DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

Submissions on the Child and Youth Wellbeing Strategy

August 2019

The Department of the Prime Minister and Cabinet has released the following submission received during its public consultation on the child and youth wellbeing strategy.

Some of the information contained within this release is considered to not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act).

- Where this is the case, the information has been withheld, and the relevant section of the Act that would apply, has been identified.
- Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes and their reference to sections of the Act:

- **9(2)a** – Section 9(2)(a): to protect the privacy of natural persons, including deceased people.

child & youth wellbeing

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Child and Youth Wellbeing Strategy – Submission Template

This document is intended for individuals or groups who wish to make a formal submission on the child and youth wellbeing strategy.

Please complete this template and email it to: childandyouthwellbeing@dpmc.govt.nz

A guide to making a submission is available on the DPMC website https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Submissions will close on **Wednesday 5 December**.

Please provide details for a contact person in case we have some follow up questions.

Contact Name:	Melissa Wilson
Email Address:	9(2)(a)
Phone Number:	
Organisation Name:	Safekids Aotearoa
Organisation description: (tell us about your organisation – i.e. who do you represent? How many members do you have? Are you a local or national organisation?)	Safekids Aotearoa was established twenty years ago by Starship Child Health clinicians determined to reduce preventable child deaths and hospitalisations from unintentional injury. The agency and its small staff is based in Auckland and works with providers and partners nationally to focus on priority populations throughout New Zealand. Safekids designs, implements and evaluates evidence-based community and advocacy initiatives that aim to reduce the incidence and impacts of preventable injuries in children aged 0 to 14 years in New Zealand. This includes policies, projects and programmes that seek to address the child injury inequities that currently exist for some groups and communities within New Zealand, Māori in particular. In New Zealand, at least one child dies every week and a further 141 are hospitalised for a preventable injury. Eight out of ten injury-related deaths in New Zealand are unintentional and preventable. Preventable injuries are the third leading cause of death for all children aged 0 to 14 years after medically-related deaths and Sudden Unexpected Death in Infancy[1]. The majority of deaths that occur are children under five years of age. Sixty-six percent of unintentional injury fatalities and 38 percent of injuries resulting in hospitalisations occur in the home environment. Male children are 1.5 times more likely to die from an unintentional injury than female. Overall, death rates in New Zealand are highest for Māori and Pacific tamariki and lowest for Asian and

[1] Sudden unexpected death in infancy, or SUDI, is a broad term that covers both sudden infant death syndrome, or SIDS, and fatal sleeping accidents. Most SUDI deaths occur in a sleeping environment.

	European children. These differences are avoidable or remediable and represent significant outcomes inequities, particularly for Māori and Pacific tamariki. [2]
Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	This submission makes six recommendations for the development of the Child and Youth Wellbeing Strategy (CWS): **1. The CWS facilitates the development of a fully integrated, coordinated cross-sector National Child Injury Prevention Strategy** This calls for the development of a fully integrated, coordinated national strategy for child injury prevention, with a sustainable funding mandate and decision profile commensurate with the burden of injury. **2. The CWS makes explicit that child injury prevention is included in all publicly-funded strategies and programmes delivering child wellbeing outcomes** This proposes a sector wide review of all programmes with investments in family and whānau-centred child wellbeing to explicitly integrate child injury prevention as a core component of wellness. Wording suggestions are provided. **3. The CWS enables consistent and equitable access to safety devices proven to keep children safe** Evidence that access to safety devices and equipment keeps children safe from preventable injury is presented. The need to ensure funded, equitable access to safety devices is a core component of child wellbeing. Wording suggestions are provided. **4. The CWS consistently use current child injury prevention terminology** The most common causes and locations of preventable injuries are justified and alternative wording to reflect accepted terminology is provided. **5. The CWS strengthens its rights-based commitment to wellbeing in Aotearoa New Zealand** This argues that the primary underpinning principle of the CWS should be the foundational role of te Tiriti o Waitangi, and its rights-based commitment be extended to include indigenous people.

[2] National Injury Query System (NQIS). Retrieved from: http://ipru3.otago.ac.nz/niqs/

	6. The CWS is connected to He Korowai Oranga, the Māori Health Strategy This proposes adopting Pae Ora aspirations and incorporating Kawa Oranga philosophy within the CWS. **Please note**, Safekids would welcome the opportunity to present these arguments in person.

Submission Content

Safekids Aotearoa strongly supports the DPMC's ongoing development of the Child and Youth Wellbeing Strategy (CWS) and welcomes the opportunity to engage to "help set the direction and focus of the first child wellbeing strategy" (para 36) and provide feedback on the CWS's Proposed Outcomes Framework.

We **highlight six areas** that will raise visibility of the role that injury prevention should play in the CWS to empower communities to improve the wellbeing and safety of all tamariki.

Please note, Safekids would welcome the opportunity to present these arguments in person.

Recommendation 1: The CWS facilitates the development of a fully integrated, coordinated cross-sector National Child Injury Prevention Strategy

This section relates to Focus Area 2 on the Proposed Outcome Framework, namely that "The community and the physical, policy and regulatory environment work together to promote children's and young people's physical safety".

Safekids recommends that a national child injury prevention strategy be framed explicitly within Focus Area 2 of the CWS. This is necessary to inform common priorities and funding allocations to appropriately reflect both the burden and preventability of childhood injury.

Nearly a decade ago an evaluation reviewed New Zealand's child and adolescent unintentional injury prevention initiatives against standardised assessments of European countries. The analysis suggested that New Zealand "…lacks specific targets and national strategies, as well as individuals/ministerial or government departments with mandated responsibility for all aspects of child and adolescent safety in particular, no lead agency available to coordinate funds and activities in order to achieve the performance criteria consistent with good practice."[3] This assessment remains true today.

Across the wider state sector and among service providers there is minimal alignment and co-ordination in preventable injury policy development, prioritisation, or in programme design and delivery. Poor coordination diminishes the effectiveness and efficient allocation of the very limited financial resources available for injury prevention.

[3] Bland, V., Shepherd, M., Amerataunga, S., Carter, J., Hassall, I., Kook, B,, Richards, G., Sapolu-Reweti, P., Dalzierl, S. (2011). Child and adolescent injury report card: New Zealand 2009. *Journal of Paediatrics and Child Health. 47: 786.*

Moreover, current practice fails to acknowledge the status of preventable injury as the third leading cause of child death in New Zealand. It also limits capability to address childhood injury within the context of child health and wellness determinants associated with injury risk, such as poverty, parental education and hazardous environments.[4] Furthermore, it leads to distortionary inequities and inconsistencies in the delivery and outcomes of injury prevention initiatives.

This submission calls for the Child and Youth Wellbeing Strategy to foster a prioritised approach to child injury prevention by:

- **Supporting the development of a fully integrated, coordinated cross-sector National Child Injury Prevention Strategy**
- **Ensuring unintentional child injury priorities are addressed within the government's national policy agenda**
- **Providing a policy mandate and decision profile commensurate with the burden of injury for sustainable investment in unintentional child injury prevention**

Recommendation 2: The CWS makes explicit that child injury prevention is included in all publicly-funded programmes delivering child wellbeing outcomes

In New Zealand, injury prevention is routinely treated as a stand-alone strand of child wellbeing that is carried out across various sectors (e.g. health, education, emergency services, transport) by numerous providers. In many cases, injury prevention efforts focus on a specific type or cause of injury (e.g. SUDI, motor vehicle crashes, drowning, burns etc.) in isolation.

More broadly, injury prevention is considered separately from child wellbeing and generally treated as an "add on" to the work of community providers who are seldom funded or trained to carry out this role. This is in stark contrast to the way parents, whānau and caregivers normally regard injury prevention; i.e.as an integral, essential part of everyday childcare keeping tamariki healthy and well.

Safekids recommends that the CWS recognise child injury prevention as a core, funded component of all publicly-funded programmes that invest in family and whānau-centred child wellbeing. Examples include: Healthy Homes Initiative, The Well Child Programme and Family Start.

With a more explicit and funded presence, injury prevention would become a legitimate part of the mandate of numerous home visit providers and benefit from already well established family and whānau relationships.

This submission calls for the Child and Youth Wellbeing Strategy to explicitly recognise injury prevention as a key element of an integrated approach to child wellness by:

- **Reviewing all programmes with investments in family and whānau centred child wellbeing (e.g. Healthy Homes Initiative, Well-Child, Family Start) to explicitly include injury prevention with dedicated and sustainable funding**
- **Providing space for coordinated collaboration between the various stakeholders with roles in injury prevention**

[4] World Health Organisation. (2008). *World report on child injury prevention*. Switzerland.

- **Showing that child safety, meaning freedom from preventable injury, is an integrated and core component of child wellbeing, and**
- **Include safety wording within the CWS to reflect injury prevention (suggestions follow)**

Current Wording	Recommended Wording
Focus Area 4: Children and young people and their families and whānau live in affordable, quality housing	**Focus Area 4:** Children and young people and their families and whānau live in affordable, quality **and safe** housing.
Focus Area 4: Second Bullet Point: Housing is warm and dry, has space and facilities to meet essential needs and supports good health.	**Focus Area 4: Second Bullet Point:** Housing is warm and dry, has space and facilities to meet essential needs, **keep children safe** and support good health.
Focus Area 5: First Bullet Point: Children, young people and families and whānau have the resources they need to meet children's basic needs, and enable them to participate fully in society.	**Focus Area 5: First Bullet Point:** Children, young people and families and whānau have the resources they need **to keep children safe**, meet children's basic needs and enable them to participate fully in society.
Focus Area 10: Children and young people and their families and whānau are empowered to make healthy lifestyle decisions for children and young people	**Focus Area 10:** Children and young people and their families and whānau are empowered to make healthy**, safe** lifestyle decisions for children and young people.
Focus Area 10: Second Bullet Point: Communities offer access to affordable, nutritious food and environments that enable children to be physically active.	**Focus Area 10: Second Bullet Point:** Communities offer access to affordable, nutritious food and environments that enable children to be physically active **and stay safe.**
Focus Area 13: Additional Bullet Point:	**Focus Area 13:** **Children and young people are supported to assess their behaviour and environments and take steps to mitigate preventable injuries**.

Recommendation 3: The CWS ensures consistent and equitable access to safety devices proven to keep children safe

Legislation and the promotion of safer choices are powerful, cost effective tools in injury prevention. Smoke detectors, bicycle helmets and child passenger restraints, for example,

have known efficacy in reducing the risk of injury.[5] Appendix A provides some evidence-based data.

Such measures are unlikely to be effective, however, if families and whānau find safer choices too costly or difficult to access. Usually, the people at greatest risk of injury in a community are those who are least likely to be able to afford or easily access the products and environments that offer the greatest level of protection.

Currently there are a limited number of avenues for families to request devices and get help installing child safety devices. What access there is varies widely within and across regions, organisations and communities. For example:

- Safekid's Home Safety Programme provides safety education and limited access to safety devices, such as safety gates and window latches
- Fire and Emergency perform home fire safety checks and install smoke alarms
- Housing New Zealand will install safety devices on request to its tenants
- WINZ provide a repayable loan for families to purchase car restraints
- The Residential Tenancy Review proposes giving tenants the right to make small prescribed modifications to a rented home without landlord permission.

These initiatives, while welcome, are largely ineffective if not connected. The CWS is an opportunity to break the cycle of uncoordinated, piecemeal and inequitable injury prevention information and access to devices and services for low income, marginalised families and whānau.

More equitable access to affordable injury prevention devices for the most vulnerable in society should aim to address child and youth safety needs in the home, on the road and at play.

This submission calls for the Child Wellbeing Strategy to ensure consistent and equitable access to safety devices:

- **Include wording to demonstrate access to safety devices and equipment is a core component of child wellbeing and keeps children safe from preventable injury**

Current Wording	Recommended Wording
Focus Area 2. Additional Bullet Point	**Focus Area 2. Additional Bullet Point: Children and young people have access to safety devices and equipment that keep them safe from preventable injury.**

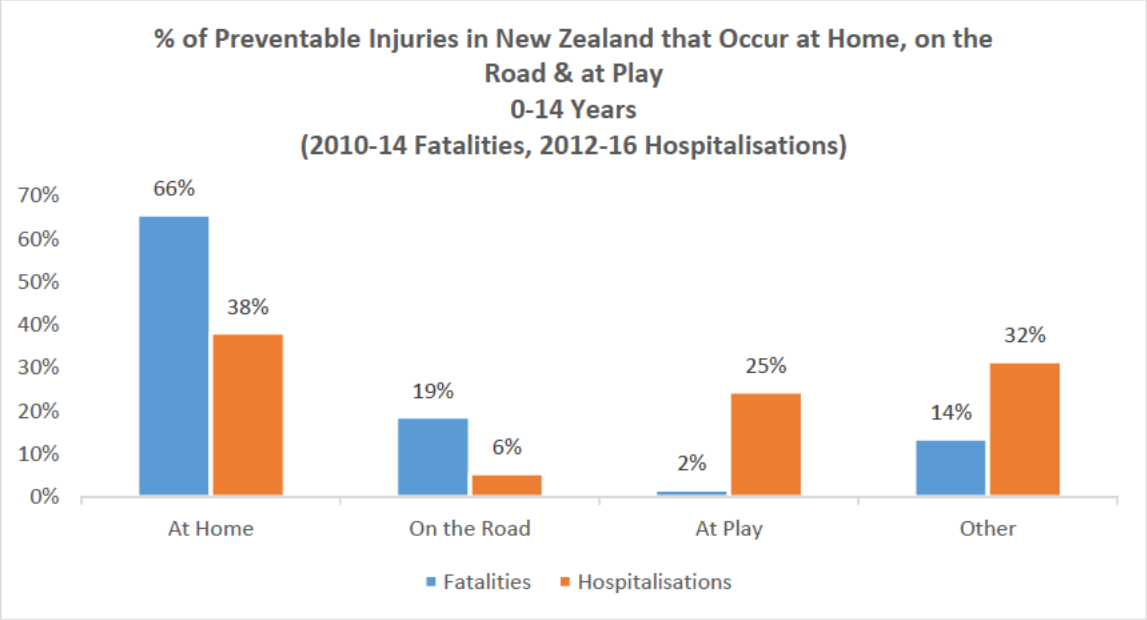
- **Recognise that funded and equitable access to safety devices is proven to minimise the risk of injury for children**
- **Mandate that child safety devices become an integrated part of a coordinated child and youth wellbeing approach**

[5] Sydney Children's Hospitals Network. (2016) *Child safety good practice guide: Good investments in unintentional child injury prevention and safety promotion.* Sydney.

Recommendation 4: The CWS consistently use current, evidence-based child injury prevention terminology

Local and international data shows that most preventable childhood injuries occur at home, on the road and at play. The CWS currently refers to a range of different contexts where safety and nurturing should be maintained and fostered. These include travel and recreation and injury at home.

Safekids recommends that the CWS consistently uses current, global child injury prevention terminology to refer to these safety focus areas. The terms: 'at home', 'on the road' and 'at play' align with the World Health Organisation's terminology.



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We also recommend that the CWS reflect the top causes of death and hospitalisation for children. This includes suffocation, vehicle crashes, falls, mechanical force-related injuries[7] and drowning.[8]

Most childhood injuries are predictable and therefore preventable. They can be controlled using a range of injury prevention interventions that have been proven to be effective both in New Zealand and internationally. Leading clinicians articulate the potential impact of not describing the risks in ways that show them to be preventable and avoidable: "If injury is considered to be the result of random, uncontrolled factors and that chance and bad luck or fate are the main factors, then there is little that can be done to prevent injury" [9]. The CWS currently refers to accidental injuries and road accidents. It is important that the CWS employ language that frames serious childhood injuries as preventable, not inevitable or accidental.

This submission calls for the Child and Youth Wellbeing Strategy to reword aspects of Draft Outcomes and Focus Areas to:

- **Reflect the most common causes and locations of preventable injuries**
- **Reflect commonly accepted injury prevention terminology that emphasises the preventable nature of many injuries**

Current Wording	Recommended Wording
Focus Area 2: Children's and young people's physical safety is protected during everyday activities like travel and recreation.	**Focus Area 2:** Children's and young people's physical safety is protected **at home, on the road and at play.**
Focus Area 2: Second Bullet: Serious injury and death through road accidents, drowning and other major accidental causes are reduced.	**Focus Area 2: Second Bullet:** Serious injury and death through **suffocation, vehicle crashes, falls, mechanical force-related injuries, drowning and other preventable causes are reduced**.
Focus Area 2: Third Bullet: The particular vulnerability of disabled children and young people to accidental injury is addressed.	**Focus Area 2: Third Bullet:** The particular vulnerability of children and young people with disabilities **to preventable injury** is addressed.

Recommendation 5: The CWS strengthens its rights-based commitment to wellbeing in Aotearoa New Zealand

Safekids Aotearoa supports the CWS being anchored upon te Tiriti o Waitangi and describing the Treaty as having a foundational role for child and youth wellbeing. Similarly, we support the CWS articulating the principle of Crown-Māori partnership and making plain our commitment to the United Nations Convention on the Rights of the Child.

Safekids recommends the CWS extend its support for the other two Treaty principles recognised in health in New Zealand - that of participation and protection.[10]

Safekids also recommends that the CWS extend its rights-based commitment to children and young people by restating Government's support for indigenous people as set out in the United Nations Declaration on the Rights of Indigenous Peoples.

This submission calls for the Child and Youth Wellbeing Strategy to:

- **Identify the foundational role of te Tiriti o Waitangi as the primary principle underpinning the approach of the CWS[11]**
- **Extend its rights-based commitment to children and young people to include indigenous people**

[6] Injury Prevention Research Unit, University of Otago. (n.d.) *National Injury Query System (NIQS).* Retrieved from: http://ipru3.otago.ac.nz/niqs/

[7] Mechanical force injuries include: cutting and piercing (e.g. sharp knives, objects and glass); struck by or against a person or object (e.g. children running into another person/object, unsecured furniture falling and striking child); and caught/crushed between objects (e.g. fingers and limbs caught in doors or between objects).

[8] Injury Prevention Research Unit, University of Otago. (n.d.) *National Injury Query System (NIQS).* Retrieved from: http://ipru3.otago.ac.nz/niqs/

[9] World Health Organisation. (2008). World report on child injury prevention. Switzerland. p 21.

[10] Ministry of Health (2014). *Treaty of Waitangi Principles*. Retrieved from: https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles

[11] Of the seven underpinning principles, Crown-Māori partnership is currently listed 4th in the Proposed Outcome Framework and 7th in the CWS Appendix B Draft Outcomes

- **Make explicit the CWS's support for United Nations Declaration on the Rights of Indigenous Peoples**

Recommendation 6: The CWS is connected to He Korowai Oranga, the Māori Health Strategy

Safekids Aotearoa is committed to achieving Pae Ora for all tamariki growing up in New Zealand, particularly tamariki Māori. Pae Ora aspirations include, but are not limited to, ambitions to reduce the burden of preventable injury inequities for Māori tamariki who are 2.6 times more likely to die from unintentional injuries than European children.[12] A Pae Ora approach involves imagining a future where tamariki growing up in New Zealand are the safest children in the world. It requires embedding the interconnected elements of mauri ora, whānau ora and wai ora[13] in all our strategies and initiatives.

Safekids recommends the CWS adopts the Pae Ora aspirations as reflected in He Korowai Oranga (the Māori Health Strategy).[14] We believe these have positive utility for all tamariki growing up in New Zealand – "if you get it right for Māori, you get it right for everyone."[15]

Similarly Safekids recommends inclusion in the CWS of Kawa Oranga[16] as articulated by the collective of General Managers, Māori Health, Tumu Whakarae. This would, they argue, drive genuine tangata whenua development and empower Māori to determine how Pae Ora is realised based on 'te au o te kanohi Māori'. Te au o te kanohi Māori is the uniqueness of a tangata whenua worldview and Māori intelligence, seen only through the lens of tangata whenua themselves.

Kawa Oranga provides philosophical and practical guidance to help ensure the physical, mental and spiritual safety and wellbeing of all tamariki growing up in New Zealand. It also provides an effective lens for identifying and mitigating inequities that create barriers to achieving wellbeing for Māori and other tamariki.

There is an emerging body of literature describing and evaluating Kawa Oranga-based approaches, models and programmes focused on improving outcomes for Māori, including:

- offender change within the prison system[17]
- traumatic brain injury[18]
- adaptive coping and wellbeing for adolescents[19]

[12] Injury Prevention Research Unit. University of Otago. (n.d.). *National Injury Query System (NIQS)*. Retrieved from: http://ipru3.otago.ac.nz/niqs/
[13] Mauri ora – healthy individuals, whānau ora – healthy families, wai ora – healthy environments. Ministry of Health. (2015). *Pae ora – healthy futures*. Retrieved from: https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures
[14] Ministry of Health. (2015). *The Guide to He Korowai Oranga – Māori Health Strategy*. Wellington: Ministry of Health: p.8
[15] Te Tumu Whakarae. (2018). *Tumu Whakarae Submission to the Government Inquiry into Mental Health and Addiction*. New Zealand: p.8.
[16] Described by Tumu Whakarae as a philosophical foundation for optimal tangata whenua wellness, inclusive of wisdom, intelligence, values, key concepts and spiritual rites throughout a lifetime.
[17] Chalmers, T (2014). Exploring Māori identity behind closed doors. An investigation of Māori cultural identity and offender change within Waikeria prison's Māori focus unit, Te Ao Marama (Degree of Doctor), Massey University, Albany
[18] Elder, H. (2018) Te Waka Oranga: An indigenous intervention for working with Māori children and adolescents with traumatic brain injury. *Brain Impairment*. 14(3): 415-424
[19] Fox, R., Neha, T., & Jose, P. E. (2018). Tū Māori mai: Māori cultural embeddedness improves adaptive coping and wellbeing for Māori adolescents. *New Zealand Journal of Psychology, 47*(2): 13-23.

- parenting practices[20]
- youth courts[21]

In the context of child and youth wellbeing and the prevention of injury this would see the adoption of the idea of children as children as taonga and the principles such as tapu, noa, and rahui embedded in practice.

This submission calls for the Child and Youth Wellbeing Strategy to:

- **Adopt Pae Ora aspirations and embed the elements of mauri ora, whānau ora and wai ora**
- **Incorporate Kawa Oranga to drive optimal tamariki wellness and safety**

Appendix A: Evidence for safety devices

Child passenger restraints

Child restraint systems are very effective at preventing fatalities, and are the most important 'in-vehicle' safety measure for children. Worldwide, correctly installed car seat or booster seats have been shown to:

- reduce deaths among infants by around 70%
- reduce deaths among small children, aged 1–4 years, by 54%
- reduce the chances of sustaining clinically significant injuries by 59% among children aged 4–7 years (148cm tall or less)[22]

In New Zealand, data show that more than 15 children (0-14 years) die in car crashes every year, half of them are tamariki Māori; and every month, more than 26 children are injured in crashes and admitted to hospital.[23]

Bicycle helmets

Cycling related injuries are one of the top three causes of injury for children in New Zealand. Wearing helmets dramatically reduces the risk of severe and fatal head and facial injuries when a crash involves a motor vehicle. [24][25] The use of cycle helmets is particularly important for older children because of their increased exposure to traffic.

[20] Social Policy Evaluation and Research Unit (SUPERU). (2015). *Parenting programmes effective with whānau.* Wellington.
[21] Henwood, C., George, J., Cram, F., Waititi, H. (n.d). *Research paper: Rangatahi Māori and Youth Justice.* Oranga Rangatahi. Iwi Chairs Forum.
[22] World Health Organisation. (2008). *World report on child injury prevention*. Switzerland
[23] Safekids Aotearoa. (n.d.). http://www.Safekids Aotearoa.nz/Safety-Topics/Details/Type/View/ID/1/Car-Seats
[24] Kwan I, Mapstone J. (2002). Interventions for increasing pedestrian and cyclist visibility for the prevention of death and injuries. *Cochrane Database of Systematic Reviews*. (2):CD003438.
[25] This systematic review foound that helmets reduced the risk of head and severe brain injury by between 63% and 88%, among cyclists of all ages - Thompson DC, Rivara FP, Thompson R. Helmets for preventing head and facial injuries in bicyclists. *Cochrane Database of Systematic Reviews*, 2005, (4):CD001855.

In New Zealand boys, and particularly tamariki Māori, are over-represented in cycling related fatalities and injuries.[26]

Window and Stair safety mechanisms

There is good evidence that the use of window latches reduces death from window falls by 35-50% and that regulation requiring window safety mechanisms on rental housing are an effective approach for areas of socio-economic deprivation. [27]

In New Zealand, between 2008 and 2012, falls-related injury were the number one cause of child hospitalisations (0-14 years), with 40% taking place in the home. Boys and tamariki Māori were more likely to be hospitalised from falls than other groups.

On average, ACC claims from child falls cost around $45 million per year[28]. This could be reduced by simple interventions in the home such as installing stair gates and window catches. Inequalities in rates of use may be partially reduced when stair gates are both supplied and installed.[29]

Smoke detectors

There is good evidence that correctly installed and charged smoke alarms with working batteries are effective early warning devices that reduce injury and fatalities from residential fires.[30]

Lockable cupboards for poisons, chemical, hazardous items

Poisoning remains one of the major causes of childhood injury in New Zealand. In the years 2004-2011, 13 children (aged 0-14 years) died as a result of unintentional poisoning. Between 2006 and 2013, 2499 children were hospitalised; 2061 were under 5yrs, making it the third most common injury type for this age group; and 71% were aged 1-2 years[31].

There is evidence to advocate for the use of cupboard safety latches and locks to support the safe storage of medications and other hazardous substances, such as household cleaning products. For example, an evaluation report on the Taranaki Paracetamol Poisoning Prevention Project found that of 138 participants who were provided with poison prevention advice, including free provision of cupboard safety latches to parents/ caregivers, 62% reported using or intending to use the latches.[32]

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[26] Safekids Aotearoa. (n.d.). http://www.Safekids Aotearoa.nz/Safety-Topics/Details/Type/View/ID/1/Car-Seats

[27] Safekids Aotearoa. (2015). *Child Unintentional Deaths and Injuries in New Zealand, and Prevention Strategies.* Auckland, NZ: p.47 http://www.moh.govt.nz/notebook/nbbooks.nsf/0/05ED778EE1B2C6D6CC257F4C007A779C/$file/Safekids%20Aotearoa%20Databook%20CIP%20NZ%20and%20Prevention%20Strategies.pdf

[28] Safe Communities Foundation New Zealand. (n.d.). https://www.safecommunities.org.nz/application/files/3114/8115/6965/Fact_Sheet_8.pdf

[29] Safekids Aotearoa. (2015). *Child Unintentional Deaths and Injuries in New Zealand, and Prevention Strategies.* Auckland.

[30] Safekids Aotearoa. (2015). *Child Unintentional Deaths and Injuries in New Zealand, and Prevention Strategies*. Auckland. http://www.moh.govt.nz/notebook/nbbooks.nsf/0/05ED778EE1B2C6D6CC257F4C007A779C/$file/Safekids%20Aotearoa%20Databook%20CIP%20NZ%20and%20Prevention%20Strategies.pdf

[31] Safekids Aotearoa. (2015). *Position Paper: Child Poisoning Prevention*. Auckland. http://www.Safekids Aotearoa.nz/Portals/0/Documents/Resources/Poisoning/Safekids Aotearoa_POISONING_Position%20Paper_final%20webNov15.pdf

[32] Kidsafe Taranaki. (2008). Paediatric paracetamol poisoning prevention project 2008: evaluation report. Taranaki.

Safe sleeping

Global evidence shows sleeping in the parents' room on a separate, safe surface lowers the chance of sudden unexpected death in infancy (SUDI) / sudden infant death syndrome (SIDS) by as much as 50%. It also helps prevent suffocation, strangulation, or entrapment that can happen when babies are sleeping in bed with adults. A large percentage of babies who die of SUDI/SIDS are found with bedding covering their head. Loose bedding in a babies' sleeping environment is not recommended.[33]

Surfacing materials

A proper playground surface is one of the most important factors in reducing injuries - and the severity of injuries - that occur when kids fall from equipment. The surface under the playground equipment should be soft enough and thick enough to soften the impact of a child's fall. However, no amount of cushioning can prevent all injuries. Moreover, the greater the height of the equipment, the more likely children may get injured if they fall from it.[34]

Hard surfaces (concrete, asphalt etc.) are unacceptable and the playground surface should be free of standing water and debris that could cause children to trip and fall. Surfacing mats made of safety-tested rubber, or rubber-like materials, are considered safe and accessible. All cushioned surfaces should extend at least 1.8m past the equipment.

Loose-fill surface materials 30cm deep should be used for equipment up to 2.5m high. Conversely, no surfacing materials are considered safe if the combined height of playground and the child (standing on the highest platform) is higher than 3.5m.

Area-wide engineering solutions (e.g. traffic calming infrastructure, cycling lanes and pathways)

Research indicates that traffic-calming solutions (or 'traffic-calming modifications') targeted to areas of socioeconomic disadvantage may reduce inequities in child pedestrian injury[35] and are a cost effective intervention to reduce child pedestrian and cycling injuries.[36], [37], [38], [39], [40]

These measures include speed management, such as road engineering procedures (speed bumps and limits), which have been shown to be effective in reducing injuries among more vulnerable road users, including children, pedestrians and cyclists.[41], [42]

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[33] WebMD. (n.d). *Baby suffocation deaths from co-sleeping rise.* Retrieved from: https://www.webmd.com/baby/news/20180212/baby-suffocation-deaths-from-cosleeping-rise

[34] Kidshealth. (n.d.). *Playground safety.* Retrieved from: https://kidshealth.org/en/parents/playground.html

[35] Jones, SJ., Lyons, RA., John, A., & Palmer, SR. (2005). Traffic calming policy can reduce inequalities in child pedestrian injuries: database study. *Injury Prevention, 11*(3), 152-156.

[36] Towner, E., Dowswell, T., Mackereth, C. and Jarvis, S. (2006). *What works in preventing unintentional injuries in children and young adolescents? An updated systematic review*, Newcastle, Australia, National Health Service.

[37] Jones, SJ., Lyons, RA., John, A., & Palmer, SR. (2005). Traffic calming policy can reduce inequalities in child pedestrian injuries: database study. *Injury Prevention, 11*(3), 152-156.

[38] Bunn, F., Collier, T., Frost, C., Ker, K., Roberts, I. and Wentz, R. (2009). *Area-wide traffic calming for preventing traffic related injuries*. Cochrane Database of Systematic Reviews.

[39] Tester, JM., Rutherford, GW., Wald, Z., & Rutherford, MW. (2004). A matched case–control study evaluating the effectiveness of speed humps in reducing child pedestrian injuries. *Journal Information, 94*(4): 646-650.

[40] Petch, RO., & Henson, RR. (2000). Child road safety in the urban environment. *Journal of Transport Geography, 8*(3), 197-211.

[41] Bunn F, Collier T, Frost C, Ker K, Roberts I, Wentz R. Area-wide traffic calming for preventing traffic related injuries. Cochrane Database Syst Rev. [Review]. 2003(1):CD003110.

[42] Elvik R. Area-wide urban traffic calming schemes: a meta-analysis of safety effects. Accident Analysis & Prevention. [Meta-Analysis]. 2001 May;33(3):327–36.

The combined use of limited speed zones, traffic-calming measures, and the presence of green zones or home zones that favour walking or cycling as a mode of transport (with separate walking and cycle lanes), has also been shown to facilitate a child's safe mobility. [43] Safe places to cross the road are advocated for child pedestrians including: pedestrian crossings, signalised intersections, pedestrian islands and school crossing patrols, and all contribute to creating a safer environment for children. This is especially crucial in areas of arterial routes and high traffic volume roads and intersections.[44]

END OF SUBMISSION

Please note that your submission will become official information. This means that the Department of the Prime Minister and Cabinet may be required to release all or part of the information contained in your submission in response to a request under the Official Information Act 1982.

The Department of the Prime Minister and Cabinet may withhold all or parts of your submission if it is necessary to protect your privacy or if it has been supplied subject to an obligation of confidence.

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[43] OECD /ECMT Transport Research Centre. (2004). *Keeping children safe in traffic policy*. Retrieved from http://www.oecd.org/sti/keepingchildrensafeintraffic.htm
[44] OECD /ECMT Transport Research Centre. (2004). *Keeping children safe in traffic policy*. Retrieved from http://www.oecd.org/sti/keepingchildrensafeintraffic.htm