

# Child Fatality Review & Fetal Infant Mortality Review

Understanding Fetal, Infant and Child Loss to Build a Safer Community

May 21, 2026

# Today's Agenda

## Fetal Infant Mortality Review (FIMR)

Program History and Overview

Data Findings

Recommendations

## Child Fatality Review (CFR)

Program History and Overview

Data Findings

Recommendations



## Holly Galicki, BSN, RN

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*Nurse Program Manager – Child Fatality Review*  
Cuyahoga County Board of Health

### WHAT DRIVES YOUR WORK IN MATERNAL AND CHILD HEALTH?

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“My commitment comes from my own experience as a teenager navigating pregnancy without the knowledge, confidence, or support to advocate for myself or my baby. During that time, I often felt unheard and unsure of my options, realizing later how much access to information, compassionate care, and self-advocacy could have changed my experience.”

- Holly





## Erin E. Dodds, MA, LPC

*Grant Manager – Fetal Infant Mortality Review*  
Cuyahoga County Board of Health

### WHAT DRIVES YOUR WORK IN MATERNAL AND CHILD HEALTH?

“My commitment is rooted in my own traumatic birth experience in 2006. I felt my baby's fetal movement had changed, but I didn't want to bother the nurses or doctors and did not feel confident to voice my concern. If I had known then that all mothers' voices do matter, I could have avoided a lot of pain for my baby. ”

- Erin





## Alexis M. Ipsaro, MPH

*Maternal and Child Health Epidemiologist*  
Cuyahoga County Board of Health

### WHAT DRIVES YOUR WORK IN MATERNAL AND CHILD HEALTH?

“My commitment is shaped by the gap between the care I received and the care I deserved. During my pregnancy, something felt wrong. I couldn't name it — I just knew. I advocated for myself in every way I knew how. And at every turn, I was dismissed and made to feel like an anxious first-time mom.

In May 2025, my son was born prematurely at 33 weeks, severely growth restricted and weighing just over 2 pounds. Severe preeclampsia was the diagnosis. Headaches. Swelling. Rapid Weight Gain. Blurry Vision. The warning signs were there, the tools to catch them existed. What was missing was my doctors willingness to listen.

I carry the weight of what could have been – and the knowledge that for too many mothers, the story ends differently. ”

-Alexis





## Tasha's Story

Aubrey and Abe were delivered at 23 weeks in September 2018.

Aubrey was still born and Abe passed 3 days later.

Tasha's rainbow baby, Asher Mekhi, was born on January 9, 2026, three weeks early.



# **Moment of Reflection**

# Fetal Infant Mortality Review (FIMR)

Program overview, history and process



# What is *FIMR*?

FIMR is a multi-disciplinary process that reviews infant deaths and fetal deaths 20 weeks or more gestation. The intent is to reduce and prevent future losses and improve the health and well-being of pregnant women and infants.

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- **Founded in 1990**

Developed by ACOG and the Maternal and Child Health Bureau (MCHB)

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- **Brought to Ohio in 2014**

Introduced by the Ohio Department of Health

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- **Community-driven process**

Multi-disciplinary, multi-agency teams uncover lessons from preventable stillbirths and infant deaths

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- **Confidential, not fault-finding**

A safe, protected process focused on learning rather than blame

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- **Life course perspective**

Examines the full arc of maternal and infant health across a lifetime

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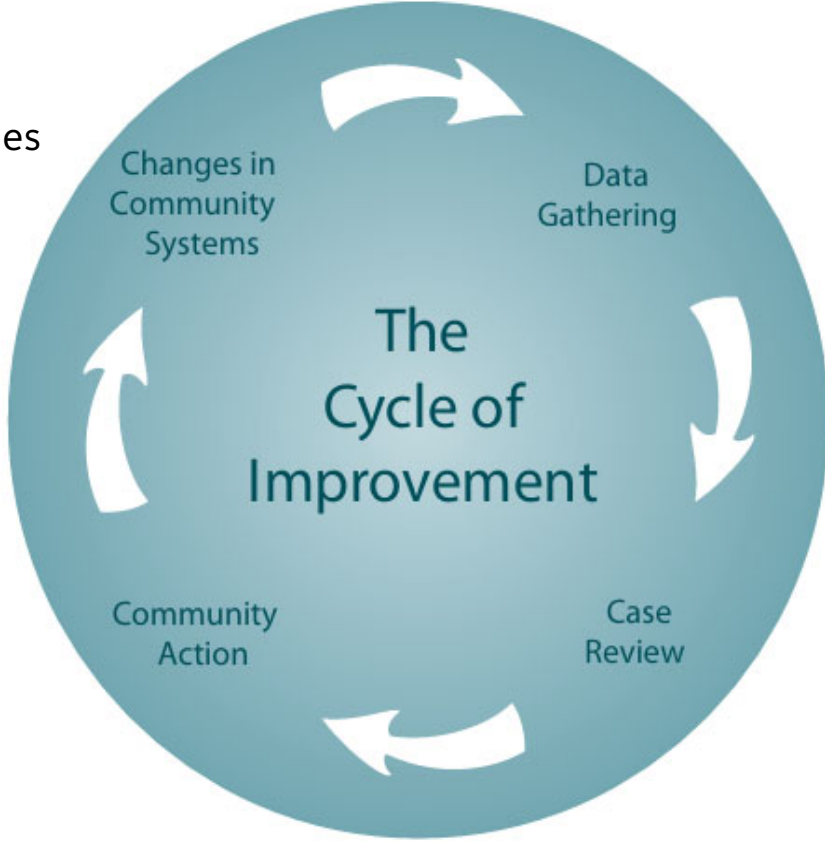
- **Drives system & policy change**

Develops and implements recommendations for meaningful, lasting improvements



# FIMR Process

Policy Change  
Systems Change  
Healthier Moms, Babies & Families



Family Interviews  
Data Abstraction (Chart Reviews)

Community Action Team  
Community Action Meetings  
Act on Recommendations

Case Review Team  
Case Review Meetings  
Recommendations



# Case Review Team

Members include: Public Health, Division of Child and Family Services (DCFS), Labor and Delivery Nurses, Social Workers, Perinatologist, Neonatologist, Certified Nurse Midwives, Community Clinics, Home Visiting, Medicaid, Multiple hospital systems

Quarterly Meetings

Reviews cases, identifies risk factors, identifies strengths, develops recommendations

Reviews 15% of fetal deaths per three-year average



# Community Action Team

Act on recommendations

- Prioritize recommendations
- Develop new & creative solutions
- Implement action & monitor progress

Increase visibility of issues related to infants, women & families in the community

Ensure continuity of policy & system changes

# FIMR Family Interview

Offers the family an opportunity to share their story



## MY STORY.

### HAVE YOU EXPERIENCED A PREGNANCY OR INFANT LOSS?

If you have experienced an infant loss in the last 5 years, we want to hear your story.

Contact us to schedule a visit or use your cell phone camera to scan the QR code to complete an online survey . You can let us know what helped and what didn't help.

Our goal is to learn from you so that, together, we can make positive change and improve pregnancy outcomes across Cuyahoga County.

**CCBH**

If you are interested in telling your story in person, contact Erin Dodds at [edodds@ccbh.net](mailto:edodds@ccbh.net) or text 216-903-6148

The FIMR program is funded by the Ohio Department of Health & managed by the Cuyahoga County Board of Health.

Scan the QR code to share your story with us confidentially online



## Fetal and Infant Mortality Review

# 2024 Top Recommendations



Support programming that addresses chronic disease management in pregnant people.



Support substance abuse programs for pregnant people.



Education on the importance of prenatal care.



Educate pregnant people on the importance of reporting changes in fetal movement.



Support mental health services for pregnant people.



Support and promote the use of doulas.



Educate pregnant people on emergency rooms that have labor and delivery services.



Education on the importance of interconception and preconception health care.



Support and promote Centering Pregnancy (peer group prenatal care).



# WAVE OF LIGHT

CLEVELAND  
PREGNANCY AND INFANT LOSS  
REMEMBRANCE DAY

**Wednesday**  
**October 15, 2025**  
**6:30 p.m. – 8:00 p.m.**

*Doors open at 5:30 p.m.*  
*Program begins at 6:30 p.m.*  
*Candle lighting ceremony at 7:00 p.m.*  
*Parking available in the Lion Lot*

**Cleveland Metroparks Zoo**  
3900 Wildlife Way  
Cleveland, OH 44109

In order to receive a candle and have your baby's name read at the lighting ceremony, please register by October 1, 2025

**Have you experienced miscarriage, stillbirth or the loss of a baby before his or her first birthday?**

**Join us for a candle lighting ceremony as we remember and honor our angel babies.**

For questions or more information, please contact: 216-682-6629 or [waveoflightevent@gmail.com](mailto:waveoflightevent@gmail.com)  
All in person participants will receive a candle

Scan here to register or visit [pailconnect.org/eventse](http://pailconnect.org/eventse)



SHERWIN-WILLIAMS.



# IN EMERGENCIES MINUTES MATTER

**Not all emergency rooms  
have full labor & delivery  
services**



## **EMERGENCY ROOMS WITH FULL LABOR & DELIVERY SERVICES:**

### **WEST SIDE:**

Cleveland Clinic Fairview  
MetroHealth  
Southwest General  
University Hospitals St. John Med Center

### **EAST SIDE:**

Cleveland Clinic Hillcrest  
University Hospitals Main Campus  
University Hospitals Ahjuja Med Center

**Talk with your doctor today  
to make an emergency plan.**

**Other details to consider in your plan:**

- Doctor's Phone Number
- Your medical history
- Transportation
- Childcare



## **EMERGENCY PREGNANCY WARNING SIGNS:**

- Change in baby's normal movement
- Decreased baby movement
- Blurred vision/severe headache
- Extreme swelling in your hands/face
- Cramping before 37 weeks
- Water Leaking
- Bleeding
- Severe Nausea or vomiting



## Cuyahoga County Pregnancy **Emergency** Information Card

Name \_\_\_\_\_ Due Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Pregnancy Health Issues: \_\_\_\_\_

Doctor/Midwife/Hospital \_\_\_\_\_

Where to call for help: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*If your life or the life of your baby is in danger call 911.*

United Way Help Center: Dial 211  
Home Visiting Information: (216) 930-3322



### Pregnancy warning signs:

Water leaking	Severe nausea or vomiting	Cramping before 37 weeks
Bleeding	Decreased baby movement	Blurred vision/severe headache

### **WHAT IS YOUR PREGNANCY EMERGENCY PLAN?**

★ Not all Emergency Rooms have Labor and Delivery Services ★

#### **Cuyahoga County Hospitals WITH Labor & Delivery Emergency Services**

##### West Side:

Cleveland Clinic Fairview

MetroHealth

Southwest General

University Hospitals St. Johns West Shore

##### East Side:

Cleveland Clinic Hillcrest

University Hospitals Main Campus

University Hospitals Ahuja Med Center

**CCBH**





## PREGNANCY AND INFANT LOSS

Hope is Here. We are Here.

### Pregnancy and Infant Loss (PAIL) Society CLE Healing Support Groups 2026

Open to parents who have experienced an infant loss, miscarriage, or stillbirth. We invite you to join a safe space to express your feelings with other bereaved parents. Let's create a network of support with bereaved parents as we discuss relevant issues and explore healing activities.

#### Join Us Monthly:

##### 3rd Saturdays

February 21	June 20
March 21	August 15
April 18	September 19
May 16	October 17

**Time:** 10am - 11am EST

**Zoom Link**



**Meetings will be held on Zoom:  
Meeting ID: 813 0856 7048**

**Registration  
Required**



For information contact: Trina Vaughn, Behavioral Health Coordinator  
at 216-682-6629 or email: [tvaughn@birthingbeautiful.org](mailto:tvaughn@birthingbeautiful.org)

**CCBH**

Contact us today to  
schedule a free assessment.

Your mental health is  
our priority.

**216-308-7592**

ownbbc@birthingbeautiful.org



OWN *our*  *wellness*  
*network*



[www.birthingbeautiful.org](http://www.birthingbeautiful.org)



OWN *our*  *wellness*  
*network*



BIRTHING BEAUTIFUL  
COMMUNITIES



**CCBH**

**University Hospitals  
Joanie & Tom Adler Bereavement Programs**

At University Hospitals, we understand the emotional impact of the loss of a baby or a child. We know this grief can be profound and complicated.

University Hospitals Adler Bereavement Programs is here to help. We want to do our best to connect you to supportive resources that are currently available. We are continually working to identify new resources in the local community as well as nationally and to find ways to create more support for parents, siblings, and families after the loss of a baby or child.

To discuss your own personal grief experience and for more unique/local resources, please feel free to contact us. The QR code below goes to our Link Tree which has information on resources as well as support and remembrance events.

We are here to support you now and always.

Scan to view our LinkTree

For more information:  
Call: 216-844-8254  
Email: [HEAL@UHhospitals.org](mailto:HEAL@UHhospitals.org)  
or visit us at <https://linktr.ee/uhbereavement>



# FIMR Data

Data findings from 2024 case reviews

# Overview & Definitions

## Miscarriage

Loss of a pregnancy before 20 weeks gestation. Includes spontaneous abortion. Subcategorized as early (<13 wks) or late (13–19 wks).

## Stillbirth

Delivery of a fetus showing no signs of life at  $\geq 20$  weeks gestation (per CDC/WHO definition). May be further classified as early (20–27 wks), late (28–36 wks), or term ( $\geq 37$  wks).

# Overview & Definitions

## Perinatal Mortality Rate

Number of stillbirths + early neonatal deaths (within 7 days of birth) per 1,000 total births.

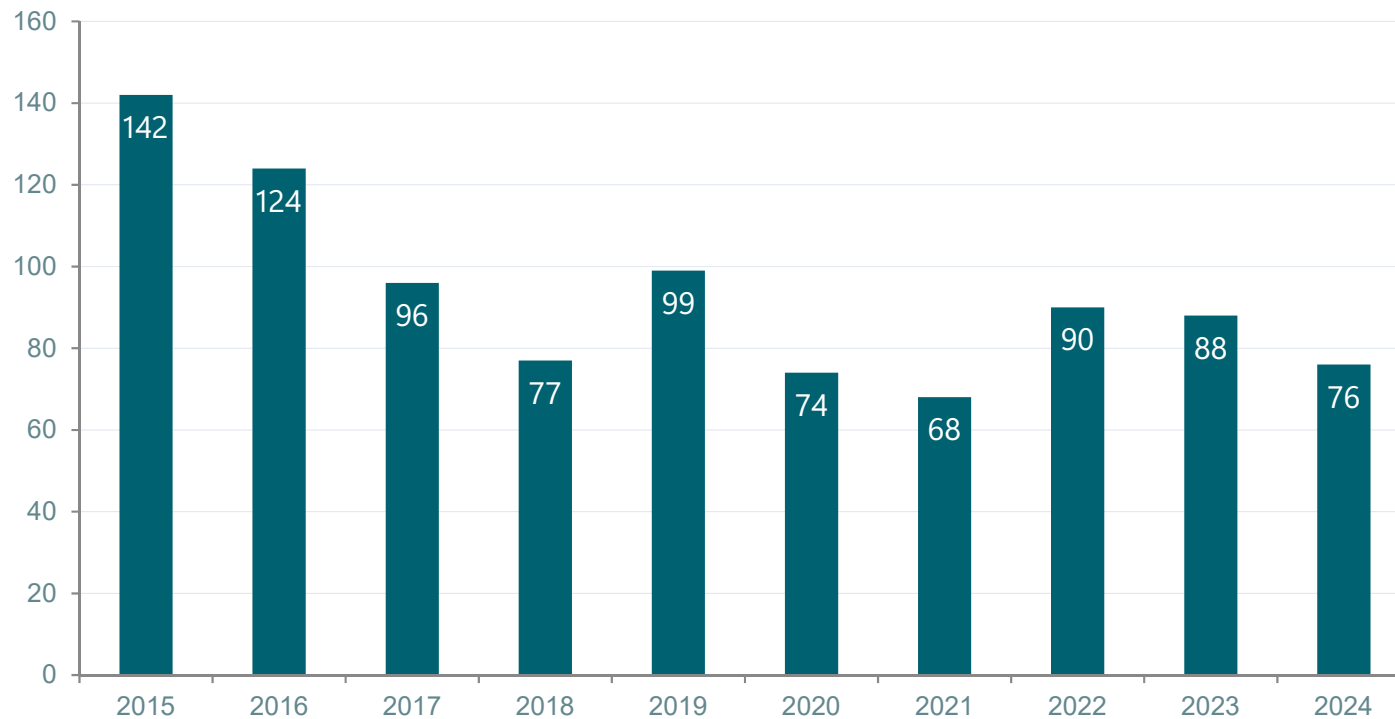
## Stillbirth Rate

Number of fetal deaths at  $\geq 20$  weeks gestation per 1,000 live births + fetal deaths.

# Stillbirths 2015–2024

76 stillbirths occurred during 2024.

A decrease of 12 (11%) from 2023, falling below the ten-year average.



**2024**  
76 deaths

**10-year average**  
93 deaths

**-11%**  
Compared to 2023

# Stillbirth Rate — County vs. Ohio vs. U.S.

Rates per 1,000 live births + Stillbirths · Cuyahoga County vs. Ohio vs. U.S. · 2024

Cuyahoga County

**6.07**

per 1,000

*10% higher than Ohio  
11% higher than U.S.*

State of Ohio

**5.51**

per 1,000

*State benchmark*

United States

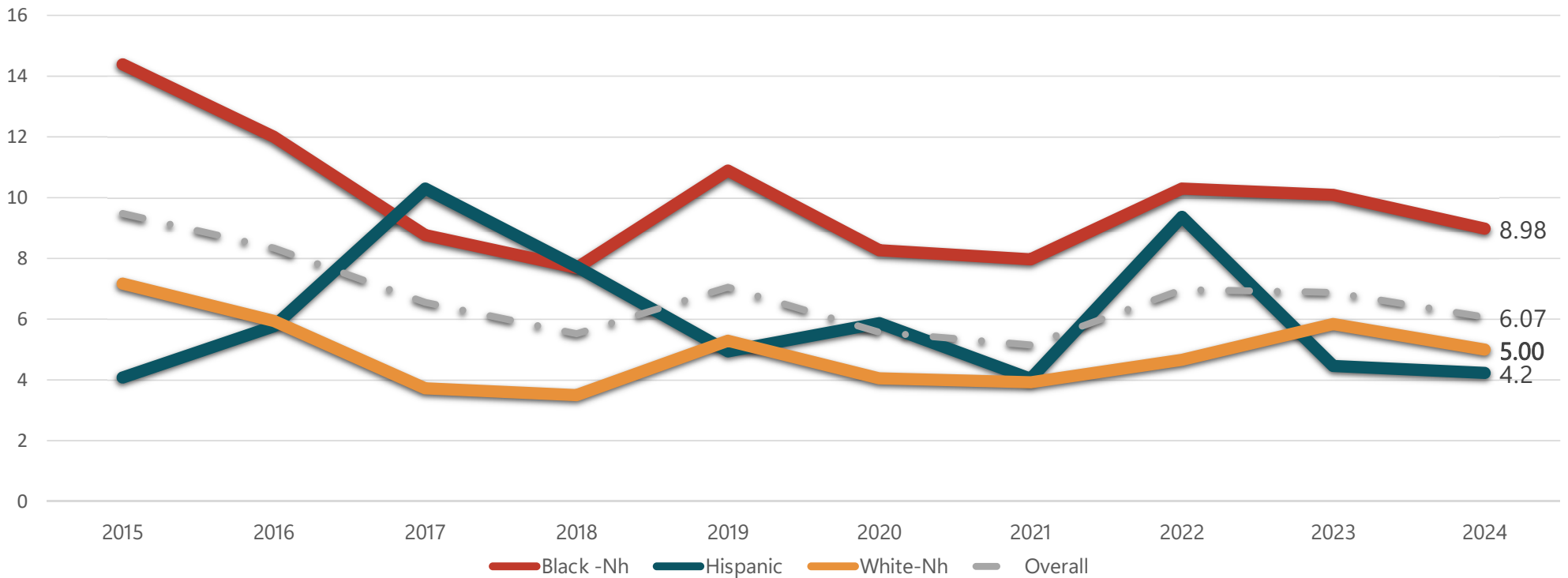
**5.44**

per 1,000

*National benchmark*

# Stillbirth Rate — Trend Over Time

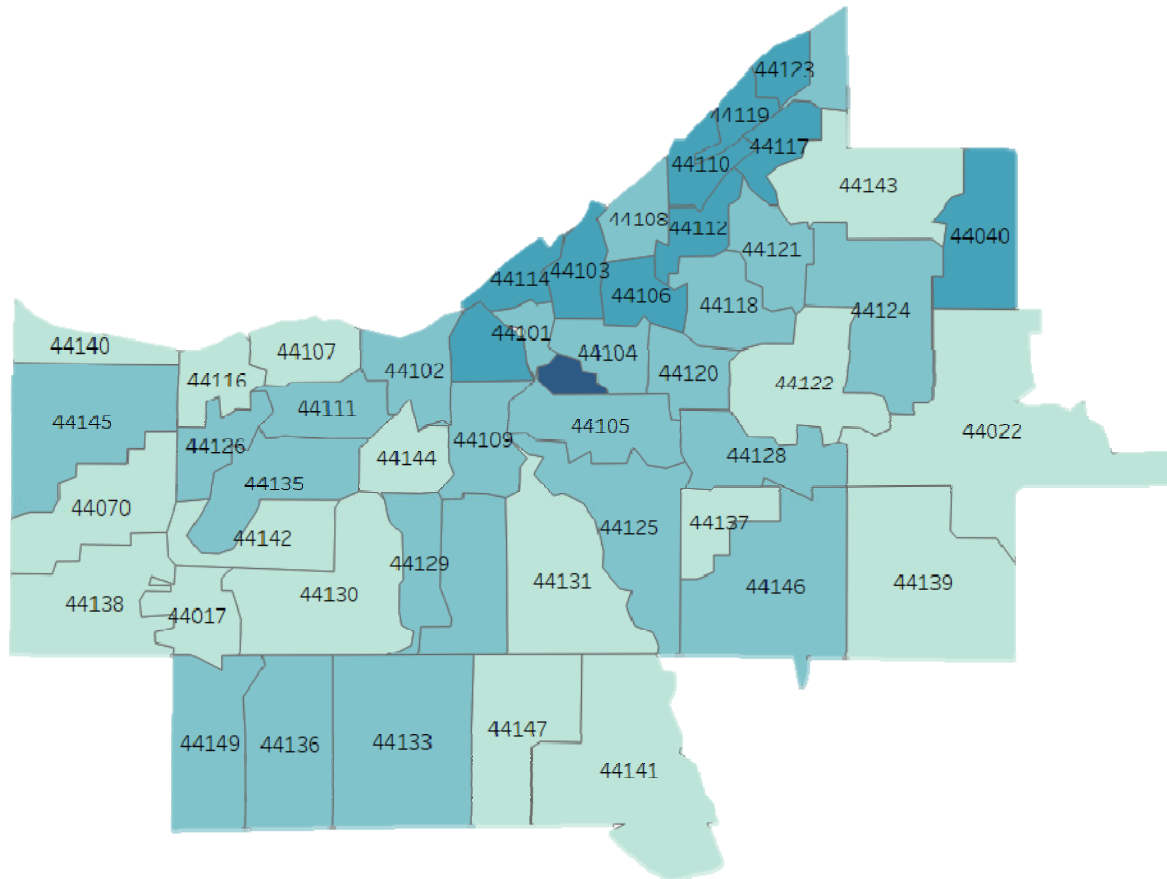
Stillbirths per 1,000 live births + Stillbirths · Cuyahoga County · 2015-2024  
Healthy People 2030 Goal – 5.7 per 1,000 births



Black non-Hispanic mothers experience stillbirths at a rate nearly double that of White non-Hispanic mothers

# Geographic Distribution of Stillbirths

Rate per 1,000 births + Stillbirths · Cuyahoga County · 2020-2024



## Geographic Disparities

**ZIP 44127**  
had the highest fetal death  
rate in the county:

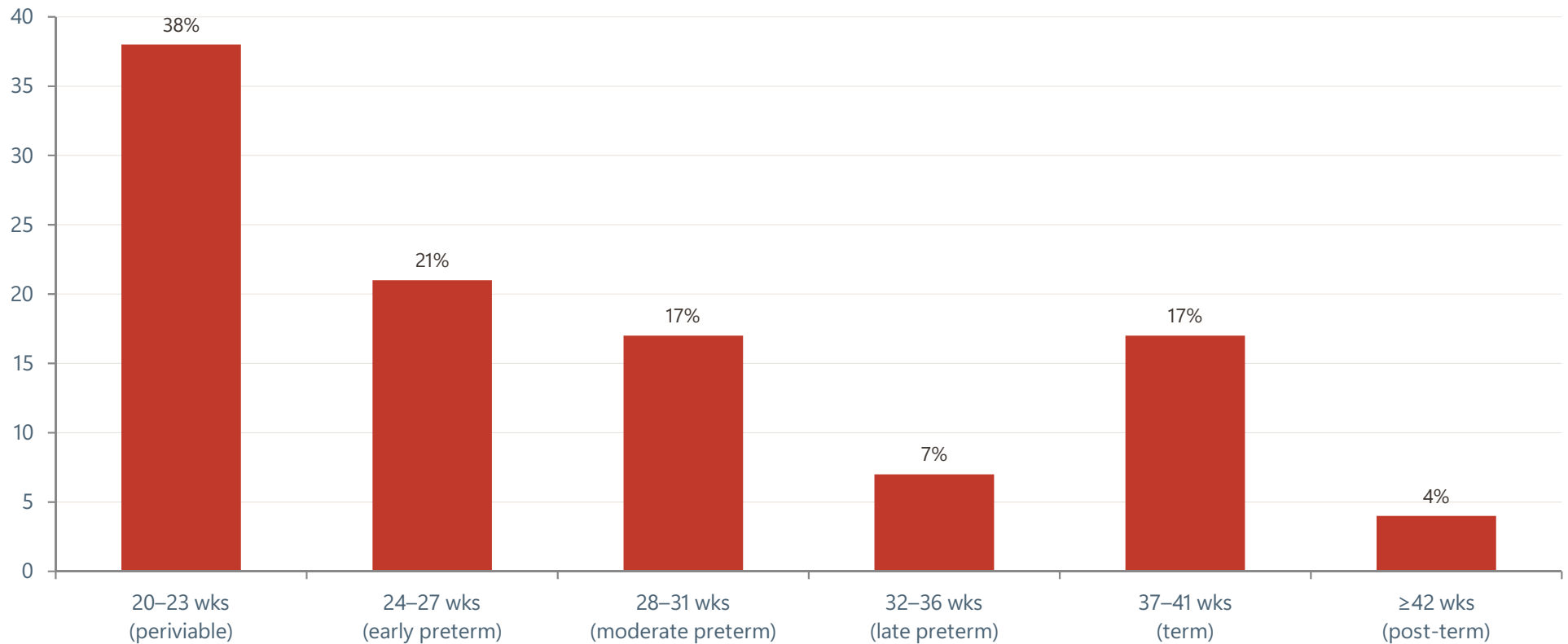
**23.44** per 1,000 live births  
+ fetal deaths (2020–2024)

### *Suburbs*

*Many had a fetal death rate  
< 5.0*

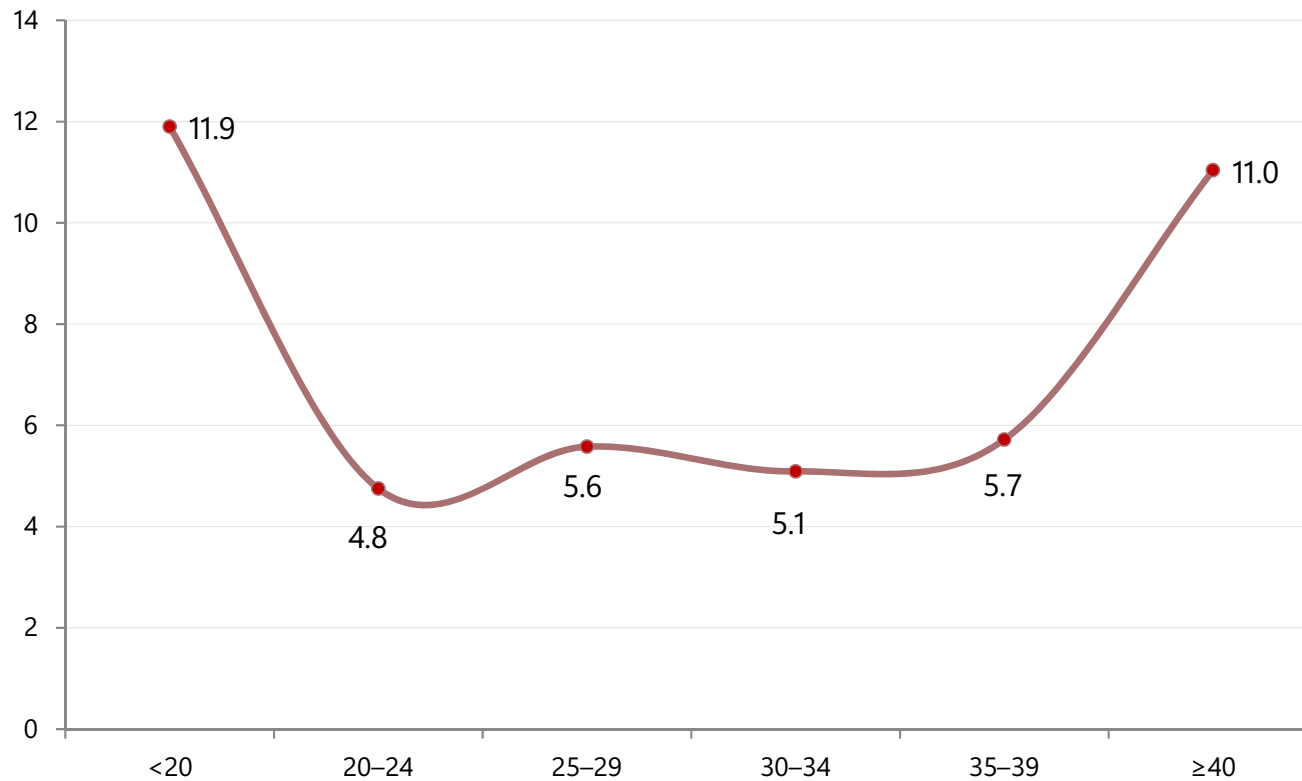
# Stillbirths by Gestational Age at Delivery

Percentage distribution across gestational age categories · 2024



# Stillbirth Risk by Maternal Age Group

Rate per 1,000 live births plus Fetal Deaths · 2024



## Lowest Risk

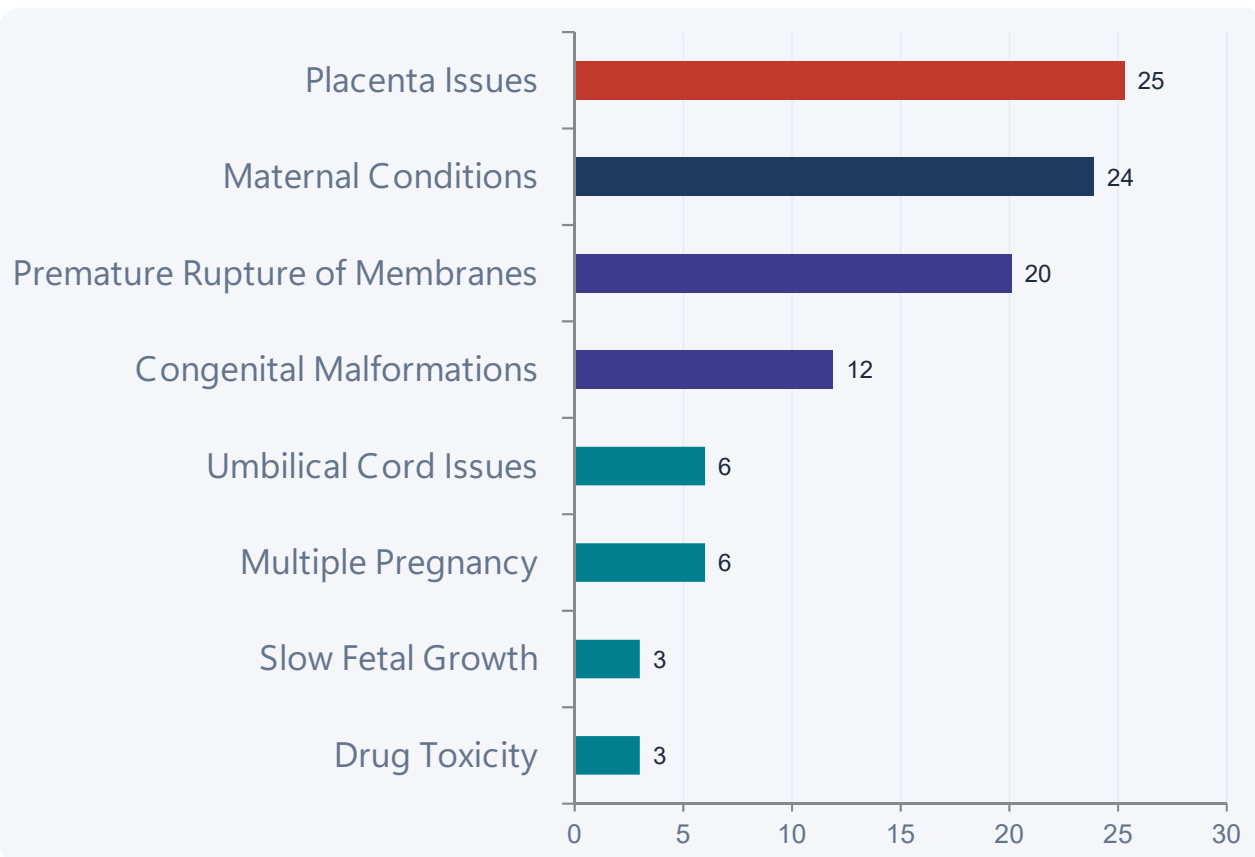
Ages 20-24 show the lowest overall stillbirth rate

## Advanced Maternal Age

Risk doubled under age 20 and over age 40

# Causes of Fetal Death

Percentage distribution across cause of death categories · 2024



## Top Maternal Risk Factors

**44%** Obesity

**31%** Hypertensive Disorders

**12%** Smoking

**11%** Diabetes

# Etiology & Risk Factors

## Fetal / Placental

- Chromosomal Abnormalities
- Placental Abruption
- Cervical Insufficiency
- Umbilical Cord Complications
- Fetal Growth Restriction
- Changes in Fetal Movement

## Maternal Health

- Hypertensive Disorders
- Pre-Eclampsia / Eclampsia
- Gestational or pre-existing diabetes
- Infections (e.g. Group B strep, STI, Chorioamnionitis)
- Mental Health

## Demographics & Social

- Advanced Maternal Age (>35)
- Obesity (BMI >30)
- Smoking / Substance Use
- Racial / ethnic disparities
- Limited prenatal care access
- Poverty
- Multigenerational trauma

# Child Fatality Review (CFR)

**Program overview, history and process**


# Child Fatality Review Board - Purpose



To conduct individual case reviews of all deaths of children less than 18 years old

Make recommendations to develop community-based prevention strategies

# CFR Multidisciplinary Board

  
**Law Enforcement & First Responders**

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Cuyahoga County Medical Examiner

---

Cleveland Division of Police

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Cuyahoga County Prosecutor's Office

---


Cuyahoga County Juvenile Court

---

Cleveland Division of EMS

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Cuyahoga County Death Scene Investigation

  
**Public Health**

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Cuyahoga County Board of Health

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Moms First

---

Cleveland Department of Health

  
**Social Services**

---

Bright Beginnings

---

Canopy Child Advocacy Center

---

Frontline Services

---


Cuyahoga County Board of Developmental Disabilities

---

Cuyahoga County Division of Children and Family Services

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ADAMHS Board

  
**Education**

---

Cleveland Metropolitan School District

---

Invest in Children

  
**Healthcare**

---

Cleveland Clinic Children's Hospital

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Cleveland Clinic Foundation

---

MetroHealth Medical Center

---

University Hospitals

---

Rainbow Babies & Children's Hospital

# What information is shared at CFR Board Meetings?



Autopsy & Toxicology



Death Scene Investigation



Police Reports & Witness Interviews



EMS Report



Child & Family Services History



Hospital Records



Juvenile Legal Records



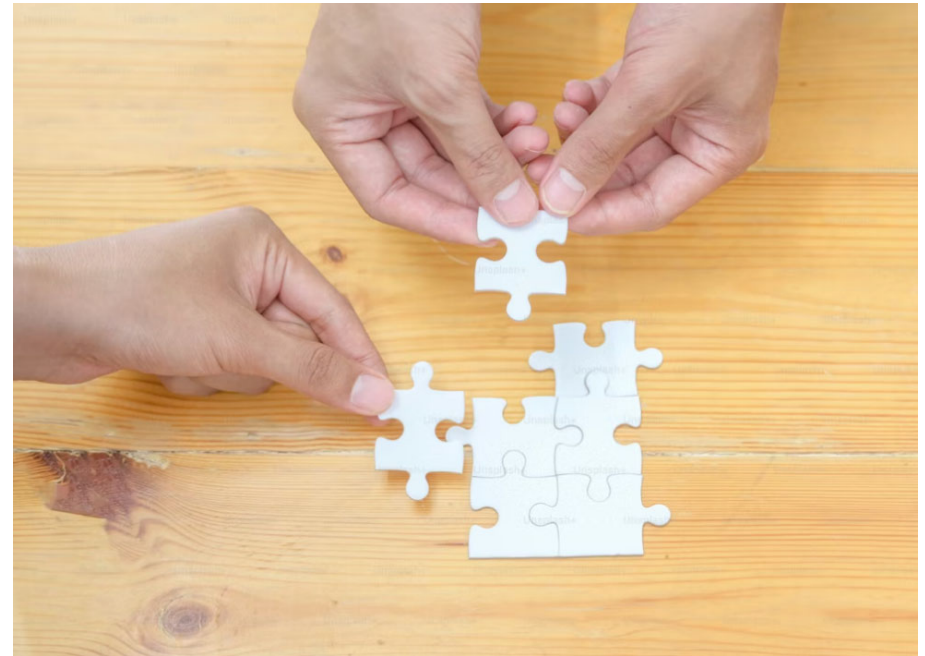
School & Community Agency Records

# Child Fatality Review Board - Benefits

Identify opportunities for prevention

Identify trends and contributing risk factors

Identify barriers and gaps in service

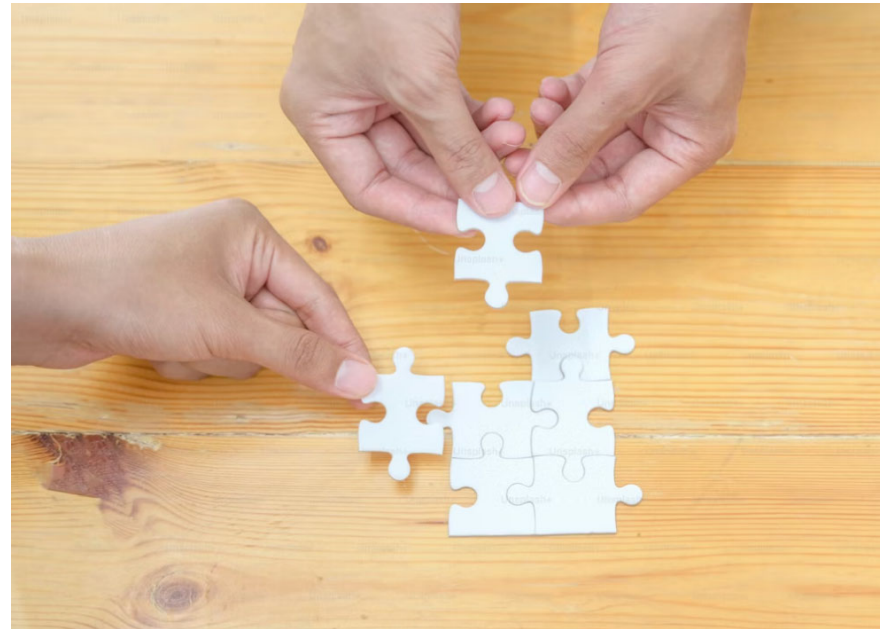


# Child Fatality Review Board - Benefits

Improve interagency communication and collaboration

Protected environment where providers can openly discuss issues to improve quality

Case reviews are the first time everyone hears the whole story



# How does the team determine if a death is preventable?

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## PREVENTABLE

A child's death is preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death.

## NOT PREVENTABLE?

### **Risk factors & recommendations still matter**

Even when a death could not have been prevented, the review process surfaces important risk factors and informs recommendations

# CFR Data

Data findings from 2024 case reviews



# 2024 In Review



**169**

Total Child Fatalities



**107**

Infant Deaths



**8.59**

Infant Mortality Rate



**18**

Sleep-Related Deaths



**27**

Unintentional  
Injury Deaths



**21**

Homicide Deaths



**6**

Abuse & Neglect

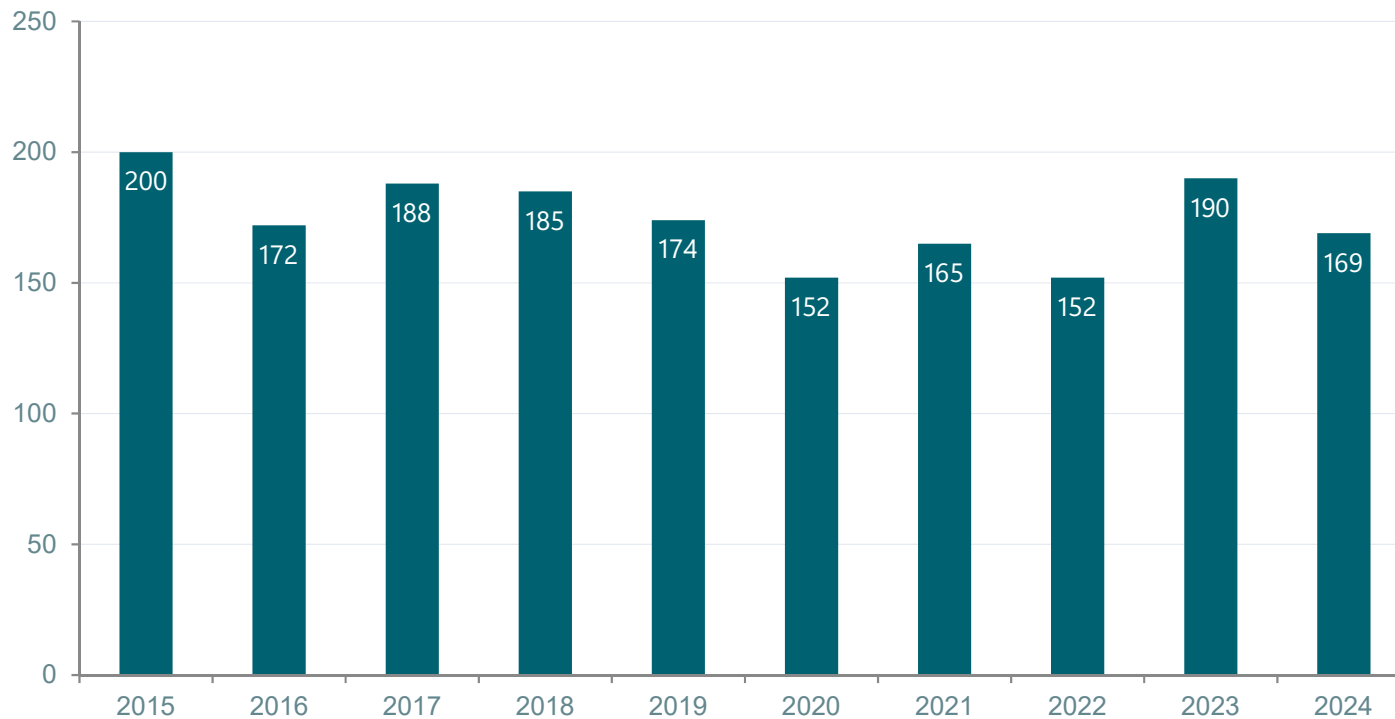


**1**

Suicide Deaths

# Child Fatalities 2015–2024

169 children died during 2024.  
A decrease of 21 (11%) from 2023, falling below the ten-year average.



**2024**  
169 deaths

**10-year average**  
178 deaths

**-11%**  
Compared to 2023

# Child Mortality Rate — County vs. Ohio vs. U.S.

Rate per 100,000 children · Cuyahoga County vs. Ohio vs. U.S. · 2024

Cuyahoga County

**67.4**

per 100,000

*22% higher than Ohio  
33% higher than U.S.*

State of Ohio

**54.0**

per 100,000

*State benchmark*

United States

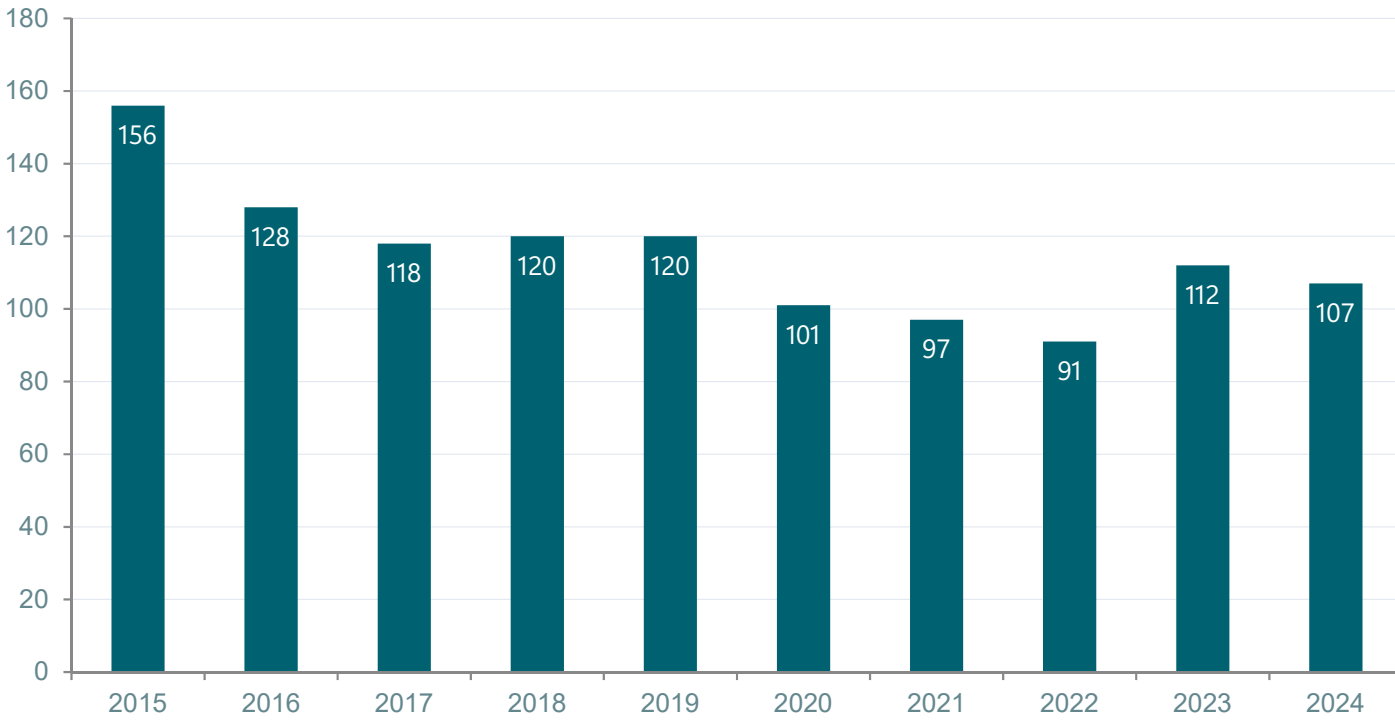
**48.4**

per 100,000

*National benchmark*

# Infant Mortality 2015–2024

107 infants died during 2024.  
A decrease of 5 (4%) from 2023, falling below the ten-year average.



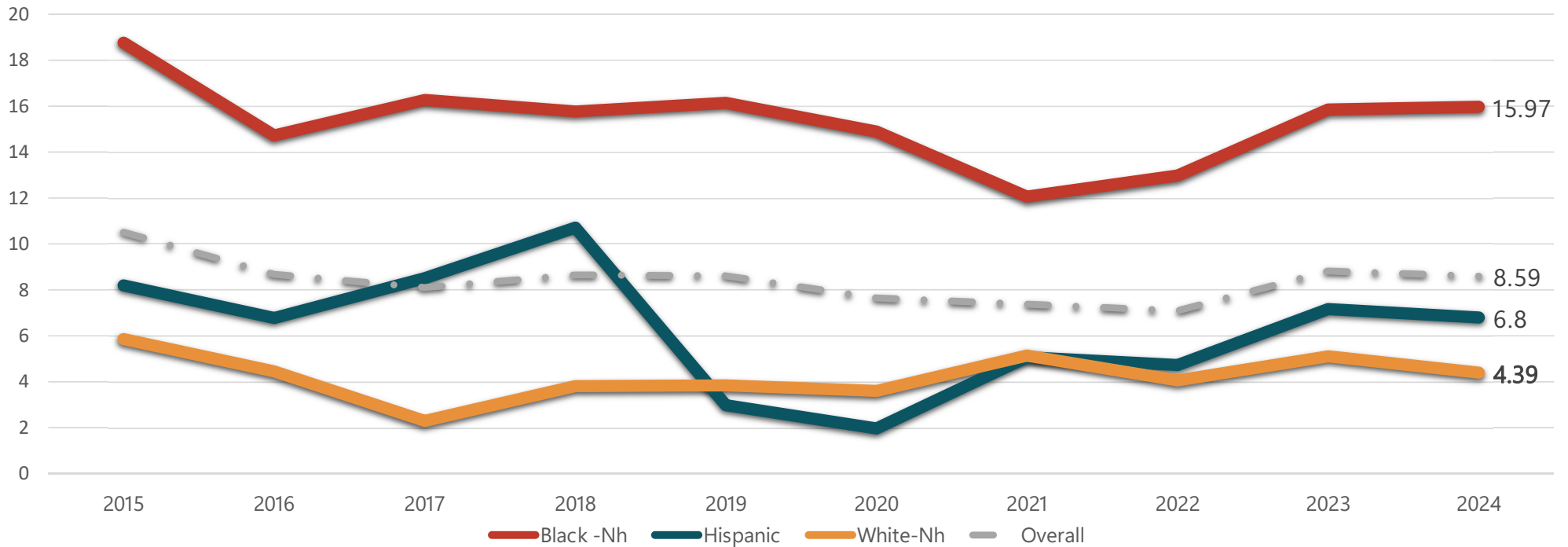
**2024**  
107 deaths

**10-yr Avg**  
115 deaths

**-4%**  
vs 2023

# Infant Mortality Rate — Trend Over Time

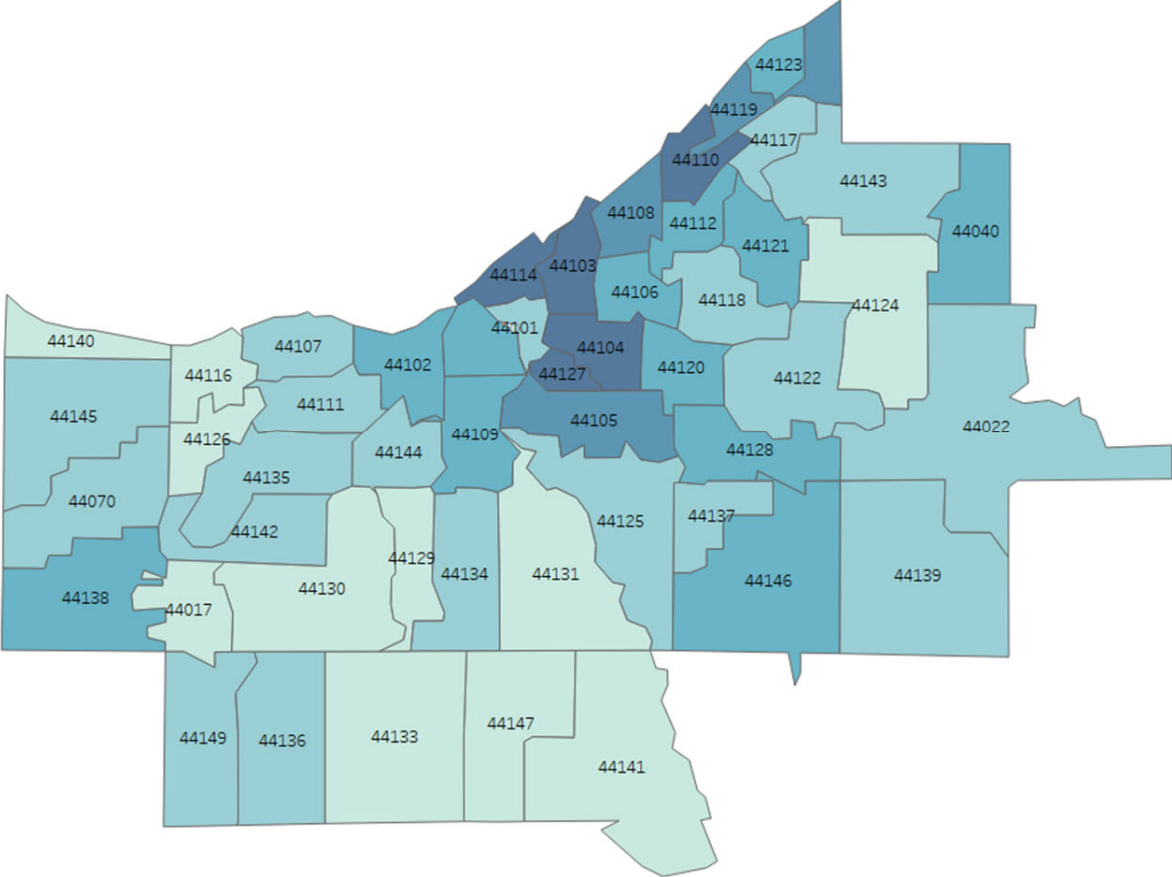
Deaths per 1,000 live births · Cuyahoga County · 2015-2024  
Healthy People 2030 Goal – 5.0 per 1,000 births



Black non-Hispanic babies die at a rate 3.64 times that of White non-Hispanic babies

# Geographic Distribution of IMR

Rate per 1,000 births · Cuyahoga County · 2020-2024



## Geographic Disparities

**ZIP 44103**  
had the highest infant  
death rate in the county:

**20.6** per 1,000 live  
births (2020–2024)



# Infant Mortality Rate — County vs. Ohio vs. U.S.

Rate per 1,000 births · Cuyahoga County vs. Ohio vs. U.S. · 2024

Cuyahoga County

**8.59**

per 1,000

*25% higher than Ohio  
43% higher than U.S.*

State of Ohio

**6.64**

per 1,000

*State benchmark*

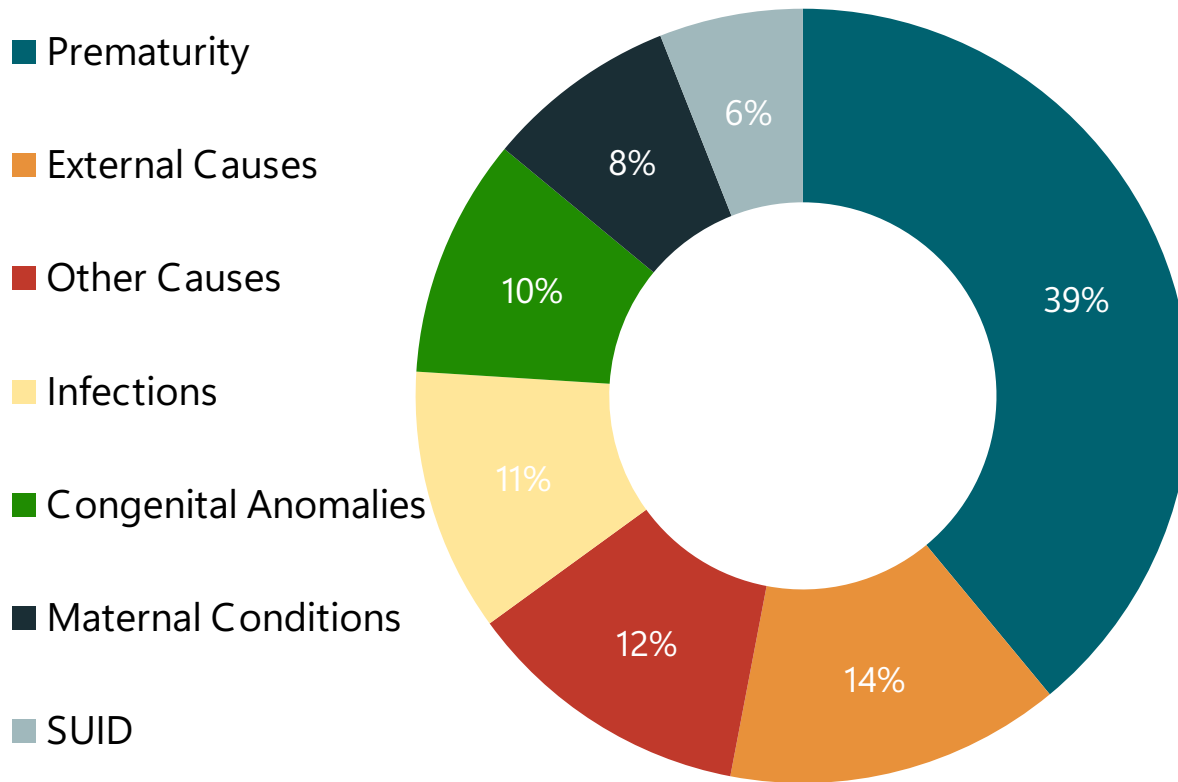
United States

**5.53**

per 1,000

*National benchmark*

# Infant Mortality – Causes of Death



## Top Finding

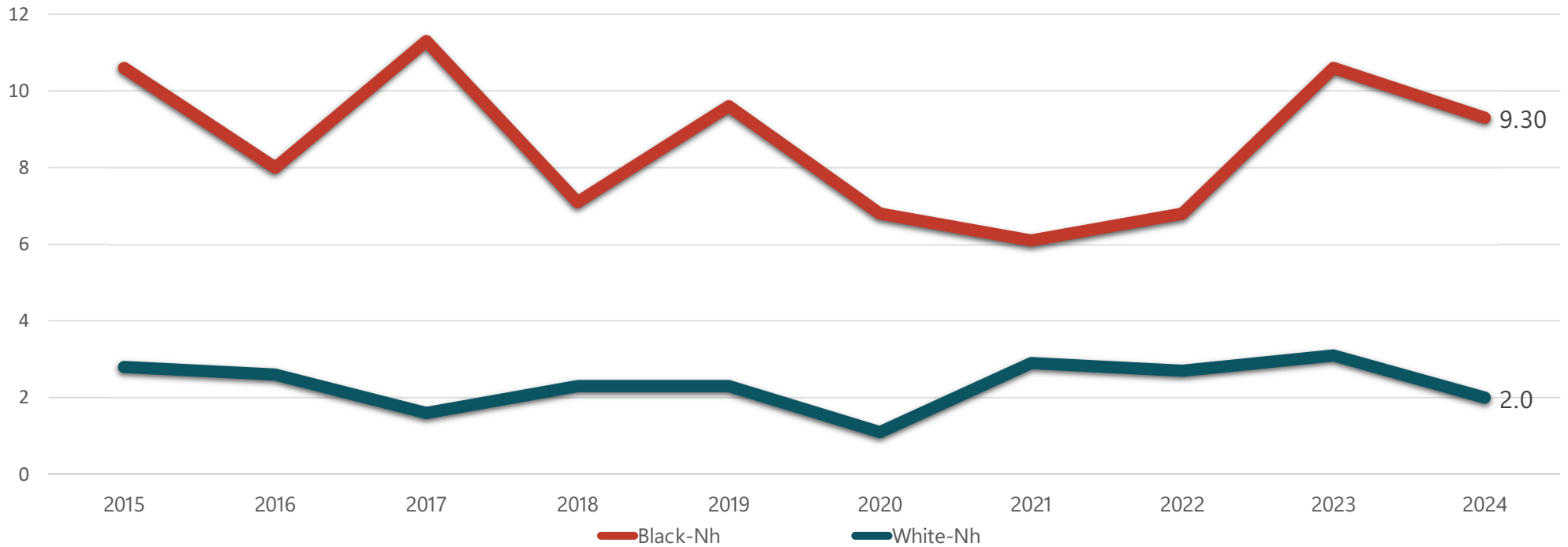
Prematurity remains the leading cause, accounting for over 1 in 3 infant deaths.

## SUID Note

Sleep-related infant deaths are largely preventable through safe sleep education.

# Prematurity Death Rate— Trend Over Time

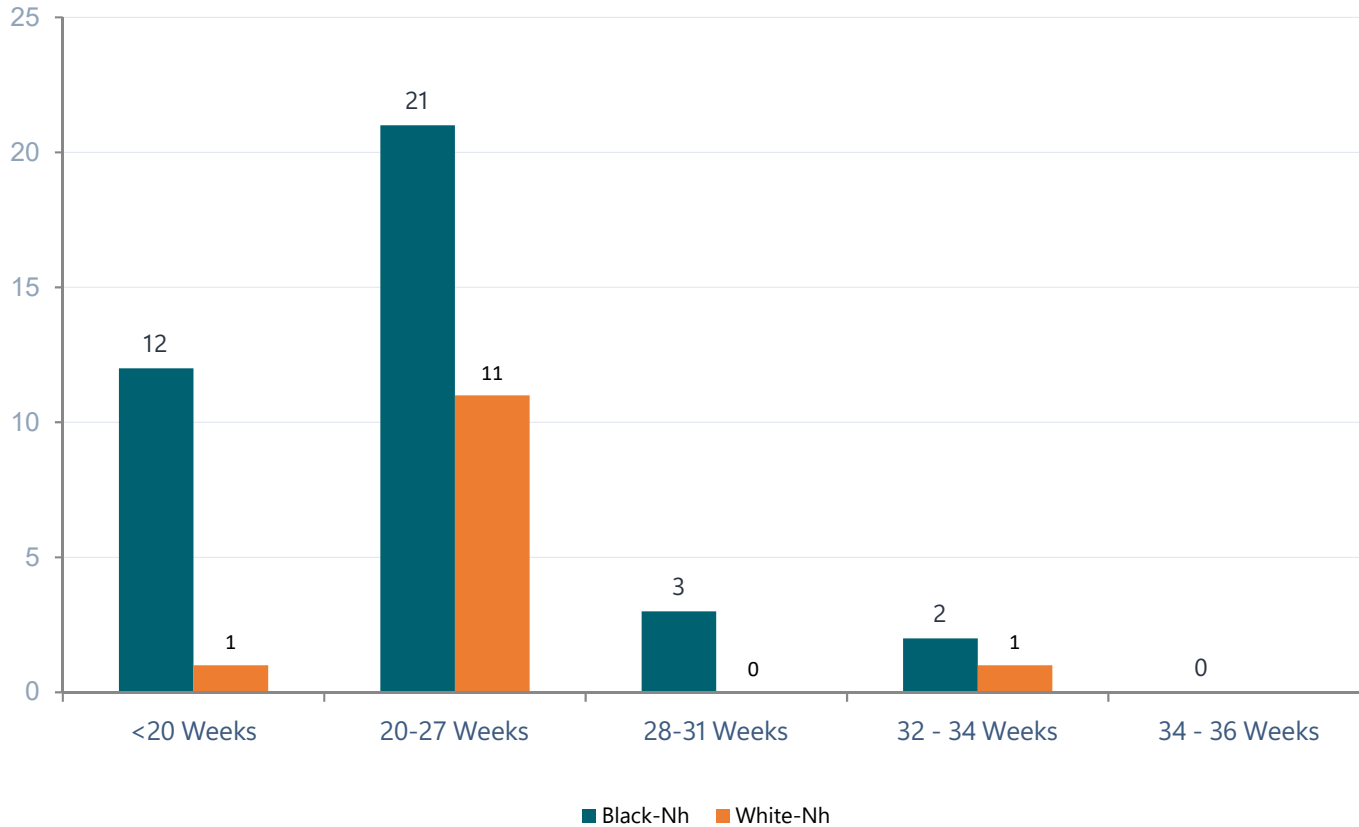
Prematurity Deaths per 1,000 live births · Cuyahoga County · 2015-2024



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

# Prematurity- Gestational Age

Prematurity infant deaths by gestational age · 2024



88%

of all premature deaths  
were extremely premature  
<28 weeks

65%

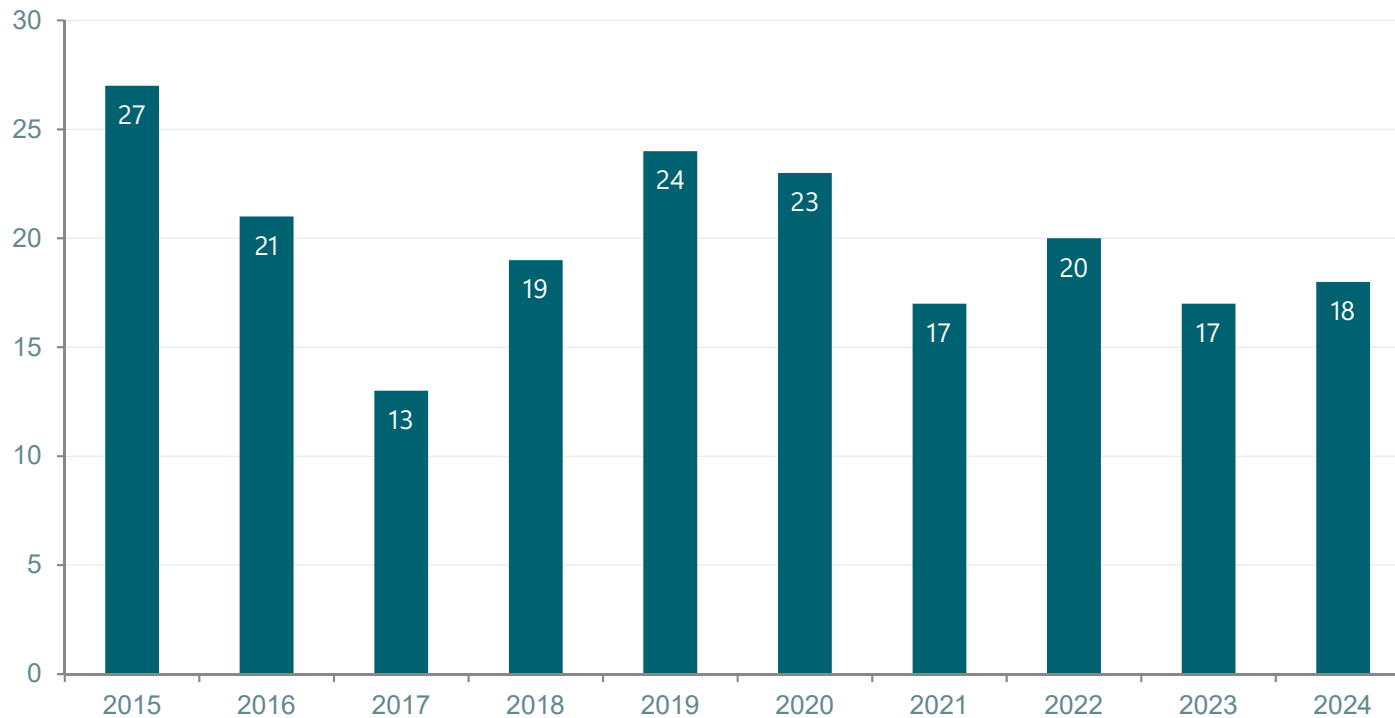
of all extremely  
premature deaths were  
Black non-Hispanic

CCBH

# Sleep-Related Deaths 2015–2024

18 infants died during 2024.

An increase of 1 (6%) from 2023, falling below the ten-year average.



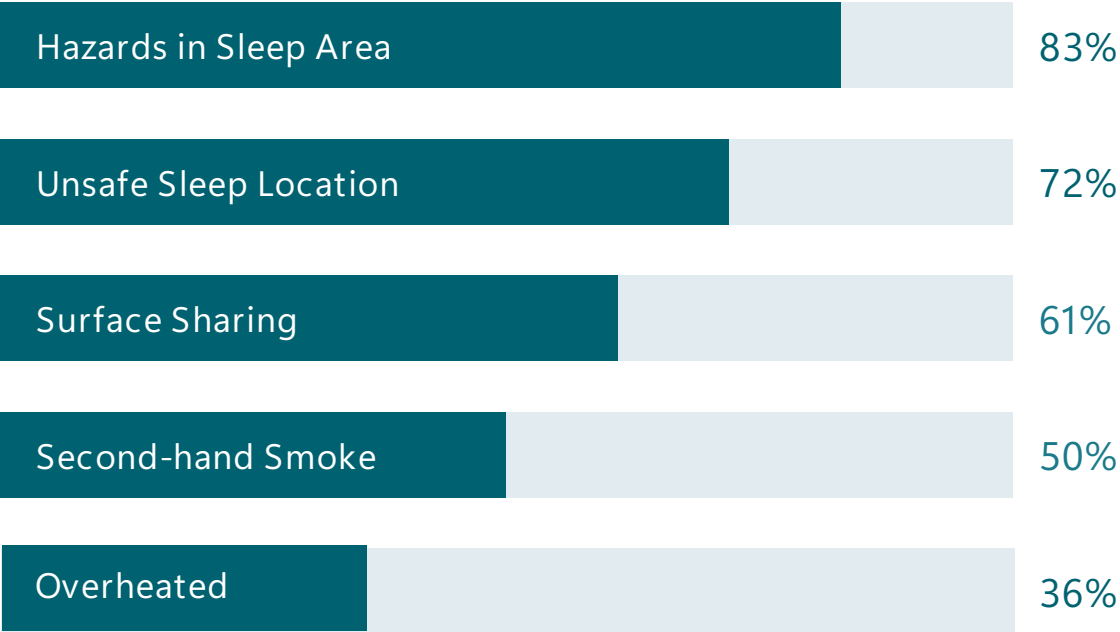
**2024**  
18 deaths

**10-year average**  
20 deaths

**+6%**  
Compared to 2023

# Sleep-related Infant Deaths — 2024

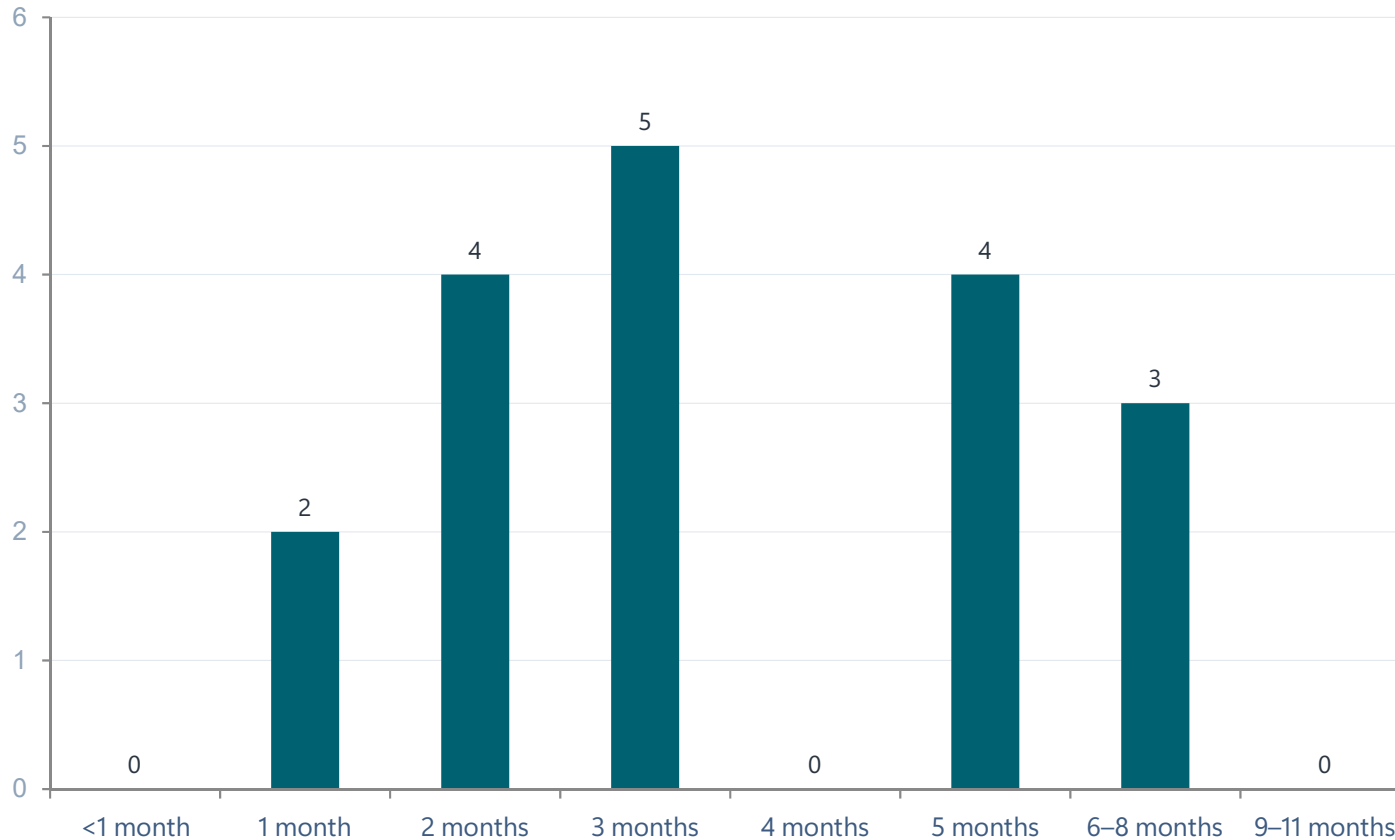
## Sleep-environment Risk Factors



Black non-Hispanic infants are 10 times more likely to die from unsafe sleep than white-non Hispanic infants

# Sleep-Related Death - Age at Death

Sleep-related infant deaths by age at death · 2024



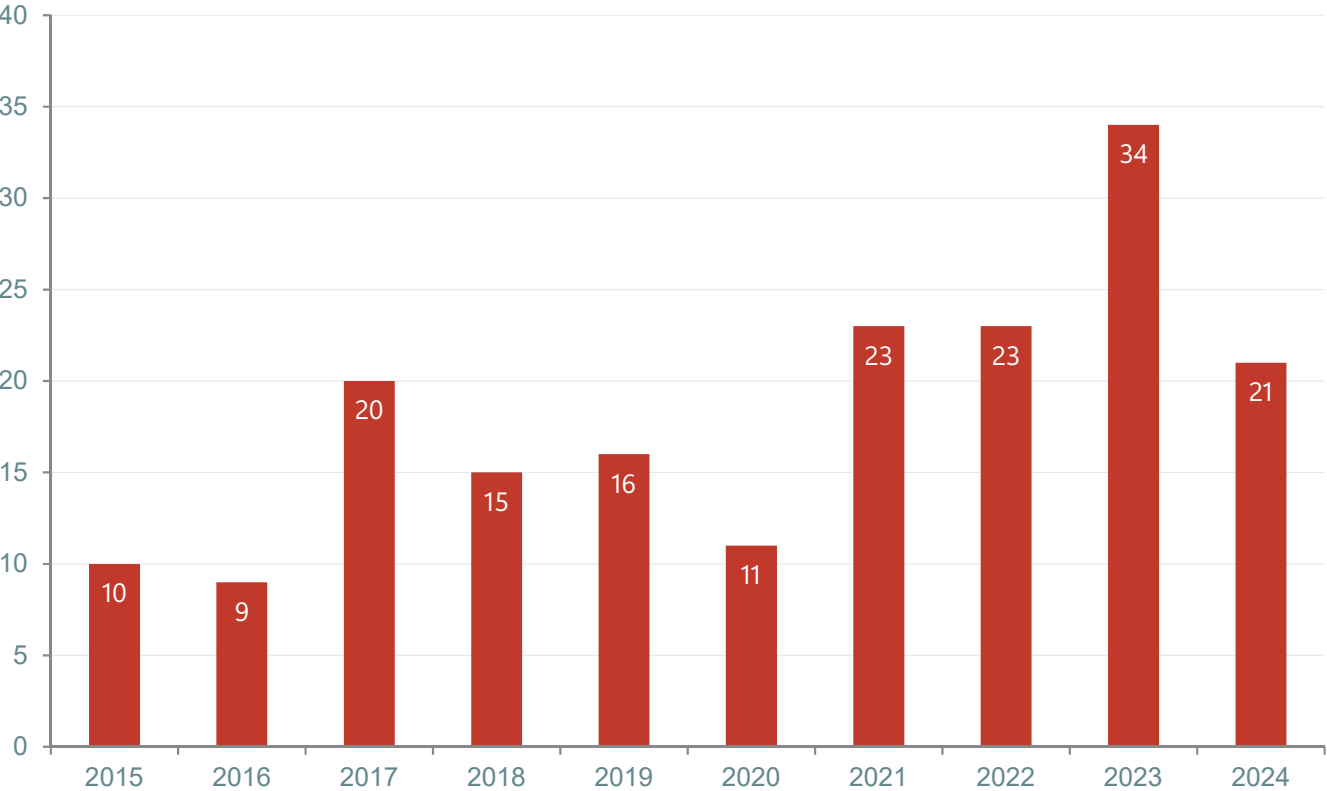
## Peak

risk at 1-5 months  
(83% of deaths)



# Homicides

Homicide is the leading cause of death in children ages 1–17. After an all-time high in 2023, homicides decreased 38%, but remain above the ten-year average.



**2024**  
21 deaths

**10-year average**  
18 deaths

**-38%**  
Compared to 2023

# Homicide Rate — County vs. Ohio vs. U.S.

Rate per 100,000 children · Cuyahoga County vs. Ohio vs. U.S. · 2024

Cuyahoga County

**8.4**

per 100,000

*87% higher than Ohio  
103% higher than U.S.*

State of Ohio

**3.3**

per 100,000

*State benchmark*

United States

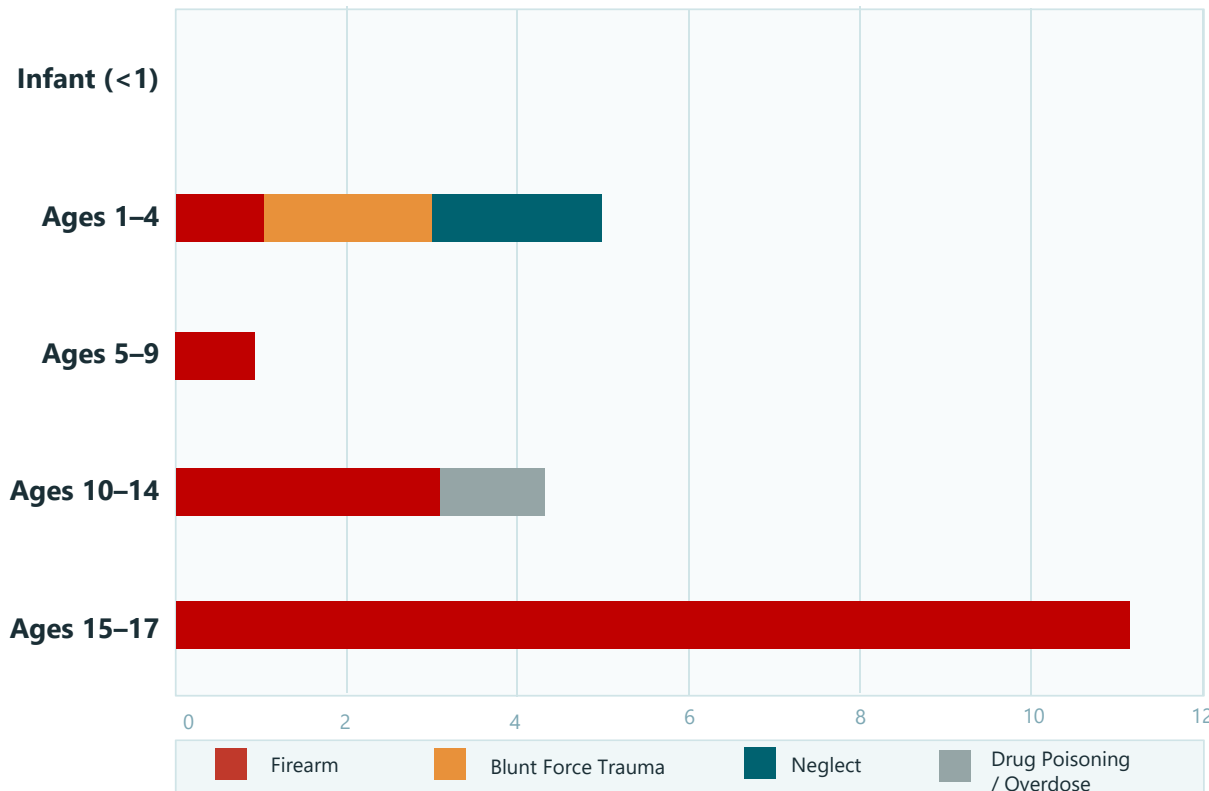
**2.7**

per 100,000

*National benchmark*

# Homicide — Cause of Death by Age Group

Number of homicide deaths by cause and age group · Cuyahoga County · 2024



## Key Finding

**Adolescents account for more than half of all homicides**

Ages 15–17 account for 12 of 21 homicides

**Firearms dominate adolescent deaths**

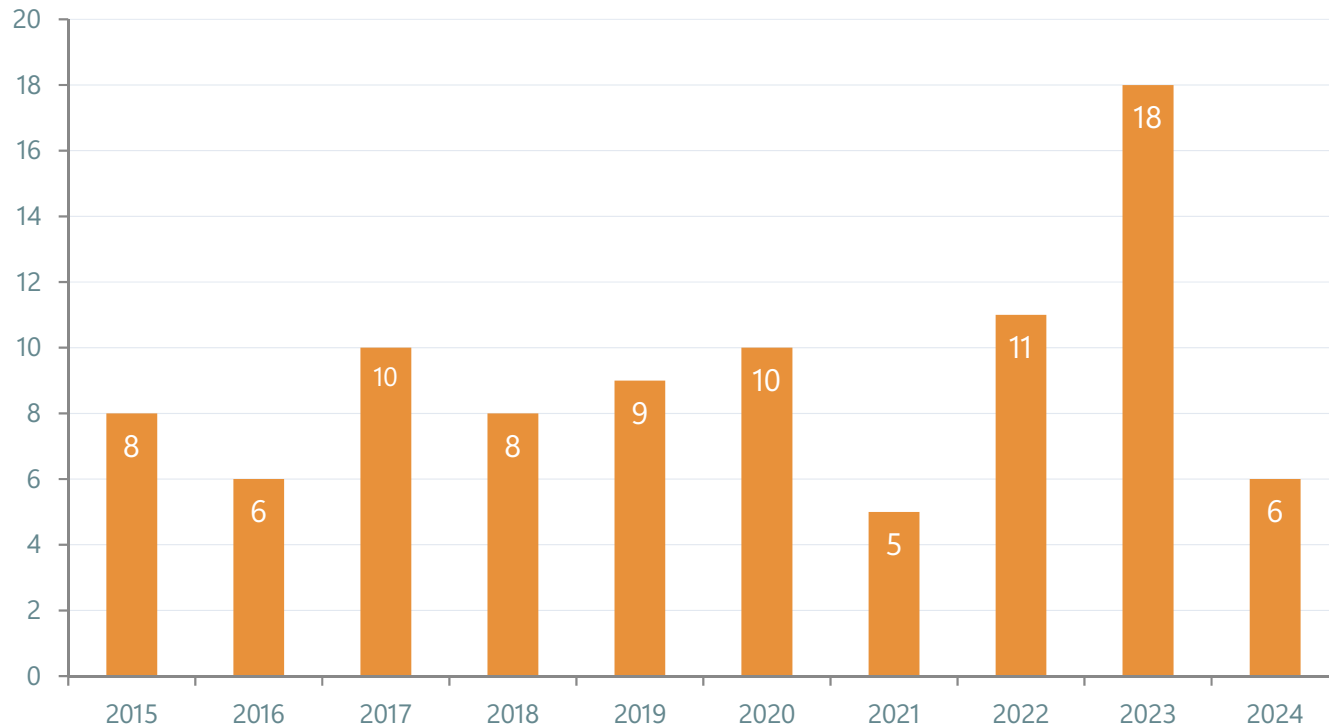
All adolescents died from a gunshot wound (GSW)

**Perpetrators change between groups**

Caregivers are the usual perpetrator in younger children, while peers, acquaintances and strangers are the perpetrators for the older children.

# Abuse and Neglect Deaths

6 infants died during 2024 due to abuse and neglect.  
An decrease of 12 (67%) from 2023, falling below the ten-year average.



**2024**

**6 deaths**

**10-year average**

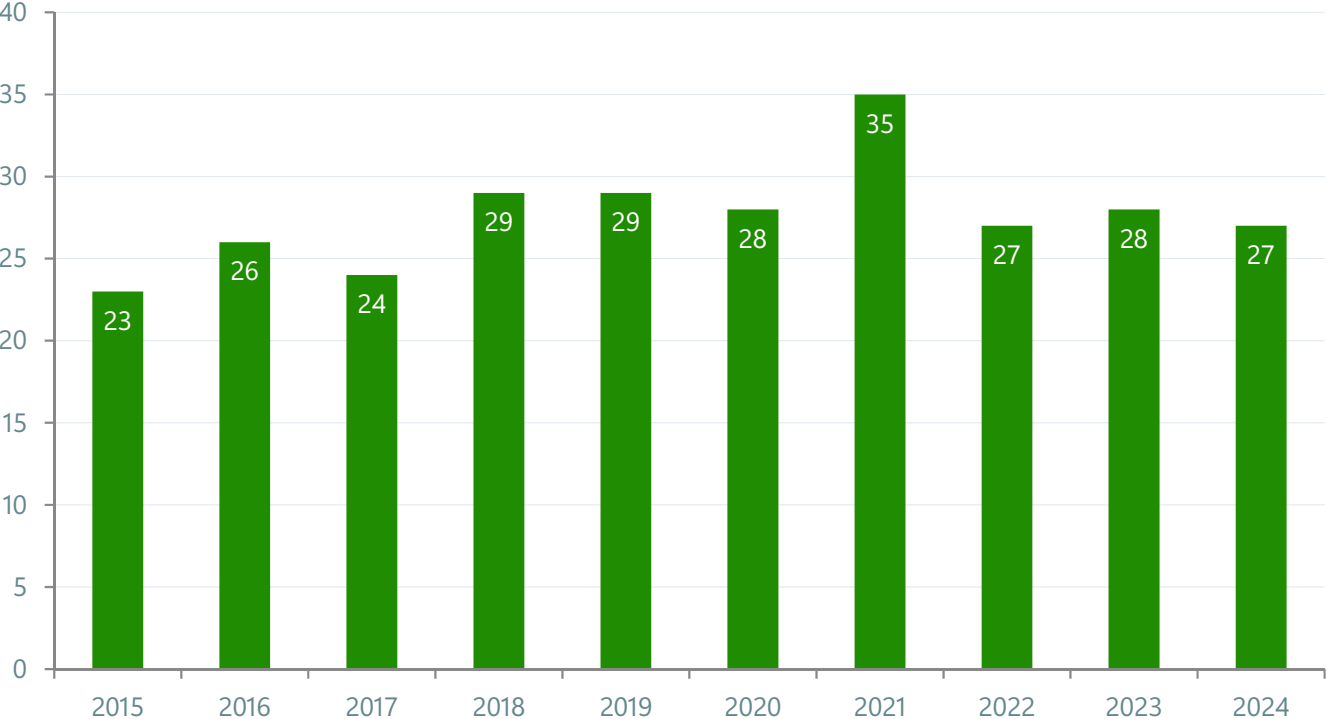
**9 deaths**

**-67%**

**Compared to 2023**

# Unintentional Deaths

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

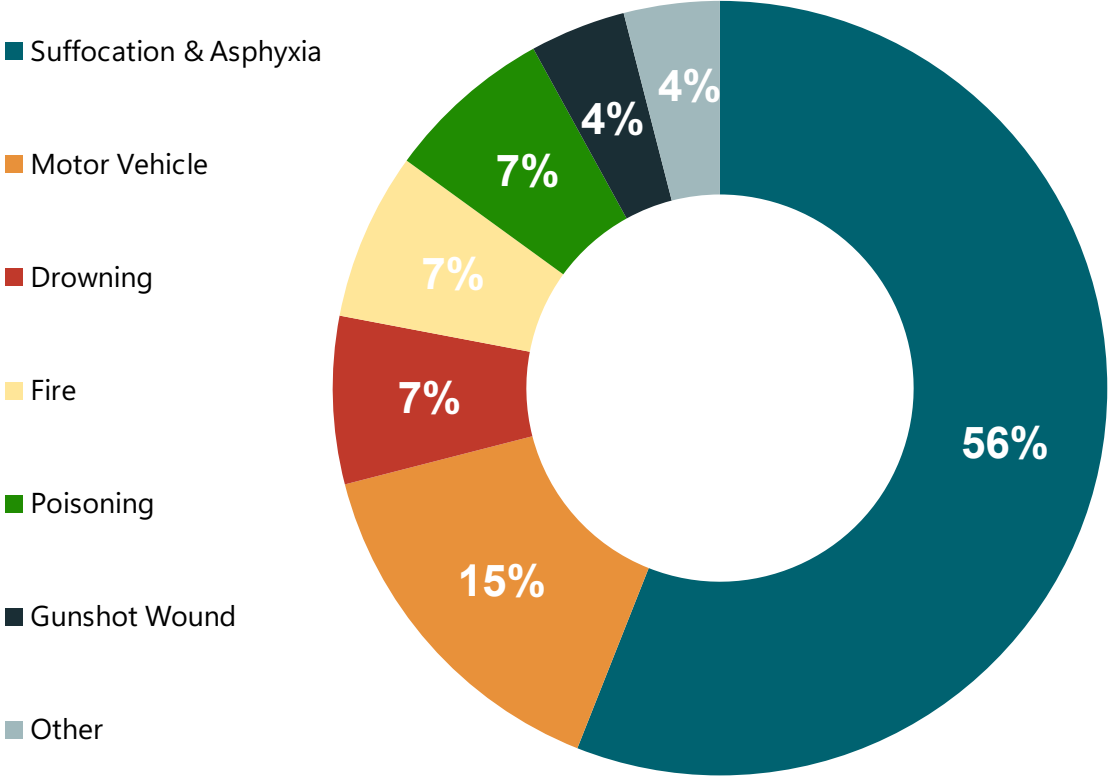


**2024**  
27 deaths

**10-year average**  
28 deaths

**-4%**  
Compared to 2023

# Unintentional Deaths



## Key Finding

Suffocation & asphyxia accounted for 56% of unintentional deaths

All occurred in unsafe sleep environments.



# Unintentional Death Rate — County vs. Ohio vs. U.S.

Rate per 100,000 children · Cuyahoga County vs. Ohio vs. U.S. · 2024

Cuyahoga County

**10.8**

per 100,000

*19% higher than Ohio  
31% higher than U.S.*

State of Ohio

**8.9**

per 100,000

*State benchmark*

United States

**7.9**

per 100,000

*National benchmark*

# 2024 Recommendations

Prevention strategies developed from case review findings

# CFR Recommendations

2024 Recommendations were restructured to be clear, specific, and action-oriented. Moving away from broad language.

Lead agencies were identified for each recommendation.

Enhances the likelihood that recommendations can be translated to policy, practice or program changes.

# CFR Recommendations

Reduce gun access for children and teens through education about responsible gun ownership, including use of a locked cabinet for storage.

*Healthcare providers, schools, EMS/fire, law enforcement, public health, community organizations, home visiting organizations, parents/caregivers, DCFS, child advocacy agency*

Assess and address social determinants of health needs at prenatal care appointments.

*Healthcare providers, social workers, community organizations*

**Encourage Boot Camp and fatherhood initiatives for Dads.**

*Healthcare providers, community organizations, home visiting organizations*

# How to Have a Voice in This Work

Stay aware of local, state, and federal policies

Understand how the political climate affects families

Contact local representatives

Vote

Attend Community Meetings

Advocate for supportive family policies at your own workplace

- Paid family leave
- Accommodating breastfeeding

Encourage conversations

“

***You came here for a reason.  
Everyone has a “why.”***

It's important to remember that.

”





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## Contact Information

**Alexis Ipsaro, MPH**

Epidemiologist

216.201.2000 ext.1625

[aipsaro@ccbh.net](mailto:aipsaro@ccbh.net)

**Holly Galicki, BSN, RN**

CFR Program Manager

216.201.2000 ext.1529

[hgalicki@ccbh.net](mailto:hgalicki@ccbh.net)

**Erin E. Dodds, MA, LPC**

FIMR Program Manager

216.201.2000 ext.1534

[edodds@ccbh.net](mailto:edodds@ccbh.net)