

2025 Annual Report

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.
- 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.
- FIMR findings from prior years have informed the Delaware Perinatal Quality Collaborative's (DPQC) 4th trimester project which aims to increase the number of women who get early postpartum checkups and connected to care.

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.
- Overdose deaths remain the leading cause for a sixth consecutive year, often involving the overlap of mental health conditions, substance use disorder and social risk factors.
- Women who died during and after pregnancy often had many significant stressors such as chronic disease, difficulty accessing health care and traumatic life experiences.
- MMR findings from prior years have informed the DPQC's peer support doula program to bring more support to women impacted by substance use disorder during and after pregnancy.

WHAT'S NEXT:

- Recommendations emphasize the importance of educating the public on the risks of return to 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 stakeholders and community members.

Across many reviews, recurring issues emerge: preventable risks, delayed access to care, and overlapping challenges facing families—pointing to the urgent need for earlier support, stronger systems, and coordinated action.

For more information and to view the full report, please visit our website at <https://courts.delaware.gov/childdeath/reports.aspx> or scan the QR code below.

