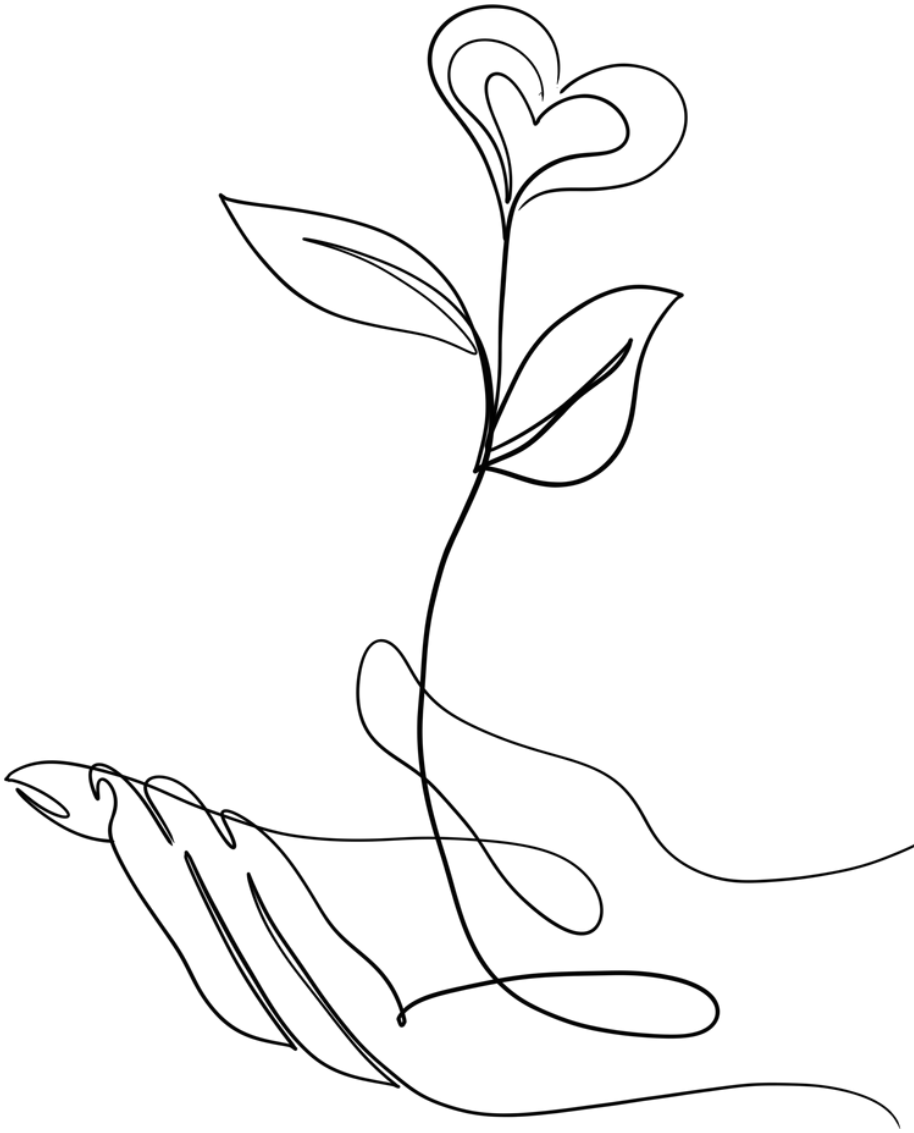
PORTAGE COUNTY HEALTH DISTRICT



2025 CHILD FATALITY REVIEW REPORT

Acknowledgments

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- **Rebecca Lehman, MPH, MPA, CHES:** Chair, Portage County Child Fatality Review Board; Health Commissioner, Portage County Health District
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  - Kirsten Orr, BSN, RN
- **Portage County Child Fatality Review Board member agencies:**
  - Portage County Coroner
  - Portage County Health District
  - Kent City Health Department
  - Mental Health and Recovery Board of Portage County
  - Portage County Job and Family Services
  - Portage County Sheriff
  - Portage County Prosecutor
  - Community EMS
  - Summa Health Systems
  - University Hospitals
  - Ravenna City Schools
  - Akron Children's Hospital

Child Fatality Review

Ohio Revised Code sections 307.621 and 307.622 mandate that all Ohio counties must establish Child Fatality Review (CFR) Boards to review the deaths of any resident children. This mandate applies to deaths that occur any time from a child's first breath until the day before they turn 18 years old.

Ohio Administrative Code rule 3701-67-03 appoints the local public health jurisdiction as the agency responsible for ensuring that reviews occur as required. CFR Boards have some compulsory members, specifically:

- Coroner or designee
- Police Chief, Sheriff, or designee
- Executive Director of Public Children's Services or designee
- Public Health official
- Executive Director of Mental Health and Addiction Board or designee
- Pediatrician or Family Practice Physician

Before a CFR Board meeting occurs, facilitators (typically local health department staff members) collect information pertaining to child deaths, such as medical records, ambulance run logs, police reports, autopsy reports, and other documentation. Once this information has been acquired and reviewed by the facilitators, they prepare case summaries, which are short narratives explaining why each death occurred. Case summaries are presented by the facilitators at CFR Board meetings to other board members.

After each case summary has been delivered, board members are invited to share any pertinent information or expertise they have relating to the death being discussed. After all discussion about a given death has ceased, board members (excluding the facilitators) vote as to whether they feel the death was preventable, or not preventable. If a death is determined by the CFR Board to be preventable, board members must provide recommendations to prevent similar deaths in the future. CFR Board members are legally bound to keep confidential any information discussed during meetings.

According to **Ohio Administrative Code rule 3701-67-02**, the purposes of reviewing child fatalities are:

1. Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children.
2. Maintaining a comprehensive database of all child deaths that occur in the county or region served by the CFR board in order to develop an understanding of the causes and incidences of those deaths.
3. Recommending and developing plans for implementing local service and program changes to the groups, professions, agencies, or entities that serve families and children that might prevent child deaths.
4. Advising ODH of aggregate data, trends, and patterns concerning child deaths.

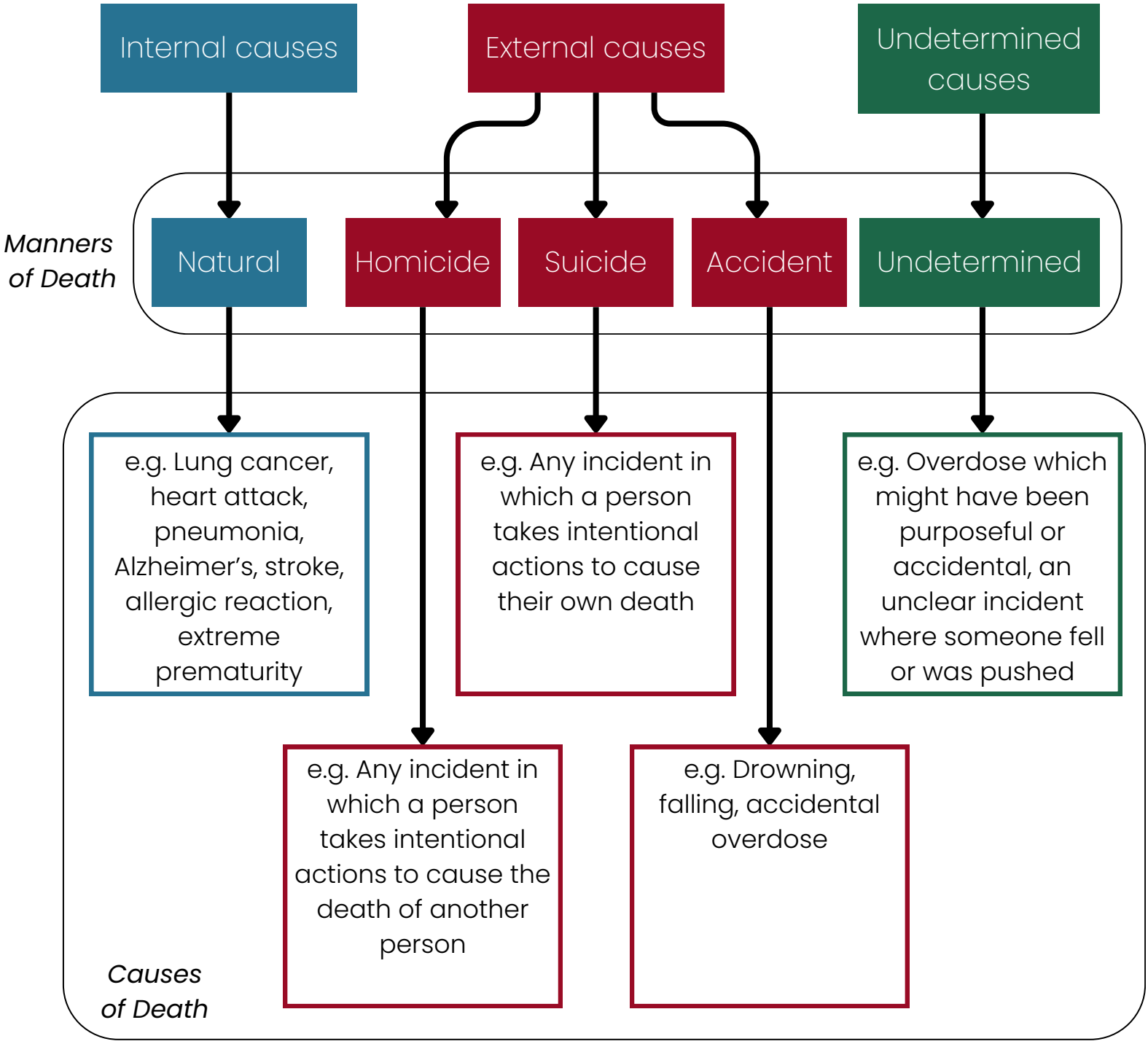
Manners and Causes of Death

Throughout this report, the terms “manner of death” and “cause of death” are repeatedly used. These terms are not interchangeable.

- **Manner of death:** Describes the way in which a death occurs, which may be homicide, suicide, accidental, natural or undetermined.
- **Cause of death:** The underlying medical condition, disease or injury that begins the chain of events resulting in death.

Every death that occurs will have a manner, which is a more general category, and a cause. For example, if someone passes away from lung cancer, their manner of death would be natural, and their cause of death would be lung cancer.

It is very important to note that manners of death are legal classifications. Specifically, using the term “natural” to describe a child’s death might be distressing to some people. It could sound as if the death should be considered “normal” or “acceptable.” In the context of public health, a natural death is simply a death occurring due to something happening inside of someone’s body, such as an infection, a genetic condition, or age-related bodily decline.


Internal causes
External causes
Undetermined causes
Manners of Death
Natural
Homicide
Suicide
Accident
Undetermined
e.g. Lung cancer, heart attack, pneumonia, Alzheimer's, stroke, allergic reaction, extreme prematurity
e.g. Any incident in which a person takes intentional actions to cause their own death
e.g. Overdose which might have been purposeful or accidental, an unclear incident where someone fell or was pushed
e.g. Any incident in which a person takes intentional actions to cause the death of another person
e.g. Drowning, falling, accidental overdose
Causes of Death

Ohio Data

Each year, an Ohio Child Fatality Review Annual Report is published by the Ohio Department of Health and the Ohio Department of Children and Youth. The most recently published data reflects cases reviewed by County CFR Boards from 2018 - 2022. Charts from the report are shown in the appendix on page 21.

County CFR boards across Ohio reviewed a total of 5,482 cases over those five years. A majority of reviewed cases were natural deaths caused by prematurity or congenital conditions. Most of the deaths that were not ruled as natural were accidental deaths; many of these accidental deaths were caused by asphyxia, which is oxygen deprivation.

Trends related to specific age groups are also analyzed in the report. Their findings are as follows:

- **Infants: Less than 12 months old**
  - Main cause of death: Medical conditions, especially prematurity and congenital conditions
- **Toddlers: 1 - 4 years old**
  - Main cause of death: Accidents, especially drowning, motor vehicle accidents, or accidents involving weapons or bodily force
- **Young children: 5 - 9 years old**
  - Main cause of death: Medical conditions, especially cancer
- **Preadolescents: 10 - 14 years old**
  - Main causes of death: Accidents, especially accidents involving weapons or bodily force
- **Teens: 15-17 years old**
  - Main causes of death: Accidents, especially accidents involving weapons or bodily force

Portage County Data

14 children residing in Portage County passed away during the 2025 review period. One of those 14 deaths occurred during the last 10 days of 2024, and as such, was reviewed with 2025 deaths. The graphs below summarize vital statistics data for all 14 of those children. The Portage County CFR Board reviewed 13 of those 14 deaths. The unreviewed death occurred in another state, and no information has been provided to the Portage County CFR Board regarding the incident.

Ohio	Trend	Portage County
✓	Most child deaths occurred due to medical conditions	✓
✓	Most accidental child deaths were caused by asphyxia	✓
✓	Most child deaths occurred in infants	✗
✓	Most infant deaths were due to prematurity	✓
✓	Most toddler deaths were due to accidents	✗
✓	Most deaths of young children were caused by medical conditions	✗
✓	Most preadolescent and teen deaths were caused by accidents	✗

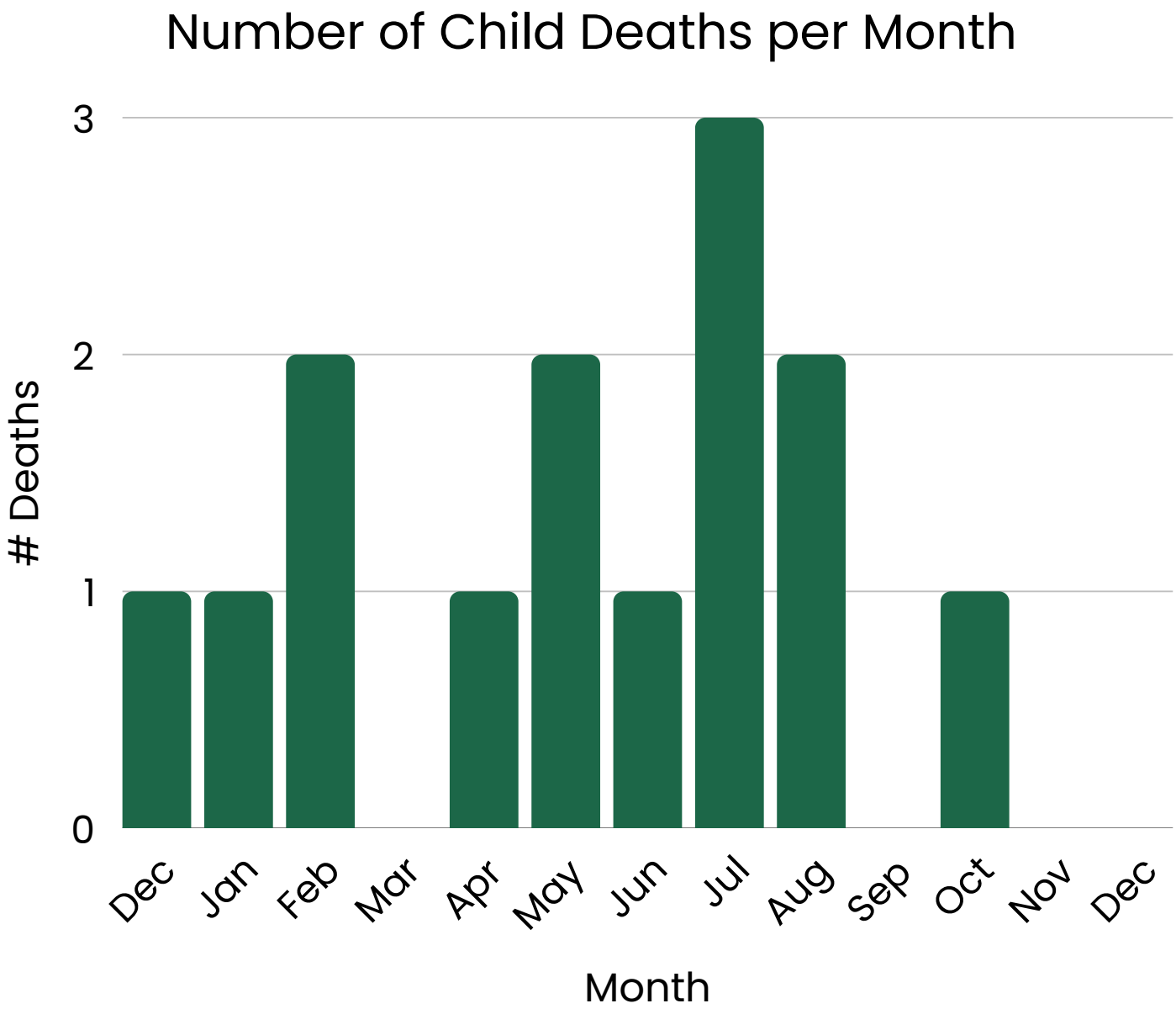


Figure 1. This chart shows the number of child deaths that occurred each month during the 2025 review period. July had the most deaths.

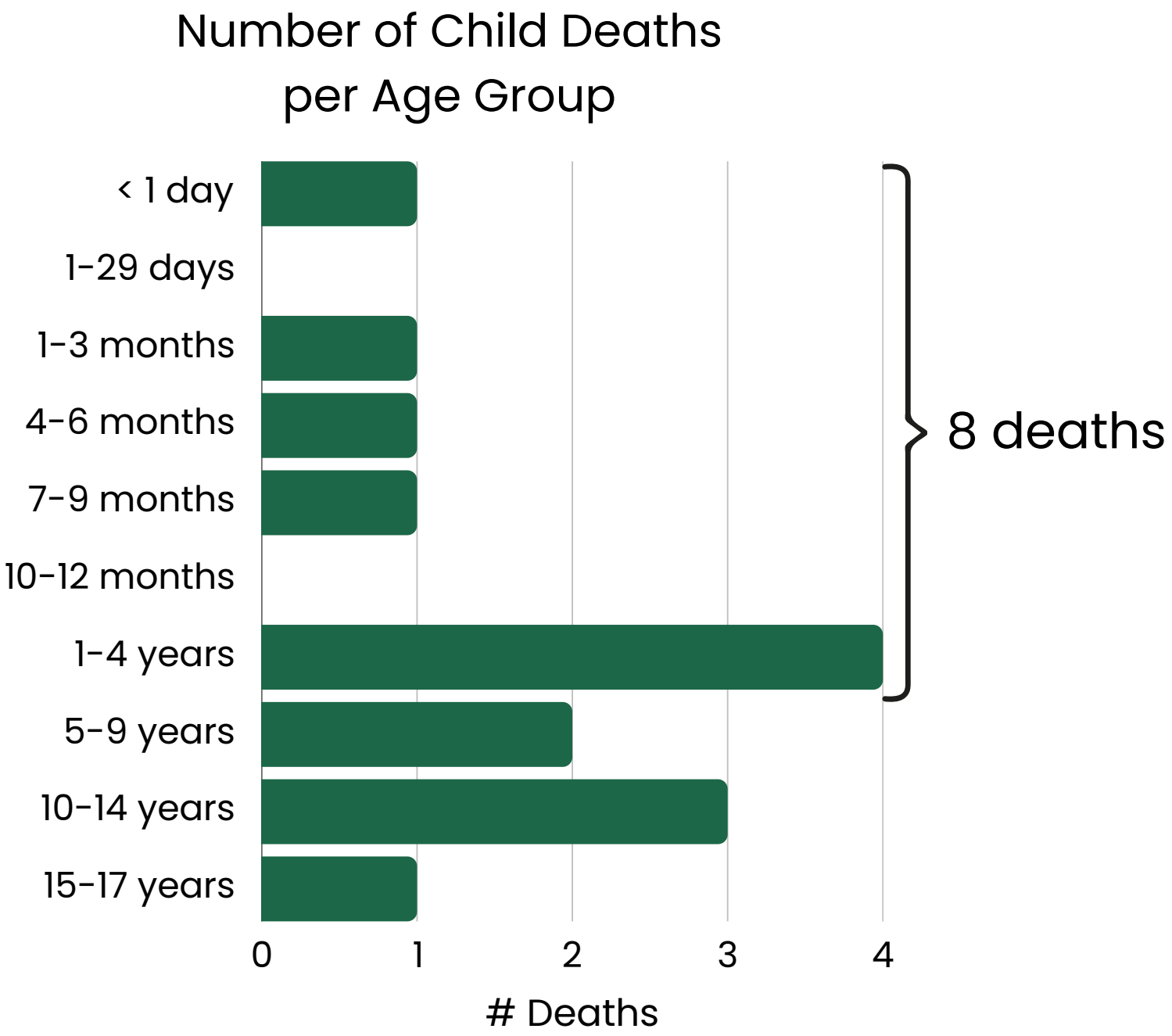


Figure 2. This chart shows the number of child deaths occurring in each age group. Most deaths occurred in the infant (children under 1 year old) and toddler age groups (children 1 - 4 years old), with each group having four deaths.

Age Group ***(years)***	**Death Rate** ***(per 10,000)***
0-4	11.28
5-9	2.64
10-14	3.58
15-17	1.87

Figure 3. This table shows the rate of child deaths for age group. Unfortunately, infants and toddlers are more susceptible to fatalities than other age groups, due to congenital conditions, underdeveloped immune systems, and higher susceptibility to accidents. This is reflected by the higher death rate of children ages 0-4 years old compared to children in other age groups.

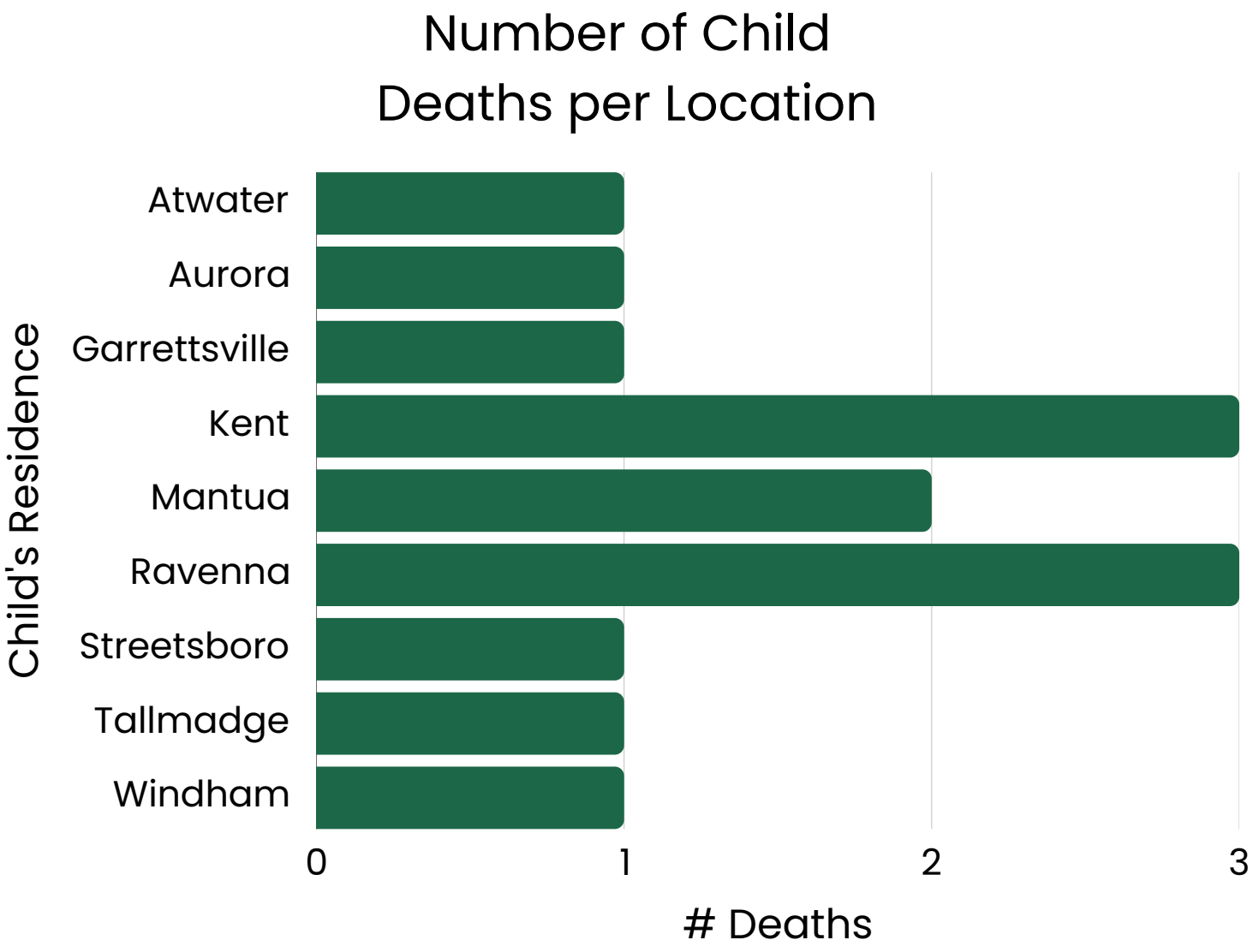


Figure 4. This chart shows the number of child deaths by location of residence. Kent and Ravenna had the highest number of child deaths, with three deaths each. These are two of the most populated areas in Portage County, meaning higher numbers of deaths would be expected for these locations. Mantua had the next highest number of deaths. It should be noted that Hattie Larlham, a specialized care facility for children with congenital and debilitating medical conditions, is located in Mantua.

Manner of Death	# Deaths
Natural	9
Accident	4
Suicide	-
Homicide	-
Pending investigation	1 (not reviewed)

Figure 5. This table shows the manners of 2025 child deaths. A majority of the deaths were natural, meaning they were caused by some type of illness, infection or other medical issue. Fortunately, there were no homicides or suicides in 2025.

Cause of Death	< 1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	TOTAL
Accidental strangulation	–	–	1	–	–	**1**
Blunt force injuries from motor vehicle strike	–	1	–	–	–	**1**
Asphyxia due to carbon monoxide poisoning	–	–	1	–	–	**1**
Other medical condition	–	2	–	3	1	**6**
Prematurity	3	–	–	–	–	**3**
Unintentional smothering	1	–	–	–	–	**1**
Pending investigation	–	1	–	–	–	**1**

Figure 6. This table shows the causes of 2025 child deaths. A majority of the deaths were caused by medical issues, such as illnesses and prematurity.

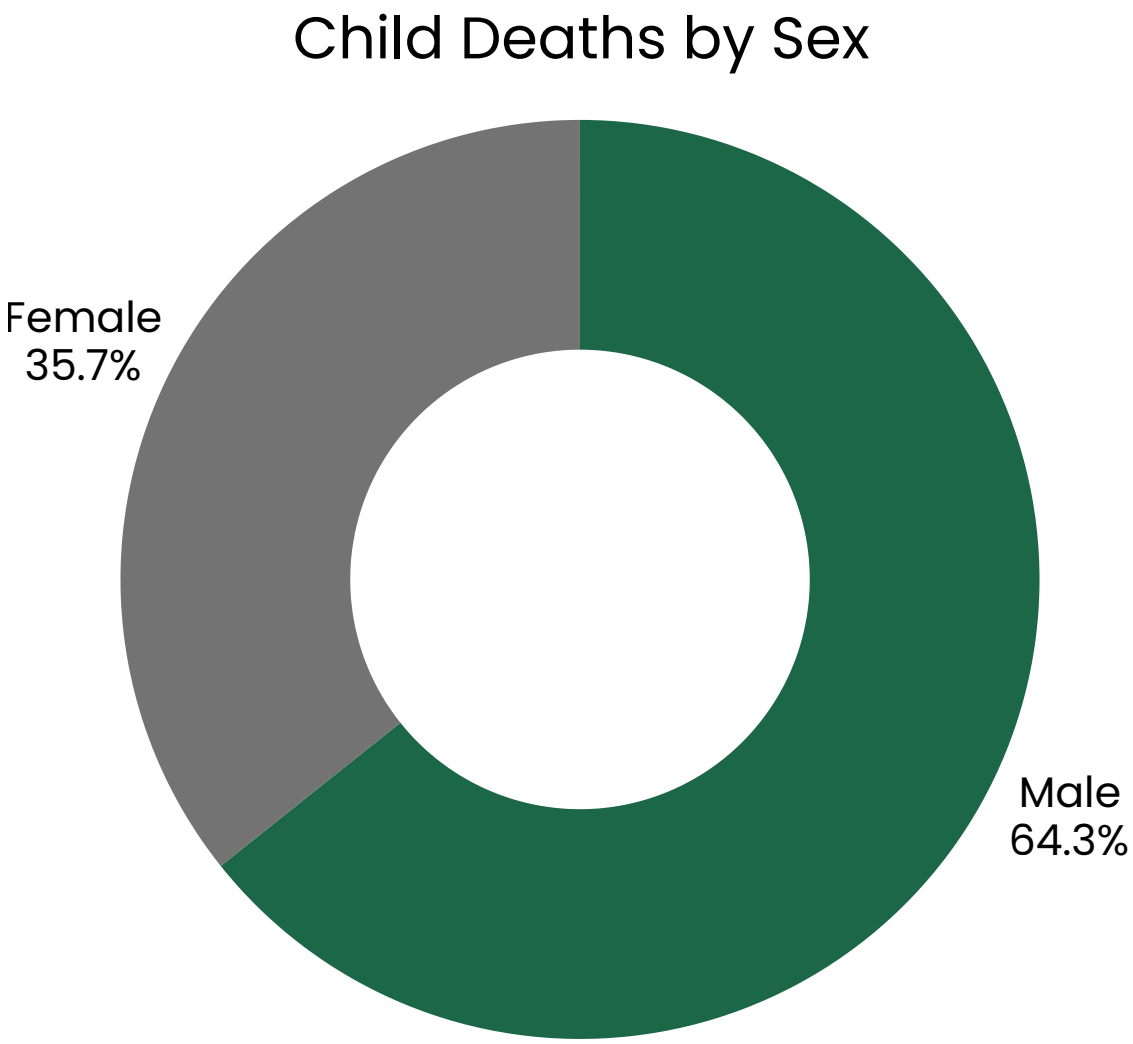


Figure 7. This chart shows the proportion of male children versus female children that passed away during the 2025 review period. A majority of the children who passed away, 64%, were males.

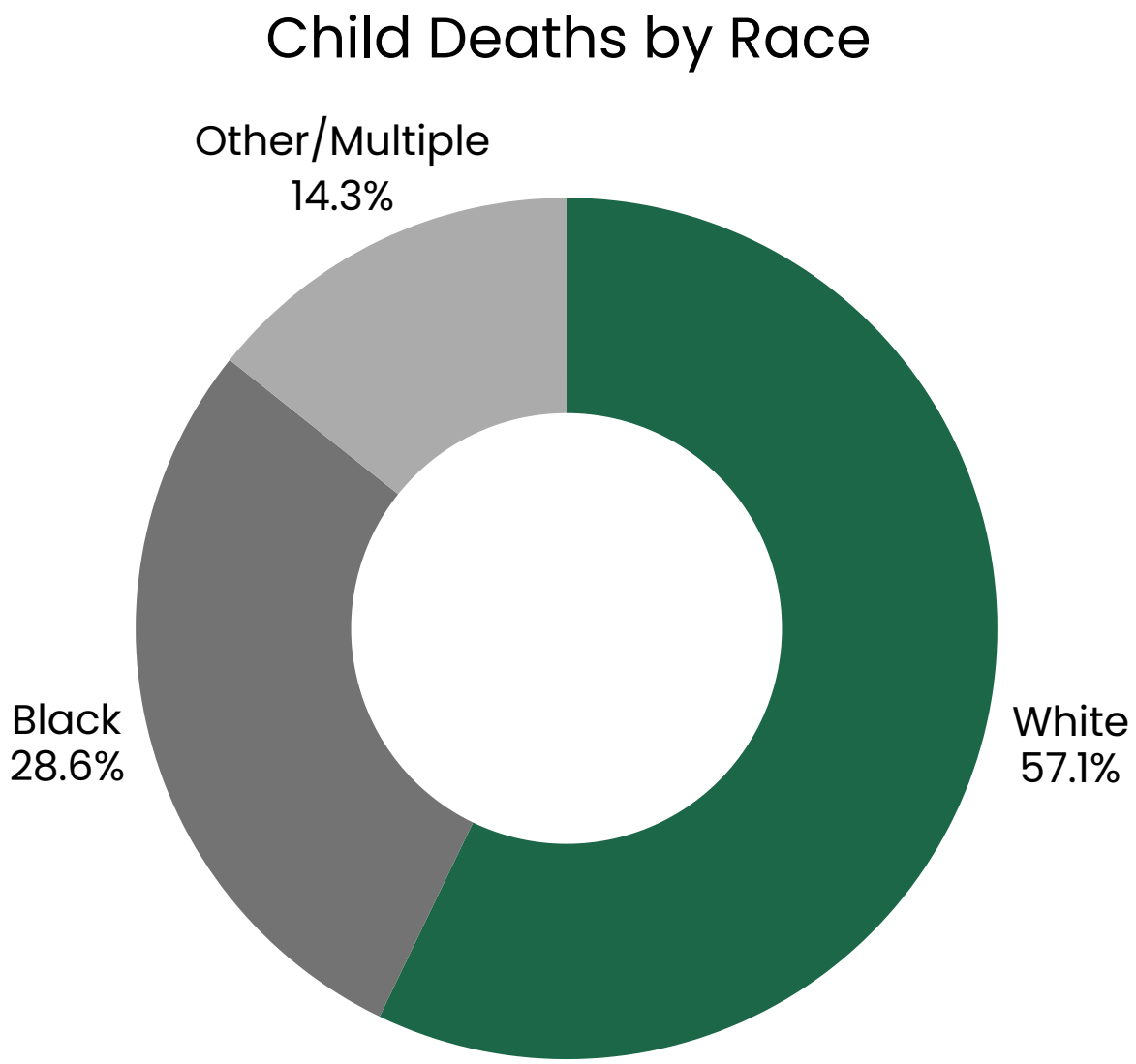


Figure 7. This chart shows the proportion of children in each racial group that passed away during the 2025 review period. A majority of the children who passed away, 57%, were white. The most recent 5-year estimate from the American census bureau indicates that 80.6% of Portage County children under age 18 are white, and 6.5% are black or African American. Given that information, the chart above shows that black children were overrepresented in 2025 deaths.

Portage County CFR Board Recommendations

Parent & Caregiver Education

- Provide parent advocacy education and resources.
- Educate parents and caregivers on child physical safety practices, including strangulation and choking hazards.
- Provide guidance and education to caregivers regarding child supervision and communication practices.
- Promote safe sleep and safe feeding education, including "tired feeding" awareness, to all parents and caregivers — not only first-time parents.

Child-Focused Prevention Education

- Provide age-appropriate education to children on recognizing unsafe or uncomfortable situations and encouraging them to report concerns to a trusted adult.
- Expand physical safety education for children, including instruction on avoiding hazardous behaviors such as placing items around the neck.

Community & Agency Outreach

- Encourage agencies and community partners to circulate safe sleep/safe feeding educational materials. Possible resource: Charlie's Kids safe sleep/safe feeding videos.
- Continue outreach to families with bereavement and counseling resources following critical incidents.

Product & Environmental Safety

- Support improved consumer product labeling, including larger print, clearer warnings, and colorful labels indicating product warnings.

Recommendation Resources

Parent & Caregiver Educational Resources

- *Prevention, Retention, Contingency program*: Portage County Health District
- *Triple P parenting classes*: Townhall II, Children's Advantage
- *Signs of abuse, internet safety*: Children's Advocacy Center
- *Social media, sextortion*: Do it for James Foundation
- *Medical advocacy training*: Stark County Family Council
- *Injury prevention*: Akron Children's Hospital, Portage County Health District
- *Nurturing Family program*: Akron Children's Hospital
- *Strangulation hazard information*: Parents for Window Blind Safety
- *Prevent carbon monoxide poisoning*: Ohio Department of Commerce

Child-Focused Prevention Educational Resources

- *Sandy Hook Say Something program*: Townhall II
- *Signs of Suicide program*: Townhall II
- *Personal body safety*: Townhall II
- *Traffic safety*: Portage County Health District, Safe Communities program

Safe Sleep/Safe Feeding Resources

- *Educational videos (www.charlieskids.org/videos)*: Charlie's Kids
- *Breastfeeding and safe sleep*: Portage County Health District, Women, Infants and Children (WIC) program
- *Safe sleep information*: Akron Children's Hospital

Bereavement Resources

- *Grief counseling for children*: Children's Advantage
- *Grief counseling and support groups*: Kelly's Grief
- *Grief and bereavement counseling*: Coleman Health Services
- *Sudden Unexpected Infant Death (SUID) support*: Portage County Health District, CFR Board

Community Health Improvement Plan

In 2025, Portage County Health District and University Hospitals embarked on a Community Health Assessment (CHA) process, engaging over 30 community partners, including Mental Health & Recovery Board of Portage County, Kent City Health Department, Axess Family Services, Townhall II, PARTA, and Coleman Health Services.

Following the CHA, these community stakeholders participated in the community health improvement process using CHA data to determine community priorities with accompanying strategies. Population Health and Safety, including child and infant health, was identified as a priority in the 2026-2028 Portage County Community Health Improvement Plan (CHIP), along with Chronic Disease and Mental Health, Substance Use, and Addiction.

Some of the strategies within the Population Health and Safety priority that relate to child safety and wellbeing can be broken into 5 categories:

1. Injury Prevention
2. Communicable Disease Prevention
3. Healthy Pregnancies
4. Support for Parents and Families
5. Online Safety

Specific activities within each strategy are listed below:

Injury Prevention

- Distributing car seats, providing installations, and providing car seat checks

- Continue Safe Communities Grant: Click it or Ticket, Drive Sober Get Pulled Over, distracted driving (Phones Down), "Save a Life" high school tours
- Promote bike safety for adults and children: Safe Mobility Project, Put a Lid On It Campaign, Safe Bike Week, Safety Town
- Hold events to promote pedestrian safety among children
- Distribute home safety checklists, flyers, and kits (gun locks, carbon monoxide detectors, fire extinguishers, medicine boxes, lock boxes, and/or prescription disposal pouches)
- Provide education to prevent unintentional ingestions
- Provide safety awareness education for teen drivers

Communicable Disease Prevention

- Provide immunization clinics throughout Portage County

Healthy Pregnancies

- Track initial birth weight and growth/development of WIC participants
- Track breastfeeding rates of mom WIC participants

Support for Parents and Families

- Provide PRC (Prevention, Retention, Contingency) Family Support Services, including child development, safety, nutrition education and material goods for infants/children birth to age 3
- Track child absenteeism and provide specific outreach to those parents
- Offer Parenting Classes (Triple P)
- Offer Nurturing Families program – one-on-one sessions with prenatal and age 0-5 categories
- Provide presentations on child abuse prevention/awareness

Online Safety

- Provide community education on cybersecurity and sextortion

Appendix

Each year, an Ohio Child Fatality Review Annual Report is published by the Ohio Department of Health and the Ohio Department of Children and Youth. The most recently published data reflects cases reviewed by County CFR Boards from 2018 - 2022. Selected charts from the report sare displayed in this appendix.

The age groups referenced in the following pages are:

- Infants: Less than 12 months old
- Toddlers: 1 - 4 years old
- Young children: 5 - 9 years old
- Preadolescents: 10 - 14 years old
- Teens: 15-17 years old

Summary

Most children died of natural causes.

Distribution of Manners of Death Among Reviews of Deaths, from 2018 through 2022 (n=5,482).

Manner of Death	Number of Deaths	Percentage of Deaths	CFR Annual Report Definition
Natural	3,492	64%	Deaths caused by the natural disease process, including prematurity, and not an accident or violence.
Accident	1,095	20%	Deaths caused by unintentional rather than by natural causes, suicide, or murder.
Undetermined or Unknown	323	6%	Following a thorough medical and legal investigation, a conclusive manner of death is not determined.
Suicide	289	5%	Deaths caused by self-inflicted behavior with the intent to die as a result.
Homicide	269	5%	The killing of a person by another person.
Pending	14	0%	Additional investigation or information is required.

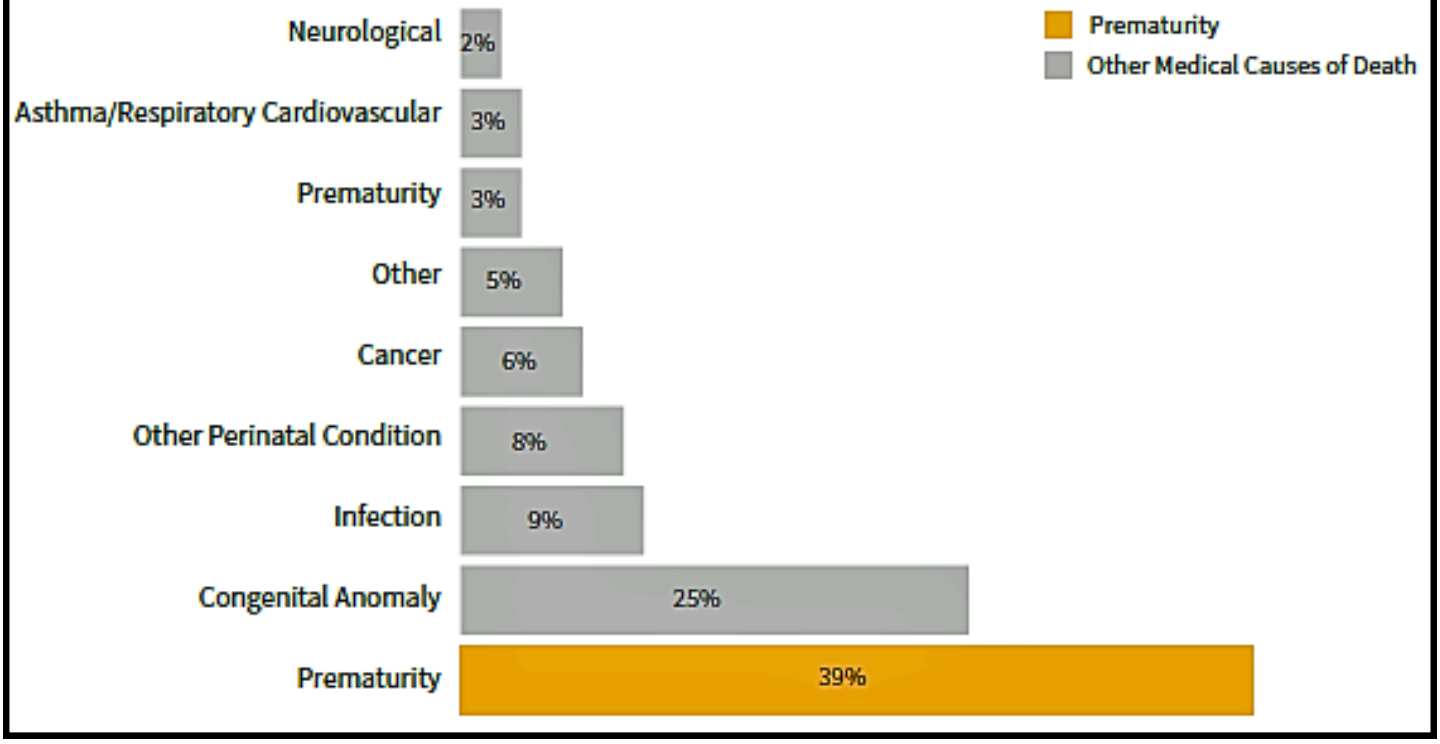
Most children died from a medical condition.

Distribution of Primary Causes of Death Among Reviews of Deaths, from 2018 through 2022 (n=5,482).

Primary Cause of Death	Number of Deaths Reviewed	Percentage of Total Primary Causes	CFR Annual Report Definition
Medical Condition	3,495	64%	Deaths caused from a natural process such as disease, prematurity, or congenital defect.
External Injury	1,689	31%	Deaths caused by injuries, either intentional or resulting from acute exposure to forces that exceed a threshold of the body's tolerance, or from the absence of such essentials as heat or oxygen.
Unknown	298	5%	Cause of death cannot be determined as medical or external or is unknown.

Most medical deaths are due to prematurity.

Reviews of Deaths by Medical Causes Among Deaths Reviewed, from 2018 through 2022 (n=3,495).

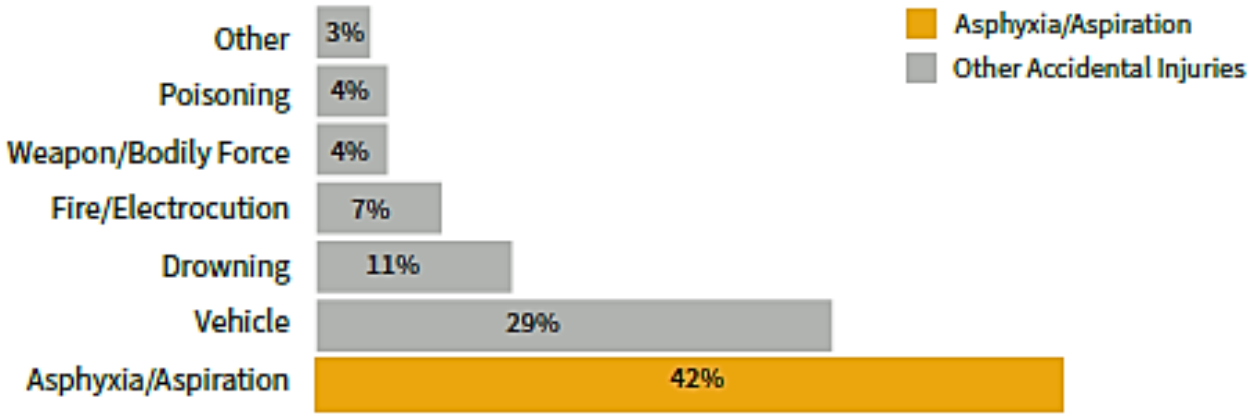


Most external injury deaths were accidental.

Distribution of Manners of Death Among Reviews of Injury Deaths, from 2018 through 2022 (n=1,689).

Asphyxia was the leading cause of accidental injury deaths reviewed.

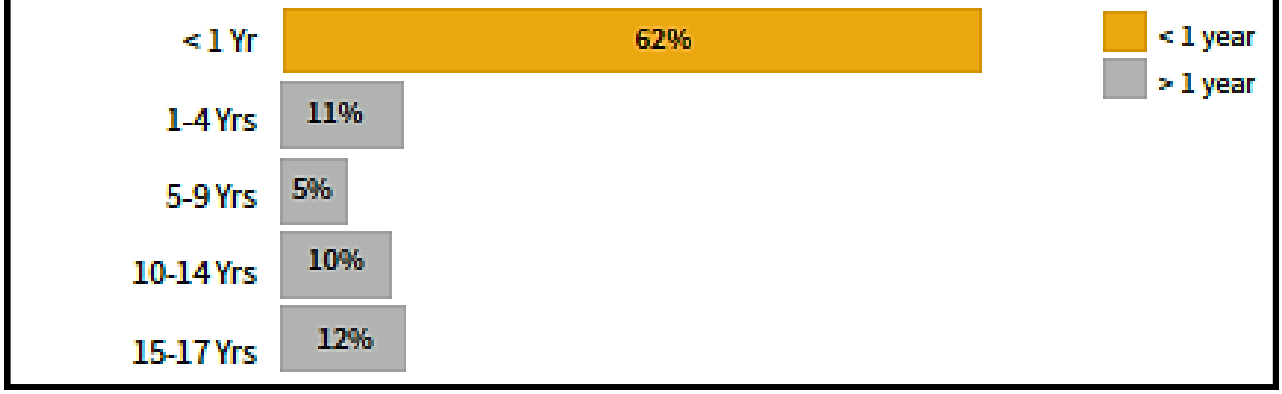
Distribution of Accidental External Injury Causes Among Reviews of Deaths, from 2018 through 2022 (n=1,081).



Infants

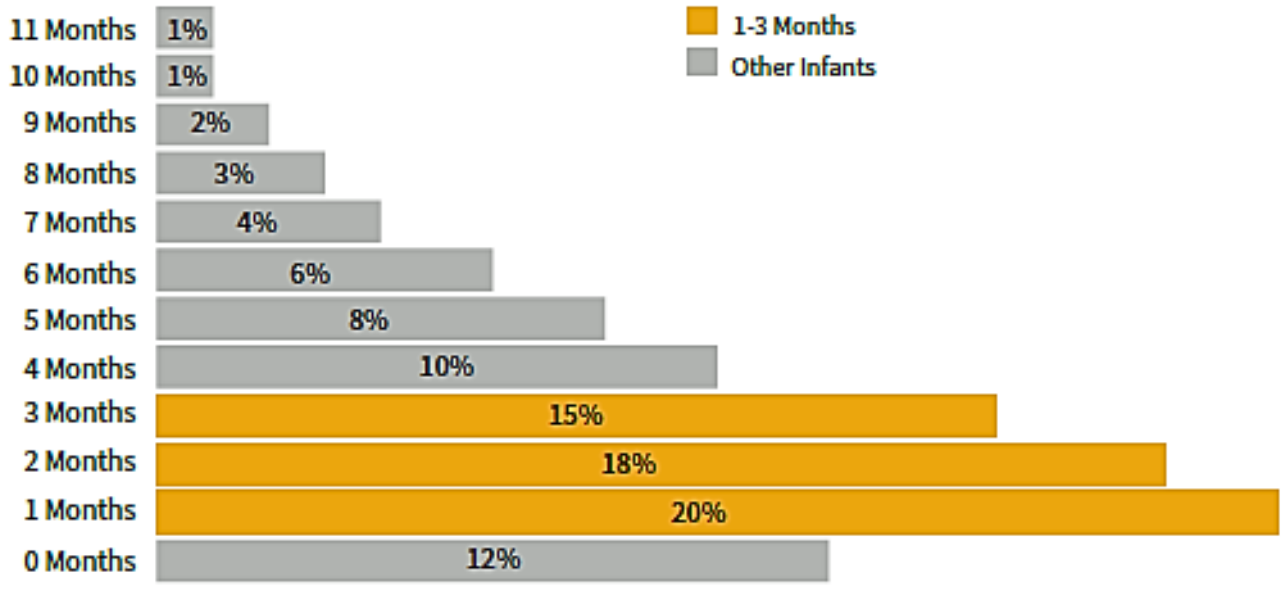
Most deaths reviewed were among Infants.

Distribution of Age Among Reviews of Deaths, from 2018 through 2022 (n=5,482).



Most Infants died at 1 to 3 months old.

Distribution of Age in Months Among Reviews of Infant Sleep-Related Deaths, from 2018 through 2022 (n=682).

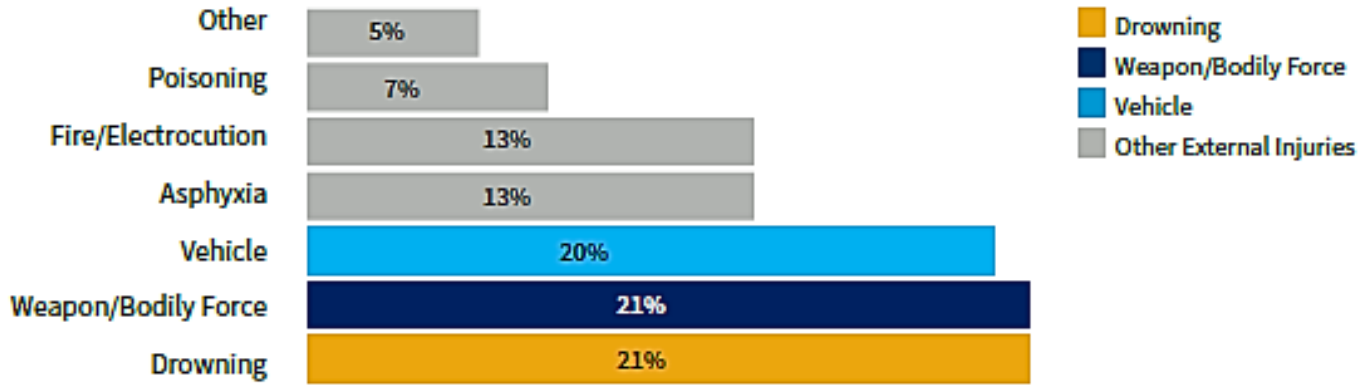


Most Infants died from medical conditions.

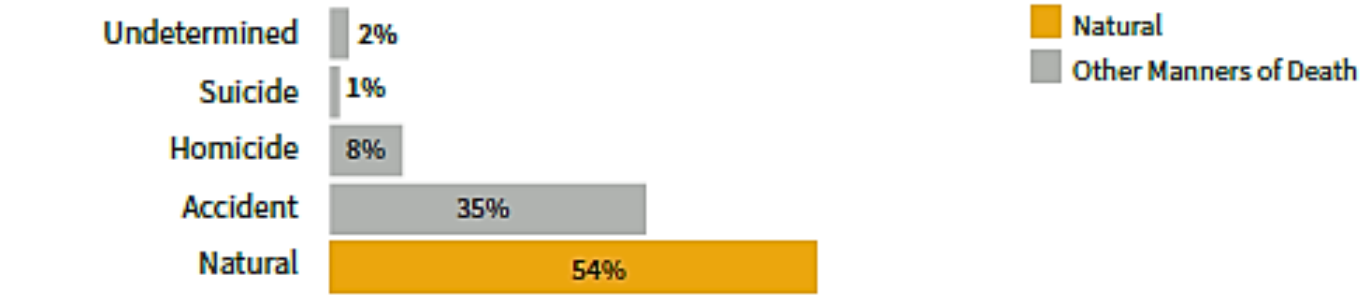
Distribution of Primary Cause of Death Among Reviews of Infant Deaths, from 2018 through 2022 (n=3,415).

Toddlers and Young Children

Most toddlers died from drowning, a weapon or bodily force, or a vehicular incident.
Distribution of External Injuries Among Reviews of Deaths in Children 1 to 4 Years, from 2018 through 2022 (n=277).



Most young children died in a natural manner.
Distribution of Manner of Death Reviews Among Deaths in Children Ages 5 to 9 Years, from 2018 through 2022 (n=300).

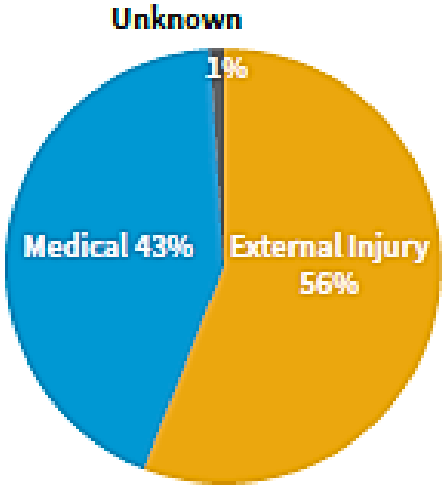


Most medical deaths reviewed among young children were from cancer.
Distribution of Medical Causes Among Reviews of Deaths in Children 5 to 9 Years, from 2018 through 2022 (n=164).

Preadolescents

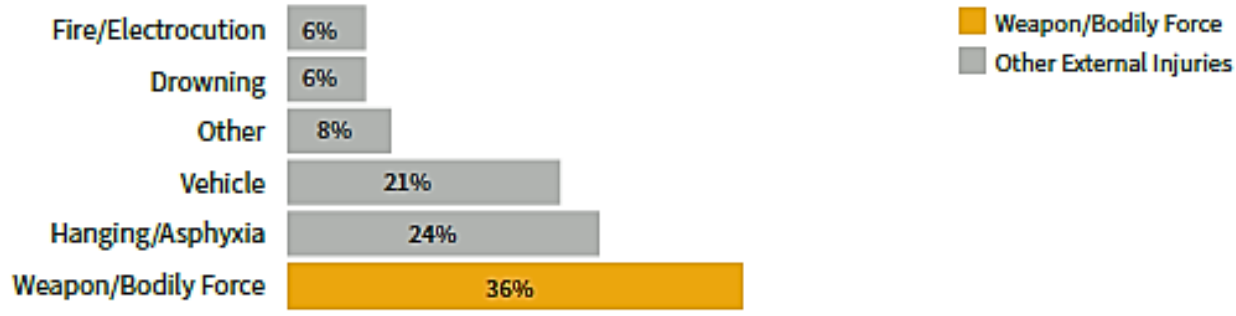
Fifty-six percent of deaths reviewed among preadolescents were due to external injuries.

Distribution of Primary Causes of Death Among Reviews of Deaths in Children Ages 10 to 14 Years, from 2018 through 2022 (n=522).



The leading cause of external injury deaths among preadolescents was trauma by weapon or bodily force.

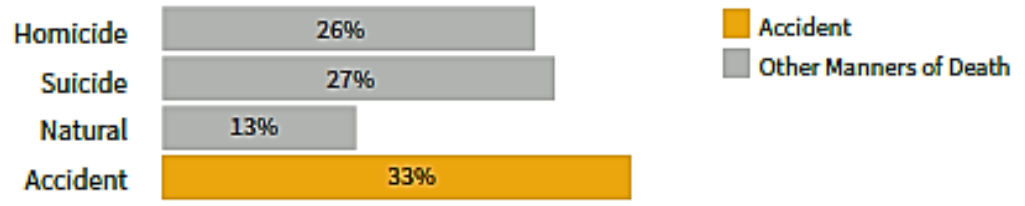
Distribution of External Injuries Among Reviews of Deaths in Preadolescents and Young Teens 10 to 14 Years of Age, from 2018 through 2022 (n=295).



Teens

Most teens died by accident.

Distribution of Manner of Death Among Reviews of Deaths in Teens 15 to 17 Years, from 2018 through 2022 (n=660).



The leading cause death due to external injuries among teenage death reviews was trauma by weapon or bodily force.

Distribution of External Injuries Among Reviews of Deaths in Teens 15 to 17 Years, from 2018 through 2022 (n=479).