

presence of the general practitioner to discuss shared care and to help avoid admission and emphasised the importance of providing support to the relatives by giving the details of local groups and services and counselling them about the illness.

Comment

Domiciliary visits are primarily intended to provide specialist advice when the patient cannot attend hospital for medical reasons. Although general practitioners valued the visits, they attended them infrequently and did not view them as a true consultation. Part of the problem may have been the timing. The need for an assessment of the patient's home situation was seen as at least as important as the patient's physical or psychiatric condition in the general practitioner's decision to request a domiciliary visit.

Evaluation of a domiciliary visit service through peer review and feedback can reduce the number of requests and the cost to a health authority.³ But how effective will this be with elderly patients when many of those considered by their general practitioner to require urgent admission do not need it according to

the consultant?⁵ Reducing admissions could save far more money than merely decreasing the number of domiciliary visits. Our findings highlight different approaches in providing services for elderly mentally ill people. Either the consultant can have a liaison role, advising the general practitioner and facilitating participation of other services and professionals in the patient's care in the community, or the consultant psychogeriatrician and multidisciplinary team can take over. The first approach requires more community resources but the second suggests an expansion of hospital related services. The ambiguities in the domiciliary visit service shown by this study suggest that the dilemma is far from over.

We thank all the doctors who participated in this study.

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Underreporting of pedestrian road accidents

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Road accidents to pedestrians caused 1706 deaths and 58 374 injuries in Great Britain during 1989.¹ These figures and other data used for road planning and safety campaigns are derived from accident data supplied by the police. I assessed the completeness of police recording by comparing their figures on accidents to pedestrians with data from a regional database of trauma care.

Methods and results

A one year review (May 1989-April 1990) of trauma care within Mersey region, North Wales, and the Isle of Man was conducted by using information from ambulance services, accident departments, and coroners. All pedestrian accidents that occurred within the Merseyside police area were then analysed in detail.

For 85 cases where pedestrians were killed or severely injured (injury severity score >15)² and where there was information on the site, date, and time of the accident we tried to correlate individual cases with those recorded by Merseyside Police central statistics unit. The unit records details of the site of the accident but not the names and addresses of the victims to maintain confidentiality.

Fourteen of the patients could not be identified in police records. Two of these 14 patients had died, one shortly after arriving at the accident department and one after surviving in a coma for three months. One was aged 74 and the other 82 and their injury severity scores were 38 and 59 (median 48). The 12 survivors had a mean age of 45 years (range 7-78), a median severity score of 32 (17-50), and occupied 1037 hospital bed days with a mean length of stay of 86 days (6-246).

The patients whose details were recorded by the police were generally younger. Of the 50 who died, 15 died at the scene of the accident (mean age 41.3 years (6-80); median severity score 45 (19-75)) and 35 died

in hospital (mean age 49.4 years (3-93); median severity score 43 (13-75)) with a mean survival of five days (0-49). The mean age of the 21 survivors was 36.2 years (4-78), their median severity score 27 (17-50), and length of stay 61 days (13-197).

We could not validate details held by the police against our survey database because of the wide definition of serious injury used by the police.

Comment

Government statistics on accidents, traffic planning, and highway design are derived from data collected by the police on road accident report form (STATS 19). In our survey Merseyside Police data underrecorded pedestrian accidents by 16%. If this figure applies nationally up to 10 000 casualties a year may be excluded from government statistics.

Accidents that cause trivial or no injuries are often not reported, and allowance is made for these. The underreporting of serious and fatal accidents, however, may lead to flaws in planning.

Details of emergency calls to accidents are routinely passed between the emergency services, but data may not reach police statistics for several reasons. Some accident victims may be driven to hospital by private vehicle (the ambulance service industrial dispute coincided with part of the study period) with no emergency call being made; accident victims may decline police involvement; and a few cases may be lost in administration before reaching the statistical unit.

Information on road traffic accidents is collected by hospitals to allow them to charge for emergency treatment. This information too is often incomplete, but there is no mechanism for passing it to a central statistical unit. Central registration, either nationally or regionally, of hospital road accident data may allow them to be collated with information from the police and coroners to provide a more complete picture of road accidents in Great Britain.

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