

FETAL & INFANT MORTALITY REVIEW

Quarterly Meeting Summary September 2026

What We Do

Fetal and Infant Mortality Review (FIMR) aims to prevent stillbirths¹ and infant² deaths in Dane County. FIMR is an evidence-based, community-driven strategy.

Through quarterly review meetings, cases are comprehensively analyzed to understand circumstances facing individuals, families, and systems in Dane County.

During Quarter 3:

13	>	3
Cases were reviewed by Public Health		Cases were reviewed by the Case Review Team
Stillbirth (7) + Infant (6)		Stillbirth (1) + Infant (2)

Records & Timeline

Dane County FIMR monitors all stillbirths and infant deaths. General timeliness is crucial to identify trends and prevention factors while they are relevant. We abstract cases as timely as records are available and aim to review within 1 year of the death.

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 2024-2026.

Themes

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



One or more maternal health issue (13)



Fetal and infant medical concerns (11)



Adverse birth situation (9) including C-section (6)



Food insecurity (9)



Placental insufficiency (7)

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Case Discussion Points: September 2026

30 partners participated in FIMR during the September case review cycle. These points reflect both major discussions and commonalities between cases.

Two cases involved sleep setting and respiratory illness.

- Both cases involved 1) a non-birthing parental caregiver, 2) other children in the home supporting childcare, 3) bed-sharing with an adult, and 4) items in the sleep setting.
- Discussion identified opportunities to reach other infant caregivers through sleep education across more settings: community campaigns, standard resources given by non-medical organizations, and teaching curriculums in schools and childcare courses.

Systemic nuances of sleep education: Absolute adherence framework impacts self-disclosure.

- Group acknowledged unintended consequences and how it disregards real life practices: the current framework minimally allows for exploration of why a family may bed-share, which could be connected to cultural practices, physical limitations, or other reasons.
- Discussion identified opportunities for organizations external to medical systems to standardize risk mitigation sleep conversations.

Two cases involved a non-birthing parent caregiver who was impaired by substances at the time preceding the infant's death.

- In these cases, both parents had substance use issues. Yet until the death investigations, there was no documentation of anyone else in the home with substance use, only documentation of the birthing person's use.
- Discussion identified opportunities to better engage and monitor: 1) ask mothers if anyone in their home uses substances, including alcohol; 2) assess for postpartum alcohol use risk during prenatal care; and 3) co-create a 'sleep plan' to map out alternative infant sleep arrangements for when/if a parent or caregiver might use.

Nine cases had BadgerCare/Medicaid insurance. All had unmet needs within the Social

Determinants of Health (SDoH) domains.

- Two notable SDoH: 1) seven cases had housing concerns and 2) seven had financial stressors.
- In a few cases, a twofold barrier was timeliness of support services and availability within BadgerCare coverage window.
- One theme is language access and the impact of not receiving care or services in the family's language.

All 13 cases had at least one maternal health risk factor.

- The number of birthing people with at least one [pregnancy risk factor](#) is increasing in WI and Dane County – notable factors for cases this quarter with number of cases in parentheses:
 - History of adverse or poor perinatal outcome (7)
 - 35 years or older birthing person (6)
 - Short interpregnancy interval (3)
- Discussion identified specific considerations: 1) risk of recurrence, 2) repeated loss, 3) how to increase care for chronic or underlying health concerns beyond pregnancy, and 4) broader health education on pregnancy risk factors.

In Dane County, birthing people who experience food insecurity during pregnancy are more likely to experience gestational diabetes and preeclampsia ([Data Book](#), p.11).

- Of the six cases with gestational diabetes, five had food insecurity.
- Of the four cases with chronic or gestational hypertension, all four had food insecurity.



Fetal Infant Mortality Review is how we honor families who have experienced stillbirth and infant loss. We are grateful for every FIMR support and participant for being engaged in this difficult work. Thank you for reading this report!

¹**Stillbirth** (fetal death) is defined as an intrauterine death at least 20 weeks gestation or a delivery weight of at least 350 grams ([Wis. Stat. § 69.18\(1\)\(e\)](#)).

²**Infant death** is defined as a death of a liveborn child before one year of life ([CDC](#)).