CUYAHOGA COUNTY

CHILD FATALITY REPORT

EXECUTIVE SUMMARY

This report is humbly dedicated to the families who have suffered the unimaginable loss of a child. May their stories inspire us to work tirelessly to prevent future tragedies.

CCBH CUYAHOGA COUNTY BOARD OF HEALTH
Your Trusted Source For Public Health Information

COUNTY OF CUYAHOGA OHIO

Invest in Children

ABOUT CFR

The **Cuyahoga County Child Fatality Review (CFR) Board** is a group of dedicated professionals committed to reducing child fatalities and improving the safety and the well-being of children in our community.

The Cuyahoga County Child Fatality Review Board brings together profressionals from various fields including healthcare, law enforcement, social services and public health to review the causes and circumstances surronding a child's death. By learning the story of the child's life, and circumstances of their death, the CFR board aims to uncover any challenges faced by the child, any systems they interacted with and risk factors that may have contributed to their death.

The ultimate goal of CFR is to use these collective findings to improve policies, programs and interventions, and develop recommendations to prevent future child fatalities.

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2024 -2025

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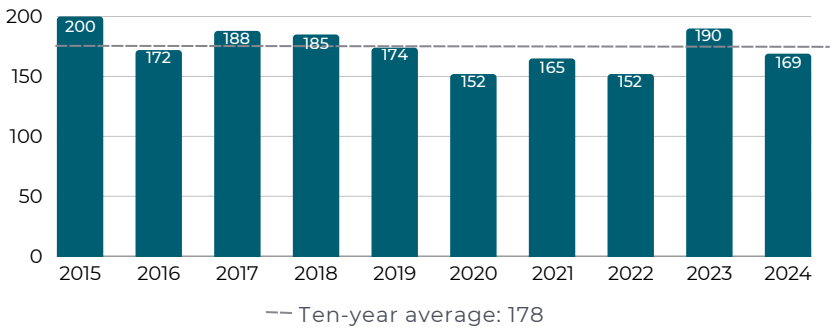
2024 IN REVIEW

Child fatalities are incredibly devastating and tragic, exposing the challenges and vulnerabilites faced by the youngest members of our commmunity.

Each child death marks not just the loss of a young life, but also serves as a reminder of the gaps within our protective systems and the need for interventions and strategies to prevent future losses.

169 CHILDREN DIED DURING 2024

▼ 21 (11%) compared to 2023

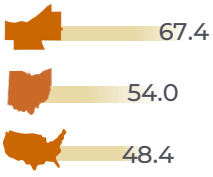


In 2024, child fatalities decreased by 21, following a rise in 2023. It's essential to look at long-term trends for a clearer understanding, as 2024's numbers were slightly below the ten-year average.

CHILD MORTALITY RATE

67.4

PER 100,000



The Child Mortality Rate in Cuyahoga County of 67.4 is 22% higher than the State of Ohio and 33% higher than the United States.

KEY TRENDS

Child fatalities decreased by 21, falling below the ten-year average.

Homicides and child abuse fell from historical highs seen in 2023, but remain above the ten-year average.

▼ 169
Total Child Fatalities

▼ 107
Infant Deaths

▼ 8.6
Infant Mortality Rate

▲ 18
Sleep-Related Deaths

▼ 6
Abuse & Neglect

▼ 27
Unintentional Injury

▼ 1
Suicides

▼ 21
Homicides

INFANT MORTALITY

Infant mortality, the death of a baby before its first birthday, is a crucial indicator of a community's health and well-being.

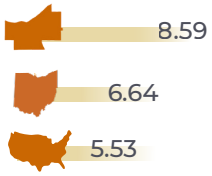
107 INFANTS DIED DURING 2024

▼ 5 (4%) compared to 2023

INFANT MORTALITY RATE (IMR)

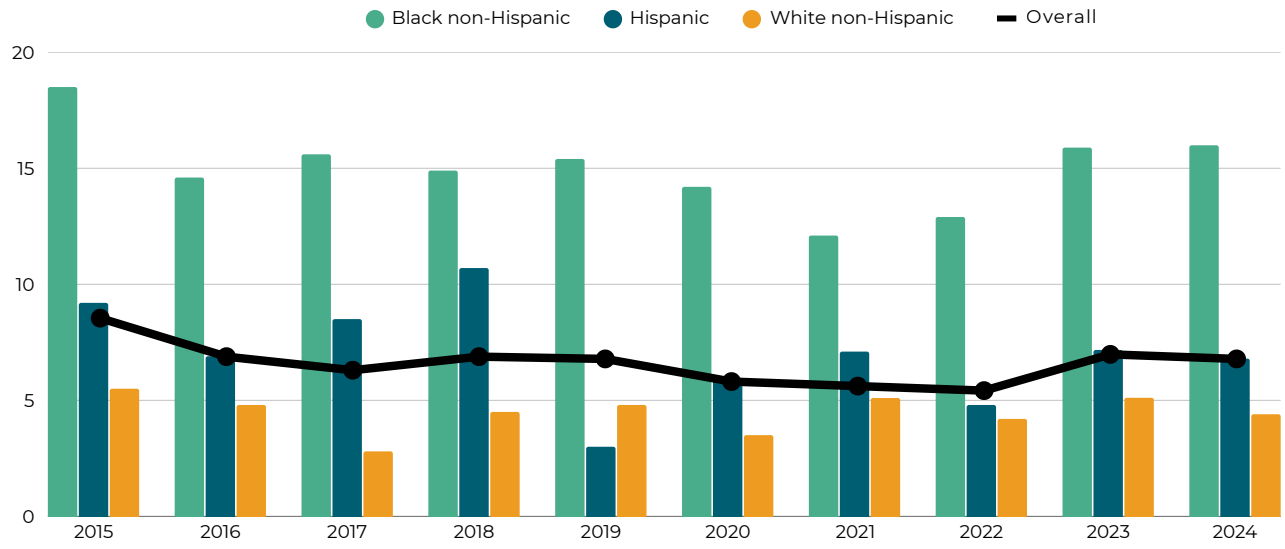
8.59

PER 1,000 BIRTHS



The Infant Mortality rate is 25% higher than the State of Ohio and 43% higher than the United States.

The 2024 Infant Mortality Rate (IMR) of 8.59 is a slight decrease from 2023. The 2024 IMR is higher than the ten-year average (8.41). The White non-Hispanic IMR fell to 4.40, meeting the HealthyPeople 2030 goal of 5.0 or less. However, **the Black non-Hispanic IMR slightly increased to 15.99.**



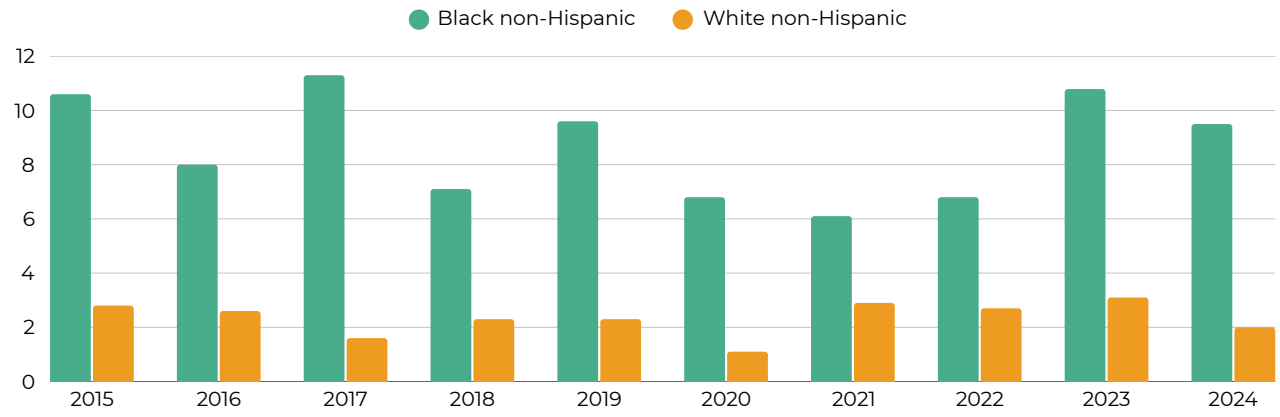
Significant racial inequities persist as black families suffer the burden of an infant mortality rate that is **3.64 times** higher compared to white families.

PREMATURITY

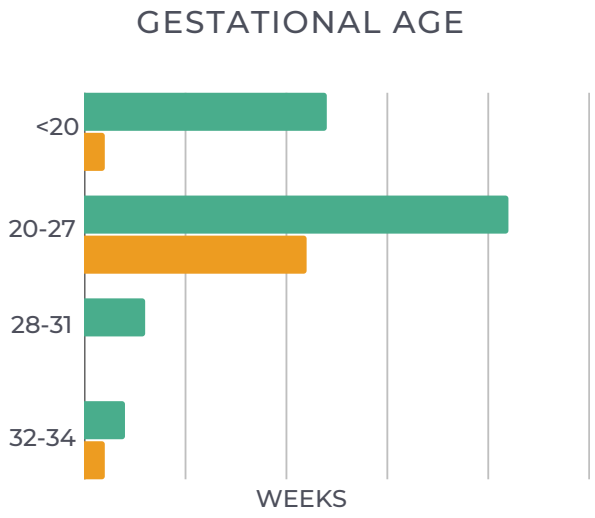
Infants born prematurely are among the most vulnerable members of the community and are highly sensitive to many Social Determinants of Health (SDoH), such as access to care, poverty and environmental factors. **Prematurity accounted for 54% of infant deaths.**

58 INFANTS DIED DUE TO PREMATURITY DURING 2024

Black non-Hispanic babies die from prematurity at a rate **4.65 times** that of White non-Hispanic babies



Extremely premature babies (<28 weeks of gestation) represent 88% of all infant deaths due to prematurity. Black non-Hispanic babies account for 65% of all infant deaths due to extreme prematurity and 92% of deaths among infants born at <20 weeks gestation.



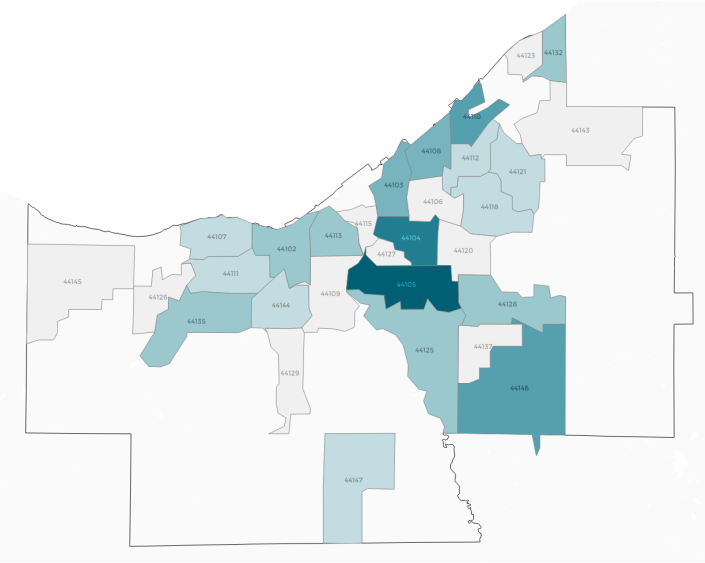
SLEEP-RELATED INFANT DEATHS

Sleep-related deaths are the second leading cause of infant deaths, accounting for 17% of all infant deaths. Sleep-related deaths are highly preventable and typically occur due to an unsafe sleep environment.

18 BABIES DIED DUE TO UNSAFE SLEEP CONDITIONS

▲ 1 (6%) compared to 2023

Black non-Hispanic infants are **7 times** more likely to die due to an unsafe sleep environment than all other races; and **10 times** more likely than white non-Hispanic infants.

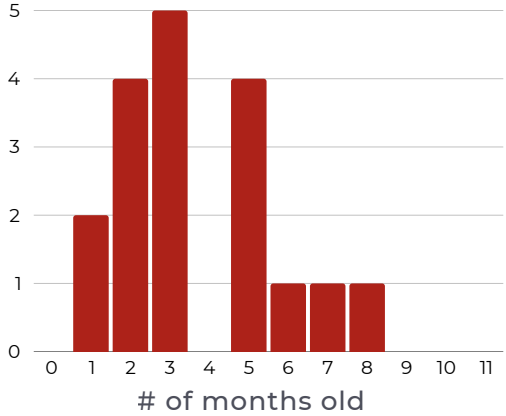


72% of sleep-related deaths over the last 5-years occurred in babies that lived in the city of Cleveland.

The Zip Codes where sleep-related deaths most often occurred include:
44105, 44104, 44146, and 44110

SLEEP-ENVIRONMENT RISK FACTORS

AGE DISTRIBUTION



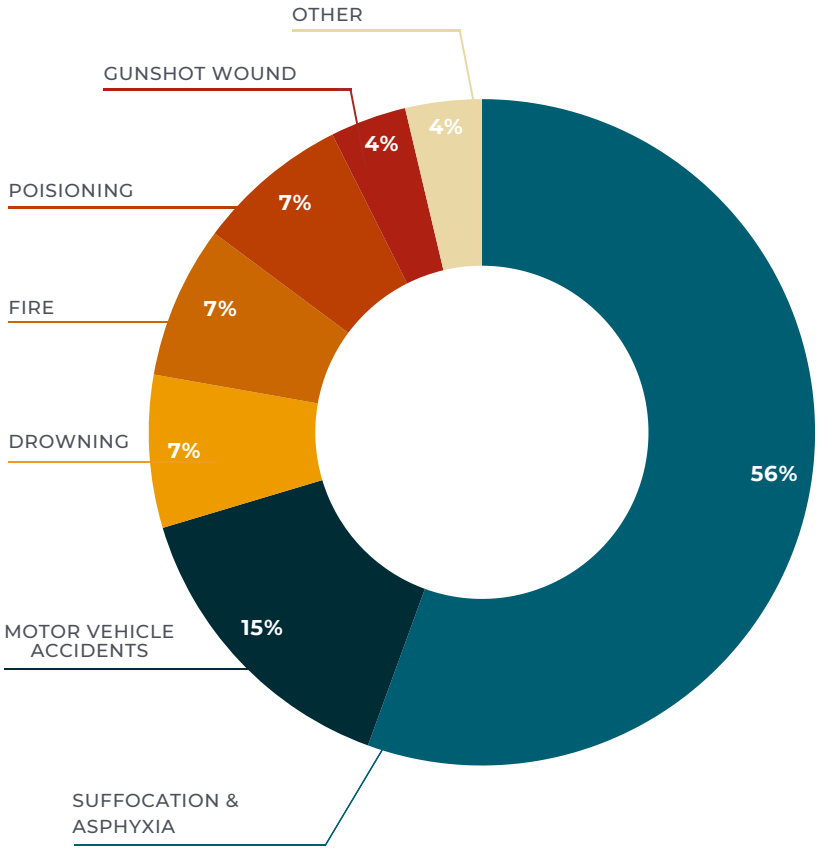
83% of sleep-related deaths occurred in the first 5 months of a babies life.

UNINTENTIONAL DEATHS

Unintentional deaths are the result of accidents, unforseeable events and circumstances that occur without the intention to cause harm.

27 CHILDREN DIED FROM UNINTENTIONAL INJURIES

▼ 1 (4%) compared to 2023

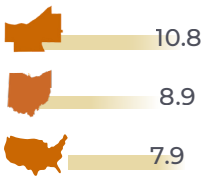


Suffocation and asphyxia accounted for over half of the unintentional deaths, all of which occurred due to an unsafe sleep environment.

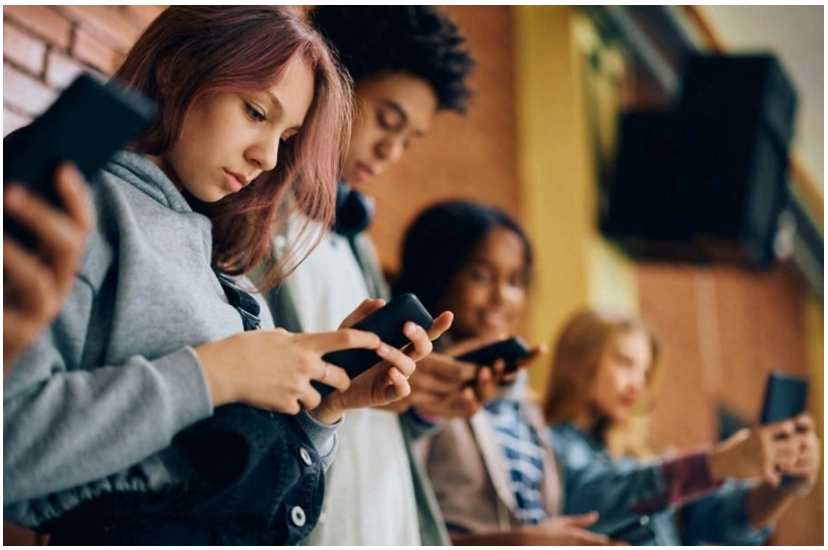
UNINTENTIONAL DEATH RATE

10.8

PER 100,000

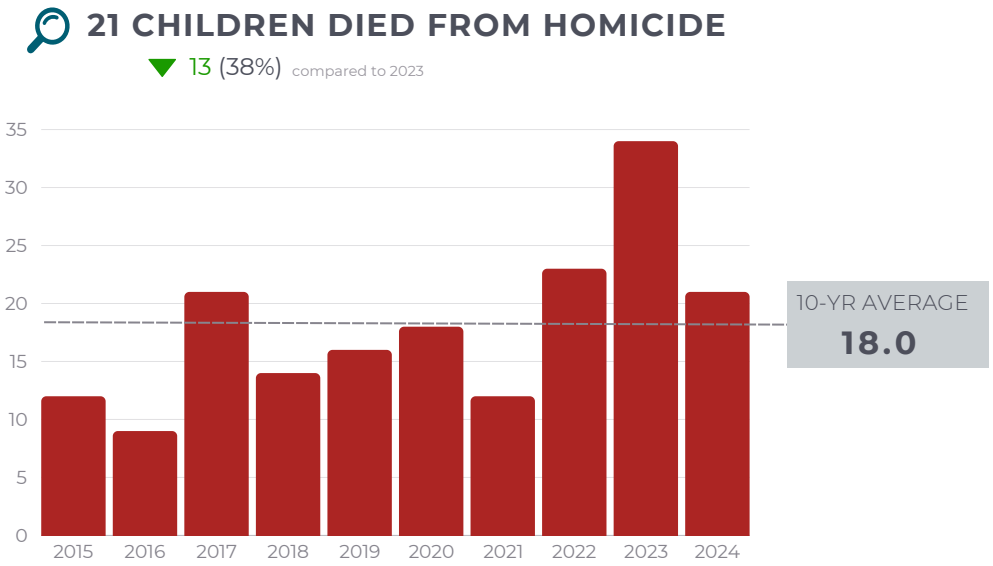


The Unintentional Injury Death rate is 19% higher than the State of Ohio and 31% higher than the United States.

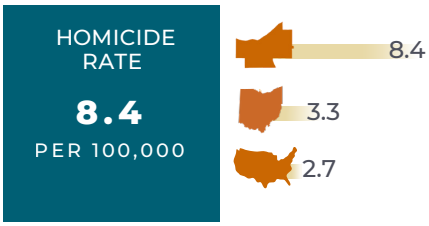


HOMICIDES

Homicide and violence have become very serious and rising issues among children in Cuyahoga County, becoming the **leading cause of death in children ages 1-17 years old.**

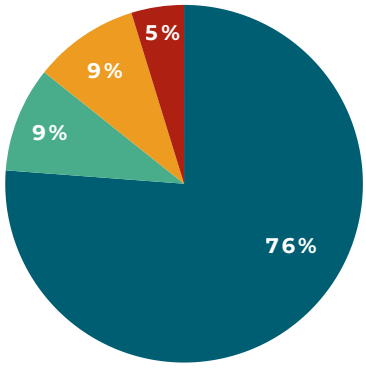


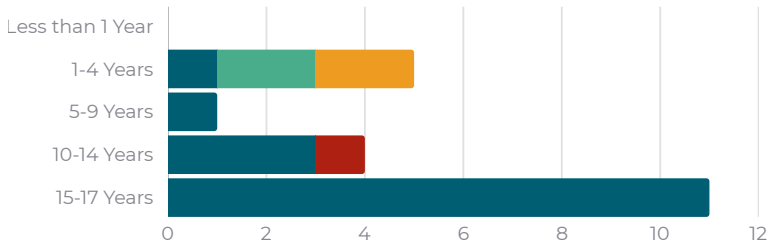
After reaching an all-time high in 2023, homicides have decreased by 38%. However, the current count remains above the ten-year average.



The Homicide rate in Cuyahoga County for 2024 is **2.5 times** higher than Ohio (3.3) and **3 times** higher than the United States (2.7).

The leading causes of death in child homicides include **Gunshot Wound**, **Blunt Force Trauma**, **Neglect** and **Drug Poisoning or Overdose**.





RECOMMENDATIONS

The Cuyahoga County Child Fatality Review Board makes recommendations for the development and improvement of public policies, programs, initiatives and interventions to support the mission of reducing child fatalities. Through its work, the Board also seeks to develop and expand the relationships between agencies that serve families and children.

Each recommendation features a list of people or groups of people "who can act" listed below it.

INTERAGENCY

Support the growth of the Cuyahoga County Child Protection Team across hospital systems
- Hospital systems, Department of Child and Family Services (DCFS), child advocacy agency

Support the development of a standard protocol for cross-healthcare system communication regarding children identified or suspected to be vulnerable to abuse and/or neglect by sharing key medical information across hospital systems including confirmation that a child is in care of a provider or care has been transferred to a different system with verified follow up
- Hospital systems, healthcare providers, DCFS

Coordinate continuation of care when transitioning individuals from inpatient mental health services to outpatient services
- Healthcare providers, social workers, parents/caregiver

Implement standardized safe sleep education at well child visits
- Hospital systems, healthcare providers

Coordinate care for pregnant mothers in need of mental health and/or drug treatment services
- Healthcare providers, social workers

PREMATURITY

Educate women and expectant parents about the warning signs of preterm labor
- Healthcare providers, public health, community organizations, home visiting organizations

Refer pregnant mothers to home visiting programs and services
- Healthcare providers, public health, community organizations, DCFS

Promote group prenatal care such as Centering Pregnancy
- Healthcare providers, public health, community organizations

Support referrals for parents to have a genetic consultation
- Healthcare providers

Provide smoking/vaping cessation education and resources
- Healthcare providers, public health, community organizations, home visiting organizations

Encourage preconception care for pregnancy planning
- Healthcare providers, public health, community organizations

Coordinate care for pregnant women managing a chronic health condition
- Healthcare providers, social workers

Refer pregnant mothers to mental health and/or drug treatment services
- Healthcare providers, social workers

Encourage providers to discuss with patients which emergency departments have labor and delivery services
- Hospital systems, healthcare providers, social workers, public health

Involve dads during pregnancy in fatherhood initiatives such as Boot Camp for Dads
- Healthcare providers, community organizations

Assess and address social determinants of health needs at prenatal care appointments
- Healthcare providers, social workers, community organizations

RECOMMENDATIONS

MEDICALLY ORIGINATED DEATHS

Reinforce among providers that multiple missed appointments for potentially life-threatening conditions (asthma, diabetes, acute mental health issues, etc.) are frequently noted in child fatality case reviews. Providers observing such patterns are in a unique position to assess the situation for barriers to compliance and determine if reporting a suspicion of medical neglect is warranted
- Healthcare providers, DCFS

Establish a cross-healthcare system agreement to confirm that a child with a chronic health condition whose parent or guardian states they have switched hospital systems has established care with a provider
- Hospital systems, healthcare providers, DCFS

Educate families and caregivers when to call the doctor for their child
- Healthcare providers, public health, community organizations, home visiting organizations

Educate parents on the importance of regular well child visits
- Healthcare providers, public health, DCFS, home visiting organizations

Advocate for a hospital policy that states an increased number of medication refills requires an appointment with the provider
- Hospital systems, healthcare providers

Provide family education to ensure families understand chronic disease management and the importance of consistent medication adherence
- Healthcare providers, home visiting organizations

SLEEP-RELATED DEATHS

Partner with family-serving agencies to provide safe sleep education to other infant caregivers, such as grandparents, relatives, and friends, with a focus on providing a safe sleep environment in any location
- Public health, community organizations

Educate families and all infant caregivers on the importance of the ABCD's of safe sleep until an infant is 1-year-old
- Healthcare providers, public health, community organizations, DCFS, home visiting organizations

Educate families and all infant caregivers on risk reduction strategies for safe sleep, while having honest and non-judgmental conversations
- Healthcare providers, public health, community organizations, DCFS, home visiting organizations

Educate families and all infant caregivers that feeding pillows such as Boppys should not be used for infant sleep
- Healthcare providers, public health, community organizations

Educate families and all infant caregivers on how and when to swaddle a newborn and when to stop swaddling
- Healthcare providers, public health, community organizations, DCFS, home visiting organizations

Promote the Cribs for Kids program for families and infant caregivers in other households who need a safe place for baby to sleep
- Healthcare providers, public health, community organizations, DCFS, home visiting organizations

Encourage Boot Camp and fatherhood initiatives for Dads
- Healthcare providers, community organizations, home visiting organizations

Standardize safe sleep education at well child visits
- Hospital systems, healthcare providers

RECOMMENDATIONS

UNINTENTIONAL DEATHS

Partner with child/family agencies to disseminate the message stressing the importance of adequate and appropriate adult supervision of children in homes, around water, and in neighborhoods
- Healthcare providers, DCFS, community organizations, home visiting organizations

Promote calling 911 for emergencies
- Healthcare providers, EMS/fire, law enforcement, home visiting organizations

Educate families on fire safety in the home including working smoke detector and a family escape plan and the danger of overloading electrical outlets
- Schools, EMS/fire, law enforcement, DCFS, home visiting organizations

Have a fire ladder in each upstairs bedroom
- Schools, EMS/fire, law enforcement, DCFS, home visiting organizations

Educate to only allow children to play outside in designated play areas
- Schools, EMS/fire, law enforcement, DCFS

Educate on the importance of wearing a helmet
- Healthcare providers, schools, EMS/fire, law enforcement, public health, community organizations, home visiting organizations

Promote gun safety in the home to prevent children from having gun access
- Healthcare providers, schools, EMS/fire, public health, community organizations, home visiting organizations, DCFS, child advocacy agency, parents/caregivers

Teach families how to child proof their home
- Healthcare providers, public health, DCFS, community organizations, home visiting organizations

Provide education on water safety – including pools, lakes, rivers, bathtubs, showers etc.
- Healthcare providers, schools, EMS/fire, law enforcement, public health, community organizations, home visiting organizations, parents/caregivers, DCFS

ABUSE AND NEGLECT

Support the development of a standard protocol for cross-healthcare system communication regarding children identified or suspected to be vulnerable to abuse and/or neglect by sharing key medical information across hospital systems including confirmation that a child is in care of a provider or care has been transferred to a different system with verified follow up
- Hospital systems, healthcare providers, DCFS

Educate parents on selecting suitable caregivers for children
- Healthcare providers, DCFS, community organizations, home visiting organizations

Refer parents/caregivers to mental health and/or drug treatment services
- Healthcare providers, DCFS, community organizations, home visiting organizations

Continue to support and develop the countywide child protection team and child advocacy program
- Hospital systems, DCFS, public health, child advocacy agency

Promote the safe reunification of families where custody of children has been removed
- Judicial system, DCFS

RECOMMENDATIONS

HOMICIDE

Support educational programs that assist parents and guardians in understanding age-appropriate behaviors, using alternative methods of discipline and choosing suitable caregivers
- Healthcare providers, DCFS, child advocacy agency

Support domestic violence education and programs that; provide access to counseling and emergency shelter and initiate early intervention to limit the effects on children in the home
- DCFS, law enforcement, child advocacy agency

Promote education and public messaging on the effects THC use in children
- Healthcare providers, law enforcement, public health, DCFS

Educate teens on intimate partner violence in school health classes
- Schools

Reduce gun access to children and teens by educating on responsible gun ownership including a locked cabinet for gun storage
- Healthcare providers, schools, EMS/fire, law enforcement, public health, community organizations, home visiting organizations, parents/caregivers, DCFS, child advocacy agency

SUICIDE

Support school programs and mental health social platforms for depression awareness, bullying, and suicide prevention that also include resources for assistance
- Healthcare providers, schools, EMS/fire, law enforcement, public health, community organizations, DCFS, child advocacy agency

Advocate for additional inpatient child psychiatric beds to meet the mental health needs of this population
- Hospital systems, healthcare providers, social workers, public health

Reduce the stigma around mental health treatment through open honest conversations in multiple settings like doctor's offices and schools
- Healthcare providers, schools, community organizations, child advocacy agency, social workers

For more information, please contact:

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