MaineHealth

Testimony of Dr. Meredith Jackson, MaineHealth
In Opposition to LD 1460, "An Act to Require Parents to Be Informed of Hospitals' Safe Sleep Rules"
April 14, 2025

Senator Ingwersen, Representative Meyer, and distinguished members of the Joint Standing Committee on Health and Human Services, I am Dr. Meredith Jackson, pediatric and newborn hospitalist at MaineHealth Maine Medical Center, and I am here to testify in opposition to LD 1460, "An Act to Require Parents to Be Informed of Hospitals' Safe Sleep Rules."

MaineHealth is an integrated non-profit health care system that provides the full continuum of health care services to the residents of eleven counties in Maine and one in New Hampshire. As part of our vision of "Working Together So Maine's Communities are the Healthiest in America," MaineHealth, which includes MaineHealth Behavioral Health, is committed to creating a seamless system of behavioral healthcare across Maine, coordinating hospital psychiatric care with community-based treatment services, and providing better access to behavioral healthcare through integration with primary care.

As a pediatric and newborn hospitalist and the co-chair of the Safe Sleep Committee at MaineHealth Maine Medical Center, I strongly oppose LD 1460, which seeks to require hospitals to provide infant safe sleep policies at admission and require parents to sign, acknowledging that they have received this information.

First, I'd like to provide some background. The national American Academy of Pediatrics recommends a safe sleep environment for all children less than 1 year of age to reduce the risk of sudden unexpected infant death. Infants less than 4 months of age, those with chronic healthcare needs, and those who are premature and/or were low birthweight are at even higher risk than others. As an example, falling asleep in a recliner or couch while holding an infant increases the risk of sleep-related infant death by more than 60 times.

As part of my job as the co-chair of the Safe Sleep Committee, I am also a member of the state Maternal, Fetal, and Infant Mortality Review board through the Maine CDC, which meets quarterly to review deaths is pregnant and postpartum women and in neonates and infants. After a multi-year decline in the infant mortality rate and number of sudden unexpected infant deaths (SUIDs) in our state, likely due in large part to widespread public safety campaigns, we experienced a devastating jump, from 9 SUIDs in 2021 to 17 in 2022, and an increase in the infant mortality rate (all causes, not just SUID) to 6.4 deaths per 1000 live births, much higher than the national average of 5.5.

In response to this devastating increase, Maine Medical Center, which has had an infant safe sleep policy approved since April 2010, decided to add to our policy that if an infant was found in an unsafe sleep environment on multiple occasions, a report would be made to DHHS out of concern for the wellbeing of the infant, in addition to always educating caregivers about the importance of a safe sleep environment. This is not meant to be punitive, but as a tool to emphasize how truly important safe sleep is, as well as to ensure that families have access to a safe sleep environment at home. In fact, if families do not have a safe sleep environment at home, we can provide it at no cost. We also included this to be fair to all of our patients – we

don't want to unintentionally over-report families due to biases (conscious or not) and give "breaks" to others. Additionally, it is our duty as mandated reporters to report when we have a concern for neglect or abuse that may endanger a child's wellbeing, whether or not that is in an official policy that has been signed or acknowledged by a parent.

Our hospital had more than 3200 deliveries, 600 NICU admissions, and 1000 admissions of children younger than 12 months old in 2024. Of these more than 4500 patients, we made 17 reports to DHHS due to repeated unsafe sleep in the hospital setting. And DHHS responded to at least 10 them – both by visiting in the hospital or making a home visit; several of these patients also had DHHS cases open for other reasons in addition to unsafe sleep.

While many families choose to utilize different methods for their infant's sleep for a variety of reasons, in the hospital setting we are unwilling to take any risk for that child's health and wellbeing during sleep – not only because we know that it is safest, but also because we know that modeling is incredibly important. Our practice is to educate all families of children younger than 1 at the time of admission on the expectation for safe sleep, as part of our discussion on hospital safety, which also includes information such as keeping the side rails up on the crib, etc. From a public health policy point of view, the best way to educate and improve uptake of safe sleep practices is ***not*** to have people sign a policy – this actually has been shown to alienate people; instead, we endeavor to educate people to empower them to decrease risky behaviors.

To be clear, our goal at Maine Medical Center is prevention instead of reaction. In that vein, we are developing a handout to give families at the time of admission regarding safe sleep. The document will include how important we think safe sleep is (and why), our expectations in the hospital, and the repercussions if not complied. We have intentionally left out a signature line – what if the caregiver refused to sign? We also are working on translation into the many languages utilized by patients in our system.

Fortunately, the infant mortality rate (IMR) has decreased in the state of Maine – to 5.8 in 2023 (# SUIDs = 10) and 4.7 in 2024 (case reviews are not yet complete by office of medical examiner yet to know exact # of SUIDs), the first time our IMR has been below 5 in more than a decade. Whether this is due to our stronger enforcement of safe sleep practices in the hospital, we cannot know, but it certainly does not argue against it.

Lastly, our hospital system has more than 400 policies and procedures that apply to infants and children, and if this were to pass it would set a very dangerous precedent of requiring the presentation and caregiver signature on every single one of them at the time of admission – something that would take hours, if not days, and does not absolve the care team from their duty to take care of their patient.

For the reasons I have provided above, I urge the committee to vote "Ought NOT to pass" on LD 1460.

Thank you for your consideration and I would be happy to answer any questions that you may have.