



Australian Government

Australian Institute of  
Health and Welfare



Flinders  
UNIVERSITY

## How many people are hospitalised or fatally injured due to firearm-related injuries?

There were 338 hospitalised cases in 2013–14 and 209 deaths in 2012–13 as a result of firearm-related injuries. The age-adjusted rates were 1.5 hospitalised cases per 100,000 population and 0.9 deaths per 100,000 population, respectively.

## Who is hospitalised and fatally injured as a result of firearm-related incidents?

Most people injured by firearms are male—93% of hospitalised cases and 91% of deaths resulting from firearm-related incidents.

There was a sharp contrast in age distribution between hospitalised cases and deaths. For hospitalised cases, 76% were aged 15–44, while for deaths, over 62% were aged 45 or over (Figure 1).

The highest rate of firearm-related injury for hospitalised cases was 3.4 hospitalisations per 100,000 for those aged 15–24, while for deaths, the highest rate was 1.8 deaths per 100,000 population for those aged 65 and over (Figure 2).

## Unintentional injury, self-harm and assault

For hospitalised cases resulting from a firearm injury, 39% (133 cases) were the result of unintentional injury and one-third (33%, or 111 cases) resulted from assault (Figure 3). In almost one-fifth (19%, or 64 cases) of cases, intent was undetermined.

In contrast, 79% (166 cases) of deaths resulted from intentional self-harm (suicide) and 17% (36 cases) resulted from assault (homicide).

## Firearm injuries and deaths



### Quick facts

In over **90%** of hospitalised cases in 2013–14 and of deaths in 2012–13 due to firearm-related injury, the injured person was a **male**.



Almost **80%** of firearm-related deaths in 2012–13 were due to **suicide**, though suicide rates due to firearms have fallen since the 1980s.



Rates were **4 and 6 times higher** in *Remote and very remote areas*, compared with *Major cities*, for hospitalised cases and deaths, respectively.



### In this fact sheet

Firearm injury cases and deaths are those classified in the International statistical classification of diseases and related health problems, 10th revision, Australian modification (NCCC 2012) and the 10th Revision of the International Classification of Diseases (WHO 1992) respectively, as unintentional (W32–W34), intentional self-harm (X72–X74), assault (X93–X95), undetermined intent (Y22–Y24) and *Legal intervention involving firearm discharge* (Y35.0). The number of hospitalised cases in 2013–14 excludes those who died after being admitted to hospital. The data were sourced from the AIHW's National Hospital Morbidity Database for 2013–14, which covers all (admitted) episodes of care in Australian hospitals. To reduce double counting, records with a mode of admission reported as a transfer from another hospital were excluded. Deaths registered in 2011 and earlier are based on the final version of cause-of-death data; deaths registered in 2012 and 2013 are based on revised and preliminary versions, respectively, and are subject to further revision by the ABS. In particular, some of the deaths classified as 'event of undetermined intent' are likely to be re-coded by the ABS to more specific causes as more information becomes available in the National Coronial Information System.



Number of cases

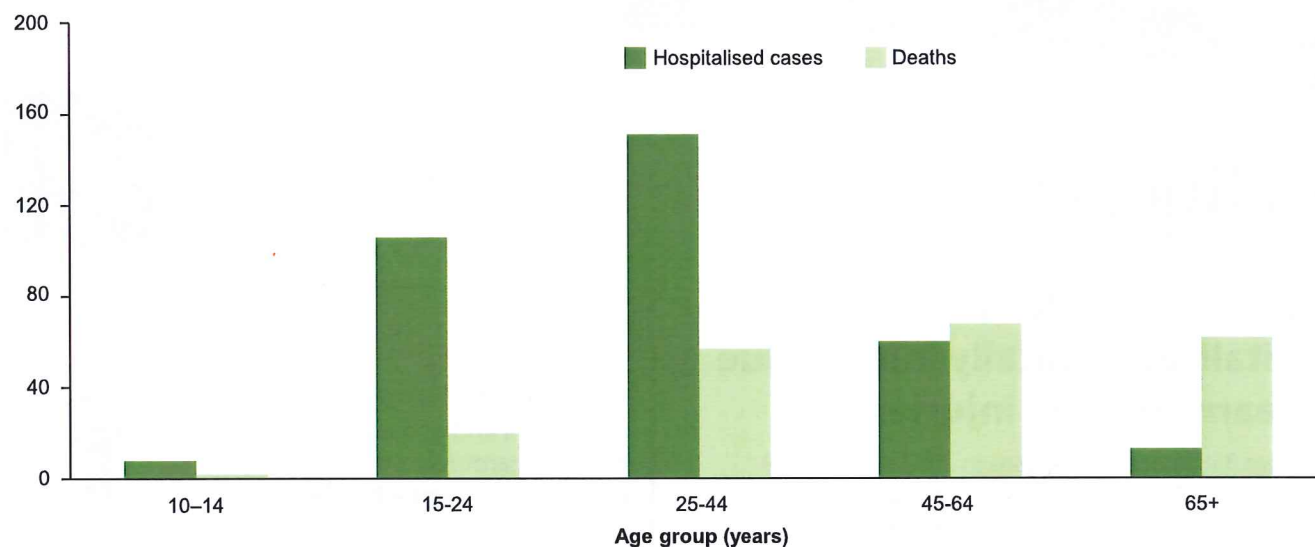


Figure 1: Firearm-related injuries, by age group, for hospitalised cases in 2013–14 and deaths in 2012–13

Cases per 100,000 population

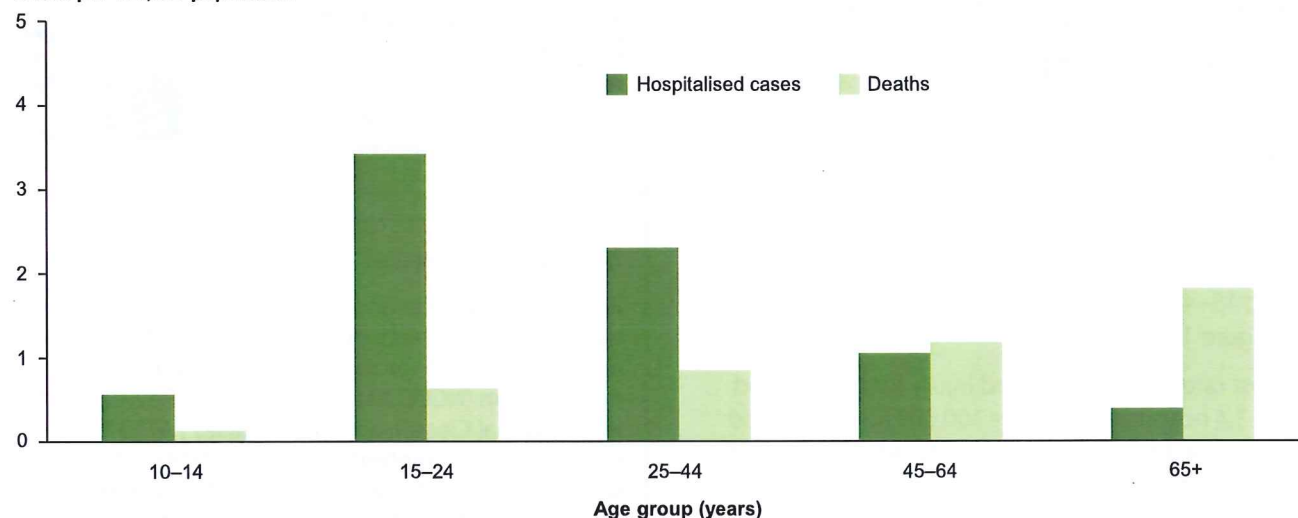


Figure 2: Firearm-related injury rates, by age group, for hospitalised cases in 2013–14 and for deaths in 2012–13

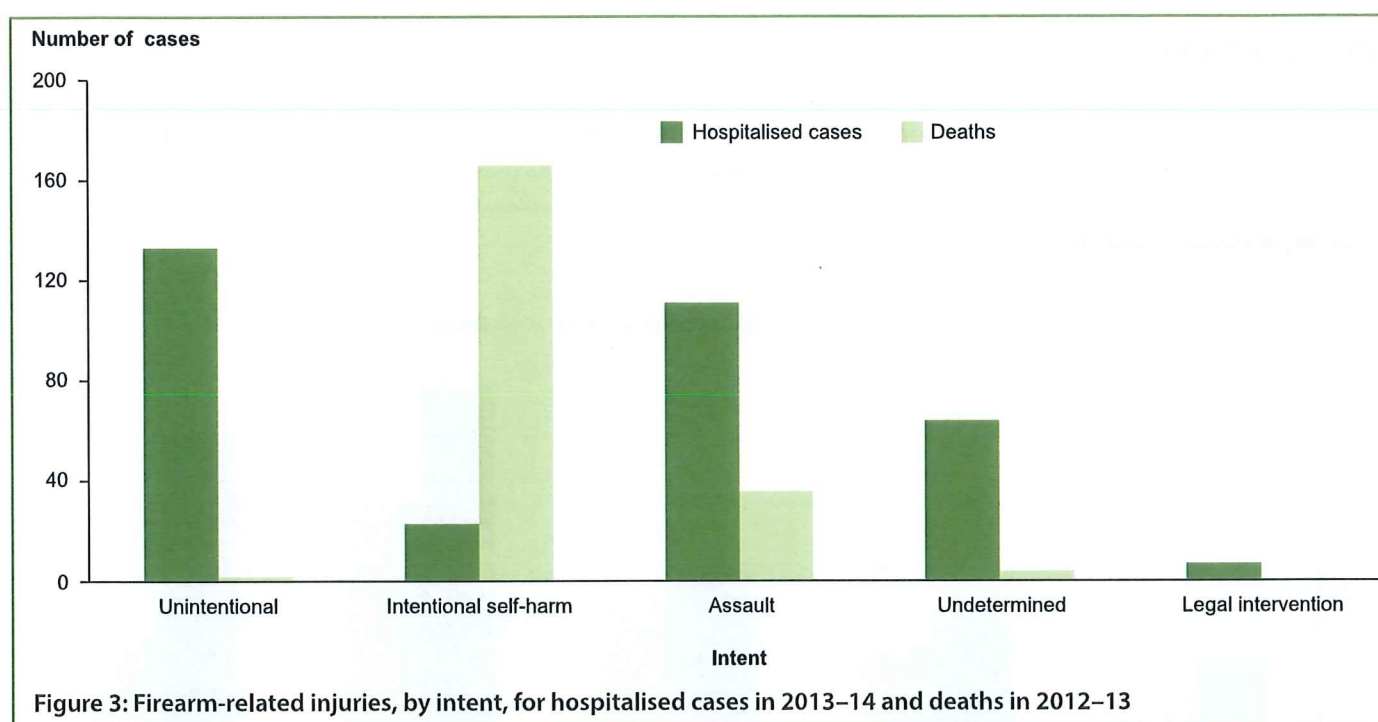
## Type of firearm used

Larger firearms such as rifles and shotguns were more commonly reported as used than handguns in cases of hospitalised injury and death.

More than one-third of the hospitalised injury cases (37%, or 126 cases) involved the use of larger firearms, while 10% of cases involved a handgun (33 cases). For the remaining 53% of cases, the type of firearm used was not specified (179 cases).

Compared to hospitalised injury cases, a higher proportion of deaths (68%) involved the use of larger firearms (143 cases). Just over 9% of deaths involved the use of a handgun (19 cases), while the type of firearm used was not specified for the remaining 23% of deaths (47 cases).

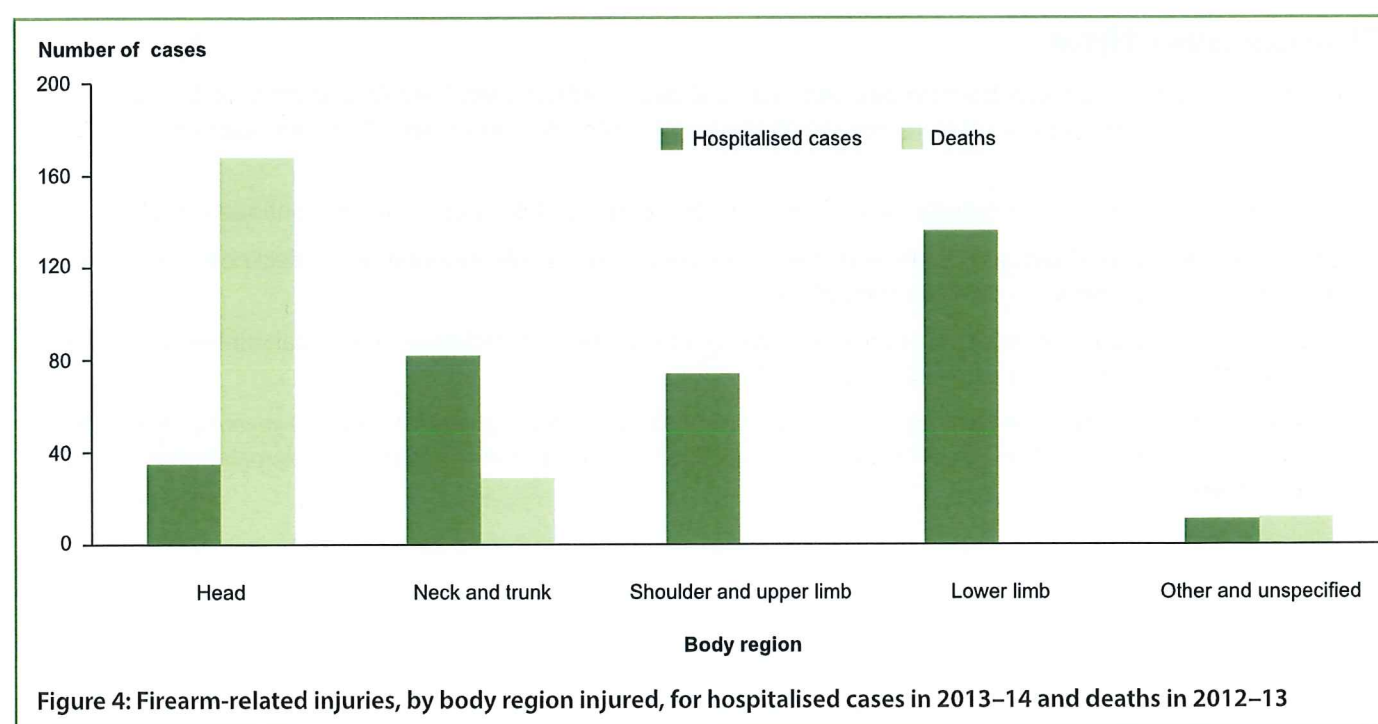




## Body region injured

For hospitalised cases of firearm-related injury, the region of the body injured varied. The most common regions injured were the lower limbs (40%), neck and trunk (24%) and shoulder and upper limbs (22%) (Figure 4).

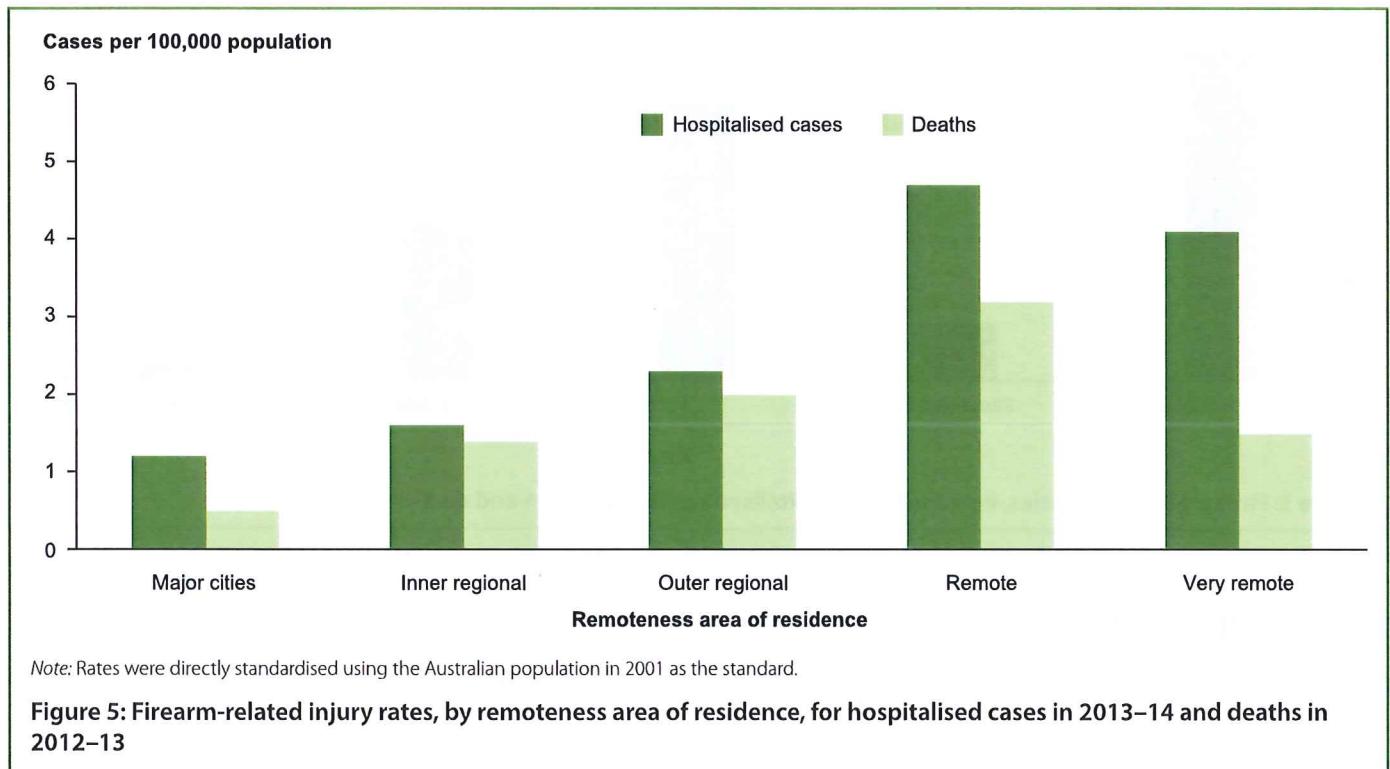
For deaths, the head was by far the most common region injured—accounting for over 80% of cases. A further 14% of cases sustained injuries to the neck and trunk.





## Remoteness area of residence

Rates of firearm-related injuries tended to increase with remoteness, based on the area of usual residence for both hospitalised cases and deaths (Figure 5). For hospitalised cases and deaths, respectively, rates were around 4 and 6 times higher for residents of *Remote and very remote* areas, compared with residents of *Major cities*.



## Change over time

Rates of firearm-related injuries for both hospitalised cases and deaths fell between 1999–00 and 2005–06 from a starting rate of 2 cases per 100,000 population to 1.5 per 100,000 for hospitalised cases and 1 per 100,000 for deaths in 2013–14 (Figure 6).

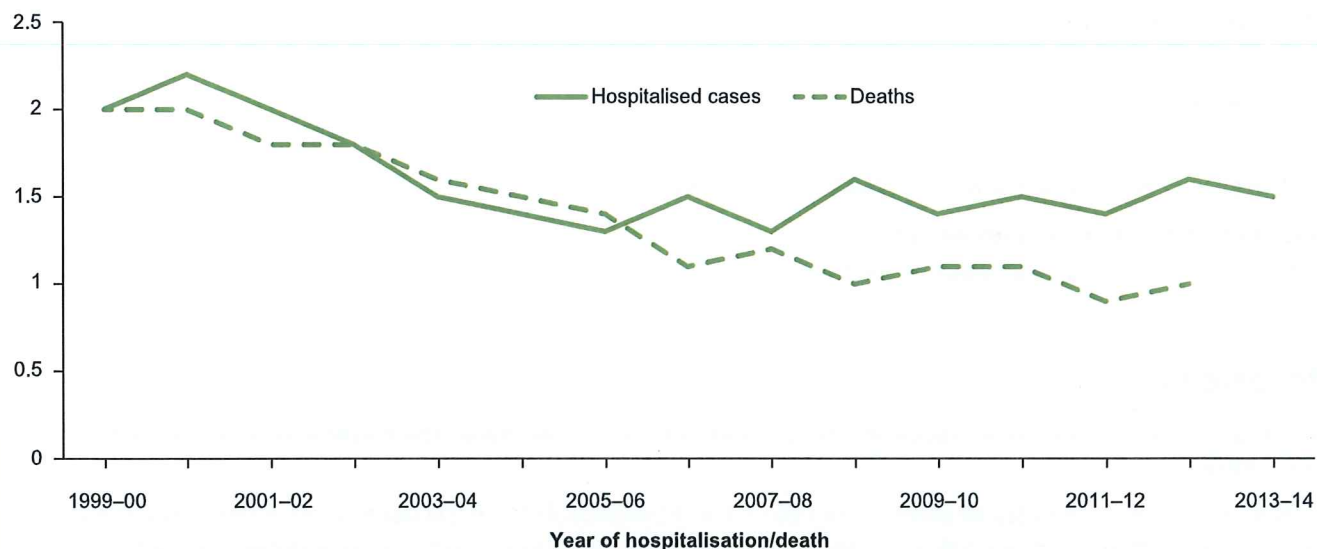
Rates for hospitalised cases were relatively steady from 2005–06 onwards, while rates for deaths continued to fall:

- The fall in rates for hospitalised cases in the early part of the period was mainly attributable to a decline in unintentional cases, from 221 to 105, between 1999–00 and 2005–06.
- The fall in rates for deaths over the entire period was mainly attributable to a decline in intentional self-harm (suicide) cases, from 236 to 166, between 1999–00 and 2012–13.

The rate of firearm suicide by males was about 6 to 7 per 100,000 population annually for about 30 years, to the late 1980s. The rate then declined to less than 1 per 100,000 by 2011 (Figure 7). A similar pattern was seen for females, although rates were much lower.



Cases per 100,000 population



Note: Rates were directly standardised using the Australian population in 2001 as the standard.

Figure 6: Firearm-related injury rates for hospitalised cases and deaths, 1999-00 to 2013-14

Deaths per 100,000 population



Note: Rates were directly standardised using the Australian population in 2001 as the standard.

Source: AIHW: Harrison&Henley 2014.

Figure 7: Age-standardised rates of firearm-related deaths, by sex, 1983 to 2011



## Where can I find out more?

### AIHW web pages and publications:

<<http://www.aihw.gov.au/injury/>>.

<<http://www.aihw.gov.au/deaths/grim-books/>>.

<<http://www.aihw.gov.au/deaths/>>.

<<http://www.aihw.gov.au/publication-detail/?id=60129550960>>.

### Research Centre for Injury Studies website:

<<http://www.flinders.edu.au/medicine/research/centres/injury-studies/publications.cfm>>.

## References

AIHW: Harrison JE & Henley G 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Cat. no. INCAT 169. Canberra: AIHW.

NCCC (National Casemix and Classification Centre) 2012. The international statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 8th edn. Wollongong: University of Wollongong.

WHO 1992. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO.

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