CUYAHOGA COUNTY BOARD OF HEALTH

Your Trusted Source For Public Health Information

Child Fatality Review & Fetal Infant Mortality Review

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

May 21, 2026

ccbh.net 216.201.2000 5550 Venture Drive, Parma, OH 44130

Today's Agenda

Fetal Infant Mortality Review (FIMR)

Program History and Overview

Data Findings

Recommendations

Child Fatality Review (CFR)

Program History and Overview

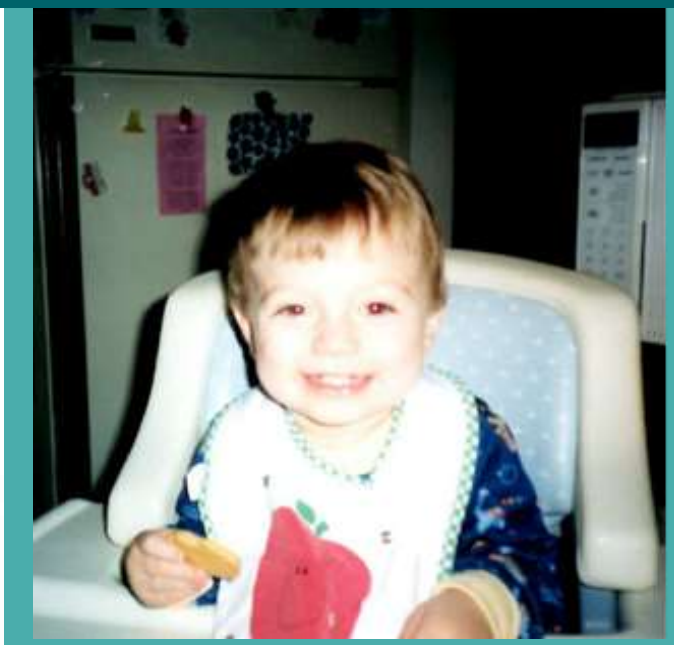
Data Findings

Recommendations

Holly Galicki, BSN, RN

Nurse Program Manager – Child Fatality Review

Cuyahoga County Board of Health



WHAT DRIVES YOUR WORK IN MATERNAL AND CHILD HEALTH?

"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

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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

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Alexis M. Ipsaro, MPH

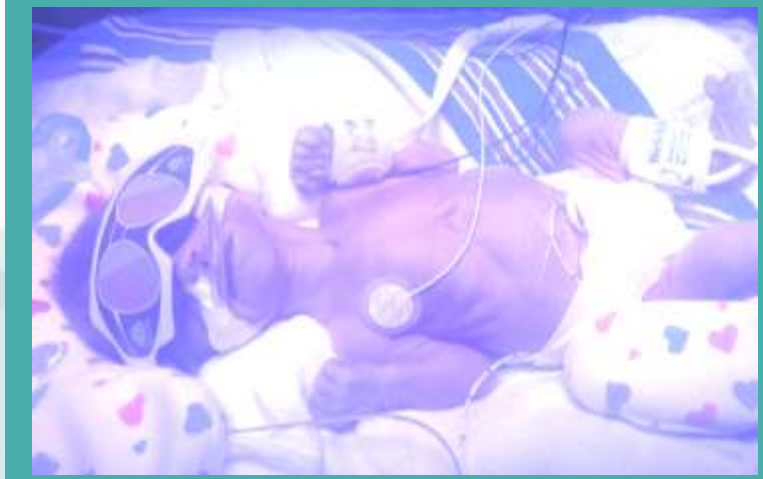
Maternal and Child Health Epidemiologist
Cuyahoga County Board of Health

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?*

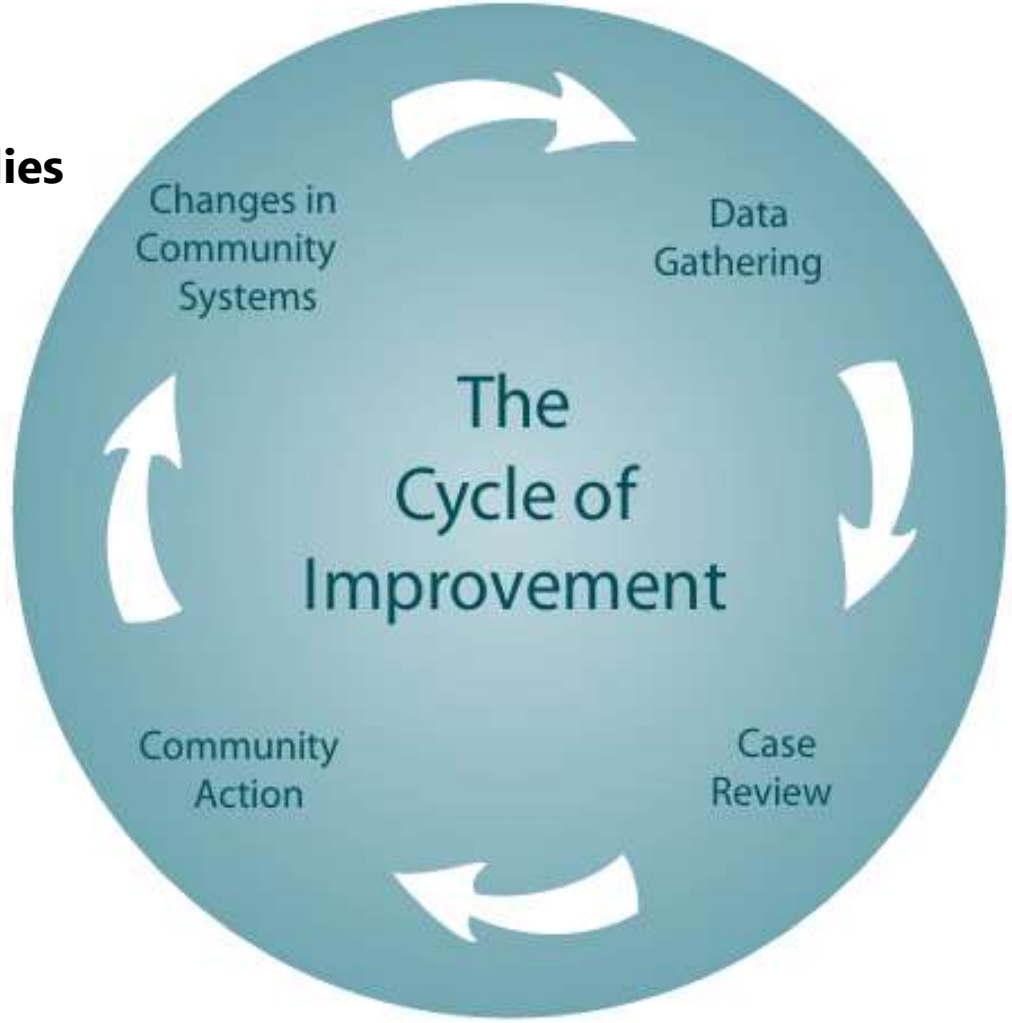
FIMR is a multi-disciplinary process that reviews infant deaths and fetal deaths 20 weeks or more gestation. The intent is to reduce and prevent future losses and improve the health and well-being of pregnant women and infants.

- **Founded in 1990**
  Developed by ACOG and the Maternal and Child Health Bureau (MCHB)
- **Brought to Ohio in 2014**
  Introduced by the Ohio Department of Health
- **Community-driven process**
  Multi-disciplinary, multi-agency teams uncover lessons from preventable stillbirths and infant deaths
- **Confidential, not fault-finding**
  A safe, protected process focused on learning rather than blame
- **Life course perspective**
  Examines the full arc of maternal and infant health across a lifetime
- **Drives system & policy change**
  Develops and implements recommendations for meaningful, lasting improvements

CUYAHOGA COUNTY FIMR
FETAL INFANT MORTALITY REVIEW

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

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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

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 CenteringPregnancy (peer group prenatal care).

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
All in person participants will receive a candle

Scan here to register or visit ***pailconnect.org/eventse***

FIRST YEAR CLEVELAND

SHERWIN-WILLIAMS.

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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 Hospitlas Main Campus
University Hospitals Ahjuja Med Centter

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**

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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 Nauea or vomiting

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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

one life
one voice
one community

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:	East Side:
Cleveland Clinic Fairview	Cleveland Clinic Hillcrest
MetroHealth	University Hospitals Main Campus
Southwest General	University Hospitals Ahuja Med Center
University Hospitals St. Johns West Shore	

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BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION
5550 Venture Drive Parma, Ohio 44130
216-201-2000 www.ccbh.net
MY STORY

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 216-682-6829 or email: tvaughn@birthingbeautiful.org

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Contact us today to schedule a free assessment.

Your mental health is our priority.

216-308-7592

ownbbc@birthingbeautiful.org

OWN our wellness network

OWN our wellness network

www.birthingbeautiful.org

BIRTHING BEAUTIFUL COMMUNITIES

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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
or visit us at https://linktr.ee/uhbereavement

University Hospitals
MacDonald Women's Hospital

Rainbow Babies
& Children's Hospital

Joanie & Tom Adler Bereavement Programs

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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 ≥20 weeks gestation (per CDC/WHO definition). May be further classified as early (20–27 wks), late (28–36 wks), or term (≥37 wks).

Overview & Definitions

Perinatal Mortality Rate

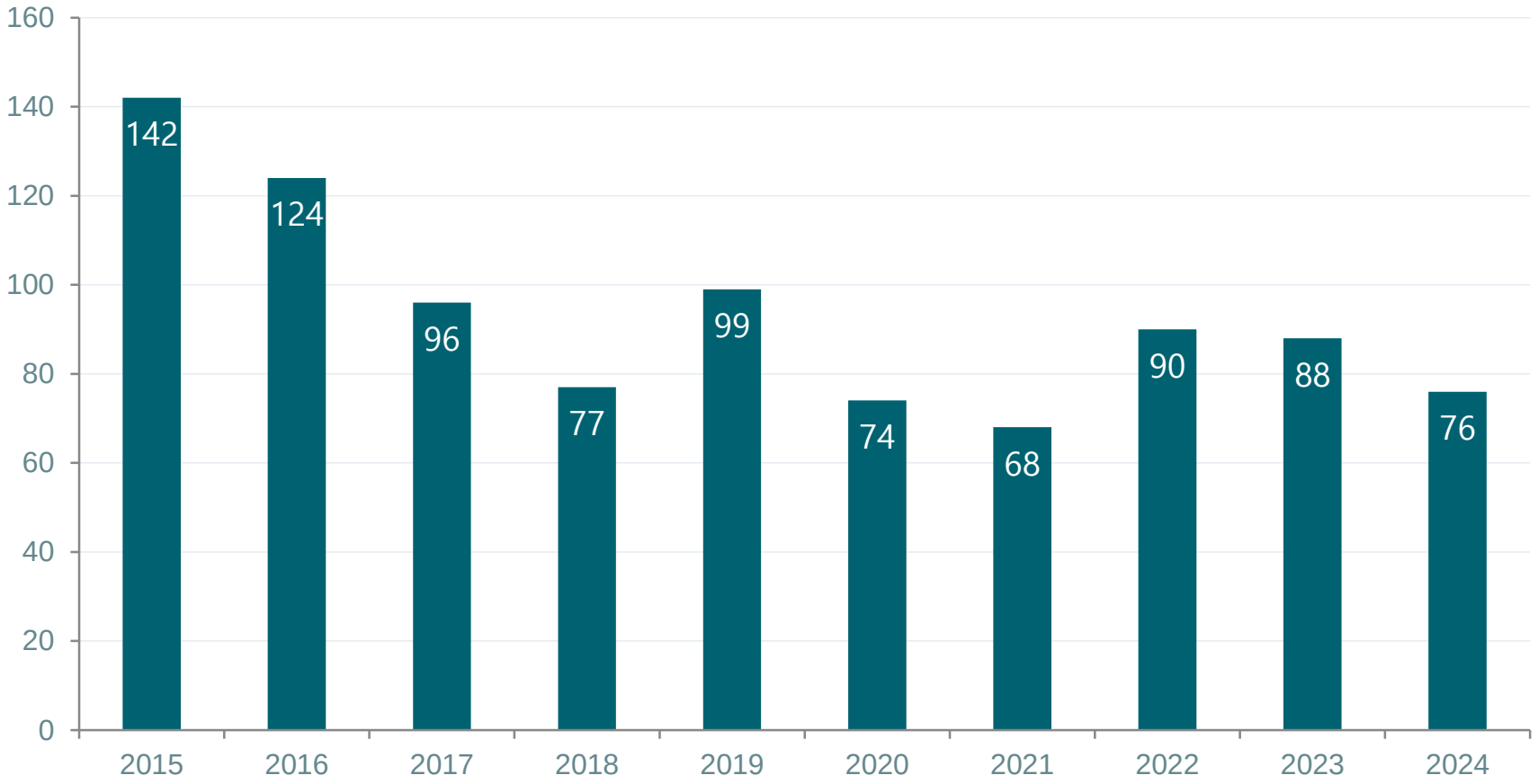
Number of stillbirths + early neonatal deaths (within 7 days of birth) per 1,000 total births.

Stillbirth Rate

Number of fetal deaths at ≥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

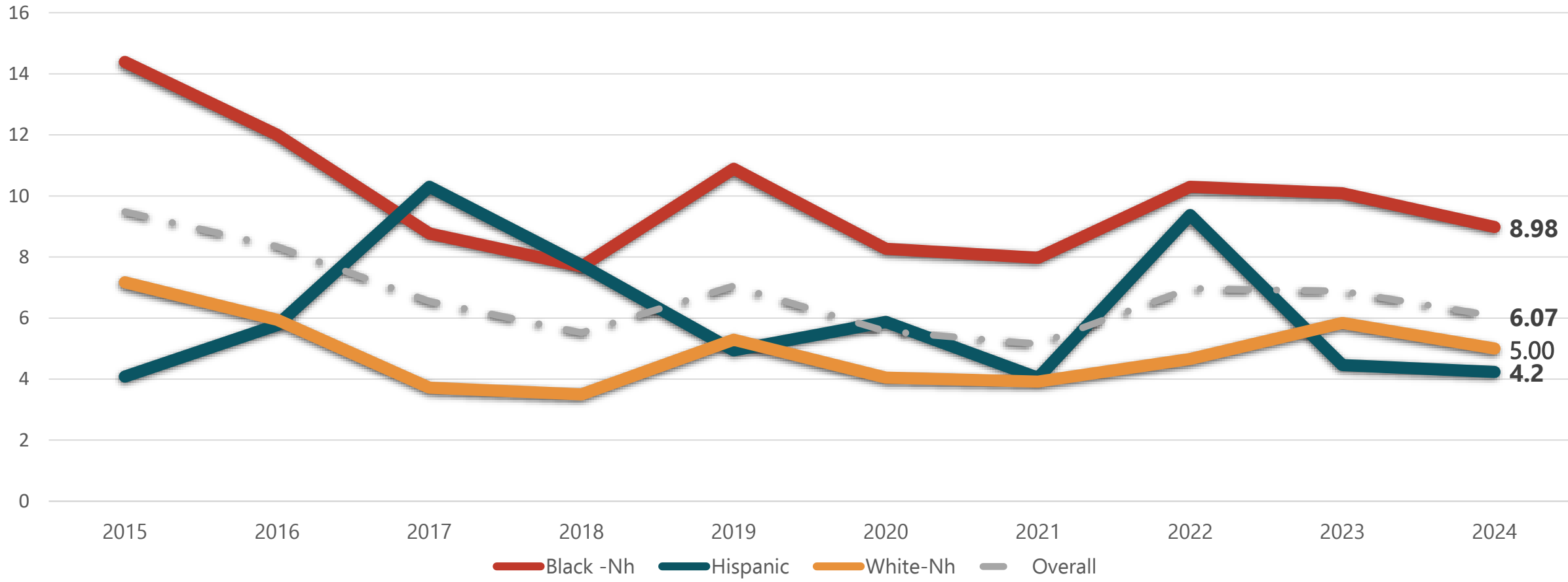
5.44

per 1,000

National benchmark

Stillbirth Rate — Trend Over Time

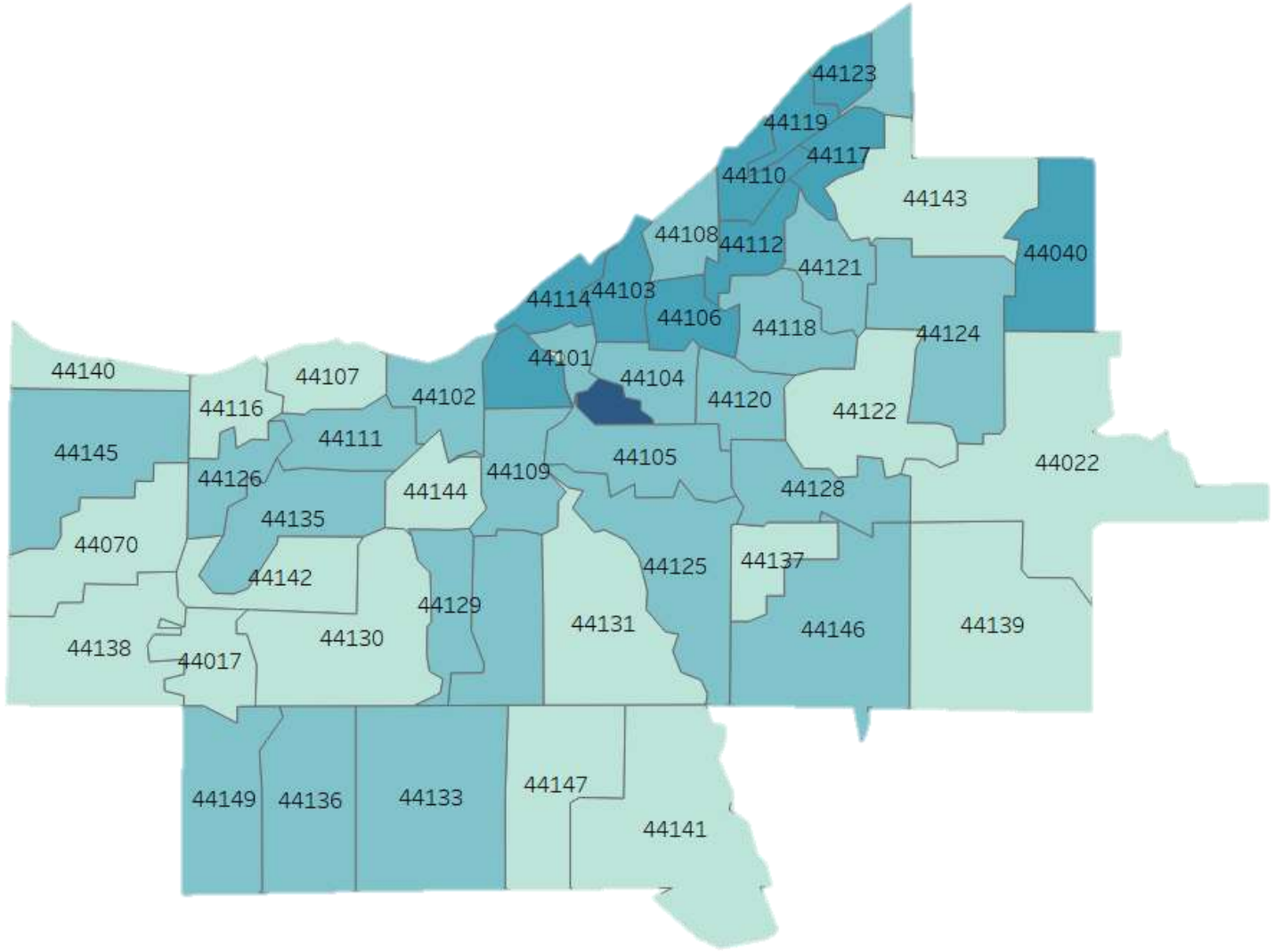
Stillbirths per 1,000 live births + Stillbirths · Cuyahoga County · 2015-2024
Healthy People 2030 Goal – 5.7 per 1,000 births



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

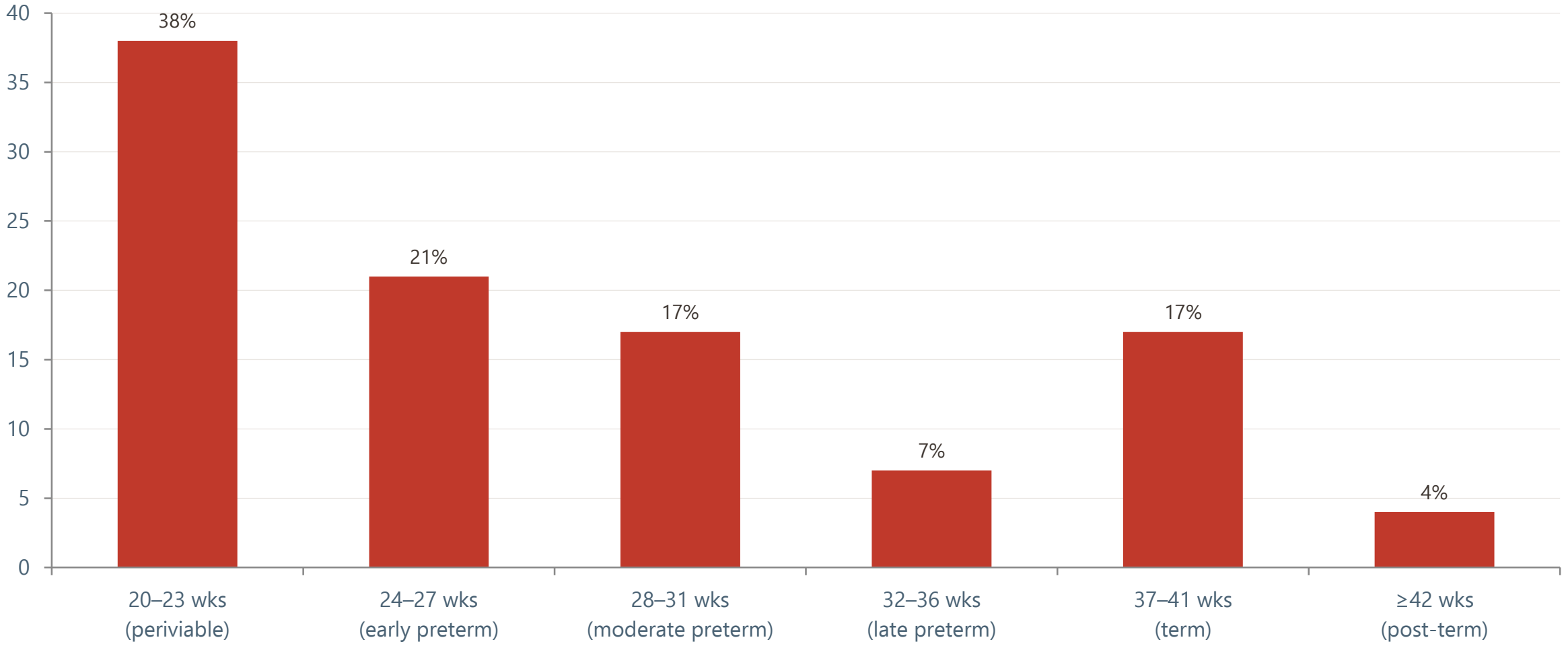
ZIP 44127
had the highest fetal death rate in the county:

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

Suburbs
Many had a fetal death rate < 5.0

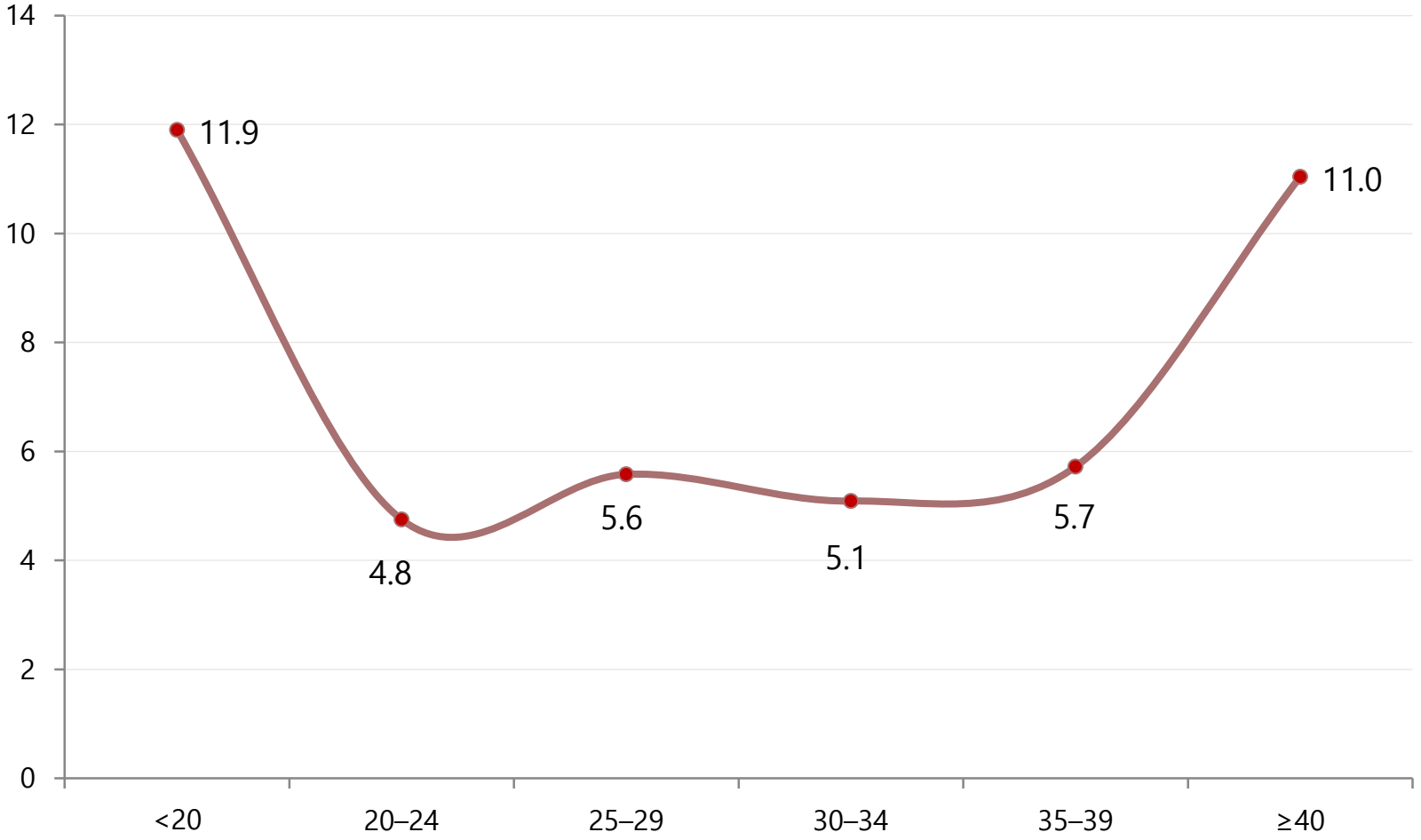
Stillbirths by Gestational Age at Delivery

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

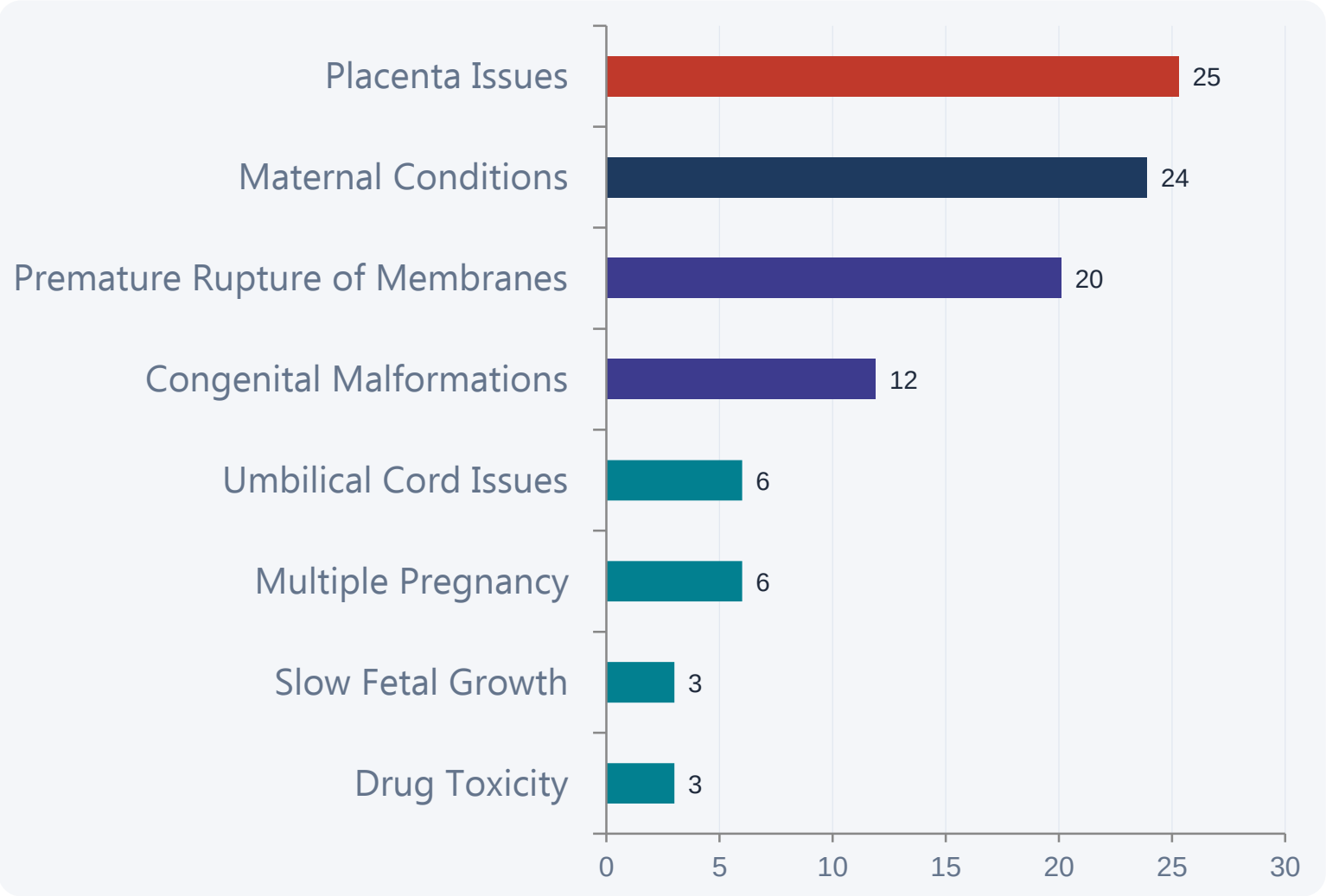
Ages 20-24 show the lowest overall stillbirth rate

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

- Cuyahoga County Medical Examiner
- Cleveland Division of Police
- Cuyahoga County Prosecutor's Office
- Cuyahoga County Juvenile Court
- Cleveland Division of EMS
- Cuyahoga County Death Scene Investigation

Public Health

- Cuyahoga County Board of Health
- 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
- ADAMHS Board

Education

- Cleveland Metropolitan School District
- Invest in Children

Healthcare

- Cleveland Clinic Children's Hospital
- 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?

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

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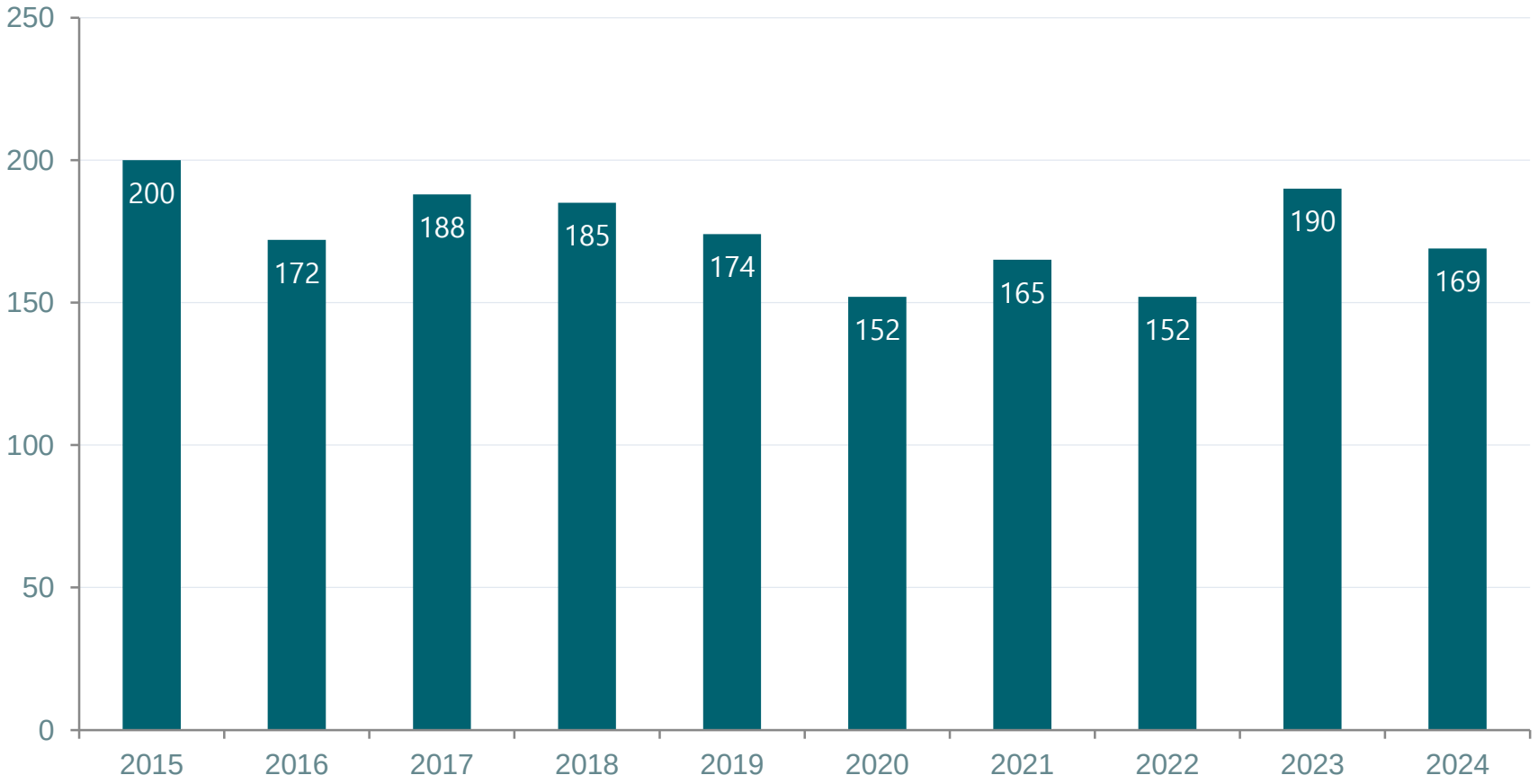
Child Fatalities 2015–2024

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

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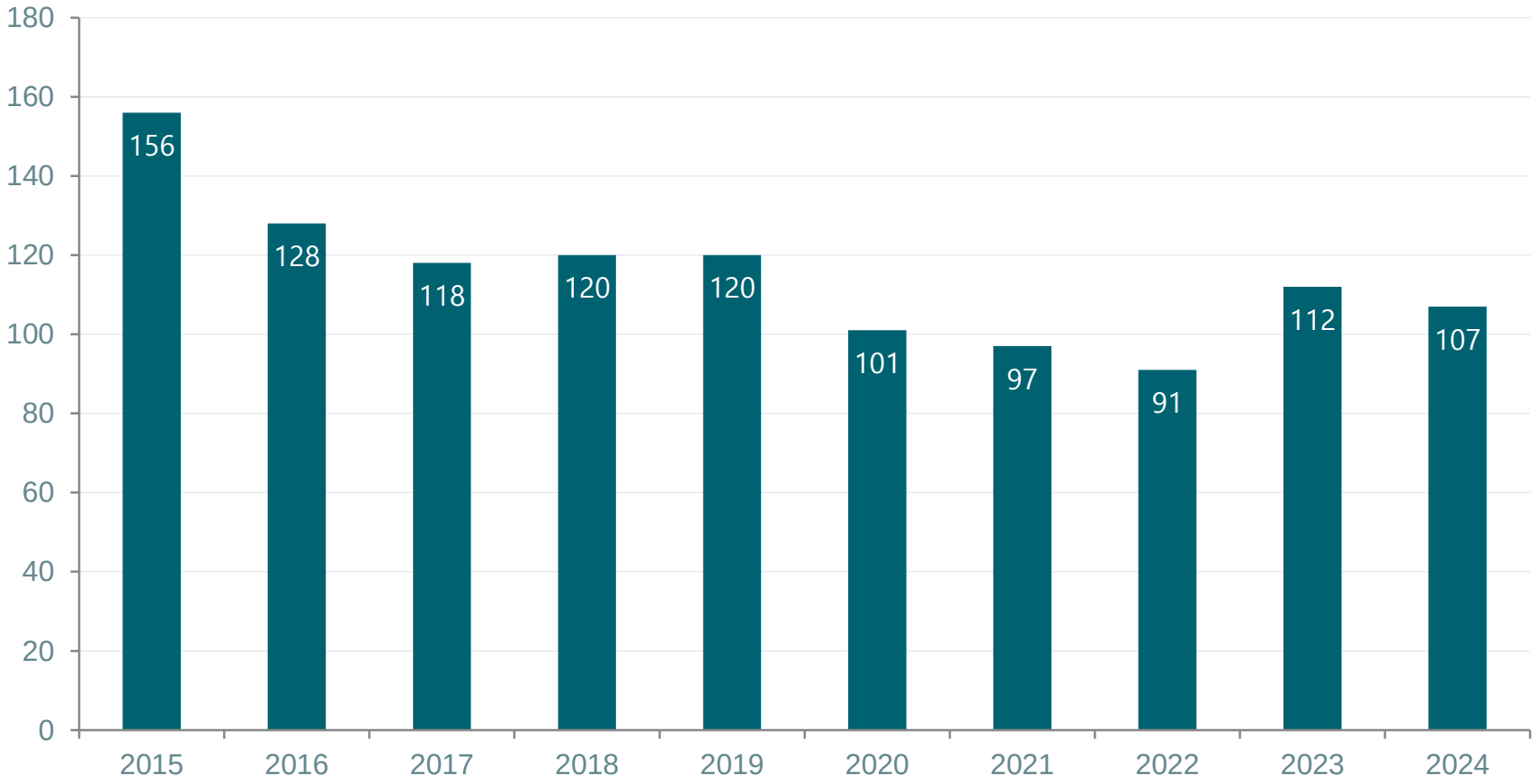
Infant Mortality 2015–2024

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



2024

107 deaths

10-yr Avg

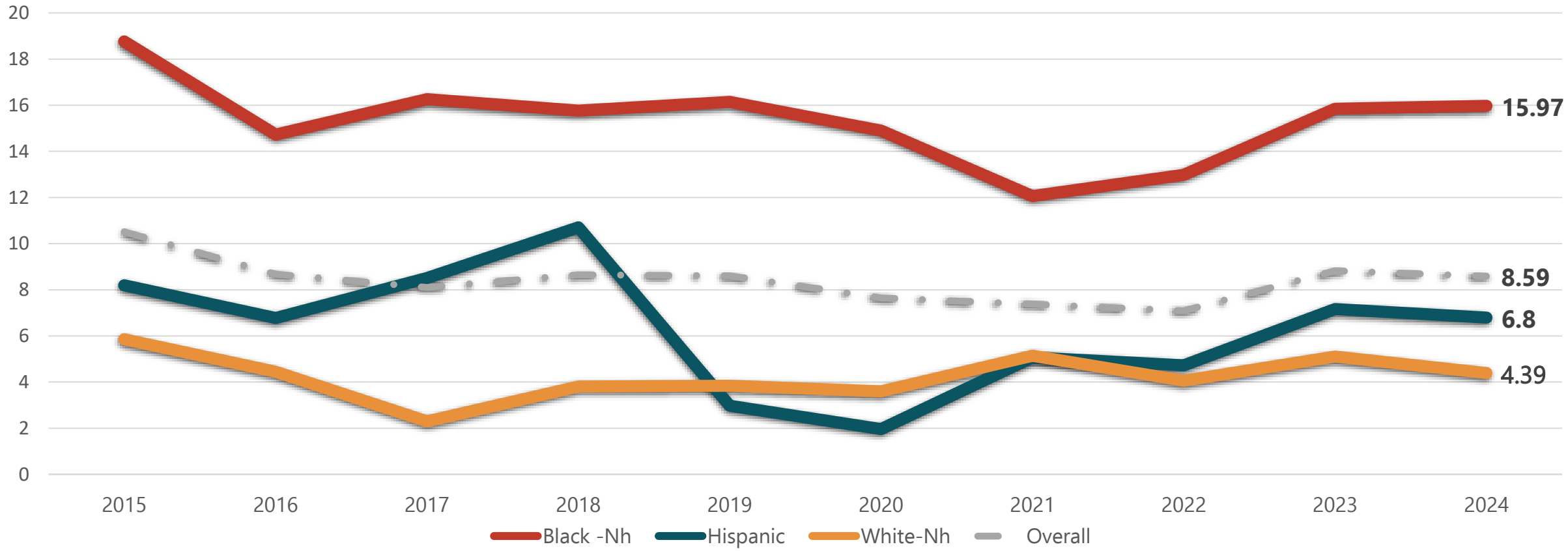
115 deaths

-4%

vs 2023

Infant Mortality Rate — Trend Over Time

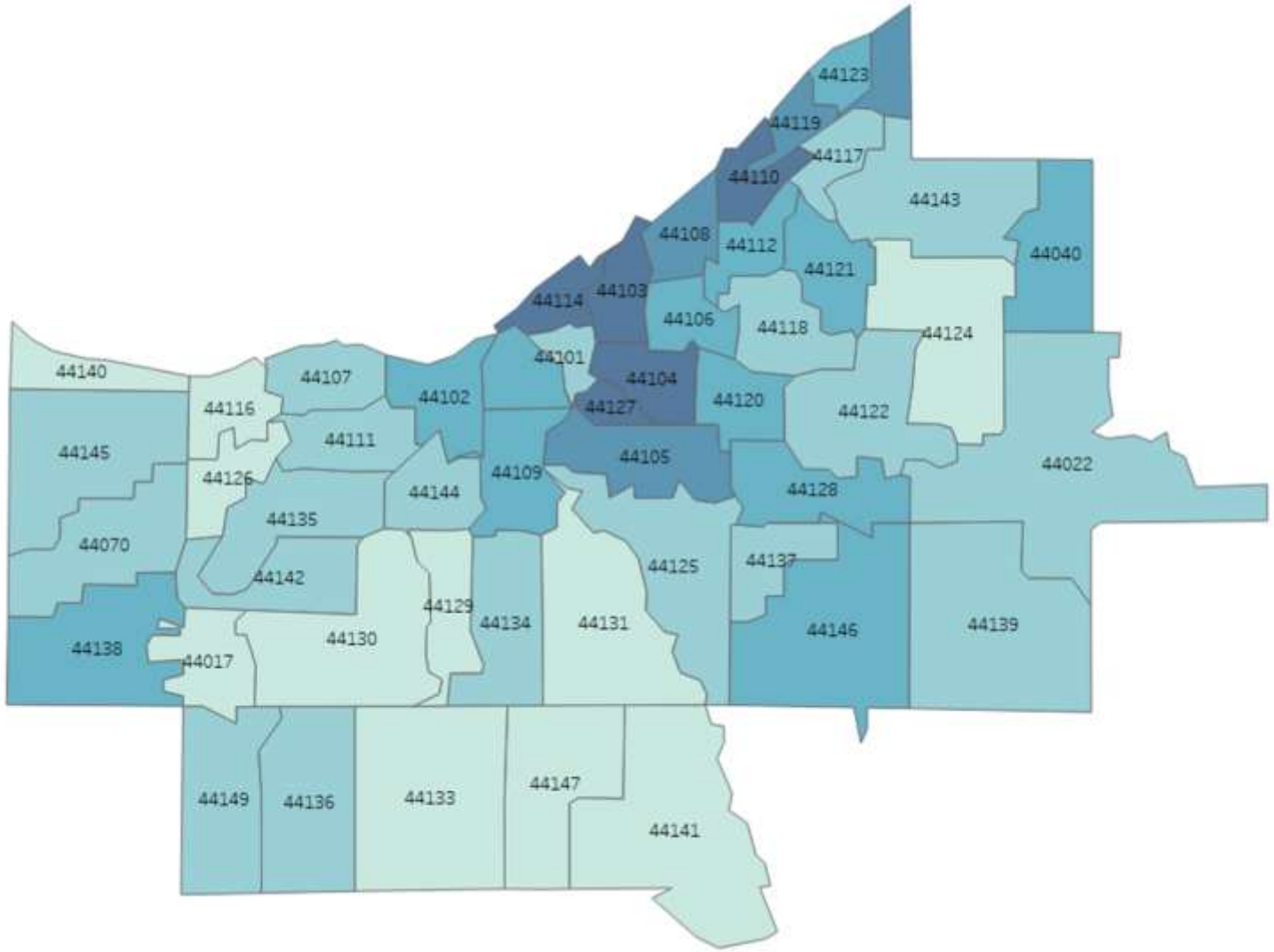
Deaths per 1,000 live births · Cuyahoga County · 2015-2024
Healthy People 2030 Goal – 5.0 per 1,000 births



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

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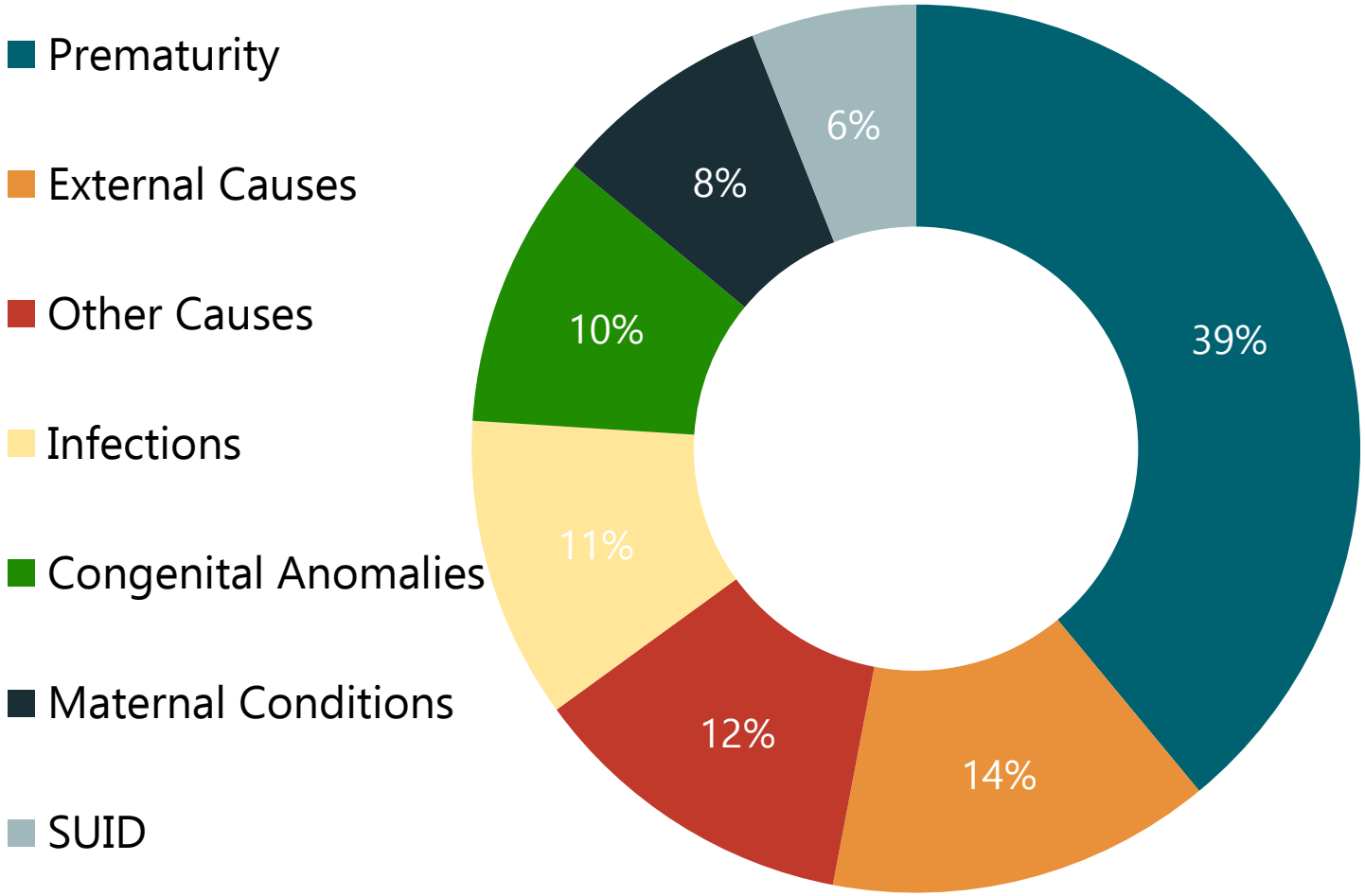
Infant Mortality – Causes of Death



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.

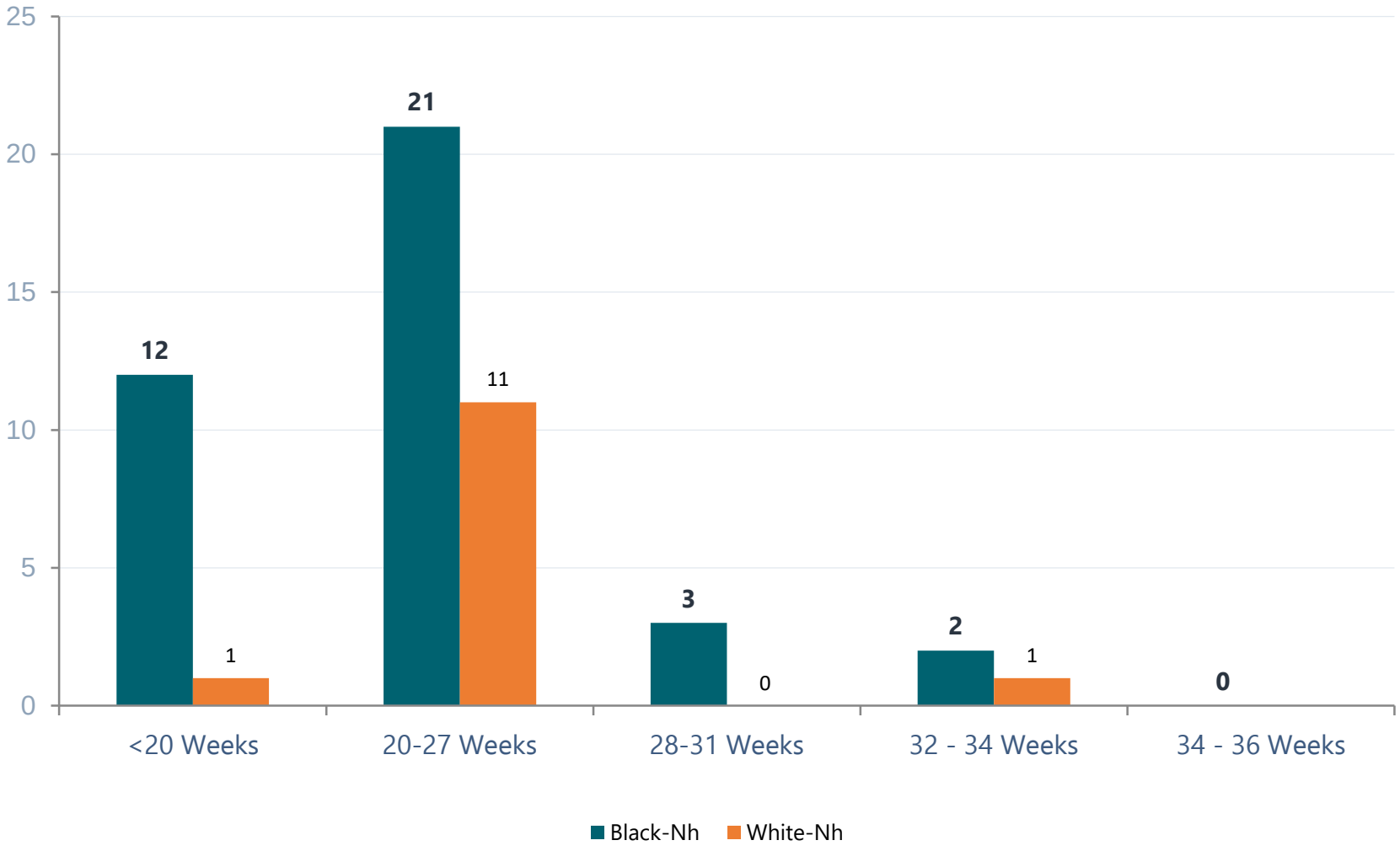
Prematurity Death Rate— Trend Over Time

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%

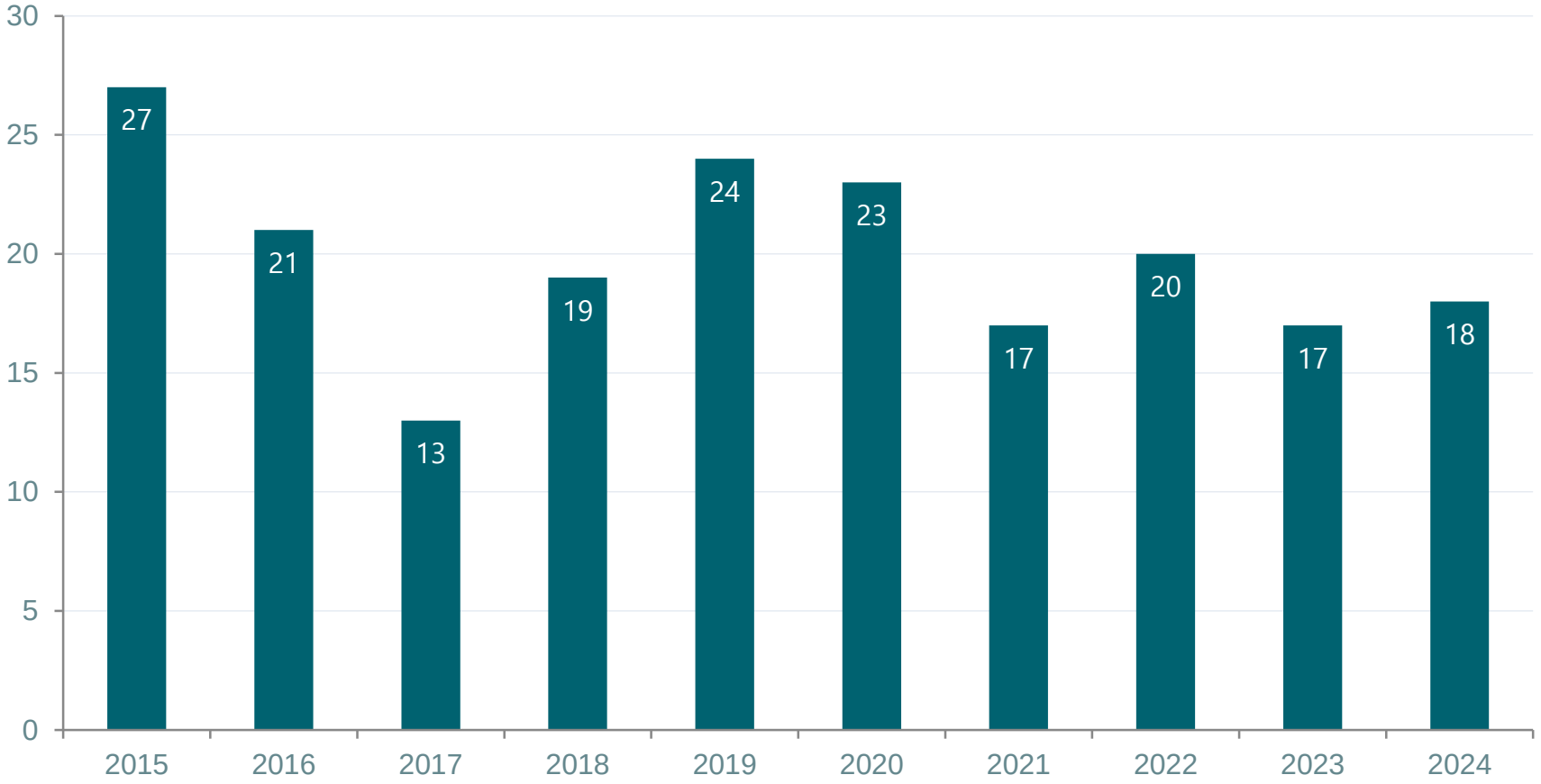
of all premature deaths were extremely premature <28 weeks

65%

of all extremely premature deaths were Black non-Hispanic

Sleep-Related Deaths 2015–2024

18 infants died during 2024.
An increase of 1 (6%) from 2023, falling below the ten-year average.



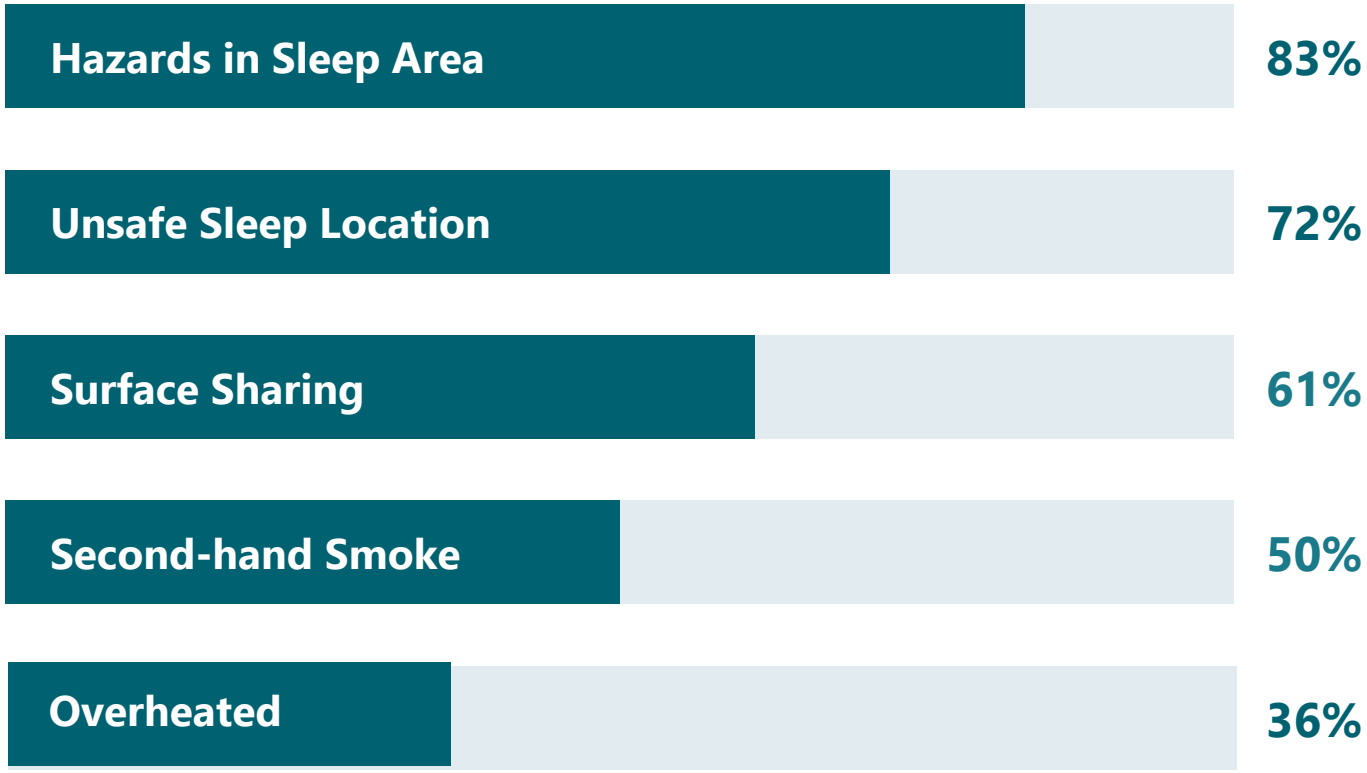
2024
18 deaths

10-year average
20 deaths

+6%
Compared to 2023

Sleep-related Infant Deaths — 2024

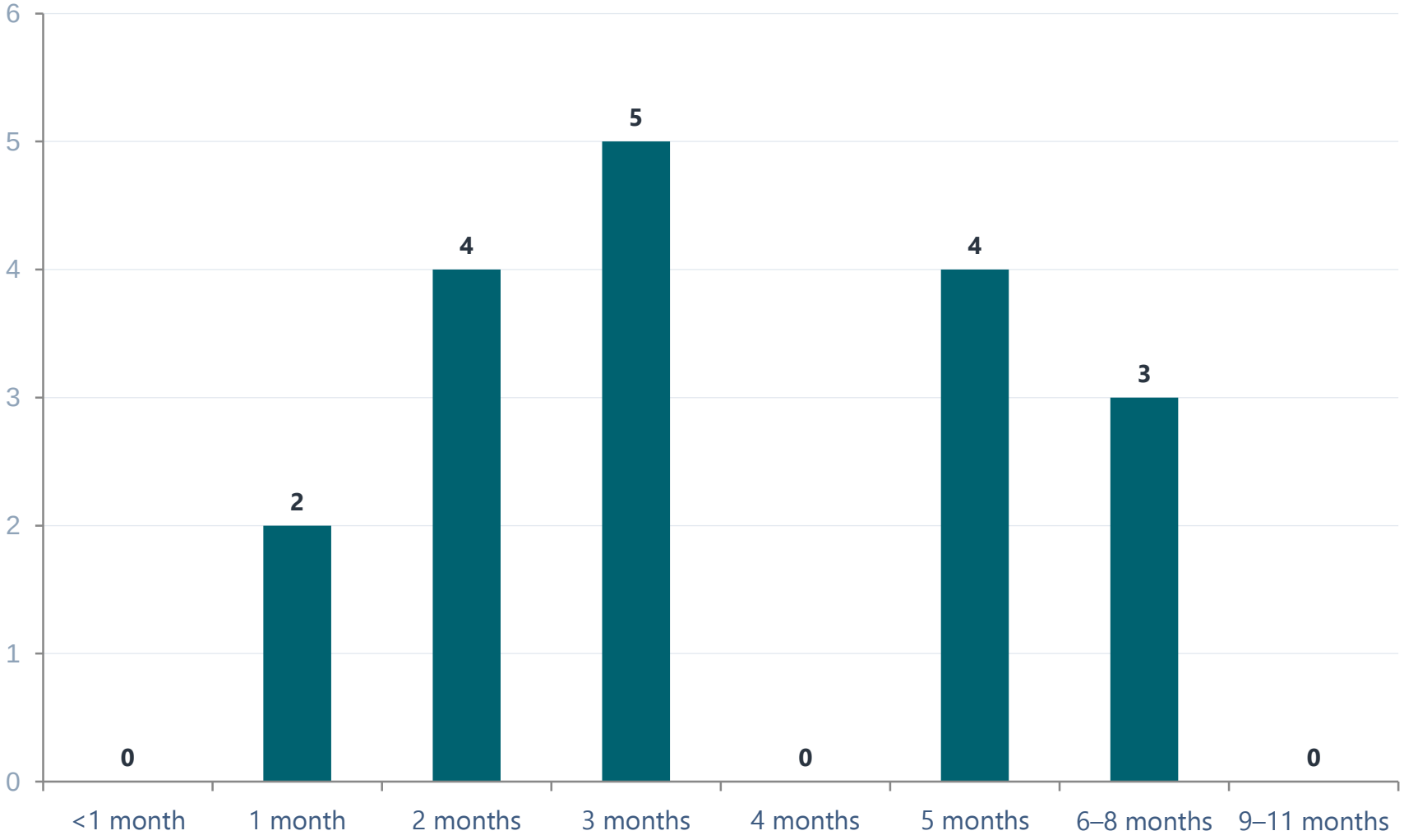
Sleep-environment Risk Factors



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)

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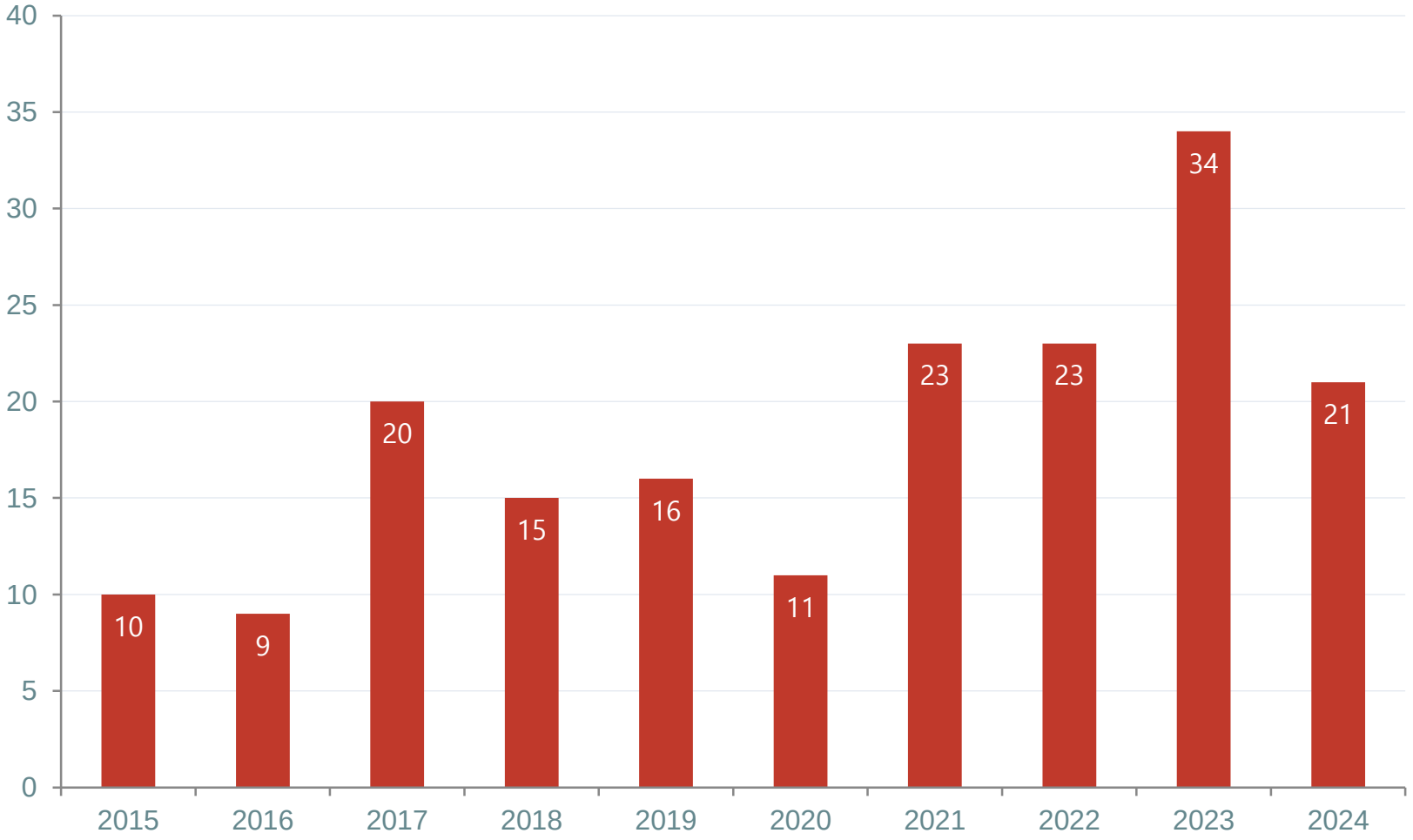
Homicides

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

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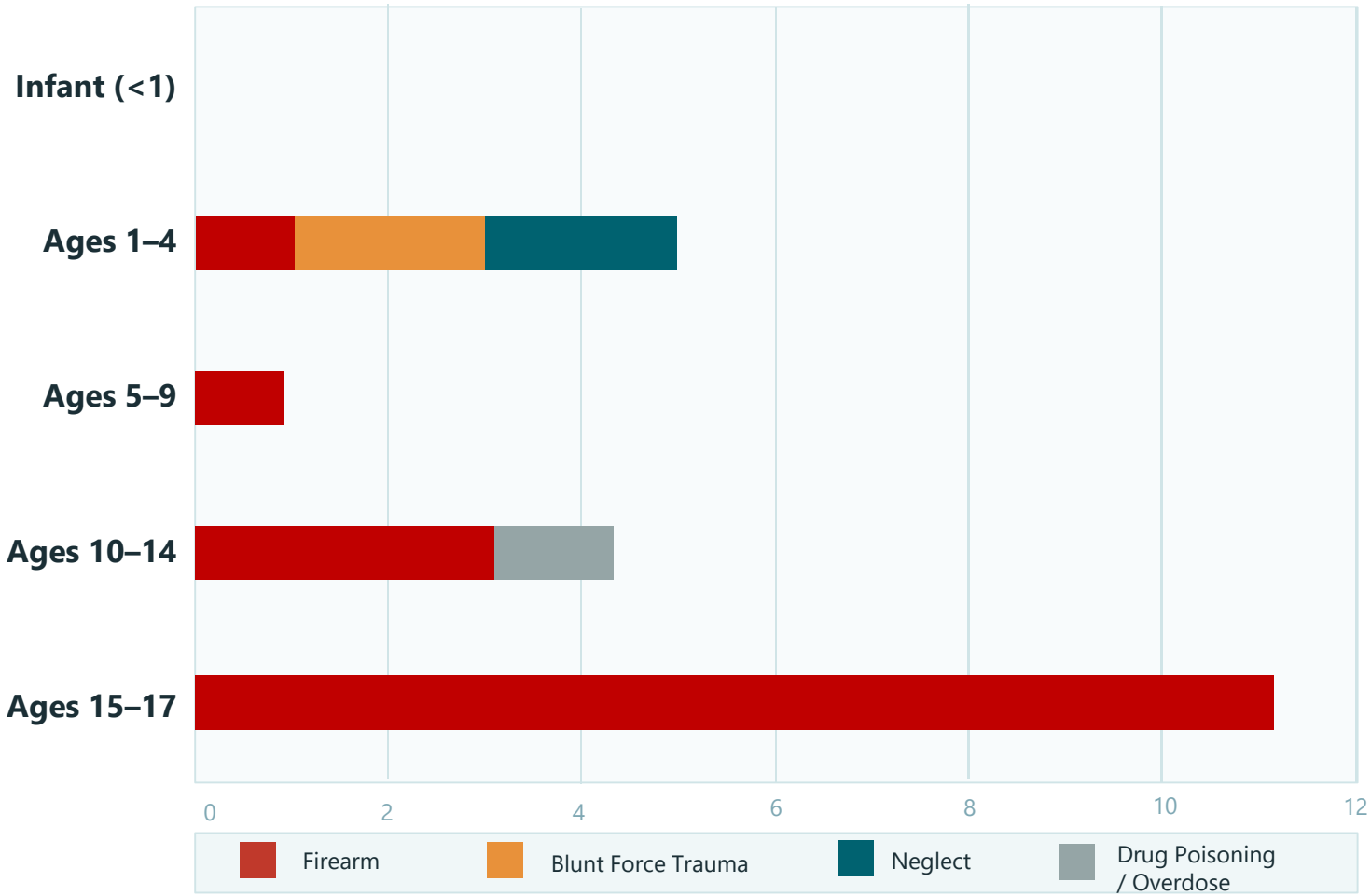
Homicide — Cause of Death by Age Group

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



Key Finding

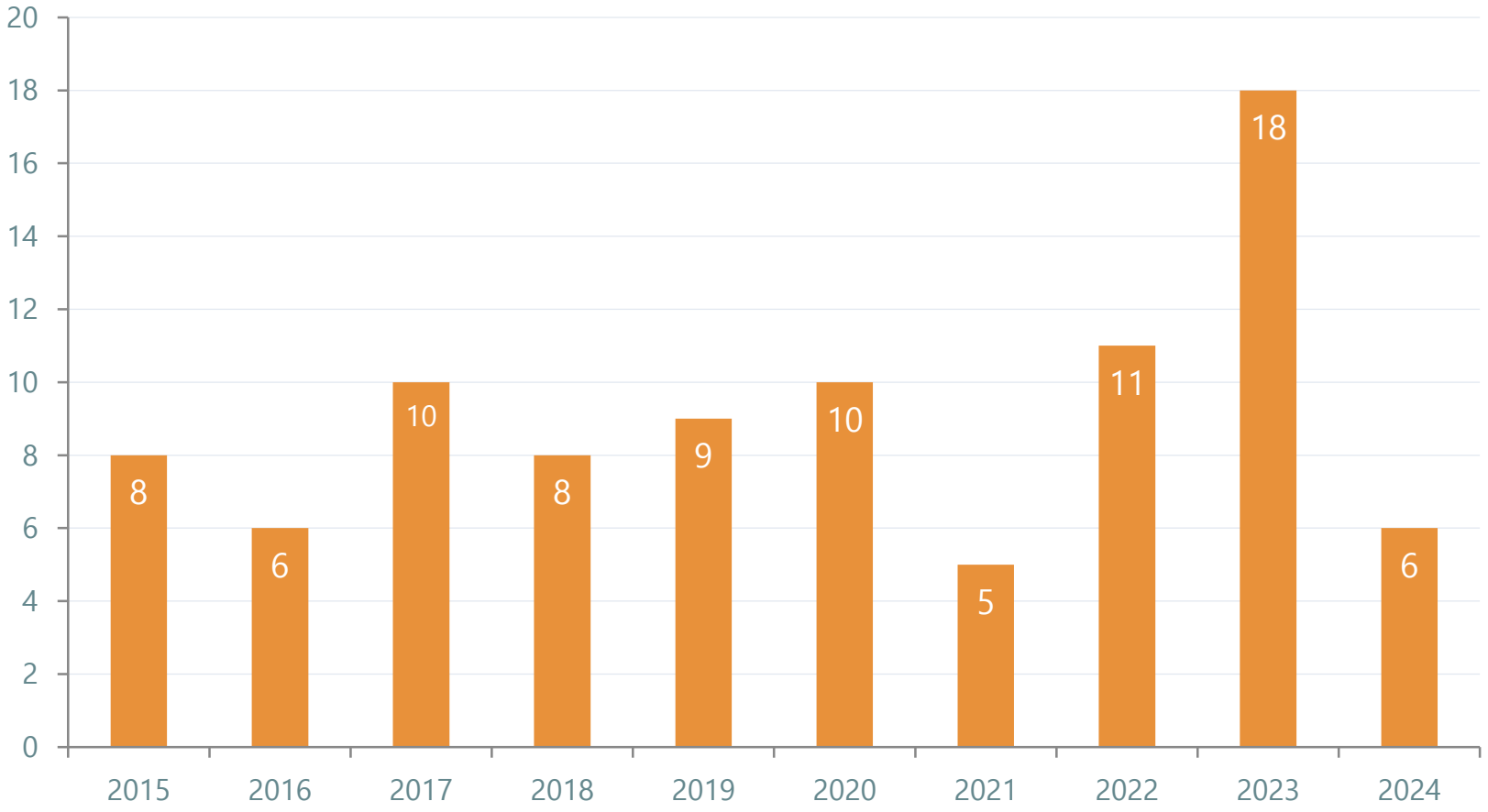
Adolescents account for more than half of all homicides
Ages 15–17 account for 12 of 21 homicides

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

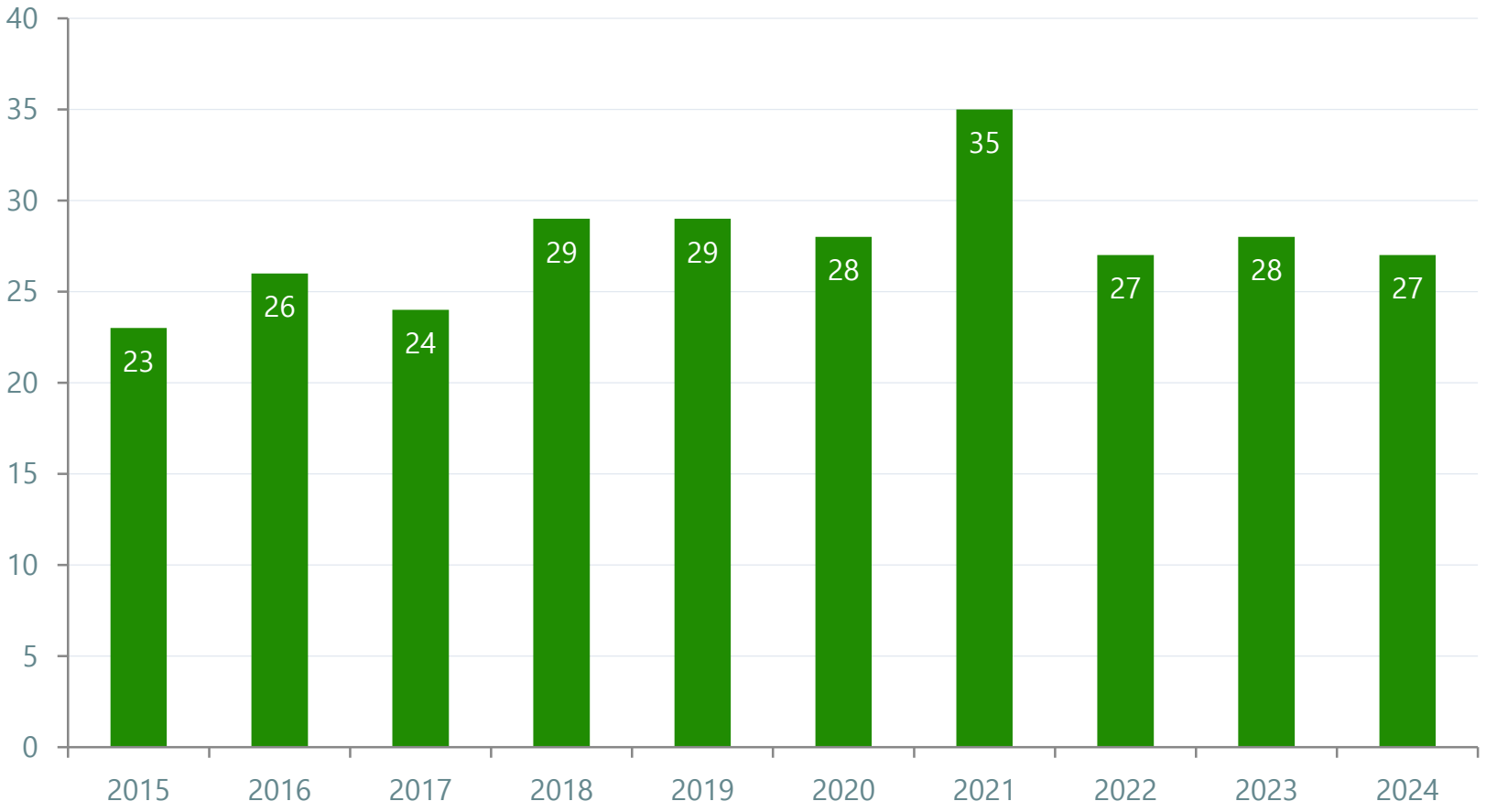
9 deaths

-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

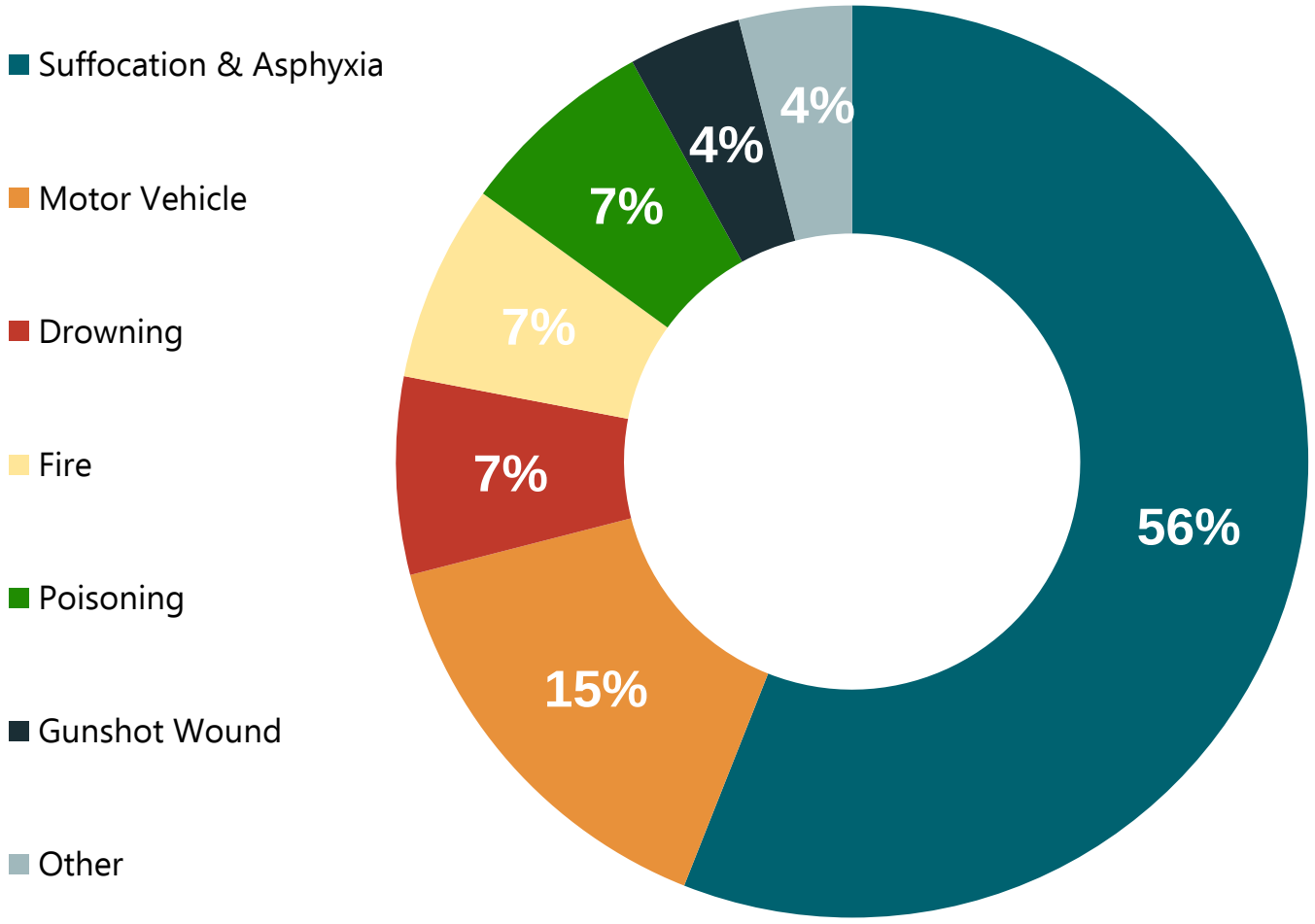
10-year average

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

CCBH

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.

CUYAHOGA COUNTY BOARD OF HEALTH

Your Trusted Source For Public Health Information

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