REPORT TO THE THIRTIETH LEGISLATURE
STATE OF HAWAII
2020

PURSUANT TO ACT 203 (SLH 2016) REQUIRING THE DEPARTMENT OF HEALTH TO PROVIDE AN ANNUAL REPORT ON CHILD DEATH REVIEW AND MATERNAL MORTALITY REVIEW ACTIVITIES
(S.B. 2317, S.D. 2, H.D. 1, C.D. 1)

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December 2019

2020 REPORT TO THE HAWAII STATE LEGISLATURE

Act 203 requires the Department of Health (DOH) to provide an annual report on child death review and maternal mortality review activities to the legislature. The annual report covers the calendar year immediately prior to the year in which the report is due and describes the total number of child and maternal deaths in Hawaii, the causes of those deaths, any review activities conducted by the department, trends, and recommendations for system changes, including any proposed legislation.

Child death and maternal mortality reviews are administered by the Department of Health's Family Health Services Division, Maternal and Child Health Branch.

CHILD DEATH REVIEW

A. Child Death Review Purpose

The purpose of child death reviews is to provide essential information needed to identify strategies to improve child health and safety preventing death and injuries in the future. Child deaths in Hawaii are reviewed one year after the death occurs. The review process includes public and private members of the community that examines the circumstances surrounding a child's death. Interagency collaboration and discussions assist team members in understanding why children die and promotes the development of interventions to protect other children.

Fatality reviews are theories and methods grounded in public health designed to identify and understand risk factors for death. It is an examination of relevant records relating to the decedent by a multidisciplinary team of professionals. The goal is to understand the causes and incidence of these deaths in Hawaii and to identify interventions for the general public reducing the number of preventable deaths.

In Hawaii, the Child Death Review System was legislatively established in 1997 by Hawaii Revised Statues §321-341. The Department of Health, Health Resources Administration, Family Health Services Division, Maternal and Child Health Branch was designated as the responsible state agency to implement these multidisciplinary and multiagency reviews of child deaths.

In 2016, the legislature passed S.B. 2317 S.D. 2, H.D. 1, C.D. 1(Act 203) authorizing the Department to conduct comprehensive multidisciplinary reviews of child deaths and maternal deaths with the submission of an annual report to the Legislature. The stated purpose of the reviews is to understand risk factors and prevent future child and maternal deaths in Hawaii.

Hawaii Revised Statues §321-343 also provides access to information from all providers of health care, social services and state and county agencies for the use of child death reviews upon written request from the Director of Health. Hawaii Revised Statues §321-346 immunity from liability states that all agencies and individuals participating in the review of child deaths shall not be held civilly or criminally liable for providing the information required under this part.

The Child Death Review Manual, a guideline of procedures and practices created for the child death review committee members was updated and includes the National Fatality Review Case Reporting Form used for each child death review. This form is inputted into the National Fatality Case Reporting System and assists the review team in coordinating data for analysis and developing status reports needed to create action plans of child death implementation recommendations.

The child death categories selected for review have been defined by the National Center for Fatality Review and Prevention and supported by the U.S. Department of Health and Human Services, Health Resources and Administration and the Maternal and Child Health Bureau to include: child abuse and neglect, homicide, suicide, undetermined, natural, and unintentional injury.

Quarterly recommendations from the statewide child death reviews are presented to the Child Death Review Council a multiagency group organized to identify system problems and make recommendations necessary for policy, procedural and legislative changes.

B. Data

Statewide Child Death Review teams on Oahu, Kauai, and Hawaii Islands and Maui County review child death cases one year after the death occurs.

1. **Total number of child deaths** for 2018 were 165. There were 42 non-natural (deaths due to an accident or violence; homicide, motor vehicle accidents, suicide, etc.) and 123 natural deaths (death caused by illness or disease internal malfunction of the body not caused by external forces).

    a. Causes of these deaths; motor vehicle, poisoning, drowning, medical condition, homicide, undetermined if injury or medical cause.
    b. Two child deaths occurred while in state custody (Department of Human Services, Social Services Division, Child Welfare Services) due to illegal substance consumed and the other, was undetermined possibly due to unsafe sleeping conditions.

2. **Trends**

   a. Most of the child death cases were in Honolulu.
   b. More than half of the natural child deaths were infant deaths (unintentional asphyxia).
   c. Among 42 non-natural child deaths (homicide, motor vehicle accidents, drownings, poisoning overdose or acute intoxication, and suicide) 22 were undetermined and an estimated one-fourth (10) were accidents.
   d. More than one-fifth of the non -natural deaths occurred in the 15 to 18-year-old age group.

3. **Recommendations including any proposed Legislation**

   a. Continue to host child, youth, and adolescent preventive informational and training conferences in Hawaii to lower the prevalence rates of suicide
   b. Increase child, youth, and adolescent prevention strategy messages via social media, at shopping malls, schools, sporting events, and parks to provide information and supports on dealing with depression and other mental health issues
   c. Continue working with the Hawaii medical health community to provide child, youth, and adolescent public health prevention literature for practitioners; encouraging distribution to parents and families in the areas of: 1) safe sleep practices to reduce or prevent infant sleep-related deaths and 2) adolescent driving education safety to reduce motor vehicle accidents and deaths.
   d. Pursuant to its charge in Act 203 (SLH 2016), the Hawaii Child Death Review team recommends the following legislative action to address drowning in children:
      i. Legislation or establishing building codes (as recommended by the American Academy of Pediatrics (May 2019) to mandate four-sided isolation pool fencing for new, and existing residential pools at the state level by 2025.
      ii. Adopting the Model Aquatic Health Code (Centers for Disease Control and Prevention) for swimming pools, and the enforcement of swimming pool standards.

C. Program Activities

1. Oahu –There were nine (9) Child Death Review team meetings completed.
2. Kauai –There were two (2) Child Death Review team meetings completed.
3. Maui – There was one (1) Child Death Review case completed.
4. Hawaii Island – There were six (6) Child Death Review team meetings completed.
5. Collaborative Fatality Review Meetings three (3) meetings held.
6. State Child Death Review Council- two (2) meetings held.

E. Collaborative Efforts

1. Partnered with state and community-based agencies to implement child death review prevention recommendations; create social media posters, apps, written literature, and providing community presentations primarily on adolescent wellness, drowning prevention, and safe sleep practices.

2. Contracted a non-profit agency to coordinate meeting logistics for the Hawaii Fatality Summit held in May 2019, the first fatality summit in the nation encompassing child death, maternal mortality, and domestic violence prevention in one venue.

3. Partnered with the DOH child and adolescent division to assist with adolescent crisis public information campaign displayed at Hawaii shopping malls promoting adolescent wellness by providing resources for depression, mental health, and suicide prevention.

4. Contracted an early childhood non-profit to assist with facilitating monthly meetings, addressing improved birth outcomes, and reducing infant mortality.

5. Partnered with a community-based injury prevention coalition through Kapiolani Medical Center for Women and Children to convene Safe Sleep Hawaii meetings and coordination of the Safe Sleep Annual Summit promoting preventive measures for infant safe sleep and a professional forum for strengthening medical, family, and community partnerships.

6. Partnered DOH programs and safe sleep community providers to promote safe sleep practices with training for families and distribution of over 90 portable infant play yards statewide.

7. Contracted a non-profit agency to develop and maintain a resource directory for families--The Parent Line--a premier resource on child behavior, child development, parenting support, and community resources. In fiscal year 2019, The Parent Line provided the following community support and services:
    a. 1,074 calls received for information and referrals
    b. 8,573 website visits
    c. 12,410 new parent packets at birthing hospitals
    d. 41,050 kindergarten readiness brochures
    e. 62,177 safe sleep brochures
    f. 66,993 community resource guides
    g. 165,177 newsletters for parents of preschoolers

F. State Collaboration

1. Partnered with the DOH Public Health Nursing Branch where registered nurses temporarily assisted in abstracting child death records for the Child Death Review during the interim period where recruitment is ongoing for a permanent Child Death Review nurse through the Maternal and Child Health Branch.

2. Consulted with the DOH Injury and Prevention Branch on adolescent suicides, water safety, and safe sleep initiatives to ensure consistency and effectiveness avoiding duplications in developing preventative child death resources within the Maternal and Child Health Branch.

3. Provided opportunities using federal grant funds for eight (8) local advocacy agency leaders and four (4) DOH staff to attend national conferences that placed emphasis on best practices in the area of prevention activities for states; effective budgeting, sexual assault, maternal mortality, and child death prevention, domestic violence, home visiting, child abuse prevention, family planning, adolescent heath, and sexual abuse prevention allowing participants to participate in mock interviews, systems planning, and developing plans of action. The attendance at these national conferences assisted the local agency leaders and DOH staff in developing best practices, interventions, strategies, and information on preventing child deaths to be shared with community organizations, clinics, non-profit organizations and within DOH programs.

4. Provided a presentation to the Hawaii Court System and Judiciary; judges, bailiff, court appointed special advocates, probation officers, and Girls Court staff on prevention programs for children and youth available through the Maternal and Child Health Branch, (adolescent health services, reproductive health services, family planning, sexual violence and domestic violence prevention). This presentation provided an awareness of available DOH Family Health Services Division, Maternal and Child Health Branch resources to assist the State of Hawaii Judiciary in making needed referrals of services for children and youth within the judicial system.

G. National Collaboration

1. The National Center for Fatality Review and Prevention provided best practices information on infant, child, and fetal deaths to public and private stakeholders in Hawaii, February 2019.

    a. Presented national fatality information at the Hawaii Fatality Summit in May 2019.
    b. Consulted with the Maternal and Child Health Branch administration on best practices for child death review training for committee members and identified the primary differences between a child death review and a fetal/infant death review.

2. Presented a two (2) day Hawaii Fatality Summit on prevention strategies, and the importance of child death, maternal mortality, and domestic violence reviews to assist in the prevention of future deaths. Coordinated for national and local speakers to provide information on medical and programmatic evidence based practices, completing death certificates sessions for physicians and other clinical professionals, utilizing technology to maximize program implementation tasks for maternal and child health programs, defining the importance of adhering to culturally sensitive and sexual minority identities when developing prevention strategies, and the significance of listening and including communities in the planning processes for addressing social and health disparities.

3. Continued consultation with the Centers for Disease Control and Prevention for maternal mortality guidance and its impact to women's health, infants, and the entire family.

MATERNAL MORTALITY REVIEW

A. Maternal Mortality Review Purpose

The purpose of the maternal mortality review process is to determine the causes of maternal mortality in Hawaii and identify public health and clinical interventions to improve systems of care and prevent maternal deaths. The death of a woman during pregnancy, at delivery, or soon after delivery is a tragedy for her family and for society. According to the Centers for Disease Control and Prevention, nationally 3 out of 5 maternal deaths are preventable. The Centers for Disease Control and Prevention also has data to support that over 700 women die from pregnancy related complications each year in the United States and in Hawaii, 80% of pregnancy-related deaths were preventable. From 2016-2019 there were 25 maternal deaths that were identified as potential maternal deaths.

The Hawaii Maternal Mortality Review Committee reviews all maternal deaths in Hawaii. A maternal death is defined as a death that occurs during pregnancy or within one year of the end of pregnancy from a pregnancy complication. At the review, a determination is made as to whether the death is pregnancy-related, or pregnancy associated. Pregnancy-related deaths are those that result from complications of pregnancy, the chain of events initiated by the pregnancy, or aggravation of an unrelated condition by the pregnancy. Pregnancy- associated death of a woman is from any cause while she is pregnant or within one year of termination of pregnancy. Following the review of each maternal death, recommendations are made by the Maternal Mortality Review Committee to create plans of action that address prevention strategies for pregnant women to limit and reduce future deaths.

B. Program Activities

The following activities were completed in 2019:

1. The Hawaii Maternal Mortality Review Committee convened two review meetings in June and December to review 2017 and 2018 maternal deaths and developed recommendations and prevention strategies based on the findings.

2. The Department submitted a grant application in May in response to the Centers for Disease Control (CDC) and Prevention Funding Opportunity Announcements "Preventing Maternal Deaths: Supporting Maternal Morality Review Committees." This grant was intended to support prevention opportunities identified by the Hawaii Maternal Mortality Review Committee. Hawaii proposal was accepted but not funded.

3. The Maternal and Child Health Branch hosted Hawaii's first two (2) day Fatality Summit in May. Activities included:
    a. Presentations on maternal mortality highlights and current changes were made by CDC participants.

b. An overview of the importance of providing prevention activities to pregnant women promoting wellness; assessments of the women's mental health status, an awareness of cultural values, and regular well baby care while pregnant was presented by the Hawaii Maternal Mortality Review chairperson. He is a practicing obstetrician-gynecologist.
c. Meeting with Centers for Disease Control (CDC) and Prevention staff to provide information on the importance of collecting Pregnancy Risk Assessment Monitoring System data using a questionnaire that collects state specific population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The DOH Hawaii Family Health Services Division currently collects this data.
d. A presentation by a local obstetrician-gynecologist on the Perinatal Quality Collaborative and the multi-state networks of teams that are working to improve the quality of care for mothers and babies. The Hawaii Perinatal Quality Collaborative network is exploring options to increase awareness of primarily clinical health care processes and the various process improvement methods available to make needed changes in the healthcare delivery system.
e. Meeting with the Perinatal Quality Collaborative co-chairperson, an obstetrician-gynecologist, during the Hawaii Fatality Summit for DOH staff and other interested stakeholders to review priorities of the Hawaii Perinatal Quality Collaborative: the identification of goals, implementation of toolkits statewide, hospital-based collaboration, and leadership team proposals. An in-depth review of Hawaii statistics was also shared such as teen birth rates, maternal mortality, pregnancy patterns of Native Hawaiians, neonatal mortality, pre-term mortality and Sudden Unexpected Infant Deaths rates.

4. The Maternal and Child Health Branch continues to abstract reports and prepare for committee reviews of maternal mortality data.

5. The Maternal and Child Health Branch research statistician attended the Maternal Mortality Review Information Application (MMRIA) User Meeting in June in Atlanta, Georgia to facilitate extraction of maternal mortality data from the national database. The MMRIA is a standardized data system that supports essential maternal mortality review functions, case abstraction, and includes access to data at the regional and national levels, enabling identification, and an analysis of emerging causes of death, summaries across geographic boundaries, and common recommendations for action. Hawaii has used the MMRIA system for over two (2) years.

C. State Collaborative Efforts 2019

1. The Hawaii Maternal Mortality Review Committee chairperson is a volunteer position resulting from a partnership between the DOH and the University of Hawaii, John A. Burns School of Medicine, Department of Obstetrics, Gynecology, and Women's Health, Division of Maternal-Fetal Medicine. The term for the new chair began in June.

2. The Hawaii Perinatal Quality Collaborative, through a contract from the DOH, conducted protocol trainings on sepsis and hemorrhage at birthing hospitals throughout the state.

3. The University of Hawaii, John A. Burns School of Medicine, Department of Obstetrics, Gynecology, and Women's Health, Division of Maternal-Fetal Medicine is convening quarterly post-partum maternal depression groups with DOH as a partner.

4. The Child Death Review and Maternal Mortality Review Council Recommendation Implementation workgroup was formed by the Hawaii Maternal Infant Health Collaborative with a focus on prioritizing recommendations and implementing prevention activities.

5. Continued collaborative efforts with the March of Dimes Hawaii Chapter and the DOH to focus on improving Hawaii's Preterm Birth Rate, Report Card initiated through the March of Dimes.

6. The Hawaii Maternal Mortality Review Committee continues to use and input Hawaii Maternal Mortality Review data to the Centers for Disease Control and Prevention Maternal Mortality Review Information Application (MMRIA) data system.

7. The DOH contracted with an agency to complete an analysis and survey of providers utilizing the One Key Question®; a tool that starts the conversation about if, when and under what circumstances women want to get pregnant and also to assess those previously trained to routinely ask women about their reproductive health needs. This information from the analysis will assist the DOH in making future recommendations for family planning activities.

D. National Collaborative Efforts 2019

1. Consultation and assistance from the Centers for Disease Control and Prevention, Building United States Capacity for Maternal Mortality Review program, continues to be imperative to ensure that the Hawaii Maternal Mortality Review committee is utilizing best practices and generating quality data and recommendations for maternal mortality prevention.

E. Hawaii Maternal Mortality Review Data

During 2019, the committee reviewed calendar year 2017 and 2018 maternal mortality cases. There were 5 cases identified for 2017 and 10 cases for 2018 for potential review:

1. 2017 Cases. There were five (5) cases reviewed at the June 2019 meeting. The number of cases reviewed were too small to identify trends.

2. 2018 Cases. There were ten (10) cases reviewed at the December 2019 meeting. Six (6) of the 10 cases were natural deaths that may have been complicated by drug abuse.

F. Recommendations and Action

1. DOH to continue as a committee member on the Hawaii Maternal Infant Health Collaborative, Child Death Review and Maternal Mortality Review recommendation implementation workgroup. This participation will strengthen the communication between public and private agencies promoting the development of preventative interventions with action plans for reducing maternal and child deaths.

2. The DOH will continue to support the efforts of the Perinatal Quality Collaborative and other related efforts that align with the objectives of preventing maternal mortality. The Perinatal Quality Collaborative works closely with the Hawaii birthing hospitals providing recommendations for policy development with the goal of reducing preventative maternal deaths.

3. In recognition of the importance of healthy pregnancies, DOH will continue to lead the effort to encourage better coordination of implementing One Key Question® in hospitals, health centers, and private physician offices. One Key Question® is: "***Do you want to become pregnant in the next year?***" This tool assists health service providers to determine reproductive health service options for women to increase the number of planned healthy pregnancies and reduce the number of unplanned/unwanted pregnancies.

4. Continued meetings with interested private and public stakeholders to discuss plans of actions for the implementation of Maternal Mortality Review recommendations from a public health and medical perspective greatly reducing preventable maternal deaths.