

Delaware Maternal & Child Death Review Commission

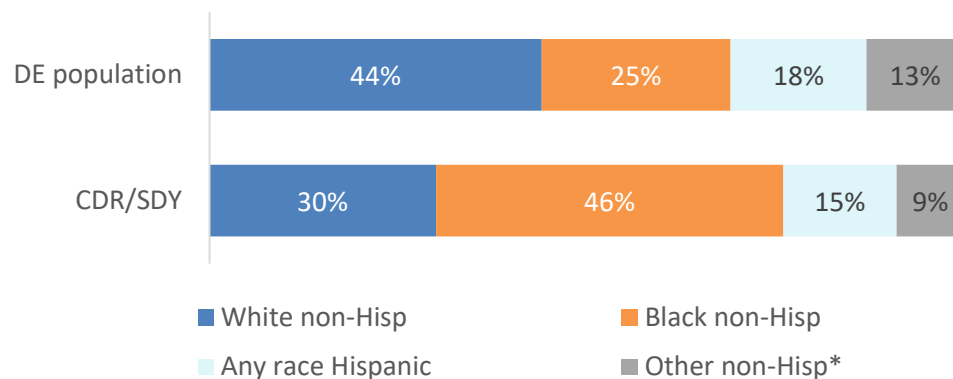
2024 Annual Report Data Addendum

Child Death Review and Sudden Death in the Young (CDR/SDY)

Overview of Cases

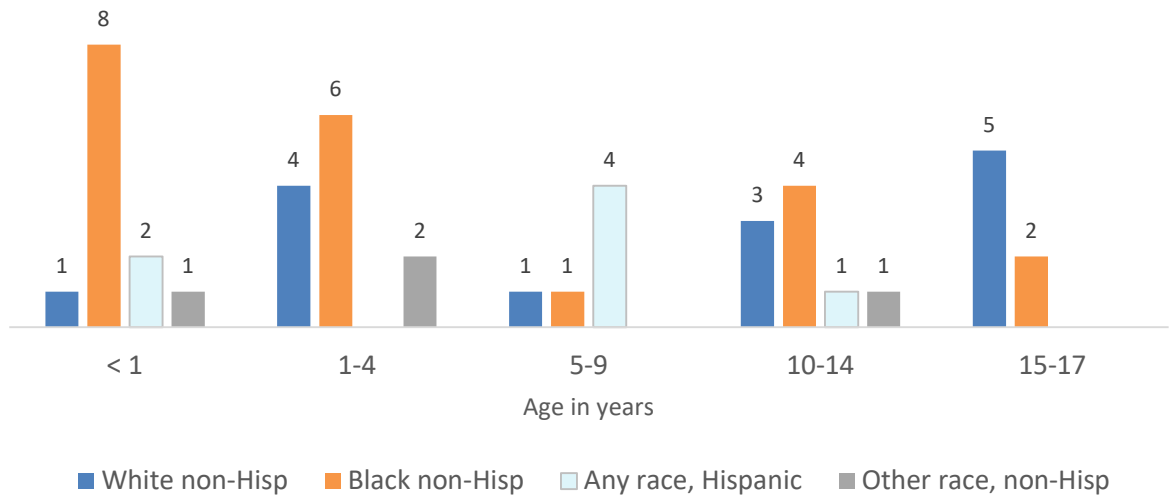
- 46 cases reviewed: CDR 35 cases, SDY 11 cases
- 10 cases administratively closed due to a delay > 2 years waiting on a prosecution status decision
 - Three cases were homicides
 - Two were accidental in manner (motor vehicle collision)
 - Four cases were undetermined in manner, and one was natural
- 12 infant cases reviewed
- 8 unsafe sleep deaths reviewed, including 1 involving children over 1 year of age
- 9 cases were reviewed jointly with the Child Abuse and Neglect (CAN) panel
- 20 children (43%) had known chronic health conditions: 19 of them died of natural causes, and one was an accidental death
- New Castle residents made up 50%, Kent 33% and Sussex 17% of cases
 - Kent County is slightly over-represented in CDR/SDY cases as 20% of children under 18 reside in this county, 58% reside in New Castle County and 22% reside in Sussex County.¹
- Males made up 61% of cases and females 39%
- The proportion of Black non-Hispanic children that made up CDR/SDY cases is higher than their proportion of total Delaware children. While Black children make up 25% of the total population of 0-19-year-olds in Delaware, they make up 46% of the 2024 cohort of CDR/SDY cases. (Figure 1)

Figure 1: Race and ethnicity of children 0-19 years in 2024¹



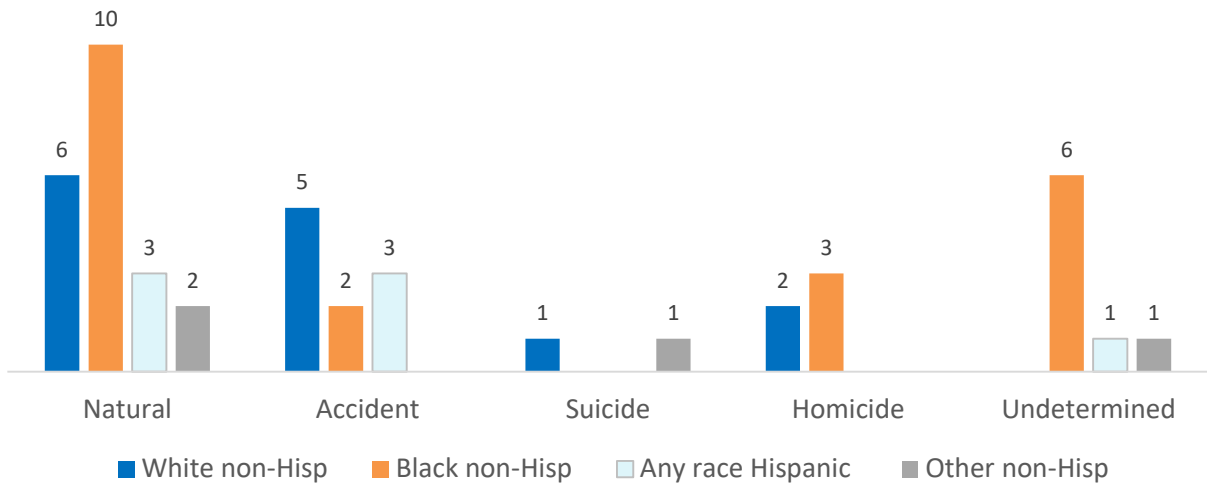
¹ Kids Count Data Center. Child Population in Delaware, 2019-2023. The Annie E. Casey Foundation. Accessed at: <https://datacenter.aecf.org/data/tables/10056-child-population?loc=9&loct=5#detailed/5/1847-1849/false/2606,2543,2454,2026,1983,1692,1691,1607/213/19451,19452> on Feb 25, 2025.

Figure 2: Age groups by race and ethnicity



- In 2024 cases, Black non-Hispanic children made up a disproportionately high number of deaths among infants and young children 1-4 years old (Figure 2).
- Black non-Hispanic children made up a large number of natural and undetermined deaths (Figure 3).

Figure 3: Manner of Death by race and ethnicity



² The MCDRC uses the terms White, Black, and Hispanic based upon the usage by the CDC, the National Center for Vital Statistics, and the National Center for Fatality Review’s database.

2024 MCDRC Annual Report Data Addendum

May 2025

Figure 4: Manner of Death by Age

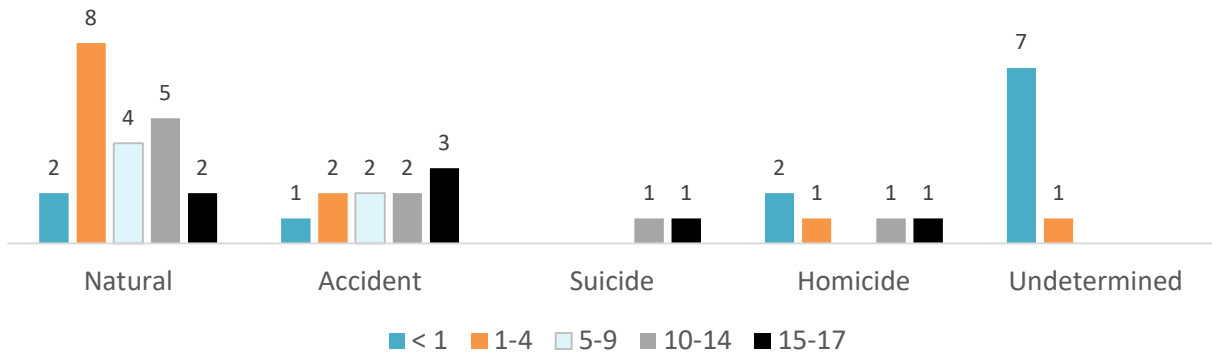
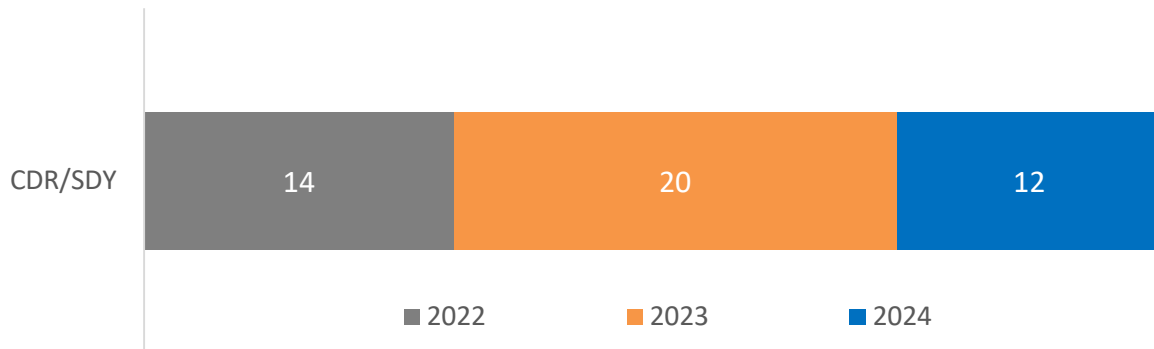


Figure 5: Year of Death



- Cases reviewed in 2024 represent deaths that occurred between 2022 and 2024 as shown in Figure 5. There is a lag between the occurrence of a death and its initial review by the CDR or SDY panel. The time to review depends on the time to referral, when the MCDRC becomes aware of a case, and the time it takes to abstract all pertinent records and get the case on a meeting agenda.
- Overall, the average time to initial panel review for CDR/SDY cases was 8 months.
 - For the 16 cases delayed due to waiting on a prosecution decision (yes/no), the average time to review was 11.5 months.
 - For the 20 cases without delays due to prosecution decisions, the average time to panel review was 5 months.

CDR/SDY Infant Deaths

- Eight of the 12 infant cases were related to unsafe sleep conditions.
- One infant was born premature, before 37 weeks gestation.
- Two infants were born low birthweight, that is under 2500 grams.

Infant Cases: Tracking Issues by Year of Review

	2024 (n=12)	2023 (n=12)	2022 (n=17)	2021 (n=9)
Intrauterine tobacco exposure¹	50%	42%	35%	44%
Intrauterine alcohol exposure¹	0%	8%	18%	0%
Intrauterine drug exposure	58%	45%	46%	29%
Late or no prenatal care²	8%	17%	12%	11%
Insurance coverage for infant				
Medicaid	100%	91%	59%	83%
Private	0%	9%	18%	17%
None	0%	0%	18%	0%
No infant safe sleep education documented	0%	0%	15%	0%
Drug screen done on mother	100%	100%	82%	83%
Neonatal Opioid Withdrawal Syndrome (NOWS) scoring	0%	60%	0%	11%
Substance-exposed infants with DFS notification	43%	80%	67%	100%
Home visiting referral made	25%	30%	35%	22%
Home visiting enrollment	33%	33%	17%	100%

¹From NCFRP standardized report

²Late prenatal care defined as >6 months into pregnancy

	2024 (n=12)	2023 (n=12)	2022 (n=17)	2021 (n=9)
Caregiver at time of death				
Parent	100%	100%	82%	78%
Other	0%	0%	18%	22%
Substance use at time of death	60% ¹	57%	25%	22%

¹All cases with substance use at time of death were related to unsafe sleep conditions.

CDR/SDY Specific Causes of Death

Unsafe sleep-related deaths reviewed in 2024 (n=9)

Findings:

- No families were a Cribs for Kids recipient.
- In 7 cases (78%), infant safe sleep education was documented in the medical record.

Figure 6: Unsafe sleep deaths by year of review and race/ethnicity

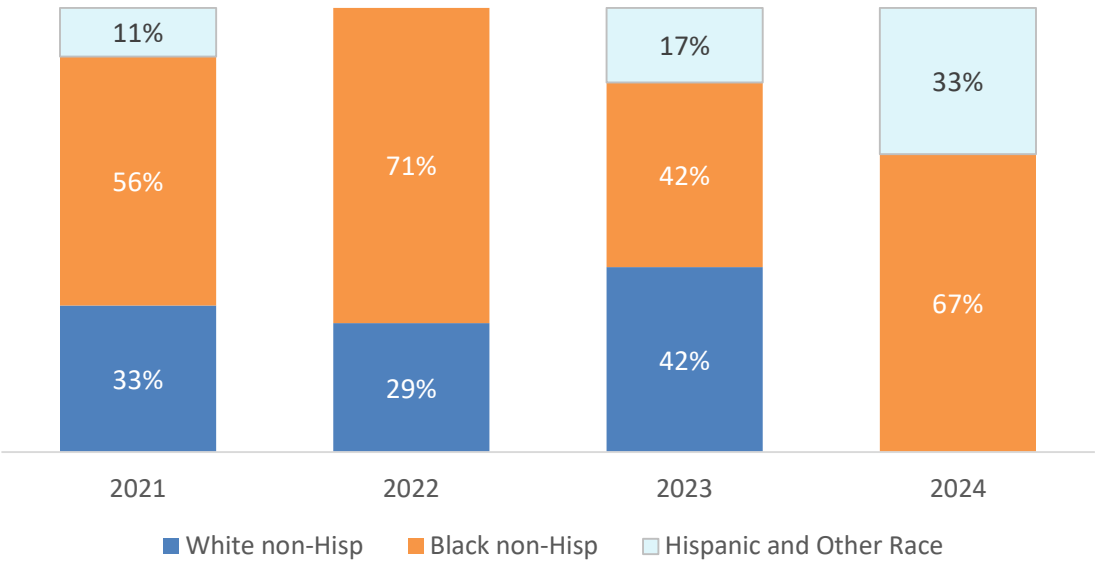
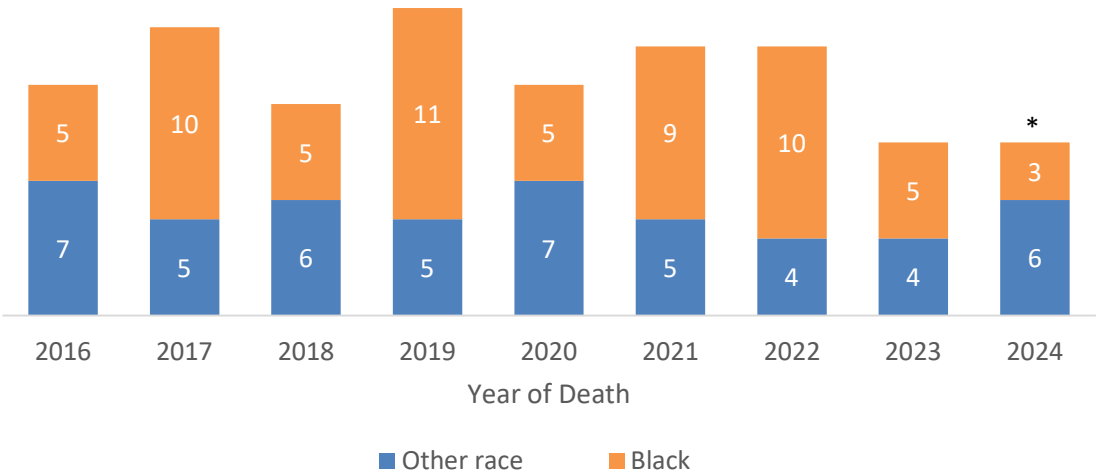


Figure 7: Number of Unsafe Sleep Related Deaths by Year of Occurrence



*There are some 2024 cases pending review that cannot be attributed to unsafe sleep until finalized, so numbers may change and will be included in future reporting.

Unsafe sleep-related deaths, associated risk factors, by year of review

	2024 (n=9)	2023 (n=12)	2022 (n=14)	2021 (n=9)	PRAMS 2022¹
Not in a crib, bassinette, side sleeper, or baby box	78%	75%	79%	78%	10% ²
Not sleeping on back	22%	42%	43%	44%	21%
Unsafe bedding or toys near infant	89%	92%	79%	89%	6% ³
Sleeping with other people	56%	50%	79%	56%	22% ⁴
Intrauterine drug exposure	56%	44%*	36%*	17%*	--
Tobacco use: mother	60%	33%	45%*	38%*	12% ⁵
Adult was alcohol or drug-impaired	67%	33%	21%	11%	--
Infant ever breastfed	45%	67%	64%*	63%*	86%
Mother fell asleep while breastfeeding	11%	0%	7%	0%	--

¹Delaware Health and Social Services, Division of Public Health. Delaware Pregnancy Risk Assessment Monitoring System (PRAMS) 2022 Analysis. November 2024.

²Not usually in crib, bassinet or pack and play in the last 2 weeks

³Sleep with toys, cushions, or pillows

⁴Baby does not often or always sleeps alone in crib or bed

⁵Any cigarettes in the past 2 years

*Only infant unsafe sleep deaths included

Findings:

- Four of the 9 unsafe sleep related cases were administratively closed due to pending prosecution and so could not be reviewed by the SDY panel.
- Six cases were jointly reviewed with CAN, in which case any findings made would be captured in the CAN panel report.

Cribs for Kids 2024 Data:

- 373 referrals received for cribs distributed by C4K partners
- Nine trainings were conducted however none were programs specifically working with persons with SUD.

Accidental deaths n=10 cases

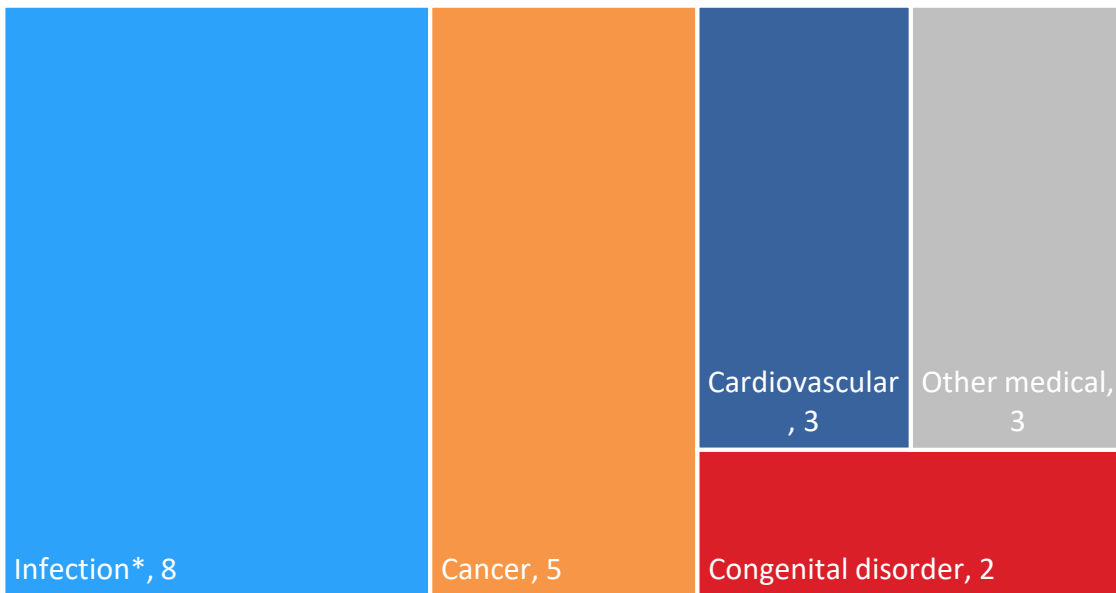
Seven cases were **motor vehicle collision** deaths, ages 1-17 years.

*

*

Natural deaths n=21

Underlying natural causes of death



*includes one death due to Covid 19

Findings:

- 90% of children had chronic medical conditions.

CDR/SDY Tracking Issues

Adverse Family Experiences, by year of review¹

	2024 Total (n=46)	2024 Infants (n=12)	2023 Total (n=54)	2023 Infants (n=12)	2022 Total (n=57)	2022 Infants (n=17)
DFS notified of death²	100%	100%	100%	100%	95%	100%
DFS rejected MDT response that should have been accepted, 0-3 year olds	0%	0%	0%	0%	0%	0%
Active with DFS at time of death	11%	25%	22%	50%	19%	35%
Active with DFS within 12 months of death	17%	33%	31%	58%	27%	53%
DFS history: parents as adults	43%	58%	58%	67%	57%	56%
DFS history: parents as children	35%	83%	40%	83%	41%	57%
Maternal substance abuse³	36%	92%	47%	73%	37%	60%
Paternal substance abuse³	44%	78%	47%	78%	31%	44%
Maternal criminal history	33%	50%	46%	67%	35%	40%
Paternal criminal history	61%	90%	57%	58%	57%	58%
Maternal mental health issue³	*	86%	*	100%	*	*
Paternal mental health issue³	*	*	*	*	*	*
Maternal intimate partner violence³	44%	67%	39%	55%	43%	46%
Paternal intimate partner violence³	41%	60%	53%	70%	42%	46%
Maternal history of abuse	9%	17%	16%	33%	8%	0%
Paternal history of abuse	11%	20%	14%	25%	7%	8%
Maternal history of neglect	23%	33%	24%	50%	30%	40%
Paternal history of neglect	23%	30%	23%	50%	10%	0%

*More than 50% of values unknown, so not reported

¹Denominator is applicable to cases with known information

²Denominator is cases specified by statute: Title 16, Chapter 9, Subsection 906(e)(3) for DFS investigation, children ages 0-3 years and manner of death is not natural

³Current, history or suspected

Infant Tracking Issues, by year of review

	2024 (n=12)	2023 (n=12)	2022 (n=17)	2021 (n=9)
No SUIDI reporting form¹	38% ²	10% ²	8%	0%
No scene investigation¹	0%	0%	0%	11%
No scene photos¹	0%	0%	0%	11%
No doll re-enactment¹	25%	10% ²	15% ²	22%
Toxicology screen of alleged perpetrator	73%	92% ²	67%	67%

¹denominator is infant deaths due to unsafe sleeping or undetermined manner

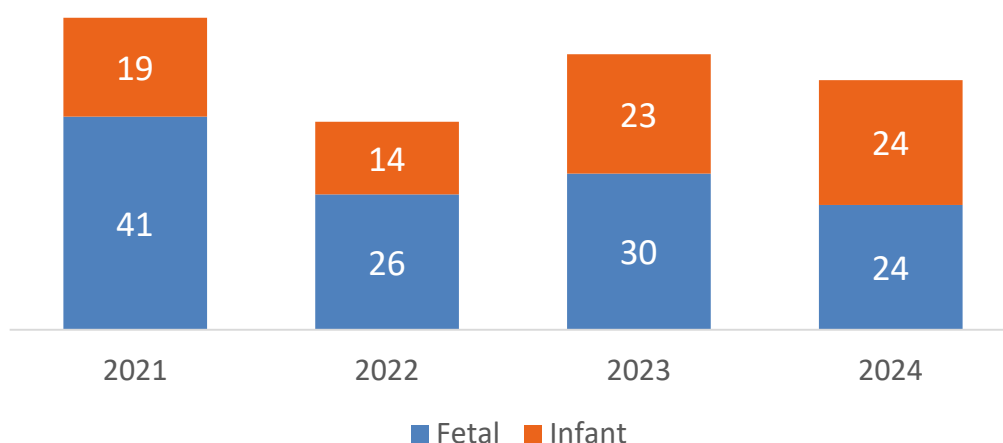
²This is mainly due to parents' refusal to cooperate

Fetal and Infant Mortality Review (FIMR)

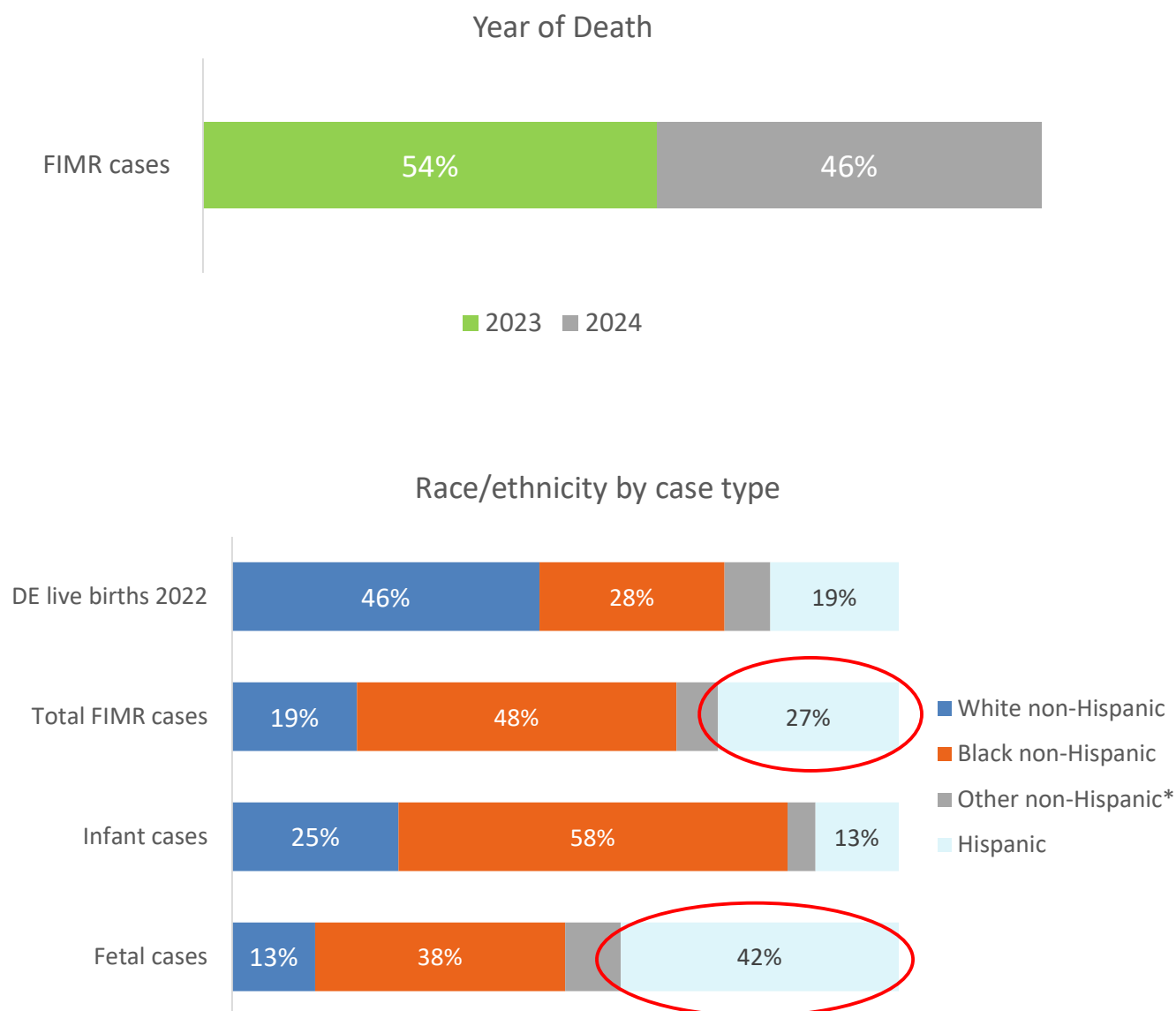
Overview of Cases

- 102 cases were referred to the MCDRC in 2024³:
 - 20 cases were out of state residents
 - 30 cases were triaged out based on even or odd date of death
 - 52 cases were triaged into FIMR either because the mother accepted a maternal interview or the even/odd date of death random selection criteria
- FIMR Case Review Teams (CRTs) reviewed 48 cases in 2024: 24 (50%) fetal deaths and 24 (50%) infant deaths, that is an average of 4 cases per meeting
- Average time between the occurrence of a death and CRT review was 5.3 months, which is slightly higher than in 2023 when it was 5.1 months.
- The maternal interview acceptance rate for cases reviewed in 2024 was 19%.

Cases by Year of Review



³ Data quality checks were done on vital statistics reporting of fetal and infant deaths occurring in calendar year 2024 and on infant deaths occurring in 2022. In 2024, six fetal deaths were not reported to the MCDRC, and three infant deaths to mothers residing in Delaware were not reported. These numbers, while still notable, are improved from 2022 when 27 infant cases were not reported to the MCDRC. Twenty of these 2022 infant cases had a Delaware death certificate, and seven had an out of state death certificate.



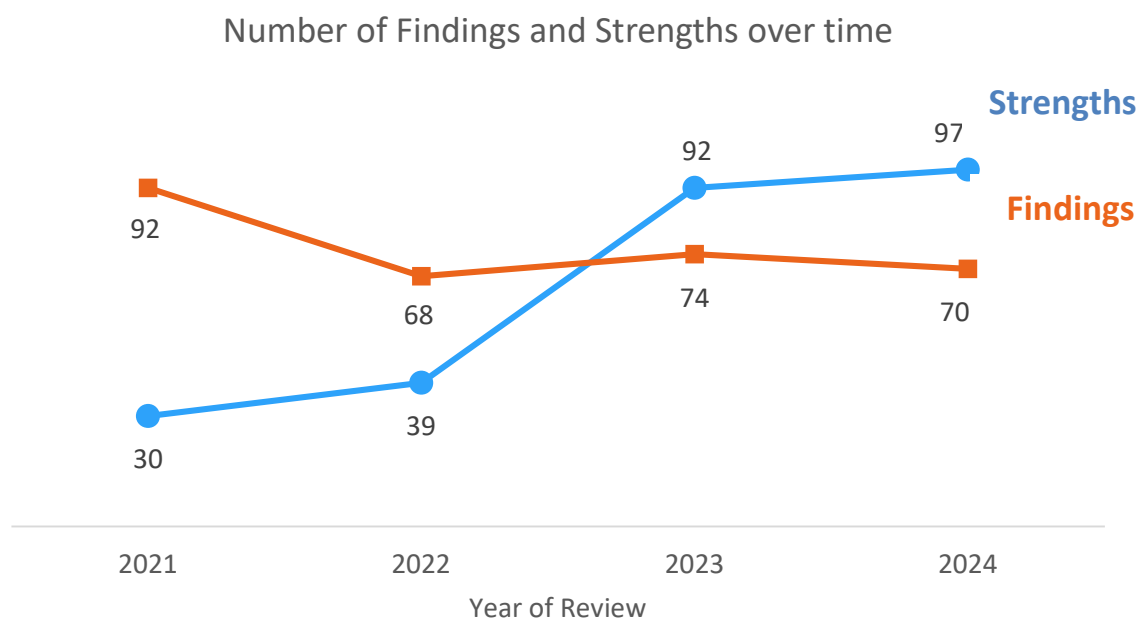
*Other race includes Asian and biracial

Source: FIMR data and Division of Public Health, Delaware Vital Statistics

Annual Report 202, "Live Births". Accessed at:

<https://www.dhss.delaware.gov/doh/ho/2022.html> on 1/9/2025.

- There was a doubling of Hispanic cases among the 2024 cohort, 27% (n=13/48) compared to 13% of the 2023 FIMR cohort. Just over half of the Hispanic mothers were foreign born (54%).
- Black infant deaths also rose a proportion of FIMR cases from 35% of infant cases in 2023 to 58% in 2024. Five out of 14 infant deaths to Black mothers involved women who were foreign born.



Findings and Strengths in 2024 FIMR Cases (n=48)

Category	Findings (n=70 total)	Strengths (n=97 total)
Maternal Health & Morbidity	4	8
Infant Health	2	1
Continuity of Care	13	20
Mental Health	5	21
Substance Use Disorder (SUD)	5	5
Quality of Care	12	14
Respectful Maternity Care	6	10
Family Support	7	9
Social Determinants of Health	3	9
Family Planning	2	4
Fetal Kick Counts (FKC)	2	0
Vital Statistics	3+	0
FIMR Process	5	0

Below you will find FIMR data organized by **Category**.

1. Maternal Health & Morbidity

FIMR Issues Summary by year of review*

Medical: Mother	2024 (n=48)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	PRAMS 2022 ⁴
Cord problem	25%	19%	23%	10%	
Placental abruption	15%	15%	28%	30%	8% ²
Chorioamnionitis	29%	30%	28%	43%	
Gestational diabetes	8%	6%	3%	8%	16%
Cervical insufficiency	21%	13%	5%	12%	
Infection: bacterial vaginosis	8%	6%	10%	5%	5%
Sexually transmitted infection	13%	6%	8%	15%	
Other infection	29%	32%, including 19% with Covid	30%	17%	
Multiple gestation	10%	11%	10%	7%	
Mother's weight BMI	60%	70%	70%	62%	
Insufficient/ excess weight gain	6%	4%	13%	12%	
Pre-existing hypertension	13%	4%	18%	22%	6.4%
Preeclampsia	10%	8%	23%	25%	18% ³
Preterm labor	35%	15%	15%	17%	
PPROM (prolonged premature rupture of membranes)	19%	17%	15%	13%	
Oligo-/polyhydramnios	25%	15%	23%	33%	
Previous miscarriages	23%	26%	38%	23%	17% ⁴
Previous fetal loss	4%	2%	5%	5%	
Previous infant loss	0%	2%	3%	2%	
Previous low birthweight delivery	4%	8%	10%	3%	8.3%
Previous preterm delivery	10%	21%	18%	13%	8.4%
Previous C-section	13%	19%	18%	23%	
Assisted reproductive tech	8%	6%	10%	7%	

*either a P (present) or C (contributing) factor

⁴ Delaware Health and Social Services, Division of Public Health. Delaware Pregnancy Risk Assessment Monitoring System (PRAMS) 2022 Analysis. November 2024.

¹PRAMS 2022. Delaware Health and Social Services, Division of Public Health. Delaware Pregnancy Risk Assessment Monitoring System (PRAMS) 2022 Analysis. November 2024.

²Includes any problem with the placenta such as abruption or previa

³This includes any hypertensive disorder of pregnancy: gestational hypertension, pre-eclampsia or eclampsia

⁴Miscarriage or fetal death in the 12 months prior to last pregnancy

Note: For brevity, some P/C factors have not been included if their prevalence is low or has not been changing over the last few years.

- One case of [severe maternal morbidity \(SMM\)](#) due to intensive care unit stay, down from five in the previous year. The 2020 SMM rate in Delaware is 68.3/10,000 deliveries =, that is 0.7% (not including blood transfusions.)⁵

FIMR Tracking Database by year of review

	2024	2023	2022	2021
Antenatal steroids used when appropriate ¹	71%	79%	50%	60%
17-progesterone offered when appropriate ²	35%	75%	45%	33%
Low-dose aspirin screening done	93%	90%	75%	78%

¹Infant cases only, viable and preterm

²History of prior spontaneous miscarriages or preterm delivery and single gestation in this index pregnancy

- The two most recent years reveal a lower prevalence of PEC and a higher prevalence of low-dose aspirin counseling.

2. Infant Health

FIMR Issues Summary by year of review*

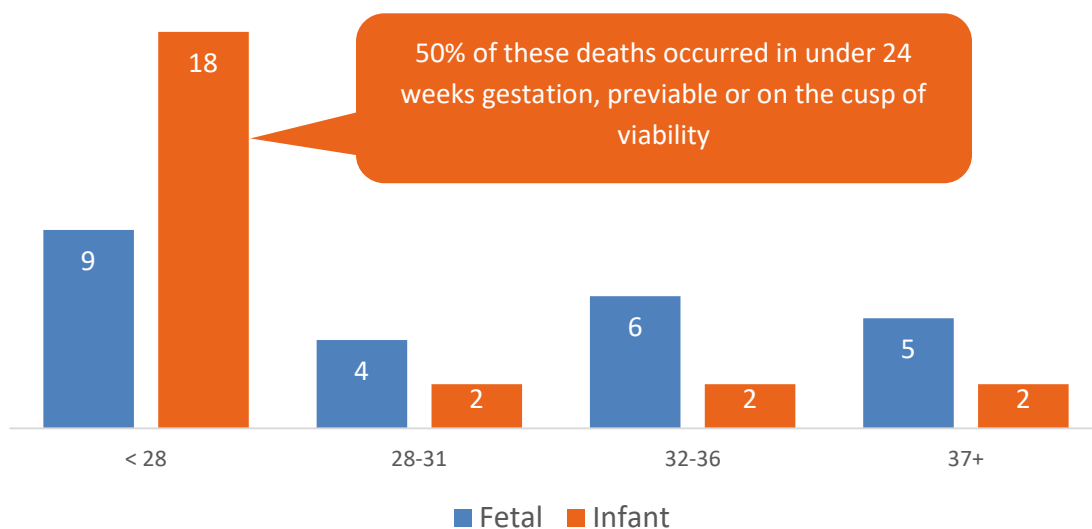
	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)
Non-viable fetus	13% (infant)	9% (infant)	14% (infant)	5% (infant)
Intrauterine growth restriction	13%	13%	23%	15%
Congenital anomaly	13%	9%	28%	23%
Prematurity	44%	32%	23%	20%
Infection/ sepsis	17%	4%	13%	12%
Respiratory Distress Syndrome	30%	25%	10%	18%

*either a P (present) or C (contributing) factor

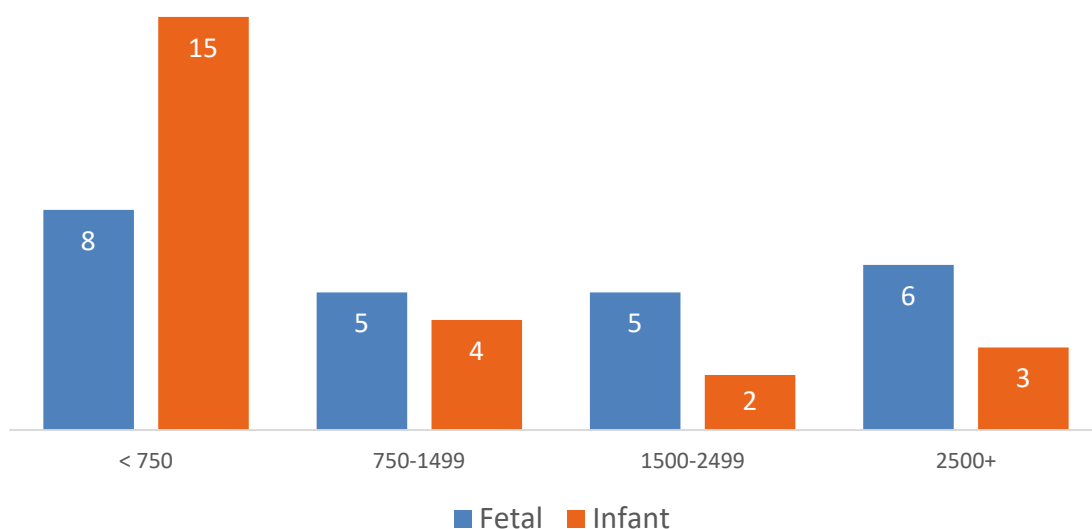
- Among infant cases, contributing issues included:
 - 13% had congenital anomalies
 - 88% had prematurity
 - 33% had infection/sepsis
- Among fetal cases, contributing issues included:
 - 13% had congenital anomalies

⁵ Delaware's Title V State Action Plan Snapshot 2020-2025. National Performance Measures. 2024 MCDRC Annual Report Data Addendum

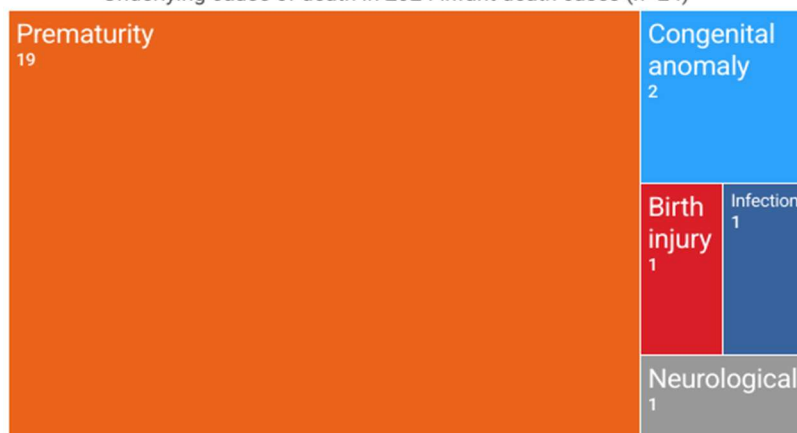
Gestational age in weeks



Birthweight in grams



Underlying cause of death in 2024 infant death cases (n=24)

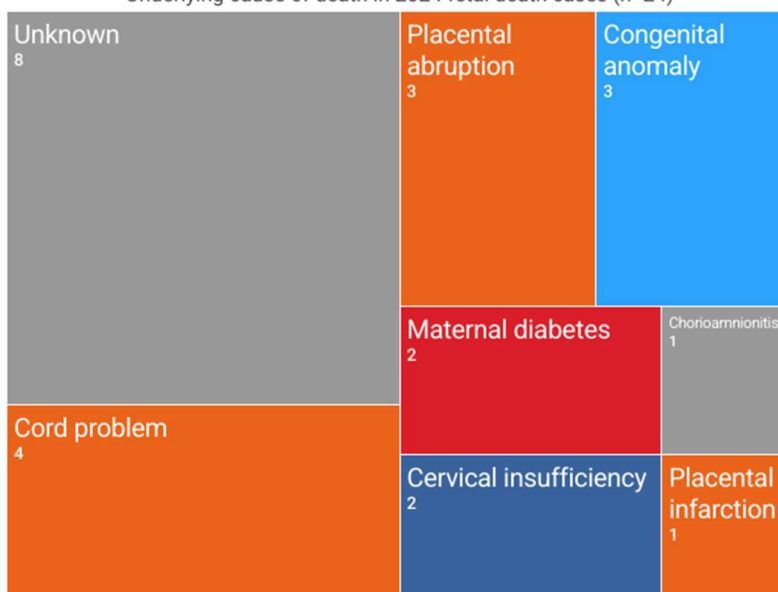
Age at infant death

- 25% of infants died in their 1st day of life
- 17% of infants (n=4) survived beyond 28 days, dying in the post-neonatal period

Location of birth

- Two infants (8%) were born in a Level 1 hospital
- Five infants (21%) were born in a Level 2 hospital

Underlying cause of death in 2024 fetal death cases (n=24)



3. Continuity of Care

FIMR Issues Summary by year of review*

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	PRAMS 2022
Preconception care	23%	19%	25%	13%	21%
Postpartum visit kept	77%	70%	74%	61%	88%
No prenatal care	13%	13%	10%	10%	3%
Late entry to prenatal care	23%	25%	18%	37%	20%
Lack of referrals	2%	0%	3%	5%	
Missed appointments	6%	17%	18%	27%	
Multiple providers / sites	6%	6%	8%	8%	
Poor provider to provider communication	0%	6%	3%	7%	

*either a P (present) or C (contributing) factor

¹PRAMS MCH indicators 2021 spreadsheet. Accessed at <https://www.cdc.gov/prams/prams-data/selected-mch-indicators.html> on 1/23/2024.

²PRAMS 2020. Did a healthcare worker talk the mother about preparing for pregnancy?

³Hussaini, K. (2021). Severe Maternal Morbidity. <https://www.census.gov/programs-surveys/popest/technical->

Timing of first postpartum visit:

- Less than 3 weeks after delivery 53% (n=25/47)—this helps inform a baseline indicator for the DPQC 4th trimester, postpartum initiative
- 3+ weeks after delivery: 23% (n=11/47)
- No postpartum visit: 23% (n=11/47)
- Unknown: n=1

4. Mental Health

FIMR Issues Summary by year of review*

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	PRAMS 2022
History of mental illness	42%	40%	43%	33%	
Depression/mental illness during pregnancy	8%	11%	20%	20%	18% ¹
Depression/mental illness postpartum period	35%	38%	45%	29%	7% ²
Depression screen documented (tracking database)	94%	92%	93%	93%	84% ³

*either a P (present) or C (contributing) factor

¹Depression only during pregnancy

²Always or often feel down, depressed or hopeless since baby was born

³Depression screening during prenatal care visit

Of those Mothers who were screened for depression in the peripartum period:

- 24% were screened on only one occasion
- 44% of women were screened twice.
- 31% were screened on 3+ occasions.

5. Substance Use Disorder

FIMR Issues Summary by year of review*

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	NSDUH 2022⁶
Positive drug test	6%	21%	28%	18%	
No drug test	10%	17%	10%	10%	
Tobacco use: history	13%	23%	10%	7%	8%
Tobacco use: current	15%	11%	25%	20%	
Alcohol use: history	13%	34%	15%	10%	
Alcohol use: current	2%	6%	8%	8%	11%
Illicit drug use: history	6%	26%	13%	10%	
Illicit drug use: current	2%	17%	20%	18%	10% ¹
Use of unprescribed meds	0%	2%	0%	5%	
Over the counter/ prescription meds	81%	83%	90%	75%	
In utero drug exposure	14%	23%	18%	15%	
NAS diagnosis	0%	0%	0%	0%	

*either a P (present) or C (contributing) factor

¹Includes marijuana

- Six out of 43 (14%) drug screens were positive, and half were positive for marijuana.

⁶ 2022 National Survey on Drug Use and Health: Detailed Tables. Available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabs8-27pe2022.pdf> Accessed January 20, 2025.

6. Quality of Care

FIMR Issues Summary by year of review

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)
Obstetric standard of care not met	4%	0%	8%	3%
Inadequate assessment	2%	2%	8%	3%

7. Respectful Maternity Care

FIMR Issues Summary by year of review

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)
Language barriers	19%	6%	5%	12%
Beliefs re: pregnancy/health	0%	4%	8%	13%
Poor provider to patient communication	8%	8%	15%	18%
Client dissatisfaction	17%	13%	23%	13%
Dissatisfaction-support services	2%	4%	0%	5%

- Nine mothers who participated in a maternal interview were asked if they felt they were treated differently or unfairly in getting services, and 3 responded yes due to: race (n=1), ability to pay and age (n=1), marital status and culture (n=1).

8. Family Support

FIMR Issues Summary by year of review

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)
Bereavement referral made	92%	74%	80%	63%
Lack of grief support	2%	2%	8%	0%
Lack of home visiting (eligible)	62%*	56%*	72%	67%
Multiple stresses	40%	42%	50%	55%

*Out of mothers on Medicaid only

FIMR Tracking Database

	2024	2023
Referred to home visiting program	N=3 ¹	N=5
Enrolled in home visiting program	N=1	N=0
Used doula services	4%	4% ²

¹One mother was seen in a clinic, one in a private office and one received her care while incarcerated during pregnancy.

²Not a certified doula

9. Social Determinants of Health

FIMR Issues Summary by year of review*

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	PRAMS 2022
Lack of family support	4%	2%	10%	18%	
Lack of neighbors/ community support	2%	2%	0%	12%	
Lack of partner support	15%	15%	10%	22%	
Single parent ¹	15%	19%	18%	27%	
Frequent/recent moves	8%	19%	20%	25%	25%
Living in shelter/homeless	0%	0%	5%	2%	3%
Mother incarcerated	2%	4%	3%	7%	3%
Father incarcerated	2%	2%	10%	7%	
Social chaos	17%	11%	13%	12%	
Concern about enough money	17%	23%	8%	18%	14%
Work/ employment problems	6%	11%	8%	10%	
Problems with family/ relatives	2%	0%	0%	5%	
Past intimate partner violence: Mom	15%	4%	8%	15%	
Current intimate partner violence: Mom	8%	4%	5%	10%	1% ¹
CPS referrals	33%	30%	50%	32%	
Police reports	29%	23%	43%	17%	
Inadequate/ unreliable transportation	13%	4%	3%	12%	2% ²

*either a P (present) or C (contributing) factor

¹During pregnancy by current husband or partner

²Lack of transportation to clinic or doctor's office impeded prenatal care access

FIMR Tracking Database by year of review

	2024	2023	2022	2021	PRAMS 2022
Family adverse experiences					
Active with Division of Family Services (DFS)	6%	6%	5%	7%	
Any DFS history	35%	58%	52%	50%	
Criminal history: mother	33%	27%	25%	25%	
Criminal history: father	50%	23%	43%	39%	
Intimate partner violence screening documented	85%	72%	90%	90%	84% ¹
SDOH screening done	63%				

¹Screened during a prenatal care visit

Insurance type:

- Private only 23%
- Medicaid MCO only 46%
- Emergency Medicaid only 15%

10. Family Planning and Birth Spacing Education

FIMR Issues Summary by year of review*

	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	2021 (n=60 cases)	PRAMS 2022
Pregnancy planning/ birth control education	90%	85%	70%	73%	48% ¹
Intended pregnancy	31%	36%	43%	20%	52%
Unintended pregnancy	42%	26%	25%	32%	
Unwanted pregnancy	0%	11%	0%	8%	
Pregnancy < 18 mo apart	25%	13%	23%	25%	

*either a P (present) or C (contributing) factor

¹During postpartum visit, received education on birth spacing

FIMR Tracking Issues by year of review

	2024	2023	2022	2021	PRAMS 2022
Counseled on birth spacing > 18 months	4%	8%	5%	2%	
Counseled on family planning postpartum	87%	91%	74%	71%	36%
Accepted family planning postpartum--any type	50%	46%	42%	47%	71%
Accepted LARC postpartum	15%	8%	8%	16%	17%

LARC = long-acting, reversible contraception

11. Fetal Kick Counts (FKC)

FIMR Tracking Issues by year of review

	2024	2023	2022	2021	PRAMS 2022
FIMR Tracking Database					
FKC education after 23 weeks gestation	33%	48%	65%	56%	87% ¹

¹At any time during prenatal care

12. Vital Statistics

- Twenty-seven cases from calendar year 2022 were not reported to the MCDRC, including 20 infant cases that were DE residents and issued a DE death certificate.

13. FIMR Process

	2024	2023	2022	2021
Number of cases reviewed	48	53	40	60
Average time to referral (days)	37	37	45	45
Maternal interview acceptance rate	19% ¹	16%	15%	13%
Average time to review (months)	5.3	5.1	5.5 ²	8.2

¹From September-December, the MI acceptance rate was 35%. This represents the period during which a new family interviewer was working for DE FIMR. From January-August, the MI acceptance rate was 10%.

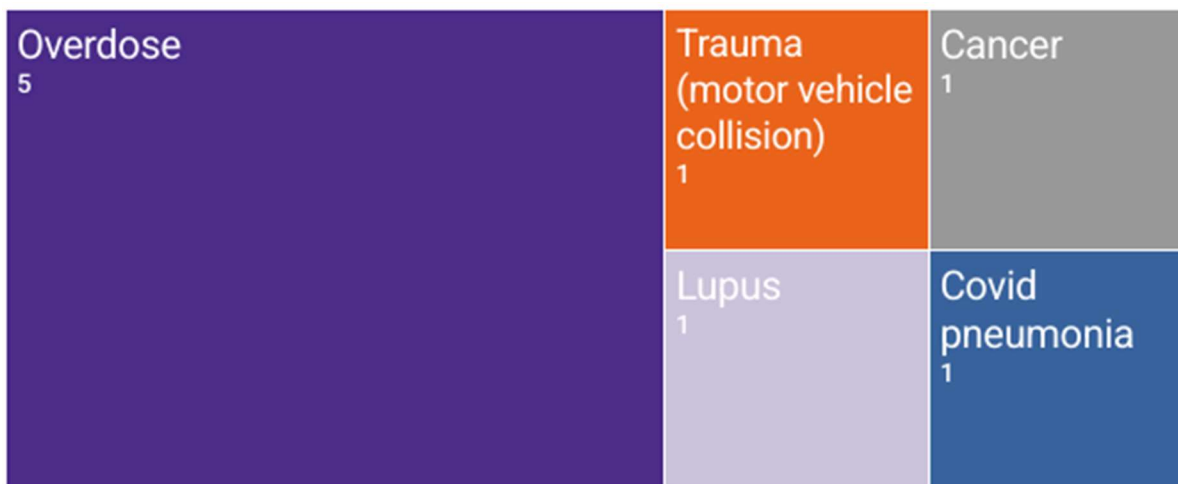
²Does not include one outlier case (MMR) that was delayed pending prosecution and dates from 2018

Maternal Mortality Review (MMR)

Overview of Cases

- Two cases were administratively closed over two years after death, both homicides with pending prosecution
- Nine cases were reviewed by the MMRC in 4 meetings--
 - Year of death ranging from 2021-2023
 - Average time between occurrence of death and review: 22 months
 - Race: 3 mothers were Black; 6 were White
 - Ethnicity: 1 mother was Hispanic
 - 6 women were on Medicaid or emergency Medicaid
 - 5 lived in New Castle County, 4 lived in Sussex (no Kent County residents)
 - Timing: all 9 deaths in the late postpartum period
 - 3 family interviews were conducted
 - Cause of death
 - 5 acute overdoses: 4 Pregnancy Associated but Not Related (PANR), 1 Unable to Determine Pregnancy Relation (UTD)
 - 3 medical causes: 2 PANR, 1 UTD
 - 1 motor vehicle collision: PANR
 - 6 cases were deemed preventable
 - There were no pregnancy related deaths

Underlying cause of death in MMR cases (n=9)



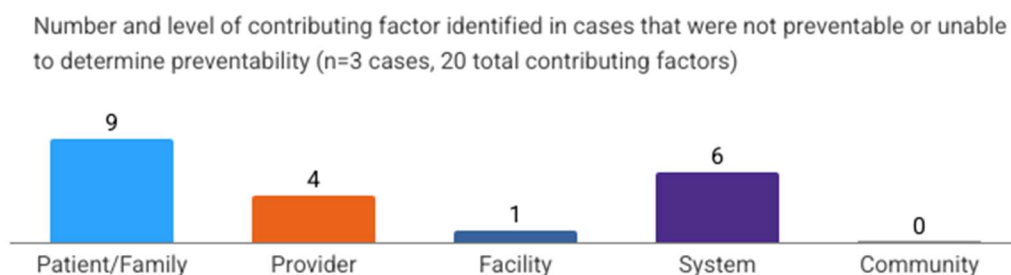
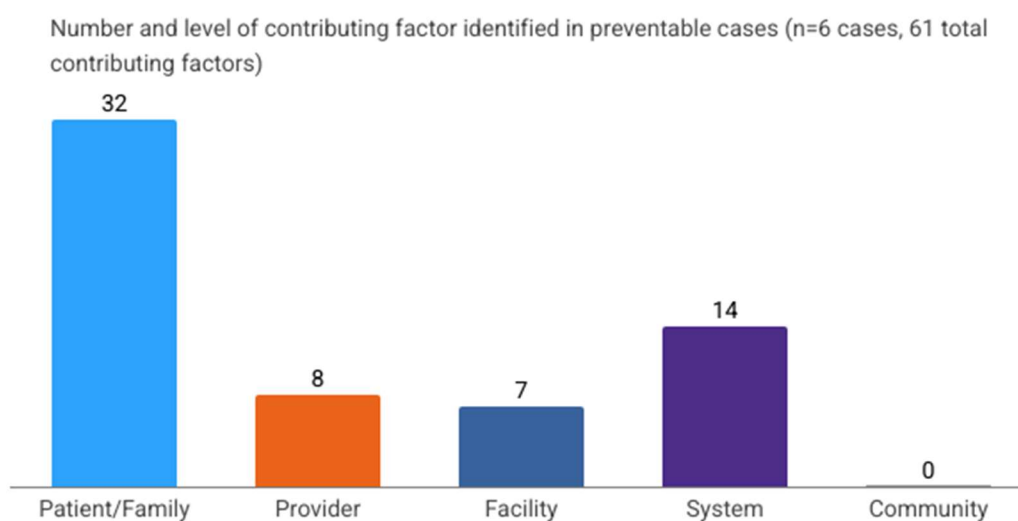
Contributing Factors & Recommendations

81 Contributing Factors were identified in 9 cases:

- Average of 9 per case
- 75% from the 6 preventable cases (n=61)
- 70% from the 5 overdose deaths (n=55)

64 Recommendations: 95% (n=61) in preventable cases, 3 in cases with UTD preventability

1 Strength: use of interpreter services

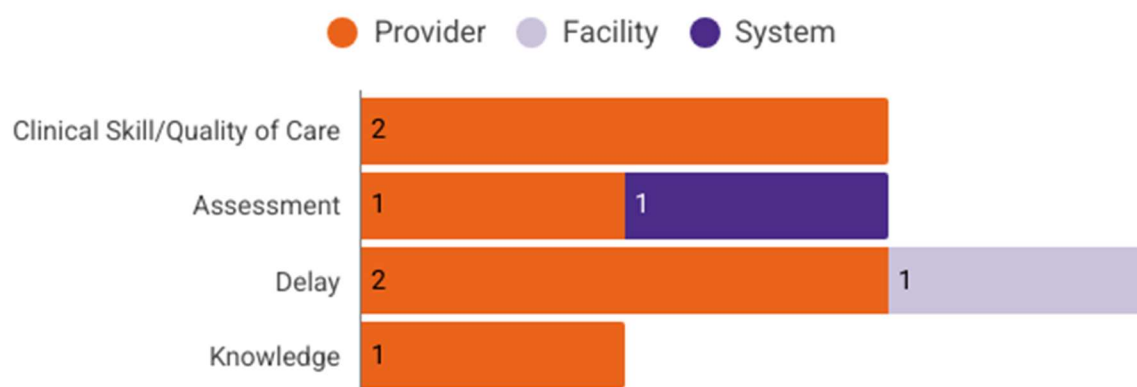


Contributing Factor Themes

A. Theme: Quality of Care

Sub-themes: Delay in care
Substance Use Disorder (SUD)
Knowledge / Clinical skill

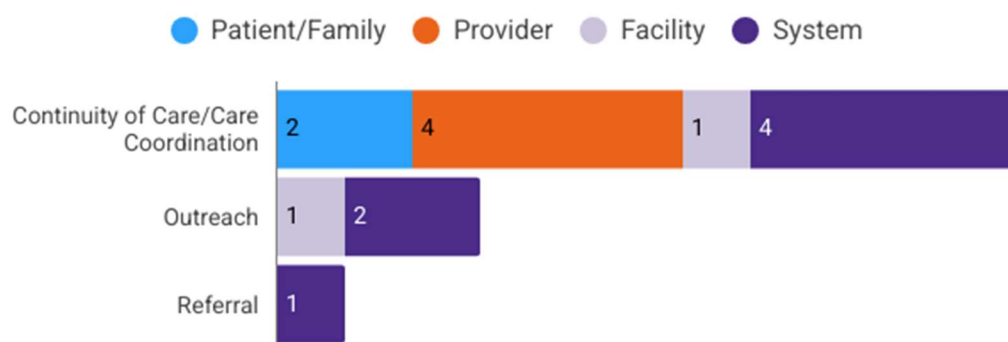
Number and level of related contributing factors identified at the time of review



B. Theme: Care Coordination

Sub-Themes: Discharge planning
Care managers
Providers / Facilities - Communication
Mental health
Complex social issues

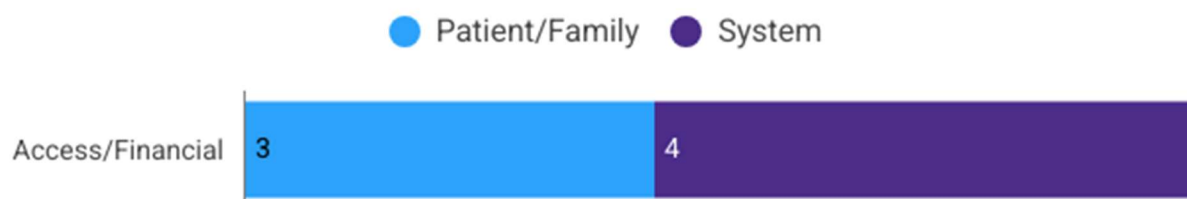
Number and level of related contributing factors identified at the time of review



C. Theme -Access

Sub-themes: Patient / Family - Lack of medical home
System - Insurance

Number and level of related contributing factors identified at the time of review



D. Theme: Structural and Social Determinants of Health (SSDOH)

Sub-themes: Unstable housing
Finances
Trauma
Social support/Isolation

Number and level of related contributing factors identified at the time of review

