

Death review process

| | Child death review (CDR) | Fetal infant mortality review (FIMR) |
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| Cases reviewed | At a minimum, CDR teams review all deaths to children younger than age 18. However, many Wisconsin teams review deaths to children and adults younger than age 25. | FIMR teams review all stillbirths weighing more than 350 grams or 20 weeks gestation and all infant deaths occurring in the first year of life. |
| Purpose | CDR teams are comprised of professionals from a variety of agencies who identify risk factors and circumstances surrounding the death in order to prevent future deaths. | FIMR teams are comprised of professionals and community members from a variety of backgrounds who seek to improve maternal and fetal (stillbirth) health. |
| Membership | Representatives from the following professions are encouraged to participate in CDR: <ul style="list-style-type: none"> • Coroner/medical examiner. • Public health. • Law enforcement. • District attorney. • Pediatrician. • Child welfare. • School districts. • Mental health. • Hospitals. • Injury prevention (e.g., Safe Kids). • Community agencies. | Representatives from the following professions are encouraged to participate in FIMR: <ul style="list-style-type: none"> • Coroner/medical examiner/pathologist. • Public health. • Child welfare. • Pediatrician. • Obstetrician. • Perinatologist. • Neonatologist. • Nurse midwife. • Labor and delivery nurse. • Physician assistant. • Social service agencies. • Community agencies. • Community members. • Health insurance. • Mental health. • Women, infants and children programs. |
| Data | CDR data are collected in the National Center for the Review and Prevention of Child Deaths Case Reporting System. | A FIMR data system for Wisconsin is being developed. |