

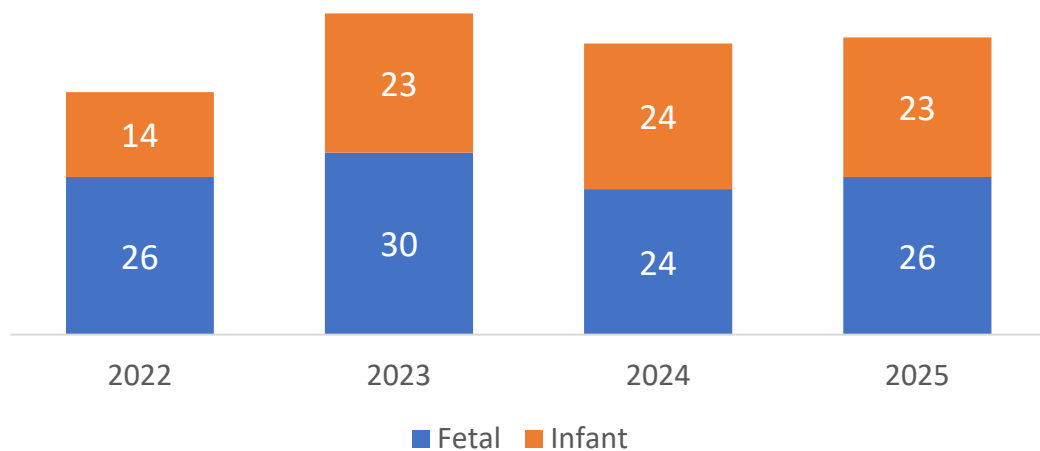
2025 Annual Report Data Addendum Maternal & Child Death Review Commission

Fetal and Infant Mortality Review

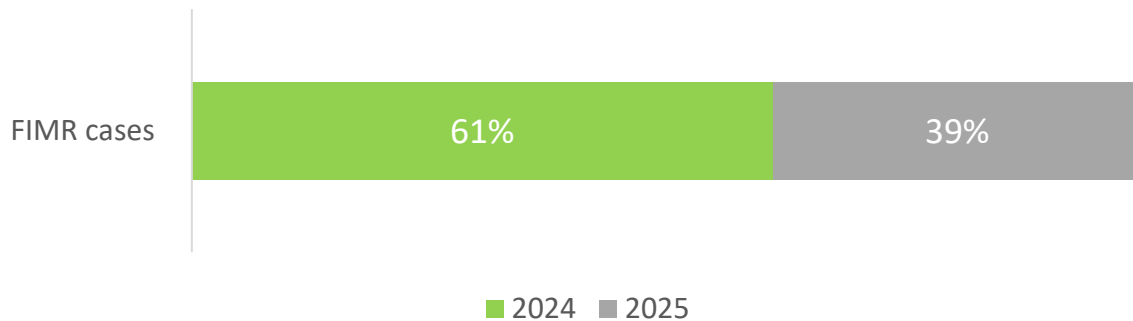
Overview of Cases

- FIMR CRTs reviewed 49 cases in 2025: 26 (53%) fetal deaths and 23 (47%) infant deaths

Cases by Year of Review

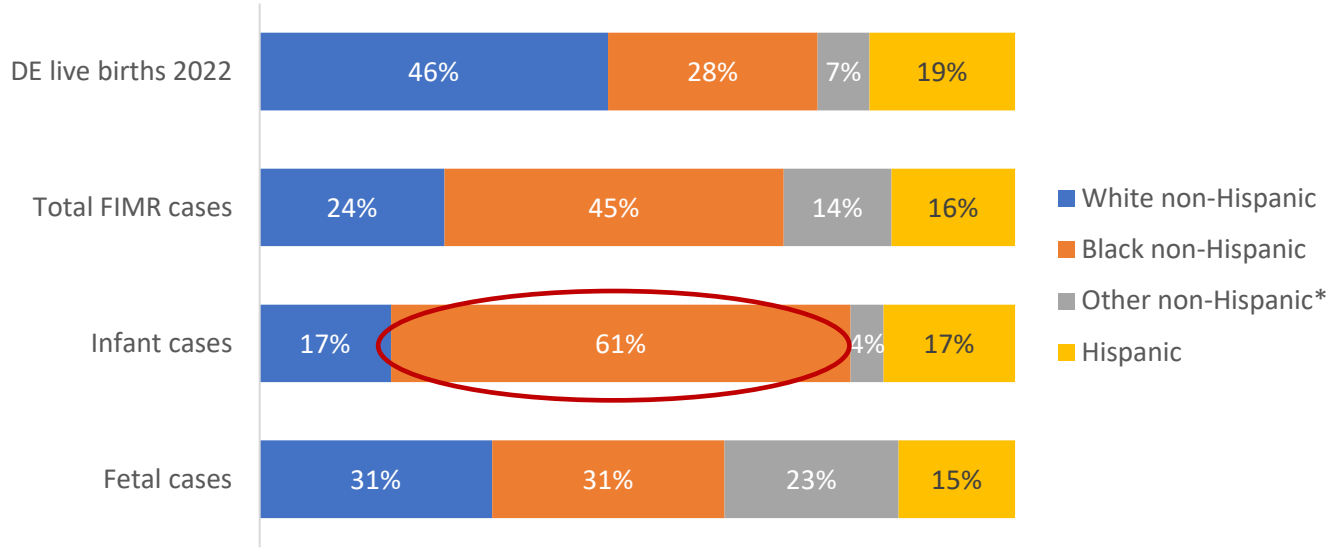


Year of Death



- Average time between the occurrence of a death and CRT review was 6.7 months, which is higher than in 2024 when it was 5.3 months.

Race/ethnicity by case type

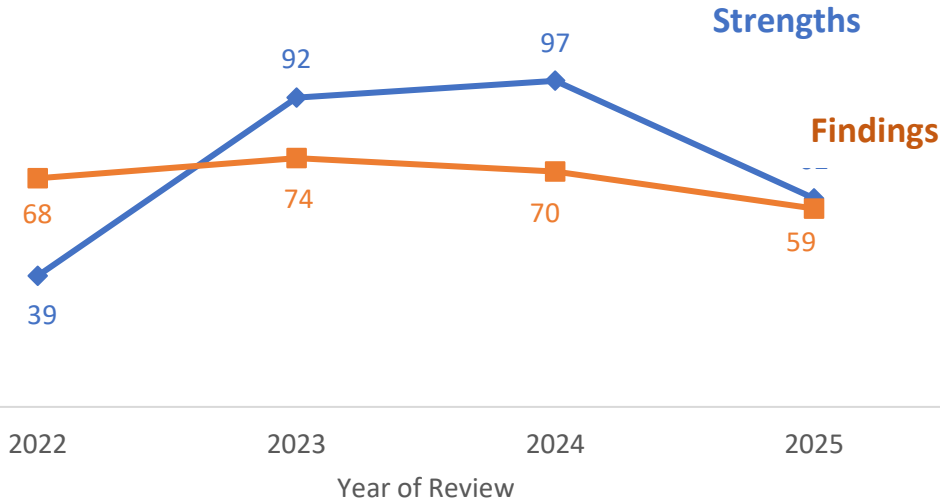


*Other race includes Asian and biracial

Source: FIMR data and Division of Public Health, Delaware Vital Statistics
Annual Report 202, "Live Births". Accessed at:
<https://www.dhss.delaware.gov/dph/hp/2022.html> on 1/9/2025.

- 38% (n=3 out of 8) Hispanic mothers were foreign born. This is decreased from the 2024 FIMR cohort, in which over half of Hispanic mothers were foreign born.
- Black infant deaths remained high among FIMR infant cases. Four out of 14 infant deaths to Black mothers involved women who were foreign born.

Number of Findings and Strengths over time



Findings and Strengths in 2025 FIMR Cases (n=49)

Category	Findings (n=59 total)	Strengths (n=62 total)
Maternal Health & Morbidity	3	4
Infant Health	3	0
Continuity of Care	9	12
Access to Care	6	0
Mental Health	1	4
Substance Use Disorder (SUD)	4	3
Quality of Care	6	7
Respectful Maternity Care / Patient-Centered Care	5	13
Family Support	8	11
Social Determinants of Health	2	4
Family Planning	0	3
Fetal Kick Counts (FKC)	2	1
Vital Statistics	4	0
FIMR Process	6	0

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

1. Maternal Health & Morbidity
FIMR Issues Summary by year of review*

Medical: Mother	2025 (n=49)	2024 (n=48)	2023 (n=53)	2022 (n=40)	PRAMS 2022¹
Cord problem	20%	25%	19%	23%	
Placental abruption	18%	15%	15%	28%	8% ^a
Chorioamnionitis	33%	29%	30%	28%	
Gestational diabetes	4%	8%	6%	3%	16%
Cervical insufficiency	8%	21%	13%	5%	
Infection: bacterial vaginosis	23%	8%	6%	10%	5%
Sexually transmitted infection	6%	13%	6%	8%	
Other infection	23%	29%	32%, including 19% with Covid	30%	
Multiple gestation	8%	10%	11%	10%	
Mother's weight BMI	57%	60%	70%	70%	
Insufficient/ excess weight gain	4%	6%	4%	13%	
Pre-existing hypertension	10%	13%	4%	18%	6.4%
Preeclampsia	10%	10%	8%	23%	18% ^b
Preterm labor	22%	35%	15%	15%	
PPROM (prolonged premature rupture of membranes)	14%	19%	17%	15%	
Oligo-/polyhydramnios	18%	25%	15%	23%	
Previous miscarriages	31%	23%	26%	38%	17% ^c
Previous fetal loss	10%	4%	2%	5%	17% ^c
Previous infant loss	4%	0%	2%	3%	
Previous low birthweight delivery	2%	4%	8%	10%	8.3%
Previous preterm delivery	10%	10%	21%	18%	8.4%
Previous C-section	29%	13%	19%	18%	
Assisted reproductive tech	2%	8%	6%	10%	

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

^a Includes any problem with the placenta such as abruption or previa

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

^c Miscarriage 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.

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

- There were two cases of **severe maternal morbidity (SMM)** due to obstetric hemorrhage requiring 4+ units of PRBCs or ICU admission. The 2022 SMM rate in Delaware was 109/10,000 hospital deliveries, or 1.1%.²

FIMR Tracking Database by year of review

	2025	2024	2023	2022
Low-dose aspirin screening done	79%	93%	90%	75%

2. Infant Health

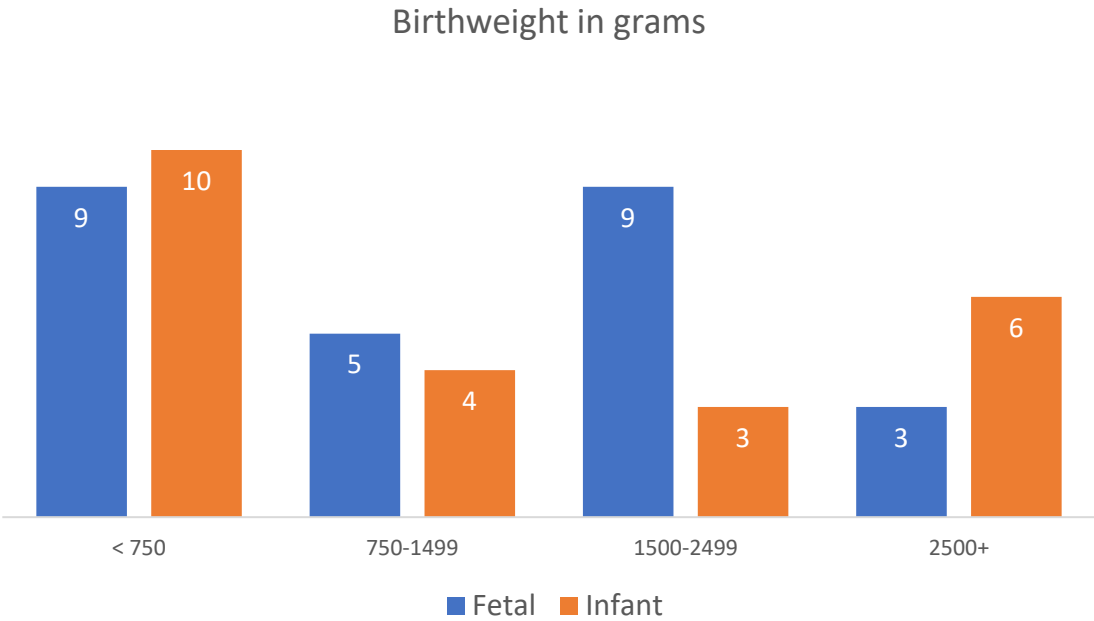
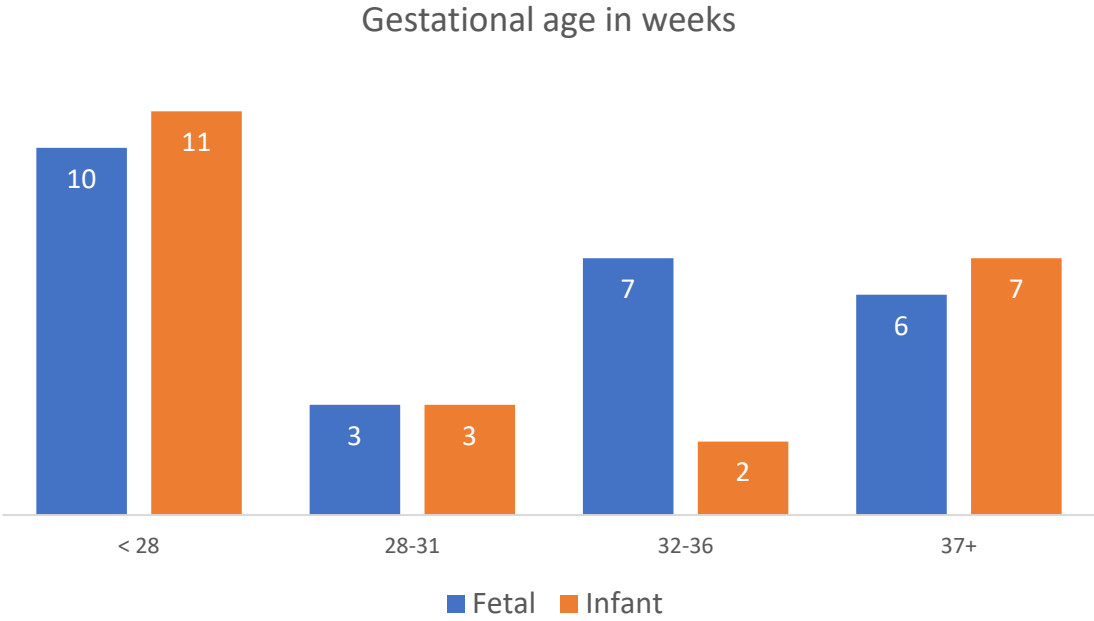
FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)
Non-viable fetus (infants only)	17%	13%	9%	14%
Intrauterine growth restriction	27%	13%	13%	23%
Congenital anomaly	35%	13%	9%	28%
Prematurity	33%	44%	32%	23%
Infection/ sepsis	8%	17%	4%	13%
Respiratory Distress Syndrome	10%	30%	25%	10%

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

- Among infant cases, contributing issues included:
 - 35% had congenital anomalies
 - 44% had prematurity
 - 13% had infection/sepsis
- Among fetal cases, contributing issues included:
 - 23% had congenital anomalies

² Agency for Healthcare Research and Quality. Severe Maternal Morbidity (SMM) among In-Hospital Deliveries for the Nation and all available States. Healthcare Cost and Utilization Project (HCUP) Fast Stats. Accessed at <https://datatools.ahrq.gov/hcup-fast-stats/> on January 20, 2026.



3. Continuity of Care

FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	PRAMS 2022
Preconception care	7%	23%	19%	25%	21%
Postpartum visit kept	70%	77%	70%	74%	88%
No prenatal care	12%	13%	12%	12%	22%
Late entry to prenatal care	25%	23%	19%	25%	22%
Lack of referrals	6%	2%	19%	25%	22%
Missed appointments	12%	6%	19%	25%	22%
Multiple providers / sites	6%	6%	19%	25%	22%
Poor provider to provider communication	4%	0%	19%	25%	22%

Location of birth—39% in non-Level 3 setting:

- Four infants (14%) were born in a Level 1 hospital
- Three infants (13%) were born in a Level 2 hospital
- Two infants were born at home

*either a P (present) or C (contraindicated)

¹PRAMS MCH indicators 2021 spreadsheet. Accessed at <https://www.cdc.gov/pr>

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

	2025	2024
< 3 weeks after delivery	69%	53%
3+ weeks after delivery	31%	23%

4. Access to Care

Demographics of LATE or NO PNC

County	Either Late or No PNC
New Castle (n=24)	5 (21%)
Kent (n=16)	7 (44%)
Sussex (n=8)	5 (63%)

Site of Care	Late PNC
Private (n=24)	6 (25%)
Clinic (n=14)	4 (29%)

Race/Ethnicity	Either Late or No PNC
White nonHisp (n=12)	2 (17%)
Black nonHisp (n=22)	10 (45%)
Other nonHisp (n=7)	3 (43%)
Hispanic (n=8)	3 (38%)

Insurance	Either Late or No PNC
Any Private (n=15)	2 (13%)
Any Medicaid (n=27)	12 (44%)
Self-pay (n=3)	3 (100%)

5. Mental Health

FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	PRAMS 2022
History of mental illness	23%	42%	40%	43%	
Depression/mental illness during pregnancy	12%	8%	11%	20%	18% ¹
Depression/mental illness postpartum period	31%	35%	38%	45%	7% ²
Depression screen documented (tracking database)	90%	94%	92%	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

Frequency of depression screening in perinatal period (pre to postpartum)

	2025	2024
1 time	44%	24%
2 times	42%	44%
3+ times	14%	31%

6. Substance Use Disorder

FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	NSDUH 2022 ³
Positive drug test	12%	6%	21%	28%	
No drug test	14%	10%	17%	10%	
Tobacco use: history	10%	13%	23%	10%	9% ^a
Tobacco use: current	14%	15%	11%	25%	
Alcohol use: history	29%	13%	34%	15%	
Alcohol use: current	6%	2%	6%	8%	8%
Illicit drug use: history	4%	6%	26%	13%	
Illicit drug use: current	2%	2%	17%	20%	10% ^b
Use of unprescribed meds	0%	0%	2%	0%	
Over the counter/ prescription meds	88%	81%	83%	90%	
In utero drug exposure ²	10%	14%	23%	18%	
NAS diagnosis	0%	0%	0%	0%	

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

^a Includes vaping

³ 2023 National Survey on Drug Use and Health: Detailed Tables. Table 8.26B. Available at:

file:///C:/Users/Meena.Ramakrishnan/AppData/Local/Temp/e19663e5-bc94-4326-b873-67168f339c8d_2023-nsduh-detailed-tables.zip.c8d/2023-nsduh-detailed-tables-sect8pe.htm. Accessed January 25, 2026.

^b Includes marijuana/cannabis use

Six out of 42 (14%) drug screens were positive:

- Two were positive for cannabis.
- One was positive for medications for opioid use disorder treatment (MOUD).
- Two were positive for iatrogenic reasons.
- One was positive for polysubstance, including MOUD.

Based on verbal history documented in FIMR reviews, 6 mothers (12%) were currently using cannabis at some point in their pregnancy. According to the National Survey on Drug Use and Health (NSDUH), in 2023 4.4% of pregnant women reporting marijuana use in the past month, and 10% of all women aged 15 to 44 years reported past month marijuana use.⁴

7. Quality of Care

FIMR Issues Summary by year of review

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)
Obstetric standard of care not met	0%	4%	0%	8%
Inadequate assessment	2%	2%	2%	8%

8. Respectful Maternity Care / Patient-Centered Care

FIMR Issues Summary by year of review

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)
Language barriers	16%	19%	6%	5%
Beliefs re: pregnancy/health	2%	0%	4%	8%
Poor provider to patient communication	4%	8%	8%	15%
Client dissatisfaction	14%	17%	13%	23%
Dissatisfaction-support services	2%	2%	4%	0%

Eleven mothers who participated in a maternal interview were asked if they felt they were treated differently or unfairly in getting services, and one responded yes due to her insurance status or ability to pay.

⁴ 2023 National Survey on Drug Use and Health: Detailed Tables. Table 8.26B.

9. Family Support

FIMR Issues Summary by year of review

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)
Bereavement referral made	79%	92%	74%	80%
Lack of grief support	0%	2%	2%	8%
Lack of home visiting (eligible)	68%*	62%*	56%*	72%
Multiple stresses	53%	40%	42%	50%

*Out of mothers on Medicaid only

FIMR Tracking Database

	2025	2024	2023
Used doula services	4%	4%	4% ¹

¹Not a certified doula

10. Social Determinants of Health

FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	PRAMS 2022
Lack of family support	12%	4%	2%	10%	
Lack of neighbors/ community support	4%	2%	2%	0%	
Lack of partner support	16%	15%	15%	10%	
Single parent ¹	16%	15%	19%	18%	
Frequent/recent moves	10%	8%	19%	20%	25%
Living in shelter/homeless	0%	0%	0%	5%	3%
Mother incarcerated	0%	2%	4%	3%	NR
Father incarcerated	4%	2%	2%	10%	NR
Social chaos	10%	17%	11%	13%	
Concern about enough money	41%	17%	23%	8%	14%
Work/ employment problems	8%	6%	11%	8%	
Problems with family/ relatives	12%	2%	0%	0%	
Past intimate partner violence: Mom	12%	15%	4%	8%	
Current intimate partner violence: Mom	0%	8%	4%	5%	1% ¹
CPS referrals	33%	33%	30%	50%	
Police reports	23%	29%	23%	43%	
Inadequate/ unreliable transportation	16%	13%	4%	3%	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

NR=not reported

FIMR Tracking Database by year of review

	2025	2024	2023	2022	PRAMS 2022
Family adverse experiences					
Active with Division of Family Services (DFS)	0%	6%	6%	5%	
Any DFS history	35%	35%	58%	52%	
Criminal history: mother	16%	33%	27%	25%	
Criminal history: father	24%	50%	23%	43%	
Intimate partner violence screening documented	83%	85%	72%	90%	84% ¹
SDOH screening done	81%	63%			

¹Screened during a prenatal care visit

Insurance type

- Private only 31%
- Medicaid 51%
- Emergency Medicaid only 4%
- Self-pay 6%
- Unknown 6%

11. Family Planning and Birth Spacing Education

FIMR Issues Summary by year of review*

	2025 (n=49 cases)	2024 (n=48 cases)	2023 (n=53 cases)	2022 (n=40 cases)	PRAMS 2022
Pregnancy planning/ birth control education	79%	90%	85%	70%	48% ¹
Intended pregnancy	27%	31%	36%	43%	52%
Unintended pregnancy	31%	42%	26%	25%	
Unwanted pregnancy	0%	0%	11%	0%	
Pregnancy < 18 months apart	39%	25%	13%	23%	

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

¹During postpartum visit, received education on birth spacing

FIMR Tracking Issues by year of review

	2025	2024	2023	2022	PRAMS 2022
Counseled on birth spacing > 18 months	13%	4%	8%	5%	
Counseled on family planning postpartum	74%	87%	91%	74%	36%
Accepted family planning postpartum--any type	59%	50%	46%	42%	71%
Accepted LARC postpartum	15%	15%	8%	8%	17%

LARC = long-acting, reversible contraception

12. Fetal Kick Counts (FKC)

FIMR Tracking Database	2025	2024	2023	2022	PRAMS 2022
FKC education after 23 weeks gestation	50%	33%	48%	65%	87% ¹

¹At any time during prenatal care

13. FIMR Process

	2025	2024	2023	2022
Number of cases reviewed	49	48	53	40
Average time to referral (days)	52	37	37	45
Maternal interview acceptance rate	22%	19%	16%	15%
Average time to review (months)	6.7	5.3	5.1	5.5 ¹

¹Does not include one outlier case (MMR) that was delayed pending prosecution and dates from 2018

Maternal Mortality Review

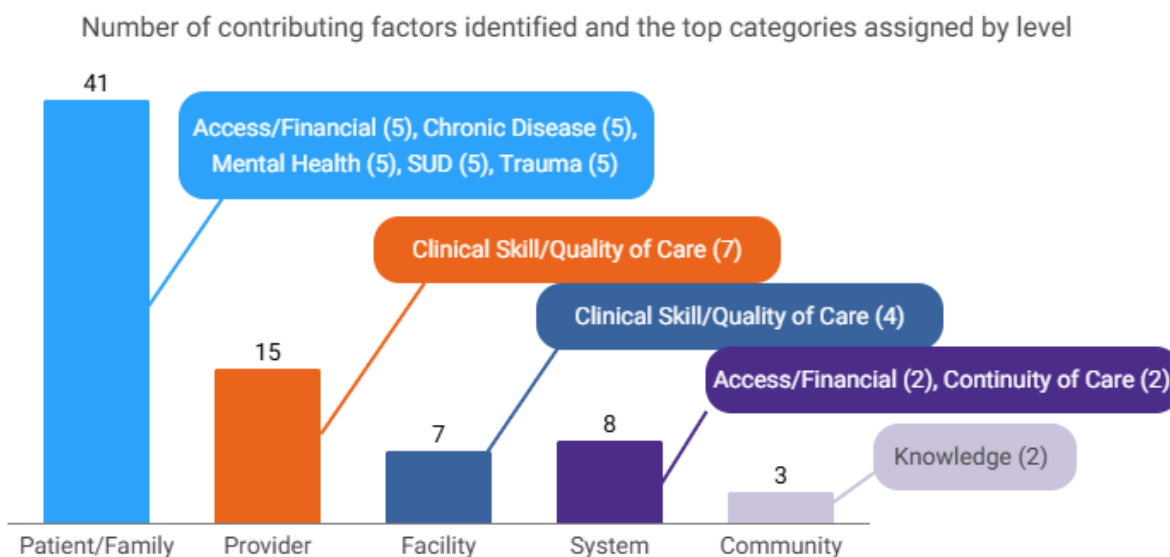
Overview of Cases

Eight cases were reviewed by the MMR Committee in 4 meetings. From these cases:

- Year of death ranged from 2023-2025
- Average time to referral: 5 months
- Average time between occurrence of death and review: 15.5 months
- Race: 6 were White, 1 Black and 1 Other race
- Ethnicity: 2 mothers were Hispanic
- 6 women were on Medicaid or emergency Medicaid, 1 on Medicare and 1 had private insurance
- All 8 women lived in New Castle County
- Timing: 6 deaths in the late PP period, and 2 were during pregnancy
- No family interviews were conducted
- Cause of death
 - 4 acute overdoses: cocaine + another drug(s)
 - 3 medical causes: 1 metastatic breast cancer, 1 sudden unexpected death in epilepsy, 1 heart failure due to valvular disease
 - 1 unknown cause (no death certificate available from out of state)
- 6 deemed preventable, 2 unable to determine (UTD) preventability
- No pregnancy related deaths: 5 pregnancy-associated but not related (PANR) and 3 UTD

Contributing Factors

- 74 Contributing Factors were identified in the 8 cases, that is an average of 9 CFs per case.
- There were also 3 strengths identified: 2 at the Provider level and one at the Facility level.

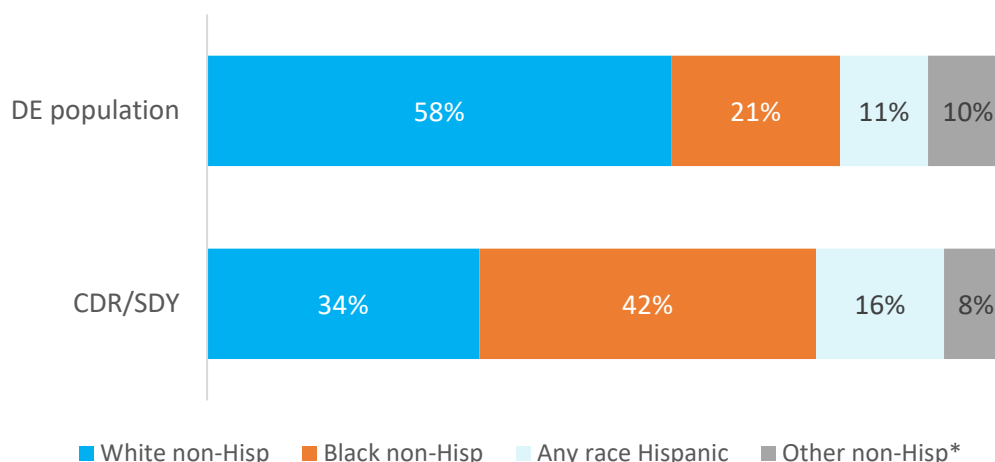


Child Death Review and Sudden Death in the Young

Overview of Cases

- 38 cases reviewed: CDR 21 cases, SDY 17 cases
- 8 cases administratively closed due to a delay > 2 years waiting on a prosecution status decision
 - Three cases were homicides
 - Three were accidental in manner (motor vehicle collision, overdose, cosleeping)
 - Two cases were undetermined in manner and unsafe sleep related
- 9 infant cases reviewed
- 11 unsafe sleep deaths reviewed, including 2 involving children over 1 year of age
- 8 cases were reviewed jointly with the Child Abuse and Neglect (CAN) panel
- 14 children (37%) had known chronic health conditions: 5 of them died of natural causes, 6 were accidental causes, 2 were homicides and 1 was undetermined manner
- New Castle residents made up 68% (n=26), Kent 5% (n=2) and Sussex 26% of cases (n=10)
 - Kent County under-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.⁵
- Males made up 55% of cases (n=21) and females 45% (n=17)
- Black children made up twice as many CDR/SDY cases as they do youth under 19 in Delaware (Figure 1).

Figure 1: Race and ethnicity of children 0-19 years in 2025²

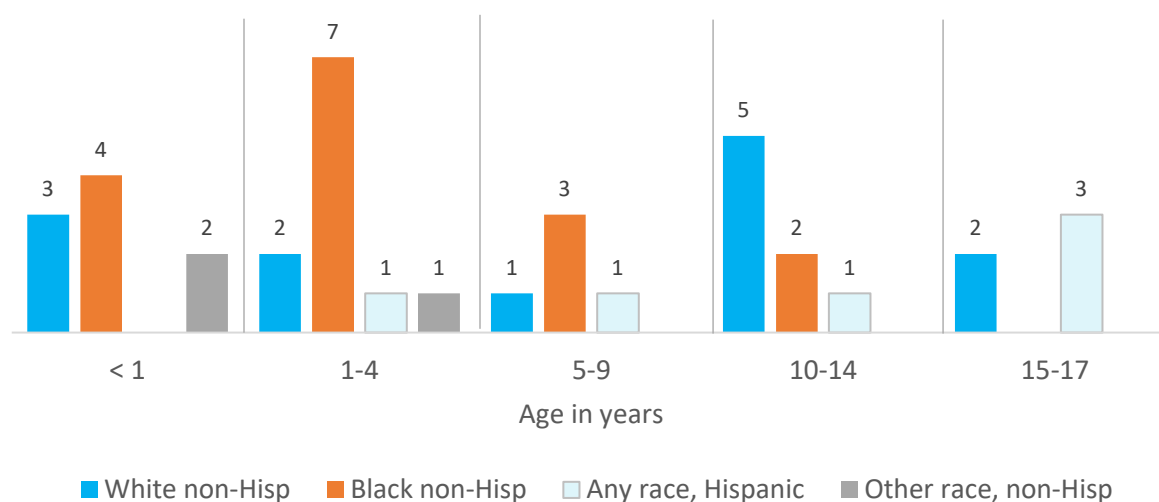


*Other refers to Asian, multiracial and unknown race as captured in the national database.

⁵ Kids Count Data Center. Child Population in Delaware, 2020-2024. 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/2675,2606,2543,2454,2026,1983,1692,1691,1607/213/19451,19452> on Feb 13, 2026.

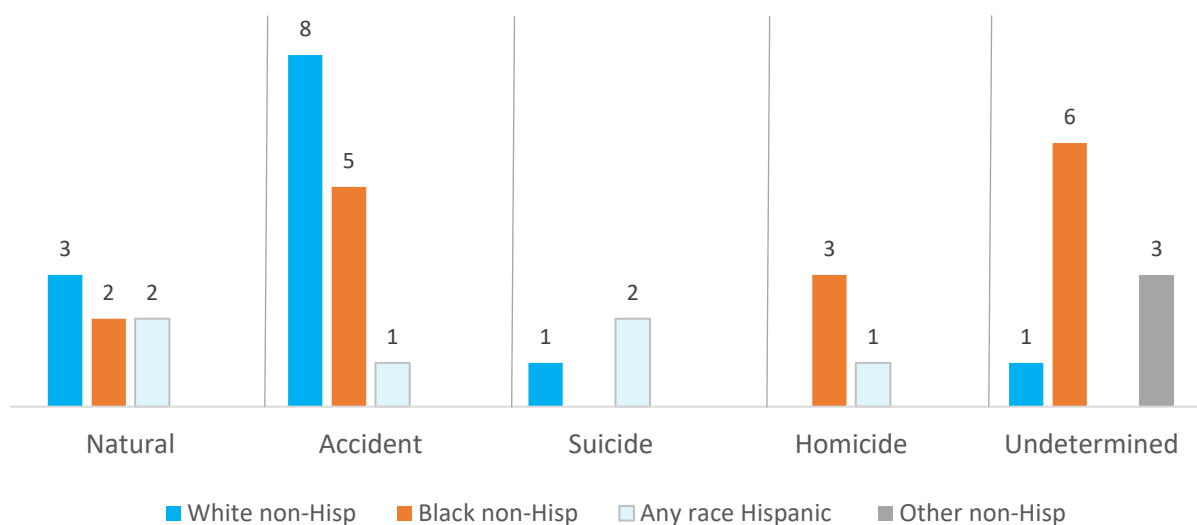
⁶ Kids Count Data Center. Population by age group, gender and race/ethnicity in Delaware. Accessed at: <https://datacenter.aecf.org/data/tables/10074-population-by-age-group-gender-and-race-ethnicity?loc=9&loct=2#detailed/2/any/false/1096/122|112|133,3,4,13,107/19473> on Feb 13, 2026.

Figure 2: Age groups by race and ethnicity



- In 2025 cases, Black non-Hispanic children made up a disproportionately high number of deaths among infants and young children 1-4 years old (Figure 2). Hispanic youth made up a disproportionately high number of older adolescent deaths 15-17 years old.
- Black non-Hispanic children made up a large number of accidental, homicide and undetermined deaths. Two out of the three suicide deaths involved Hispanic youth (Figure 3).

Figure 3: Manner of Death by race and ethnicity



⁷ 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.

Figure 4: Manner of Death by Age

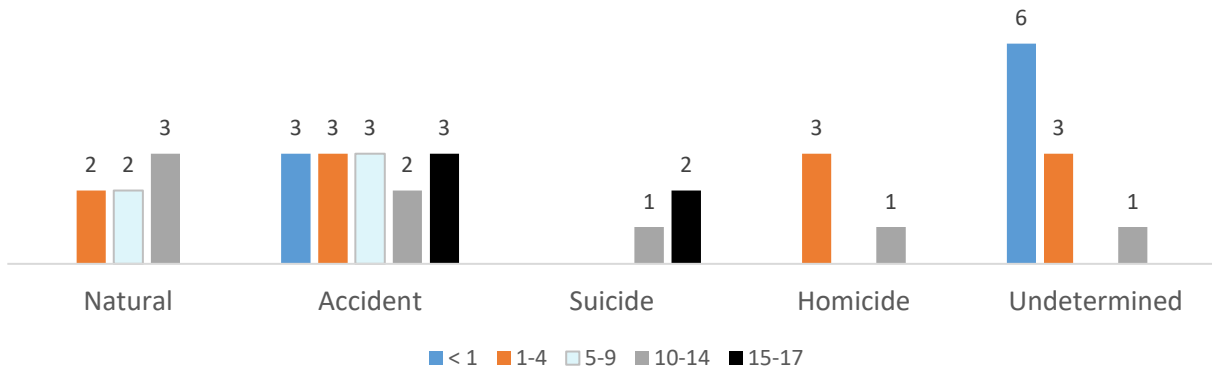
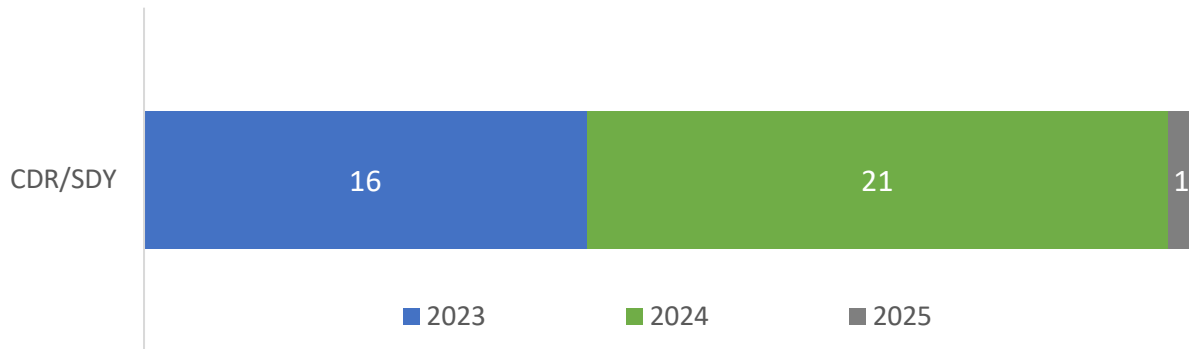


Figure 5: Year of Death



- Cases reviewed in 2025 represent deaths that occurred between 2023 and 2025 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 13 months.

CDR/SDY Infant Deaths

- All nine infant cases were related to unsafe sleep conditions.
- One infant was born premature, before 37 weeks gestation.
- One infant was born low birthweight, that is under 2500 grams.

Infant Cases: Tracking Issues by Year of Review

	2025 (n=9)	2024 (n=12)	2023 (n=12)	2022 (n=17)
Intrauterine tobacco exposure¹	11%	50%	42%	35%
Intrauterine alcohol exposure¹	0%	0%	8%	18%
Intrauterine drug exposure¹	0%	58%	45%	46%
Late or no prenatal care²	0%	8%	17%	12%
Insurance coverage for infant				
Medicaid	56%	100%	91%	59%
Private	22%	0%	9%	18%
None	0%	0%	0%	18%
No infant safe sleep education documented	0%	0%	0%	15%
Drug screen done on mother	75%	100%	100%	82%
Neonatal Opioid Withdrawal Syndrome (NOWS) scoring	0%	0%	60%	0%
Substance-exposed infants with DFS notification	NA	43%	80%	67%
Home visiting referral made	13%	25%	30%	35%
Home visiting enrollment	Unknown	33%	33%	17%

¹From the NCFRP standardized report²Late prenatal care defined as >6 months into pregnancy

	2025 (n=9)	2024 (n=12)	2023 (n=12)	2022 (n=17)
Caregiver at time of death				
Parent	100%	100%	100%	82%
Other	0%	0%	0%	18%
Substance use at time of death	50%	60%	57%	25%

CDR/SDY Specific Causes of Death
Unsafe sleep-related deaths reviewed in 2025 (n=11)

- No families were a known Cribs for Kids recipient
- In all 9 infant cases, Infant Safe Sleep education was documented in the medical record.

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

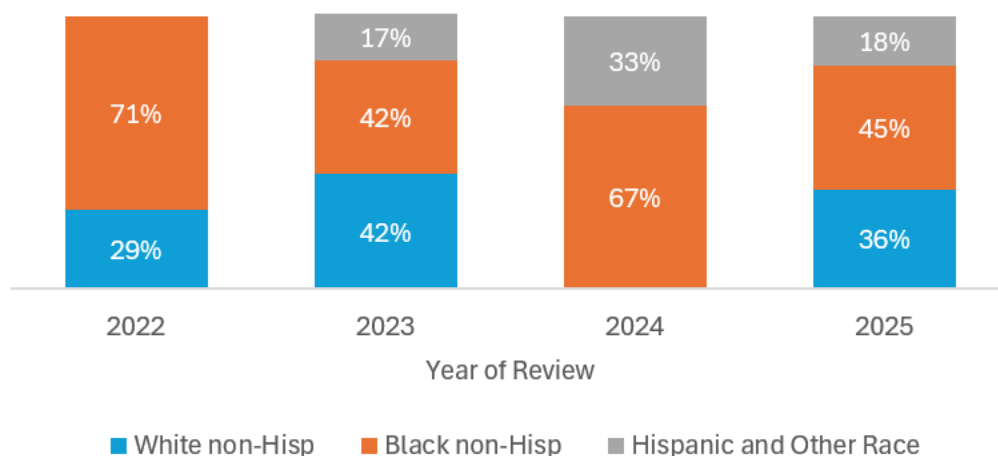
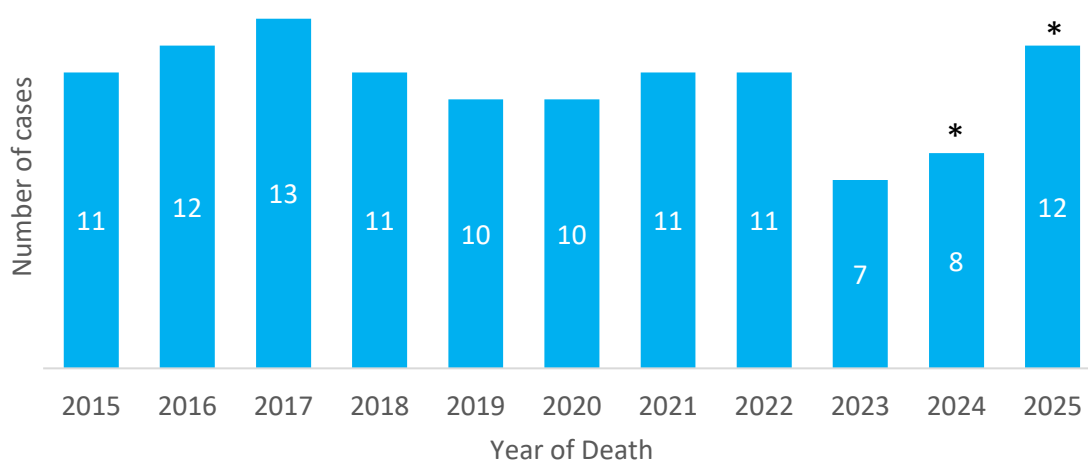


Figure 7: Infant deaths related to unsafe sleep by year of occurrence



*There are some 2024 and 2025 cases pending review that cannot be attributed to unsafe sleep until finalized, so numbers may change and will be included in future reporting.

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

	2025 (n=9)	2024 (n=9)	2023 (n=12)	2022 (n=14)	PRAMS 2022 ¹
Not in a crib, bassinette, side sleeper, or baby box	67%	78%	75%	79%	10% ²
Not sleeping on back	67%	22%	42%	43%	21%
Unsafe bedding or toys near infant	89%	89%	92%	79%	6% ³
Sleeping with other people	56%	56%	50%	79%	22% ⁴
Intrauterine drug exposure	0%	56%	44%*	36%*	--
Tobacco use: mother	11%	60%	33%	45%*	12% ⁵
Adult was alcohol or drug-impaired	44%	67%	33%	21%	--
Infant ever breastfed	78%	45%	67%	64%*	86%
Mother fell asleep while breastfeeding	11%	11%	0%	7%	--

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

Cribs for Kids 2025 Data

494 cribs were distributed through partners in 2025.

- 12 families had a substance exposed infant.
- 64% of cribs went to residents in NCC.
- 35% of families were Hispanic (158 of 450 with ethnicity known).
- Overall, there was a good match between where cribs are being distributed and where infant unsafe sleep deaths are occurring. (See Figure 9.)

Twelve trainings were conducted in 2025 with the following partners:

West Side Health, Highmark Health Options, CC Middletown ED, Kent County Health Services DPH, Delaware First Health, Center for Women's Emotional Wellness, Do Care Doula Foundation, New Day Pregnancy Care Center, Delaware State Housing Authority, Impact Life Peer Doula Program, Shipley Service Center DPH, Network Connect.

CDR/SDY Tracking Issues

Adverse Family Experiences, by year of review¹

	2025 Total (n=38)	2025 Infants⁴ (n=9)	2024 Total (n=46)	2024 Infants (n=12)	2023 Total (n=54)	2023 Infants (n=12)
DFS notified of death²	20%	0%	100%	100%	100%	100%
DFS rejected MDT response that should have been accepted, 0–3-year-olds	33%	NA	0%	0%	0%	0%
Active with DFS at time of death	11%	33%	11%	25%	22%	50%
Active with DFS within 12 months of death	11%	*	17%	33%	31%	58%
DFS history: parents as adults	45%	*	43%	58%	58%	67%
DFS history: parents as children	35%	*	35%	83%	40%	83%
Maternal substance abuse³	26%	44%	36%	92%	47%	73%
Paternal substance abuse³	43%	88%	44%	78%	47%	78%
Maternal criminal history	26%	22%	33%	50%	46%	67%
Paternal criminal history	50%	63%	61%	90%	57%	58%
Maternal mental health issue³	31%	75%	*	86%	*	100%
Paternal mental health issue³	24%	*	*	*	*	*
Maternal intimate partner violence³	32%	43%	44%	67%	39%	55%
Paternal intimate partner violence³	*	*	41%	60%	53%	70%
Maternal history of abuse	13%	22%	9%	17%	16%	33%
Paternal history of abuse	30%	38%	11%	20%	14%	25%
Maternal history of neglect	16%	13%	23%	33%	24%	50%
Paternal history of neglect	28%	43%	23%	30%	23%	50%

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

¹Denominator is applicable to cases with known information²Denominator 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 natural³Current, history or suspected⁴Many cases do not have complete information as transition to the APRICOT database led to some forms not correctly opening. This will be corrected in the next year of reviews but was not picked up before doing quality assurance and closing cases.

Infant Tracking Issues, by year of review

	2025 (n=9)	2024 (n=12)	2023 (n=12)	2022 (n=17)
No SUIDI reporting form¹	11%	38% ²	10% ²	8%
No scene investigation¹	0%	0%	0%	0%
No scene photos¹	0%	0%	0%	0%
No doll re-enactment¹	33%	25%	10% ²	15% ²
Toxicology screen of alleged perpetrator	78%	73%	92% ²	67%

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

²This is mainly due to parents' refusal to cooperate