FETAL INFANT MORTALITY REVIEW

December 2025

Quarterly Meeting Summary

What We Do

The Dane County Fetal and Infant Mortality Review (FIMR) aims to prevent pregnancy loss[1] and infant deaths[2] in Dane County.

FIMR is an evidence-based, community-driven prevention strategy. The purpose of case review is to identify systems-level problems and advocate for change.

11	8	3
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 3 Infant: 8

Records & Timeline

General timeliness is crucial for case review to identify and illustrate themes, trends, and issues facing individuals and systems in our community. FIMR case review timeliness varies, and we review cases as timely as records are available. The cases reviewed are not a comprehensive record of *all* deaths that occurred during a specific timeframe.

During the December case review cycle, the deaths reviewed happened during 2023 and 2025. For infant deaths, the pregnancy and/or birth may have occurred in the calendar year prior to the year of death.

Themes

Themes are factors that influence health outcomes. Certain themes were consistent in several cases. The number of cases for each theme is in parentheses.

One or more maternal health issue (7)

Adverse birth situation (7) including C-section (3)

Infant and fetal medical concerns (7)

Maternal nutrition needs (6)

Mental health concerns across perinatal course (6) including (4) with substance use

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Case Review Discussion Points

Across Pre-FIMR and Case Review Team meetings, 24 total partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

During the past two years, FIMR has reviewed 10 infant deaths involving sleep. Nine of these infants had a respiratory illness at the time of their death.

- Although these cases only represent a portion of infant deaths from the past two years, these deaths exhibit the impact on sleep when an infant's respiratory system is compromised.
- How to protect baby during respiratory illness season provides information on FIMR's work to increase awareness.

This quarter, two cases involved sleep setting and respiratory illness.

- Group identified nuances that impacted sleep in these cases: 1) physical limitations, 2) accessibility, and 3) cultural practices.
- Three specific physical limitations: 1) type of surface used for sleep; 2) what covers the sleep surface: mattress cover/sheet, material, and fit; and 3) no separate sleep space for infant.

Missed opportunities for referrals and resources.

- In one case, the mother refused referrals after initially accepting. In two other cases where the mothers consistently attended medical care, referrals were inconsistently documented as done. Group questioned a blanket approach, as these cases show that there is not a single solution.
- Discussion identified possibilities for optimizing medical touchpoints to connect families to services and the need to strengthen direct connections to community-based resources for medical systems.

Two cases with the birthing person under 20 years old highlighted youth vulnerability during the perinatal period.

- Discussion revealed limitations for systems to identify youth vulnerability indicators in combination with general limited awareness of signs a pregnant or parenting youth is in a vulnerable, or unsafe, situation.
- These cases had an adverse birth situation and complex socioeconomic, family, and psychological factors. Indicators of need were missed, and long-term support was inadequate.
- Three areas of concern: 1) human trafficking, 2) family dynamics when the birthing person is a minor, and 3) justice system involvement.

Fetal and Infant Mortality Review is an important way to honor families who have experienced pregnancy and infant loss. While FIMR is an essential process that works toward preventing tragedies, we also acknowledge how heavy and challenging this work can be. Thank you to every FIMR support and participant for being engaged in this difficult work.

[1]*Pregnancy loss (fetal death)* is defined as an intrauterine death at least 20 weeks gestation or a delivery weight of at least 350 grams (WI statute).
[2]*Infant death* is defined as a death of a liveborn child before one year of life (CDC).

Year in Review: 2025

- Four formal case review cycles of FIMR were completed in 2025.
- In total, 44 cases were reviewed → 15 of those were reviewed by the Case Review Team.
- Improvement on the goal to abstract and review all FIMR cases within one year of their death event: We met this for nearly 90% of FIMR cases, compared to 80% for 2024.

With every case, 42 themes and social determinants were tracked. The three most common **themes** across cases reviewed during 2025:

One or more maternal health issue (33)

Adverse birth situation (28) including C-section (11)

Mental health concerns (26) including (10) with substance use

On average, 27 partners participated per quarter

These are key reflections on their involvement in 2025 and why FIMR is important:

- FIMR **honors every death** by working to understand and make an impact.
- FIMR is **systems-thinking** or 'big picture' analysis through the lens of individual cases.
- Case review **connects issues to solutions** in broad contexts and across systems: The **necessary voices** at the 'FIMR table' are diverse perspectives and experiences. Collectively, FIMR digs deeper to identify gaps and challenges.
- For providers working in the systems being analyzed, FIMR is a space for them to **inform change**.

Collective impact: One of the most valuable aspects of FIMR is multidisciplinary collaboration.

- Individuals learn from others about different or unfamiliar perspectives that they would not typically get to interact with.
- CRT members are better informed on systems and how systems interact.
- Individuals bring themes and actionable ideas back to the systems they are a part of.

Behind every single number and theme is at least one person in our community who has been impacted. The death of any child is a tragedy no family should have to experience.

Thank you for taking the time to read this report and honor the most vulnerable losses in Dane County.

fimr@cityofmadison.com