **Danish report to InVS regarding the “Rapid Alert” project**

How administration is organised regarding ”new” injuries (regulation, authority, surveillance, alert notification)

Authorities in the area of product safety:

Danish Safety Technology Authority (founded on January 1st 2004, gathered from different safety authorities, e.g. the Danish consumer agency)

The Danish Safety Technology Authority will focus on the safety technological aspects relevant to fires, accidents and explosions. It is their mission to set the standard in safety technology in Denmark, Europe and internationally. The Danish Safety Technology Authority is a part of the Danish Ministry of Economic and Business Affairs. The authority was founded by merging task from several councils and agencies. The merger of these technical tasks has taken place to ensure greater effectiveness.

Authority:

- Overall responsibility for gas safety in connection with all types of gas installations and plants.
- Overall responsibility for electrical safety, both in connection with production, transmission, distribution and the use of electricity.
- Administer authorisations with respect to electricity, gas, plumbing and sewage.
- Administer general product safety, incl. safety control of baby products and other consumer products.
- Are responsible for safety concerning fireworks, incl. approval of certified pyrotechnicians
- Conduct the industrial policy and have the general authoritative responsibility for metrology and accreditation. DANAK (Danish Accreditation) is the performing party whose work for the agency is based on a contract.

DSTA is the Danish contact point for the Rapex alert system.

Electric products and gas products are approved and spot-checked by the Safety Technology Authority.

General consumer product testing (not on a regular basis) is still performed by the National Consumer Agency as these test concerns many aspects of the product quality, including product safety.

RAPEX Notifications from Denmark:

DSTA (Danish Safety Technology Authority) notifies the EU Commission on interventions performed by DSTA or other authorities. It can be orders regarding stop for sale or withdrawal, or voluntary measures, which producer, importer or vendor has performed in cooperation with the authority.

The notification is sent on a special form and accompanied by a digital photo of the product.

At the same time the Ministry of Foreign Affairs is informed by DSTA.

Notifications to Denmark:

When DSTA receives a notification, it first assesses if it concerns a product that is regulated by another authority. If so, the notification is forwarded to this authority, which should inform DSTA as fast as possible, whether the product exist in the Danish market, and what measures that are taken. DSTA then informs the Commission.

Notifications regarding products not belonging to other authorities are considered by DSTA. The notification is sent to industrial organisations, supermarket chains etc.

When DSTA receives feedback, it informs the EU Commission whether the product is found in the Danish market, and informs about the measures taken regarding the product.

When receiving a RAPEX notification:

If product is not known, nothing should be done. DSTA then expects that the product does not exist on the Danish market. Attention should, however, be taken to the risk related to the notified product.

If selling the notified product, the marketing responsible has to act in relation to the notification. The same applies if selling products with similar risks.

Usually the responsible chooses to take the same steps as in the notifying state (e.g. sales stop). If this does not happen voluntarily, DSTA – unless special circumstances – will order the same measure against the product as in the notifying state.

Information on negotiation regarding a notified product and which steps that are taken in relation to the notification should be sent to DSTA as fast as possible and within 1 month from the receipt of the notification.

After this deadline DSTA – in the cases when the EU Commission requests fast feedback – inform the Commission whether the product exists in the Danish market.

### **Other institutions involved in injury prevention**

Other institutions and organisations involved in injury prevention and surveillance: The Danish Consumer agency, Healthy Cities Network, Safe community network, Ministry of Health and internal affairs, Board of Health, National Institute of Public Health, county-specific surveillance systems (e.g. in Odense)

### **Examples of atypical events reported by Denmark**

During the project, Denmark has provided four examples of atypical events or clusters of events and reported them to the EASI system:

1) Accident with children playing in gardens with chutes, an increase from 3 cases in 1998 to 17 cases in 2003, typically falls. There were a relatively large amount of fractures. The increase may be due to an increased number of chutes in the gardens.

2) An increasing number of injuries with electric appliances related to electric current, typically lamps, leads, sockets, plugs, often related to wet environment. The increase was from 23 accidents in 1998 to 61 accidents in 2003. Here it is of great interest to see whether there are similar increases in other European countries.

3) Trampoline accidents in gardens. These accidents have strongly increased the last years. It may be due to lack of safety precautions, or just to an increase in the number of these trampolines. There seems to be a large variation between different counties in Denmark.

4) Correction fluid: There have been two cases of exploded bottles with correction fluid during 2003.

My own point of view on the necessity / utility to put in place such an alert system, as well as the criteria for assessing a specific situation

I think that products are very important in the surveillance, and are far the easiest to monitor. In my experience, you may often find changes in accident frequency related to combinations of e.g. place, age and mechanisms. The important question is how to identify the causes behind these changes. I therefore think it is useful to create some kind of an alert system based on injury surveillance. I think it preferably should be at an informal level, to strengthen conclusions regarding what is going on nationally – is it a national problem, or is it an international problem?

Criteria for alerts:

Alerts should be related to "new" events, events that have not happened before, or has increased "significantly" (whatever this means), or an increase in the severity of the injuries. This increase may be due to an increase of the frequency of a particular product or situation, or due to changes in the products or their use, or other unknown factors.

The purpose of an alert is primarily to indicate the need for gathering more information, including injury data from other countries. Based on that knowledge, a study may be conducted to find the causes leading to the alert. Then eventual preventive measures could be taken to prevent the injuries.

# Portugal

*Baltazar Nunes, João Brandão, décembre 2004*

*Observatorio Nacional de Saude – Instituto Nacional de Saude Dr. Ricardo Jorge – Av. Padre Cruz, 1649-016  
Lisbonne - Portugal*

## **Injury alert system in Portugal**

Portugal has currently no implemented wide scope injury alert system.

The injuries with products involved are surveilled by the Rapex system which is divided into two separate surveillance centres (centre point of contacts): (a) non-food products: The Consumer's Institute and (b) food products: General Directorate for Inspection and Control of Quality of Food.

(a) every time a product is classified as hazardous in one of the member states of the EU, or every time a restrictive measure is applied to a product being put for sale due to security issues, the Member state issues a notification (in annex – Rapex Notification.doc) to the European Commission, who validates and deploys it to the other member states. When a notification is received, it is forwarded to the General Inspection of Economic activities and other institutions, depending on the category of the product: Infarmed (pharmaceutical peer) if is a cosmetic product, Regional Directorates of Economy if a machine, Customs General Directorate if it's the product originates in a foreign country or member state.

Consumption responsibility is hence divided by three institutions, according to the product characteristics:

**Non-food:** Safety Commission of Consumers Institute

**Food:** General Directorate for Inspection and Control for Quality of Food

**Pharmaceutical products:** Infarmed (Institute of Pharmacy and Drugs)

In the field of injuries the epidemiological surveillance is divided in different organizations, depending on their cause:

**Home and leisure accidents:** National Health Observatory of the National Health Institute Dr. Ricardo Jorge, Ministry of Health.

**Traffic accidents:** Observatory of Road Security, General Directorate of Traffic, Ministry of Internal Administration

**Occupational accidents:** General Directorate of Studies, Statistics and Planning of the Ministry of Social Security, Family and Child

In the case of injuries due to Home and Leisure Accidents, the warnings should be reported to the General Directorate of Health and the Consumers Institute. Injury prevention is responsibility of the General Directorate of Health and the Consumers Institute. Other private or non-governmental (non-profit) organizations with an important work in this field are EDIDECO (Portuguese Association for the Consumer Protection) and APSI (Association for Promoting Child Security).

## **Examples of atypical HLA injuries**

The examples proposed by the Portuguese team were the following reported in the system, which represent a low percentage of the total amount of cases that in reality take place (EASI cards in annex):

1. Poisonous sting by *Trachinus draco* (Greater weever) fish at the beach (25 cases)
2. Struck with sea medusas during swimming activity (1 case)
3. Hitting glass doors while running/walking or playing (22 cases)
4. Hair coiled by mixers till ripped off scalp (2 cases)
5. Hit ground or furniture and burns due to falls from baby walkers (47 cases)

## Importance and specifications of ESAI system

### Utility and necessity:

A system such as ESAI, with a more enlarged scope of activity than the Rapex, is seen with a great added value by the Portuguese partner of this project.

We believe that a surveillance system for atypical situations in Home and Leisure Injuries could be, in one way, a source of information for Rapex, when a product is involved in the accident, but also, and mainly for the other group of the HLI where a manufactured and commercialized product is not involved, or there is a issue of probable or certified inadequate use of the product.

The large amount of data collected by the HLI national surveillance systems (Ehlass) should be target of more exhaustive research for rare and particular situations that may not been considered relevant by the injury prevention entities.

In reality, within the Portuguese HLI surveillance system, unless there is a specific request for information in some situation atypical by a third party there is no working mechanism in place that detects rare and particular accidents.

In 2003 the National Health Observatory tried to implement a new procedure within the HLI surveillance system, to detect emerging/peculiar accidents, named ADL'IRIS (Unexpected/Rare/Peculiar HLA). For the functioning of this recent system, ADL'IRIS forms were distributed to all Health Units working for the HLI surveillance system (EHLASS/ADELIA) network. These forms were used by the health Units to report such atypical accidents directly by fax, e-mail or mail so we can immediately search the complete and updated database for similar episodes and react by alerting other health units involved, and the interested institutions like the General-Directorate for Health, Consumers Institute, etc. This tryout was nevertheless unsuccessful as despite al effort made to keep adl'iris well alive at the reporting end, not even one notification was received. We still believe this procedure has some value and should be tested on a national level or with a strongly committed large health unit, for if made active, it could provide a good working tool for ESAI.

Also the interchange of information between the EU countries could help in more rapid detection of these situations providing, alternatively, a wider image of the problem, causes and solutions.

### Assessing a specific situation:

The criteria proposed to select these cases were the following:

1. A great number of cases (accidents) in a short period or a cumulated effect of a small number of accidents but repeated over a longer period of time
2. The seriousness of the accidents under consideration
3. The novelty of the type of accident
4. The frequency with which individuals are exposed to similar circumstances
5. The clear identification of a cause: circumstance/product/behaviour
6. An increase in the importance of a known type of accident

Flagging an HLI should be based on the simultaneous emergence of at least 2 of these factors

Our comments on this set of elements are:

- An automated procedure should be implemented to flag HLI cases as defined previously
- To have success, some of the collected criteria should be better defined or rated, specifically points: 2. "The seriousness of the accidents under consideration", based on the information present in the IDB we should define indicators of injury severity; 3. "The novelty of the type of accident", create a knowledge data base with known accidents (e.g. based no key words) to test the novelty of the introduced case.
- Point 3 can only be analysed with information out of the IDB

The decision tree (flow chart) presented to decide on the alert issuing is, in our opinion, good, comprehensive and the steps are well defined. Nevertheless it should be defined who should be the EASI expert committees and who would be responsible at the EU level for the implementation of the *ad hoc* studies.

# Sweden

*Henrik Nordin, 29 novembre 2004*

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## **Remarks on the Alert project**

It has been a great pleasure to cooperate with the Institut de Veille Sanitaire and all other partners in this well-managed, practical and important project. This document contains a few closing remarks on the project from the Swedish Consumer Agency.

## **Recipients of information**

The project has come up with a tool for the dispersion of information about injuries which has a potential to be very useful for injury prevention. For this to be achieved in individual member states, there should be designated recipients of the information provided. Ideally, such recipients would be the authorities responsible for safety enforcement in the field in which each respective injury has occurred.

In Sweden, as in most countries, this responsibility is spread over a large number of authorities, depending on product category, type of activity, type of risk etc. Responsible in Sweden under the General Product Safety and Toy Directives is the Swedish Consumer Agency. The Agency's responsibility also covers personal protective equipment for private use, and consumer services which are not covered by other legislation. A few examples of other authorities and their fields of responsibility are the Medical Products Agency for drugs and other medicinal products, the National Food Administration for foodstuffs, the Swedish Chemicals Inspectorate for chemical risks, the Swedish National Electrical Safety Board for electrical risks in products and installations, the Swedish Road Administration for traffic and vehicle safety. These, and other authorities responsible for safety enforcement in other sectors, are also for the most part strongly active in preventive work, as are several non-governmental organisations, too many to be listed here. The number of organisations involved implies that, if a tool such as the one developed within the project is to be put into operation, it would probably be necessary to assign a central contact point in each member state willing to participate, at least in an initial phase. Although no commitments can be made at this stage, it could be a natural task for the Swedish Consumer Agency to take on such a role for Sweden.

## **Sources of information to a signalling system**

Due to legal and administrative particularities, the Swedish Consumer Agency has not yet access to case data of EHLASS type after 2001. Hence, no relevant statistical analyses could be made to extract examples to be signalled during the test phase of the project. Instead, a different approach, which was initially deemed potentially fruitful was tried: The coding staff at the Swedish EHLASS hospitals were contacted via e-mail and telephone, informed of the project and its objective, and asked to consider if cases or tendencies that might be noted during registration would be relevant to signal. The coding staff in Sweden is well-informed, motivated and always willing to assist in different matters, and discussions with the hospitals showed that the issue was discussed between coders, and serious efforts were made to find cases worth signalling. In spite of this, no new examples came out of this approach, only trampolines were mentioned as a growing problem, but this was already at the attention of the Swedish Consumer Agency. Instead, two examples of which the Agency has been informed through other channels were considered important enough to be signalled: the growing use of snowblades with non-release bindings, and children being poisoned by ignition fluid for charcoal grills, due to dysfunctional child-proof caps (not yet reported). These experiences indicate that 1) injury registration is probably most likely to yield important examples through statistical analyses, (not least considering the interesting tendencies signalled by other partners using that approach) and 2) that you can not refrain from other sources than injury registration to provide input to a signalling system.



### **Database more important than formal alerts**

An information database containing all reports to the system could very well be the most interesting aspect of a system put into operation, possibly more interesting than the formal 'alerts' that could come out of the administrative and scientific process outlined in a slide presented at the project meeting 23/10/2003 ("Alert system steps process", slide no. 10). Such a database could provide vital information of trends and developments concerning injuries in other European countries, potentially very useful for those working with safety enforcement and injury prevention. The process to determine whether an alert should be issued could be laborious, and would probably have to involve efforts from the person or organisation which sent in the initial report. This would be likely to limit the inclination to send in reports to the system, as very few organisations have the resources for such investigative contributions. If people and organisations are expected to voluntarily provide information on interesting trends and developments, the 'cost' for them must be as low as possible, and no further work can be required.

It is understood that this position may deviate from the system as originally envisioned, but for the purposes of practical enforcement and prevention, the scientific quality of the information is not always of the greatest importance.

### **Information on preventive action**

An important implication of the project is the potential to disperse not only information on injuries and risks, but also on preventive action that has been taken in other member states to counter the risk in question. In the area of general product safety, Prosafe is a forum for the exchange of such experiences, mainly in regular meetings. Considering the amount of different legislations, and hence different authorities, that may be involved in the cases signalled through a system such as the one developed within this project, a similar arrangement may not be feasible. Instead, it may be more realistic to envision an open web forum tied to the system, in which preventive actions can be suggested and discussed.

### **Suggestions for the development of the signalling tool**

The signalling tool used in the pilot project needs development if the system is to be put into operation. (This is in no way intended as criticism, to develop a perfect tool for the pilot would definitely have been the wrong priority.) For example, in the web-based 'signalling card' the answers filled in could not easily be graphically distinguished from the questions. As a 'signaller', you should be able to feel that the filled in 'card' looks good, and that the graphics help to make the message clear. Apart from benefiting the recipient of the information, this will also serve to motivate the person who provides it.

In line with the remark above, that an information database would be a valuable aspect of a system, it would naturally be a great advantage if an application could be developed to search and view a selection of reports, using a free text search. The information collected would be interesting also after the immediate alert stage, and historical reports should be kept available. As the number of reports increase, a tool to make selections in the mass of information will be necessary. Furthermore, it would also be very useful if the reports could be viewed in a more compact format than the 'signalling cards' as they were filled in, e.g. if a selection of cases could be downloaded in Excel or a similar format with a row for each report and questions/variables in columns.

Finally, a detail in the 'signalling card': the French phrase 'Éléments singuliers qui rendent cet accident atypique' is much clearer than the English 'Other atypical elements'. A phrase such as '[Particular] factors which make this accident unusual' could be used instead.

# Psytel

Plan du rapport final de Psytel, en date du 30/11/2004

Contexte

Compte-rendu chronologique des travaux

Documents contributifs

- Réflexion sur le fonctionnement du système d'alerte

- Position du problème

- Définitions complémentaires concernant le EASI

- Notes sur le système TRAPEX

- Compte-rendu de la réunion à la DGCCRF

- Compte-rendu de la réunion à la CSC

- Le site Internet « Alerte rapide »

- Procédure de recherche de cas à signaler à partir du texte libre

- Compte-rendu de la réunion téléphonique du 10/11/2004

Conclusions

Annexes

- Proposition d'organisation du projet « Alerte rapide »

- Programme de travail de la réunion de projet des 23 et 24 Octobre 2003

- Les fiches de signalement collectées (au 10/11/2004)

- Dictionnaire des mots EPAC dans les fichiers 2004 (extrait)

- Projet de plan du rapport intermédiaire

- Éléments d'information sur le cas « trampoline »

# Appendix VIII

**Meeting of July 2, 2003**

**With the Direction générale de la consommation, de la concurrence et de la répression des fraudes**

*Etaient présents : M. Bailbled, Mme Peyronnet, Mme Zylberman (DGCCRF), B. Thélot, E Szego (InVS), M. Nectoux (Psytel)*

## **Points abordés :**

La notion d'alerte est au cœur de nombreuses discussions au sein des administrations nationales et de la Commission. Il existe des alertes produits (alimentaires, non alimentaires), des alertes sur les maladies transmissibles, sur les problèmes d'environnement, les produits pharmaceutiques, etc. Définir en quoi consiste une alerte n'est pas si simple. Définition proposée : une alerte est une information nécessitant une action dont l'absence pourrait nuire à la santé du citoyen.

Il existe plusieurs niveaux d'actions en réponse à une alerte allant de la simple demande d'information aux mesures restrictives (ex : arrêté d'interdiction). Il y a deux composantes dans RAPEX : RASFF (réseau pour les alertes alimentaires) et un réseau pour les alertes non alimentaires. Pour 2002, il y a eu dans le système RAPEX environ 500 alertes alimentaires et 150 concernant des produits non alimentaires. Il existe aussi deux niveaux d'information dans le système RASFF : l'alerte et la simple information (news). La non conformité dans la composition d'un produit ne suffit pas à déclencher une alerte, au moins en France.

Les attitudes des différents Etats membres ne sont pas forcément homogènes : certains Etats notifient peu, d'autres beaucoup plus fréquemment (ex : la non conformité suffit parfois, le Royaume-Uni est peu penché vers la réglementation, etc.). Il y a donc des sensibilités nationales différentes face à la question de l'alerte « produit ». Une organisation centralisée (ex : France) facilite le fonctionnement par opposition à des modes de fonctionnement plus décentralisés de l'Etat (ex : Allemagne, Espagne).

Une étude anglaise, commandée par la Commission fait le point sur les critères devant contribuer à déclencher une alerte : gravité des cas rapportés, âge des victimes, reproductibilité de l'accident, caractère prévisible de l'utilisation du produit, niveau d'information fourni au consommateur, existence d'une réglementation dans le secteur, etc.

L'alerte sur les produits alimentaires (ou de type pesticide par exemple) se fait le plus souvent sur la base d'un examen objectif et systématique de la composition des produits. L'alerte sur des produits non alimentaires se fait essentiellement sur la base de signalement ponctuel d'accidents déjà survenus.

Outre le système RAPEX, il existe aussi en France des remontées d'information à partir des Directions Départementales (DDCCRF). Elles constituent une sorte de système national

propre. Ces remontées sont traitées ensuite dans les différents bureaux de la DGCCRF selon la nature des produits impliqués. Ils font ou non l'objet d'une notification dans RAPEX.

### **Notifications dans RAPEX :**

La notification RAPEX est faite sur la base d'un danger « grave et immédiat ». Pour justifier une notification, il faut que l'accident concernant un produit réponde à des « conditions normales ou raisonnablement prévisibles » d'utilisation. Une accumulation de cas peut déclencher une alerte. Un des atouts d'un système européen est de pouvoir cumuler des cas semblables dans plusieurs Etats membres. Il faut distinguer si le produit ou la catégorie de produits s'inscrit dans un contexte réglementaire ou non. Dans les alertes produits, il faut une identification claire et précise du produit pour déclencher une alerte (marque commerciale, n° de lot, importateur, etc.).

#### Exemples évoqués :

- cas des boîtes de conserve à ouverture rapide : plusieurs consommateurs se font des coupures importantes en ouvrant la boîte (danger du produit ou seulement maladresse de l'utilisateur ?)
- cas des piments indiens : la coloration en rouge des certains petits piments indiens se fait avec un produit interdit cancérigène. Faut-il le signaler dans RAPEX ? Ce n'est pas un danger immédiat, mais le danger peut survenir lors d'une consommation répétée. Le cas a finalement été notifié par la France dans RAPEX
- cas des bonbons chinois : petits bonbons en gélatine (konjac ?) qu'il faut gober. Des consommateurs peu habitués peuvent s'obstruer les voies respiratoires. Des cas mortels ont été signalés au Canada. Les autorités canadiennes (ou d'autres pays) peuvent informer directement certains MS ou la Commission sur le danger de certains produits. Après réalisation d'un test de viscosité, ces bonbons ont été interdits en France.
- cas d'un fusil sous-marin : violente décharge d'air comprimé alors que le consommateur examinait et dévissait l'objet près de son visage, entraînant un œil crevé.
- cas d'un savon liquide : conditionné sous forme d'aérosol, la pression trop violente du jet entraînant des irritations de l'œil.

On voit dans ces exemples que le comportement de l'utilisateur est une variable importante de la survenue de l'accident, pourtant on reste dans le cadre d'une utilisation « normale » (?).

Pour un système spécifique sur les accidents de la vie courante, il serait possible d'insister sur les notions de « risque faible » et de « risque différé, en abandonnant ou en ne rendant pas obligatoire la notion de « rapide » dans alerte rapide, et/ou en minimisant ou en abandonner la notion de gravité et d'immédiateté dans la caractérisation de l'alerte. Il faudra définir les critères spécifiques de l'alerte AcVC, mais aussi les niveaux de réponse et d'actions possibles (quels cas signaler ? quand les signaler ? à qui ? comment et où ? pour quelles actions (réseaux d'experts pour valider l'alerte ou la réponse possible ? suivant quelle légitimité ?), etc. Il faudra dans tous les cas s'attacher à distinguer ce qui dans l'alerte relève d'une part de la dangerosité du produit lui-même et d'autre part du comportement du consommateur,

## **Meeting of July 4, 2003**

### **With the Commission de la sécurité des consommateurs**

*Etaient présents : Mme Françoise Briand, M. Hugues Cahen (CSC), B. Thélot, E Szego (InVS), M. Nectoux (Psytel)*

#### **Points abordés :**

Le processus de signalement des cas à la Commission de la sécurité des consommateurs :

Le processus est informel. Le mode le plus fréquent est une saisie par courrier ou mail d'un consommateur concernant un produit possiblement défectueux (10 à 12 par mois). Il existe aussi un réseau informel d'interlocuteurs au niveau européen (membres de l'IPP Network : CEREPRI - G, CSI - NL, Sicher Leben - AT, etc.) qui signale des cas. Des signalements peuvent aussi se faire via des Associations de consommateurs (ex : UFC, Que Choisir, etc.), par lecture directe de la presse spécialisée (revues sur la sécurité des consommateurs aux USA, Canada, etc.), par une veille informelle des informations diffusées par les média ou encore par transmission directe d'informations par des journalistes. Enfin, les appels à témoin constituent aussi des points d'entrée pour le signalement des cas.

Après signalement, il y a un processus de validation de la plainte (la CSC n'instruit pas de plaintes dans les domaines financiers et/ou des services). Si le signalement est valide, il sera examiné dans une séance plénière de la Commission qui décidera s'il y a constitution d'une saisine formelle. Cette assemblée décide aussi des suites à donner : enquêtes complémentaires, tests à effectuer. L'instruction du dossier peut se terminer par un classement sans suite ou un avis rendu.

En 2002 il y a eu 123 saisines (dont 2 auto saisines : la CSC peut se saisir elle-même d'un dossier, sans signalement extérieur). Il y aura pour cette année là, 7 classements sans suite et 11 avis rendus. Les avis sont assez généraux, ils se rapportent à des classes de produits et constituent généralement des réponses à plusieurs saisines.

La CSC n'a pas de pouvoir réglementaire, ni de pouvoir de sanction. La CSC est une relativement petite structure (15 personnes). Son site Web est assez fréquenté (environ 250 visites/jour). Elle travaille en étroite collaboration avec la DGCCRF. Il est toujours possible de diffuser des alertes avant qu'il y ait eu un avis rendu par la CSC, mais il faut alors l'accord du fabricant. En cas d'urgence extrême, il y a toujours moyen d'agir par contact direct avec la DGCCRF, communiqués de presse, etc.

#### **Exemples évoqués :**

Cas de petites perles cousues sur des baskets d'enfants : risque d'arrachement et d'ingestion des perles. Une pré enquête peut se dérouler pour décider de la validité et de l'étendue du problème. La CSC examinera alors aussi le cas des petites perles cousues sur d'autres types de vêtements pour enfants (jeans, jupes, etc.).

Cas d'une commode pour enfant : un enfant a renversé une commode, un tiroir s'est détaché et lui a brisé la nuque (décès). Dossier en cours.



# Appendix IX

## Minutes of the teleconference on 10 November 2004

### Contexte :

- L'équipe de projet voulait faire le point sur l'avancement des travaux et notamment sur les fiches de signalement collectées et disponibles sur le site Web du projet. La réunion téléphonique a semblé le moyen le plus adéquat et pertinent pour cette discussion.

*Ont participé à la réunion téléphonique : F. Briand (CSC - F), R. Bauer (ISL - AT), A. Lévêque (B), H. Nordin (SCA - S), B. Thélot (InVS - F), M. Nectoux (Psytel - F), J. Brandao (INS - PT), B. Laursen (NIPH - DK).*

### Points abordés :

#### 1. Les signalements collectés :

- 26 fiches de signalement ont été collectées et chargées sur le site Web à cette date (voir Annexe) : 2 fiches de l'Autriche, 3 fiches de la Belgique, 4 fiches du Danemark, 10 fiches de la France, 5 fiches du Portugal, 2 fiches de la Suède. Après ce rappel, les participants échangent des informations sur les différents cas collectés. Par exemple :

- trampoline (DK+S+F) : 3 pays ont signalé des cas d'accidents avec des trampolines dans les jardins. L'équipe de projet a regardé s'il existait d'autres cas en France, dans la base EPAC (287 cas pour 2000, 2001 et 2002) et en Europe, dans la base IDB (302 cas pour 2000 et 2001). Une étude approfondie est en cours.

- piercing (F) : pas d'autres cas rencontrés dans les autres pays.

- effet de loupe (F) : pas de cas relevés ailleurs.

- snowblade (S) : accidents provoqués par des fixations qui ne sont pas de sécurité (non-released bindings) qui équipent fréquemment les snowblades. D'autres accidents similaires en Autriche et en France. Mme Briand signale que la CSC va bientôt rendre un avis sur ce produit.

- sea medusa (PT) : en France nous avons aussi des cas de ce type, mais le problème n'est pas vraiment nouveau. Le nombre de cas est variable selon les conditions climatiques et météorologiques.

- cheval (B) : la Belgique a signalé le cas d'un cheval infligeant une morsure grave à la personne qui le nourrissait.

La Belgique doit nous faire parvenir deux nouveaux cas.

#### 2. La gestion des signalements :

- Après l'évocation de ces cas particuliers, les participants abordent plus globalement la question de la gestion des signalements. On s'oriente vers le processus suivant :

T1 : Il semble indispensable de faire d'abord circuler l'information sur chaque cas auprès des NDA (National Database Administrator) de chaque pays.

T2 : Voir s'il existe des cas similaires dans :

T2.1 les bases nationales

T2.2 la base européenne IDB

T2.3 d'autres sources de données

pour déterminer la fréquence et l'évolution du nombre de cas dans le temps

T3 : approche bibliographique sommaire et lien avec RAPEX

A propos du chargement des bases nationales dans IDB : le rythme des mises à jour de la base IDB est encore trop lent (par exemple, il n'y a pas les fichiers nationaux 2002 actuellement). Il faut donc aller voir dans les bases nationales qui sont consolidées généralement au printemps de l'année N+1 pour les données de l'année N. Les NDA ont aussi accès aux fichiers mensuels de l'année en cours (Mois +2 à +3).

C'est le premier niveau de réaction. En fonction des réponses, on peut passer à d'autres niveaux de réaction :

T4 : discussion sur la pertinence de mise en place d'une étude ad hoc, prenant en compte les avantages escomptés en regard des contraintes et du coût de l'étude.

T5 : Si réponse positive à l'étape précédente, mise en place de l'étude ad hoc, avec protocole, collecte spécifique, analyse, rendu de résultats.

### **3. Le point sur le projet :**

- B.Thélot signale aux participants que, dans le cadre de leur contrat, ils doivent remettre pour le 30 novembre 2004 un rapport écrit à l'InVS relatant l'ensemble des travaux qu'ils ont effectué pour ce projet. Les participants sont aussi invités à donner leur point de vue sur le fonctionnement et l'opportunité de la continuation du EASI system (European Alert and Signalement on Injuries System).

- Ms. Bauer et Laursen soulignent l'importance de l'échange d'information sur les signalements, comme cela a pu se dérouler au cours de cette réunion. Une réunion téléphonique régulière, tous les trimestres, par exemple, serait particulièrement utile dans le cadre de la continuation de ce projet. Cette proposition est validée par l'ensemble des participants. Mme Briand signale que dans le projet RAPEX, des meetings sont régulièrement organisés par la structure PROSAFE. Pour notre projet, une réunion plus informelle et téléphonique pourrait tout à fait convenir.

- L'ensemble des participants semble avoir une opinion positive sur le projet et sur l'utilité de recommander la mise en œuvre d'un système de type EASI, avec un fonctionnement relativement léger, auprès de la Commission.

- Suite attendue du projet : rédaction d'un projet de rapport final à partir du mois de décembre, nourri par les échanges et les rapports partiels des participants. Ce projet de rapport sera transmis pour appréciation aux partenaires avant sa finalisation.



# Appendix X

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