FETAL INFANT MORTALITY REVIEW

September 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	5
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 September 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.

Infant and fetal medical concern(s) (7)

One or more maternal health issue(s) (6)

One or zero postpartum OB appointment(s) (6)

Mental health concerns across perinatal course (6) including (3) with substance use

Adverse birth situation (6) including C-section (2)

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Case Review Discussion Points

Across Pre-FIMR and Case Review Team meetings, 31 total partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Two cases involved sleep setting and respiratory illness.

- With respiratory illness or any respiratory compromise, an infant is at an increased risk of sleep difficulties.
- Discussion revealed different ideas on 'how', but all agreed on the need to shift infant sleep education so it is responsive and realistic to a family's needs, yet contextualizes ways to help baby sleep.

Dental needs during pregnancy continues to be a steady theme across FIMR cases over time.

- Specifically tracking this theme has reinforced how access is directly tied to insurance type: BadgerCare is a systemic barrier to dental care, as the availability of timely dental providers in Dane County who accept BadgerCare is low.
- Two cases needed urgent dental care during pregnancy, and both had BadgerCare. They both sought initial care at a hospital emergency department, then could not get into a dentist for 1-2 weeks.

Three cases had one or both parents who used substances, including alcohol. During the past seven (March 2024-September 2025) review cycles, at least one case every quarter had a caregiver with current or historical substance use.

- Group consensus was that alcohol consumption is normalized in WI and commonly viewed as different than 'substance use'. This can be seen through substance use screening when questions about alcohol are positive, no or minimal follow-up is done.
- Discussion highlighted two considerations: 1) substance use screening concurrently with mental health screenings both prenatally and postpartum; 2) follow-up questions and robust conversation with family/parent about impacts of alcohol consumption on caregiving.

The way certain systems are set up can dictate how families navigate services concurrently.

- This may force a family to prioritize getting a need met at the expense of another, or prolong a need not getting met in order to qualify for a service.
- One particular area of concern is when this involves housing: Housing assistance is impacted by how "need" is assessed by a local housing service, but having to navigate housing instability while being pregnant causes a cascade of harm.

Health literacy is impacted by individual, social, systemic, and situational factors.

- These factors include age, education, employment, housing, stress, trauma, missed appointments, multiple medical providers or systems involved, and complex medical needs. It is important to acknowledge that many of these factors are not in one's control, yet health illiteracy can be a barrier to adequate medical care.
- Two cases with very different factors limiting their health literacy had difficulty navigating medical care, monitoring medical needs, and no follow-through on repeated referrals.

Pervasive need for care coordination yet multiple missed opportunities, especially with medical or social complexities.

- In one case, the mother was distressed trying to navigate systems. This caused increasing distrust compounded by miscommunication from care teams.
- Discussion revealed two potential factors: 1) systemic barriers with limited time per appointment and 2) deficits in medical staff awareness of barriers to accessing certain resources.
- Discussion focused on opportunities to increase engagement with families through education and coordinating multiple services/providers at OB appointments.

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).