FETAL INFANT MORTALITY REVIEW

June 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 level prevention strategy. The purpose of case review is to identify systems-level problems and advocate for change.

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

Stillbirth: 8 **Infant: 3**

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 June case review cycle, the deaths reviewed happened during 2023 and 2024. 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 issues (10) including chronic hypertension (4)

Adverse birth situation (8) including C-section (2)

Mental health concerns across perinatal course (6)

Close interval: Less than one year between pregnancies (6)

Placental insufficiency or placenta issues (6)

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Public Health Madison & Dane County coordinates the Fetal Infant Mortality Review process for Dane County.

Case Review Discussion Points

Across Pre-FIMR and Case Review Team meetings, 27 total partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Considerations for birthing people with adverse or complex birth histories and prior loss.

- Documentation on classifying these as risk factors widely varied and is commonly contradicted during interconception (between pregnancies) care.
- Birth trauma is minimally addressed in subsequent pregnancies.
- Four cases had one or more prior loss.

Care coordination gaps may result from screenings being done with no immediate nor consistent follow-up to respond to identified needs.

- In a few cases, the mother had to navigate barriers and services to meet their basic needs.
- Discussion revealed likely gaps in medical staff knowledge about community resources, as evidenced by cases in which the birthing person and/or their family needs were documented but no action to address.

Communicating the seriousness of risk factors and potential outcomes can be challenging, but it is essential to explore all labor and delivery interventions collaboratively. This is critical to support informed consent.

- Four context considerations: 1) treating adverse pregnancy history as a risk factor, 2) previous birth trauma, 3) trial of labor after C-section (TOLAC), and 4) managing chronic conditions that need multiple types of providers/medical care.
- In certain cases with especially complicated risk factors, it emphasized that attending an appointment does not guarantee reciprocal communication or understanding.

Hospital staff don't have longstanding relationships with a family, yet they have to help them during emergencies and lifechanging medical decisions.

- One particular area of concern is that medical staff have rotating shifts, so a family immediately post-loss may feel bombarded by different staff trying to check-in and provide information. This is best practice for medical staff, but to a family this may be overwhelming.
- Specific considerations: 1) limiting who meets with a family in the hours immediately after a loss (e.g. a single 'messenger' to communicate with family), 2) both mother and baby in intensive care/extended hospitalization, and 3) intentional space for the family to talk with no expectation.

Cesarean section (C-section) births are multifaceted, uniquely individual experiences that impact the birthing person and their reproductive health.

- Discussion highlighted how stigma can impact a person's perspective that their C-section, regardless of context, was "less-than" a vaginal birth.
- Both discussion and a Conversation About Loss (CAL) case revealed that some pregnant people may feel pressured into a C-section without fully understanding the clinical indications.

In six cases, bereavement support and grief resources were limited or declined.

- Both Conversation About Loss (CAL) cases provided unique insight into grief and how it evolved over the year after their losses. This revealed the need for periodic check-ins with families in the 6-12 months after a loss.
- Discussion focused on opportunities for individualized, non-reactive grief care and that there is no blanket solution to make sure all people are supported in their grief.

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.

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[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).

Conversations About Loss

Conversations About Loss (CAL) are discussions with people who have experienced stillbirth[1] or infant loss[2]. Public Health's Core FIMR team created the CAL program to provide an opportunity for people to share their loss story in a way that may be meaningful for them. The Conversation is focused on experiences before, during, and after the loss of their baby.

CAL is a qualitative approach to FIMR case conceptualization: Every CAL will help us learn firsthand about difficulties experienced, so we can change our systems for the better.

The CAL project just completed its pilot phase: We contacted several parents who experienced loss 8-12 months prior and offered a Conversation. In early 2025, we facilitated two Conversations! Then this quarter, we reviewed both cases with their CAL summarized. The cases included key quotes and themes from each CAL, which represented the birthing person's story in ways data and medical records cannot.

The consensus of FIMR participants is that CAL is crucial:

* Emphasized the importance of understanding an experience through the voice who lived it.
* Humanized the case by contextualizing that the death is connected to a real person and experience in our community, not just a medical synopsis to analyze.
* Direct quotes from CAL allowed for inclusion of how and what the parent experienced in their words and exact emotions. This removed assumptions that are common with case review, as it elevated lived experience, not what the providers observed or interpreted.
* Created a broader perspective and scope of the loss situation, which led to deeper and more meaningful case review.

We are truly fortunate to work in this space and hope to continue honoring loss through more Conversations. At this time, CAL are paused until we secure more support in the form of capacity and funding.

If you are interested in partnering with us to co-facilitate CAL or have opportunities and resources that could sustain our CAL initiative, **please email fimr@cityofmadison.com**.

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