



# Child Death Review and Fetal Infant Mortality Review Programs

## Secretary's Advisory Committee on Infant Mortality (SACIM)

*September 21, 2021*

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**Director, Division of Child, Adolescent and Family Health**  
**Maternal and Child Health Bureau (MCHB)**

**Vision: Healthy Communities, Healthy People**



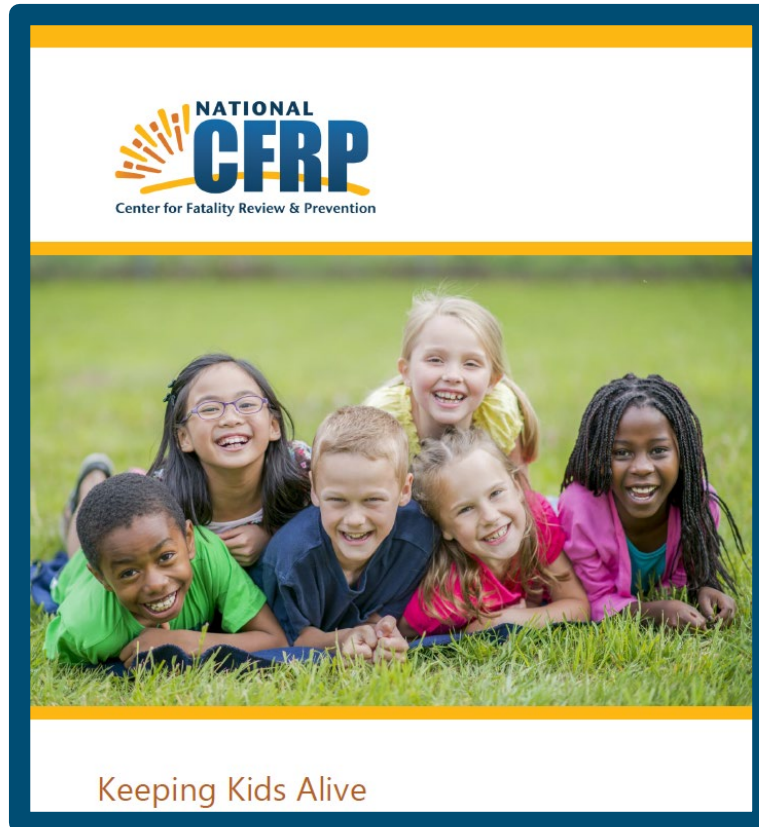
# HRSA's Maternal and Child Health Bureau

- **Mission:** To improve the health and well-being of America's mothers, children, and families.
- **Vision:** An America where all mothers, children, and families are thriving and reach their full potential.

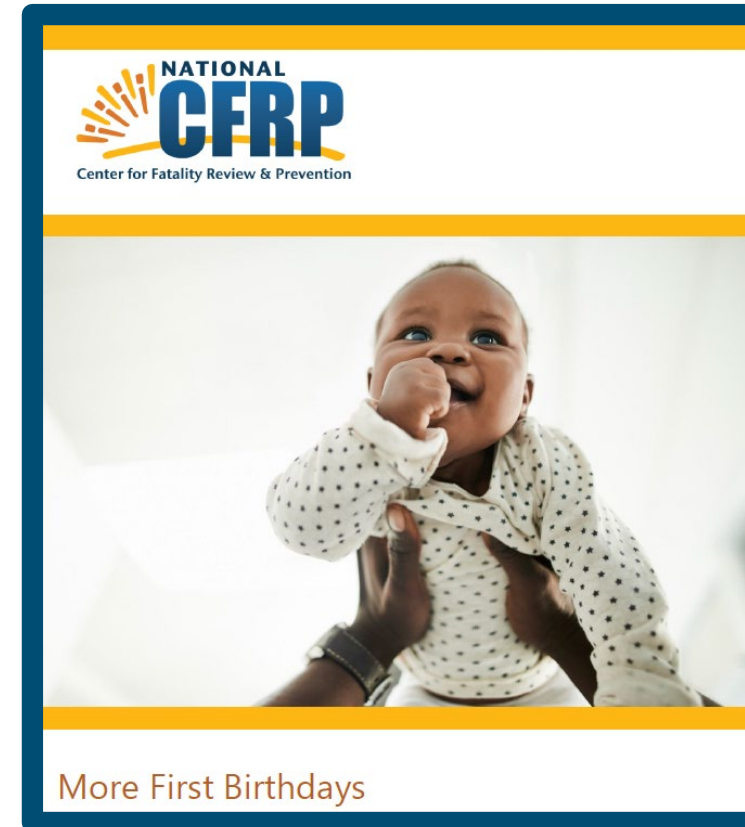


# National Fetal, Infant, Child Death Review Program

## Child Death Review

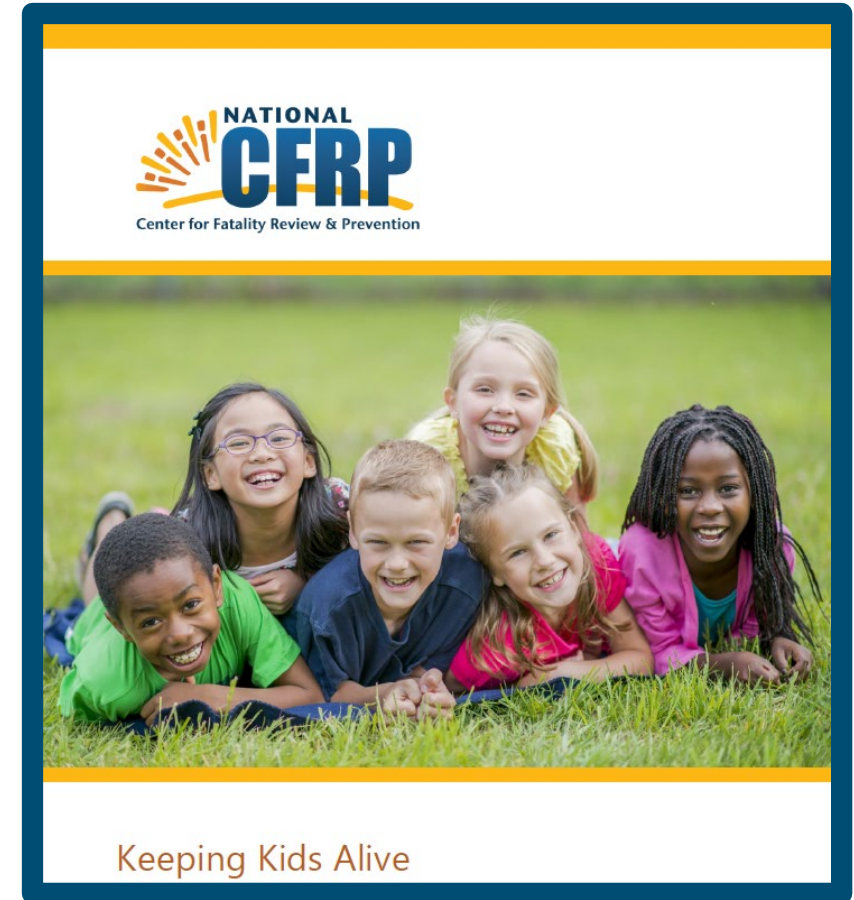


## Fetal, Infant Mortality Review



# Child Death Review

**Child Death Review (CDR)** is a multidisciplinary process where teams meet to discuss case information to better understand how and why children die and to inform prevention efforts to reduce future child fatalities.

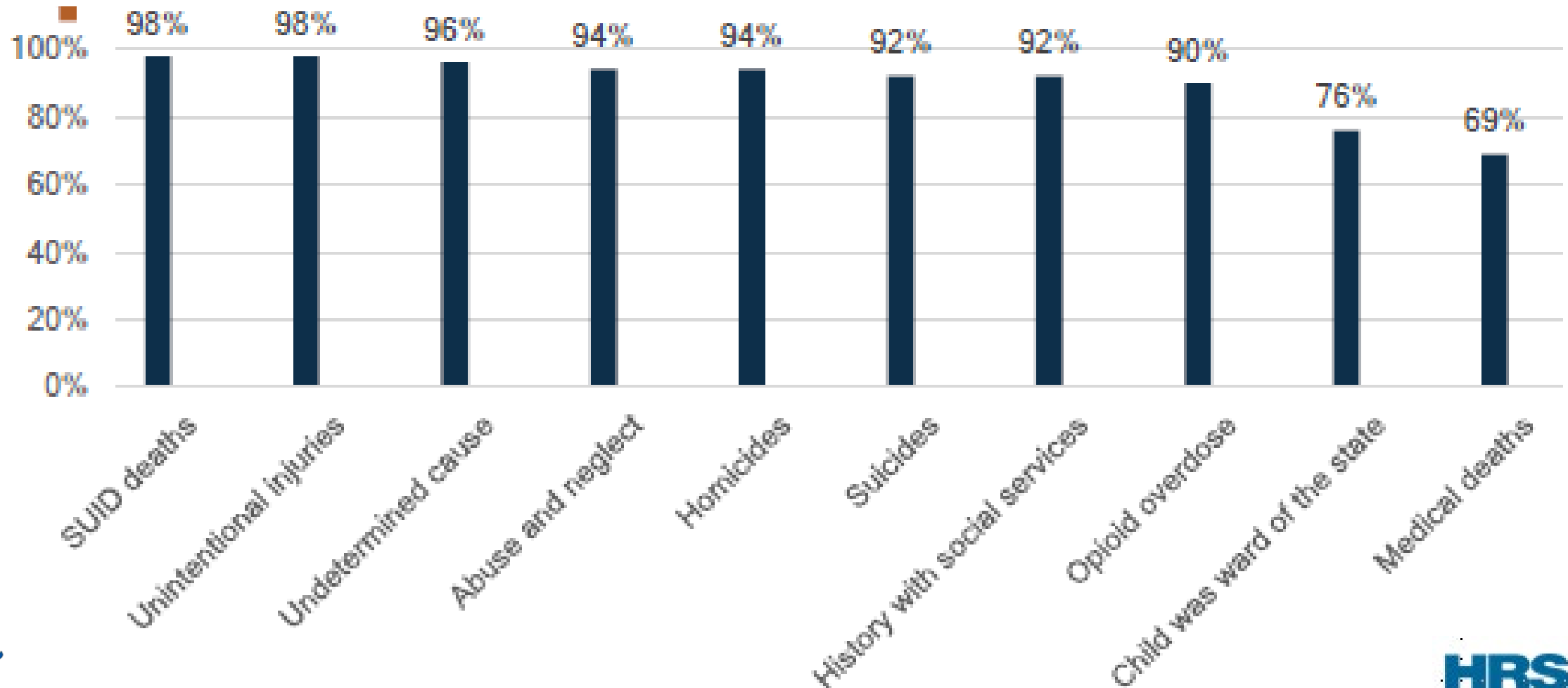


# CDR Programs in the US

Sites	State Legislation	Lead Agency	Funding
<ul style="list-style-type: none"> <li>• 1,350 CDR teams</li> <li>• 50 states &amp; DC</li> <li>• 9 states have tribal CDR teams</li> </ul>	<ul style="list-style-type: none"> <li>• 44 states mandate or permit state CDR teams</li> <li>• 27 states mandate or permit local CDR teams</li> </ul>	<ul style="list-style-type: none"> <li>• 29 States led by State Health Department</li> <li>• 10 States led by Social Service Agency</li> </ul>	<ul style="list-style-type: none"> <li>• 23 Title V Funds</li> <li>• 22 SUID/SDY Case Registry funds</li> <li>• CAPTA</li> <li>• State Funds</li> </ul>



# Case Selection: Varies by State



# Child Death Review Process

**CDR Team  
Members  
Provide  
Information**

**CDR Team  
Reviews Case**

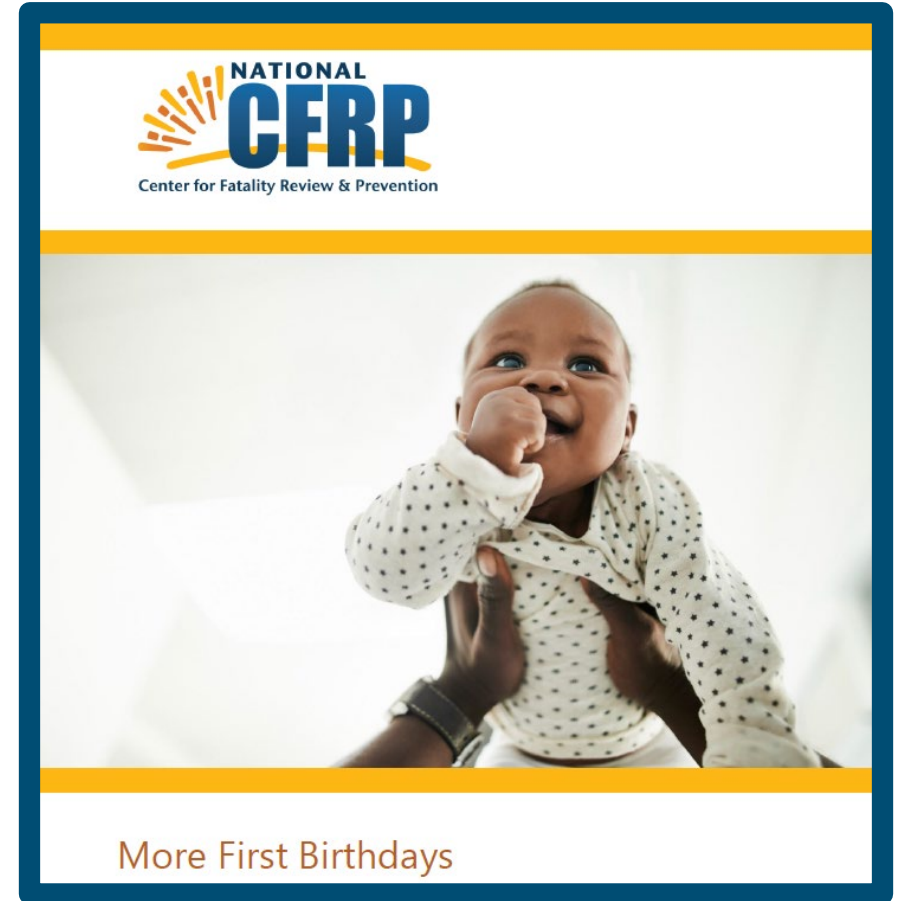
**Identify  
preventable  
deaths/risk and  
protective  
factors**

**Catalyze  
Prevention  
Efforts**  
(43 State Advisory Boards)



# Fetal Infant Mortality Review

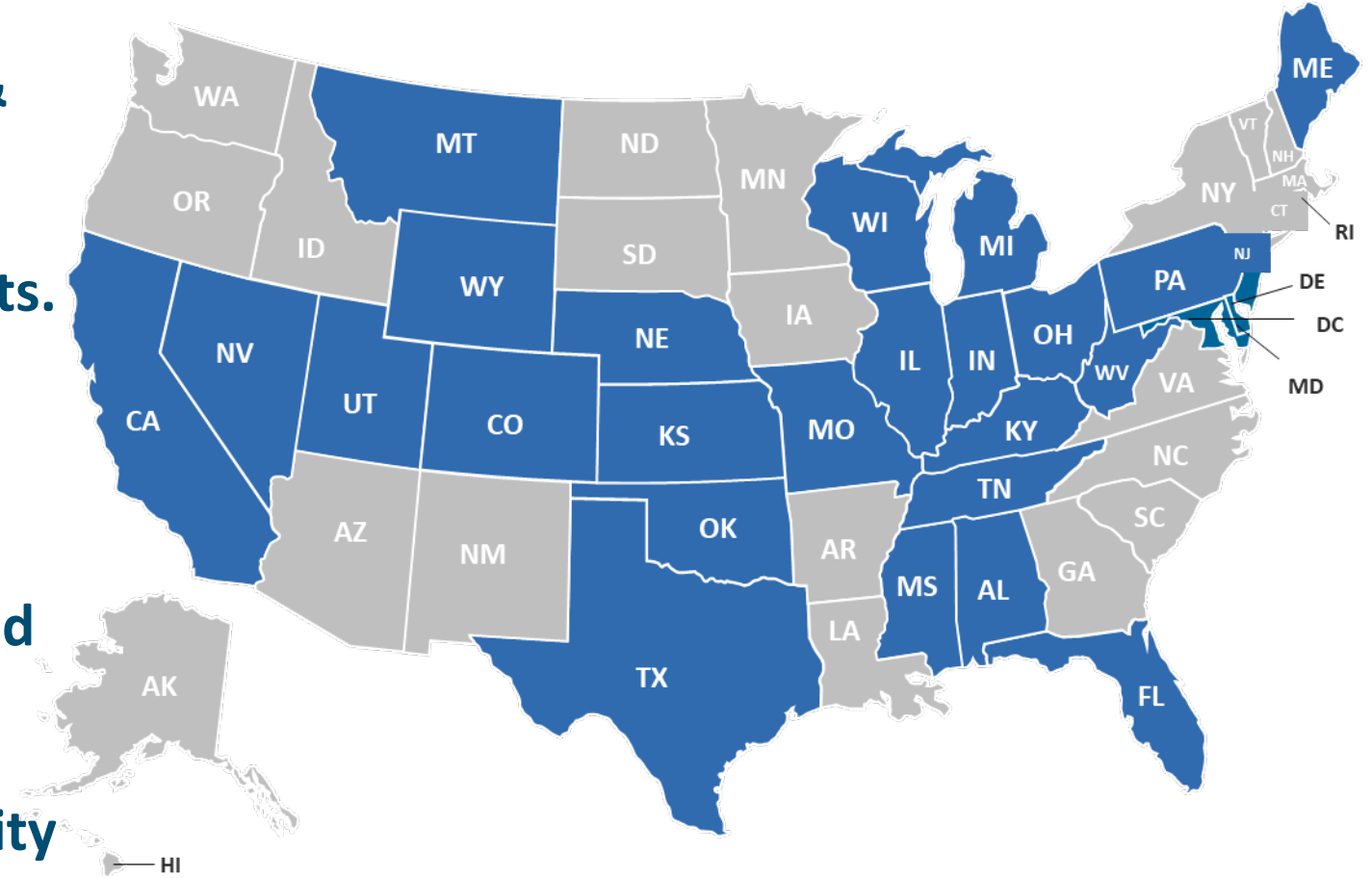
**Fetal Infant Mortality Review** is a community-based, action-oriented process of reviewing de-identified fetal and infant death cases to make recommendations and develop and implement innovative local actions that improve systems of care, services, and resources for women, infants, and families.





# FIMR Programs in the United States

- 154 local FIMRs in 27 States, DC & US territories
- 82% led by state/local health depts.
- Authorization is mainly through local public health surveillance
- 72% funded by Title V & supported by Healthy Start Program
- Case Selection varies by community



Blue States have FIMR Teams

# Fetal Infant Mortality Review Process

Records abstracted, de-identified

**Family Interview**

**Case Review Team**  
Reviews data & develops recommendations

**Community Action Team**  
Uses recommendations to develop solutions

Implements system/policy prevention efforts




# CDR & FIMR Data

Case Sections

- # - Case Definition
- A - Child Information
- A1 - All Ages
- B - Biological Parents
- C - Primary Caregivers
- D - Supervisor
- E - Incident
- F - Investigation
- G - Cause of Death
- I - Circumstances
- I1 - SDY
- I2 - Sleep Related
- I3 - Consumer Product
- I4 - Another Crime
- I5 - CAN/Supervision/Hazard
- I7 - Life Stressors
- I8 - COVID-19 Related Deaths
- J - Person Responsible
- K - Services
- L - Findings
- M - Review
- N - SUID and SDY
- O1 - Narrative
- P - Form Completion

Save and Exit

Saving Lives Together



Case saved successfully

CDR - Enter Case Information [47-01-2021-00005] [Print this section](#)

Section A1: All Ages

1. Child's name  Unknown

First  Middle  Last

2. Child's date of birth  Unknown

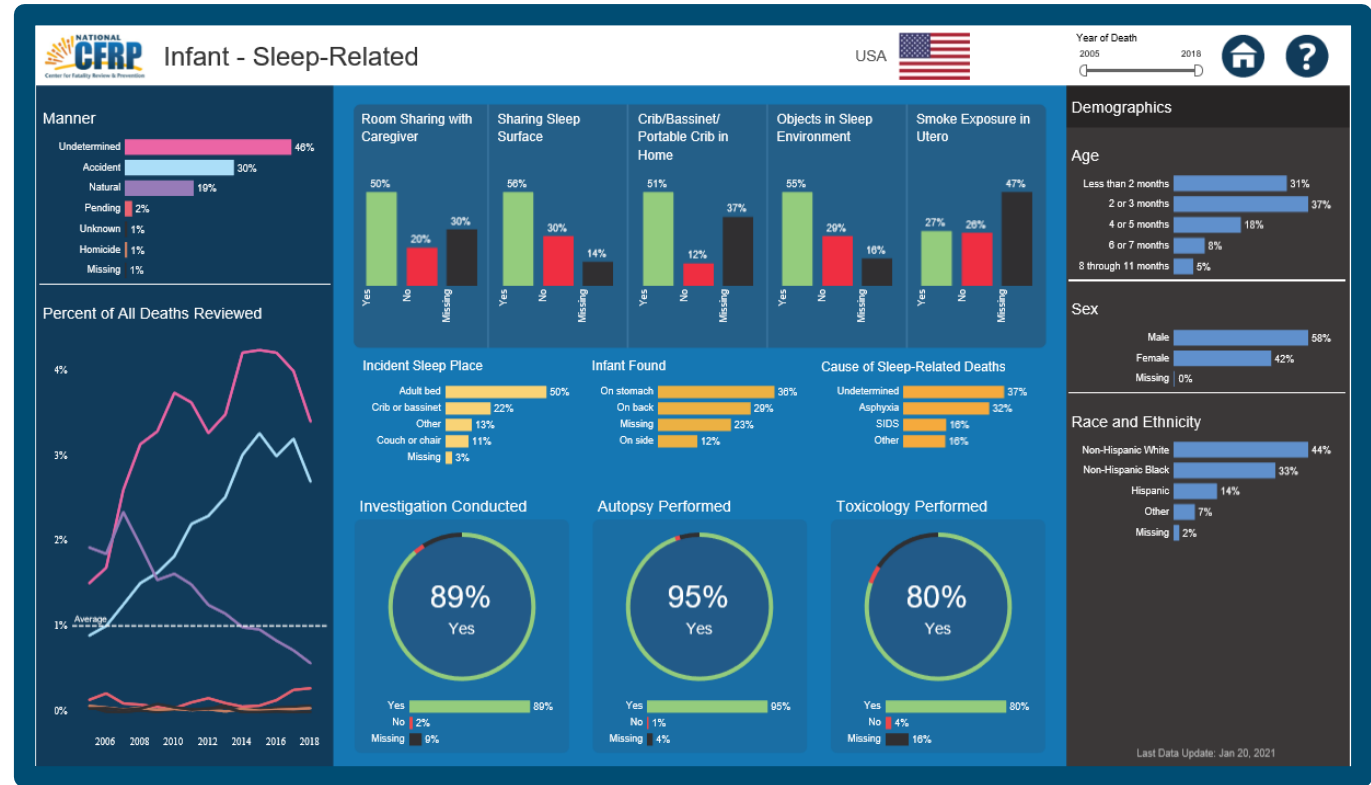
3. Child's date of death  Unknown

4. Child's age  Unknown

5. Child's race

White  
 Black  
 Asian  
 American Indian  
 Alaska Native  
 Native Hawaiian  
 Pacific Islander  
 Unknown


6. Child of Hispanic or Latino origin?  Yes  No  Unknown [Deselect answer](#)



# National Fatality Review-Case Reporting System

## National Fatality Review-Case Reporting System (NFR-CRS):

- Web-based, standardized case reporting platform
- Enter case data and summarize findings
- Review team recommendations
- Create standardized reports

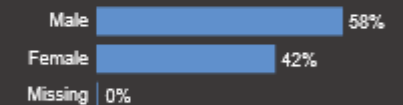
 **NATIONAL CFRP** Infant - Sleep-Related  
Center for Fatality Review & Prevention

### Demographics

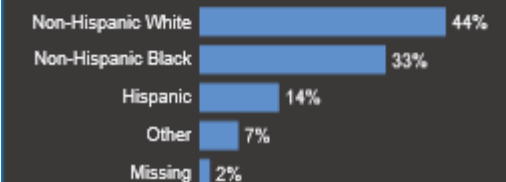
#### Age



#### Sex




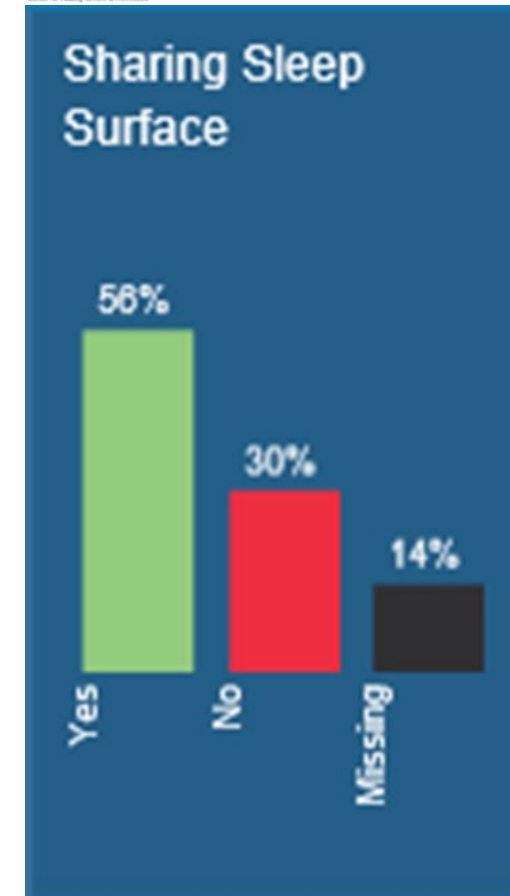
#### Race and Ethnicity



# CDR & FIRM Data Overview

- 47 states use NFR-CRS
- 50% of CRS cases are infant deaths = 127,348 cases
- Represents ~33% of all infant deaths
- 3,263 FIMR team cases are in the CRS
- Most common causes of infant deaths reviewed:
  - congenital anomaly
  - prematurity
  - asphyxia
  - SUIDS

 Infant - Sleep-Related



# CDR & FIRM Data: Dashboard



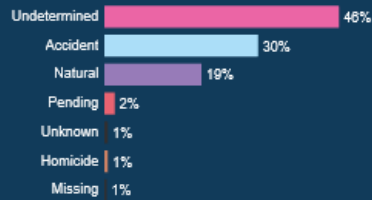
Infant - Sleep-Related



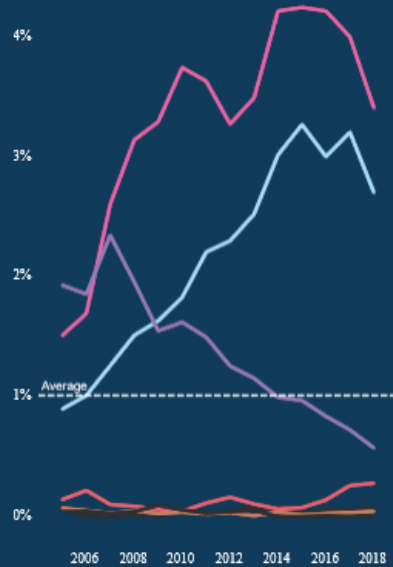
Year of Death  
2005 2018



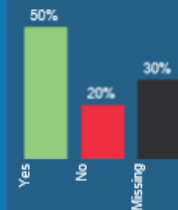
## Manner



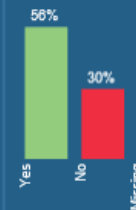
## Percent of All Deaths Reviewed



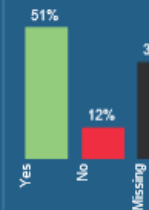
## Room Sharing with Caregiver



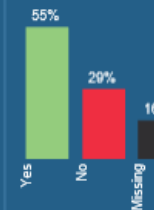
## Sharing Sleep Surface



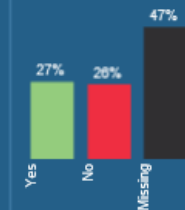
## Crib/Bassinet/ Portable Crib in Home



## Objects in Sleep Environment



## Smoke Exposure in Utero

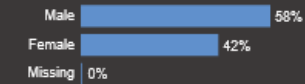


## Demographics

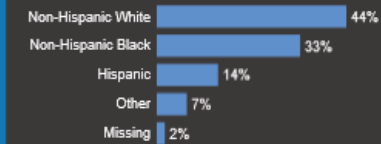
### Age



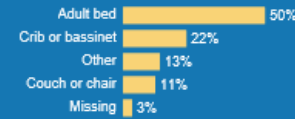
### Sex



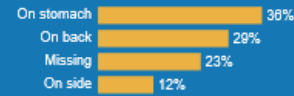
### Race and Ethnicity



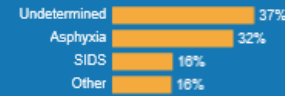
## Incident Sleep Place



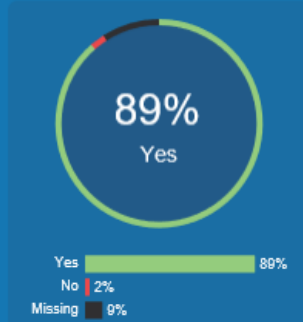
## Infant Found



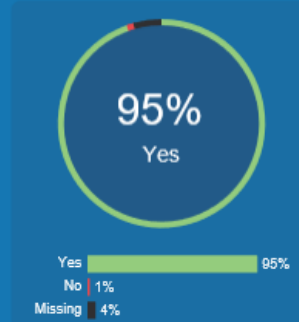
## Cause of Sleep-Related Deaths



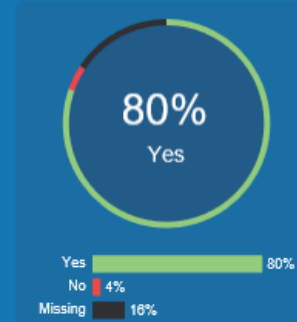
## Investigation Conducted



## Autopsy Performed



## Toxicology Performed



Last Data Update: Jan 20, 2021



# Impact of COVID on Fatality Reviews

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- **CDR and FIMR Teams**
  - Delayed reviews
  - Virtual reviews
  - State and local staff reassigned to COVID response
- **National Center Response**
  - New COVID questions added to NFR- CRS to identify cases directly or indirectly resulting from COVID
  - Tools for virtual reviews
  - Self care resources



# Fatality Review Impact: **Publications**

Anderson TM, Allen K, Ramirez JM, Mitchell EA. **Circadian variation in sudden unexpected infant death in the United States.** Acta Paediatrica. 2021 May;110(5):1498-504.

Burns KM, Cottengim C, Dykstra H, Faulkner M, Lambert AB, MacLeod H, Novak A, Parks SE, Russell MW, Shapiro-Mendoza CK, Shaw E. **Epidemiology of sudden death in a population-based study of infants and children.** The journal of pediatrics: X. 2020 Mar 1;2:100023.

Montgomery M, Conrey E, Okoroh E, Kroelinger C. **Estimating the Burden of Prematurity on Infant Mortality: A Comparison of Death Certificates and Child Fatality Review in Ohio, 2009–2013.** Maternal and child health journal. 2020 Feb;24(2):135-43.

Cottengim C, Parks SE, Lambert AB, Dykstra HK, Shaw E, Johnston E, Olson CK, Shapiro-Mendoza CK. **U-shaped pillows and sleep-related infant deaths, United States, 2004–2015.** Maternal and child health journal. 2020 Feb;24(2):222-8





# Fatality Review Impact: **System/Policy Change**

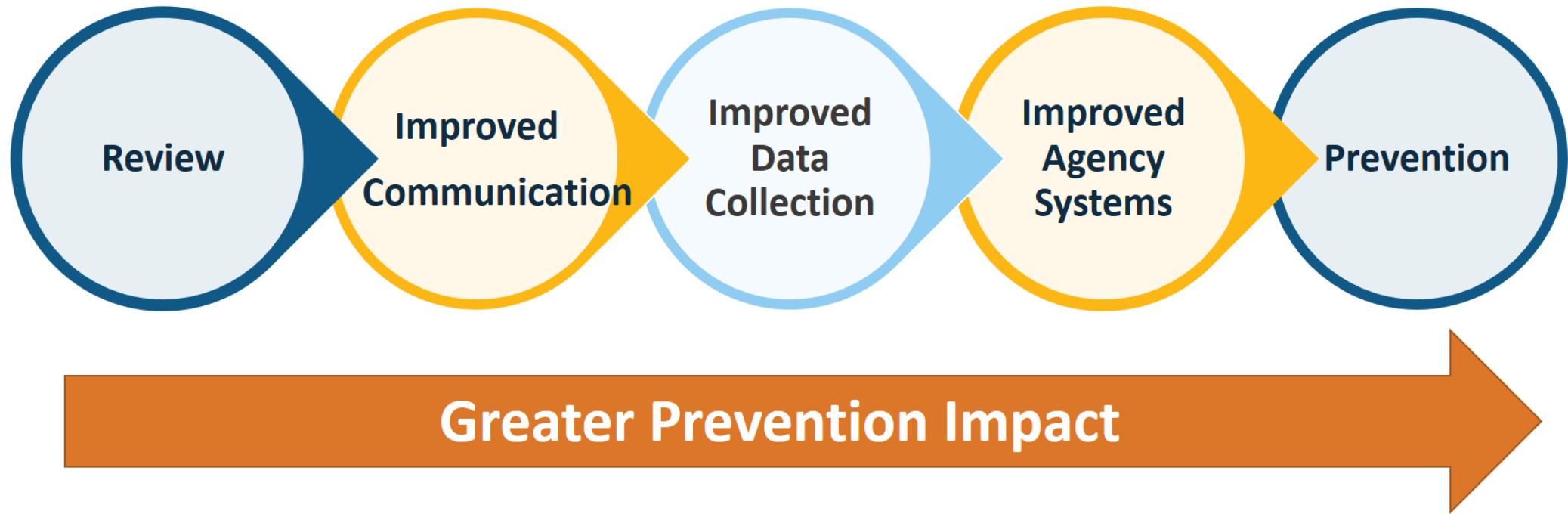
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**Wisconsin:** Safe sleep education to childcare providers

**Maryland:** Support obstetric care providers to complete the Prenatal Risk Assessment

**Colorado:** Paid parental leave

# Fatality Review Impact



# Discussion and Questions



# Contact Information

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**Health Resources and Services Administration (HRSA)**

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