Assaults

Key Points

- Assaults have a substantial impact on all agencies. Crime and Disorder Reduction Partnerships (CDRPs) should take the lead on ensuring a multi-agency approach is taken to reduce the number of assaults across Cheshire and Merseyside.
- Those most at risk of assault-related Accident and Emergency (A&E) attendance are males, individuals aged 15-29 years and individuals visiting the night time economy.
- Liverpool City Centre and Birkenhead Town Centre were identified as hotspot areas for assaults across Merseyside. In particular Bold Street, Concert Square, Slater Street, Mathew Street, London Road and Hardman Street were identified as key areas for assaults resulting in A&E attendance across Liverpool City Centre.
- Just under half of assault attendees at A&E had been drinking prior to their assault.
- Over a quarter of assault attendees to A&E did not intend on informing the police of their assault. This highlights the importance of using health intelligence alongside police intelligence to gain an accurate picture of the level of assaults. A&E, ambulance service and police intelligence should be routinely shared to ensure accurate and up to date intelligence on assaults is used to inform intervention strategies.

1. Introduction

Assaults have a substantial impact on all agencies from health and criminal justice to local authorities and social services. The Trauma and Injury Intelligence Group (TIIG) is a subgroup of the Cheshire and Merseyside Public Health Network. TIIG collects data from Accident and Emergency (A&E) departments and the Ambulance Service in Cheshire and Merseyside. It is able to assess changes in the level of assaults, the demography of assault attendees at A&E and those using ambulance services. Combined with hospital episodes, mortality and police data, this report provides evidence of the impact of assaults on public services and at risk groups across Cheshire and Merseyside. Hotspot areas for assaults are identified and hence where interventions should be focused.

1.1 Background

Violence is increasingly becoming a major public health issue. In 1996 the World Health Assembly adopted Resolution WHA49.25, which declared that violence is a growing public health concern across the world. In October 2002, the World Health Organization (WHO) launched a global campaign for violence prevention following the release of the World Report on Violence and Health (Krug et al, 2002). The report aimed to raise awareness about the problem of violence, highlight the crucial role that public health can play in addressing its causes and consequences, and encourage action at every level of society. As a result, many national governments have prioritised violence prevention, including the United Kingdom. During March 2005, an international conference on violence prevention was held in the North West of England with the aim of promoting a multi-agency approach to violence prevention in the UK as recommended by the WHO.

Violence comes in many forms including physical, emotional, political and sexual. Individuals can experience one type of violence or be subjected to a range of types of violence at any one time. Many forms of violence such as assaults or domestic violence result in injury and contribute to physical and mental health problems. The effects of violence from threatening behaviour to murder or assault can be devastating to the health and well being of individuals along with the wider community. For example, violence in the night time economy affects a range of individuals. Firstly, many assaults lead to injury and impact not only on the individual, but also place an added burden on local police and health care resources. A report conducted on National Health Service (NHS) staff in 1996 found that physical assault was the fourth most common type of staff incident. This has led to the NHS developing a range of strategies to reduce violence against their staff, including consideration of the environment in which NHS staff work, and educating staff and patients on the effects of violence and possible delays caused to their treatment (Comptroller and Auditor General, 2003). Costs of damage to property or of cleaning up after a violent incident are suffered by local authorities, bars, clubs and other businesses (Hughes et al, 2003). Fear of violence has negative repercussions as it can deter people from visiting city centres during the evening hours (Home Office, 2000). This affects businesses that focus on family entertainment.
1.2 Policy

The issue of violence is now receiving much attention. From the global push by the WHO to national governments and local communities, there is a drive to reduce levels of violence experienced by the public. In the UK, the issue of violence crosses many policy areas. Recognising the need for multi-agency working, the 1998 Crime and Disorder Act established partnerships between the police, local authorities, probation services, health authorities, the voluntary sector, and local residents and businesses with an aim to reduce crime and disorder within their local area. Promoting partnership working, a requirement was set for the groups (Crime and Disorder Reduction Partnerships) to conduct local crime audits to identify problems experienced by all and devise strategies to overcome these problems. One of the main issues identified was alcohol-related crime, and in response Home Office guidance has been published on the collection and analysis of alcohol-related crime and disorder data (Tiemey and Hobbs, 2003).

The Private Security Industry Act 2001 should also impact on the levels of assaults occurring in and around bars and clubs. The Act requires door supervisors to be trained and licensed, and prevents individuals with a serious criminal conviction from gaining a licence to be a door supervisor. Research conducted in Liverpool illustrated that door supervisors were responsible for 11% of club-goer assaults presenting at A&E (Luke, 1998). Whilst local registration schemes for door supervisors have been running across Cheshire and Merseyside for many years, this national Act should ensure only suitable and appropriately trained individuals are employed as door supervisors who are able to resolve conflict and help reduce the levels of violence in the night-time economy. The introduction of the Licensing Act 2003 has led to increased flexibility of opening hours for pubs and clubs. Part of the rationale behind this is that fixed closing times result in large numbers of intoxicated individuals emptying out onto the street when bars and clubs close. This leads to a high demand for public transport and creates a situation in which violence and disorder can flourish. The idea behind flexible closing times is that a gradual departure of individuals from premises will alleviate these problems. However, feelings are mixed on this issue, since it is also perceived that flexible opening times may lead to violence and disorder occurring later into the morning hours, putting further pressure on police and healthcare resources (Westminster Police and Community Consultative Group Licensing Working Party, 2000).

The White Paper 'Choosing Health' published in 2004 sets out key principles for supporting the public to make healthier and more informed choices in regards to their health (Department of Health, 2004). One of the aims of the paper is to support young people and prevent youth violence by targeting health information at young men on a range of issues including violence and depression. The paper also highlights the contribution the NHS can make in helping those experiencing domestic violence.

Reducing levels of violence will have benefits for all. From improving people’s health and creating a society more pleasurable to live in, to reducing the pressures on local services. One direct result of reducing the number of assaults would be a reduction in A&E presentations and ambulance call outs. For example, the NHS has set key target indicators to reduce the time patients spend in A&E. The requirement is that 98% of patients spend four hours or less in A&E from arrival to discharge from January 2005 (HealthCare Commission, 2004). A reduction in assaults will be conducive to this target.

1.3 Local interventions to address assaults

There are a range of initiatives in place to reduce violence and disorder. Nationally, the Tackling Violence Crime programme (a joint initiative between the Police Standards Unit, the Prime Ministers Delivery Unit and the Home Office Violent Crime team) is currently being rolled out across England and Wales. The aim of this programme is to reduce violent crime, with a focus on reducing alcohol-related violent crime and domestic violence. Locally, Citysafe, the Crime and Disorder Reduction Partnership and the Drug and Alcohol Action Team for Liverpool aim to reduce crime and disorder in the Liverpool area. One of their objectives is to reduce incidents of street violence including stranger attacks and alcohol-related violence (Citysafe, 2002). The Wirral has produced an Evening and Night-time Strategy and an Alcohol Strategy. Alcohol-related violence is highlighted as a priority area and a target has been set to reduce alcohol-related assault attendees at A&E by 15% by 2008 (Wirral Alcohol Strategy, 2005). Similarly, the Safer Warrington Partnership has set a target to reduce alcohol-related assaults in Warrington by 10%. They aim to do this by collecting and analysing alcohol-related assault data to identify hotspots and target police interventions (Safer Warrington Partnership, 2002).
In Southport the Nitelite initiative was set up to examine and tackle safety-related issues in Southport’s night time economy. A consultation with users of the night time economy took place and found that although individuals had not necessarily witnessed an act of violence or aggression in the night time economy, perceptions of violence occurring were still high. Interventions were put in place to reduce people’s negative perception of Southport by increasing awareness of CCTV, setting up local door supervisor training, and holding outreach events in bars and clubs to promote safety messages (Duffy et al, 2004).

2. TIIG Assault Data

2.1 Mortality
Death is the most severe result of an assault. Mortality statistics are based on registrations of deaths using International Classification of Disease codes (WHO, 1992). However, it is difficult to present timely and accurate statistics on assault-related deaths. This is because many are caught up in legal processes, such as police investigation. This leads to a delay in the registration of the death, thus crime related mortality statistics are generally not deemed to be accurate until a few years later. Figures for 2002 illustrate that for Cheshire and Merseyside there were seven deaths directly associated with assault (Department of Health, 2004a). It needs to be remembered that assault-related deaths are the tip of the burden of injury iceberg. Many assaults do not lead to death and result in hospital admission or A&E attendance.

2.2 Admissions to Hospital
The severity of an assault is influenced by many factors, such as whether a weapon is used or number of attackers; hence the extent of required treatment can vary widely. More serious assaults require admittance to hospital. Information on assault-related hospital attendances are captured via Hospital Episode Statistics (HES), which provide information on all patients admitted to NHS hospitals in England.

HES data for Cheshire and Merseyside illustrate that between April 2002 and March 2003 there were 2,978 assault-related admissions to hospitals across the region. Analysis of these admissions by age and gender enables the identification of at risk groups. For the ages of 10 - 44 years, assault-related admission was one of the top ten reasons for admission to hospital across Cheshire and Merseyside. Further analysis by gender identified assault-related hospital admission as the leading cause of hospital admission for males aged 15 – 24 and the second leading cause for males aged 25 – 34. The pattern was dramatically different for females, where assault-related admission did not appear in the top ten causes of admission for any age groups (Department of Health, 2004b).

2.3 Accident and Emergency attendances
Many assaults require treatment at A&E departments. Although A&E Information Technology (IT) systems vary between departments, they provide an excellent opportunity to gather information on the extent of assaults. The following analysis of A&E data provides a breakdown of assault attendees at Aintree, Alder Hey, Arrowe Park and Royal Liverpool A&E departments for the period July to December 2004.

2.3.1 Demographics of Accident and Emergency assault attendees
During the six months of July to December 2004 there were 2,205, 1,488, 1,373 and 236 assault attendances at Royal Liverpool, Aintree, Arrowe Park and Alder Hey A&E departments respectively. There was a significant difference in the proportion of males and females attending as assault attendee. Males accounted for 74%, 73%, 77% and 62% of assault attendees at Aintree, Royal Liverpool, Arrowe Park and Alder Hey A&E departments, respectively. Over half of all assault attendees at Aintree, Royal Liverpool, Arrowe Park and Alder Hey A&E departments were aged 15 – 29 years (Figure 1). The majority (92%) of assault attendees to Alder Hey Children’s A&E were aged 10 - 17 years.

Figure 1: Accident and Emergency assault attendees by age group, July to December 2004
Information collected at the Royal Liverpool A&E department showed that two thirds (67%) of assault attendees were White British, 24% Unknown, 6% Other Ethnic Group, 1% White Irish and 1% Other Black Background. Assault attendees to Alder Hey A&E were primarily classed as White British (93%).

2.3.2 Location and time of assault

Location and time of assault attendance can be used to identify hotspot areas and peak times for assault, where interventions may be best targeted. This information is collected at all four hospitals, although the detail of information varies between each A&E department. For all A&E departments, assaults generally occur in a public space, such as a street/road. Further information on particular street/road location is collected at Royal Liverpool A&E department and analysis of this information highlights Liverpool City Centre as a hotspot area for assault. In particular, Bold Street, Concert Square, Slater Street, Mathew Street, London Road and Hardman Street were identified as key areas for assault across Liverpool City Centre (Figure 2).

![Figure 2: Top twenty street/road locations for assault, Royal Liverpool Accident and Emergency department, July to December 2004](image)

Assaults occurring in the home accounted for 17%, 15%, 8% and 5% of assault attendees at Aintree, Arrowe Park, Alder Hey and Royal Liverpool A&E departments respectively. Research conducted on the Wirral during January to September 2004 found that domestic violence accounted for more violent offences than alcohol-related violence, at 29% compared to 15% (Brown, 2005). The Wirral had the second highest number of domestic violence offences for 2004 across Merseyside, at 20% of all violent offences, with North Liverpool being the highest at 28%. There are a number of barriers to analysing the level of domestic violence. Although improvements are being made, domestic violence is largely under reported to the police (McVeigh et al, 2005). Even when individuals report domestic violence to the police, the complexities of coding and IT systems mean it is often difficult to provide accurate analysis of the level of domestic violence. Hence, A&E departments present an opportunity to collect further information on domestic violence and such work is currently being carried out at many of the A&E departments across Cheshire and Merseyside. Further marketing has been carried out by Merseyside Police to highlight their commitment to zero tolerance to domestic violence and increase public reassurance.

The month of A&E attendance can be used to identify peak times for assaults. Through July to December 2004 there was no major difference in the number of assault attendees presenting at Aintree, Arrowe Park or Royal Liverpool A&E departments. This will be revisited when a years worth of data is available. However, at Alder Hey Children's A&E department, the distribution was not consistent, with 8% of assaults occurring in August and 25% occurring in October. Analysis of time and day of assault attendance at Aintree, Arrowe Park and Royal Liverpool A&E departments highlight Friday, Saturday, Sunday and Monday as peak days. Somewhat different, peak days for Alder Hey Children's A&E department were Thursday (20%), Friday (17%) and Saturday (14%).

Figures 3 and 4 show peak times for assault attendance at Arrowe Park and Royal Liverpool. Although there will be a delay between the time of assault and time of A&E attendance, this information is useful in identifying time trends. Peak times for assault attendance at Arrowe Park and Royal Liverpool were identified as during the evening/morning hours over the weekend period. A similar pattern is shown at Aintree A&E. However a much expected difference is seen at Alder Hey A&E where the number of assault attendees on Thursday and Friday increases throughout the day until 12 midnight and then decreases dramatically. On Saturdays, assault attendance increases up until 2am and then slowly decreases into the early hours.
2.3.3 Type of assault

Further information on assaults is collected at Arrowe Park and Royal Liverpool A&E departments. Number of attackers can illustrate the type of violence occurring. At Arrowe Park, for six in ten (58%) assault attendees, the assault involved one attacker. However, almost a third (30%) of assault attendees had been involved in assaults with more than one attacker, suggesting more vicious gang fighting. Data collected at Royal Liverpool show over half (52%) of assault victims were unable to detail the number of individuals involved in their attack. A quarter (24%) had been attacked by one individual, with the other quarter (24%) being attacked by more than one individual. This high unknown response rate at Royal Liverpool means precise conclusions cannot be made here (Table 1). However, when looking at known responses only, the figures for Royal Liverpool show a similar trend to that of Arrowe Park.

### Table 1: Number of assault attackers, Arrowe Park and Royal Liverpool Accident and Emergency departments, July to December 2004

<table>
<thead>
<tr>
<th>Number of attackers</th>
<th>Royal Liverpool A&amp;E</th>
<th>Arrowe Park A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>521</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>171</td>
<td>8</td>
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<td>16</td>
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<tr>
<td>Unknown</td>
<td>1152</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td>2205</td>
<td>100</td>
</tr>
</tbody>
</table>

Nearly eight in ten (79%) assault attendees at Arrowe Park A&E department had been struck, while 2% had been stabbed or ‘glassed’, compared to 4% at Royal Liverpool A&E (Table 2).

Additional information on assaults is collected at Royal Liverpool A&E via an electronic questionnaire regarding assaults. As can be seen in Table 2 there is a high unknown response rate to the questions in this survey. Improvements need to be made in data procurement to enable better conclusions from assault information.

1 The high percentage of Sunday morning assault attendances is due to Saturday night pubs/clubs closing early hours Sunday morning.
Table 2: Royal Liverpool Assault Patient Questionnaire, July to December 2004

<table>
<thead>
<tr>
<th>Royal Liverpool Assault Patient Questionnaire</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>With what were you attacked?</td>
<td>56% unknown, 33% body part, 5% blunt object, 2% bottle, 2% knife, 2% glass</td>
</tr>
<tr>
<td>What was your relationship with your attacker?</td>
<td>58% unknown, 29% stranger, 7% acquaintance/friend, 2% bouncer, 1% partner, 1% ex-partner, 1% police, 1% family member</td>
</tr>
<tr>
<td>Gender of attacker?</td>
<td>51% unknown, 44% male, 3% female, 2% both</td>
</tr>
<tr>
<td>Have you or do you intend on informing the police?</td>
<td>46% unknown, 27% yes, 27% no</td>
</tr>
</tbody>
</table>

2.3.4 Alcohol
Arroe Park collects further information on alcohol involvement in assaults. Analysis highlighted that just under half (49%, N=669) of assault attendees had been drinking prior to their attack, illustrating the relationship between alcohol and violence. Six in ten (60%) alcohol-related assault attendees were aged 15-29 years, whilst 80% were male. A high level of alcohol consumption, along with being male, aged 16-29 years and visiting a pub/club have been identified as some of the risk factors associated with alcohol-related violence in England and Wales (Budd, 2003). Further analysis shows that 10% (N=68) of alcohol-related assault attendees were under the age of 18 years. Analysis of these under age drinkers found eight had been assaulted in a nightclub or public house.

2.3.5 Area of residence of assault attendees
Area of residence of assault attendees can identify two issues. Firstly, it can show whether it is local people involved in local violence and secondly it can identify areas other than where assaults occur, where educational interventions may be targeted.

Aintree
Figure 5 illustrates the spatial distribution of residences of assault attendees in relation to Aintree A&E department. The map highlights that the ward of Linacre had the highest rate of assault attendees at Aintree A&E during July to December 2004, at 7 per 1,000 population.
Figure 6 demonstrates that Birkenhead, Tranmere and Bidston had the highest rates of assault attendees at Arrowe Park A&E during July to December 2004, at 9.2, 8.8 and 7.2 per 1,000 population respectively.

Figure 6: Ward of residence of Arrowe Park Accident and Emergency department assault attendees, all persons, rate per 1,000 population, July to December 2004

Royal Liverpool

Figure 7 highlights the postcode area of residence of assault attendees at Royal Liverpool A&E department. Data supplied by Royal Liverpool A&E contain first part postcode only (e.g. L1) and therefore TIIG are unable to map rates as for other hospitals. The map hence shows raw numbers.

The map illustrates that the postcode areas of L8, L6 and L7 had the highest number of individuals attending Royal Liverpool A&E as a result of an assault, at 240, 189 and 171 respectively.

Figure 7: Postcode area of residence of Royal Liverpool Accident and Emergency department assault attendees, July to December 2004

2.4 Ambulance call outs

Mersey Regional Ambulance Service (MRAS) respond to ambulance call outs in the Cheshire and Merseyside region. For each call out MRAS responds to, valuable information such as reason for call out, location of incident and time and date of incident are collected. Such data are used here to build a pattern of assault-related ambulance call outs in Cheshire and Merseyside during September to November 2004.

Data coding systems at MRAS means ambulance call outs for assault and rape are categorised into one group (assault/rape). The following analyses break down this group of ambulance call outs by time, day and location.

During September to November 2004 there were 1,244 ambulance call outs for assault/rape in the Cheshire and Merseyside region. Call outs for assault/rape peaked over the weekend period, with 16%, 25% and 20% occurring on a Friday, Saturday and Sunday respectively. Analyses of assault/rape call outs by time and day showed peak times to be the weekend evenings (Figure 8).
Figure 8: Assault/rape related ambulance call outs by time of call out, all persons, Cheshire and Merseyside, September to November 2004

Figure 9: Ward location of assault/rape ambulance call outs, rate per 1,000 population, all persons, Cheshire and Merseyside, September to November 2004

Data provided by MRAS (full postcode of incident location) allows the exact location of ambulance call outs to be plotted and hence provide a more precise location of where these incidents occurred. Figure 10 shows exact location of assault/rape call outs focusing on Liverpool, Wirral and surroundings areas.

Figure 9 illustrates the location of ambulance call outs for assault/rape during September to November 2004. Peak areas for assault/rape related call outs were Liverpool City Centre and Birkenhead Town Centre.
2.5 Police recorded crime figures
Police recorded crime figures collate all recorded crimes across England and Wales. Recorded crimes are categorised into nine main groups, one of which is violence against the person. This category groups together offences such as common assault, murder and wounding. Figure 11 illustrates the number of violence against the person offences per 1,000 population for Crime and Disorder Reduction Partnerships across Cheshire and Merseyside. The CDRP areas of Liverpool, Halton and Wirral had the highest rates of violence against the person offences, at 27, 21 and 18 per 1,000 population respectively.

Figure 11: Incidence of violence against the person offences by Crime and Disorder Reduction Partnership area, rate per 1,000 resident population, Cheshire and Merseyside, 2002/2003 to 2003/2004

3. Summary
Violence is a major public health issue. Many forms of violence result in injury and affect the physical and mental well-being of individuals and the wider community. Assaults in particular affect individuals through injury and fear and are thus detrimental to mental health. Impacts are also placed on local resources such as police, health care and local authority services along with the health and well-being of staff working in these services.

The seriousness of an assault will influence the type of injury caused, from bruising to a more serious injury leading to death. During 2002 there were seven assault-related deaths in Cheshire and Merseyside. Other serious assaults may require hospital admittance or treatment at A&E, whilst victims of less serious assault may not seek or require treatment and hence go unrecorded. During 2002/2003 there were 2,978 assault-related admissions to hospitals across Cheshire and Merseyside. Assault-related admission was one of the top ten admissions to hospital across Cheshire and Merseyside for all persons aged 10-44 years. For males aged 15-24 years, assault was the leading cause of hospital admission and the second leading cause for males aged 25-34 years.
Local A&E data also identify young males as being an at risk group for assault. Consistent with other research, assaults impact on A&E resources heavily on weekend nights and largely occur in and around pubs and clubs (Finney, 2004; Budd, 2003). In particular Bold Street, Concert Square, Slater Street, Mathew Street, London Road and Hardman Street, all in Liverpool City Centre’s night time economy, were identified as hotspot areas for assaults resulting in attendance at Royal Liverpool A&E department. Ambulance data support this conclusion, with peak times for assault-related ambulance call outs being weekend evenings and prominent hotspot areas for assaults across Cheshire and Merseyside identified as Liverpool City Centre and Birkenhead Town Centre.

Further information on assaults is collected at a number of A&E departments across Merseyside. Just under half of assault-related attendees presenting at Arrowe Park had been drinking prior to their assault. This further highlights the relationship between alcohol use and assault. Royal Liverpool A&E department collects information on assaults via an electronic assault patient questionnaire. Information includes weapon of attack, relationship with attackers, gender of attackers and whether the individual had or intended to inform the police of the assault. Where this question was answered, 50% of assault attendees stated they would not be informing the police of their attack. This illustrates the importance of using A&E data along with police statistics to estimate the level of assaults across an area. The high ‘unknown’ response rate to the majority of questions on assaults means it is difficult to draw precise conclusions from this information. Such information is crucial in helping local agencies target their resources and focus interventions on hotspot areas. Improvements in data collection are required if this potentially useful information is to be used to its full capacity.

4. Recommendations

1. The impact of assaults affects not only individuals but also a range of organisations such as the NHS, police and local authorities. CDRPs should take the lead on ensuring a multi-agency approach is taken to reduce the number of assaults across Cheshire and Merseyside.
2. Not all assaults are reported to the police. A&E intelligence and Ambulance intelligence are valuable resources. These two data sources along with police intelligence should be routinely shared to ensure comprehensive intelligence on assaults is used to inform intervention strategies.
3. A&E and ambulance intelligence are useful resources in providing an evidence base to monitor the level of assaults. However, improvements in data procurement and quality are necessary if these data are to be used to their full potential. The Trauma and Injury Intelligence Group will continually work with data providers to ensure data quality is of the highest standard.
4. The Injury Surveillance System established by the Trauma and Injury Intelligence Group aims to cover the Cheshire and Merseyside region. Advancements will be made to bring Cheshire A&E departments into the TIIG system over the coming year.
5. Police data are also crucial in establishing the level of assaults across Cheshire and Merseyside. TIIG aim to start collecting Merseyside Police data this year and such data will be used in future reports on assaults.

This report aims to provide an overview of assault injuries across Cheshire and Merseyside, bringing together a variety of trauma and injury sources. Other thematic reports will include Children and Inequalities, Fire and Burns and Road Traffic Accidents. The Trauma and Injury Intelligence Group would welcome any comments you have regarding this report or future thematic reports.

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References:


TIIG reports

TIIG Themed Report 1: Older Adults and Falls. March 2005
TIIG Situational Analysis. August 2004
TIIG Bulletin 1: By Accident or Design. August 2003
TIIG Strategy for Forward Development. July 2002
Accident, Injury and Trauma. Information and Intelligence initiatives in Merseyside, the North West and Nationwide. December 2001

All reports are available on the TIIG website: - www.nwpho.org.uk/ait

Useful references and websites

www.dh.gov.uk/assetRoot/04/06/49/50/04064950.pdf

Club Health: Protecting Health in Night-time Environments.
www.clubhealth.org.uk/

Home Office: Alcohol Related Crime.
www.homeoffice.gov.uk/crime/alcoholrelatedcrime/index.html

North West Public Health Observatory
www.nwpho.org.uk

World Health Organization Department of Injuries and Violence Prevention.
www.who.int/violence_injury_prevention/en/

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