

SCAN FOR FULL DATA DASHBOARD

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.





2023





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

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

Erin Dodds, MA, LPC Cuyahoga County Board of Health

Yolanda Eiland Cleveland Metropolitan School District

Kayla Eyster, LSW MetroHealth Medical <u>Center</u>

Anna Faraglia, JD Cuyahoga County Prosecutor's Office

Josh Friedman, MD MetroHealth Medical Center

Holly Galicki, RN Cuyahoga County Board of Health

Thomas Gilson, MD Cuyahoga County Medical Examiner

Sgt. Teresa Gomez Cleveland Division of Police **Jacqueline Hairston, MS** Cuyahoga County Juvenille Court

Kristyn Hajduk, MPH Cuyahoga County Board of Health

Susan Hatters-Friedman, MD Case Western Reserve University

Alexis Ipsaro, MPH Cuyahoga County Board of Health

Britany King Cuyahoga County ADAMHS Board

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

John Ladd, MNO Invest in Children

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

Katie Parker, MA Bright Beginnings

Kitty Russ, RNC, MSN, MSHA Cleveland Clinic Fairview Hospital Leah Schraff, LSW Cleveland Clinic Children's Hospital

Mike Shaedler Cuyahoga County Death Scene Investigation

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

Marni Turell, MD Cleveland Clinic Foundation

Allison Turton, MSSA, LISW-S MetroHealth Medical Center

Jennifer Wagner, MSW Cuyahoga County DCFS

Kaitlin Weaver, DO Cuyahoga County Medical Examiner's Office

Nicole Williams, MSSA, LSW Cuyahoga County DCFS

Hannah Verba, MPH MomsFirst

2023 IN REVIEW

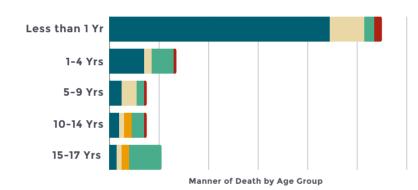
Child fatalities are incredibly devastating and tragic, exposing the challenges and vulnerabilites faced by the youngest members of our community.

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.

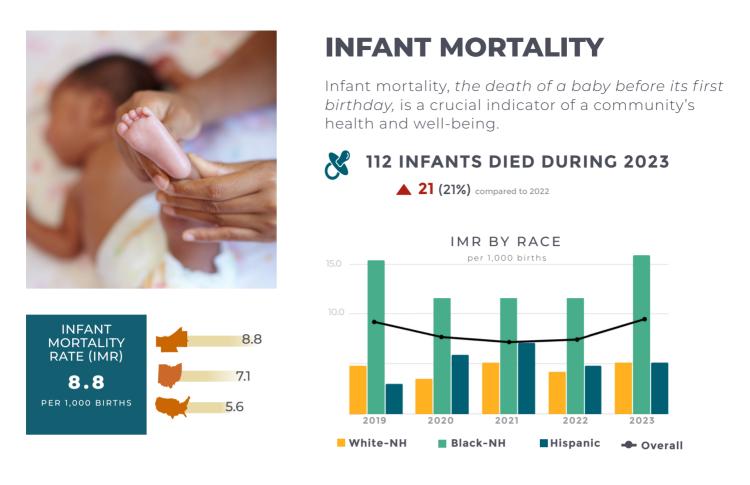


* denotes 2023 deaths and arrow denotes change from 2022

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.

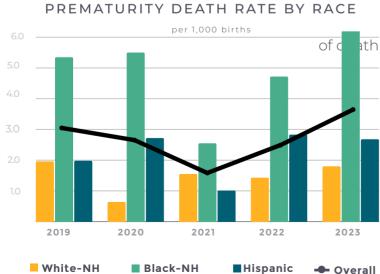


The 2023 Infant Mortality Rate of 8.82 is the highest in the last five years and secondhighest in last 10 years. The 2023 IMR is also higher than the five-year average.

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.



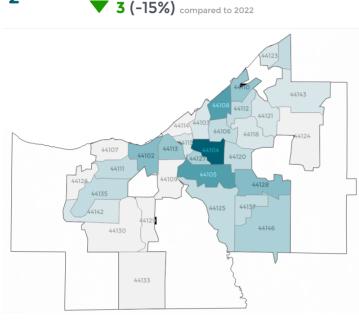
Prematurity was a contributing factor ath in 65% of infant deaths and was the cause of death (as denoted in their death certificate) in 40% of all infant deaths.

> 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.

Z_{Z} 17 BABIES DIED DUE TO UNSAFE SLEEP CONDITIONS



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 oftenly occured include:

44104, 44105, 44108, 44128, and 44102

SLEEP-ENVIRONMENT

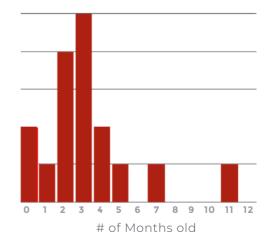
Individual case reviews of sleep related deaths take note of risk factors found in the environment, and how often they were present.



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



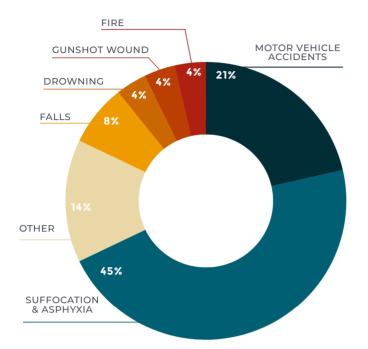
2023 SLEEP-RELATED DEATH AGE DISTRIBUTION



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

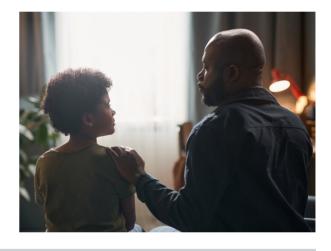
UNINTENTIONAL DEATHS

Unintentional deaths are the result of accidents, unforseeable 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 UNINTENTIONAL DEATH RATE 11.2 PER 100,000 1 (4%) 8.7

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.



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.

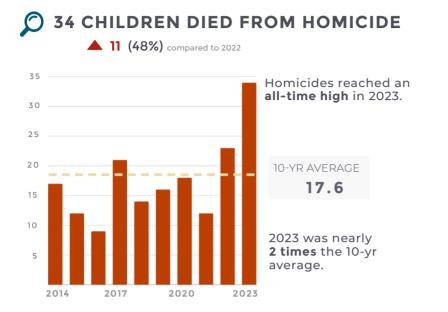
80% of suicide deaths are the result of a self-inflicted gunshot wound.



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

HOMICIDES

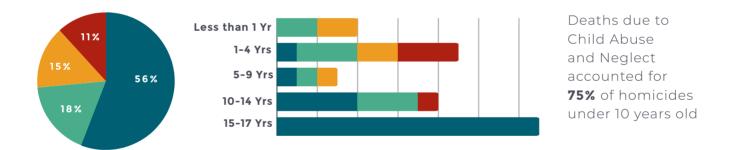
Homicide and violence have become very serious and rising issues among children in Cuyahoga County, with more children losing their lives to violence each year. **Homicide is the leading cause of death in children ages 1-17 years old.**



HOMICIDE RATE 13.6 **13.6** PER 100,000 4.5 **3.2**

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.



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



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.



8 out of 10 homicide victims are MALE

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.

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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