MATERNAL AND CHILD DEATH REVIEW PROGRAM

2019 1ST QUARTERLY REPORT & RECOMMENDATION SUMMARY

ABOUT THE PROGRAM

The Alaska Maternal and Child Death Review (MCDR) follows a national evidence-based model to systematically and comprehensively review deaths using a multi-disciplinary consensus decision making 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. Committee membership include 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, and child protection workers.

ABOUT THIS REPORT

This report is limited to the deaths of children aged 0 to 17 years that were reviewed by the MCDR Committee between October and December of 2018 (n=39). The MCDR Committee reviews death case files when all applicable records have been received, which can be several months following a death. Therefore, the information presented in this report does not represent the incidence or trend of child deaths in Alaska.

It is important to note that this report is based on the recommendations of services and public health efforts known to committee members who were present at the review meeting, and may not reflect all prevention/service efforts at the time of death or currently available.

MCDR Committee findings are presented in this report for children ages 0-17 years. This report does not include information on maternal mortality as those deaths were not reviewed during this quarter. A review meeting was held during this quarter to review all 2017 deaths that occurred in a Neonatal Intensive Care Unit (NICU), which are described in the "Infants under 1 year of age" section of this report. Suicides are described within their own section as this is a priority area for prevention in Alaska. All committee recommendations generated this quarter are contained in this report for all deaths (both preventable and non-preventable).

CHILD DEATHS 1-17 YEARS (EXCLUDING SUICIDE) (OCT-DEC 2018)

- The committee reviewed 16 deaths of children ages 1-17 years. 10 child deaths were due to unintentional injuries. 4 deaths were due to medical causes. 2 deaths were undetermined.
- Of the 16 child deaths reviewed this quarter, the review committee generated prevention recommendations for 13 cases and determined that 10 of the deaths could have been prevented (63%).

Table 1. Unintentional injury deaths by primary cause of injury

CAUSE OF INJURY	DEATHS
Motor Vehicle	4
Fire, burn, electrocution	3
Asphyxia	1
Weapon	1
Other	1
TOTAL	10

Table 2. Prevention recommendations: Child injury deaths

Cause of injury *n = number of cases with recommendations	Committee Recommendations
Motor vehicle (n=4)	Educate parents to never move vehicles when children are playing nearby; young children should not supervise toddlers around vehicles; provide and encourage adults to take an accident prevention course that includes tips for safely driving around small children
	Continue anti-drunk driving campaigns-target parents; children should always wear seatbelts; encourage family/community members to stand up when they feel something is unsafe even when it is the parent doing the unsafe behavior
	Rebuild trust in this community with their law enforcement; teach and empower people to stand up when they feel something is unsafe even when it is the parent doing the unsafe behavior; encourage proper use of sober caregivers; continue anti-drunk driving campaigns
	Suggest new motorcycle drivers gain more experience before traveling on the most dangerous stretch of road in the state; suggest new motorcycle drivers use the most stable motorcycles available until they have more

	experience; suggest always checking tire pressures on motorcycles before starting a trip
Fire (n=3*) *2 cases had same recommendations	Primary care providers (PCPs) and therapists should ensure that fire safety discussions happen with families and children with Oppositional Defiant Disorder (ODD)/Attention Deficit Disorder (ADD)/behavioral concerns; ensure hardwired and connected smoke alarms throughout all units of multi-family homes; give fire/police/etc. the authority and capacity to enforce fire regulations in single family homes; fire and law enforcement should do peer reviews of investigations to improve investigation reports
	Install smoke detectors in all homes; keep ignition sources away from all children but especially those with a history of playing with them; offer bereavement counseling for everyone involved
Unintentional Asphyxia (n=1)	Improve and increase parents education on household strangulation hazards; when parents notice children playing with items that are strangulation hazards they should takes steps to remove those items from the home-not just instruct the children not to play with them; increase access to respite care for parents of children with special needs
Firearm (n=1)	Firearm owners should receive training on how to operate new firearms if they are not familiar with them; loaded firearms should never be kept or handled within homes

Table 3. Prevention recommendations: Child Medical/Undetermined deaths

Cause of death *n = number of cases with recommendations	Committee Recommendations
Medical (n=2)	Have Automated External Defibrillators (AEDs) available anywhere children are being active and ensure there is always someone around who know where it is located and how to use it in addition to being CPR certified
	Educate parents on the dangers of putting children on planes when they are very sick (high fevers)
Undetermined (n=2)	Toddlers should be placed in a safe sleep environment, especially when they are sick; continue educating parents on risk reduction techniques for infant/toddler sleeping and ensure they include adult obesity as a risk factor
	Toddlers should be placed in safe sleep environments and supervised; known choking hazards should be removed from toddler's reach especially if the child is known to place things in their mouth; children of all ages should always have at least 1 sober caregiver present; law enforcement should get toxicology tests on all Caregivers who were present at the time of a child death

INFANT DEATHS (UNDER 1 YEAR OF AGE) (OCT-DEC 2018)

- The committee reviewed 20 infant deaths. 15 deaths were due to medical causes (such as congenital anomalies or prematurity). 4 deaths were due to unintentional injury and 1 death was undetermined.
- 4 of these cases were classified as Sudden Unexpected Infant Deaths (SUID) by the MCDR committee using the Centers for Disease Control and Prevention (CDC) classification guidelines.
- 13 infant deaths occurred in the neonatal period. 7 infant deaths occurred in the postneonatal period. 43% of postneonatal deaths were due to unintentional injury.
- Of the 20 infant deaths reviewed this quarter, the review committee generated prevention recommendations for 9 cases and determined that 7 of the deaths could have been prevented (35%).

Table 4. Prevention recommendations: Infant injury deaths

Cause of injury *n = number of cases with recommendations	Committee Recommendations
Unintentional Asphyxia (n=3)	Continue to encourage and teach parents how to place infants in a safe sleep environment; encourage parents to quit smoking or at least stop smoking around their infants
	Education on proper use of car seats (should not be used for sleeping, especially on soft surfaces); education on following safe sleep recommendations; education on providing a sober caregiver at all times (including when children are sleeping); encourage behavioral health and grief treatment for everyone associated to this death
	View/edit health aide manual regarding “2 week well child visit” vs “2 week metabolic screening” on what safe sleep education is triggered; encourage parents to follow safe sleep practices especially when infants are sick; continue educating parents on risk reduction techniques for infant sleeping and ensure they include adult obesity as a risk factor; educate parents on increased risk of SIDS/SUIDs when infant is exposed to second hand smoke

Table 5. Prevention recommendations: Infant Medical/Undetermined deaths

Cause of death *n = number of cases with recommendations	Committee Recommendations
Medical (n=5)	Consider progesterone and Maternal Fetal Medicine (MFM) consult for pregnant women with more than one risk factor for premature delivery
	Develop city-wide call pool for reading electroencephalograms (EEGs); recruit additional pediatric EEG readers (the state currently only has one); identify symptoms/lab levels to help identify meningitis cases early and develop a protocol for treatment
	Educate this infant's mother to initiate prenatal care early in pregnancy and to be evaluated for cervical incompetence. Additionally, should receive 17-hydroxyprogesterone with future pregnancies
	Recommend early prenatal care for all pregnant women; consider 17-hydroxyprogesterone and cerclage for this specific woman
	Continue to educate parents on risk of poor outcomes when recommended C-section is delayed due to maternal desire for trial of labor (TOL).
Undetermined (n=1)	Always provide a sober caregiver even when children are asleep; train foster parents in CPR; continue education for safe sleep practices including risk reduction

CHILD DEATHS RELATED TO SUICIDE (OCT-DEC 2018)

- The committee reviewed 3 adolescent suicide deaths.
- Of the 3 suicide deaths reviewed this quarter, the review committee generated prevention recommendations for all 3 cases and determined that 2 of the deaths could have been prevented.

Table 6. Prevention recommendations: Child suicide deaths

Cause of death *n = number of cases with recommendations	Committee Recommendations
	Improve quality and availability of mental health services in rural areas; improve/support peer to peer connections and support especially in rural areas; children's reports of depressive symptoms should always be addressed even if they appear minor

Strangulation (n=2)	Improve/support peer to peer connections and support especially in rural areas; increase the availability of school and/or community activities in rural areas especially for teens; teens that have experienced a breakthrough when working through sexual assault should be checked in on by their behavioral health providers, do not expect teen to call to make therapist appointments; parents should know where their teens are at all times so when they are missing they know right away
Firearm (n=1)	Increase access to and raise awareness of programs that help teens cope with break ups in a healthy way; increase support for families with children with mental health issues; keep firearms in locked cabinets and do not store them with ammunition; children experiencing a crisis should not be allowed to leave school and be at home unattended