FETAL INFANT MORTALITY REVIEW

September 2024
Quarterly Meeting Summary

What We Do

The Dane County Fetal and Infant Mortality Review (FIMR) aims to prevent pregnancy loss and infant deaths 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 solutions.

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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: 3 Infant: 6

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 September case review cycle, the deaths reviewed happened during 2022-2024.This does not necessarily mean the pregnancy and birth occurred in the same year.

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.

- Limited bereavement support (8)
- One or more maternal health issues (7)
- One or zero postpartum appointments (6)
- Inconsistent or limited prenatal care (5)
- Mental health concerns across perinatal course (5)

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Major Case Review Discussion Points

During both Pre-FIMR and Case Review Team meetings, 28 partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Person-centered and wraparound care must meet at the intersection of harm reduction and trauma-informed approaches.

- These approaches prioritize respect, compassion, and collaboration to foster support and trust. Discussion emphasized that this multi-faceted, individualized approach is crucial to caring for people and families in complex situations.
- Group consensus about difficulty screening for environmental factors and social determinants of health led to discussion on the importance of building a trusted relationship as the foundation to initiate conversations around challenges. The level of trust may be more realistic for certain types of providers and settings.

Three of the cases involved a caregiver with current or historical substance use.

- Specific considerations: 1) generational or whole-family substance use, 2) perinatal recovery planning, and 3) impact on environment and home dynamics.
- Discussion highlighted the importance of substance use screening during all perinatal periods and the need for whole family resources.

Considerations for birthing people and families with prior pregnancy and infant loss, especially extensive loss histories.

Discussion revealed the potential long-term impact of loss on future pregnancies, relationships, mental health, stress, and behaviors.

Significant and varied impact on children who experience the loss of their infant sibling.

Areas of concern: 1) during death investigations, 2) direct witness of traumatic death, 3) trauma and grief support, and 4) provider education of on age-appropriate responses to trauma.

If the infant death required investigation at multiple levels, this commonly took a year or longer.

- Communication with the family on cause and manner of death were seemingly delayed in the cases, and when they did receive communication, it commonly caused frustration or confusion.
- Communication between investigative systems and families significantly varied.

There are opportunities to talk with families about safe sleep that are realistic and relevant to their lives, but sleep education is stigmatized and commonly punitive.

Discussion highlighted barriers to individualized sleep education using a lens of harm reduction: how to bring in protective factors for sleep, based on a family's situational context, structure, and their environment.

Grouped Case Review

The FIMR model involves grouped review with cases that have similar causes of death, situationally alike, or specific factors. Grouped case review allows for comparison across similar cases to identify commonalities related to upstream themes and areas of intervention.

Dane County FIMR has not facilitated grouped case review in recent years, until this September case review cycle. The theme was infant deaths with Medical Examiner autopsies that had cause and manner of death classifications. Three cases were classified as injury-related and one was classified as Sudden Unexpected Infant Death (SUID).

Fetal and Infant Mortality Review is an important way to honor families that have experienced fetal and infant death. FIMR is a needed process that works toward preventing tragedies, but we also want to acknowledge the heaviness of this work. We thank every FIMR support and participant for being engaged in this difficult work.