Child Death Review and
Fetal Infant Mortality Review Programs
Secretary’s Advisory Committee on Infant Mortality (SACIM)

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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

Keeping Kids Alive

More First Birthdays
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

<table>
<thead>
<tr>
<th>Sites</th>
<th>State Legislation</th>
<th>Lead Agency</th>
<th>Funding</th>
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<tbody>
<tr>
<td>• 1,350 CDR teams</td>
<td>• 44 states mandate or permit state CDR teams</td>
<td>• 29 States led by State Health Department</td>
<td>• 23 Title V Funds</td>
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<tr>
<td>• 50 states &amp; DC</td>
<td>• 27 states mandate or permit local CDR teams</td>
<td>• 10 States led by Social Service Agency</td>
<td>• 22 SUID/SDY Case Registry funds</td>
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<td>• 9 states have tribal CDR teams</td>
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<td>• State Funds</td>
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Case Selection: Varies by State

- SUD deaths: 98%
- Unintentional injuries: 98%
- Undetermined cause: 96%
- Abuse and neglect: 94%
- Homicides: 94%
- Suicides: 92%
- History with social services: 92%
- Opioid overdose: 90%
- Child was ward of the state: 76%
- Medical deaths: 69%
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 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
Fetal Infant Mortality Review Process

1. Records abstracted, de-identified
2. Family Interview
3. Case Review Team
   - Reviews data & develops recommendations
4. Community Action Team
   - Uses recommendations to develop solutions
5. Implements system/policy prevention efforts
CDR & FIMR Data
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
**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
Impact of COVID on Fatality Reviews

- 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


Fatality Review Impact: System/Policy Change

**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

Review → Improved Communication → Improved Data Collection → Improved Agency Systems → Prevention

Greater Prevention Impact
Discussion and Questions
Contact Information

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