

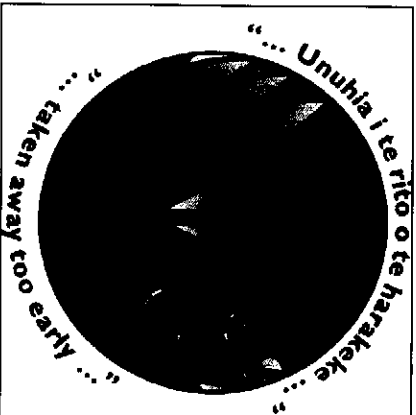
CHILD AND YOUTH MORTALITY REVIEW COMMITTEE

Te Rōpū Arotake Aua Mate o te Hunga Tamariki,

Taiohi

Thursday 15 February 2007

9.00 pm to 4.00pm



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| In Attendance: | Barry Taylor (BT), Russell Franklin (RF), Christopher Morris (CM), Marie Connolly (MC) left at 1200, Riana Manuel (RM), Anganette Hall (AH), Liz Craig (LC), Nick Baker (NB), Eru George (EG)- arrived 9.45 |
| Apologies: | Pat Tuohy (PT) |
| Guests | Glenys Needs – Data Group Manager (GN), Ian Hassall- former Committee member (IH) from 1000am. |
| Secretariat: | Faith Roberts (FR), Gillian Bohm (GB). |

Agenda Items: **Summary of Discussions and Decisions**

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| <p>1. Matters arising from last meeting 24 November 2006</p> | <p>Moved as a correct record by RF & BT <u>Parent/Family Feedback</u> Since form finalised for trailing there has only been one entry Waiting for more parents to try it before we publicise it more and reprint the leaflet that includes information about the Family Feedback Form. Need to think about further publicity for the form No clear data about whether this improves mortality data, research related to parent feedback on immunisation data showed that it did not appear to improve data. May need to include how people can access help after filling in form and an acknowledgement that filling in the form could be distressing. Action: Draft additional comments for end of website form. FR & GN. Action: Talk to Kids Health About link to CYMRC leaflet on their website. FR <u>Prospective Local Child and Youth Mortality Review Groups</u> Existing Groups: MidCentral, Tairāwhiti, Taranaki, Canterbury, Otago, Hawke's Bay, Waikato As part of the requirement of the Crown Funding Agreement with the Ministry of Health, DHBS are required to have a local Group. This is difficult to enforce and there is not funding "ring fenced" for these activities. The new Quality Improvement Committee may assist as the new Chair is also the Chair of a DHB Board.</p> |
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| | <p>Committee members were encouraged to support and/or attend their Local Child and Youth Mortality Review Groups. There will be further discussion on issues and challenges at the Coordinators Workshop. Seeing value of data, may encourage others to join. Local Groups are encouraged to send reports to the DHB CPHAC.</p> <p>Action: Continue to develop reporting template for Local Groups to report to their local CPHAC. BT & GN. <u>Cross Departmental Research Project (CDRP)</u> BT outlined the CDRP</p> <p>Tina Ireland, project manager has recently resigned</p> <p>There have been some difficulties with this project particularly between different government departments. The potential role of the new Chief Coroner in assisting with these difficulties was discussed.</p> <p>The project funding will be used to pay for Health Trained investigators in pilot sites for 2 years. It was discussed whether Māori SIDS may be able to help coordinate this.</p> <p>Action: Meet with Neil MacLean (Chief Coroner) BT</p> <p>Action: Liase with manager of Public Health Intelligence about employing a new Project Manager. BT <u>Family Violence Taskforce</u></p> <p>Ministry of Health have been charged with the role of making recommendations to the Taskforce on how best to process death reviews. FR on Ministry Steering Group as link with CYMRC. MC is on a Steering Group for the Ministry of Health.</p> <p><u>Scientific Group Report</u></p> <p>BT outlined the role of this Group for the new members. The group considers applications from people wanting to use the data and reviews the data prior to each Committee meeting. BT & PT currently members.</p> <p>Action: LC to consider being on this Group. Report from Data Group was discussed. Applicants for data have been asked to complete application forms.</p> <p>Need to determine whether Causes of Death can be shared with individual in Otago and also with Child, Youth and Family Services CYFS. Would be very important for CYFS to have the Cause of Death from the mortality database. Currently have to pay to access information on the Death Certificate from BDM. It is still hoped to exchange data with Plunket but have not had reply to our letter.</p> <p>Action: Seek Legal Opinion. FR</p> <p>Action: Contact the Vaccine Group for final report and any useful information from their reviews if available. FR</p> <p>Action: Follow up on Plunket who have not replied to our letter. BT & FR.</p> <p><u>Correspondence:</u> BT has had correspondence with Southland Coroner and Police.</p> |
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| | <p><u>What's Up Phone line</u> IH is on the Committee supporting this. The line receive a high number of calls. It was noted that a high number of males access the services (usually males are less likely to use these kind of services). Calls seem to be fairly evenly distributed across the country. Action: respond to Grant Taylor Exec Director of What's Up, appreciate the work they are doing, his group benefit from making contact with those involved in wider health strategies, kids health website etc. BT & FR <u>NSW Child Health Commission</u> New Zealand and Australia Child Death Review Group meeting in 23 March. BT and GN to attend. <u>Letter to nappy manufacturers & distributors</u> Letter asking them to consider safe sleeping messages. Action: Send out letter. CM & FR.</p> |
| <p>CYMRC Website</p> | <p>Please note that the CYMRC website has changed to www.cymrc.health.govt.nz Action Website: Please send photos and bio to Faith for website (FR remove previous Committee members). AH, EG, LC, NB Please supply any useful links or information for website</p> |
| <p>Local Child and Youth Mortality Review Groups Workshop</p> | <p>Committee members welcome to attend the workshop 9 March 2007, please let Faith know if you are intending to attend</p> |
| <p>UNICEF Report discussed</p> | <p>UNICEF report was released yesterday afternoon. IH discussed the report which highlighted the where data is not available for NZ and services that are not available in NZ. <u>PMMRC and CYMRC overlapping</u> BT provided an outline of the Annual Report including where data may overlap with the PMMRC. Age is counted from actual birth date not expected birth date and so a 4 week baby could still die from prematurity problems. Children over 4 weeks old die in neonatal units better for this to be reviewed by PMMRC processes. May be better for CYMRC to review deaths of babies under 4 weeks old that die at home. Better to keep all (Sudden Unexpected Death in Infancy) SUDI deaths together despite age. Action: Need to change Agent form to allow for this cross-over in age groups. FR Action: Discuss coverage of deaths with Cindy Farquhar Chair of Perinatal and Maternal Mortality Review Committee. Action: Review Figure 4 (SUDI deaths by age) in the Annual Report where not all the under 1 month old deaths are in the graph and gives wrong impression. BT <u>Infant Mortality</u></p> |
| <p>Fourth Annual Report reporting mortality 2002-2005</p> <p><i>(The numbers are given for Figures in this section it refer to graphs in the annual reports)</i></p> | |

Need to decide whether to split out post neonatal data from infant mortality and only report this in the CYMRC report.

Consider putting in international comparisons.

For fifth report need to insert new line graph as Figure 3 (b) To show the trend of the at gap between Māori and non-Māori post neonatal mortality will need to have a gap to indicate the change in ethnicity recording that occurred in 1995.

Action: Look at how PH1 looks at relative risk through the inequalities work for Figures 3 (a) and (b) (Post-neonatal mortality rate for Māori vs non-Māori). GN

Child 5-9

Comment:

Some transport deaths in cars may be due to older children not using car seats.

For some cases it may be useful to group the age ranges to more clearly demonstrate important causes.

Young People/Youth 20-24 years

Comment:

WHO refers to Youth as being up to age 24 so this should be the title of this section.

Death during dangerous activity/risky behaviour category to be reported in next report. A definition for collecting this data will need to be agreed.

The undetermined intent transport deaths seem to be high and increasing. Difficult to determine if some accidents are intentional (ie, suicide). Is there a risk of reporting a transport related death as "undetermined intent" as this may lead people to identifying transport as a means of suicide.

Action: Add paragraph to describe when deaths are categorised "Undetermined intent" to chapter 2. GN

Fifth Annual Report

Comment:

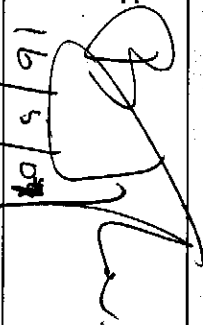
Change pie charts to put suicide and undetermined cause together in 2 parts.

Consider incorporating breakdown of Figure 20 by gender. Need to insert the line from change of NZHIS data to CYMRC data in this figure.

Figures 20 and 21 cannot be combined, as post neonatal cannot go on figure 20 because of the differing scales used. May be a good idea to have a "mini graph" or "cross section" of Fig 21 inserted near to Fig 20.

Action: LC to show BT example of this.

Consider doing Figure 21 by 100,000 rather than 1000 live births. The Māori analysis figures eg, Fig 13 should perhaps be amalgamated in next report.

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| | <p>Suicide Comparability across countries is limited because of different recording systems. Action: Re order Fig 22 from descending alphabetical order BT Action Check if the current Well Child Books identify the need for the Health Professional to discuss safe sleeping practices. FR. Action: Bring copy of the reporting requirements associated with the Well Child contract to next meeting. PT.</p> |
| | <p>Farewell and thanks to Ian</p> |
| <p style="text-align: center;">Next meeting: 9 March Local Child and Youth Mortality Review Groups Workshop 11 April 2007 (Teleconference 2-3pm); 16 & 17 May 2007; 27 July 2007 (Teleconference 2-3pm); 20 & 21 September 2007 15 & 16 November 2007.</p> | |
| <p>Minutes Approved:</p> | <p>Signature:  Date: 16/5/07</p> |