Alaska Maternal and Child Death Review (MCDR) Surveillance Update

July 2026

MCDR team

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Executive Summary

The Alaska Maternal Child Death Review (MCDR) committee was established by the Department of Health to review maternal, infant, and child deaths occurring in Alaska and provide recommendations for system-level change. This report summarizes the findings of the MCDR from 2025 committee reviews of pregnancy-associated deaths and Sudden Unexpected Infant Deaths (SUID) [see definitions below]. It describes committee determinations and recommendations, provides maternal and SUID data analyses, and presents program updates.

During the 2025 committee year (April 1, 2025–March 31, 2026), the Maternal committee reviewed 16 pregnancy-associated deaths that occurred during 2021–2024 over five review meetings. The committee determined that 5 (31%) were pregnancy-related, 9 (56%) were pregnancy-associated but not related, and for 2 (13%) cases the committee was unable to determine pregnancy-relatedness. Of the 16 deaths reviewed, the committee determined that substance use contributed to 13 (81%) cases and mental health conditions contributed to 11 (69%) cases. The committee determined that all but one of the 16 deaths were preventable.

During the 2025 committee year, the Infant/Child committee reviewed 17 SUID that occurred in 2024 over five meetings. The committee determined that all the deaths reviewed were preventable. The most common life stressors identified at or around the time of death were lack of childcare, lack of family/social support, and poverty. Using the CDC algorithm for categorizing SUID, the committee determined that 4 deaths (24%) were explained by suffocation due to external obstruction caused by soft bedding, overlay, and wedging.

Operationally, MCDR established a new committee recruitment and appointment process, creating separate committees for maternal and infant/child death reviews, and completed multiple data dissemination, outreach, and collaboration efforts including those listed below.

- MCDR published an Epidemiology Bulletin[1] on infant mortality and a factsheet on maternal mortality.
- MCDR collaborated with the Alaska Native Tribal Health Consortium (ANTHC) Epidemiology Center to publish pregnancy-associated mortality data on the ANTHC Epi Center dashboard.
- MCDR and the Alaska Perinatal Quality Collaborative held their annual joint Summit in March 2026. Sessions included MCDR and AKPQC updates, a CDC presentation of national maternal mortality data with a focus on a study of maternal sepsis, perinatal substance use, perinatal mental health, violence prevention, Office of Children's Services information, doula care, newborn bloodspot screening, and severe maternal morbidity (SMM) trends.

Background

MCDR is authorized by Alaska State statute to collect information about and review maternal, infant, and child deaths. Data and information obtained through the MCDR committee reviews may be published and shared if confidentiality of the decedents is maintained. The purpose of this report is to summarize the findings of the 2025 MCDR committee and provide program updates. The recommendations presented in this report reflect the expertise and deliberations of the MCDR committee and are offered independently of official conclusions by the Alaska Department of Health or the State of Alaska.

MCDR has four main objectives that inform the program's mission to reduce mortality rates by preventing future deaths:

- Collect and summarize data on infant, child, and maternal deaths occurring to Alaskan residents.
- Perform comprehensive data analyses to identify patterns in causes and contributing factors that may be preventable.
- Share findings to inform and improve public health programs, policies, services, and systems.
- Engage and educate communities, providers, and professionals about efforts to reduce mortality rates.

MCDR is housed in the Women's, Children's, and Family Health Section of the Alaska Department of Health, Division of Public Health.

MCDR activities are supported by federal funding from the CDC National Center for Chronic Disease Prevention and Health Promotion to review maternal and SUID deaths: Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) and the Sudden Unexpected Infant Death Case Registry. MCDR is also partially funded by the Title V Maternal and Child Health Block Grant through HRSA and federal funding from Partnership Programs to Reduce Maternal Deaths due to Violence through Office of the Assistant Secretary for Health (OASH).

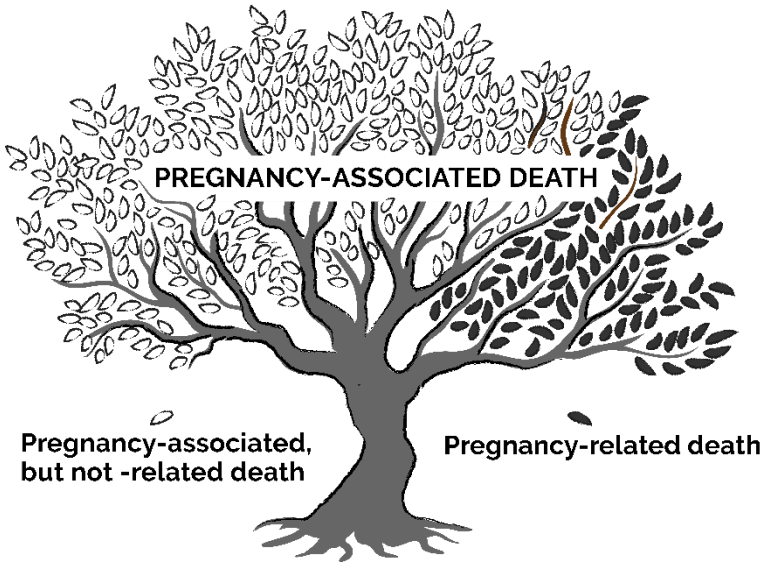
Definitions

Pregnancy-associated death: A death during pregnancy or within a year of the end of pregnancy irrespective of cause.

Pregnancy-associated but not-related death: A death during or within a year of the end of pregnancy from a cause that is not related to pregnancy.

Pregnancy-related death: A death during pregnancy or within a year of the end of pregnancy from a pregnancy complication, a chain of events initiated by the pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy.

Image 1. Visualization of maternal death definitions



Child death: The death of a child 1 to 17 years old.

Infant death: The death of an infant 0 to 364 days old. MCDR only includes infant deaths where the birth weight exceeds 499g (or 1.10 lbs).

Neonatal death: The death of an infant 0 to 27 days old.

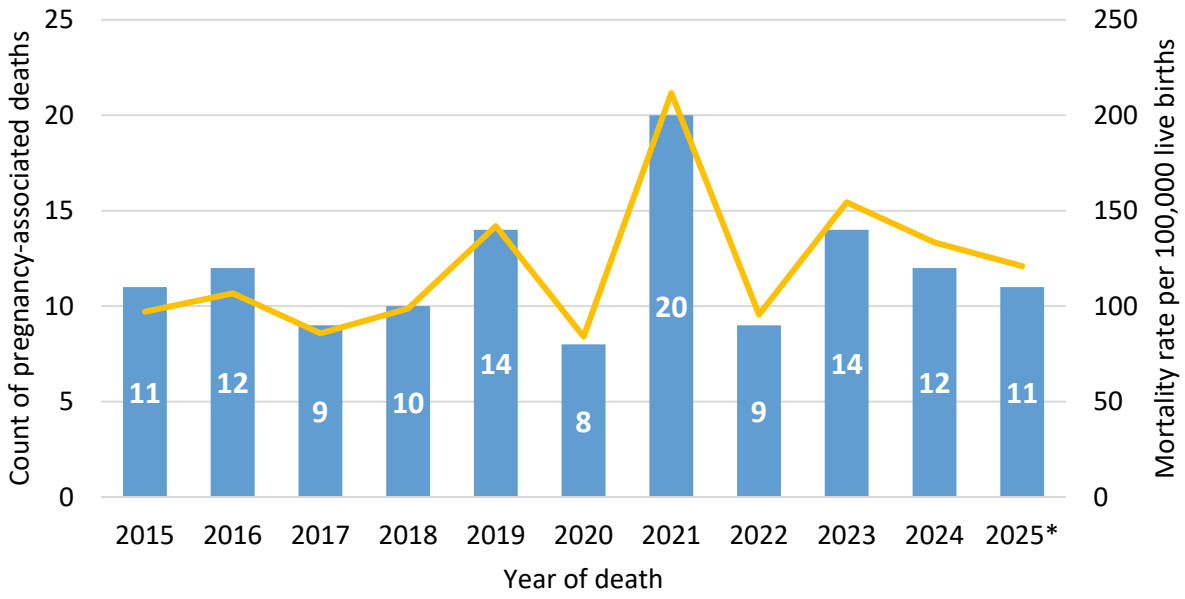
Postneonatal death: The death of an infant 28 to 364 days old.

Sudden Unexpected Infant Death (SUID): Cases where the death certificate indicates the cause as unknown, undetermined, Sudden Infant Death Syndrome (SIDS), SUID, unintentional sleep-related asphyxia/suffocation/strangulation, unspecified suffocation, cardiac or respiratory arrest without other well-defined causes, or non-specific causes (e.g. respiratory illness) with potentially contributing unsafe sleep factors. Intentional homicides are excluded.[2]

Pregnancy-associated mortality data

Excluding 2021, the average number of annual pregnancy-associated deaths among Alaska residents during 2015–2024 was 11. There was a spike in 2021 pregnancy-associated mortality, and since then, the pregnancy-associated mortality rate has returned to pre-pandemic levels (Figure 1).

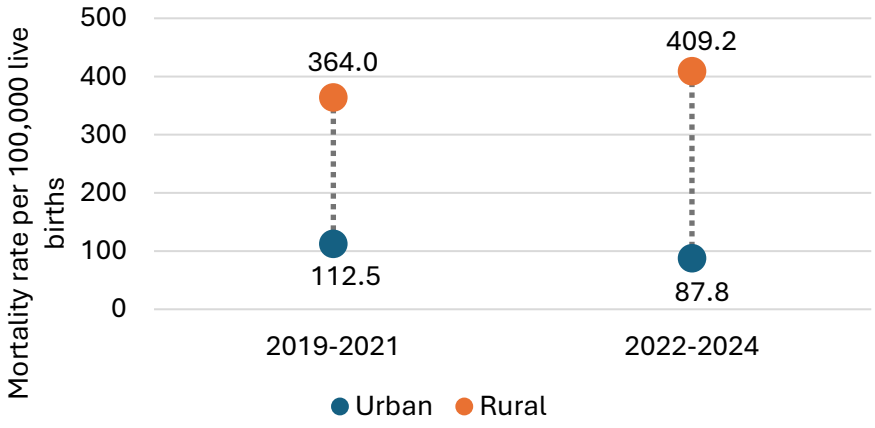
Figure 1. Number of pregnancy-associated deaths per year and rate per 100,000 live births, Alaska 2015–2025



*2025 data are provisional

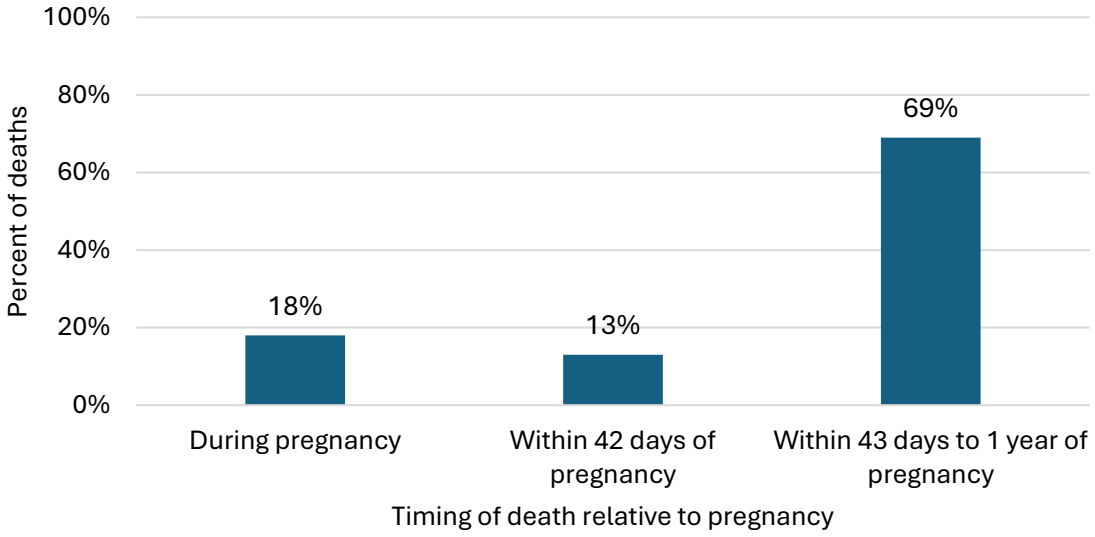
MCDR has observed differences in pregnancy-associated mortality among rural and urban residents. Figure 2 shows pregnancy-associated mortality rates by rural and urban residence status in 2019–2021 and 2022–2024. During 2019–2021, the rural mortality rate was 3.2 times the urban rate, however during 2022–2024, the rural rate was 4.7 times the urban rate. This equates to a 47% increase in the rural-urban pregnancy-associated mortality rate ratio.

Figure 2. Pregnancy-associated mortality rates in rural and urban Alaska between 2019–2021 and 2022–2024



Of the reviewed pregnancy-associated deaths that occurred in 2019–2024 (n=55), 69% (38) occurred in the late postpartum period, or 43 days to one year after pregnancy (Figure 3). Additional information on these deaths was published by MCDR in the maternal mortality factsheet[3] published in August 2025.

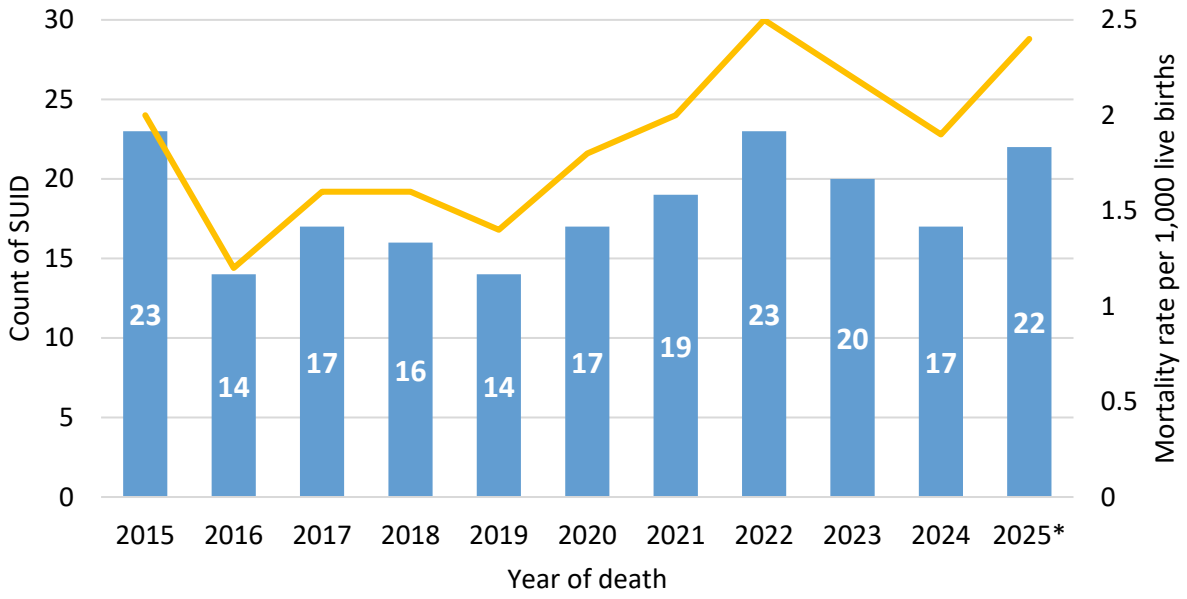
Figure 3. Timing of pregnancy-associated deaths that have been reviewed (n = 55), 2019–2024



SUID data

The average number of SUID per year in 2015–2025 among Alaska residents was 18.1 (Figure 4). To be included in these annual counts, deaths had to meet the CDC SUID Case Registry definition.[2] SUID make up approximately one third of all annual infant deaths in Alaska. During the observed 11-year period, there has been no significant overall trend in the SUID mortality rate.

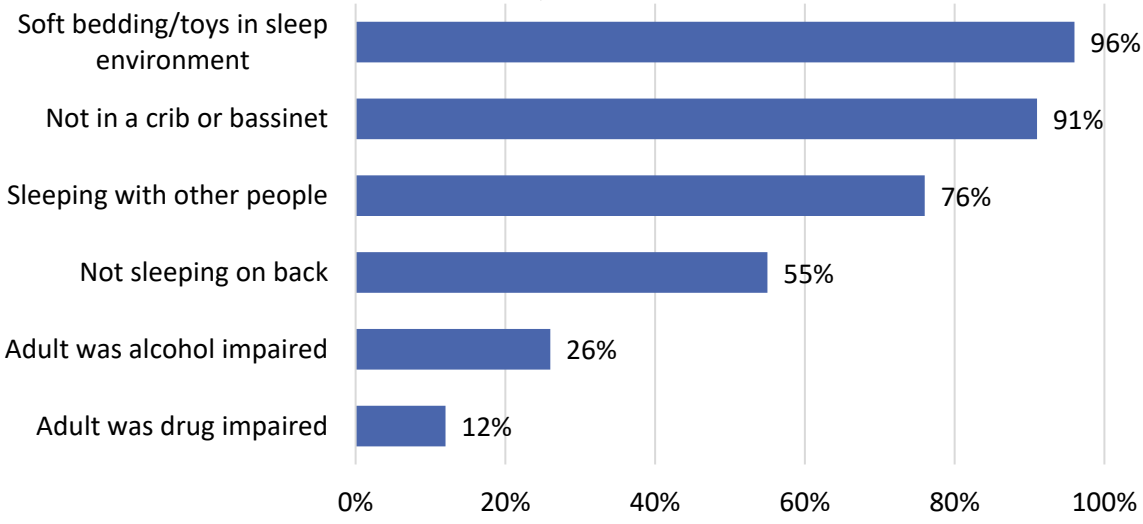
Figure 4. Number of SUID per year and mortality rate per 1,000 live births, Alaska 2015-2025



*2025 data are provisional

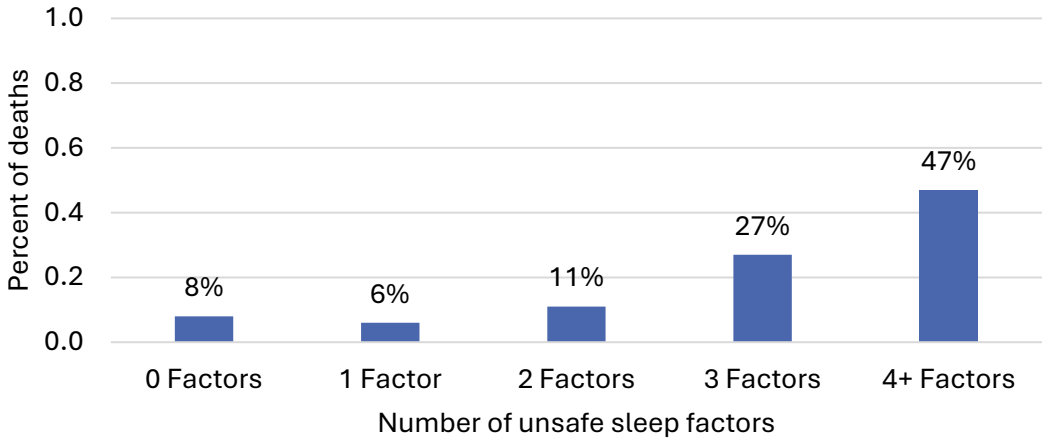
The majority of SUID are associated with the presence of unsafe sleep factors. During 2015-2024, almost all SUID had soft bedding or toys present in the sleep environment at the time of death (96%), and/or were not in a crib or bassinet at time of death (91%) (Figure 5). Other common unsafe sleep factors include sleeping with other people (76%) and not sleeping on back (55%).

Figure 5. Most common unsafe sleep factors present at time of death, Alaska SUID, 2015–2024



SUID often have multiple unsafe sleep factors present. Almost half of the SUID during 2015–2024 (47%) had four or more unsafe sleep factors present at time of death, and 85% of deaths had two or more unsafe sleep factors (Figure 6).

Figure 6. Percent of deaths by number of unsafe sleep factors, SUID, 2015–2024



Maternal Committee

In the 2025 committee year, the Maternal Committee reviewed 16 pregnancy-associated deaths over five meetings. The virtual meetings were held on Zoom every other month from April 2025–March 2026 (excluding December) on Fridays from 9am to 1pm.

MCDR endeavors to review all maternal deaths within two years of the date of death. As of May 2026, MCDR has reviewed 38 of the 51 deaths that occurred during 2020-2023 (75%) and has yet to review 13 (Table 1). The deaths that have not yet been reviewed are primarily delayed due to pending legal action, which prevents MCDR from accessing law enforcement records.

Table 1. Pregnancy-associated case review status by year of death, 2020–2025

	2020	2021	2022	2023	2024	2025*
# deaths	8	20	9	14	12	11
% reviewed	88%	95%	89%	29%	25%	0%
# not yet reviewed	1	1	1	10	9	11

*2025 data are provisional

Review outcomes

MCDR uses the Maternal Mortality Review Information Application (MMRIA) Committee Decisions Form to guide the committee in making determinations (Appendix A). Of the 16 pregnancy-associated deaths reviewed in 2025, the committee determined that 5 (31%) were pregnancy-related, and 9 (56%) were pregnancy-associated but not related. The committee was unable to determine pregnancy-relatedness for the remaining 2 (13%). The committee determined the following underlying causes of death for the five pregnancy-related deaths, utilizing PMSS-MM codes (Pregnancy-Mortality Surveillance System):

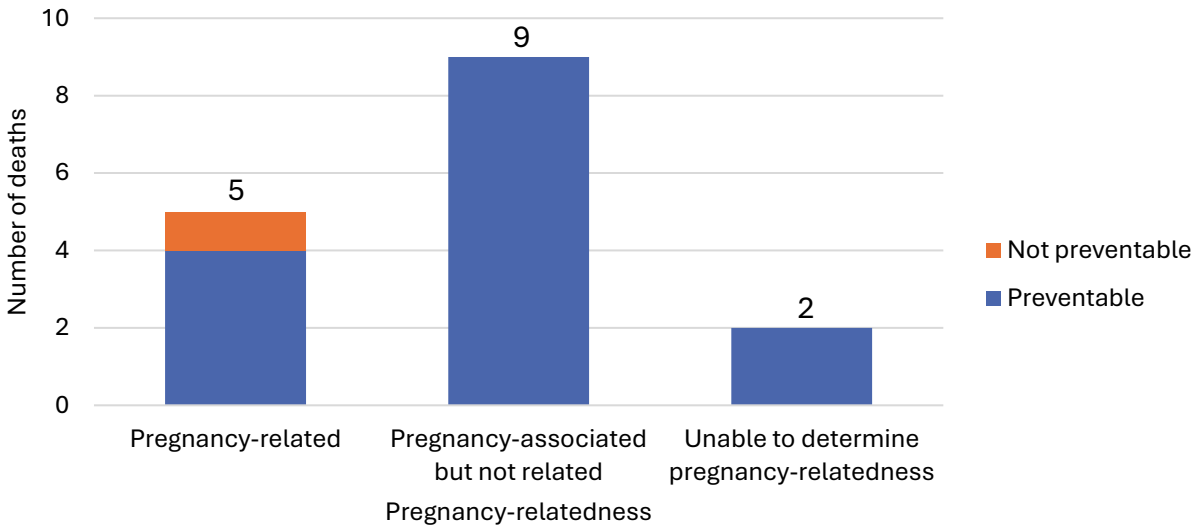
- Amniotic fluid embolism (PMSS-MM code 31.1)
- Chronic hypertension with superimposed preeclampsia (PMSS-MM code 60.1)
- Hemorrhage – laceration/intra-abdominal bleeding (PMSS-MM code 10.10)
- Vascular aneurism/dissection (non-cerebral) (PMSS-MM code 90.4)
- Conduction defects/arrhythmias (PMSS-MM code 90.7)

Of the 16 deaths, there was one suicide and two homicides. The committee was unable to determine pregnancy-relatedness for one of the homicides, while the suicide and the other homicide were determined to be pregnancy-associated but not related.

The MMRIA Committee Decisions Form asks the committee to make determinations about the contribution of four specific circumstances surrounding the death. The committee determined that substance use contributed to 13 (81%) deaths, mental health conditions contributed to 11 (69%) deaths, and discrimination contributed to 10 (63%) deaths. The committee determined that obesity did not contribute to any of the 16 deaths reviewed.

For maternal deaths, a death is considered “preventable” if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors. The committee determined that all but one of the 16 deaths were preventable.

Figure 7. Pregnancy-relatedness and preventability findings among all Alaska pregnancy-associated deaths reviewed in the 2025 committee year

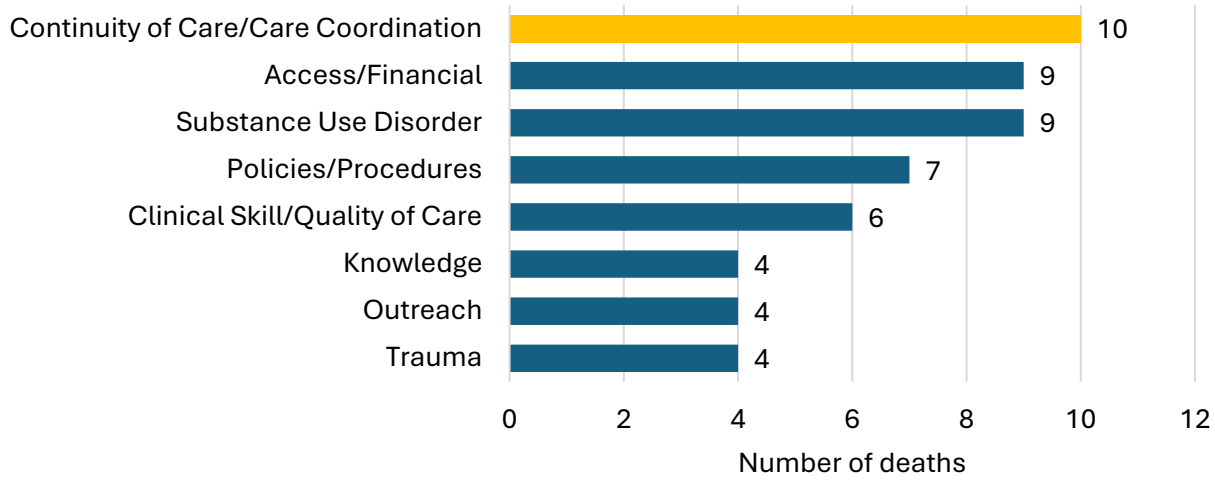


Maternal recommendations

The committee made 58 unique recommendations for 14 of the 16 deaths that were reviewed in the 2025 committee year. No recommendations were made for the pregnancy-related death that the committee determined was not preventable. The other death that did not receive recommendations was a pregnancy-associated unintentional overdose. The median number of recommendations per death was 4 and the average was 4.9.

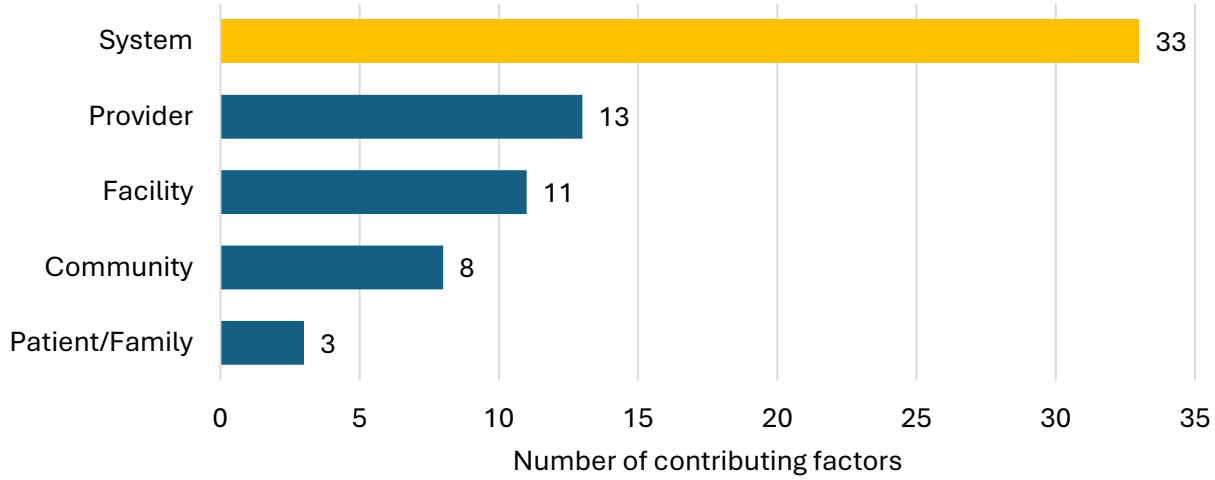
The committee identified multiple contributing factors for every death reviewed, ranging from 2 to 18 factors per death. The most common contributing factors assigned by the committee were continuity of care/care coordination, access/financial, and substance use disorder (Figure 8).

Figure 8. Most common contributing factors in pregnancy-associated deaths reviewed in the 2025 committee year



During reviews, the committee assigns a level to each contributing factor. Figure 9 shows the frequency of each contributing factor level among all of those identified. The committee most often identified contributing factors at the system level.

Figure 9. Contributing factor levels in pregnancy-associated deaths reviewed in the 2025 committee year



Themes from the committee's recommendations to prevent pregnancy-associated but not related and unable to determine deaths included strengthening mental health and substance use care, especially for perinatal patients, increasing care coordination, increasing housing and other social support services, and supporting systems-level investment in healthcare and social services.

Below are all the committee recommendations made following reviews of the pregnancy-related deaths that were determined to be preventable (n = 4). A complete list of the 2025 committee recommendations is provided in Appendix B.

Pregnancy-related recommendations

All recommendations reflect the expertise and deliberations of the MCDR committee and are offered independently of official conclusions by the Alaska Department of Health or the State of Alaska.

1. Hospitals should provide regular training in obstetric emergency events to non-OB providers, even in facilities that infrequently treat cases with severe maternal morbidity.
2. When an unexpected maternal death occurs in a hospital and the State Medical Examiner's Office (SMEO) does not assume jurisdiction, the hospital should conduct an autopsy.
3. Providers and health systems should expand outreach on perinatal education with families and communities to increase knowledge and trust in perinatal care providers and interventions.
4. Providers, including non-obstetricians, should receive education on treating vasoconstriction syndrome in pregnancy.
5. Cardiac centers and providers should prioritize patients who are pregnant.
6. Healthcare facilities should support education for perinatal care providers on up-to-date resources for patients concerning intimate partner violence, maternal housing, and substance use.
7. Substance use treatment, including medication treatment options such as Naltrexone, should be offered by perinatal care providers to patients experiencing alcohol use disorder.
8. Healthcare systems should prioritize keeping mothers and infants together by coordinating transfers whenever either requires a higher level of care. Policies or protocols should include not discharging one member of the couplet early solely because the other requires transfer or for other social reasons.
9. All patients, regardless of their perceived medical knowledge, should be provided with the same level of care and education.

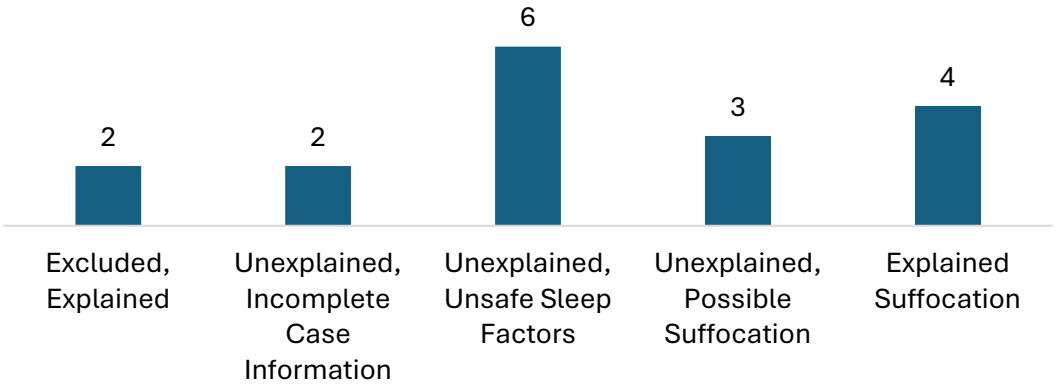
Infant/Child Committee

Review outcomes

During the 2025 committee year, the Infant/Child Committee reviewed 17 SUID over five reviews. The meetings were held every other month from April 2025 – March 2026 on Fridays from 9am to 1pm. Every meeting was held virtually on Zoom. All 17 deaths occurred in 2024; they represented 85% (17/20) of SUID that occurred to Alaska residents in 2024. Two 2024 SUID were reviewed in the prior committee year. The final 2024 SUID was internally reviewed by MCDR staff in March 2026.

MCDR receives funding from the CDC to support participation in the national SUID Case Registry Program. One purpose of this program is to improve SUID case ascertainment through use of an algorithm (Appendix C) that determines the likelihood that the death can be explained by suffocation caused by an external obstruction. The committee considers all the evidence that MCDR staff presents and relies on the committee's multidisciplinary expertise to guide decisions. Figure 10 shows the results of the categorizations for SUID reviewed in the 2025 committee year.

Figure 10. SUID categorizations from the 2025 committee year

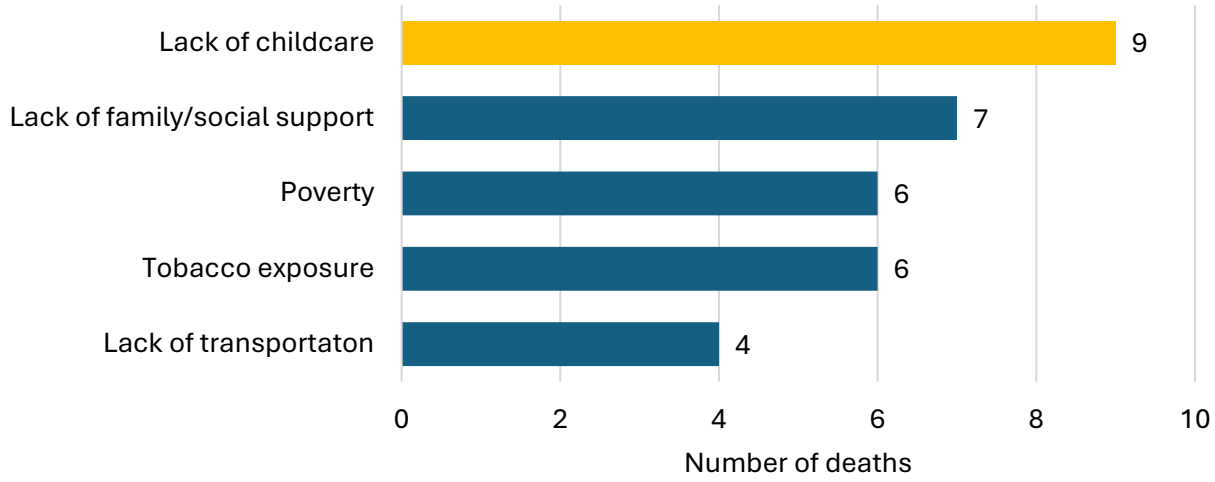


The committee categorized **4** as **explained suffocation** with unsafe sleep factors. For the deaths that are categorized as explained or unexplained, possible suffocation (n = 7), the committee may choose one or more mechanisms that caused suffocation by external obstruction. Soft bedding was a mechanism in all 7 deaths. Wedging was present in 3 deaths and overlay was present in 1 death.

The committee determined that all 17 deaths were preventable. Recommendations were not made for individual deaths but are discussed annually as described below.

The committee also determines and catalogs life stressors that were present at or around the time of death for the infant and family. The most common life stressor the committee identified was lack of childcare, followed by lack of family/social support, poverty, and tobacco exposure (Figure 11).

Figure 11. Most common life stressors present at or around time of death, SUID, reviewed in 2025 committee year



SUID recommendations

In January 2026, MCDR staff hosted a recommendations meeting for SUID committee members with a goal of creating a short list of prioritized recommendations. Initially, members reviewed recommendations from deaths that occurred during 2021–2023 that had been grouped by theme, and prioritized recommendations from each theme to identify those with the greatest overall impact on Alaskans. Members did this in two groups (virtual and in-person), then the groups came together to compare their prioritizations.

MCDR staff then asked committee members to review recommendations and notes from deaths reviewed in 2024 (primarily reviewed in 2025) to determine if anything should be added to the prioritized list. Finally, members voted on the list of recommendations to identify six recommendations that would have the greatest overall impact. These final six recommendations included some that were combinations of multiple original recommendations.

After the meeting, MCDR staff sent draft recommendations to committee members for feedback and final edits. Below are the final 6 prioritized recommendations; the list of 20 additional recommendations from deaths that occurred 2021-2024 can be found in Appendix D.

Prioritized SUID recommendations

All recommendations reflect the expertise and deliberations of the MCDR committee and are offered independently of official conclusions by the Alaska Department of Health or the State of Alaska.

1. Behavioral health facilities, hospitals, clinics, medical societies, community groups, service organizations and state agencies should collaborate to reduce stigma

surrounding substance use disorder and increase access to treatment for parents with active and previous substance use disorders.

2. Families should have a designated, appropriately chosen, sober caregiver for infants when parents and other household adults engage in substance use, including alcohol; this should be promoted and normalized by community health agencies through social media and other public health messaging approaches. The identification of a caregiver should be a collaborative conversation between the family, their health care providers, and any other agency involved with the family.
3. The Division of Public Health and Tribal Health organizations should develop an education program for all individuals who interact with families of newborns, including clinicians, hospital staff, and social workers, that emphasizes discussions about safe sleep. This safe sleep education should incorporate harm reduction strategies for families that co-sleep, strategies that are culturally appropriate, and strategies that adjust safe sleep practices as babies grow.
4. The Committee recommends increased funding for improving pre- and post-natal care access across Alaska, providing comprehensive support that expands the safety net for families during and after pregnancy.
5. Healthcare systems, including Tribal healthcare and social service agencies, should develop and/or expand capacity of existing resources to increase access to home-visiting services to families (e.g. evidence-based home-visiting, community doula programs, midwifery).
6. Businesses and organizations that employ doulas should train and hire recovery doulas with lived experience of substance use to provide trauma-informed support to pregnant and postpartum women.

Program Updates

Committee restructure and recruitment

In 2024, a revision to the Alaska State statute authorizing review organizations (AS 18.23.070) was passed by the legislature. One key change removed the requirement that 75% of the members of review organizations established by the Commissioner of Health to review public health issues regarding morbidity and mortality be healthcare providers. The statute update also moved approval of new members from the Alaska State Medical Board to the Department of Health (DOH) Chief Medical Officer (CMO). To operationalize these changes, in 2025 MCDR staff reconstituted the longstanding committee into two subcommittees: one focusing on maternal deaths and one focusing on infant and child deaths. An open application period was implemented in January 2025 to allow interested individuals to apply to serve on the committees.

The recruitment focused on increasing representation of non-clinical experience, representatives from Alaska Native communities and other communities that experience high rates of infant and maternal mortality, and individuals who work or live in rural areas of Alaska. The effort used strategies such as the MCDR listserv, asking previous members to

share the recruitment notice, and individually contacting Tribal leaders and local tribes. As a result, MCDR successfully increased both the number of Alaska Native/American Indian individuals on the subcommittees and the number of members affiliated with Tribal Health organizations and rural healthcare providers. The new committee members were appointed in March 2025. The committee term officially began April 1, 2025, and ended March 31, 2026.

Maternal committee member professions by primary role:

Certified Nurse Midwife/Nurse Practitioner/Physician Assistant: 4
Physician: 4
Behavioral and mental health: 3
Birthworker/doula: 2
Nurse: 2
Child protective services: 2
Public health: 2
Emergency services (EMS/Fire): 1

Infant/Child committee member professions by primary role:

Certified Nurse Midwife/Nurse Practitioner/Physician Assistant: 2
Physician: 6
Behavioral and mental health: 1
Birthworker/doula: 1
Nurse: 3
Child protective services: 3
Legal: 1
Medical Examiner/Pathology: 1
Emergency services (EMS/Fire): 1

Organizations represented by Maternal and Infant/Child committee members:

Alaska Native Birthworkers Community
Southcentral Foundation
State of Alaska Office of Children's Services
Set Free Alaska, Inc.
Norton Sound Health Corporation
Providence Alaska Medical Center
Alaska Council on Domestic Violence and Sexual Assault
Yukon-Kuskokwim Health Corporation
Chena Health
Alaska Native Tribal Health Consortium
Mat-Su Midwifery and Family Health
Camai Community Health Center
State of Alaska Public Health Nursing
Matanuska-Susitna Borough Department of Emergency Services

Partnerships

MCDR partners with the Alaska Native Tribal Health Consortium (ANTHC) in maternal committee work. ANTHC received federal funding in 2024 to explore the feasibility and opportunities for creating tribally led maternal mortality review committees. In 2025, MCDR and ANTHC continued building the partnership and finding ways to collaborate on MCDR work. An epidemiologist from ANTHC served on the Maternal committee advisory board and facilitated sections of review meetings. During 2025, MCDR also finalized an appendix of the data use agreement DPH shares with ANTHC, allowing the ANTHC epidemiologist access to the MMRIA platform (maternal mortality database) to inform ANTHC policies and outreach and improve health interventions that particularly impact Alaska Native people.

MCDR has had an established contract with the Alaska Hospital and Healthcare Association (AHHA) since 2020. Through the contract, AHHA helps to disseminate and promote committee recommendations to prevent maternal deaths, promote rural hospital representation on the committee, provide or coordinate applicable training to hospitals, support the timely review of maternal deaths by MCDR, and participate in maternal health-related conferences and evaluation activities.

Publications and presentations

MCDR published a factsheet on pregnancy-associated mortality in August 2025, which was distributed to the MCDR listserv and published on the MCDR website. In November 2025, MCDR published an Epidemiology Bulletin on infant mortality which was distributed to over 5,000 members of the GovDelivery system and published on the MCDR website. The Research Analyst and the WCFH Perinatal Nurse Consultant responded to several media inquiries received in response to the Bulletin, giving two interviews about SUID data and safe sleep messaging.

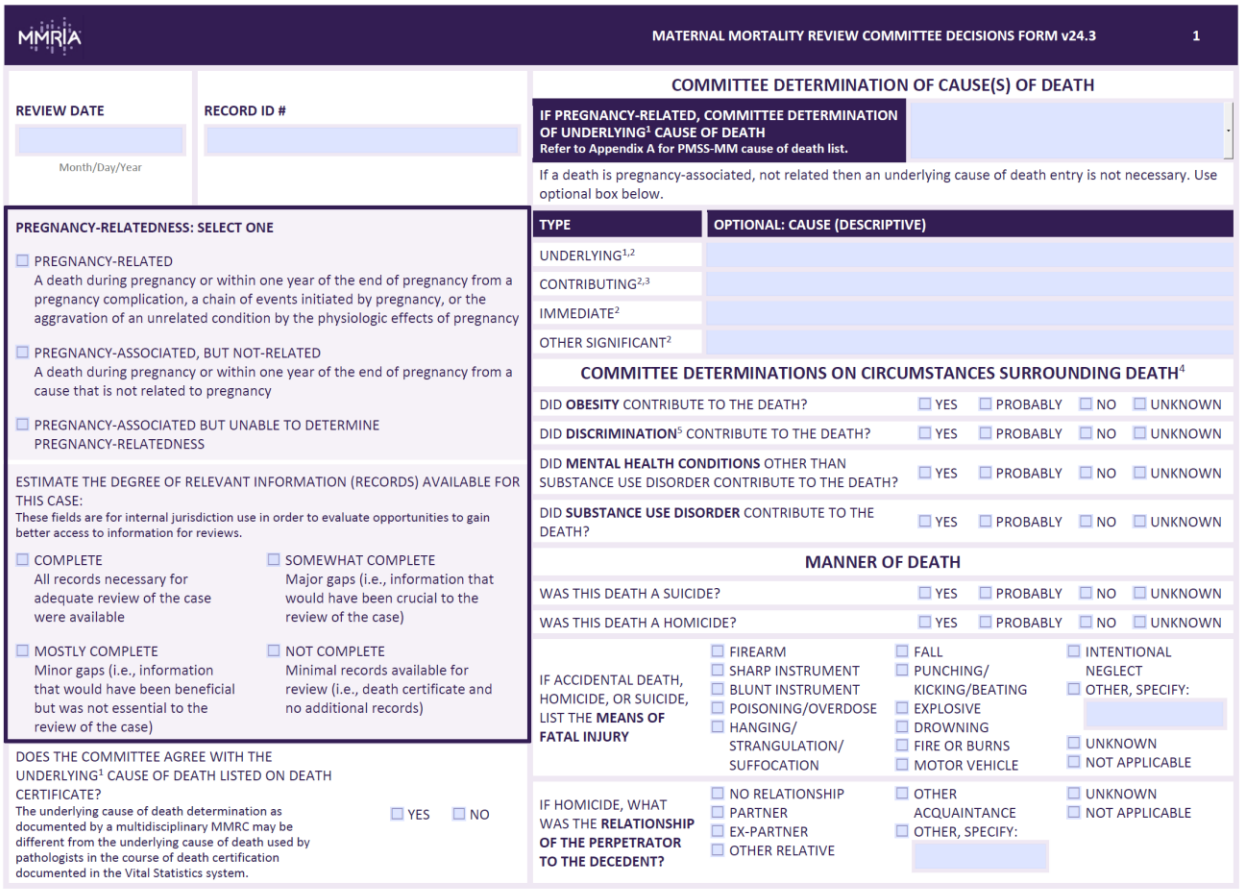
In addition, MCDR and the ANTHC Epidemiology Center collaborated to publish pregnancy-associated mortality rates by Alaska Native/American Indian (AN/AI) and non-AN/AI on the Epidemiology Center data dashboards. MCDR plans to provide updated pregnancy-associated data annually for the dashboard.

2026 AKPQC/MCDR Joint Summit

MCDR held their annual joint summit with the Alaska Perinatal Quality Collaborative (AKPQC) on March 19th and 20th, 2026. The Summit served as the conclusion of the first year for the new committee appointments. Educational sessions included MCDR and AKPQC updates, CDC presentation of national maternal mortality data with a focus on a study of maternal sepsis, perinatal substance use, perinatal mental health, violence prevention, Office of Children's Services information, doula care, newborn bloodspot screening, and severe maternal morbidity (SMM) trends.

Appendix A: MMRIA Committee Decisions Form

[Link to MMRIA form]



MMRIA — MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24.3 — 1

REVIEW DATE (Month/Day/Year) | RECORD ID #

PREGNANCY-RELATEDNESS: SELECT ONE

- ☐ PREGNANCY-RELATED — A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy
- ☐ PREGNANCY-ASSOCIATED, BUT NOT-RELATED — A death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy
- ☐ PREGNANCY-ASSOCIATED BUT UNABLE TO DETERMINE PREGNANCY-RELATEDNESS

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:
These fields are for internal jurisdiction use in order to evaluate opportunities to gain better access to information for reviews.

- ☐ COMPLETE — All records necessary for adequate review of the case were available
- ☐ SOMEWHAT COMPLETE — Major gaps (i.e., information that would have been crucial to the review of the case)
- ☐ MOSTLY COMPLETE — Minor gaps (i.e., information that would have been beneficial but was not essential to the review of the case)
- ☐ NOT COMPLETE — Minimal records available for review (i.e., death certificate and no additional records)

DOES THE COMMITTEE AGREE WITH THE UNDERLYING[1] CAUSE OF DEATH LISTED ON DEATH CERTIFICATE?
The underlying cause of death determination as documented by a multidisciplinary MMRC may be different from the underlying cause of death used by pathologists in the course of death certification documented in the Vital Statistics system.
☐ YES ☐ NO

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING[1] CAUSE OF DEATH
Refer to Appendix A for PMSS-MM cause of death list.

If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.

TYPE	OPTIONAL: CAUSE (DESCRIPTIVE)
UNDERLYING[1,2]	
CONTRIBUTING[2,3]	
IMMEDIATE[2]	
OTHER SIGNIFICANT[2]	

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH[4]

DID **OBESITY** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **DISCRIMINATION**[5] CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **MENTAL HEALTH CONDITIONS** OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **SUBSTANCE USE DISORDER** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

MANNER OF DEATH

WAS THIS DEATH A SUICIDE?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
WAS THIS DEATH A HOMICIDE?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

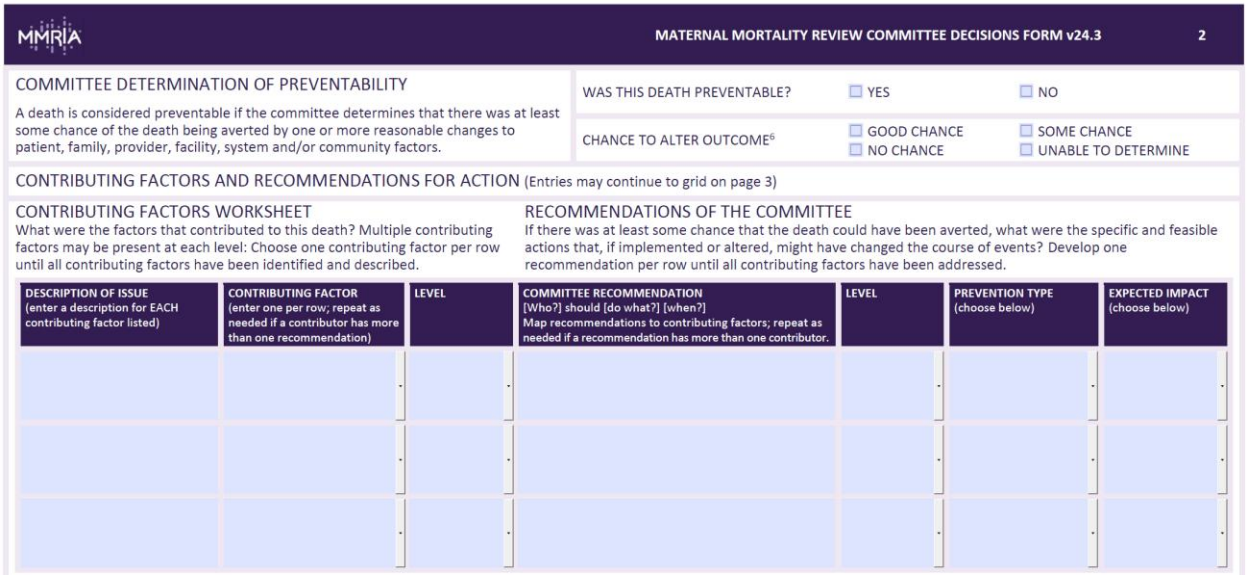
IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE **MEANS OF FATAL INJURY**

- ☐ FIREARM
- ☐ SHARP INSTRUMENT
- ☐ BLUNT INSTRUMENT
- ☐ POISONING/OVERDOSE
- ☐ HANGING/ STRANGULATION/ SUFFOCATION
- ☐ FALL
- ☐ PUNCHING/ KICKING/BEATING
- ☐ EXPLOSIVE
- ☐ DROWNING
- ☐ FIRE OR BURNS
- ☐ MOTOR VEHICLE
- ☐ INTENTIONAL NEGLECT
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

IF HOMICIDE, WHAT WAS THE **RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?**

- ☐ NO RELATIONSHIP
- ☐ PARTNER
- ☐ EX-PARTNER
- ☐ OTHER RELATIVE
- ☐ OTHER ACQUAINTANCE
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

[1] Underlying cause refers to the disease or injury that initiated the chain of events leading to death or the circumstances of the accident or violence which produced the fatal injury.
[2] OPTIONAL field, CDC does not use this data.
[3] Add descriptions of contributors in the pathway between the immediate and underlying cause of death, as provided by the committee. Note that this is different from the contributing factors worksheet on page 2.
[4] If "Yes" or "Probably" is selected for preventable deaths, then an aligned contributing factor class and description would be expected in the grid on page 2.
[5] As described in Appendix B.



MMRIA — MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24.3 — 2

COMMITTEE DETERMINATION OF PREVENTABILITY

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

WAS THIS DEATH PREVENTABLE?	☐ YES	☐ NO
CHANCE TO ALTER OUTCOME[6]	☐ GOOD CHANCE ☐ NO CHANCE	☐ SOME CHANCE ☐ UNABLE TO DETERMINE

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Entries may continue to grid on page 3)

CONTRIBUTING FACTORS WORKSHEET
What were the factors that contributed to this death? Multiple contributing factors may be present at each level: Choose one contributing factor per row until all contributing factors have been identified and described.

RECOMMENDATIONS OF THE COMMITTEE
If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events? Develop one recommendation per row until all contributing factors have been addressed.

DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	CONTRIBUTING FACTOR (enter one per row; repeat as needed if a contributor has more than one recommendation)	LEVEL	COMMITTEE RECOMMENDATION [Who?] should [do what?] [when?] Map recommendations to contributing factors; repeat as needed if a recommendation has more than one contributor.	LEVEL	PREVENTION TYPE (choose below)	EXPECTED IMPACT (choose below)

Appendix B: All 2025 maternal recommendations

*All recommendations reflect the expertise and deliberations of the MCDR committee and are offered independently of official conclusions by the Alaska Department of Health or the State of Alaska.** indicates recommendation made more than once

COMMITTEE RECOMMENDATION
Adult Protective Services should be contacted whenever a vulnerable adult is identified within the healthcare system to ensure timely access to treatment, safe housing, and other essential support services.
All patients, regardless of their perceived medical knowledge, should be provided with the same level of care and education.
Cardiac centers and providers should prioritize pregnant patients.
Employers should not discriminate against unhoused people and people with disabilities in recruitment and hiring processes.
Facilities should increase accredited education and training for emergency providers and hospitalists on alcohol use and addiction treatment modalities (e.g., administering Vivitrol).
Health systems and community partners should implement and expand programs such as home visiting, community-based doula services, and train-the-trainer models that promote healthy families and safe spaces. These initiatives should provide culturally tailored education and support to reduce isolation, improve trust in the healthcare system, and encourage family involvement in health decision-making.
Healthcare facilities should support education for providers on up-to-date resources for perinatal patients concerning intimate partner violence, maternal housing, and substance use.
Healthcare systems should implement routine screening for traumatic brain injuries, particularly among patients exhibiting impaired judgment or attempting to leave against medical advice, and ensure appropriate clinical evaluation and support are provided to address potential cognitive impairments impacting decision-making capacity.
Healthcare systems should prioritize keeping mothers and infants together by coordinating transfers whenever either requires a higher level of care. Healthcare providers should not discharge one member of the couplet early solely because the other requires transfer or for other social reasons.
Hospitals and community partners should integrate comprehensive safety planning and standardized protocols for identifying housing instability into the discharge planning process, ensuring coordinated care that includes social work, case management, and connections to community-based housing and support services, particularly for complex patients at high risk of leaving against medical advice or experiencing instability post-discharge.
When an unexpected maternal death occurs in a hospital and the State Medical Examiner's Office (SMEO) does not assume jurisdiction, the hospital should conduct an autopsy.*
Hospitals should educate non-emergency maternity care providers on the Title 47 process, including court involvement and pathways to culturally-appropriate guardianship during pregnancy, to ensure safe, respectful, and legally sound care for patients who may lack decision-making capacity.
Hospitals should have addiction medicine referral services available for patients, especially upon discharge.
Hospitals should implement targeted interventions at the facility level, by providing comprehensive training to personnel on recognizing, responding to, and documenting risks

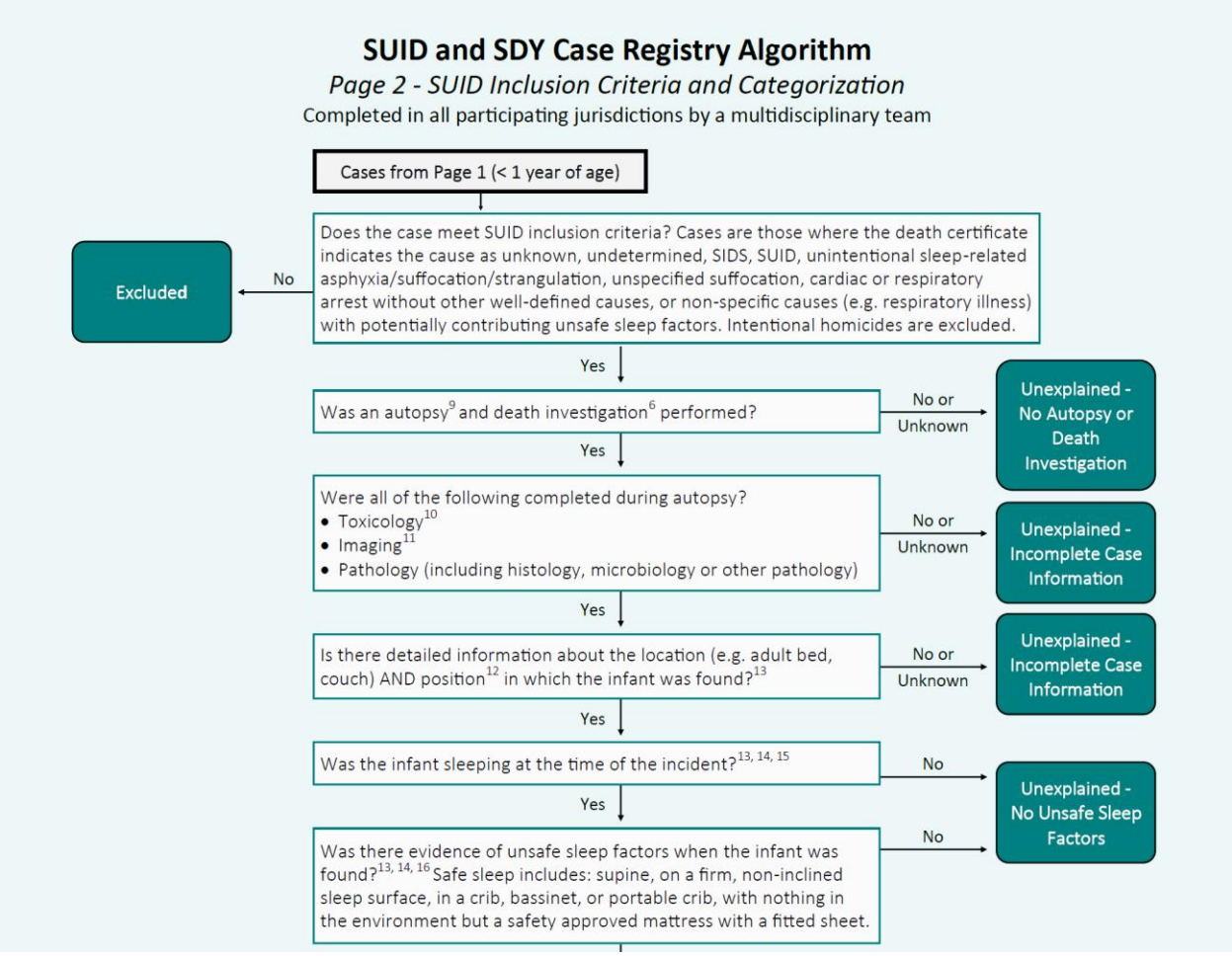
COMMITTEE RECOMMENDATION
associated with patients leaving against medical advice, with an emphasis on assessing decision-making capacity and ensuring appropriate follow-up care.
Hospitals should increase access to psychiatric services, social work, and specialty medical providers across all shifts to support comprehensive case management, care coordination, and mental health and social support for complex patients, reducing the risk of premature discharge or leaving against medical advice.
Hospitals should provide regular training in obstetric emergency events to non-obstetrician providers, even in facilities that infrequently treat cases with severe maternal morbidity.
Medicaid should continue to support payments for travel for a support person for pregnant recipients who are traveling farther distances to a care facility for birth.
Municipal and community funders, in partnership with hospitals and primary care, should develop mobile outreach units to treat and provide consistent follow-up to medically complex patients who lack transportation and/or other resources to access care.*
Policymakers should immediately prioritize substance misuse and mental health care, including addressing the problem of inadequate inpatient facilities and access to affordable, immediately available substance abuse and mental health treatment.*
Policymakers should increase funding, pay, and workforce development opportunities for Village Police Safety Officers (VPSOs). Every rural community should have a public safety officer.
Policymakers should prioritize increasing resources, pay, and workforce development opportunities for Community Health Aides.
Providers and health systems should expand outreach on perinatal education in families and communities to increase knowledge and trust in perinatal care, providers, and interventions.
Providers should make referrals to culturally specific, holistic services to address trauma and grief for perinatal patients when identified, especially when patients are having difficulty engaging in care. Screening for perinatal patients (i.e. mental health) should always include screening for interpersonal violence.
Providers should screen youths with a demonstrated use of THC for suicidality, given the association of THC use with suicidality in adolescents.
Providers, including non-obstetricians, should receive education treating vasoconstriction syndrome in pregnancy.
Public health agencies and community-based organizations should advocate for increased funding and resources to expand the capacity of the judicial system, enabling courts to process guardianship claims efficiently and in a culturally-responsible manner, ensuring equitable access to guardianship proceedings for all individuals, especially during pregnancy.
Schools and community groups should educate teens in reproductive health and healthy relationships.
State agencies and community-based partners should expand investments and advocate for increased legislative funding to improve the quality of services and increase access to shelters, mental health group homes, and supportive housing services, ensuring timely access for individuals with complex medical and behavioral health needs and reducing the risk of harm and preventable mortality following hospital discharge or departure against medical advice.
State agencies, community-based organizations, and the court system should collaborate to educate maternity care providers, families, and judicial stakeholders on the Title 47 process, including court involvement and culturally-appropriate guardianship options during pregnancy, to ensure coordinated, legally sound, and culturally respectful care for individuals with impaired decision-making capacity.

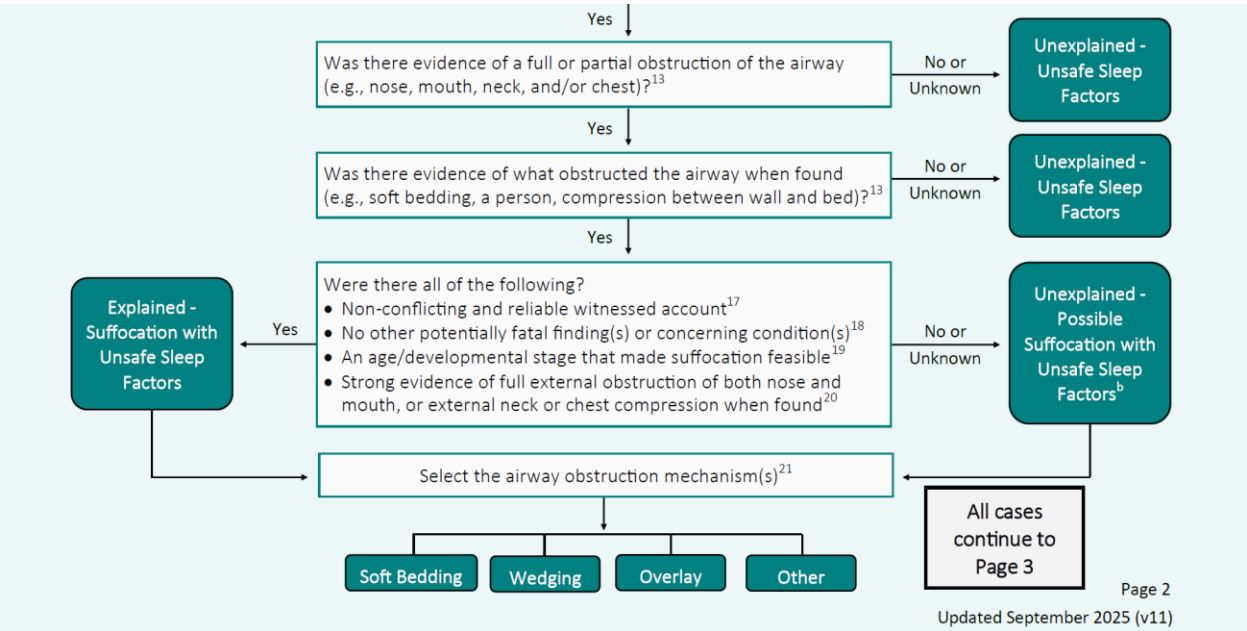
COMMITTEE RECOMMENDATION
State and Tribal health programs should increase funding for culturally-responsive, community-based initiatives that strengthen family and social support systems for high-risk individuals. These efforts should be grounded in core principles of family and community wellness, with a focus on early intervention, connectedness, and culturally-appropriate care.
The committee recommends that State legislators should increase targeted funding for psychiatric care at designated institutions (e.g. Alaska Psychiatric Institute) to expand capacity and ensure high-risk individuals have access to sustained, stabilization-focused treatment. Investments should support comprehensive services such as medication management, behavioral health support, and transitions to assisted living or step-down care.
State programs and Tribal Health systems should launch public education campaigns and provider training initiatives to increase understanding of legal processes related to emergency guardianship, involuntary hospitalization, and mandated mental health treatment, particularly for individuals with complex needs during pregnancy or other vulnerable periods.
State, federal, and tribal health programs should fund and deploy intensive case management teams (e.g., Assertive Community Treatment [ACT] teams) to engage individuals with serious mental health needs and unstable housing where they are. These teams should build trusting relationships, serve as consistent points of contact, advocate for clients' needs across systems, coordinate care and services, and support resolution of complex issues such as guardianship and access to treatment.
Substance use treatment, including medication treatment options such as Naltrexone should be offered by providers to perinatal patients experiencing alcohol use disorder.*
The State and local systems need to increase development and support of housing assistance programs, as well as improve outreach and awareness of such resources for people facing housing instability.*
The committee recommends that the State and statewide actors increase funding and resources for Child Advocacy Centers to support minors affected by sexual abuse and assault.*
The committee recommends that the State and statewide actors increase funding and resources for sexual assault prevention.*
The committee recommends that the State of Alaska and community health partners increase funding for Child Advocacy Centers (CACs) to expand early intervention strategies, strengthen multidisciplinary support services, and build trust between families and the health system—laying the foundation for improved long-term health, safety, and well-being outcomes for children and caregivers.
The State of Alaska, medical facilities, and Tribal Health Partners should increase access to substance use treatment facilities with family housing capabilities during the pre- and post-natal periods and expand existing programs (e.g. NEST) to increase engagement/adherence to the support and services offered.*
The committee recommends that the State adequately fund schools to provide mental health counselors and resources so students may access quality and consistent mental health supports.
The State should expand resources for law enforcement infrastructure in rural areas that have limited or no safety personnel.
The State, in partnership with mental health stakeholders, should increase funding and access to in-patient and out-patient mental health and substance use treatment facilities in Alaska.*
Tribal health organizations should work together to identify best practices and support equity in access for all villages and areas in Alaska to support mental health and healthcare need.

COMMITTEE RECOMMENDATION
The State of Alaska and Tribal Health partners should collaborate to prevent mortality among patients who leave treatment facilities against medical advice by enhancing data utilization, expanding education for both the public and providers, and strengthening clinical response protocols.
The State legislature should strengthen legal mechanisms to support timely, court-ordered mental health treatment for high-risk individuals, particularly during pregnancy. This may include creating clear criteria for temporary commitment, allowing family-initiated petitions, and establishing a structured process for short-term mandated treatment (e.g., 30-day inpatient care), with safeguards to ensure release once clinical stability is restored.

Appendix C: SUID Case Registry Algorithm

[Link to the SUID Case Registry Algorithm]





Appendix D: Expanded list of prioritized SUID recommendations

All recommendations reflect the expertise and deliberations of the MCDR committee and are offered independently of official conclusions by the Alaska Department of Health or the State of Alaska.

- Behavioral health systems and state agencies should collaborate to reduce stigma surrounding substance use disorder, provide ongoing assessment, and increase access to treatment for parents with active and previous substance use disorders.
- The Division of Public Health and Tribal Health organizations should develop an education program for all individuals who interact with families of newborns, including hospitals and social workers that emphasizes discussions about safe sleep including harm reduction for families that co-sleep and culturally appropriate strategies.
- The committee recommends that the State of Alaska increase funding for pre- and post-natal care access across Alaska, providing comprehensive support that expands the safety net for families during and after pregnancy.
- Develop or expand capacity of existing resources to increase access to home-visiting services to families (e.g. evidence-based home-visiting, community doula programs, midwifery).
- Businesses and organizations that employ doulas should train and hire recovery doulas with lived experience of substance use to provide trauma-informed support to pregnant and postpartum women.
- Healthcare providers should check in with caregivers who have a substance use history that could result in environmental exposure to the child. Harm reduction

alternatives such as discussing healthy coping strategies and referral to support groups or treatment centers as appropriate.

- Families should have a designated sober caregiver for infants when parents and other household adults engage in substance use.
- Identification of a sober babysitter or alternate caregiver when parents choose to use alcohol or substances should be promoted and normalized by community health agencies through social media and other public health messaging approaches.
- Safety planning (by Office of Children's Services (OCS) or other agencies) should always include a plan for a sober caregiver for infants and children who are in the care of parents who use alcohol/substances.
- Safe sleep education by providers and professionals should be ongoing as infants grow to review sleep environment and ensure the sleep surface being used is still the appropriate size for the baby.
- The Committee recommends the State of Alaska coordinate with tribal governments to explore and fund safe caregiving options.
- All providers caring for pregnant women and newborns should be required to complete culturally sensitive, trauma-informed training to build relationships with parents while having sensitive conversations about their care, including mandated reporting to OCS of high-risk behaviors.
- OCS, the Division of Public Health, and obstetric partners should work to identify barriers preventing the distribution of information concerning high-risk mothers, working to coordinate care and integrate communication when the child is born, both in hospitals and birthing centers alike.
- Caregivers who adopt or assume care of an infant, especially unexpectedly, as in the case of substance-exposed newborns who are placed with them on an urgent basis, should be guaranteed access to home-visiting services including ILP and public health nursing.
- Health systems should redefine the postpartum care period to cover the entire postpartum year and incorporate all needed services to strengthen families through holistic services including reproductive and physical health, behavioral health, parenting support and substance use treatment when needed.
- Behavioral health systems, parental education and resulting referral services should be distributed with equal consideration to male caregivers and foster parents.
- Health care systems should ensure that counseling and bereavement services are offered to families that have experienced the loss of child, linking them to resources and services available in their community.
- The State of Alaska should continue to optimize EHR and inter-agency communication.
- Perinatal providers should review the April 2025 report "Recommendations for Newborn Toxicology Testing" released by the AKPQC for recommendations on reporting substance-exposed newborns to OCS.

- The State of Alaska should explore policies to increase communication between OCS and healthcare providers including reporting of cases where there are barriers to accessing key services such as prenatal care and to allow providers to inquire about patient child welfare history as needed.
- The State of Alaska should create regulations for centralized CPT-1A Arctic Variant caregiver training/education of healthcare providers, OCS workers, educators, and people working in shelters.
- The Division of Public Health Injury Prevention program and MCDR team should conduct a study looking at transportation/baby wearing practices in rural Alaska and identify how many infants are at risk, disseminating relevant findings and recommendations on how to safely transport infants as appropriate.
- Public health and public agencies should support violence prevention programs that are culturally driven and are tailored for the individual community.

References

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2. Shapiro-Mendoza CK, Camperlengo L, Ludvigsen R, et al. Classification System for the Sudden Unexpected Infant Death Case Registry and its Application. PEDIATRICS. 2014;134(1):e210-e219. doi:https://doi.org/10.1542/peds.2014-0180
3. Factsheet. “Pregnancy-Associated Mortality in Alaska, 2019–2023.” August 2025. Available at: https://health.alaska.gov/media/mkloz5xy/2025_mcdr_maternal_factsheet_remediated.pdf