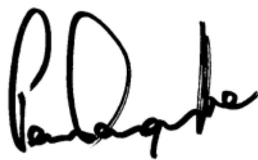
Newsletter - *September 2008*

MESSAGE FROM THE CHAIR

I am pleased to welcome Readers to the Spring edition of Council's Newsletter in my new capacity as Chair of Council following Dr Parsons' recent departure to take up the position of Chief of Division of Intensive Care and Associate Professor of Paediatrics at the Alberta Children's Hospital in Calgary, Canada. I will be undertaking the Chairman's role until the end of the current term. In the meantime, I am very pleased to report that the 2006 Annual Report has been finalised and now archived on the Council's website. Preparations for the 2007 Annual Report have already commenced and will be completed as soon as possible. I wish to sincerely thank members of Council for their continued support and significant contributions to Council and its ongoing activities.



A/Prof Peter Dargaville
Chairperson
Council of Obstetric & Paediatric Mortality & Morbidity

COUNCIL NEWS

Current membership in accordance with the Terms of Reference includes; Dr Peter Dargaville (Chair); Professor Allan Carmichael; Dr James Brodribb; Dr Geoff Shannon; Ms Ros Escott; Mr Peter Askey-Doran, Associate Professor Bipin Gupta, Mr Paul Mason; & Mr Tony Sansom. The Council welcomes its new *Tasmanian Branch of the Paediatric Health Division of the Royal Australian College of Physicians* representative -Dr David Strong. Dr Amanda Dennis continues to be invited by Council to attend as an Observer at future meetings or as a proxy RANZCOG member as required.

The Council website continues to archive newsletters, Annual Reports and other relevant resource information. The updated website address is as follows:
http://dhhs.clients.squiz.net/about_the_department/about_us/partnerships/registration_boards/copmm
Please note that *RHH Clinical Practice Guidelines and Protocols* can be accessed from the intranet link included in Council's website.

CLINICAL MATTERS

1. **Outcome of Australasian Seminar on Child Death Inquiries & Reviews (June 2008) & Child Death Review Committee update -** The Commissioner for Children reported that the Australasian Seminar had been attended by Ms Alison Jacob (Deputy Secretary, DHHS) & Ms Pip Shirley (DHHS) representing the Government, Mr Arnold Shott (Chief Magistrate), Mr Paul Mason (Commissioner for Children) and Dr Chris Lawrence (State Forensic Pathologist) representing COPMM on behalf of its Paediatric Mortality & Morbidity Subcommittee. It was reported that Ms Jacob had delivered a pre-agreed joint presentation at the Seminar where Tasmania was loudly applauded for saying that representatives had 'come to learn' from other jurisdictions and that it did not currently have a Child Death Review (CDR) model. It

was highlighted that there were as many different models as there were jurisdictions (every state and territory plus New Zealand). Most included deaths of children "known to" child protection, some included their siblings, some included all children and some included critical incidents as well as deaths. It was reported that the objects of Child Death Reviews were often related to their political origins (e.g., as a response to a public scandal; a controversial Inquiry; or a redesign of a child protections system). It was noted that the Seminar had since been followed by a conference between the Deputy Secretary, the Chief Magistrate and the Commissioner for Children, at which it was discussed how to cross-link the 3 major players; that is, the Coroner, the COPMM and Child & Family Services to produce minimum waste and duplication and yet obtain maximum useful information not only for avoiding deaths, but also improving services during life. Also discussed was whether the Tasmanian model would consider critical incidents as well as deaths, and all children or "known" children. The Commissioner for Children reported that the Government would produce a model for the Minister and for Stakeholders well before the end of 2008.

It has subsequently been advised that a Working Group will be formed in the near future to discuss the detail of a model that encompasses a strategic framework for Child Death Review processes in Tasmania. A representative from COPMM will be sought for this Working Group. It will also include DHHS representatives, The Commissioner for Children, a representative from Police and from the Magistrate's Court. A letter will be forwarded soon to Council for its update and consideration of this matter.

2. **Support for Statewide Community Paediatrician Position**- the Health Minister has indicated her support for the recommendation made by Council to establish a statewide community paediatrician position in Tasmania who would have particular responsibilities in child protection issues. Unfortunately however, funding for such a position still currently remains unavailable.

3. **Electronic Perinatal Database-** The State budget for 2008-09 has an allocation of $300,000 for the development of an Electronic Perinatal Database system. Chris Showell (Manager of Information Systems) recently provided a clear overview regarding issues related to the Electronic Perinatal Database system to Council members. The most important aim of the Electronic Perinatal Database project is to allow paperless entry of perinatal data from all birthing units in Tasmania, replacing the existing perinatal data form with a web-based system for data entry.

   The Perinatal Data Collection is managed by Clinical Data Services within the Resources and Health System Performance Section of the Department's Health Services group, and is supervised by Peter Mansfield. The purpose of this Collection is to provide the analysis and reporting which the Council requires in order to discharge its obligations under the *Act*. The system which is currently used to maintain the Perinatal Data Collection has recently been redeveloped, and was suitable for the purpose for which it was used. Any reporting delays were not considered a result of defects in the information system, but rather due to the business processes used to get data into it.

   Timeframe for implementation would depend upon the successful progression of the following requirements: tender specifications (4-6 wks), open tender (6wks), evaluation of responses (4 wks), implementation (@ 2-3 sites including staff training time- 6mths) (Total ~11-12mths).

4. **Recommendations from the 2006 Annual Report-** A number of recommendations have been produced on the basis of findings and trends reported in the 2006 Annual Report which has been archived on Council's website.

Key Recommendations in the Annual Report for 2006 include:

Recommendations on Stillbirths

1. Once again the Council recommends that all stillbirths should be investigated according to the previously distributed recommendations from the *Council of Obstetric and Paediatric Mortality and Morbidity*. It is apparent, from the process of reviewing perinatal deaths that many of the perinatal deaths in 2006 would have benefited from post-mortem examination of the baby. This process is recognised to be challenging for parents who lose babies in pregnancy. As such, the request for such an examination is probably best performed by a senior member of the obstetric staff.
2. Foetal growth restriction remains a significant and preventable cause of foetal loss. As commented on last year, antenatal care is now provided by many healthcare workers. As such, protocols should be developed in all units and by all practitioners in order to identify the 'at risk' foetus with inadequate growth assessment. Sufficient resources now exist to allow careful assessment of the at-risk foetus by ultrasound, once identified by screening protocols.
3. Practitioners are reminded that premature rupture of membranes (PROM) is now acknowledged to have a very high rate of pre-existing underlying chorioamnionitis, usually sub-clinical, at the time of onset of the PROM. Management of very pre-term pregnancies, at the boundaries of viability, in association with PROM is difficult given the competing needs of prolonging the pregnancy against the often clinically difficult matter of diagnosing early active chorioamnionitis. PROM at later gestations requires a balancing the merits of prolonging a pregnancy where infection is highly likely to be present and the current % survival at particular gestations. The risk of central nervous system and respiratory morbidity and cerebral palsy is strongly associated with intra-uterine sepsis.
   Note: Stillbirths associated with preterm premature rupture of membranes and chorioamnionitis were prominent this year. These deaths appear in the pre-term birth categories as the primary cause of death – category 9, hence do not appear under perinatal infection – category 2.
4. Council would expect that all perinatal deaths be reviewed by an obstetric audit in the relevant obstetric unit, once all relevant investigations have been completed.

Recommendations on Neonatal Deaths:

Nil

Recommendations on Maternal Deaths:

Pregnant women admitted to hospital as an emergency, unconscious and shocked or in cardio-pulmonary arrest, should be examined promptly, using trans-abdominal ultrasound in the Emergency Department, looking for free fluid within the peritoneal cavity.

Recommendations on Paediatric Deaths:

1. The number of children dying in traffic-related road trauma in 2006 was concerning and the Council believes that traffic accidents/road trauma is a primary contributor to paediatric death within Tasmania and is preventable. In response to this concern, Council has, in the past, recommended effective strategies to reduce the risk of road trauma. The Council still strongly supports the implementation of a dual divided carriageway between our major cities; and construction of better bicycle and pedestrian trail systems, ensuring that they

remain separate from our roads, and again asks for the issue of daytime running headlights to be examined by the appropriate authorities. The Council recognises that further efforts to reduce road related trauma are required and are ongoing by the State government. The development of the new *Tasmanian Road Safety Strategy 2007-2011* under the auspices of the *Tasmanian Road Safety Council* (TRSC) is welcomed by the Council. The Council continues to support the view that a network of pedestrian and cycle pathways separate from our roads remains under-developed in Tasmanian rural and urban areas.

2. Furthermore, in a number of cases of road trauma deaths, poor vehicle condition of the cars driven was considered to be an important contributing factor to the tragic outcomes. In view of such cases, the Council recommends that vehicle registration in Tasmania be updated to include the review of vehicle condition and overall maintenance to ensure improved safety. This concept however has been recently rejected by the appropriate authorities on the grounds of cost-effectiveness to the community.

3. In view of the slightly elevated number of unexplained infant deaths reported in 2006, the issue of safe sleeping practices remains unresolved in the Tasmanian community. Council views 'accidental suffocation' as currently holding more relevance in terms of the cause of death associated with unsafe sleeping, rather than the term 'unexplained infant death' or the old and misleading term 'SIDS'. The Council is aware of an ongoing DHHS initiative to produce a safe sleeping educational video for all new parents.
4. The one death from non-accidental injury occurred in a child known to Child & Family Services and thus Child Protection Services is of concern to the Council. This information and previous activities of the Council has contributed to the recent review of child protection services in Tasmania.[1]
5. The startling number of reported hangings by young adolescents in 2006 suggesting a trend for increased youth suicide in Tasmania is worrying. Improvement in and increased awareness of available services to assist in prevention of youth suicide in Tasmania should be encouraged.

6. A further death of a child with a congenital myopathy without timely rigorous review and consultation with paediatric specialists in long-term respiratory support for children is of concern to the Council. The Council recommends that a multidisciplinary group be established involving paediatric neurology, rehabilitation specialists, paediatric physiotherapy and respiratory/intensive care specialists to supervise the care of all such children in Tasmania.

7. Children continue to die by accidental drowning. Thus, education programs to remind parents of their responsibilities to supervise children whilst swimming and insuring boating safety are supported.

8. A death from severe sepsis serves to remind all practitioners of modern sepsis guidelines that encourage aggressive management of suspected severe sepsis and to encourage hospitals to ensure adequate central line infection prevention protocols.

9. The one death from short gut syndrome also serves as a reminder of the importance of the new small bowel transplant program underway at the Royal Children's Hospital in Melbourne. This was not available at the time.

[1] Child Death Review Report July 2007

Recommendation from Council on Smoking during Pregnancy:

As reported in 2005, interventions to reduce smoking in pregnancy are important particularly in view of reducing the incidence of IUGR and hence stillbirth rate. Standard antenatal care should therefore incorporate smoking reduction advice for all women who smoke as provided by QUIT Tasmania.

SUBCOMMITTEES

PAEDIATRIC Mortality & Morbidity

This subcommittee will continue to meet bimonthly to review statewide paediatric deaths and progress actions as they arise despite the temporary leave of absence of some members during the latter part of this year. Dr Anita Cornelius (Paediatric Intensivist, RHH) is welcomed to this Committee. Dr David Strong has been asked to provide Paediatric Representation on this Committee during Dr Williams' leave of absence. As suggested at last Council meeting and supported by Council members, a Senior Child Protection Practice Consultant will be invited to undertake membership on this Committee in the future to improve lines of communication between Child Protection Services and COPMM. It was agreed that Dr Chris Lawrence be Acting Chair of this Committee in the interim. 2007 review of cases has been completed and 2008 cases are continuing to be reviewed.

PERINATAL Mortality & Morbidity

Dr Tony de Paoli has been welcomed as a new representative on this subcommittee and will participate in the review and classification of neonatal deaths reported in future COPMM Annual Reports. Review and classification of perinatal deaths (including stillbirths and neonatal deaths) have been entered for 2007 and review of classification of these deaths will commence shortly. Recommendations will be formulated in due course in view of cases reviewed.

MATERNAL Mortality & Morbidity

No maternal death cases have been reported in Tasmania since the case reviewed in 2006.

MEMBERSHIP CHANGES

Dr Peter Dargaville is new Chairman until end of current 3-year term. The new term will commence in early 2009. Dr David Strong is welcomed as the new *Tasmanian Branch of the Paediatric Health Division of the Royal Australian College of Physicians* representative on COPMM. Dr Amanda Dennis continues to be welcomed by Council as an Observer at future meetings or as a proxy RANZCOG representative as required. The current term for Council members is for a 3 year period (2006-2009). Renewal of Council membership will be progressed early in 2009.

MEETINGS FOR 2008

Next Council Meetings:

- Thursday 20 November, 12.30-2.00pm, DSU Meeting Room

Note: Subcommittee meetings will be advised.

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