

2023

CUYAHOGA COUNTY

CHILD FATALITY REPORT

EXECUTIVE SUMMARY

(SELECT DATA FROM THE ONLINE DASHBOARD)

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.



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

CFR BOARD MEMBERS

2023 -2024

Mike Bokmiller, MSSA, LSW
Canopy Child Advocacy Center

Jacqueline Hairston, MS
Cuyahoga County Juvenile Court

Leah Schraff, LSW
Cleveland Clinic Children's Hospital

Daralynn Constant, LISW-C
Rainbow Babies & Children's Hospital

Kristyn Hajduk, MPH
Cuyahoga County Board of Health

Mike Shaedler
Cuyahoga County Death Scene Investigation

Erin Dodds, MA, LPC
Cuyahoga County Board of Health

Susan Hatters-Friedman, MD
University Hospitals

Sgt. Paolo Tantangelo, EMT-P, MPA
Cleveland Division of EMS

Yolanda Eiland
Cleveland Metropolitan School District

Alexis Ipsaro, MPH
Cuyahoga County Board of Health

Marni Turell, MD
Cleveland Clinic Foundation

Kayla Eyster, LSW
MetroHealth Medical Center

Britany King
Cuyahoga County ADAMHS Board

Allison Turton, MSSA, LISW-S
MetroHealth Medical Center

Anna Faraglia, JD
Cuyahoga County Prosecutor's Office

Matthew Krock, MSSA, LISW-S
Rainbow Babies & Children's Hospital

Jennifer Wagner
Cuyahoga County DCFS

Josh Friedman, MD
MetroHealth Medical Center

John Ladd, MNO
Invest in Children

Kaitlyn Weaver, DO
Cuyahoga County Medical Examiner's Office

Holly Galicki, RN
Cuyahoga County Board of Health

Lolita McDavid, MD, MPA
Rainbow Babies & Children's Hospital

Nicole Williams, MSSA, LSW
Cuyahoga County DCFS

Thomas Gilson, MD
Cuyahoga County Medical Examiner

Katie Parker, MA
Bright Beginnings



Hannah Verba, MPH
MomsFirst

Sgt. Teresa Gomez
Cleveland Division of Police

Kitty Russ, RNC, MSN, MSHA
Cleveland Clinic Fairview Hospital

2023 IN REVIEW

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

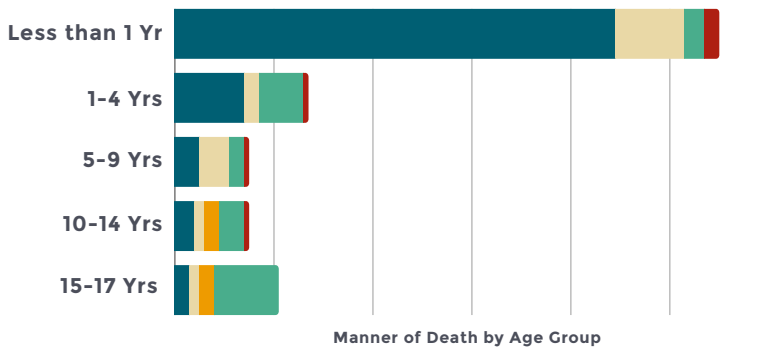
Each child death marks not just the loss of a young life, but also serves as a reminder of the gaps within our protective systems and the need for interventions and strategies to prevent future losses.



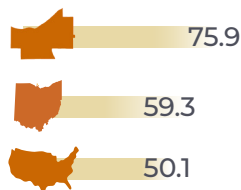
190 CHILDREN DIED DURING 2023

▲ **38 (25%)** compared to 2022

Deaths due to **Natural** causes accounted for 61% of all child deaths, followed by **Homicide** (18%), **Accidental** (15%), **Suicide** (3%) and **Undetermined** (3%).



Infants, and young children most commonly die from natural causes originating from a medical condition or illness, whereas adolescents tend to die from external causes originating from an injury, such as a gunshot wound or motor-vehicle accident.



The Child Mortality Rate in Cuyahoga County of 75.9 is 25% higher than the State of Ohio and 41% higher than the United States.

KEY TRENDS

Homicides increased by 48% and deaths due to Child Abuse and Neglect increased by 67% and both reached an unprecedented, all-time high.

The Infant Mortality Rate (IMR) is the highest in a 5-year period and the 2nd highest in 10-year period.

- ▲ **190**
Total Child Fatalities
- ▲ **112**
Infant Deaths
- ▲ **8.8**
Infant Mortality Rate
- ▼ **17**
Sleep-Related Deaths
- ▲ **18**
Abuse & Neglect
- ▲ **28**
Unintentional Injury
- ▲ **6**
Suicides
- ▲ **34**
Homicides

* denotes 2023 deaths and arrow denotes change from 2022

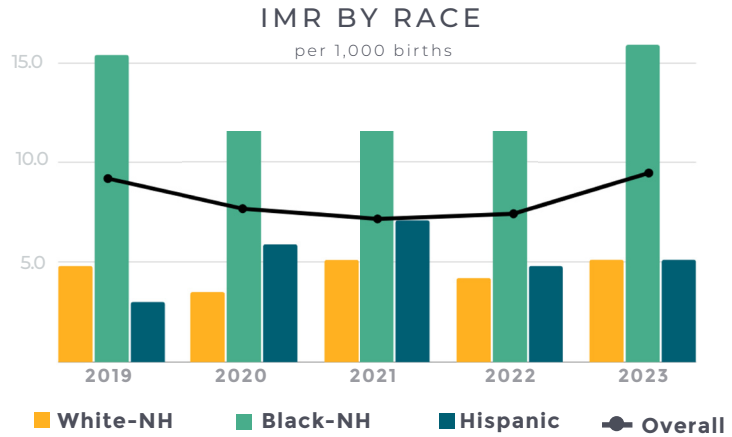
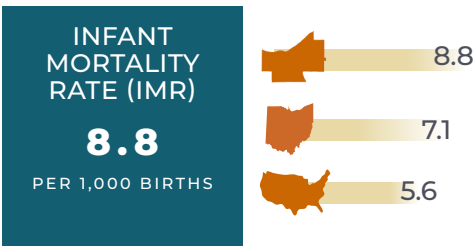


INFANT MORTALITY

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

112 INFANTS DIED DURING 2023

▲ 21 (21%) compared to 2022

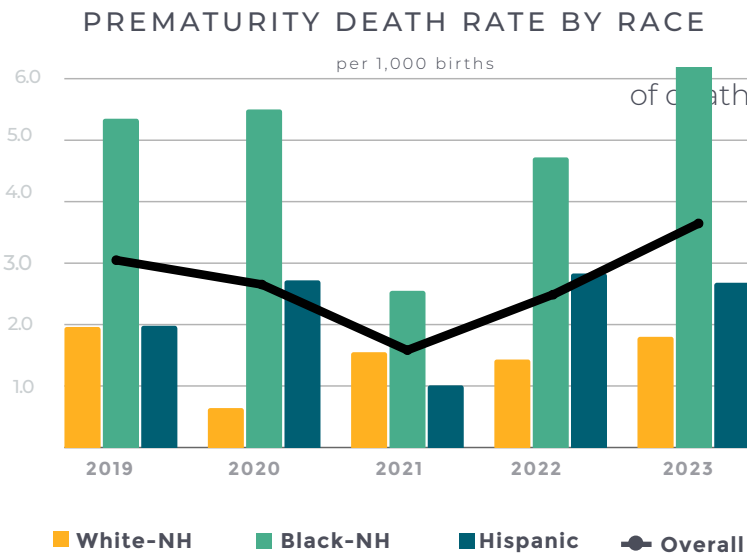


The 2023 Infant Mortality Rate of 8.82 is the highest in the last five years and second-highest in last 10 years. The 2023 IMR is also higher than the five-year average.

Significant racial inequities persist as black mothers suffer the burden of an infant mortality rate that is **3.11 times** higher compared to white mothers.

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 was a contributing factor of death in 65% of infant deaths and was the cause of death (as denoted in their death certificate) in 40% of all infant deaths.

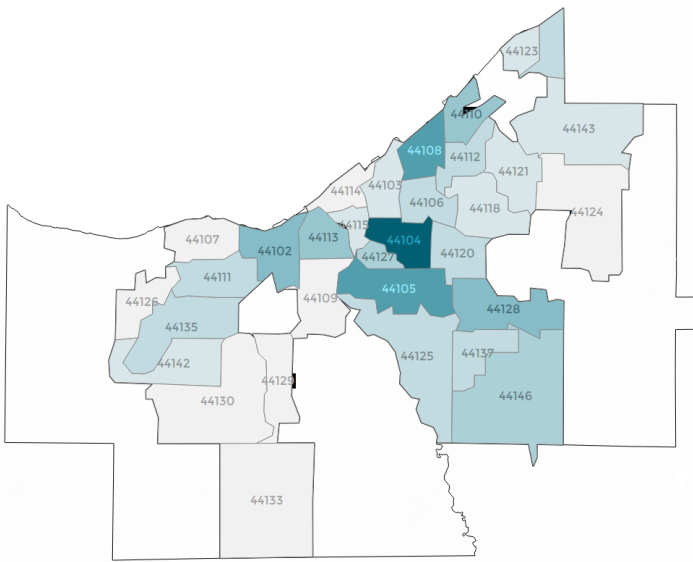
Black Non-Hispanic babies die from prematurity at a rate **3.72 times** than White Non-Hispanic babies

SLEEP-RELATED INFANT DEATHS

Sleep-related deaths are the second-leading cause of infant deaths, accounting for 15% of all infant deaths. Sleep-related deaths are highly preventable and typically occur due to an unsafe sleep environment.

Zz 17 BABIES DIED DUE TO UNSAFE SLEEP CONDITIONS

▼ **3 (-15%)** compared to 2022



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:

44104, 44105, 44108, 44128, and 44102

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

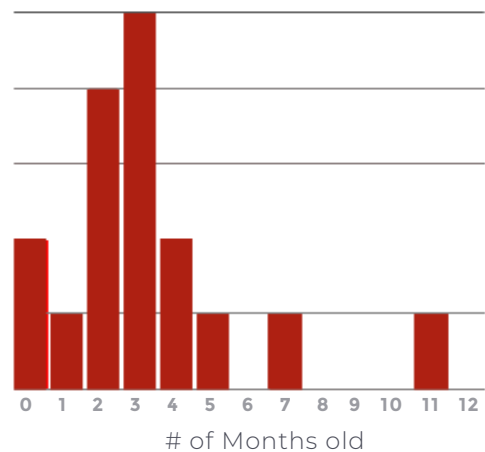


SLEEP-ENVIRONMENT

Individual case reviews of sleep related deaths take note of risk factors found in the environment, and how often they were present.



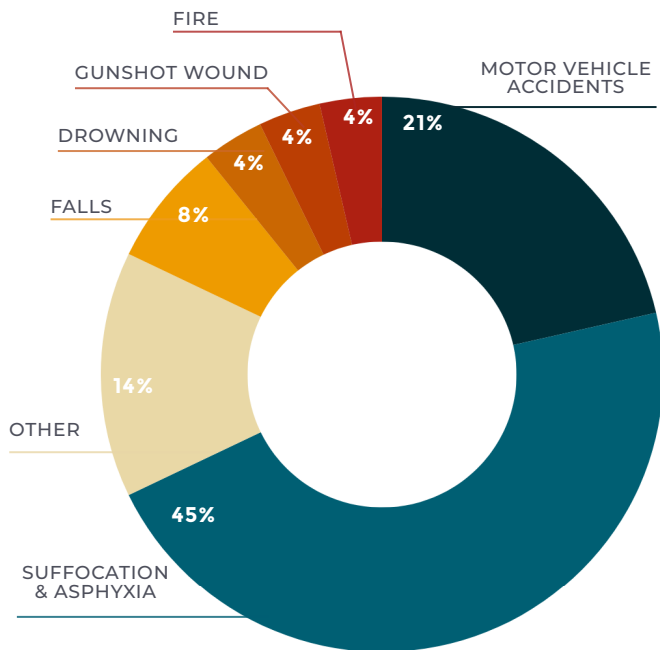
2023 SLEEP-RELATED DEATH AGE DISTRIBUTION



88% of sleep-related deaths occur in the first 5 months of a babies life.

UNINTENTIONAL DEATHS

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

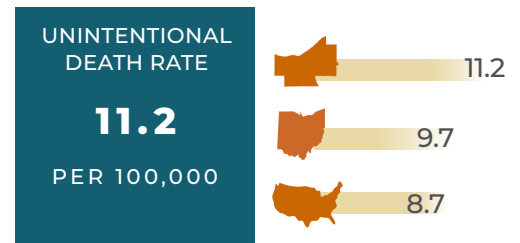


Suffocation and asphyxia accounted for nearly half of the unintentional deaths, all of which occurred due to an unsafe sleep environment.



28 CHILDREN DIED FROM UNINTENTIONAL INJURIES

▲ 1 (4%) compared to 2022



The Unintentional Injury Death rate is 14% higher than the State of Ohio and 25% higher than the United States.



SUICIDES

Mental health and suicide among adolescents continue to be serious issues in Cuyahoga County.



6 CHILDREN DIED FROM SUICIDE

▲ 1 (20%) compared to 2022

Suicide is the second-leading cause of death in adolescents. All of the suicides occurred in children ages 13 and up. Male adolescents were nearly twice as likely to commit suicide than female counterparts.

80% of suicide deaths are the result of a self-inflicted gunshot wound.



The Suicide rate in Cuyahoga County is in line with the State of Ohio (5.0) and the United States (4.7)

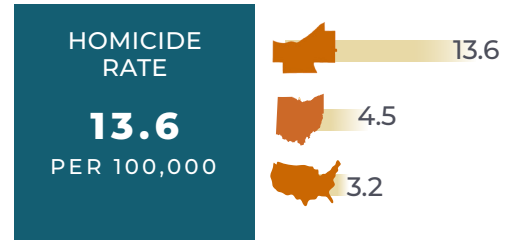
HOMICIDES

Homicide and violence have become very serious and rising issues among children in Cuyahoga County, with more children losing their lives to violence each year.

Homicide is the leading cause of death in children ages 1-17 years old.

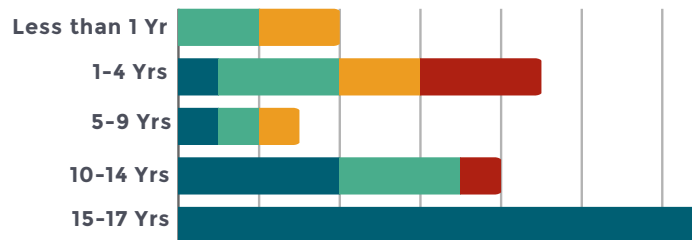
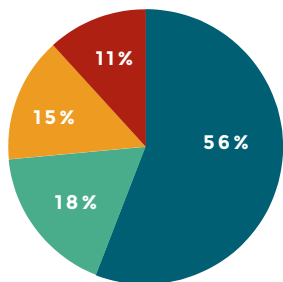
34 CHILDREN DIED FROM HOMICIDE

▲ 11 (48%) compared to 2022



The Homicide rate in Cuyahoga County for 2023 is **3 times** higher than Ohio (4.5) and **4 times** higher than the United States (3.2).

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



Deaths due to Child Abuse and Neglect accounted for **75%** of homicides under 10 years old

Stark racial disparities are evident in homicide deaths with black males dying disproportionately due to violence and homicide.



8 out of **10** homicide victims are **MALE**

The **Black-White Disparity** indicates that Black non-Hispanic children in Cuyahoga County are **60 times more likely** to die from homicide than their White or Hispanic counterparts.

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.



INTERAGENCY

Support the continued growth of the newly established Cuyahoga County Child Protection Team program as it works to operate to the full guidelines of the National Children's Alliance. Align efforts and funding so that a cross-system multidisciplinary team – backed by interagency memorandums of understanding – is enabled to provide medical chart review, triage, coordination, assessment, diagnosis, and provide information to authorities.



PREMATURITY

Support research and public awareness regarding the causes, risk factors, and lifelong effects of prematurity. Continue to educate women and expectant parents about the warning signs of preterm labor, the importance of interconception care, and the significance of a “Life Course Perspective” to decrease the risks of preterm births.



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.

Continue to educate staff at birthing and pediatric hospitals in Cuyahoga County about the importance of role modeling safe sleep in the hospital. Educating all caregivers, having conversations with families about barriers to safe sleep, and providing tips to help parents continue safe sleep after discharge.



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.



UNINTENTIONAL INJURIES

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.



HOMICIDE

Support educational programs that assist parents and guardians in understanding age appropriate behaviors, using alternative methods of discipline and choosing suitable caregivers.

Support domestic violence education and programs that: help families identify warning signs; outline actions to take, especially for escalating behaviors; provide access to counseling and emergency shelter; and initiate early intervention to limit the effects on children in the home.



SUICIDE

Support school programs and mental health social platforms for depression awareness, bullying and suicide prevention that also include resources for assistance.

Advocate for additional inpatient child psychiatric beds to meet the mental health needs of this population.

For more information, please contact:

ALEXIS IPSARO, MPH

Cuyahoga County Board of Health
(216) 201-2000 Ext. 1625
aipsaro@ccbh.net

HOLLY GALICKI, RN

Cuyahoga County Board of Health
(216) 201-2000 Ext. 1529
hgalicki@ccbh.net

JOHN LADD, MNO

Invest in Children
(216) 443-6583
John.Ladd@jfs.ohio.gov