MATERNAL AND CHILD DEATH REVIEW PROGRAM

2020 QUARTERLY REPORT & RECOMMENDATION SUMMARY

OCTOBER- DECEMBER 2019

ABOUT THE PROGRAM

The Alaska Maternal and Child Death Review (MCDR) program resembles the nationally recommended evidence-based model for systematically and comprehensively reviewing deaths using a multi-disciplinary decision-making process. Built on the public health approach, this model specifically aims to identify causes and contributing factors to maternal, infant, and child deaths in Alaska and develop recommendations to prevent future deaths. This goal is accomplished through expert committee reviews of medical records, autopsy reports, death scene investigation reports, and other relevant information that is compiled for every death.

MCDR committee members serve on a voluntary basis and are approved by the Department of Health and Social Services (DHSS) Commissioner and State of Alaska Medical Board. The Committee includes professionals with expertise in the field of maternal and child health and injury prevention, including pediatricians, neonatologists, obstetricians, and nurses as well as social workers, public health professionals, emergency response workers, child protection workers, and behavioral health clinicians.

ABOUT THIS REPORT

A total of 28 deaths of children aged 0 to 17 years were reviewed by the MCDR committee during the fourth quarter of 2019 (October – December). No maternal deaths were reviewed during this quarter.

The MCDR Committee reviews case files when all applicable records related to the death have been received, which can be several months following a fatality. Therefore, the information presented in this report does not represent the incidence or trend of child deaths in Alaska during this timeframe. However, it does provide some characteristics of the deaths reviewed, with a focus on the prevention recommendations arising from the multi-disciplinary discussion.

Have these recommendations impacted your work?

If your agency uses this information to gain support for existing efforts, or if you make a policy or program adjustment in response to an MCDR recommendation, we would appreciate hearing about it!

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Although efforts are made to include experts with diverse and varying knowledge, the recommendations are naturally limited only to those interventions, services and resources known

to the committee members who were present at the review. Therefore, the recommendations contained in this report may not reflect all of the prevention/service efforts in place at the time of death or currently available. This report contains all recommendations generated by the committee for the deaths reviewed during this quarter (both preventable and non-preventable). The recommendations presented are those of the MCDR committee and do not necessarily represent the views of the Alaska Division of Public health.

INFANT DEATHS, UNDER 1 YEAR OF AGE REVIEWED OCTOBER-DECEMBER 2019

The committee reviewed 17 infant deaths. Eleven of those were due to medical causes, two were due to injuries, and four were due to undetermined causes. One death from injury and one from an undetermined cause were classified as Sudden Unexpected Infant Deaths (SUID) by the MCDR committee using the Centers for Disease Control and Prevention (CDC) classification guidelines.

Seven deaths occurred in the neonatal period and ten in the postneonatal period.

The review committee generated prevention recommendations for 14 infant deaths, with a determination that six deaths could have been prevented (35%).*

1. Injury Death | RECOMMENDATIONS

- Develop a mandatory reporting system in which the Office of Children's Services (OCS) is immediately informed when a mother with multiple substance abuse incidents gives birth. This will contribute to development of proactive strategies for newborn safety.
- Safe sleep education should include risk reduction techniques and ensure that substance misuse, particularly marijuana, is highlighted as an impairment. All parents should be counseled on the risks of secondhand smoke and offered smoking cessation resources if applicable.

2. Medical Death | RECOMMENDATIONS

- All hospitals that provide delivery services should have a clear protocol to follow when a pregnant woman presents with vaginal bleeding after 24 weeks gestational age, or with signs of systemic infection and they should have the capability to conduct an immediate bedside ultrasound.
- Hospitals that provide delivery services and do not have 24/7 OB coverage should have a plan to utilize an alternate physician in the event of an obstetrical emergency.
- Hospitals should conduct drills to simulate obstetrical emergencies. Providers should chart their decision-making processes in the records and include an accurate timeline of events.
- All women should have access to long-acting reversible contraceptives or other appropriate means of contraceptives. Identify barriers to accessing prenatal care or comply with transfer recommendations and take action to reduce barriers. Women who have histories of preterm deliveries should seek prenatal care as soon as possible and discuss pregnancy spacing with their providers.
- Access to contraceptives should be integrated into substance use treatment programs.

- Women who have undergone a classical C-section should be on reliable contraceptives for at least 18 weeks to reduce the risk of uterine rupture in subsequent pregnancies.
- Universal cord toxicology screen should be performed in cases of placental abruption. Protocols should be in place to notify pediatrics when placental abruption is identified on placental pathology.
- Delivering facilities without a level 3 NICU should have a low threshold for transporting pregnant women with potential for needing level 3 NICU intervention.
- Develop an Haemophilus influenzae type A (Hia) vaccine. Educate communities about haemophilus influenza symptoms and when to seek care.
- Patient housing should question guests on sleeping arrangement needs at intake. Law enforcement should establish clear protocols for accessing residential areas at local hospitals for non-emergency and emergency situations.

3. Undetermined causes | RECOMMENDATIONS

- All foster parents should receive CPR training. Caregivers should follow safe sleep recommendations for all sleep including naps. Safe sleep recommendations should be reviewed with foster parents at every home and licensing visit.
- Caregivers of infants with CPT1A Arctic variant should be educated at every sick visit about recommended feeding schedules to prevent hypoglycemia. Provide training for OCS and ICWA workers on CPT1A Arctic Variant to facilitate additional conversations with caregivers.
- Caregivers should follow safe sleep recommendations. Children should have at least one sober caregiver at all times. Provide education to communities on the dangers of caring for children while impaired. Education and outreach should be prioritized for communities with higher rates of substance misuse.
- Death scene investigations should be conducted for all sleep-related infant deaths even if it is initially believed to be a medical cause of death.
- Increase education about the protective factors of nurse home visiting. Increase nurse home visiting program availability and expand eligibility requirements.

CHILD DEATHS 1-17 YEARS (EXCLUDING SUICIDE) REVIEWED OCTOBER-DECEMBER 2019

The committee reviewed eight deaths of children aged 1-17 years. Four child deaths were due to medical causes, andfour were due to injuries. Of the injury deaths, two involved a firearm, one was due to drowning and one resulted from an overdose.

The review committee generated prevention recommendations for all eight cases and determined that five of the deaths could have been prevented (63%).*

1. Injury Death | RECOMMENDATIONS

Firearm homicide:

- Alternative high schools should perform random drug screening for students and have resources available to help with treatment if tests come back positive. Additional public education should be provided to parents and children on the dangers of marijuana use. Firearms should be kept in a locked location and teens should not have access to keys or knowledge of codes. Accomplices in felonies should have mandated counseling and evaluations.

Firearm accident:

- Firearms should be kept unloaded in a locked location and in a separate locked location from ammunition. Young children should not be taught how to use firearms and especially should not be taught to take the safety off the firearm.
- Parents should be instructed to supervise children when in an area where a firearm is stored. Children should have age-appropriate bed times. Education on child development and parenting should be part of the high school curriculum. Funding should be increased to community agencies so all children are able to receive pre-K education, ideally Headstart.

Drowning:

Children should always wear life jackets when playing around the water, in addition to when they are swimming or in a boat. Danger signs should be posted near all known dangerous open water.

Intoxication/Overdose:

- Parents should be aware of their children's location and activities, in both rural and urban areas. Always provide counseling to children who witness the death of a friend. Increase awareness among youth about the danger of substance abuse.

2. Medical Death | RECOMMENDATIONS

- Children with complex medical needs should have case management to assist with communication between specialists, including those in different states. Parents of children with complex medical needs should be educated by their specialists on how important primary care is for well-child visits and helping with case management. Primary care providers should be educated on the importance of assisting with care coordination between specialists. Families who have a child with a significant and/or terminal illness should have a clear goal of care (palliative, full intervention, etc.) and end of life plan so treatments and surgeries can be properly advised.
- Healthcare providers should be trained in recognizing signs of volume depletion in sick infants; when a clearly ill child is seen in a rural clinic with no improvement after the initial intervention, the provider should consider the possibility of early transfer to the best-equipped hospital. All children should be vaccinated against Haemophilus Influenza.
- Expand the indications for Synagis to include older children with compromised immune systems.
- Medical researchers should continue research on the curative treatment of Hemophagocytic Lymphohistiocytosis.

ADOLESCENT SUICIDE

REVIEWED OCTOBER-DECEMBER 2019

The committee reviewed three adolescent suicide deaths. The review committee determined that all three deaths could have been prevented. Prevention recommendations were generated for each of the cases.*

Adolescent Suicide | RECOMMENDATIONS

- Primary care providers should check in with patients who received sports physicals in prior years, but who have not requested a physical in the current year (i.e. perhaps due to losing interest in healthy activities).
- Well-child visits should include insurance-billable time (including Medicaid) to conduct screenings and education with patients. All parents of pre-teens and teens should receive Youth Mental Health First Aid training to assist in understanding what is normal teenage behavior and what is cause for concern. Friends and family of children who die should be specifically checked in on after the death and counseling should be offered. Teens should receive Safe Talk, Assist, and/or Teen Mental Health First Aid training as part of their junior high and high school curriculum. Patients who are identified as at risk of suicide in a hospital should receive monthly check in calls for 6 months. Primary care providers should always require psychiatric consults when psychiatric medications are considered for teens. Family counseling should be recommended when teens being treated for depression and suicidal ideation are noted to be unable to effectively communicate with parents.
- When a child dies from suicide, counseling should be provided to friends, relatives and everyone impacted by the incident. Provide community education and campaign on suicide awareness and prevention. Provide education to parents, teachers and teens on the precipitative events that can trigger suicidal attempts. During the adolescent's physical examination, healthcare providers should evaluate the whole body to exclude scars from prior suicidal attempts.

Common risk factors are often seen across cases, which may result in similar prevention recommendations for different causes of death. Recommendations have been arranged for readability, which may include grouping of information by type of recommendation rather than by each case.

POSITIVE ACTIONS/INTERVENTIONS

In 2019, MCDR began tracking notable positive elements in each reviewed case. These could be positive interventions or actions taken by family members, child welfare workers, healthcare entities, law enforcement, the state medical examiner's office and other entities involved in child death cases. It is important to continue to empower these individuals and systems by acknowledging the important protective factors they provide.

Parent/Family/Community

- Parents worked with a child care agency and utilized all the resources available. They had a bassinet in the house. Parents were strong advocates for the child and good historians. Family received support by a chaplain/pastor of their chosen faith. Parents traveled to prenatal appointments, even relocated to an urban area so the child could receive care. The caregiver set alarms for feeding.
- A teen's supervisor called the parent very soon after the child did not show for work. A youth reached out to peers when dealing with suicidal thoughts. Parents were concerned and ensured that firearms were secured.
- A mother had a family member with her for support at delivery. Comfort care was handled well. Mother was attentive and appropriately sought care.
- A neighborhood had good video surveillance systems that helped with an investigation.A witness came forward to law enforcement to provide key information.
- A grandmother accompanied her expectant daughter during care and during travel from a rural to an urban area. A mother maintained care with the same OBGYN for two pregnancies. Her infant received all well-child checks and immunizations.
- Grandparents were actively involved in child care.
- A village provided support to a mother after her child's death.

Response/Investigation Team

- Law enforcement and EMS did a thorough investigation, completed a SUIDI form and doll reenactment and Tox screen was conducted.
- Bodies were recovered very quickly after drowning.
- Law enforcement followed up on discrepancies between witness statements.
- Law enforcement administered BRACs to parents. Law enforcement utilized the cab company to identify the suspects.

Healthcare System

- Good coordination of care between healthcare systems. Sibling received good support by hospital/palliative care team during infant's dying process. Health aides in the rural area did everything possible to resuscitate infant, including two hours performing CPR.
- Health care providers were diligent in their efforts to engage a pregnant woman in prenatal care.
- Infant received an appropriate and thorough work up when he first presented to the hospital.
- A depression questionnaire was given at a well child visit.
- Mental health and substance abuse treatment were coordinated by a local hospital following a mother's release from incarceration.

- OBGYN screened for postpartum depression**.** Mother survived and did not undergo a hysterectomy**.** OB notes extremely detailed, providers worked hard to protect this infant before she was born.

Child Welfare/Protective Service

- OCS intervened appropriately and provided good case management and second child born to mother was placed in the same foster home as this child.
- OCS supervisor coordinated very well with law enforcement during the investigation.