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>Kristin Thomas</td>
<td>HomeSafe</td>
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<td>Lisa Greenwood</td>
<td>Healthy Mothers Healthy Babies of PBC</td>
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Collective Case Deliberation/Review Notes

Case #31:

Significant Issues/Present and Contributing Factors:

1. Preconception/Medical History of Mother
   - Unsafe sleep environment
   - Lack of education (cognitive)
   - Depression
   - Late teen pregnancy
   - Unemployed
   - Less than 8th grade education
   - Exposure to cigarette smoke
   - Late entry into prenatal care
   - Unintended pregnancy
   - Lack of home visiting (eligible)
   - Positive drug test
   - Illicit drug use (Marijuana)
   - Financial stress
   - Substandard housing
   - Multiple stressors
   - Single parent
   - Support system was not educated on infant safe sleep practice

2. Prenatal
   - History of high blood pressure throughout pregnancy & delivery
   - Gestational diabetes

3. Medical: Fetal/Infant
   - Failure to thrive
   - Feeding problem

Strengths:

- Mom received safe sleep education from multiple sources and in different formats
- Bereavement support offered
- Postpartum visit kept
- Support system (caregiver at time of death) initiated CPR
- Medicaid + WIC + navigation (HB)
- Self-advocate (when mom noticed feeding problem, she sought medical care for infant)
Gaps in Service Delivery or Community Resource Systems:

- No gaps in services- behavioral issue

Recommendations:

- Case management for younger mothers (initiated automatically during hospital stay)
- Safe sleep education for all who care for baby (not just parents or immediate caregiver) including hospital staff
- Incentive driven mandatory legislation for high risk pregnant moms to receive home visiting services

Was this death preventable? Yes

Case #32:

Significant Issues/Present and Contributing Factors:

2. Preconception/Medical History of Mother

- Financial stress (concerns about money)
- Unable to go on bed rest because of financial responsibilities
- Single parent
- Previous preterm delivery
- Poor nutrition
- Unintended pregnancy
- Lack of home visiting (eligible)
- Depression during pregnancy/and in postpartum period
- Health issues with mom
- Many barriers to access available services
- Lack of family support

2. Prenatal

- UTI & BV infection (unable to tolerate medication)
- Vaginal bleeding
- Oligo/polyhydramnios
- Placental previa
- Preterm labor

3. Medical: Fetal/Infant
• Extreme Prematurity
• ELBW (<750)
• Sepsis
• Respiratory Distress Syndrome

Strengths:
• Employed
• Early entry to PNC
• Medicaid
• Good prenatal education
• Postpartum visit kept
• FOB involvement
• Referred to perinatology
• Family/friends support
• Mom attempted financial planning for baby’s arrival
• Mom’s coworkers donated PTO time for bedrest

Gaps in Service Delivery or Community Resource Systems:
• Lack of financial resources to assist mom who was put on bedrest

Recommendations:
• Medicaid case manager/ medical case manager
• Financial assistance for moms on bedrest
• Link to community/social services (not just a referral but follow-up)

Was this death preventable? Yes, if mom was able to stay on bedrest as recommended by doctor

Case #33:

Significant Issues/Present and Contributing Factors:

3. Preconception/Medical History of Mother
• Gestational diabetes
• Obese
• Poor nutrition
• Unintended pregnancy
• Non-compliance with medical care
• History of mental health illness
• Depression
• GBS positive
• No bereavement referral noted in medical record
• Lack of home visit (eligible)
• Did not attend postpartum appointment

2. Prenatal
• Chorioamnionitis

3. Medical: Fetal/Infant
• Macrosomia
• Missed appointments

Strengths:
• Father of baby involved
• Intended pregnancy
• Employed
• Referred to perinatology
• Referral to appropriate mental health & medical services
• Early entry to PNC
• Mom continuing her education
• Medicaid
• Financial planning for baby’s arrival
• Mom saw/held baby after delivery

Gaps in Service Delivery or Community Resource Systems:
• N/A; behavioral health issue

Recommendations:
• Referral to prenatal plus services
• Community awareness education on gestational diabetes (using parents testimonials)
• Provider offices (Doctors & WIC) to run CSC resource videos on a loop
• Medical compliance

Was this death preventable? Yes, if patient is compliant with plan of care