PROTECTING TOMORROWS:

Understanding and Preventing Maternal and Child Deaths

2025 ANNUAL REPORT

Delaware Maternal & Child Death Review Commission

The Delaware MCDRC REVIEW & PREVENTION OF MATERNAL AND CHILD DEATHS

A Report from

Delaware's Maternal and Child Death Review Commission

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Submitted to

The Honorable Matt Meyer, Governor

State of Delaware

Garrett H.C. Colmorgen, MD, Chair

Table of Contents

Executive Summary

Delaware's Maternal and Child Death Review Commission (MCDRC; the Commission) is made up of six interdisciplinary teams who review the deaths of infants, children, and mothers to better understand how similar deaths could be prevented in the future. MCDRC investigated 95 deaths in 2025. Key findings and actions include:

- **Stillbirths and Infant Deaths—Fetal and Infant Mortality Review (FIMR):**
    - Among 49 cases of this type, 53% were stillbirths (fetal deaths).
    - Delaware's FIMR team was able to review cases in almost real-time, with only a seven-month lag between death and review.
    - FIMR findings from prior years have informed the Delaware Perinatal Quality Collaborative's (DPQC) 4th trimester project. This project aims to increase the number of women who get early postpartum checkups and connected to care.
    - One in three FIMR cases involved difficulties and delays in a mother accessing prenatal care which affected her ability to recognize and manage pregnancy complications.
    - *What's Next:* Recommendations include advocating for a state-wide perinatal psychiatry consult program to increase the receipt of evidence-based care for perinatal mood and anxiety disorders, reinvigorating a fetal movement tracking education campaign for pregnant women, and educating the public more widely about the risks of cannabis use during pregnancy and while caring for young children.
- **Maternal Deaths—Maternal Mortality Review (MMR):**
    - Eight maternal death cases were reviewed in 2025.
    - Women who died during and after pregnancy often had many significant stressors such as chronic disease, difficulty accessing health care and traumatic life experiences.
    - Overdose remain the leading cause of maternal deaths for a sixth consecutive year, often involving the overlap of mental health conditions, substance use disorder (SUD) and social risk factors.
    - MMR findings from prior years have informed the DPQC's peer support doula program to help women impacted by SUD during and after pregnancy.

- *What's Next:* Recommendations emphasize the importance of educating the public on the risks of return to drug use after a period of abstinence given the deadly mix of drugs on the street, promoting a culture of respectful maternity care, and reducing delays in enrolling pregnant women in Medicaid.

- **Child Deaths—Child Death Review and Sudden Death in the Young (CDR/SDY):**
  - Among 38 child deaths, 9 were infant deaths and 29 were deaths of children aged 1-17.
  - Families who lost a child often faced multiple challenges like financial strain, unstable housing, domestic violence and mental or behavioral health issues.
  - Nine sudden, unexpected infant deaths were linked to unsafe sleep environments (such as soft bedding or the baby sleeping somewhere other than a crib). There were usually multiple, overlapping environmental hazards that put the baby at risk for suffocation.
  - The Cribs for Kids (C4K) program, promoting safe sleep environments, expanded significantly, engaging partners throughout the state.
    - C4K partners distributed 494 cribs, a 32% increase from the prior year.
    - 35% of C4K recipients were Hispanic families.
    - Twelve trainings on infant suffocation prevention were held with new or existing C4K partners, helping to ensure that safer sleep environments reach more communities statewide.
  - *What's Next:* The MCDRC will increase offerings of C4K educational materials on infant safe sleep to include family friendly resources in Spanish and Haitian Creole.

- **Community Engagement:**
  - The Commission shifted its community engagement strategy to focus on social media platforms to share information on its work, and disease prevention and health promotion tips for women, children and families.
  - The Commission convened one public meeting--in conjunction with the DPQC--to share its findings and recommendations from the prior year with partners and community members.

Introduction

Every child and family hold tremendous promise. Protecting health and well-being is fundamental to the values we share in Delaware. When untimely deaths occur, they represent not only a tragic loss but also a call to action.

The Maternal and Child Death Review Commission (MCDRC; the Commission) seeks to learn from the loss of infants, children, and mothers in Delaware, meticulously examining fetal, infant, child, and maternal deaths to uncover preventable causes. This work is driven by the knowledge that we have the ability to safeguard lives and foster healthier futures. The work of Delaware's maternal and child health partners has already made a remarkable difference: between 2000 and 2021, the state achieved a 36% decrease in infant mortality.[1] By continuing to study the circumstances surrounding maternal and child deaths, we can strengthen support systems, address unfair and uneven conditions that can complicate pregnancies and births, and ensure that every child and family gets a strong, healthy start.

This report shares what the Commission has learned in its review of deaths in 2025. The findings show that women's mental well-being bears on their health and pregnancy experience, significant social stress puts families at risk for untimely deaths, and providing extra support to these families at highest risk can help them take care of themselves and their children for the most productive and healthy lives possible. This knowledge calls us to take continued action to reduce these avoidable deaths and their ripple effects on our communities.

This report unfolds in five parts:

- Key developments in the Commission's work during 2025
- Findings and recommendations from review of stillbirths and infant deaths
- Findings and recommendations from review of maternal deaths
- Findings and recommendations from review of child deaths and sudden deaths in the young
- Appendices with more details, data, and definitions

[1] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2021*. Delaware Department of Health and Social Services, Division of Public Health: 2024.

Key Developments

While the work of preventing maternal and child death in Delaware is well-established and ongoing, 2025 was a year that involved new perspectives and important changes.

Building on the lessons and successes achieved, the Commission increased its focus on working closely with maternal and child health partners, bringing more partners to the table and deepening efforts undertaken in partnership. This increased collaboration is necessary to make faster progress on issues that cause higher rates of preventable deaths in lower-income communities, rural communities, and communities of color.

Commission staff also created new and varied types of data products to get information on its works and findings out to partners and the public. The following data products were released in 2025:

- A data brief analyzing five years of findings and recommendations from infant unsafe sleep-related deaths
- A data brief analyzing five years of maternal overdose deaths
- A family-focused "Lactation after Loss" informational brochure offering information and support in English, Spanish and Haitian Creole
- A retrospective ten-year study of MMR cases, findings and recommendations published in the December 2025 issue of the Delaware Journal of Public Health

Partnerships in Action

The Commission values and continues to work with its long-time partners to review cases, reveal opportunities for prevention and act on recommendations. Review teams that carefully consider each death are made up of dedicated partners in medicine, nursing, behavioral health, public health, insurers, social work, education, child welfare, forensics, law enforcement, and community advocacy. The Commission's Community Action Team (CAT) had to be reconfigured due to funding uncertainty. Instead of a standing CAT, the Commission's community engagement strategy shifted. Staff began attending more partner events in the community to share educational materials and prevention strategies that bear on causes of death impacting women and children. A new communications consultant was hired to create social media messages on the Commission's work and share information promoting maternal and child health.

The Delaware Healthy Mother and Infant Consortium (DHMIC) and the Delaware Perinatal Quality Collaborative (DPQC) do important work to improve community-based and clinical care for women and infants. The DPQC oversees two initiatives that continued

in 2025 and that are based on findings from the Commission: their 4th trimester project seeks to improve smooth transitions and continuity of care in the postpartum, and their peer support doula program seeks to improve outcomes for pregnant and postpartum women impacted by substance use disorder (SUD) and their children. More partners and more collaboration are needed to do this work and bring everyone along.

National Funding to Conduct Thorough, High-Quality Reviews

The Commission had support from three federal grants to conduct its work in 2025. For high-quality reviews of sudden child deaths, funding from the Centers for Disease Control and Prevention (CDC) enables Delaware to participate in the Sudden Unexplained Infant Death (SUID) and Sudden Death in the Young (SDY) case registry. CDC support through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant funds dedicated staff to review maternal deaths and funds community engagement efforts to raise awareness on how to safeguard maternal and infant health. In addition, a grant from the National Center for Fatality Review and Prevention allowed for focused support to strengthen the Fetal and Infant Mortality Review (FIMR) program's ability to contact mothers, request an interview and offer them "Lactation after Loss" resources.

Stillbirths and Infant Deaths

Ensuring women are as healthy as possible before, during and after pregnancy is crucial to children being born healthy and having a strong start in life. Fetal and Infant Mortality Review (FIMR) looks closely at the systems to care for women during and after pregnancy to find opportunities to better support them. In 2025, 49 stillbirths and infant deaths were reviewed by the FIMR program. (For a description of how cases get selected for FIMR, see Appendix B.) These cases often include women at higher risk for pregnancy complications due to their medical or social conditions. Many cases also include babies who have genetic differences that affect their development. FIMR cases provide key insights on how women and babies with complications are cared for, and what can be done to improve their chances for the best possible outcome.

Noteworthy FIMR findings include:

- **The most common cause of infant deaths was prematurity, the baby being born too early.** Extremely premature infants are at the greatest risk of death, and 30% of infant deaths were babies who were born under 24 weeks gestation (6 months).
- **Birth defects accounted for one out of three stillbirths and infant deaths.** Compared to prior years of review, more 2025 cases were due to a birth defect that had a large impact on the baby's development in the mother's uterus.
- **Almost one in three women experienced a mental health condition, such as anxiety or depression, in the postpartum period.** Women who experience a loss due to stillbirth or infant death have an increased risk of anxiety, depression or another mental health condition. They need closer follow up and supports to help identify and reduce their suffering from mental health issues.
- **Cannabis and tobacco were the most commonly reported substances used by pregnant women.** There were missed opportunities by providers to counsel women on the effects these substances can have on their pregnancy and their developing baby.
- **Only half of eligible women received documented education on fetal movement tracking.** Tracking fetal movement, or fetal kicks, in the third trimester is one of the ways a woman can get to know her baby's pattern of movement and be able to notice if her baby's movements change. A change in the baby's kicks is a sign the baby may be having a problem in the uterus. Women who notice a change in their fetal kicks are advised to go to the hospital to get checked out.

Based on these findings, the MCDRC recommends these priorities:

1. **Make perinatal psychiatry consults available to all providers.** To help women who have mental health complications before or after pregnancy, we recommend the State and state agencies consider implementing a perinatal psychiatry consult program to offer providers real-time support to manage pregnant and postpartum patients with mental health or substance use issues.
2. **Increase the availability of educational materials and counseling on the effects of cannabis use in pregnancy.** To educate families about the risks of cannabis use during pregnancy and while caring for young children, we recommend that state agencies work with community partners on a public messaging campaign about the effects of cannabis use during and after pregnancy.
3. **Promote more options for women to track their fetal movements during pregnancy.** We recommend that the Division of Public Health (DPH) partner with Count the Kicks to reinvigorate a patient education campaign that includes the option of the Count the Kicks app.

More details on these findings, the analysis behind them, and the full list of FIMR recommendations follow.

Cases Reviewed

In 2025 multidisciplinary teams including nurses, women's health providers, social workers and geneticists reviewed 49 cases of stillbirths (also known as fetal deaths) and infant deaths. Eleven of these cases included a maternal interview which added meaningful detail about the mother's story of her pregnancy, health care, delivery experience and postpartum. The time between the occurrence of a death and case review was about seven months on average, so the information from cases represents women's recent experiences with the health care system.

Just under half of the FIMR cases were infant deaths. These deaths were most often due to the baby being born early (premature) or having a genetic difference (birth defect) that affected the baby's development while in the mother's uterus. None of the infants went home, their complications were serious enough that they remained hospitalized until they died, most often in the days to weeks after birth. Figure 1 provides details on the causes of the infant deaths reviewed by the FIMR team.

Stillbirths made up 26 of the 49 cases reviewed.[2] Figure 2 gives details on the causes of stillbirths determined by the review team. In about one out of four cases, the team could not identify a specific cause of death based on the information they had

[2] A stillbirth is when a baby dies inside the uterus and does not have any signs of life at delivery. For a full glossary of terms used in this report, see Appendix D.

available. When they could decide on a cause, birth defects, problems with the placenta or cord, or other pregnancy complications were the reasons identified for the stillbirths.

Figure 1

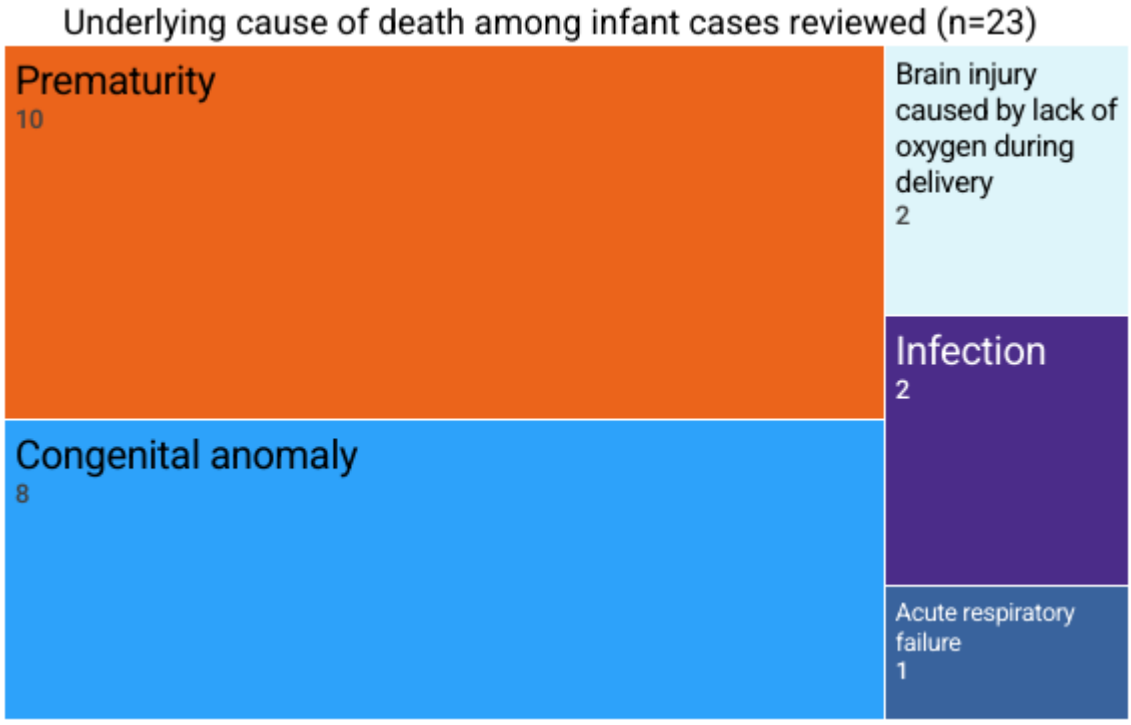
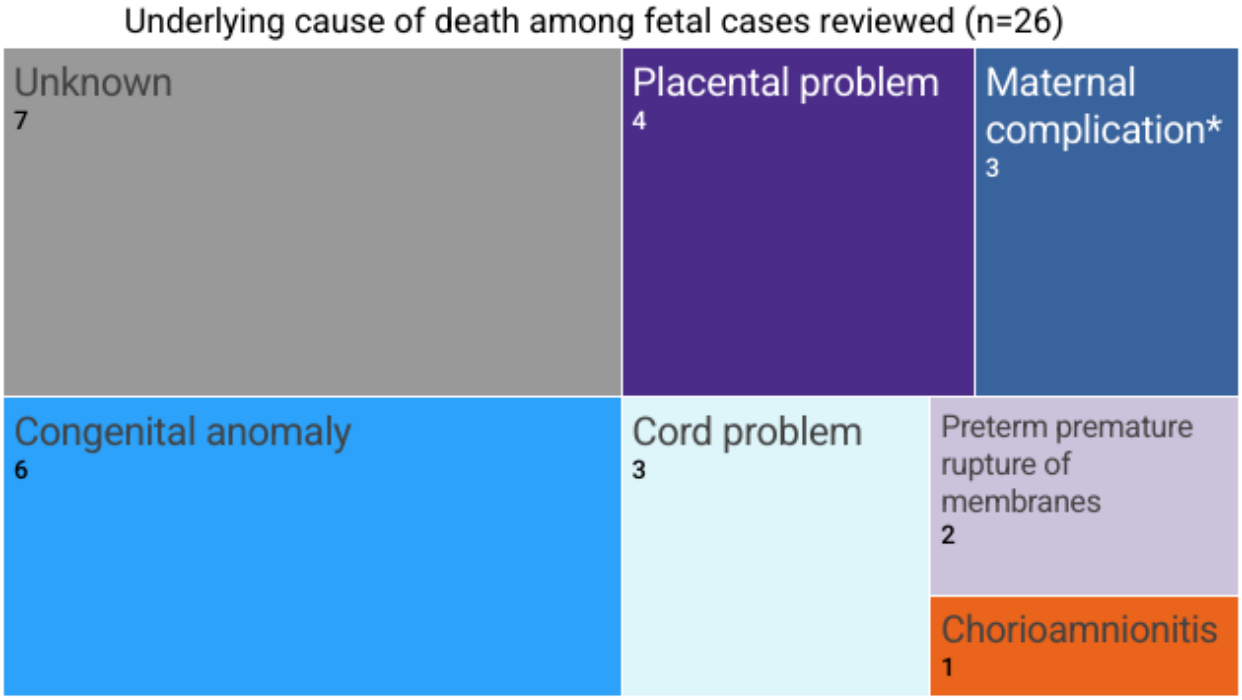


Figure 2



*Uncontrolled diabetes, hypertension, uterine problem

Patterns in the Data

FIMR uses a national database to guide the careful review of each case. The team tries to get as full a picture as possible of what happened to the mother during and after her pregnancy based on the available information. When a maternal interview is available, the information is much more complete and helpful to understand the mother's experiences, her challenges, stressors and any helpful resources that allowed her to get the care she wanted or needed.

Pulling together the data from the 49 cases and tracking trends over several years of reviews identify some important patterns in the 2025 group of cases[3].

Areas for Attention:

- **Over one-third of women (37%) had late or no prenatal care.** Half of women living in Kent or Sussex Counties had late or no prenatal care compared to 21% of New Castle County mothers. Women with Medicaid were three times more likely to have late or no prenatal care compared to those with private insurance.[4]
- **Postpartum care after a loss is essential and widespread—but is not reaching everyone.** Follow up care is particularly important for women who have experienced a stillbirth or infant death. Medical care can help address underlying conditions and mental health consequences and connect women who want to conceive again to the appropriate screening and levels of pregnancy care. It's good news that 70% of women were seen for a postpartum visit and most of them got an early checkup within 3 weeks after their delivery, which is an emerging best practice and part of the 4th trimester model of care. However, 30% of women did not get connected to postpartum care, so there is still room to improve hospital and clinic practices to ensure fewer women are lost to follow up.
- **More women had a short time between pregnancies.** Having less than 18 months between pregnancies can increase a woman's risk of having a complication. Thirty-nine percent of mothers in the 2025 group of cases had a short interval between their prior pregnancy and the one resulting in a loss. Fewer women—only 7%--had a preconception visit, one in which they saw their doctor to help plan for their most recent pregnancy.
- **Sixty-one percent of infant deaths reviewed in 2025 involved Black babies.[5]** The percent of FIMR cases involving Black babies is higher than expected, and this was

[3] For additional details, see Appendix A: Key 2025 Facts and Figures and the 2025 Annual Report Data Addendum.
[4] For more details, see the 2025 Annual Report Data Addendum.
[5] The term Black refers to persons who have a single race identified as Black and are non-Hispanic. See the glossary in Appendix D for definitions of terms to describe subpopulations by race and ethnicity.

particularly true among infant deaths. Black babies make up about one in four babies born in Delaware, but they make up almost half of all FIMR cases reviewed (45%) and 61% of infant deaths reviewed.

Promising Trend:

- **Screening for social needs that can affect health is increasing.** Just over 80% of women were screened at some point in their care for health-related social needs, such as their having a safe place to live, adequate money for food and transportation. This is a higher rate of screening than in the previous year. The most common social needs identified were concerns about money (41%) and inadequate or unreliable transportation (16%).[6] Screening for health-related social needs is the first step in offering families more support and empowering them to get the care they want.

Learning from Reviews: Maternal Health in Action

Maternal Health in Action

A key partner of the MCDRC's work is the Delaware Perinatal Quality Collaborative (DPQC), a group representing all birthing facilities in Delaware with the participation of obstetric and pediatric staff. Based on FIMR and MMR findings highlighting the need for additional supports in the postpartum period, the DPQC developed an initiative to get more women seen for an early postpartum checkup. DPQC members acted upon FIMR data revealing that about 30% of women with a pregnancy loss were not seen for a postpartum visit and on MMR data that showed that the riskiest period for a maternal death is the postpartum.

The DPQC was awarded a federal grant in 2024 to support its postpartum initiative based on the 4th trimester model of care, a model promoting continuous, uninterrupted transitions from prenatal, delivery to postpartum and well woman care. The initiative's aim is to have all birthing hospitals schedule an early postpartum visit within 3 weeks of delivery prior to hospital discharge. This visit information then becomes part of the patient's discharge instructions.

The DPQC will be implementing its 4th trimester project in 2026 with the rollout of a provider toolkit to educate women's health professionals on the benefits of an early postpartum checkup and the key components of this early visit. The project also aims to standardize the information provided to women at discharge after a hospital delivery. The recommended discharge information should include:

[6] For more details, see the 2025 Annual Report Data Addendum.

1. The benefits of having an early postpartum checkup
2. Urgent maternal warning signs to continue to be aware of in the postpartum
3. Birth spacing recommendations and family planning options

Hospital teams will gather for an in-person training and develop implementation plans using small steps of change and data review to meet the larger project goals.

Learning from Reviews: Recommendations for Change

Reviewing the findings and data from all the 2025 cases, the FIMR team identified three priority recommendations and three additional recommendations that they felt could improve care for mothers and babies and potentially prevent future losses. These recommendations are described here along with some of the findings from FIMR cases that explain why they are important.

Supporting mental health during and after pregnancy: access to perinatal psychiatrists

Mental health issues are the most common complication of pregnancy affecting about one in five pregnant women.[7] Among women who experience an infant loss or stillbirth, mental health conditions are even more common. Many women also have a mental health condition diagnosed before pregnancy, and they may come into pregnancy on a medication to control their symptoms, such as an antidepressant. However, some behavioral health therapists and primary care providers may not feel comfortable managing these medications during pregnancy. Sometimes therapists or providers counsel a woman to stop her medication because she is pregnant, and as a result she suffers more from her mental health conditions then she needs to. This is when a specialist in perinatal psychiatry becomes very important to ensure a pregnant woman's medications are safely and effectively treating her mental health symptoms or substance use.

31%

FIMR cases show us that about one in three women have a documented mental health issue in the postpartum period following the loss of their baby.

Perinatal psychiatrists are highly trained professionals in both obstetrics and psychiatry, and while their services are important, there are very few of them in the U.S. Having a program with on-call specialists who can speak to therapists or primary care

[7] Maternal Mental Health Leadership Alliance. Fact sheet: Perinatal Psychiatry Access Programs. Feb 2025.

providers—including women's health providers and family doctors—allows more healthcare givers to get the expert input of a perinatal psychiatrist and to manage the common mental health or substance use conditions experienced by their pregnant patients. Perinatal psychiatrists can give advice on how to screen, refer and prescribe medications, when needed, to treat mental health or drug withdrawal symptoms and relieve suffering. In the U.S., half of states have a perinatal psychiatry consult program, however, Delaware is not one of them.

Evidence from both FIMR and Maternal Mortality Review (MMR) show us the important unmet need for perinatal psychiatry expertise in Delaware. While there are some specialists in Delaware, they are not spread out throughout the state. In FIMR cases we see instances of women being told to stop their behavioral health medication when they get pregnant. In other cases, around the time of delivery, we see differing practices of treating drug withdrawal symptoms depending on if there are addiction medicine specialists working in the birthing hospital. In the postpartum, women may lose touch with healthcare providers but still be at risk for developing a mental health condition or worsening of symptoms. Most maternal deaths reviewed by the MMR team involve women suffering from both mental health and substance use. Managing their symptoms with effective and safe medicine remains a top priority in the postpartum period. (See page 28 for more information from MMR cases.)

FIMR Strength: an example of provider counseling on behavioral health medications

We discussed that many mental health medications are safe to take in pregnancy and that we would generally recommend (a) patient remain on medications if she has been stable on them.

--Prenatal provider

What we can do: establish a perinatal psychiatry consult program in Delaware

The State and state agencies are encouraged to consider implementing a perinatal psychiatry consult program in Delaware to help ensure consistent, quality care and offer providers across all sites real-time support to manage pregnant and postpartum patients with mental health or substance use issues.

Empowering families to make safe choices now that cannabis is legal

The legalization of cannabis, also referred to as marijuana, in Delaware took effect in 2023 with recreational marijuana sales beginning in 2025. These were important steps to regulate the cannabis supply and decriminalize its use by adults. However, even though cannabis is legal, it effects the health of pregnant women and developing babies and can lead to complications during pregnancy and in childhood. It is important for women and families to know that though legal, cannabis is not safe for pregnant women, babies or young children.

If a pregnant woman uses cannabis, it can cross the placenta and effect the development of her growing baby. The baby's developing brain is particularly sensitive to cannabis. Studies have shown cannabis use by pregnant women increases their risk for low birthweight babies and preterm birth.[8] [9] Exposure to cannabis before birth also affects children's ability to problem solve, learn and focus attention as they grow and enter school.[10]

In 2025, 12% of women in FIMR cases reported cannabis use at some point during their pregnancy. Nationally, 4%-8% of pregnant women report using cannabis, making it one of the more common substances used during pregnancy.[11] Sometimes women take it to control nausea and vomiting during pregnancy, but the American College of Obstetricians and Gynecologists (ACOG) advises against cannabis use during or after pregnancy and recommends safer alternatives to manage nausea.[12] The American Academy of Pediatrics (AAP) discourages cannabis use by mothers while breastfeeding.[13]

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[8] Corsi DJ, L Walsh and D Weiss. *Association between self-reported prenatal cannabis use and maternal, perinatal, and neonatal outcomes*. JAMA 2019: 322 (2).
[9] Marchand G, et al. *Birth outcomes of neonates exposed to marijuana in utero*. JAMA Net Open 2022. 5(1): e2145653.
[10] American Academy of Pediatrics. Is cannabis harmful for children & teens? AAP policy explained. Accessed at: https://www.healthychildren.org/English/ages-stages/teen/substance-abuse/Pages/legalizing-marijuana.aspx on Mar 31, 2026.
[11] Substance Abuse and Mental Health Services Administration (SAMHSA). 2023 National Survey on Drug Use and Health: Detailed Tables. Accessed at: https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables on February 1, 2026.
[12] ACOG. *Cannabis use during pregnancy and lactation*. Clinical Consensus No. 10. Obstet Gynecol 2025; 146: 6100-611.
[13] AAP. Marijuana use during pregnancy & breastfeeding FAQs. [Updated Jul 31, 2019.] Accessed at: https://www.healthychildren.org/English/ages-stages/prenatal/Pages/Marijuana-Use-During-Pregnancy-

We also see from Child Death Review (CDR) and Sudden Death in the Young (SDY) findings that cannabis use by caregivers increases the risk of an infant unsafe sleep death and accidental poisonings in young children.

With the growing information that we have from research studies, professional organizations and our own review panels, the time is right to follow cannabis legalization with more public education. It is important to make sure that families get clear information on the risks of cannabis use so they can make informed decisions to take care of themselves and protect children to the best of their ability.

What we can do: provide unbiased, clear information on cannabis use

State agencies are encouraged to work with community partners to develop a public messaging campaign about the effects of cannabis use during pregnancy and while caring for young children. The campaign should take a nonpunitive approach to build families' trust and provide unbiased information on the effects of cannabis during pregnancy and on babies' development and on safe storage to reduce the risk of accidental poisonings in young children.

Revitalizing efforts to Count the Kicks: talking about stillbirth prevention

One in 175 births are a stillbirth, and each year about 21,000 babies are stillborn in the U.S.[14] Stillbirths can occur throughout pregnancy, and about one in four may be preventable with more consistent monitoring in pregnancy and education to reduce risk factors like smoking and diabetes.[15] An important part of stillbirth prevention education is talking to pregnant women about monitoring their babies' movements, what is often known as fetal kicks.

In Delaware, a statewide education campaign was launched in 2011 to encourage Fetal Kick Counts in the third trimester of pregnancy. More recently, Count the Kicks is a program with partnerships in more than 30 states. Count the Kicks offers a free mobile app to get women to count fetal kicks, understand trends and patterns in their babies' movements and know when to contact their doctor or get checked out at a hospital.

Breastfeeding.aspx?_gl=1*24zel2*_ga*NjUyNzkxMjUxLjE3NzQ5NzE1ODE.*_ga_FD9D3XZVQQ*czE3NzQ5NzE1ODAkbzEkZzEkdDE3NzQ5NzIyMjAkajU3JGwwJGgw on Mar 31, 2026.

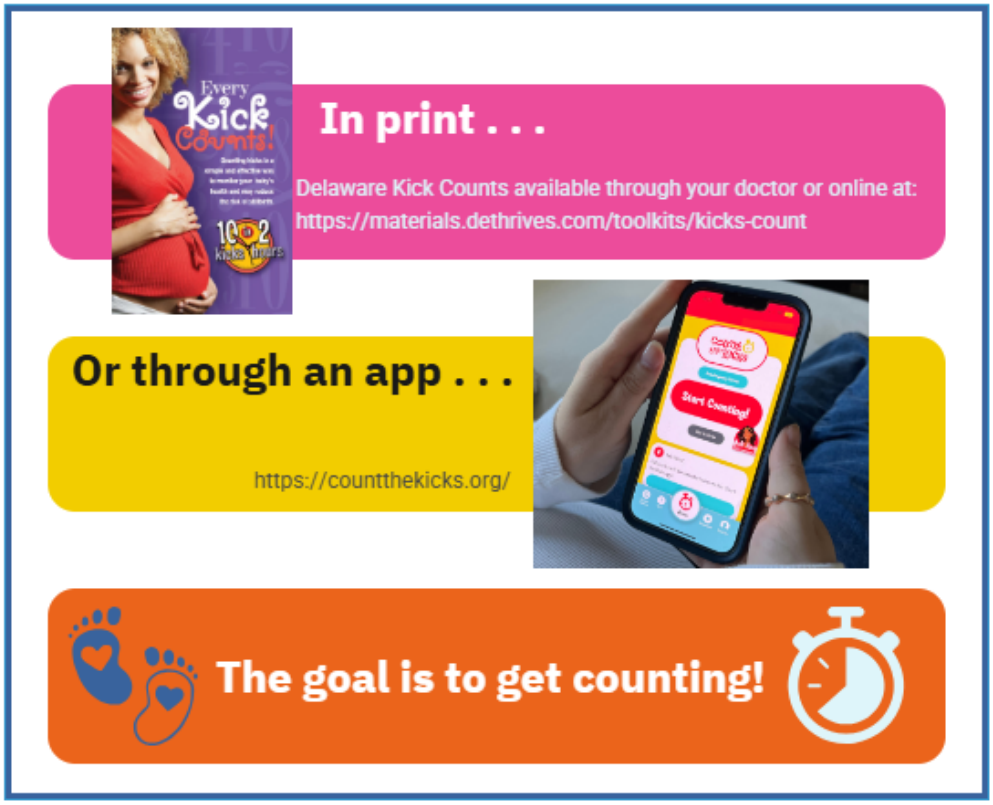
[14] CDC. *Data and statistics on stillbirth*. Accessed at: https://www.cdc.gov/stillbirth/data-research/index.html on Mar 31, 2026.

[15] PUSH for Empowered Pregnancy. *Why PUSH?* Accessed at: https://www.pushpregnancy.org/why-push on Mar 31, 2026.

Whether promoting the paper materials available through Delaware's Fetal Kick Counts or the national Count the Kicks app, doctors and nurses should be talking to pregnant women about tracking fetal kicks. FIMR data has shown a decrease in this type of counseling in recent years, with only half of 2025 records noting third trimester fetal movement education. From FIMR data we also see that many stillbirths occur near or at term, including six of the 29 stillbirths reviewed. This means there is often time for providers to see women at prenatal visits and educate them on fetal movement tracking before a stillbirth occurs.

50%

of 2025 FIMR cases beyond 23 weeks gestation had documented fetal kick counts education



What we can do: educate pregnant women on fetal movement tracking

The Division of Public Health is encouraged to partner with Count the Kicks to reinvigorate a public education campaign on fetal movement tracking that offers the Count the Kicks app.

Supporting women after a loss: the importance of interconception care in the 4th trimester

Women who have experienced a stillbirth or infant death are at risk of emotional and physical problems after their delivery. As many of these deaths are associated with pregnancy complications, the road to healing can be long and difficult. Many women are left with unanswered questions about what happened to their baby and why. Their loss may have implications for their physical health in a future pregnancy. Their loss is also a big risk factor for postpartum depression, anxiety or posttraumatic stress.

The interconception period, the time between pregnancies, is an important one for women to recover from the last pregnancy, grieve the loss of their baby and heal their physical, mental and emotional scars as best as possible. Women who have had a loss are a high priority for follow-up care and counseling in this time between pregnancies. Yet many FIMR cases show us that women are not getting the care and counseling they may need in the interconception period. Thirty percent (30%) of women who had a loss did not attend a postpartum visit. As a result, the women may not get some of the results from tests done around the time of the delivery, tests which may hold some answers to why their baby died. The postpartum visit is an important opportunity for the provider to go over what happened in the last pregnancy and make a plan to help the mother recover as much as possible prior to another pregnancy. Women should be educated about why the first few months after delivery, the 4th trimester, is important for their health so that they understand that their postpartum visit is a key part of their ongoing care.

70%

of FIMR mothers had a postpartum visit

The DPQC is working on an initiative to encourage all women who deliver to follow up early for a postpartum checkup within three weeks, this work is highlighted in the "Learning from Reviews: Maternal Health in Action" section above. The good news is that even before the official launch of the DPQC initiative, we saw more women get in for an early postpartum checkup in 2025. Of the 70% of FIMR mothers who had a postpartum visit, almost 70% were seen for an early checkup, which is up from 53% in 2024. This indicates that clinical practice may be changing as doctors recognize the importance of closer follow up after delivery, especially for women who had pregnancy complications.

There are notable points of care that differ for women after a loss compared to others who have a surviving baby. These additional touch points of care following a loss can be incorporated into the DPQC's 4th trimester project as an additional clinical checklist to remind providers of bereaved parents' special needs.

FIMR Story Moment: life after loss

The mother said that time is both a blessing and a curse as she feels better but the memories of holding her baby are starting to fade.

--Maternal Interview Excerpt

To continue to improve our collective efforts and support women and families after a stillbirth or infant loss, FIMR teams identified the following additional recommendations for change.

What we can do: educate pregnant women about the 4th trimester

Women need to know why the 4th trimester is important for their future pregnancies and overall health. A public education campaign on what the 4th trimester and interconception care are would complement the current DPQC initiative to increase the receipt of early postpartum checkups.

What we can do: create a clinical checklist to support women after a loss

The DPQC 4th trimester project should include a clinical pathway for the care of women who experience a pregnancy loss. Aspects of care could include:

1. The importance of a debrief with an obstetric provider on what happened and why.
2. Communication to parents on any lab tests or autopsy results that may reveal what happened to their baby or affect the health of the mother.
3. Mental health assessments for depression, anxiety and posttraumatic stress with referrals to appropriate grief support services as needed.

What we can do: facilitate record releases for the early postpartum checkup

The DPQC is encouraged to consider adding a release of records request to the hospital discharge planning checklist as part of their 4th trimester project toolkit. This release of records would identify the postpartum provider and initiate the transfer of delivery hospital records to the outpatient office if they use different electronic record systems.

FIMR Story Moment: looking for answers

It was overwhelming not knowing what caused my first baby to die and worrying that something would happen again. . . . I want children on this earth. I am scared.

--Maternal Interview Excerpt

Delaware Fetal & Infant Mortality Review

Lactation after Loss

FIMR reviews show us the importance of supporting women through the days following a stillbirth or infant loss

- One identified need was giving families information on options when the mother's milk comes in. This led the FIMR staff to develop a handout on **Lactation after Loss**.
- This handout contains resources and information on stopping milk production, donating breast milk and using breast milk as a keepsake to remember a baby.
- The handout is available in English, Spanish and Haitian Creole and was distributed to all birthing hospitals in Delaware in June 2025.

Materials are available in three languages

Handout page 1

Handout page 2

FIMR introduction card for families

For more information or to request materials, email: MCDRC@delaware.gov

Maternal Deaths

Untimely deaths among women in Delaware diminishes the potential for a healthy, thriving society. In 2025 the Delaware Maternal Mortality Review (MMR) team considered eight cases of maternal deaths, also known as pregnancy associated deaths.[16]

Noteworthy findings from these reviews include:

- **Most maternal deaths could be prevented.** The MMR team votes on whether or not they think the death could have been prevented, and in the majority of cases they said yes.
- **Overdose continues to be the most common cause of death reviewed by the MMR team.** Many women who were struggling with substance use disorder (SUD) also had a serious mental illness and social risk factors such as exposure to violence or traumatic experiences.
- **The late postpartum period, months after delivery, is when most deaths are occurring.** In the group of cases reviewed, 75% of deaths occurred in the late postpartum. This is contrary to what people may think is the riskiest period: it is not on the day of delivery but months later. Especially for women dealing with SUD, a mental health condition or social stressors, the postpartum period can be a time when it is harder for them to stay connected to the supports they need.

Based on these findings, the MCDRC recommends these priorities:

1. **Make perinatal psychiatry consults available to all providers.** Since mental health and SUD are common risk factors seen in maternal deaths, we recommend the State and state agencies consider implementing a perinatal psychiatry consult program to offer providers real-time support to manage pregnant and postpartum patients with mental health or substance use issues.
2. **Educate communities about the dangerous, potent mix of drugs sold illegally.** To address the continuing toll of overdose as a cause of death among young women, we recommend that the Division of Substance Abuse and Mental Health (DSAMH) develop a public service campaign on the dangerous and unpredictable mix of drugs sold illegally in Delaware and neighboring areas. Especially if a person has been in recovery for a period of time and has a return to use, they will have decreased tolerance for the very potent illegal drugs sold on the streets and increased risk of overdose.

[16] A pregnancy associated death is the death of a woman while pregnant or up to one year after the end of pregnancy from any cause. For more definitions, see the glossary in Appendix D.

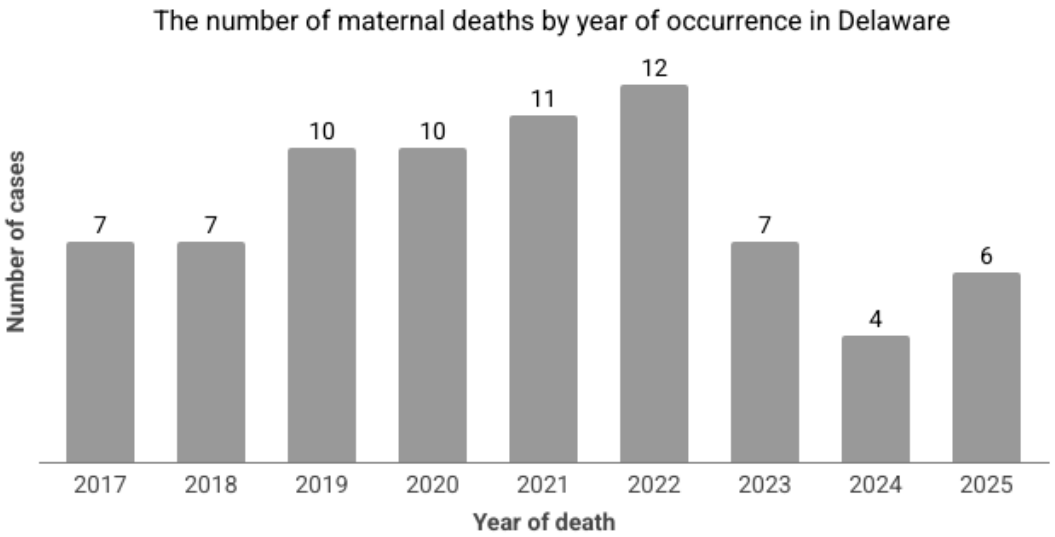
More details on the circumstances of the cases reviewed, the contributing factors and rationale for the full list of recommendations follow.

Cases Reviewed

Understanding why young women die during or after pregnancy is a crucial question public health agencies across the country strive to understand so they can make improvements in the medical and social programs caring for women and young families. Delaware's MMR team investigates all cases when a woman dies while pregnant or up to one year after the end of the pregnancy, no matter what the cause of death is. In Delaware we have about 8 pregnancy associated deaths each year. The MMR team takes a careful look at these deaths to try and understand what were the contributing factors that put the woman at risk and then propose ideas for how to address these factors through recommendations. In the course of doing these reviews, the MMR team tries to understand if the death was due in any way to the woman's being pregnant. If so, these deaths are classified as being pregnancy related.

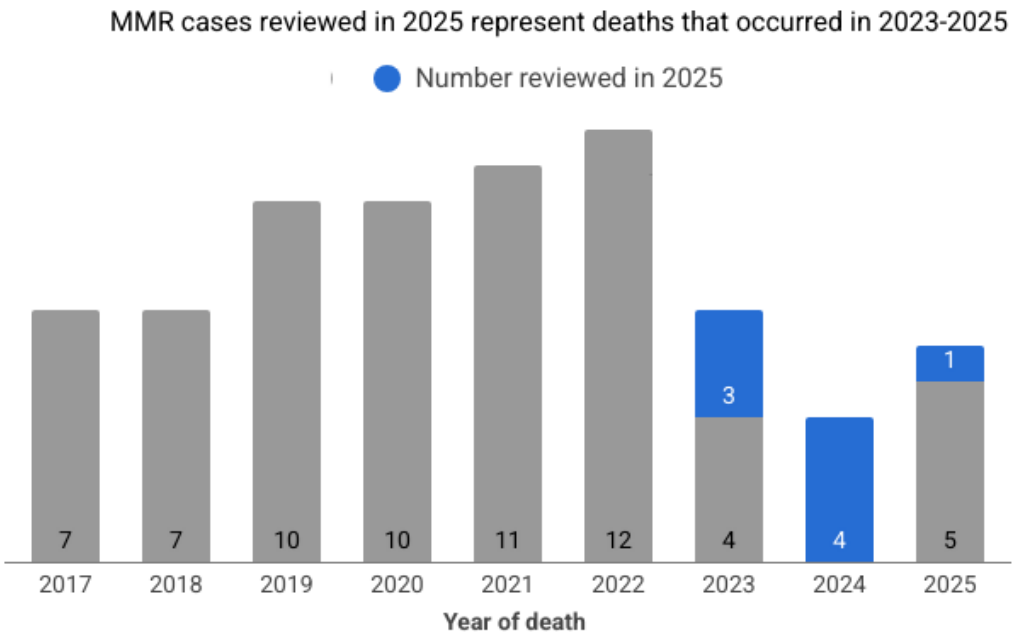
In 2025 the Delaware MMR team reviewed eight pregnancy associated cases. The cases represent deaths that occurred on average 15 months prior, dating from 2023 through 2025. Of the eight cases reviewed, six women were White, one was Black, and one was another race.[17] Two women were Hispanic. Figure 3 shows the number of pregnancy associated deaths reported to the Commission by year of death, and Figure 4 shows which of these deaths were reviewed in 2025 and included in this report.

Figure 3



[17] The term White refers to persons who have a single race identified as White and are non-Hispanic. See the glossary in Appendix D for definitions of terms to describe subpopulations by race and ethnicity.

Figure 4



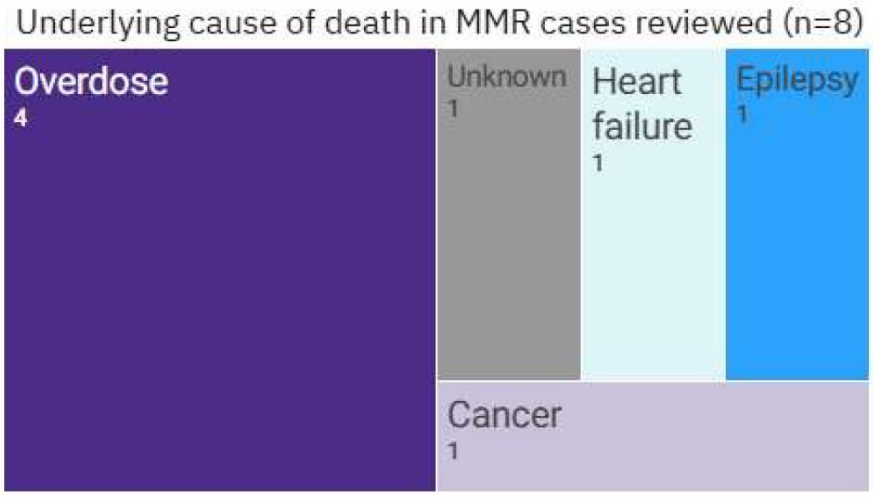
Patterns in the Data

Of the eight cases reviewed in 2025, four of them were due to drug overdose (Figure 5). Overdose has been the most common cause of death among MMR cases for the last six years in Delaware.

Key findings in the eight cases reviewed include:

- **No case was determined to be pregnancy related.** For a second year in a row, the MMR team did not find any death to be definitively linked to the woman's being pregnant. However, in three of the eight cases, the team felt they did not have enough information to determine pregnancy relation.
- **There was an average of nine contributing factors identified for each maternal death reviewed.** Over half of the risk factors identified were at the individual level. At the provider and hospital level, quality of care was a common issued identified; and at the system level, access to care and continuity of care were the common issues identified.
- **Multiple individual stressors put women at higher risk of dying.** Women at the highest risk of maternal death often face multiple health and social stressors such as financial insecurity, lack of access to continuous health insurance, chronic disease, mental health conditions and traumatic life events in their childhood or adulthood. Better screening for these risk factors can help healthcare providers identify women at highest risk who can then be offered additional supports through pregnancy and postpartum.

Figure 5



Learning from Reviews: Maternal Health in Action

With overdoses being the leading cause of maternal deaths for six years and counting, our partners at the DPQC decided it was time to do more. With a State Maternal Health Innovation grant from the Health Resources and Services Administration (HRSA), DPQC partnered with the community-based recovery specialists at Impact Life to create the peer support doula program. Five peer support specialists were provided additional training to be co-certified as doulas and thus better equipped to support women through pregnancy and postpartum. A doula is a trained professional who offers individualized physical, emotional and educational support to persons throughout pregnancy, birth and postpartum.[18] Doulas have been shown to improve women's birthing experiences, shorten the duration of labor, reduce the need to have a Caesarian section, increase breastfeeding initiation, and reduce the risk of postpartum depression and anxiety.[19]

Women affected by SUD can enroll in the Impact Life program and get partnered with a peer support doula. The peer support doulas not only address regular prenatal and postpartum concerns but also bring lived experience to the recovery journey and a

[18] For a full list of definitions, see the Glossary in Appendix D.
[19] Cleveland Clinic. Doula. Accessed at https://my.clevelandclinic.org/health/articles/23075-doula on May 8, 2026.

holistic perspective to help women with transportation, medical advocacy, life skills development and emotional support. The peer support doula innovation is a demonstration project that is being evaluated as an adjunct to care that may decrease maternal morbidity and mortality. Results on its effectiveness to improve outcomes for women and their children will be shared with state and national partners with the goal of expanding access to doula services during and after pregnancy.

Learning from Reviews: Recommendations for Change

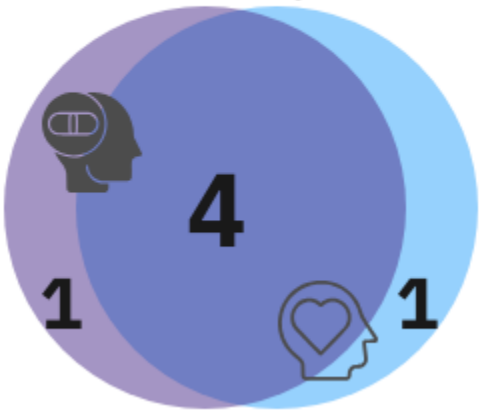
Supporting mental health during and after pregnancy: access to perinatal psychiatrists

Recommendations for Change: MMR

As seen over many years of MMR cases, most maternal deaths involve the risk factors of both a mental health condition and substance misuse or abuse. In 2025, four of the eight women who died were dealing with a mental health condition and SUD as depicted in Figure 6. One woman had a mental health condition alone, and another had SUD alone.

Similar to the FIMR team, the MMR panel identified the priority recommendation of Delaware's implementing a perinatal psychiatry consult program. Two of the eight MMR cases revealed that women with long-standing mental health diagnoses abruptly stopped their antidepressant medicine while pregnant. As a result, they suffered more symptoms of their depression.

Figure 6: The number of 2025 cases with **Mental Health** and/or **Substance Use Disorder (SUD)** as a factor contributing to the death



MMR Finding: undertreating depression

The mother experienced postpartum depression and was initially treated by a medication. She was taken off that medicine and not put on any other antidepressant for several months. Her depression was undertreated and was her main concern a few weeks before she died.

--MMR panel finding

What we can do: establish a perinatal psychiatry consult program in Delaware

The State and state agencies are encouraged to consider implementing a perinatal psychiatry consult program in Delaware to help ensure consistent, quality care and offer providers across all sites real-time support to manage pregnant and postpartum patients with mental health or substance use issues.

For more information on FIMR findings relevant to this recommendation and background on perinatal psychiatry consult programs, please see page 15.

What you don't know can kill: public education on the unknown and lethal mix of street drugs

Accidental overdose has been the leading cause of maternal deaths in Delaware for the last six years. In 2025, four out of the eight cases reviewed were due to overdose. Over the last six years of review, the most common drugs found at the time of death were a combination of opioids (usually fentanyl) plus cocaine. In one case, xylazine was also detected.

The illegal drug supply is ever changing with new and more potent drugs being added. For example, xylazine is a cheap and powerful animal sedative that drug traffickers have used as a filler since the early 2000s to make drugs seem stronger or to inflate their street value. It is not approved for human use. When mixed with fentanyl, xylazine increases the risk of overdose. Naloxone (Narcan) cannot reverse xylazine's effects, and routine toxicology screenings do not detect it. This makes for a risky situation for anyone using illegal drugs because they do not know what substances they are taking. More recently medetomidine, an animal tranquilizer, has been found in the illegal drug supply and is 100-200 times more potent than xylazine.[20] [21] While naloxone does not directly help medetomidine overdose, since there is often a mix of substances, naloxone can still help reverse the effects of any opioids present.

[20] Overdose Response Center. *Delaware Street Drug Report: March 2026*. Delaware Division of Substance Abuse and Mental Health.
[21] Philadelphia Dept Public Health. *Medetomidine*. Accessed at: https://www.substanceusephilly.com/medetomidine-2 on Apr 9, 2026.

If someone who has abstained from drug use has a return to use, they are especially susceptible to an overdose. Their body becomes less tolerant of strong drugs when they are in recovery, so if they return to use, a smaller dose can have a more dangerous effect on them. The changes in the body when someone abstains from drugs and the more dangerous substances in the illegal drug supply are important for the general public to know about. There are ways to reduce the risk of overdose. Taking a less stigmatizing harm reduction approach that teaches people how to protect themselves from overdose is important life-saving education. Overdose prevention steps include: using fentanyl or medetomidine test strips to check the drugs a person has, being around others if using, and making sure those around you have naloxone and know how to use it. Based on the continuing issue of maternal deaths due to overdose and the potent, dangerous drugs in the illegal drug supply, the MMR team made community education a top priority.

MMR Finding: understanding risk

The mother's return to use after years of sobriety may have made her more vulnerable to the mix of substances in the illegal drug market. Xylazine was in the fatal mix that led to her overdose death.

--MMR panel finding

What we can do: educate the public on the risks of more potent illegal drugs

The Division of Substance Abuse and Mental Health (DSAMH) should develop a public education campaign to make communities aware of the risks when a person stops using drugs and then returns to use. Their body's decreased tolerance and the ever-changing combination of lethal drugs sold on the streets put them at higher risk for overdose.

Promoting a respectful, safe culture in health facilities

Adverse events—from witnessing or experiencing violence to surviving a natural disaster—can have damaging effects on people's behavior, physical health, mental health, employment status and relationships. When people experience severe adversity, they may develop psychological trauma if support is not available. Many MMR cases occur in women who have a history of or ongoing adversity and exposure to violence and discrimination.

There are proven ways institutions can support people who are recovering from trauma, known as "trauma-informed" strategies. The Substance Abuse and Mental Health Services Administration's (SAMHSA) principles of trauma-informed care recommend prioritizing safety, peer support, transparency, collaboration and individual empowerment.[22] Without trauma-informed care, there is a risk that people can be retraumatized or not well served in healthcare settings. We can equip our institutions to play a part in addressing trauma and restoring well-being, making resilience a real possibility.

To create safe spaces for all patients, healthcare providers and staff should always practice in a way sensitive to possible trauma history and provide respectful care. The MMR panel specifically considered discrimination as a possible contributing factor in three cases reviewed in 2025. Based on these cases, the following two recommendations acknowledge the need for reviewing hospital policies to ensure they promote respectful, trauma-informed care and for ongoing provider education to reduce the impact of implicit bias.

What we can do: work to ensure safe, welcoming healthcare spaces

Health facilities should undertake internal assessment of their practices, policies and personnel with the goal of promoting a respectful, safe culture and one that actively protects against discrimination. This includes review of comments and feedback provided through the IRTH app on how their facility is caring for Black and Hispanic women.

What we can do: facilitate ongoing provider education

The DPQC and Medical Society of Delaware are encouraged to curate a list of evidence-based, on-demand webinars that address bias and discrimination in healthcare settings. Healthcare employers and professional organizations can encourage their staff or members to participate in these webinars to fulfill continuing education requirements.

[22] SAMHSA. Trauma-informed approaches and programs. Accessed at: https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs on May 11, 2026.

Raising awareness of expanded Medicaid benefits during and after pregnancy

Pregnant and postpartum women have broader Medicaid eligibility criteria with higher income cutoffs, a policy that allows more pregnant and postpartum women to qualify for Medicaid and acknowledges these periods of time are important ones to ensure women have access to healthcare. In 2022 the Delaware General Assembly passed legislation extending expanded Medicaid eligibility from 60 days to the full year postpartum. In some maternal deaths reviewed, the MMR panel continues to see limited access and disruptions to health insurance coverage impacting women's ability to get into needed care. Overall, about 60% of pregnant Delaware women with Medicaid get into prenatal care in the first trimester or within 42 days of Medicaid enrollment. This is, however, lower than the national average of 72% of pregnant women with Medicaid who receive timely prenatal care.[23] Access to care is also more challenging in southern Delaware where there are limited numbers of obstetric practitioners. While some headways are being made--for example with the opening of the University of Delaware's nurse midwifery program--many challenges remain to increase timely access to prenatal and postpartum care.

What we can do: promote Medicaid enrollment processes

Delays in establishing Medicaid eligibility and enrollment have delayed access to prenatal care. The Division of Medicaid and Medical Assistance should consider a campaign to educate women and providers on women's expanded Medicaid eligibility and benefits during pregnancy and postpartum and how to begin the enrollment process.

Continuity of care: follow up at vulnerable transitions of care

We have seen over many years of reviews the major impact that a woman's mental health has on her well-being during and after pregnancy. Mental health was a contributing factor in five of the eight cases reviewed by the MMR team in 2025. Some of the most vulnerable points in caring for a person's mental needs is when they are transitioning between sites of care, for example after a hospitalization. Planning for follow up after discharge is important to make sure someone is not left alone and at risk.

[23] Medicaid/CHIP Core Set Data Dashboard. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?keywords=%5B%22672%22%5D&focusStates=%5B%22DE%22%5D on Feb 11, 2026.

What we can do: strengthen discharge planning

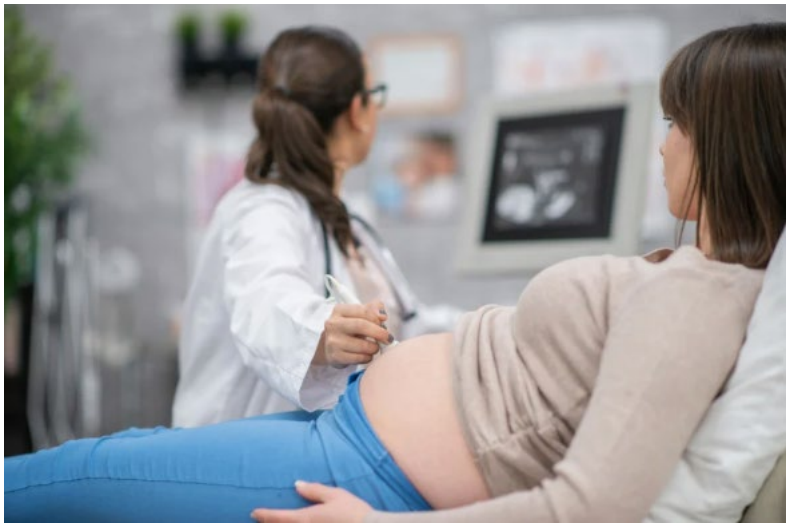
Discharging facilities should ensure that patients have a clear plan of care especially when coming from a challenging situation such as inpatient psychiatric care or incarceration. Quality plans include having scheduled follow up appointments already made and peer support in place.

Ensuring every pregnant patient has a medical decision maker

Maternal deaths often involve complications--such as being unconscious or seriously ill--that can affect a person's ability to make decisions for themself. Having a medical decision maker identified helps ensure that a person's wishes are best carried out if complications arise and healthcare providers know with whom to work.

What we can do: plan ahead in case of an emergency

Health facilities and providers should discuss the importance of identifying a medical decision maker for pregnant and postpartum persons. Medical health emergencies can and do occur during pregnancy, labor and delivery and in the postpartum period. Critical and complex decisions require a responsible individual willing and capable to assist medical staff when a patient is incapacitated.



Child Deaths and Sudden Deaths in the Young

Protecting the health and well-being of children is one of the most crucial roles of families, health care and government. The in-depth review of why children die before their 18th birthday and what we as a society can do to protect them from preventable deaths is at the heart of the MCDRC's mission. The 2025 review of 38 child deaths and sudden deaths in the young represent a diverse set of circumstances and causes. These reviews reveal opportunities for prevention, improving care for children and supporting families.

Noteworthy findings include:

- **Most infant sleep-related deaths occurred when multiple environmental risks overlapped.** The factors present in the babies' sleep environment at the time of a sudden, unexpected death were often a combination of soft bedding or toys, sleeping on an adult bed or couch and sleeping with other people.
- **The Cribs for Kids (C4K) program distributed a record number of 494 Pack N' Plays through its partner network.** Many families who received Pack N' Plays lived in zip codes at higher risk for infant unsafe sleep deaths such as in the City of Wilmington. About one-third of recipient families were Hispanic.
- **Youth suicides have decreased from their 2021 Covid-related peak but have persisted with 3-4 deaths per year and are an important public health issue.** Suicide deaths represent the tip of the iceberg of a much larger youth mental health problem, and many more youth consider suicide (17% of Delaware high schoolers) or make a suicide attempt (10% of Delaware high schoolers).[24]

Based on these findings, the MCDRC recommends these priorities:

- Due to the variety of causes of deaths reviewed by the Child Death Review (CDR) panel, MCDRC staff will review panel expertise and recruit new members to fill gaps in knowledge, thus allowing for more thorough review of system level factors.
- Since the C4K program serves a high percentage of Hispanic families, program staff will increase the offerings of educational materials on infant safe sleep available in Spanish and Haitian Creole.
- Due to the persistent number of youth suicides each year and the high prevalence of mental health concerns among youth, the MCDRC will publish a data brief detailing

[24] Delaware State Epidemiological Outcomes Workgroup. The 2025 Delaware Epidemiological Profile Substance Use, Mental Health, and Related Issues: Mental Health and Wellness. Accessed at https://bpb-us-w2.wpmucdn.com/sites.udel.edu/dist/9/12983/files/2025/10/FINAL-Mental-Health-_alt-text-access-21-Oct-2025.pdf on April 27,2026.

findings and recommendations made in reviews of suicide deaths over the last ten years.

More detail on these findings, the analysis behind them, and the resulting recommendations follow.

Cases Reviewed

In 2025, multidisciplinary teams including pediatricians, child welfare professionals, and social workers reviewed 38 infant and child death cases. Reviews included 17 cases in which a child (ages 0-17) died suddenly and without an immediate explanation (Sudden Death in the Young/SDY review). The Child Death Review (CDR) team examined an additional 21 cases in which the manner of death was homicide, suicide, natural or accidental. Figures 7 and 8 provider more details on the causes or manner of death reviewed by the SDY and CDR teams. Reviews tried to answer key questions about what happened and why, so that in similar circumstances in the future, we can take steps to avert child deaths. For more detail on how cases are assigned to either a SDY or CDR team, see Appendix B.

Figure 7

Cause of Death in Sudden Death in the Young (SDY) cases (n=17)

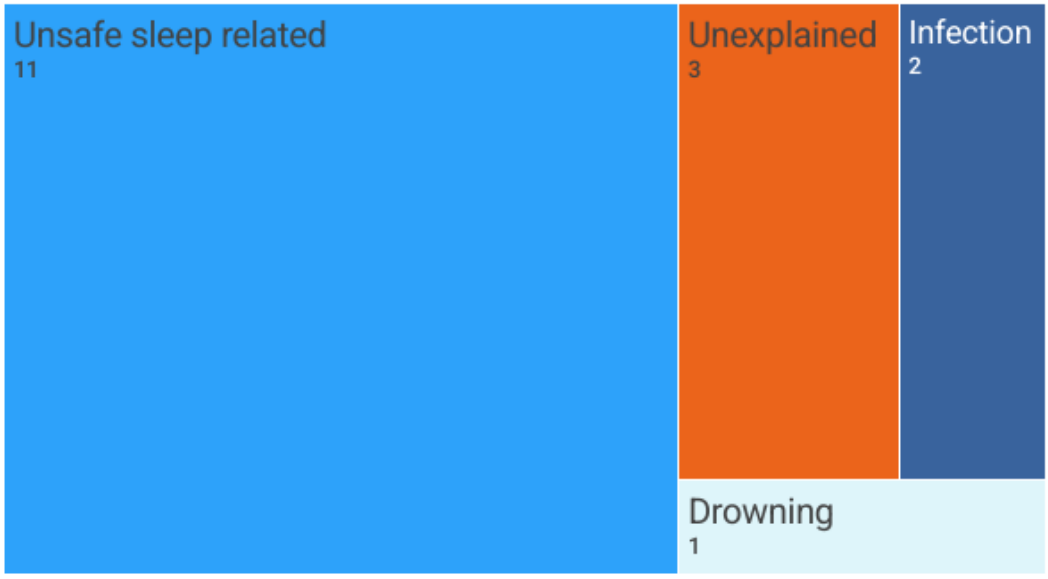
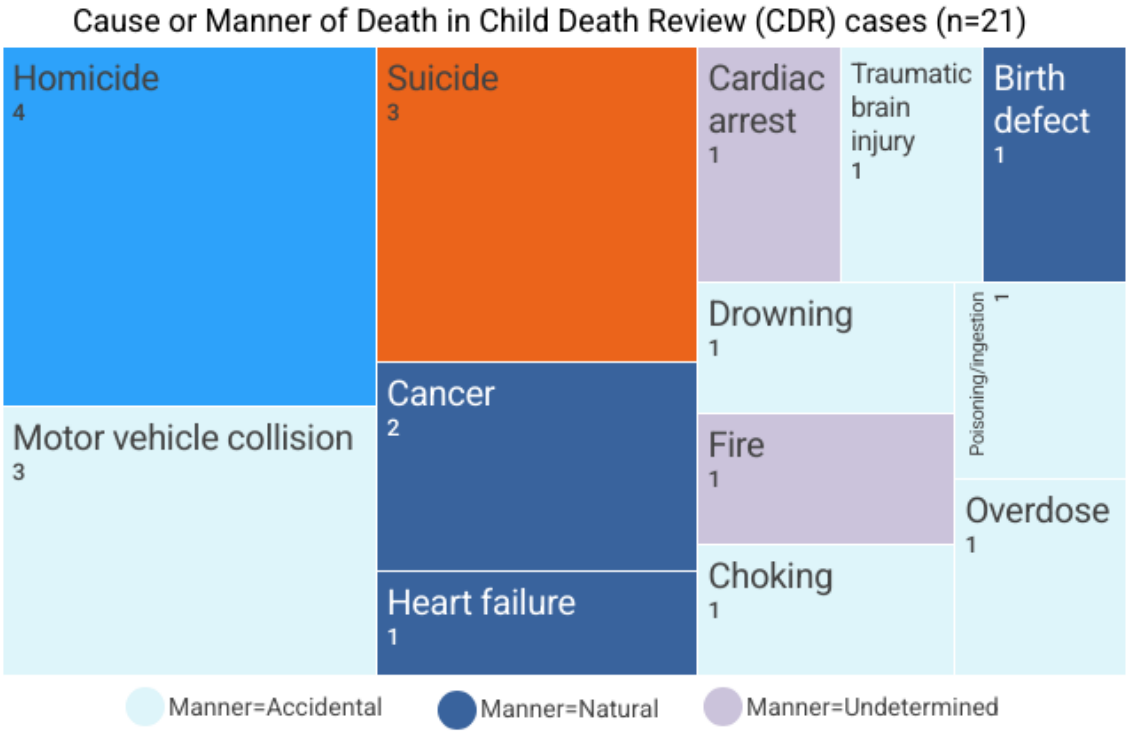


Figure 8



Patterns in the Data

To inform effective programs and partnerships, the Commission carefully analyzes the data to spot patterns related to specific populations and the factors affecting their health. By pinpointing community-specific challenges, child health partners can work with affected communities to develop approaches that meet the community's needs. This helps to ensure that all children and youth in Delaware, no matter their background, have a full and fair opportunity for health and well-being.

A closer look at the data by geography, race, ethnicity, and other demographics spotted important patterns:

- **Families who lost a child were typically facing many serious—yet addressable—stressors.** Financial strain, overcrowded or unstable living arrangements, domestic violence, incarceration, substance use in the family, and difficulty accessing health care were among the factors that were commonly faced by families who lost a child. (For more details see the 2025 Annual Report Data Addendum.)

- **Families who are Black faced a higher risk of losing a child.** In 2025, Black children made up 42% of CDR/SDY cases in Delaware. This exceeds their proportion (21%) of the state's total child population.[25]
- **The most common ages of child death varied by race/ethnicity.** The number of cases was highest among 1-4-year-olds, followed by infants (under 1 year). Black children represented a high-than-expected number of deaths under the age of 9. White youths were most frequent among deaths between 10 and 14 years old, and Hispanic youth among older adolescents (15-17 years old). See the 2025 Data Addendum for more detail.
- **The manner of death varied by race/ethnicity.** White youth made up most cases of accidental deaths. Black youth accounted for more sleep-related deaths and homicides.

Because the causes of death reviewed by the SDY and CDR panels can be very different—from complex medical causes to gunshot wounds—panel members from various backgrounds and expertise are needed to ensure a thorough review is conducted. It has been a few years since the Commission has reached out to increase membership.

What we can do: increase panel membership for thorough reviews

The MCDRC staff will identify gaps in expertise on the CDR and SDY panels and recruit new members to fill those gaps. A child fatality retreat will be convened in the upcoming year with new and existing panel members to discuss best practices for conducting high quality reviews.

Infants' Sleep Environment and Safety

Sleep is an important but complex topic in infant health. Sleep is a basic human need both for babies and their adult caregivers. Yet families caring for newborns face a variety of challenges and changes to their daily routine. Caring for a baby is exhausting, and without flexible schedules and resources, adult caregivers are under even more stress. Household conditions such as overcrowding or moving between residences can affect the physical environment available for the baby to sleep. Caregivers' routines such as work hours or shift work can affect who is available to help care for the baby during the days and nights. There is also a very human need to bond with the baby, and for many caregivers the time sleeping together may be a time of closeness and connection. Cosleeping between

[25] Kids Count Data Center. Population by age group, gender and race/ethnicity in Delaware. Accessed at: https://datacenter.aecf.org/data/tables/10074-population-by-age-group-gender-and-race-ethnicity?loc=9&loct=2#detailed/2/any/false/1096/122|112|133,3,4,13,107/19473 on Feb 13, 2026.

adult caregivers and their babies is probably more common than reported, and other countries have revised their safe sleep guidelines to acknowledge this reality.

What Reviews Revealed

The Commission carefully reviews every unexpected death in Delaware and identifies any and all elements of the sleep environment that could have posed a risk to the child. Sudden, unexpected infant deaths most often are found to have multiple conditions in the sleep environment that posed overlapping risks for the baby. Most often, reviews found that infants were sleeping with soft bedding and toys, on an adult bed or couch and with other people. All of these factors increase the risk of suffocation. Figure 9 details the risk noted in infants' sleep environments at the time of death and compares them to how often they generally occur.

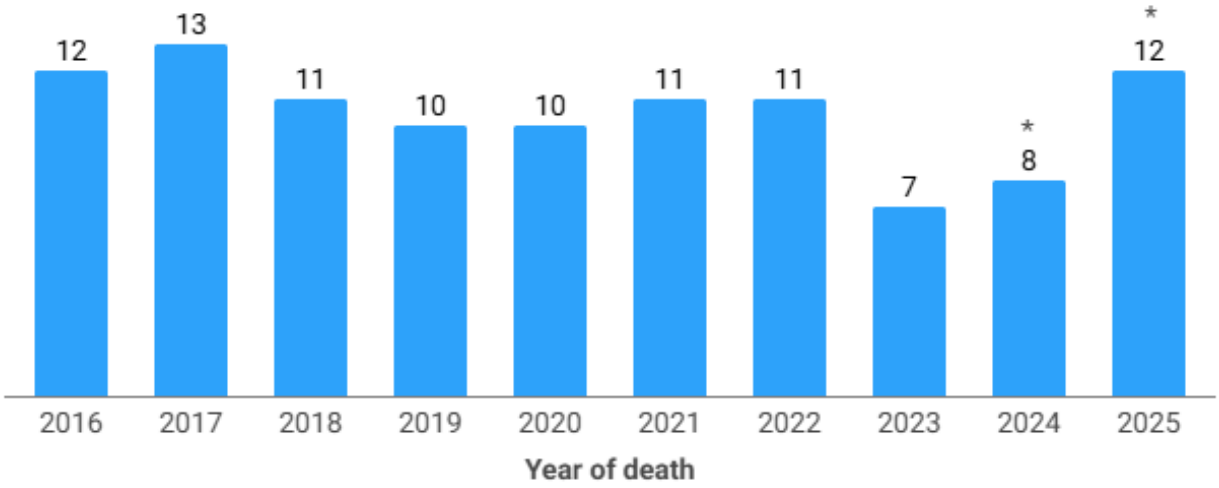
Figure 9: Risks in infants' sleep environment
In many cases of death involving unsafe sleep, more than one of these risk factors were present

	Risk in baby's sleep environment	General percent of infants in Delaware*	Percent of sleep-related infant deaths
	Not in crib, bassinette or side sleeper	10%	67%
	Not sleeping on back	21%	67%
	Unsafe bedding or toys near infant	6%	89%
	Sleeping with other people	22%	56%
	Intrauterine drug exposure	--	0%
	Tobacco use: mother	12%	11%
	Adult was drug or alcohol impaired at time of death	--	44%

*According to 2022 data on infant care practices among women who delivered in Delaware. Data collected by DPH Pregnancy Risk Assessment Monitoring System (PRAMS). Data accessed through personal communication with George Yocher. See 2025 Data Addendum for more details on PRAMS survey questions.

While the number of unsafe sleep-related deaths fluctuates a bit from year to year, this issue has been a longstanding one in Delaware with one infant dying each month, on average, from this preventable cause. Figure 10 shows the number of infant unsafe sleep deaths occurring each year for the last ten years.

Figure 10: Number of unsafe sleep-related infant deaths by year of occurrence

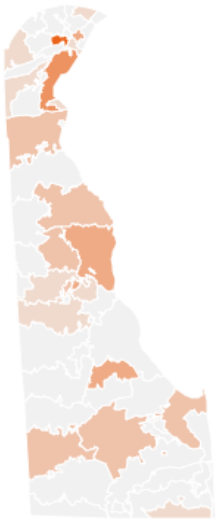


*Some 2024 and 2025 cases are pending review, so numbers are subject to change and will be included in future reporting.

Providing a Safe Sleep Option for Families: Delaware's Cribs for Kids Program

For families who need a safe sleep option for their infant and meet criteria, the Delaware Cribs for Kids (C4K) program provides free Pack N' Plays through a network of partnering agencies across the state. C4K staff trains agencies to educate families on infant suffocation prevention. In 2025 twelve trainings were conducted to onboard new partners or as a refresher course for existing partners. Just under 500 cribs were distributed through partners (n=494), a 32% increase from the year prior. In a mapping of where infant unsafe sleep-related deaths occur and where C4K Pack N' Plays are distributed, there was good overlap with cribs going to communities at higher risk. Forty-two percent of Pack N' Plays went to residents living in the City of Wilmington, an area where 29% of infant unsafe sleep-related deaths occurred based on a five-year analysis of cases. In the heat map below, darker shades of color represent areas with higher numbers of infant unsafe sleep-related deaths (in orange) and areas with more Pack N' Plays distributed (in blue).

Figure 11: A heat map of where infant unsafe sleep deaths are occurring and where Cribs for Kids (C4K) Pack N' Plays are being distributed in Delaware



Infant unsafe sleep deaths reviewed by zipcode 2020-2024 (n=43). 29% of deaths occurred in the City of Wilmington, an area that accounts for only about 8% of total live births in Delaware.

C4K crib distribution in 2025 by zipcode (n=481). Does not include 2 out of state recipients and 11 families with unknown zipcode. Overall 42% of cribs were distributed in the City of Wilmington.

C4K data also revealed that 35% of families who received a Pack N' Play in 2025 were Hispanic. To better serve families from various backgrounds, the Commission will translate C4K program materials into Spanish and Haitian Creole. This includes materials such as educational brochures, consents and hold harmless agreements. The C4K staff will add a question on the referral form to indicate the family's preferred primary language so that this information can better be tracked moving forward.

What we can do: provide more family friendly resources

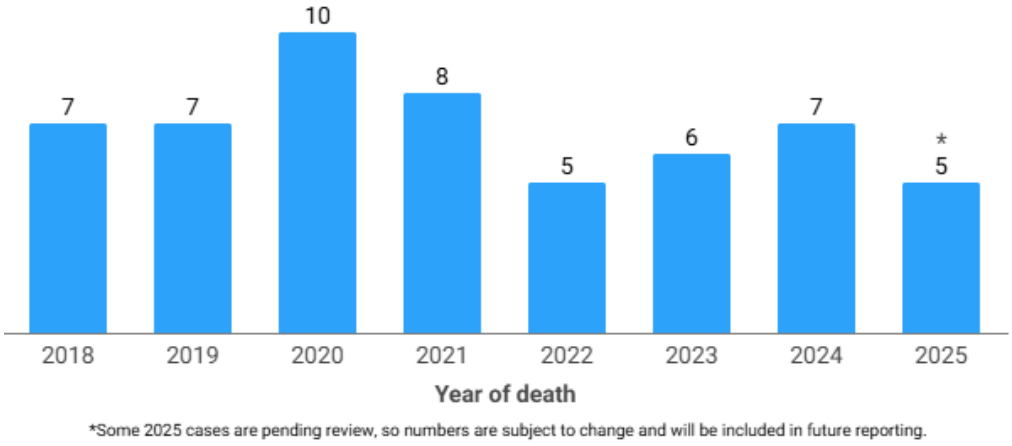
The MCDRC will increase the offerings of educational materials on infant safe sleep made available through the Cribs for Kids program to include family friendly resources in Spanish and Haitian Creole.

Youth Homicides

Since the Covid peak in youth homicides in 2020-2021, the number of these deaths has decreased but still remains unacceptably high at about one child victim every other month in Delaware. Some homicides do not get a full panel review because prosecution decisions are still pending two years after the death, at which point, by statute, the case must be administratively closed by the Commission. These deaths are still counted in the figure below, but we cannot learn from those cases without a full review. In the past year,

cases that did come before the CDR panel involved both young children under the age of five and teens.

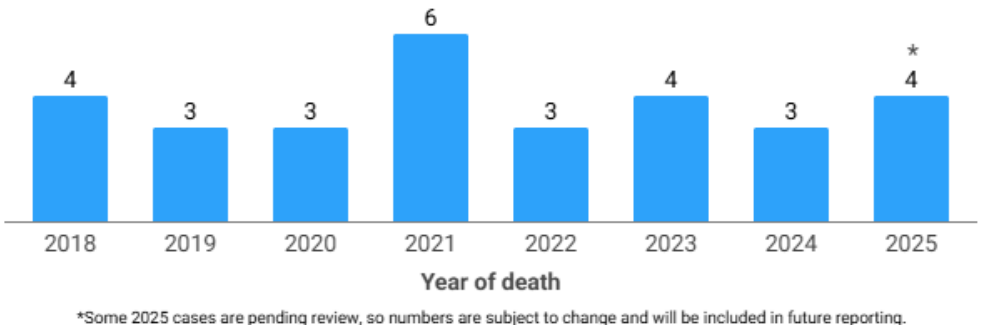
Figure 12: Number of youth homicides by year of occurrence



Youth Suicides

Good mental health is the basis for young people's developing a strong sense of belonging, connection and growing. Many factors influence mental health, and supports in schools, health care, communities and families are needed to recognize youth mental health challenges early and intervene to help. Youth suicides peaked after the Covid pandemic as seen in Figure 13. While numbers have returned to the pre-pandemic level, all suicide deaths are a tragedy and point to ways we can potentially better support young people.

Figure 13: number of youth suicides by year of occurrence



Few conclusions can be drawn from a single year of review, so the MCDRC staff will conduct a multiyear analysis looking into the circumstances surrounding youth suicides to help inform prevention efforts. This analysis will be released later in 2026.

What we can do: learn from a multiyear analysis

The MCDRC will conduct a multiyear analysis of youth suicide deaths to be published as a data brief in the upcoming year. This analysis will summarize key demographics, findings and recommendations from case reviews and highlight gaps and opportunities to better meet the mental health needs of children and adolescents.

Child Abuse and Neglect

Protecting children who experience child abuse and neglect is a critical task of our state and local agencies. The MCDRC works closely with the Child Protection Accountability Commission (CPAC) to review the systems in place to protect children from harm and identify opportunities to strengthen these systems. The chair of the MCDRC is a statutory member of the CPAC and the current chair of the Child Abuse and Neglect Steering Committee. In 2025 eight child deaths involving suspected abuse and/or neglect were jointly reviewed with CPAC's Child Abuse and Neglect Panel. This team has different kinds of experts to review these cases thoroughly. Findings and recommendations from these cases, along with other cases of serious injury due to child abuse and neglect, are reported out in the CPAC Fiscal Year 2025 Annual Report. This report highlights CPAC's ongoing work to:

- train frontline professionals to respond to reports of child abuse and neglect following standard protocols
- identify system challenges and advocate for reforms to strengthen collaborative and thorough responses
- monitor legislative initiatives that affect the child welfare system
- support young people who experience foster care

In addition, a Joint Action Plan is developed collaboratively by the MCDRC and CPAC every two years to guide efforts to improve the systems in place to protect children. Both Commissions met in September 2025 to update the Joint Action Plan based on recent findings from case reviews.

Community Engagement

2025 saw changes to the MCDRC's community engagement strategy. Due to federal funding uncertainty for much of 2025, the Commission made the difficult decision to pivot away from a free-standing Community Action Team (CAT). Instead, the Commission felt having its staff attend partners' community events and provide education would be a more efficient and sustainable use of resources. The MMR Coordinator and C4K Coordinator are the main staff engaged in these community-based education efforts. They expanded their network of partners in 2025 to increase collaboration and identify opportunities for information sharing.

In addition, the Commission hired a communications consultant in 2025 to promote its work and educate on maternal and child health through social media outlets, namely Facebook and Instagram. The communications consultant began posting in November 2025 and linking to our partnering agencies and programs in Delaware. This investment in social media will hopefully reach more families and offer content in manageable, small but frequent posts that can keep health promotion strategies forefront in people's minds.

TURNING DATA INTO PREVENTION: OUR SOCIAL MEDIA OUTREACH

From Review to Reach

Social media allows us to bring the lessons from our reviews directly into the community. By translating complex findings into clear, supportive, and actionable information, we help families, caregivers, and professionals understand risks and learn ways to prevent future deaths.

Our goal is not simply to share information, but to increase awareness, provide practical guidance, and connect Delaware families to resources that support safer pregnancies, healthier infants, and thriving children.

Through thoughtful, evidence-based messaging, our social media platforms extend the reach of our work beyond reports and meetings—ensuring that the knowledge gained through review leads to real-world prevention and stronger communities.

Delaware Maternal and Child Death Review Commission

de_mcdrc

Prevention in Action: Sample Posts

Mission & Impact
Posts that explain who we are, what we do, and why maternal and child death review matters.

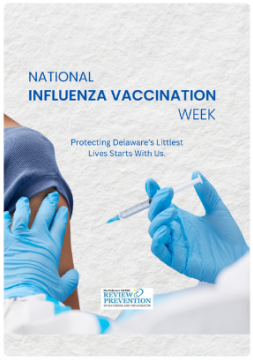
Purpose: Build understanding and trust in the review process.

Data & Insights
Posts that translate key findings from annual reports into clear, understandable messages.

Purpose: Turn data into awareness and action.

Prevention Tips & Education
Posts that provide simple, evidence-based guidance for families and caregivers.

Purpose: Empower families with practical knowledge that can save lives.



Awareness & Community Engagement
Posts that connect our work to national observances, community partners, and resources.

Purpose: Amplify important issues and connect families to support.

Conclusion

The prevention of maternal, infant and child deaths is of great importance to all Delawareans. It is the work to strengthen families so that all people, especially our youngest, can live their healthiest life possible and fulfill their greatest potential. The work of the Commission relies on its dedicated partners and volunteers who look at some of the most tragic losses in our society, bear witness and seek to do better.

This report shares our lessons from the losses. We hope it adds, in some small way, to the case for doing better by our communities, one family at a time.

Appendix A: Key 2025 Facts and Figures

Overall:

- MCDRC reviewed 95 cases of fetal, infant, child or maternal death in 2025.
- Six separate review teams met regularly throughout the year to accomplish detailed reviews of each case.
- MCDRC held one public meeting to share its findings and recommendations widely.

Stillbirths and Infant Deaths (Fetal and Infant Mortality Review):

- Among 49 cases of this type, 53% were stillbirths.
- Delaware's FIMR team was able to review cases in almost real-time, with only a 7-month lag between death and review.
- 1 in 3 FIMR cases involved difficulties and delays in a mother accessing prenatal care.

Maternal Deaths (Maternal Mortality Review):

- 8 cases reviewed.
- Overdose was the leading cause of maternal death for the sixth consecutive year.

Child Deaths (Child Death Review/Sudden Death in the Young):

- Among 38 cases of this type, 9 were infant deaths and 29 were deaths of children aged 1-17.
- All 9 infant deaths were linked to unsafe sleep environments, such as sleeping in an adult bed or couch or having soft bedding or toys nearby.
- The Cribs for Kids (C4K) program distributed 494 cribs, a 32% increase from the prior year.
- 12 trainings on infant suffocation prevention were held to onboard new C4K partners or as a refresher training for existing partners, helping to ensure that safer sleep education reaches more communities statewide.

For more details see the 2025 Annual Report Data Addendum.

Appendix B: How cases are assigned to one of four types of review panels

Delaware's Maternal and Child Death Review Commission organizes and conducts four types of reviews of deaths: Child Death Review; Sudden Death in the Young; Fetal and Infant Mortality Review; and Maternal Mortality Review. All reviews are based on the MCDRC's statutory obligation to review all maternal deaths and deaths of children and youth under 18 years of age who are Delaware residents.

Each type of review is an in-depth, multidisciplinary effort to understand what happened and why, so that the appropriate agency, organization, or system can take steps to avert preventable deaths in the future.

Child Death Review and Sudden Death in the Young

CDR and SDY panels review different types of cases. The CDR panel reviews cases that are assigned suicide or homicide as the manner of death, as well as many of the accidental and natural causes of death. For SDY, the defining question is if the death was sudden and unexpected. Often, SDY cases are initially undetermined or possibly unsafe sleep related in manner or circumstance. Occasionally, SDY will review the death of an older child due to drowning.

Fetal and Infant Mortality Review

Some deaths of infants (children less than one year old) are assigned to a FIMR team if they do not involve suspected abuse, neglect or unsafe sleep factors. FIMR also reviews cases of stillbirths that occur after 20 weeks gestation. For all FIMR cases that are referred to the MCDRC, staff reach out to the mother and invite her to participate in a family interview. If she accepts, her case is fully reviewed. A subset of other cases to review are randomly selected so that about half of fetal and infant deaths occurring in Delaware receive a full FIMR review.

Maternal Mortality Review

Deaths of women during pregnancy and up to one year after the end of a pregnancy, from any cause, are assigned to Maternal Mortality Review.

Appendix C: 2025 MCDRC Recommendations

Maternal Mental Health

- The State and state agencies are encouraged to consider implementing a perinatal psychiatry consult program in Delaware to help ensure consistent, quality care and offer providers across all sites real-time support to manage pregnant and postpartum patients with mental health or substance use issues.

Clinical Care

- The DPQC 4th trimester project should include a clinical pathway for the care of women who experience a pregnancy loss. Aspects of care could include:
  1. The importance of a debrief with an obstetric provider on what happened and why.
  2. Communication to parents on any lab tests or autopsy results that may reveal what happened to their baby or affect the health of the mother.
  3. Mental health assessments for depression, anxiety and posttraumatic stress with referrals to appropriate grief support services as needed.
- Health facilities should undertake internal assessment of their practices, policies and personnel with the goal of promoting a respectful, safe culture and one that actively protects against discrimination. This includes review of comments and feedback provided through the IRTH app on how their facility is caring for Black and Hispanic women.
- Health facilities and providers should discuss the importance of identifying a medical decision maker for pregnant and postpartum persons. Medical health emergencies can and do occur during pregnancy, labor and delivery and in the postpartum period. Critical and complex decisions require a responsible individual willing and capable to assist medical staff when a patient is incapacitated.

Care Coordination

- The DPQC is encouraged to consider adding a release of records request to the hospital discharge planning checklist as part of their 4th trimester project toolkit. This release of records would identify the postpartum provider and initiate the transfer of delivery hospital records to the outpatient office if they use different electronic record systems.
- Discharging facilities should ensure that patients have a clear plan of care especially when coming from a challenging situation such as inpatient psychiatric

care or incarceration. Quality plans include having scheduled follow up appointments already made and peer support in place.

Community Education

- Women need to know why the 4th trimester is important for their future pregnancies and overall health. A public education campaign on what the 4th trimester and interconception care are would complement the current DPQC initiative to increase the receipt of early postpartum checkups.
- State agencies are encouraged to work with community partners to develop a public messaging campaign about the effects of cannabis use during pregnancy and while caring for young children. The campaign should take a nonpunitive approach to build families' trust and provide unbiased information on the effects of cannabis during pregnancy and on babies' development and on safe storage to reduce the risk of accidental poisonings in young children.
- The Division of Public Health is encouraged to partner with Count the Kicks to reinvigorate a public education campaign on fetal movement tracking that includes the use of the Count the Kicks app.
- Delays in establishing Medicaid eligibility and enrollment have delayed access to prenatal care. The Division of Medicaid and Medical Assistance should consider a campaign to educate women and providers on women's expanded Medicaid eligibility and benefits during pregnancy and postpartum and how to being the enrollment process.
- The Division of Substance Abuse and Mental Health (DSAMH) should develop a public education campaign to make communities aware of the risks when a person stops using drugs and then returns to use. Their body's decreased tolerance and the ever-changing combination of lethal drugs sold on the streets put them at higher risk for overdose.
- The MCDRC will increase the offerings of educational materials on infant safe sleep made available through the Cribs for Kids program to include family friendly resources in Spanish and Haitian Creole.

Provider Education

- The DPQC and Medical Society of Delaware are encouraged to curate a list of evidence-based, on-demand webinars that address bias and discrimination in health care settings. Health care employers and professional organizations can encourage their staff/members to participate in these webinars to fulfill continuing education requirements.

Data Analysis and Sharing

- The MCDRC will conduct a multiyear analysis of youth suicide deaths to be published as a data brief in the upcoming year. This analysis will summarize key demographics, findings and recommendations from case reviews and highlight gaps and opportunities to better meet the mental health needs of children and adolescents.

Fatality Review Process

- The MCDRC staff will identify gaps in expertise on the CDR and SDY panels and recruit new members to fill those gaps. A child fatality retreat will be convened in the upcoming year with new and existing panel members to discuss best practices for conducting high quality reviews.

Appendix D: Glossary

Black: Persons who identify as Black non-Hispanic, usually as marked on a vital statistics document such as a birth or death certificate.

Child death: The death of a child before their 18th birthday.

Chorioamnionitis: An infection of the placenta and amniotic fluid.

Doula: A doula is a trained professional who offers individualized physical, emotional and educational support to persons throughout pregnancy, birth and postpartum.

Fetal death: Sometimes known as "stillbirth," fetal death is the spontaneous death of a developing human in the uterus two months or more after conception.

Fetal mortality rate: The number of fetal deaths at 20 weeks of gestation or more per 1,000 live births and fetal deaths in a defined population.

Fourth (4th) trimester: The three months following delivery that is a unique time for a woman's recovery after pregnancy.

Hispanic: Persons who identify as being of Hispanic ethnicity, usually as marked on a vital statistics document such as a birth or death certificate.

Infant death: The death of a child before their first birthday.

Infant mortality rate: The number of infant deaths per 1,000 live births in a defined population.

Interconception: The time between the end of one pregnancy and up to the conception of the next pregnancy.

Low birth weight: An infant born weighing less than 5 pounds, 8 ounces or 2500 grams.

Maternal death: A term used synonymously with "pregnancy associated death" in this report.

Naloxone: A medication that rapidly reverses the life-threatening effects of opioid overdose.

Peer support doula: A person with lived experience who is trained as both a peer recovery specialist and a doula to offer more specialized support to pregnant and postpartum persons dealing with substance misuse and/or mental health issues.

Perinatal: The time around birth, ranging from pregnancy conception and through the first year postpartum.

Postpartum: The time after pregnancy when a woman's body is recovering from pregnancy.

Preconception: The time before a woman becomes pregnant.

Pregnancy associated death: A death during pregnancy or within one year of the end of pregnancy from any cause. Also referred to as a "maternal death" in this report.

Pregnancy associated but not related death: A death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.

Pregnancy related death: A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy.

Prematurity or premature birth: An infant born before 37 weeks gestational age.

Stillbirth: A term used synonymously with "fetal death" in this report.

White: Persons who identify as White non-Hispanic, usually as marked on a vital statistics document such as a birth or death certificate.

Appendix E: List of Abbreviations

AAP	American Academy of Pediatrics
ACOG	American College of Obstetricians and Gynecologists
C4K	Cribs For Kids
CAT	Community Action Team
CDC	Centers for Disease Control and Prevention
CDR	Child Death Review
CPAC	Child Protection Accountability Commission
DHMIC	Delaware Healthy Mother and Infant Consortium
DMMA	Delaware Medicaid and Medical Assistance
DPH	Division of Public Health
DPQC	Delaware Perinatal Quality Collaborative
DSAMH	Division of Substance Abuse and Mental Health
ERASE MM	Enhancing Reviews and Surveillance to Eliminate Maternal Mortality
FIMR	Fetal and Infant Mortality Review
HRSA	Health Resources and Service Administration
MCDRC	Maternal and Child Death Review Commission
MCH	Maternal child health
MCO	Managed Care Organization
MMR	Maternal Mortality Review
SAMHSA	Substance Abuse and Mental Health Services Administration
SDY	Sudden Death in the Young
SUD	Substance Use Disorder
SUID	Sudden Unexplained Infant Death

Appendix F: Commissioners and Review Team Members

Maternal and Child Death Review Commission

Role	Designee
Department of Justice	Patricia A. Davis
State Police	Master Corporal Andrea Warfel
Delaware Medicaid and Medical Assistance	vacant
Department of Services for Children, Youth and their Families	Trenee Parker
Department of Education	Cassandra Codes-Johnson
Office of the Child Advocate	Tania Culley (retired July 2025) Kelly Ensslin (current)
Division of Substance Abuse and Mental Health	Heather Doncaster
Office of the Medical Examiner	Gary Collins
Division of Public Health	Vacant
SDY Panel Chair	Mary Ann Crosley (retired) Benay Johnson (current)
SDY Advanced Panel Chair and Pediatrician	Amanda Kay
CDR Panel Chair and OB/GYN	Philip Shlossman
MCDRC Co-Chair, FIMR New Castle Chair	Aleks Casper
FIMR Kent/Sussex Chair	Bridget Buckaloo
MCDRC Chair, MMR Chair and Perinatologist	Garrett Colmorgen
Neonatologist	David Paul
Delaware Nurses Association	Nancy Forsyth
Licensed Mental Health Professional	Fran Franklin
Police Chiefs Council	Chief Laura Giles
New Castle County Police Department	Captain Mike Bradshaw
Child Advocate, non-profit	Patti Dailey-Lewis
Maternal Advocate, non-profit	Doris Griffin
Certified Nurse Midwife	Michelle Drew

CDR Panel Members
Nicole Alexander
Angela Birney
Ann Covey
Moira Dillon
Marcela Krause
Jen McCue
Capt. John Laird
Det. Sgt. Jennifer Lynch
Nicholas Perchiniak
Philip Shlossman, Chair
Capt. Darren Short
Lt. Matthew Smith
Tina Ware

SDY MDT/First Level Panel Members
Olufolake Remi Adepoju
Nicole Alexander
Angela Birney
Cassandra Codes-Benjamin
Mary Ann Crosley, Chair (retired 2025)
Moira Dillon
Greer Firestone
Sgt. John Jefferson
Benay Johnson, Chair (current)
Marcella Krause
Stewart Krug
Sgt. Charles Levy
S. Sgt. Kevin Mackie
M/Sgt. Ron Mullin
Tina Ware

SDY Advanced
Aaron Chidekel
Gary Collins
Ember Crevar
Stephanie Deutsch
Stephen Falchek
Aisha Frazier
Karen Gripp
Amanda Kay, Chair
Bradley Robinson
Joel Temple
Takeshi Tsuda

FIMR New Castle County
Mychal Anderson-Thomas
Heather Baker
Aleks Casper, Chair
Megan Coalson
Patricia Fiorelli
Dara Hall
Connita Henry
Barbara Hobbs, Co-Chair
Alethea Miller
Nancy O'Brien
Kim Petrella
Tomaro Pilgrim
Rosita Quinones
Lesley Tepner
Kimberly York

FIMR Kent/Sussex
Bridget Buckaloo, Chair
Lisa Butterworth, Co-Chair
Megan Coalson
Kathy Doty
Anna Drocella
Dara Hall
Nanette Holmes
Alethea Miller
Tina Raab
Carrie Snyder
Linda Spires
Sara Watson
Kimberly York

MMR Committee

Bridget Buckaloo
Aleks Casper
Margaret Chou
Patricia Ciranni
Megan Coalson
Garrett Colmorgen, Co-Chair
Lindsey Davis
Heather Doncaster
Michelle Drew
Jessica Fields
Fran Franklin
Dara Hall
Sarah Hall
Tracy Harpe
Connita Henry
Matthew Hoffman
Vanita Jain, Co-Chair
Susan Kelly
Pamela Laymon
Starr Lynch
Douglas Makai
Alethea Miller
Hazel Morales-Ayala
Trenee Parker
Kim Petrella
Melanie Samardza
Philip Shlossman
Carrie Snyder
Lesley Tepner
Michael Vest
Maria Webster
Destiny Wood
Kimberly York

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Lise Esper, Records Technician
Johanna Gerisch, Fatality Review Coordinator
Joan Kelley, FIMR Program Coordinator
April Lyons-Alls, Community Action Team Coordinator (January-September 2025)
Cynthia McAlinney, Medical Abstractor
Meena Ramakrishnan, Epidemiologist
Courtney Rapone, Outreach Coordinator

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