	<p><b>CHILD AND YOUTH MORTALITY REVIEW COMMITTEE</b></p> <p>Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi</p> <p><b>Committee Meeting Minutes</b> <b>Wednesday 16 &amp; Thursday 17 May 2007</b></p>
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<b>In Attendance:</b>	Barry Taylor (BT), Russell Franklin (RF), Christopher Morris (CM), Kelly Anderson (KA), Riana Manuel (RM), Eru George (EG); Anganette Hall (AH), Liz Craig (LC),
<b>Apologies:</b>	Nick Baker (NB), Pat Tuohy (PT)
<b>Secretariat:</b>	Faith Roberts (FR), Gillian Bohm from (GB),
<b>Mortality Database Group:</b>	Glenys Needs (GN)
<b>Invited Guests:</b>	See sections 5 & 6 – joined at 10.30
<b>Agenda Items:</b>	<b>Summary of Discussions and Decisions</b>
<b>Minutes from Teleconference 11 April 2007</b>	<p>P 1 – EC to be on Scientific Group in place of Jo Baxter not David as it says currently</p> <p>P 1 – The Action was to ask Neil to next meeting not David</p> <p>Approved with changes CM, EG</p>
<b>Matters arising from 11 April 2007 &amp; 15 February 2007</b>	<p><u>Wording for the end of data collection form for parents</u> Committee to think about this</p> <p><u>Reporting requirements for Well Child providers</u> PT to report back next meeting the requirements that are in the agreement with providers.</p> <p><u>SUDI messages on nappies</u> No replies yet, FR phoned Kimberley Clark they had forwarded letter within the organisation but did not sound like they would be doing anything. <b>ACTION: FR to follow up with the manufacturers</b></p> <p><u>CDRP</u> Barry Borman on Annual Leave, position has not been advertised.</p> <p><u>Kids Health</u> <b>ACTION: Talk to them about link on their website to our website. FR</b></p> <p><u>Website updates</u> <b>ACTION: Photos to go on website FR</b></p> <p><u>Overlap of age groups between PMMRC and CYMRC</u> BT has discussed with Cindy Farquhar, Chair PMMRC and agreed that CYMRC will review neonatal deaths in PMMRC age group if they die in Neonatal Units as well as SUDI deaths under 4 weeks old. <b>ACTION: When planning meeting for next year include a joint meeting between PMMRC &amp; CYMRC – include common issues eg, Relationship with Coroner, Forensic pathology</b></p>

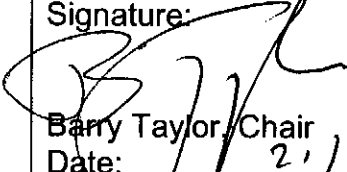
	<p><u>Recent media publicly about safe sleeping</u> Noted that some advice given was incorrect. Consider media statement to correct the information. After SUDI workshop in May a communication to Health Professionals and been drafted but those attending had not got it yet. <b>ACTION: Follow up whether the letter went out about SUDI messages. FR</b></p> <p><u>Coronial Advisor</u> Chief Coroner to take over from David Dowthwaite who was Advisor. <b>ACTION Arrange formal thank you. FR &amp; BT</b></p> <p><u>Teleconference for 27 July</u> Current date coincides with Maternal Working Group, Secretariat ask to change CYMRC Teleconference. <b>ACTION: Change next teleconference to Friday 20 July at 2pm</b></p> <p><b>RM apologies for the Teleconference</b></p>
<b>Correspondence</b>	<p>Correspondence log circulated BT noted his planned letter to CEOS etc following on from Health and Disability Commissioner report Discussion about accessing data from the Te Puaruruhau group in Starship. <b>ACTION: Formally request information from Starship as per Patrick Kelly's email 28 April. FR &amp; BT</b></p> <p>Letter from College of Midwives re the recommendation about LMC handover to Well Child in the Third CYMRC Annual Report. In some Well Child providers they respond to referral from LMC in a way that could be audited. This transfer is a key part of the Well Child Services contract. RF quoted the wording regarding this from the current Well Child Book. Consider inviting College for discussion on this matter. <b>ACTION: Draft response to this. FR &amp; BT</b></p> <p>Email from Alan Collins about current work from Ministry of Consumer Affairs <b>ACTION: Write to Allan and ask about what Consumer Affairs had done about the Bath Seats that CYMRC had discussed with them. FR</b></p>
<b>Update on Quality Improvement Committee (QIC)</b>	<p>BT outlined priorities to be focus of QIC work – Medicine safety, Mortality Review, Consumer participation, Infection control, Education, Patient Flows, Incident Reporting and Management Need to have money dedicated for these projects BT included funding for CYMRG Coordinators in each DHB in the proposal. RM discussed how DHBs have to respond to recent public health and disability commissioner cases, all DHBs taking it very seriously. RM also talked about Waikato developing mortality review more widely, agreed that Waikato can use any of the CYMRC material.</p>

<p><b>Advisors</b></p>	<p><b>ACTION: ensure next Advisors session commences with a time for introductions. Secretariat</b></p> <p><u>Lloyd Denmark from Forensic Pathology</u> 6 full time forensic pathologists (4 Auckland, 1 Wellington, 1 Christchurch) Wellington pathologist will take over role of Advisor to CYMRC Change in Coroners Act will affect work of Forensic Pathologists Group dealing with 90% of homicides. Attached to service are 2 pathologists one with Perinatal expertise and another with neurological expertise. There are very few Paediatric Forensic Pathologists around the world shortage is not just a NZ problem. Not all SUDI cases go to Forensic Pathology services, there is need for paediatric expertise but it is not always possible. Jon Skinner raised role of TRADEGY in discussion this issue. See also relevant statement in the Forensic Pathology Guidelines.</p> <p><u>Susan Wauchop Ministry of Youth Development</u> Role of CYMRC critical in raising the profile of child and youth health. <i>"health data continues to fuel concern about NZ young people's health status relative to their international counterparts"</i> <b>ACTION: See Lancet March series on adolescent health and consider link on CYMRC website. FR</b> <i>"Some positive signs that in some NZ regions there is more investment in young people and their health, but this is by no means universal. "</i> Graph showing that death rate of 15-24 year olds much higher than 1-14 age groups. MYD use CYMRC Annual Report. Would be keen to be involved in recommendations that go in the CYMRC Annual Report. Important to involve youth in decisions about their health eg, drug and alcohol and driver education in schools does not help. Modelling behaviours like HEHA works well.</p> <p><u>Nicola Atwood Office of Children's Commissioner</u> Only 15 staff. Covers 0-18 year olds Monitors CYF Key strategic foci of OCC: Poverty Violence Improving attitudes towards children Developing Framework Te Ara Tukutuku based on UK approach – 4 universal assessments at these stages: Pregnancy, primary school, transition to next stage of education after primary, transition out of high school. Also working on the Report Card – looking at indicators. This is designed to be accessible information. Will be available in folder with discussion sheets. OCC too have interest in SUDI</p>
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	<p><u>Misty McCarthy, Te Puni Kokiri</u> (attended as observer)  <u>Bill Harrison, Police</u> (left at 1200)  Will be Advisor from now, may bring others such as person from policy which has a families unit.  Police link with many other groups.  Police are usually first responders at SUDI, Youth Suicide etc.  Police Youth Education Guidelines available for circulation.  Would welcome opportunity to talk to the group for longer.  BT noted that the Police involvement in the Local CYMRG is really appreciated, Bill had attended Auckland pilots.  <u>Erin Beatson, Plunket</u>  92% of all NZ children born are seen by Plunket staff  6-8 visits based on socio-economic model  raised concerns about fragmentation of services – It was noted that the Chief Advisor Nursing, Ministry of Health is promoting role of School nurse/public health nurse type role, Plunket feel that this will be very valuable.  Plunket working on issues about messages and communication with parents.</p>
<b>Cardiac Inherited Disease</b>	<p>Also involved in Trans Tasman Response Against Sudden Death in the Youth (TRAGADY).  <a href="http://www.cidg.org">www.cidg.org</a>  See presentation  Useful to come up with common term so that we can determine size of problem eg, “presumed cardiac arrhythmia”  Currently takes about 6 months to determine looking to decrease this to 3 months.  Forensic pathology/coroner notifies CIDG. CIDG talks to family and undertakes genetic screening, has psychologists etc. Does not go through Doctor but they are sent the result.  <b>ACTION: Need to determine how CIDG data can go on the Mortality Database. GN, BT.</b>  What CIDG want from CYMRC identified – see.</p>
	<b>LUNCH</b>
<b>Role of Advisors</b>	<p>Purpose was to ensure that Committee was aware of what the different Government organisations were doing in relation to child and youth.  Need Mental health advisor from Ministry of Health  <b>ACTION: Talk to Mental Health Direction about representative from the Mental Health Policy. GB &amp; FR</b>  Need advisors from Mental Health, TPK, OCC, MYD, Dept of Education, Ministry of Pacific Affairs, Ministry of Consumer Affairs, Police, Coroner, ? ACC and ? Plunket  Consider Ministry of Transport rep. and Ministry of Social Development from the Family and Community Services.  <b>ACTION: Contact Ministry of Transport. FR</b>  Dedicate a half morning twice a year to the advisors  Issues raised need to be followed up including how CYMRC can involve youth in its work. May be something to develop later as process matures. There are a number of youth focus groups that</p>

	<p>could be used for consultation. Need to consider as a courtesy involving other groups/professionals in compiling report where the recommendations may have implications for them.</p>
<b>Scientific Group Report</b>	<p>Report tabled Decision to keep determining residence as Data Group does currently. Comment on the draft Terms of reference for the Australian and New Zealand Child Death Review teams, issues about age range, cost implications, purpose of relationship for CYMRC. Response needed by 29 June.</p>
<b>Template for local data reporting</b>	<p>Issue about how to report the deaths, whether to use aggregated data, average or actuals. Looking at using actual rate for DHB as compared with actual NZ rate which is adequate for population health planning. Timing of the report going to CPHAC needs to be considered so it is in good time for planning, still to work out the timing in relation to the main CYMRC report.</p>
<b>Chief Coroner</b>	<p>Neil MacLean Hope to have 14 appointments by end of May Each Coroner will have full time Coronial Coordinator(civilian) Undertaking Iwi consultation Data collection and storage an issue but will endeavour to get to system that all relevant, up to date information is passed onto CYMRC, PMMRC and a Family Violence Review group if/when established and the Ministry. CDRP discussed Neil keen to have idea of the skill set of the HTI Neil felt that Melbourne coronial model is excellent, with counselling included etc.</p>
<b>Friday 18 May</b>	<p>Barry Taylor (BT), Russell Franklin (RF), Christopher Morris (CM), Kelly Anderson (KA), Riana Manuel (RM), Eru George (EG); Anganette Hall (AH) from 10.45, Liz Craig (LC), Kelly Anderson (KA) from 10.40 Apologies: Pat Tuohy, Gillian Bohm</p>
<b>Vehicular deaths in driveways/ Death from low speed impact of moving vehicle/ Non-traffic pedestrian injuries</b>	<p>See NB presentation See also Driveway-related motor vehicle injuries in the paediatric population: a preventable tragedy. <i>The New Zealand Medical Journal</i>. Vol. 115 No 1160. Murphy, White and Morreau. Clear seasonal trend – higher in summer CYMRC role: Data Definition Key elements to extract relating to risk, casualty and preventable elements. Recommendation: Joint work with Safekids and interested clinicians? CYMRC supports the appointment of a student to undertake a descriptive study into non-road vehicular deaths in New Zealand.</p>

	<b>ACTION: Prepare research paper. NB, BT, RM and James Hamill</b>
<b>The Royal Australasian College of Surgeons New Zealand trauma Team</b>	<p><u>James Hamill attended and presented.</u> See James' presentation Deaths from accidents and injuries – UNICEF report showed NZ highest rate of OECD countries. See <i>A Trauma Plan for Queensland</i> ACC funding national trauma database (adults and children), Waikato DHB starting this and involving Tauranga, Rotorua, Taranaki and Gisborne.</p> <ul style="list-style-type: none"> <li>• RACS Trauma verification for Starship</li> <li>• Ministry and DHB support for the Nation Trauma Database</li> <li>• Ministry of Health and stakeholder to scope a national paediatric Trauma System</li> </ul> <p>Important to link the different organisations together – this would occur with a national Trauma System <b>ACTION: Find out more about national Taskforce on Injury Prevention. Arrange presentation to CYMRC and arrange for them to link with James. BT</b> <b>ACTION: Find out if there is an Injury Control Strategy. FR</b></p>
<b>Anti Smoking Public Health campaign</b>	<p><u>Karen Evison and Jo Muschamp attended and presented</u> See presentation 28 August 2008 the pictorial warnings will be on tobacco. Comments from Committee: Stopping smoking in pregnancy should be a key focus – needs an intense level of support eg, twice a week, face to face LMCs need to provide the smoking cessation as people often don't want to have to see another health practitioner, in addition adolescents prefer to see a person they know already. Good to bring the people doing cessation in the general wider health care team. Positive modelling. School policy seems to be to ban from school children who smoke, would be better to provide them with support.</p>
<b>Suicide review</b>	<p><u>Sarah Roberts and Maraea Johns attended</u> Discussion about cluster in Otago (6 deaths in 6 months) in school age young people. Otago Child and Youth Morality Review Group devised process for analysis of the cluster including talking to parents and youth focus group. Reviewed "near miss" numbers have not changed. Interest in contagion (eg, attending a funeral of a person who committed suicide), texting and internet use. Report to be provided to the DHB and CYMRC will have a copy. Public Health team are currently devising Action Plan out of the Suicide Strategy. Post vention support contract will be with Victim Support. Influence of technology needs to be reviewed eg. use of phones for texting suicide notes.</p>
<b>LUNCH</b>	
<b>Family Violence</b>	<u>Sue Dahl and Jennifer Martin attended and presented</u>

<b>Taskforce – Ministry of health update</b>	See presentations <b>ACTION: Look at whether information from Family Court reviews can be collected for the Mortality Database. BT &amp; GN</b> <b>ACTION: Jennifer to return to meeting in September to report back. May be possible to include this work in Fifth Annual Report. FR.</b>
<b>Next meeting: Teleconference 20 July 2pm, Committee meeting 20 &amp; 21 September, 15 &amp; 16 November 2007</b> <b>Venue: Brentwood Hotel</b>	
<b>Minutes Approved:</b>	<b>Signature:</b>  <b>Barry Taylor, Chair</b> <b>Date: 21/9/07</b>