

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 well-being of children in our community.

The Cuyahoga County CFR Board brings together professionals from various fields including healthcare, law enforcement, social services and public health to review the causes and circumstances surrounding 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 purpose of CFR is to turn these findings into better policies, programs and interventions, along with recommendations to prevent future child deaths.

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2025 -2026

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2025 IN REVIEW

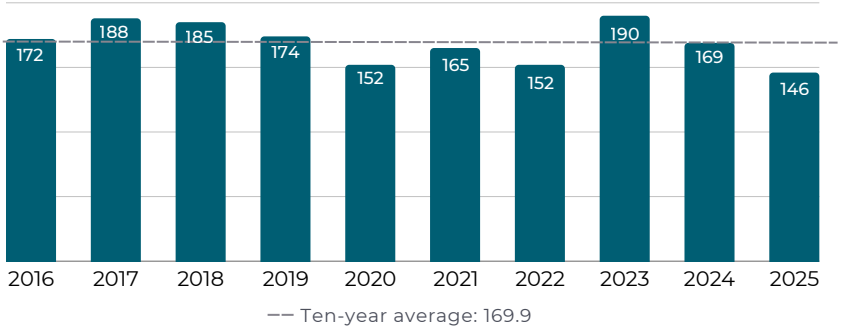
Child fatalities are incredibly devastating and tragic, exposing the challenges and vulnerabilities faced by the youngest members of our community.

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.



146 CHILDREN DIED DURING 2025

▼ 23 (14%) compared to 2024

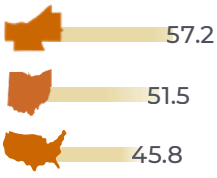


In 2025, child fatalities decreased by 23, **reaching a county all-time low**. This also marks the second consecutive year of a decrease and is 14% below the ten-year average of 169.9.

CHILD MORTALITY RATE

57.2

PER 100,000



The Child Mortality Rate in Cuyahoga County of 57.2 is 11% higher than the State of Ohio and 25% higher than the United States.

KEY TRENDS

The infant mortality rate dropped to 7.26, yet Black infants died at 4.11 times the rate of White infants, the widest gap in five years.

Prematurity remains the leading cause of infant death.

Homicides decreased for the second consecutive year, but firearms of all intent remain a top concern, accounting for 33% of deaths in children 1-17 years old.

▼ 146
Total Child Fatalities

▼ 89
Infant Deaths

▼ 7.3
Infant Mortality Rate

(=) 18
Sleep-Related Deaths

▲ 12
Abuse & Neglect

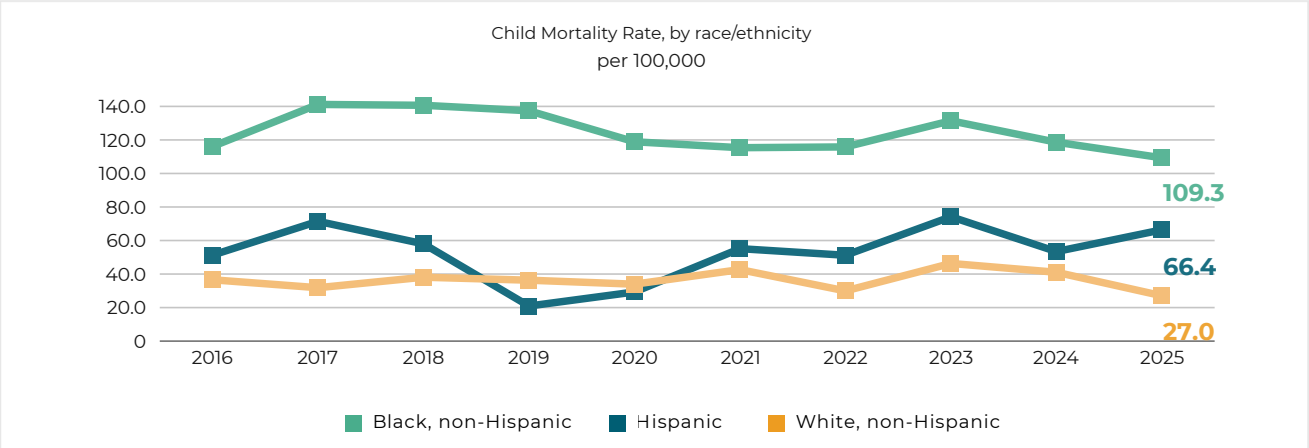
▼ 24
Unintentional Injury

▲ 5
Suicides

▼ 20
Homicides

2025 IN REVIEW

Large racial disparities in child mortality persist in Cuyahoga County. In 2025, the Black, non-Hispanic child mortality rate was 109.3 per 100,000, about 4 times higher than the White, non-Hispanic rate of 27.0 per 100,000.



While the table below summarizes causes of death, manner of death describes the circumstances or intent surrounding the death. Most child fatalities (63%) were classified as natural deaths, with leading causes including prematurity, birth defects, cancer, infections, and other medical conditions.

Collectively, accidents (16%), homicides (14%), and suicides (3%) accounted for one-third of child deaths. Firearms and unsafe sleep environments were major contributors to these preventable fatalities. Given the preventable nature of many injury- and violence-related deaths, targeted prevention strategies focused on firearm safety, violence prevention, and safe sleep practices have the potential to substantially reduce child mortality. Deaths of undetermined intent accounted for 3% of all child deaths.

Cause of Death	Under 1	1-4	5-9	10-14	15-17	Total
Prematurity	46	0	0	0	0	46
Firearms	0	0	1	3	15	19
Medical	4	3	5	3	4	19
Sudden Unexpected Infant Death	18	0	0	0	0	18
Birth Defects	15	0	0	0	0	15
Infection	4	1	0	2	0	7
Cancer	1	1	0	3	1	6
Other Intentional Injuries	0	1	0	2	3	6
Motor Vehicle Accidents	0	2	0	2	0	4
Drowning	0	2	0	0	0	2
Other Unintentional Injuries	0	0	0	0	2	2
Undetermined	1	1	0	0	0	2
	89	11	6	15	25	146

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.

89 INFANTS DIED DURING 2025

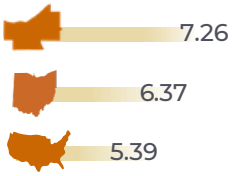
▼ 18 (17%) compared to 2024



INFANT MORTALITY RATE (IMR)

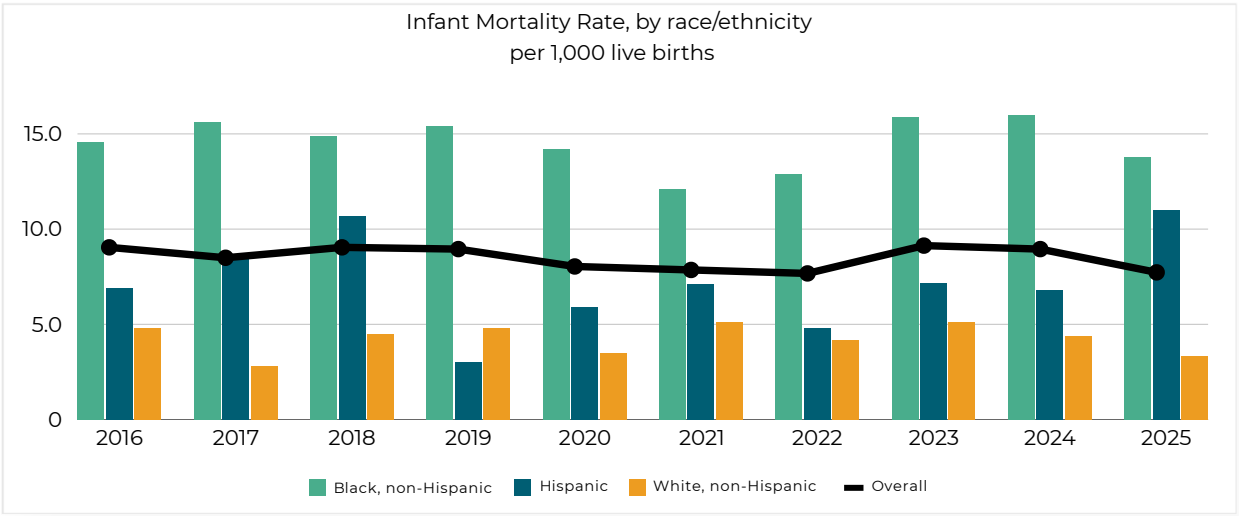
7.26

PER 1,000 BIRTHS



The Infant Mortality rate is 14% higher than the State of Ohio and 35% higher than the United States.

The 2025 Infant Mortality Rate (IMR) of 7.26 per 1,000 live births, decreased from 2024 and is below the ten-year average of 8.10. The White non-Hispanic IMR fell to 3.35, meeting the Healthy People 2030 goal of 5.0 or less. **The Black non-Hispanic IMR also declined, to 13.77, which is 4.11 times higher than the White non-Hispanic rate.** This disparity ratio represents the highest Black-White disparity in the last five years. The Hispanic IMR moved in the opposite direction, rising to 11.0, its highest level in a decade. These numbers show that the overall improvement has not been shared equally across racial and ethnic groups.



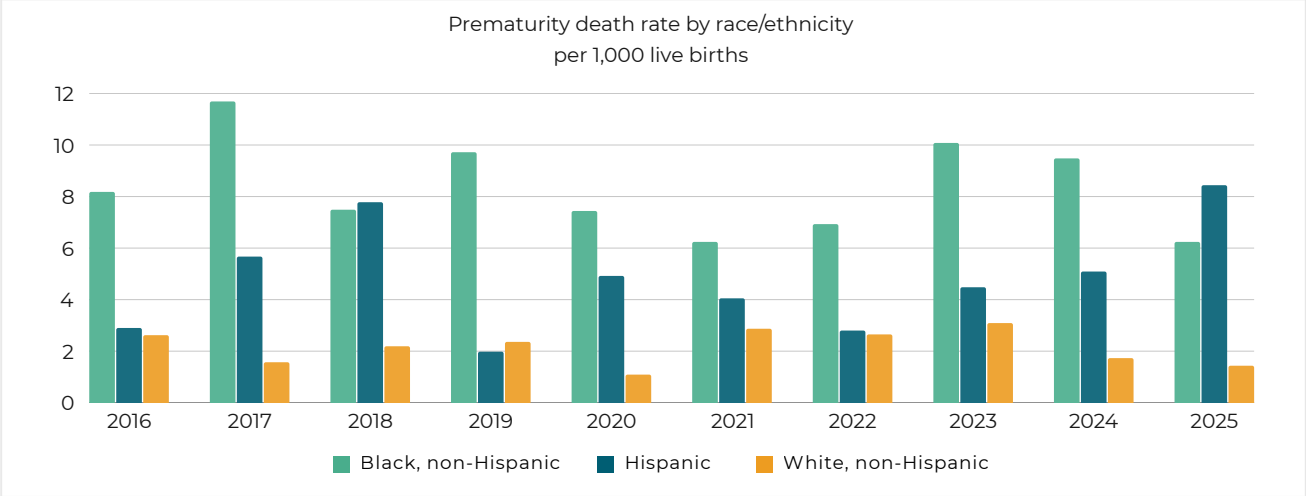
Of the 89 infant deaths, 67% occurred within their first 28 days of life, also known as the *neonatal period*. Neonatal deaths are often linked to prematurity and birth defects, while postneonatal deaths are more often linked to unsafe sleep and other preventable causes.

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 52% of infant deaths.**

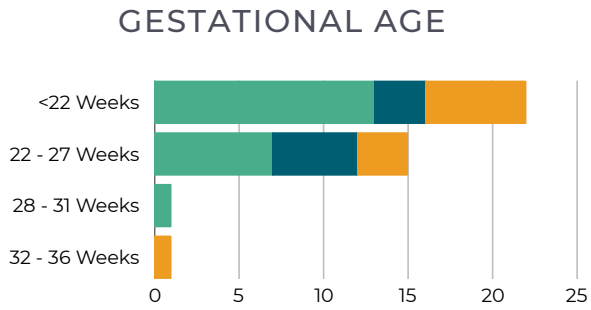
46 INFANTS DIED DUE TO PREMATURITY DURING 2025

Black non-Hispanic babies die from prematurity at a rate **4.34 times** that of White non-Hispanic babies. The Hispanic prematurity rate has trended up over the last few years.



Extremely premature babies (<28 weeks of gestation) represent 89% of all infant deaths due to prematurity. Black non-Hispanic babies account for 54% of all infant deaths due to extreme prematurity and 60% of deaths among infants born at <22 weeks gestation.





Maternal obesity was the leading risk factor for the 46 infants that died due to prematurity (73%). Poverty was a risk factor in 68% of these deaths. Hypertensive Disorders in Pregnancy (HDiP) was present in 29% of premature infant deaths.

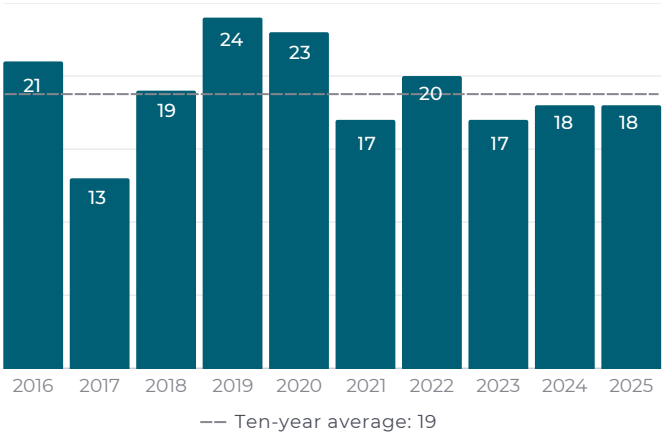
SLEEP-RELATED INFANT DEATHS

Sleep-related deaths are the leading cause of Sudden Unexpected Infant Death (SUID) and the second leading cause of infant deaths, accounting for 20% of all infant deaths. Sleep-related deaths are highly preventable and occur due to unsafe sleep environments.

18 BABIES DIED DUE TO UNSAFE SLEEP CONDITIONS DURING 2025

(=) No change compared to 2024

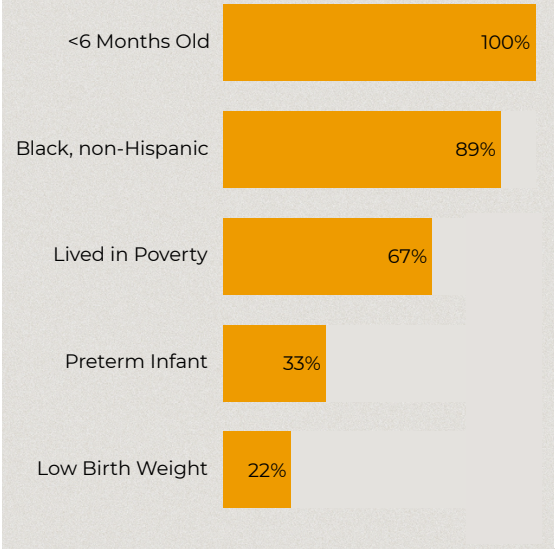




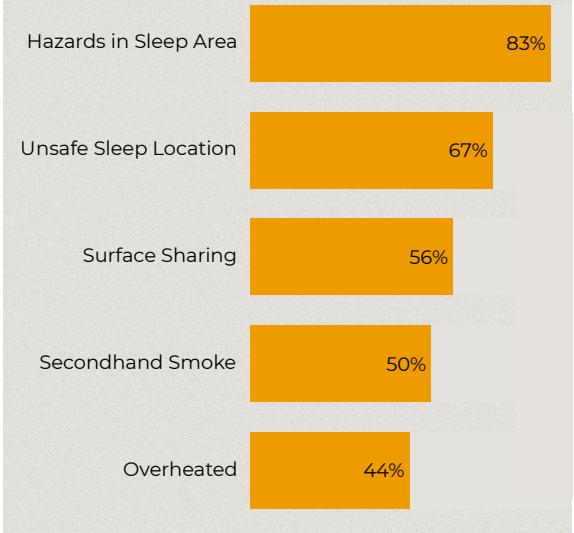
Sleep-related deaths have remained stable for several years with little year-to-year change. The 10-year average of sleep-related deaths showed slight improvement to 19, after remaining at 20 for several years.

68% 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, 44110** and **44108**

VULNERABLE INFANT RISK FACTORS



SLEEP-ENVIRONMENT RISK FACTORS

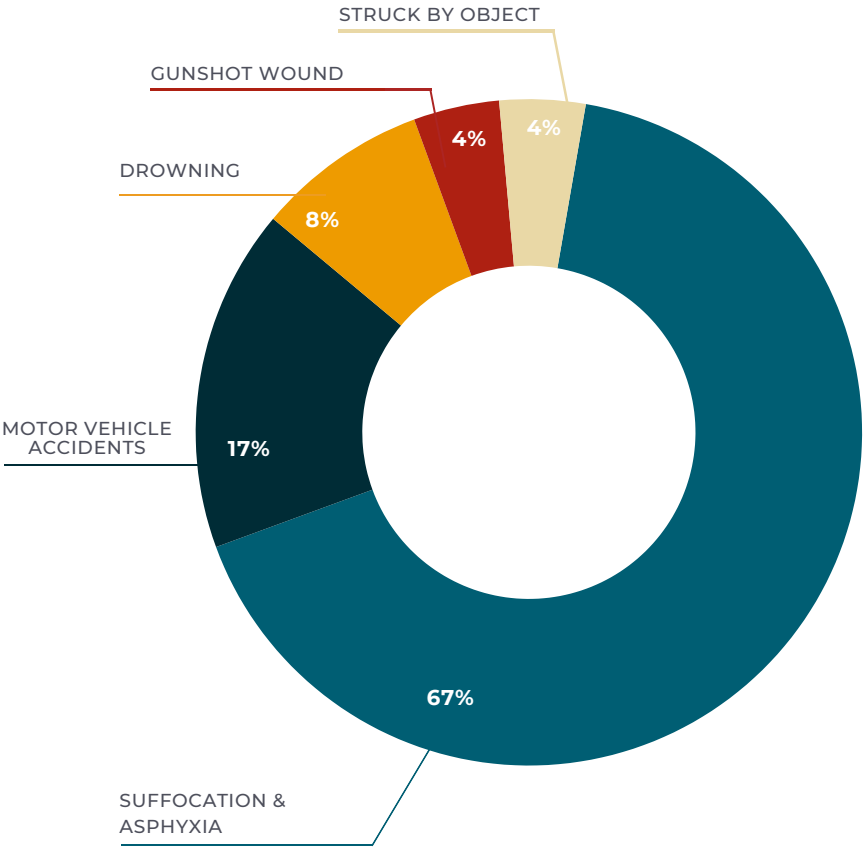


UNINTENTIONAL DEATHS

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

24 CHILDREN DIED FROM UNINTENTIONAL INJURIES DURING 2025

▼ 3 (11%) compared to 2024

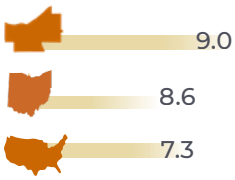


Suffocation and asphyxia accounted for two-thirds of unintentional deaths, all of which occurred due to an unsafe sleep environment.

UNINTENTIONAL DEATH RATE

9.0

PER 100,000



The Unintentional Injury Death rate is 5% higher than the State of Ohio and 23% higher than the United States.

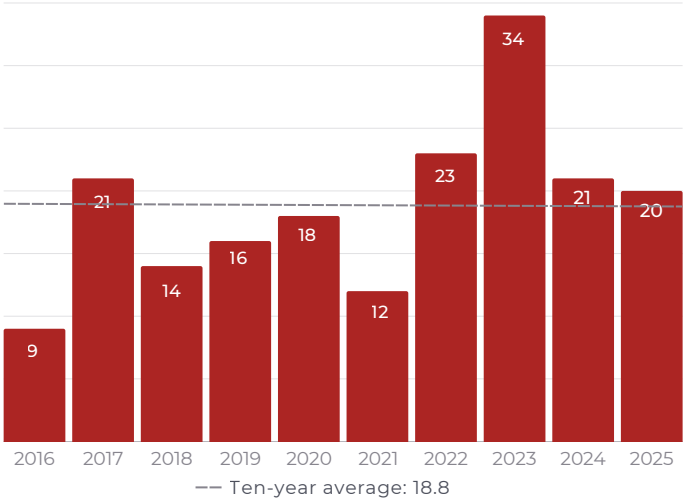


HOMICIDES

Homicide continues to be the leading cause of death for children ages 1–17 in Cuyahoga County, a position it has held since 2022. This makes violence against children one of the county's most persistent public health concerns.

20 CHILDREN DIED FROM HOMICIDE DURING 2025

▼ 1 (5%) compared to 2024



In 2025, child homicides were down slightly from 21 in 2024 and 41% below the all-time record high of 34 in 2023.

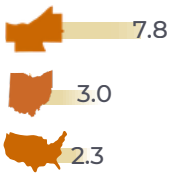
While this marks a second consecutive year of decline, the 2025 total remains above the ten-year average of 18.8 for the fourth consecutive year.



HOMICIDE RATE

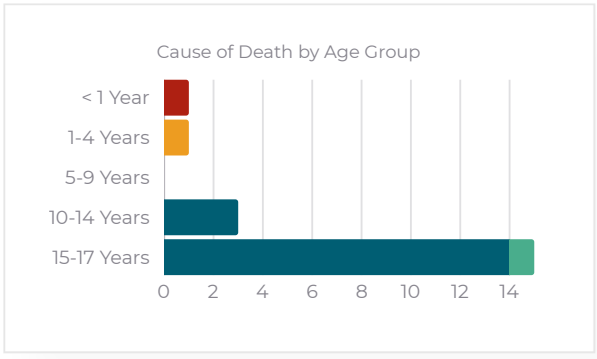
7.8

PER 100,000



The Homicide rate in Cuyahoga County for 2025 is **160% higher** than Ohio (3.0) and **239% higher** than the United States (2.3).

The leading cause of child homicide is a **Gunshot Wound (85%).** **Stabbing, Starvation** and **Other** means each represented 5% of child homicides.



Stark racial disparities are evident in homicide deaths, with Black, male adolescents (15-17 years old) accounting for 65% of all homicides in 2025.

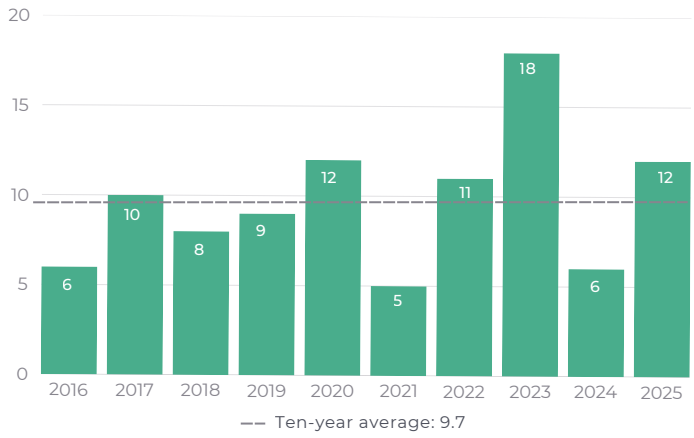
Black male adolescents are **41 times more likely to die from homicide** than their White or Hispanic counterparts.

CHILD ABUSE AND NEGLECT

Protecting children from child maltreatment remains an ongoing and urgent priority in Cuyahoga County. In 2025, 7,396 reports of suspected child maltreatment warranted assessment or investigation (according to Ohio's Interactive Children Services Dashboard) underscoring the persistent need for prevention, early intervention and family support.

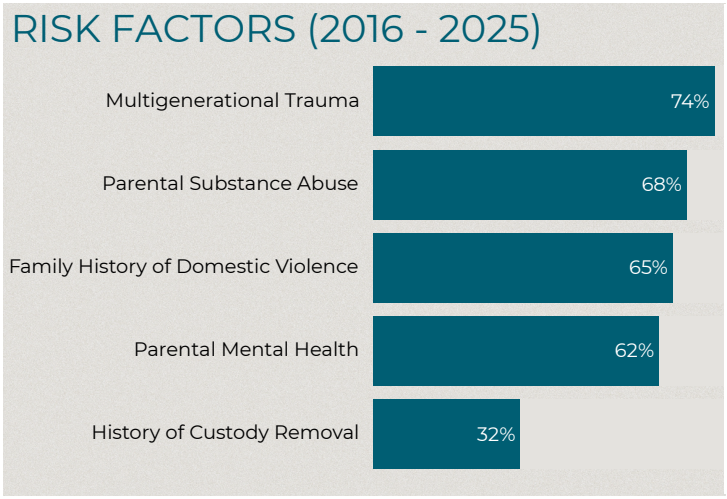
12 CHILDREN DIED FROM ABUSE AND NEGLECT DURING 2025

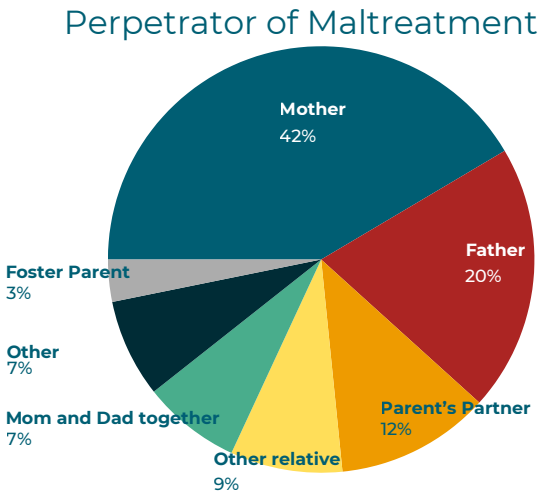
▲ **6** (100%) compared to 2024





Child maltreatment fatalities encompass deaths resulting from abuse, neglect, and medical neglect. These deaths may result from inflicted injuries, inadequate supervision, exposure to hazards, unmet basic needs or failure to receive necessary medical care. In 2025, 58% of these deaths involved neglect and 33% involved medical neglect. Physical abuse was involved in 25% of deaths.





From 2016 to 2025, mothers (42%) were the most frequently identified perpetrators, followed by fathers (20%) and parents' partners, including stepparents and unmarried partners (12%). This pattern likely reflects caregiving roles, as mothers are most often the primary caregiver responsible for the child.

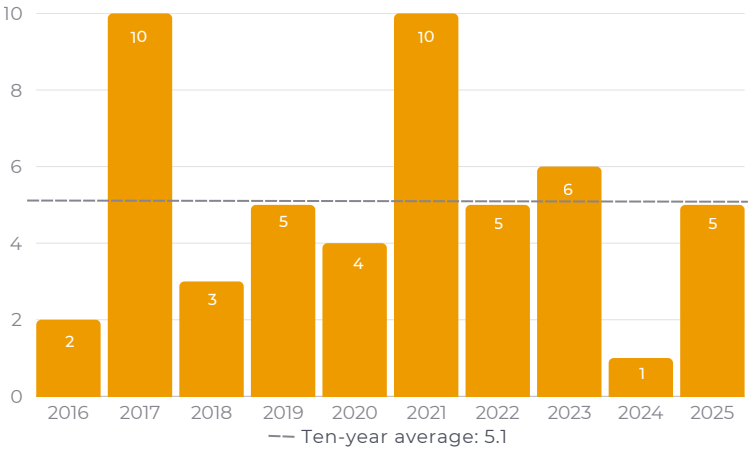
SUICIDE

Suicide deaths often reflect the intersection of mental health challenges, adverse life experiences, and moments of acute crisis. In some cases, suicidal behavior may occur during periods of intense emotional distress, when impulsive actions can turn an acute crisis into a fatal outcome.

5 CHILDREN DIED FROM SUICIDE DURING 2025

▲ 4 compared to 2024





SUICIDE RATE

1.9

PER 100,000

1.9

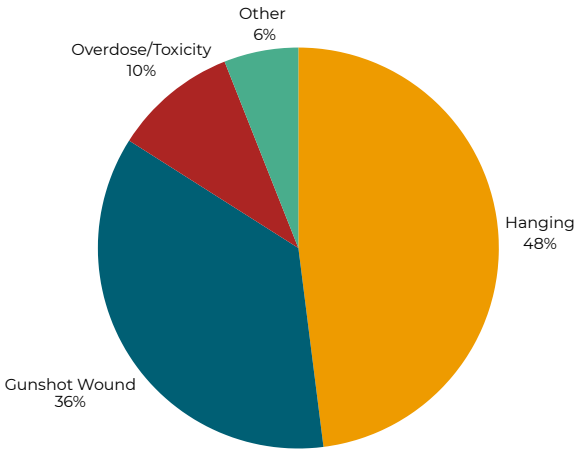
2.9

2.4

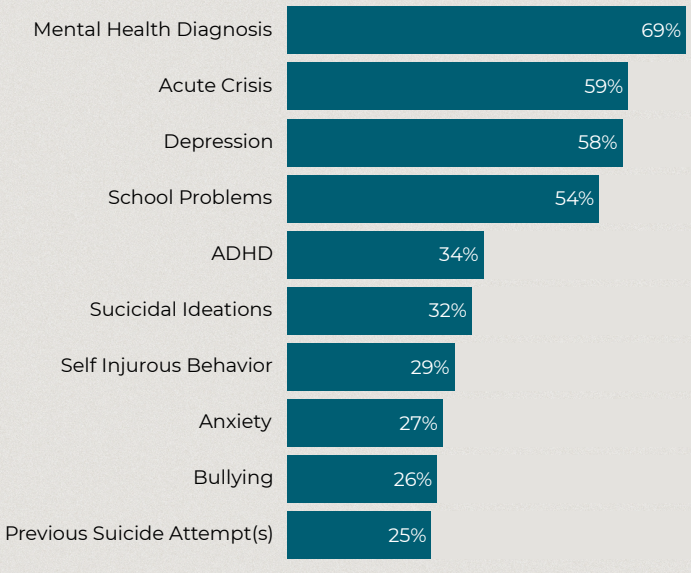
The youth suicide rate in Cuyahoga County for 2025 of 1.9 is 34% lower than Ohio (2.9) and 21% lower than the United States (2.4).

Notably, suicide was the only cause-of-death category in which Cuyahoga County experienced a lower rate than both state and national benchmarks.

Cause of Death (2016-2025)



RISK FACTORS (2016 - 2025)



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

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
- 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 proper swaddling technique, when to stop swaddling an infant, and recommend use of a ready-to-wear swaddle product when available
- Healthcare providers, public health, community organizations, DCFS, home visiting organizations

Promote the Safe Sleep Cuyahoga 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

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

Provide a safety check list to assist parents in selecting a daycare or childcare home provider
- Healthcare providers, public health, home visiting organizations, DCFS, Ohio Department of Jobs and Family Servies (ODJFS)

Advocate for pack'n play, bassinet and crib manufacturers to have safe sleep education printed inside every safe sleep space
- Public health, medical professional associations, nonprofit/advocacy groups

Provide and promote affordable babysitting education for youth responsible for caring for siblings or other children
- Schools libraries, American Red Cross, faith-based organizations, recreation departments

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 should assess the situation for barriers to compliance and determine if reporting a suspicion of medical neglect is warranted
- Healthcare providers, DCFS

Establish an agreement across health care systems to confirm continuity of care for medically complex children whose families report transferring to a different hospital system
- 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

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

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

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 childproof their home
- Healthcare providers, public health, DCFS, community organizations, home visiting organizations

Educate on the importance of wearing a helmet and endorse adoption of more protective helmet designs. Mandate helmet use in all youth sports with a high risk of head injury
- Medical professional associations, schools, injury prevention advocacy groups, community organizations

Encourage coordinated schools district and media campaigns to inform students, parents and the community about dangerous social media "challenges"
- Schools, media sources, public health

Advocate for homeowners' associations in waterfront housing communities to permit protective fencing to reduce child drowning risks
- Public health, local government

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 of 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

Promote and expand accessible organized youth programs to provide safe and constructive alternatives to risky behaviors
- Schools, community organizations, faith-based organizations, Juvenile Justice

Support mentorship initiatives and conflict resolution education in schools or community programs to reduce violence and promote positive peer relationships
- Schools, community organizations, faith-based organizations, Juvenile Justice

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

Implement routine mental health screening for children experiencing homelessness
- Healthcare providers, schools, DCFS

For more information, please contact:

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