MESSAGE FROM THE CHAIR

With Christmas fast approaching, Council has recently held its last meeting for the year and for the current term that concluded on November 22, 2015. At this meeting, members who have been re-nominated by their respective Colleges and/or organisations to provide representation in the new three-year term, accepted to again undertake their respective positions into the new term following Ministerial appointment. With the support of COPMM colleagues, I have also agreed to continue as Chair of Council in the new term and look forward to engaging in and progressing COPMM activities as required.

Preparations for the 2014 COPMM Annual Report are underway with the preliminary 2014 Paediatric Mortality and Morbidity Committee Report having already been finalised and attached here for reader interest.

Again, I wish to sincerely thank our Manager and COPMM members for their continued support and significant contributions to Council and its ongoing activities. On behalf of Council, I would also like to thank you, the readers, for your continued interest in and support of Council activities throughout the year and would like to take this opportunity to wish you all a very happy and safe Festive Season and a successful, healthy and happy New Year.

Dr Michelle Williams
Chairperson- Council of Obstetric & Paediatric Mortality & Morbidity

COUNCIL NEWS

Membership for the new term 2015-2018 term in accordance with the Terms of Reference includes: Dr Michelle Williams (Chair- Paediatrician and RACP rep), Prof Peter Dargaville (employed in the delivery of Neonatal Services); Dr Anagha Jayakar (UTAS rep); A/Prof Amanda Dennis (UTAS Rep), Dr Jill Camier (RACGP rep); Ms Kate Cuthbertson, Barrister at Law (Council nomination), Ms Sue McBeath (ACMTas rep), Dr Tania Hingston (RANZCOG rep), Commissioner for Children, Mr Mark Morrissey (Council nomination) and Dr Kelly Shaw (interim DHHS Rep). Efforts are currently underway to secure Ministerial appointments for these members in the new term as soon as possible.

The Council website continues to archive newsletters, Annual Reports and other relevant resource information.

Manager, Contact Details: Dr Jo Jordan; email: jo.jordan@dhhs.tas.gov.au
CLINICAL MATTERS

1. **Recommendations from the Preliminary Paediatric Mortality and Morbidity Committee Report 2014** – Council wishes to highlight the preliminary recommendations that have been formulated by the Paediatric Mortality and Morbidity Committee of COPMM following the completion of its review and classification of 2014 paediatric death cases (see below).

   i) The Paediatric Mortality & Morbidity Committee strongly supports the recommendations previously made by Coroner McTaggart with regards to youth suicide. To young persons whose friends have told them they are thinking about suicide, the Coroner recommends that (1) the statement is to be taken seriously; (2) do not keep it a secret, even if your friend has asked you to; (3) tell a teacher or counsellor as soon as possible about what your friend has told you; and (4) encourage your friend to seek help from a trusted adult such as a counsellor or to call a helpline such as listed below:

   a. Emergency services 000
   b. Lifeline 131 114
   c. Suicide Call Back Service 1300 659 467
   d. Beyond Blue support service 1300 224 636
   e. Kids Helpline 1800 551 800
   g. Youth Beyond Blue have also developed the check in app, to assist young people who are concerned about a friend but worried about saying the wrong thing. [https://www.youthbeyondblue.com/help-someone-you-know/thecheckin](https://www.youthbeyondblue.com/help-someone-you-know/thecheckin)

   Classification systems used nationally are also being considered with a view to propose that jurisdictions consider using a consistent national classification system for review of paediatric death cases.

   ii) That all health professionals should be advised to inform relevant family members, carers or guardians of a child who may be at risk of suicide of that risk.

   iii) That the Paediatric Mortality & Morbidity Committee strongly endorses the recommendations made by Coroner McTaggart in her 2015 decision relating to Youth Suicide regarding the reporting by the Media of paediatric death cases related to suicidal behaviour. In particular, it is recommended that the Media, in publishing articles and editorial on suicide, ensure complete compliance with Mindframe Guidelines.

   iv) That the Media clearly outline appropriate and available support helplines at the time of reporting on paediatric death cases that have been particularly related to suicidal behaviour.

   v) That appropriate support is available to all young people engaged in the use of social media networks such as Facebook where the issue of youth suicide may be discussed. This is particularly important where a young person may have committed suicide.

   vi) That a clear and consistent message is used as part of the universal distribution...
of educational material concerning safe sleeping practices to all new parents. It is also recommended that further education packages are provided to parents highlighting the risks associated with parental use of illegal and prescribed drugs and co-sleeping. As highlighted in previous reports, it is also recommended that more effective crime or death scene examinations be undertaken to establish whether the cause of death is due to overlying.

vii) That the community continue to be alerted to risks associated with unsatisfactory restraint of children as passengers in moving vehicles and encouraged to ensure that all children are safely restrained with seatbelts when travelling in motor vehicles and preferably seated in the rear of the car. That age, height and weight restrictions for children sitting in the front of a motor vehicle should be better defined and that children should not ride in motor vehicles as front seat passengers based on height/weight guidelines as well as age restrictions. That children should not wear lap belts whilst travelling as passengers in a motor vehicle. As reported in previous years, the benefits of young children wearing harnesses with and without booster seats have been highlighted.

viii) That children less than 5 years of age are appropriately and safely supervised by an adult when playing around backyard pools and that all safety devices (such as gates, fences, pool covers) are well-maintained.

ix) That there is increased driver awareness and caution exercised where children alight from the rear of buses especially in school zones.

2. **Coroner’s Report into Youth Suicide in Tasmania - Highlighted Recommendations**

Council wishes to applaud the extensively comprehensive and valuable work undertaken by the Coroner into reported youth suicide cases in Tasmania. Council wishes to support and highlight some of the key recommendations included in the report that are pertinent to youth suicide. An excerpt of these recommendations are highlighted below:

i) Coroner recommends that government agencies, GP organisations or organisations providing services for adolescent mental health consider compiling a comprehensive register of services available to assist adolescents with mental health issues; the register to be regularly updated; to contain information regarding the nature of those services and how young persons may be referred to those services; to be made easily accessible to general practitioners and other health professionals treating the mental health of young people.

ii) Coroner recommends that GP organisations or relevant bodies consider compiling a register of general practitioners with an interest, or subspecialisation, in adolescent mental health; such register for distribution to general practitioners for the purpose of inter-referring, and/or to other health professionals for referral purposes.

iii) Coroner recommends that general practitioners consider the increased use of case conferencing with other mental health professionals and specialists in respect of patients who are young persons with mental health issues engaged with multiple health professionals.

iv) Coroner recommends that general practitioners consider ways in which flexible and understanding appointment and billing arrangements can occur such as to maximise engagement by young persons requiring treatment for mental health issues.

v) Coroner recommends that CAMHS consider, and if appropriate implement,
measures for important patient documentation and treating information to be consistently provided to general practitioners to assist with their treatment of young persons with mental health issues.

vi) Coroner recommends that a dedicated inpatient unit for adolescents or young persons between the ages of 12 and 25 years be established, designed around the needs of that cohort including for the treatment of those suffering from an acute state of mental illness or suicidality.

vii) Coroner recommends, additionally or alternatively to 6 above, that consideration be given to the establishment of a multi-disciplinary facility for young persons suffering from an acute state of mental illness or suicidality; such facility to have a comprehensive through-care and after-care model to provide ongoing community-based risk management.

viii) Coroner recommends that CAMHS be staffed to the equivalent of best practice for such an organisation, so as to provide an adequate service for children and adolescents with mental health issues, and to:

a) Ensure that there is no “freeze” in accepting referrals;
b) Eliminate a “wait list” for referrals;
c) Provide for clinical directorship of the Service;
d) Allow access to a wider group of adolescents suffering mental health issues;
e) Develop a comprehensive early intervention program for the 0 to 3 years age group and their families, including to identify those children at high risk and focusing upon early intervention in the infant attachment period; and
f) Develop a school based multisystemic approach to developing mental health disorders for the 5 to 12 years age group.

ix) Coroner recommends that the Department of Health and Human Services establish statewide positions of suicide prevention co-ordinators to provide necessary outreach between discharge from hospital and entry into appropriate services; such positions to assist with a streamlined approach to discharge planning, collaboration between service providers and continuity of care.

x) Coroner recommends that hospitals offering emergency medicine consider developing and implementing a suicide risk assessment tool, to be applied consistently on a statewide basis where suicidal risk assessment is required.

xi) Coroner recommends that hospitals consider implementing a policy of providing patients and their guardians with discharge summaries and contact details for follow-up treatment together with appropriate services to contact, in the event of the admission of a youth in crisis.

3. ObstetrixTas System - COPMM and its Committee members wish to thank the Statewide ObstetrixTas (EPD) Systems Owners Group which continues to provide updates around progress of this system within the state. COPMM wishes to again remind all services that do not have access to the ObstetrixTas system, namely private hospitals and birth centres where the birth occurs, or private midwifery and medical practitioners who deliver babies outside hospitals that completion of the Tasmanian Perinatal Data Collection Form is a mandatory requirement for data collection under the OPMM 1994 Act. A copy of the form and associated guidelines can be accessed via COPMM’s website.
COMMITTEES of COPMM

PAEDIATRIC Mortality & Morbidity
This Committee chaired by Dr Michelle Williams continues to meet bimonthly to review statewide paediatric deaths and progress actions as they arise. The first preliminary 2014 Paediatric M&M Committee Report has been completed and attached with this newsletter. A total of 24 paediatric deaths were reviewed and reported in Tasmania in this year. This Committee continues to progress the review and classification of paediatric deaths reported in 2015 and will commence work to review cases reported in 2016 when it next meets in February 2016.

PERINATAL Mortality & Morbidity
Work will commence shortly to undertake the review, classification and reporting of 2014 perinatal deaths. Members of this Committee continue to recommend that Tasmania’s private hospitals use PSANZ guidelines in the future to report on perinatal cases to provide COPMM with more comprehensive information on reported stillbirth cases as required.

MATERNAL Mortality & Morbidity
This Committee, chaired by Associate Professor Amanda Dennis, is currently finalising the Tasmanian maternal death cases reported in 2014. There has been notification of two late maternal deaths reported in this year in addition to the already noted indirect maternal death. These cases are to be reviewed shortly. There have also been two late maternal deaths reported in 2015. Progress of the Australian Maternity Outcomes Surveillance System (AMOSS Project) will continue to be tracked and its relevance to Tasmania’s reporting assessed etc.

DATA MANAGEMENT
Professor Peter Dargaville continues to chair this committee in the current term and a combined meeting of this Committee and the Perinatal Mortality and Morbidity Committee will be scheduled before the end of the year.

MEETINGS FOR 2016

Next Council Meetings:  

Note: Committee meetings will be advised

- Thursday 25 February, 12.30-2.00pm, Videoconference Meeting Room, Level 4, 34 Davey St
- Thursday 12 May, 12.30-2.00pm, Videoconference Meeting Room, Level 2, 34 Davey St
- Thursday 25 August, 12.30-2.00pm, Videoconference Meeting Room, Level 4, 34 Davey St
- Thursday 24 November, 12.30-2.00pm, Meeting Room, Level 4, 34 Davey St

Newsletter- Christmas Edition 2015