FETAL INFANT MORTALITY REVIEW

March 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.

11	9	5
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 6 **Infant: 5**

Records & Timeline

General timeliness is crucial for case review to identify and illustrate themes, trends, and factors 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 March case review cycle, the deaths reviewed happened during 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 issue (10) including hypertension (4) and diabetes (3)

Mental health concerns across perinatal course (7)

Adverse birth situation (7) including C-section (4)

One or zero postpartum OB appointment (6)

Placental insufficiency (5)

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Case Review Discussion Points

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

In seven cases, the mother's weight was categorized as overweight or obese. Out of these seven, five had minimum one chronic condition.

- With maternal health issues as one of the most common themes across FIMR cases, discussion centered on how to improve care for chronic conditions during pregnancy, but also management before a person gets pregnant, and that this management must factor in social determinants.
- Discussion emphasized the importance of interconception (between pregnancies) medical care to identify all risk factors, in order to concretely work towards management and promotion of general reproductive health.

The timing of postpartum OB appointments widely varied, regardless of birthing situation.

- For the cases with one OB appointment, that appointment was at or before 3 weeks postpartum.
- For the cases with at least two, all had their first OB contact by 2 weeks and nearly all had an OB appointment around 5-6 weeks postpartum.

"Count the Kicks" is a method to monitor and document fetal movement during pregnancy. This monitoring can signal to a pregnant person that their baby's movement has changed.

- Several cases had no documentation of this method being taught, yet one case did document "Count the Kicks" as reason for noticing decreased fetal movement.
- Discussion revealed potential discrepancy across healthcare systems and clinics with varying levels of "Count the Kicks" being taught.

Seeking needed care and accepting referrals varied, which may reflect the significance of both the content of information and the way it is communicated.

- In certain cases, even if a resource or referral is needed, the birth person/family declined or did not follow through on a recommendation.
- Discussion highlighted complex factors that may impact acceptance of referrals or support: 1) who is the messenger, 2) literacy and comprehension level, 3) cultural and social context, 4) trust, and 5) capacity to self-navigate information.

How can referrals and resources be increased for all birthing people and their families during perinatal care?

- This question stems from the need for standardized wraparound care that could be built into the perinatal care model.
- Three particular contexts of concern: 1) historical or existing mental health concerns, 2) social isolation, and 3) folks who recently immigrated.

A major need in Dane County is services and support for pregnant people who recently immigrated.

- Group consensus acknowledged that this need is greater than services currently available and we have few bilingual/bicultural providers.
- This has created built-in barriers for providers to navigate in order to find appropriate services, potentially perpetuating vulnerability of an already vulnerable situation.

Two Noteworthy Protective Factors

- The current prenatal care model schedules the first prenatal appointment during the first trimester, or by 12 weeks: seven cases met this timing.
- All the cases with reported food insecurity were enrolled in the Special Supplemental Nutrition Program for Women, Infants & Children (WIC).

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).

FETAL INFANT MORTALITY REVIEW

June 2025

Quarterly Meeting Summary

What We Do

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11	9	2
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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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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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.

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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.

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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.

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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