Palm Beach County Fetal and Infant Mortality Review

Case Review Team Meeting Notes

Tuesday, May 14, 2019

Meeting Results:
By the end of the meeting the CRT will:
- Review each case prepared by the Palm Beach County FIMR team
- Individually and in assigned groups identify the factors/causes contributing to the case
- Review the case collectively during the FIMR Abstractor team presentation
- Following the review, deliberate collectively on the contributing factors, strengths and suggestions
- Collectively determine if the death was preventable
- Formulate recommendations to be shared with the Community Action Group (CAG)

Meeting Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Jennifer Boutin</td>
<td>Nutritious Lifestyles</td>
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<td>Dr. Janis Jones</td>
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<td>Dr. John Caravello</td>
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Program Staff

Collective Case Deliberation/Review Notes

Case #00021:

Significant Issues/Present and Contributing Factors:
1. Preconception/Medical History of Mother
   - Pregnancy <18 months apart (present)
   - History of chlamydia (present)
   - Poor nutrition (present)
   - Mother’s BMI >35 (present)
   - Previous C-Section (present)
   - No birth control (present)
2. Prenatal Care/Delivery
   - Late entry to prenatal care (present)
3. Environment
   - Unsafe sleep location (present)
   - Not back sleep position (present)
4. Social Support
   - Lack of partner/FOB support (present)
   - Single parent (present)
5. Mental Health/Stress
   • Depression/mental illness during pregnancy (present)
   • Multiple stresses (present)
   • Concern about enough money (present)

6. Post-Partum
   • Sleep deprivation
   • Complicated grief (teenager when mother passed away)
   • Missing data
   • Lack of home visiting (eligible) (present)

7. Infant Health
   • Gap in follow-up to infant health appointments
   • Sepsis

8. Bereavement
   • Lack of family grief support (present)

Strengths:
   • Adequate prenatal care
   • Mother knew how to administer infant’s medications
   • Enrolled in Triple P Parenting Program

Gaps in Service Delivery or Community Resource Systems:
   • Possible lack of social support
   • Mother had part-time job
   • Shared housing
   • Mother did not recognize signs that baby was getting sick
   • Mother was enrolled in parenting class, but no others
   • Lack of follow-up with provider
   • Unknown as to whether nurses followed up with mother after infant health appointments

Recommendations:
   • Difficult to determine recommendations due to lack of information about infant’s asthma diagnosis:
     o How much follow-up was there?
     o Who kept giving steroids?
     o What barriers existed to getting access to services?
   • If child is high-risk and has a chronic health condition, require/mandate parents to enroll in HB programs
   • Closer follow-up post-discharge (lack of information on follow-up/instructions given)
   • Provide grief support for entire family
   • Best practice suggestion to pediatrician offices with high-risk infants that present with respiratory or other chronic health issues: have staff reach out within 24/48 hours after appointment

Was this death preventable? Yes

Case #00022:
Significant Issues/Present and Contributing Factors:
1. Preconception/Medical History of Mother
   • History of infertility
   • Chorioamnionitis (present)
   • Gestational diabetes (contributing)
   • STI: Herpes 1 (present)
   • Poor nutrition (present)
• Preterm labor (contributing)
• Previous fetal loss (present)
• No birth control (present)

2. Prenatal Care/Delivery
• Lost a twin
• Lack of referrals (present)

3. Medical: Fetal/Infant
• Very Low Birth Weight (VLBW) (contributing)
• Prematurity (contributing)
• Infection/sepsis (contributing)
• Respiratory Distress Syndrome (contributing)

4. Mental Health/Stress
• Multiple stresses (present)
• Concern about enough money (present)

5. Services Provided
• Lack of home visiting (eligible) (present)

6. Documentation
• Missing data (present)

7. Bereavement
• Possible grief/depression from losing twin

Strengths:
• Mother was educated and employed

Gaps:
• Mental health concerns were not documented
• Warning signs of depression were not addressed
• Mother did not recognize warning signs of preterm labor

Recommendations:
• Educate mothers about warning signs/what to do when feeling symptoms of preterm labor
• Emphasize the importance of mental healthcare in prenatal care

Was this death preventable? No

Case #00023:

Gaps:
• Not enough information about mother’s health history/risk for stillbirth to review case (abstractors to gather additional records to add to case summary; case will be held for next meeting)