



**Public Health**  
Prevent. Promote. Protect.  
Dayton & Montgomery County

# CHILD FATALITY REVIEW

Report to the Community  
2009-2016

## EXECUTIVE SUMMARY



Dear Community Member:

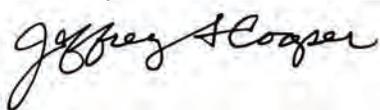
This *Executive Summary* highlights findings from the Montgomery County Child Fatality Review Board's sixth *Report to the Community*. Montgomery County began reviewing the deaths of its children in 1997. The report is an evaluation of child deaths occurring in the years 2009 through 2016 and provides cumulative data from 1997 through 2016.

A comprehensive, multidisciplinary review is completed for every death of a child residing in Montgomery County. The results of these reviews are shared annually with the State of Ohio and are contained in the final report. What cannot be captured in this summary is the great loss and sorrow to family, friends and community when a child death occurs. We continue to examine the factors contributing to these children's deaths, so that we may improve our understanding of how to prevent them.

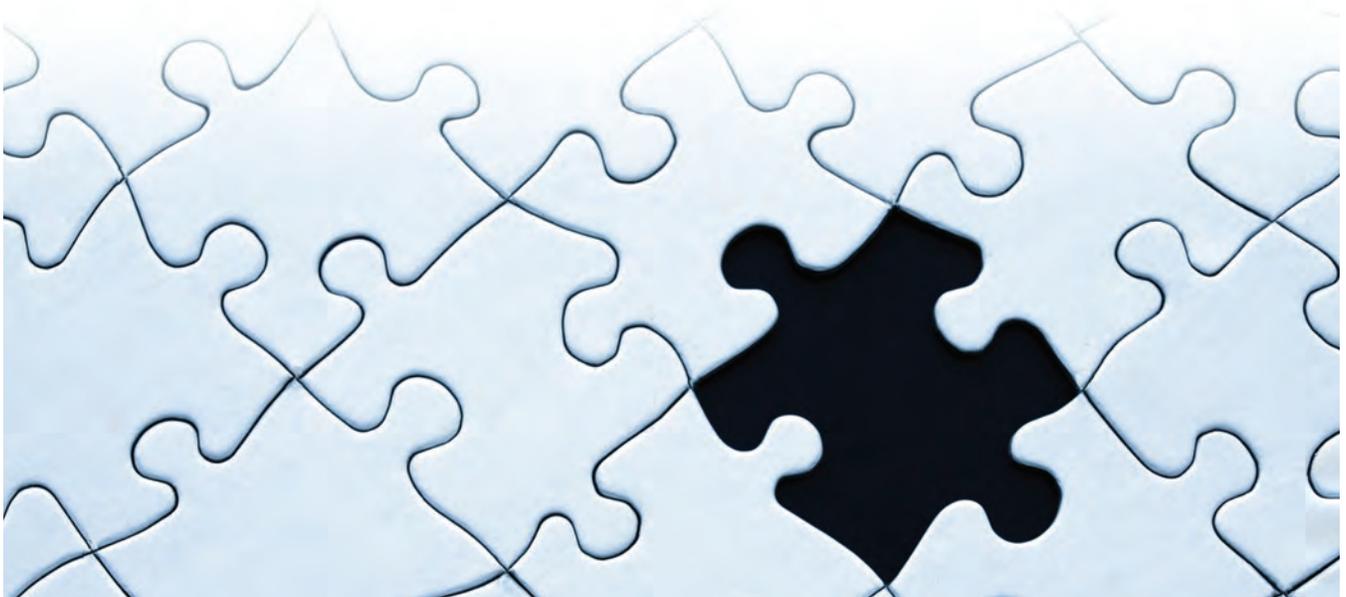
I wish to express my sincere appreciation to those individuals who volunteer time from their already demanding schedules to serve on the committees associated with the Child Fatality Review Board. These professionals truly make a difference in the lives of the children and families in our community.

We hope the information presented in this summary report motivates you to review the full report at [www.phdmc.com/final report](http://www.phdmc.com/final-report). Please share this information with others who have a role in improving the health of children in Montgomery County. No one organization, department, or policy can solve the complex social problems we face as a society. We encourage our community to work collectively to solve the issues we face. By doing so, we will give our children the best opportunity at a safer and healthier future.

Sincerely,



Jeffrey A. Cooper, MS, Chair  
Montgomery County Child Fatality Review Board

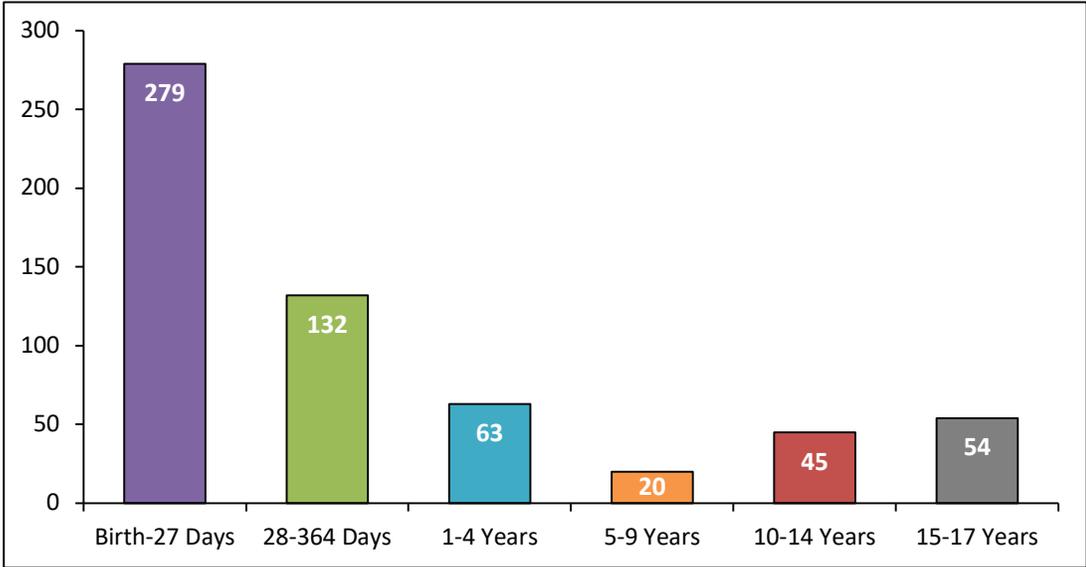




## Child Deaths by Demographic Characteristics: Age, Race, and Sex

The Montgomery County CFRB reviewed the deaths of 593 children who died between 2009-2016. Child deaths are sentinel events signaling a need for investigation or response. Reviewing these deaths by demographic characteristics such as age, race, and sex allows for the identification of disparities that may exist.

**Child Deaths by Age, 2009-2016 (n=593)**



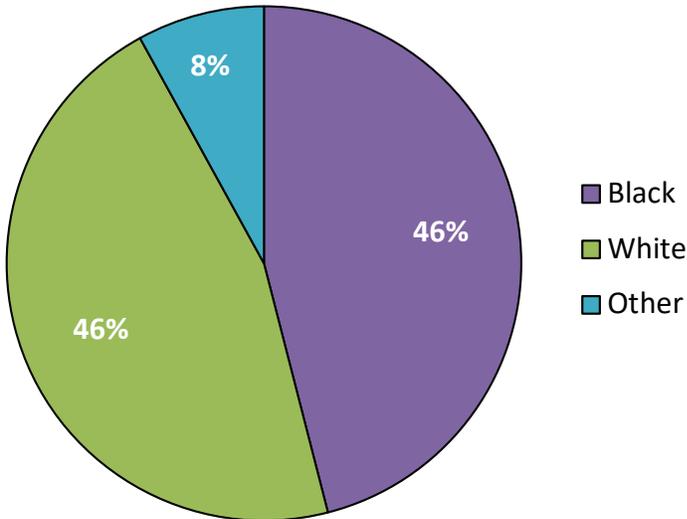
### Child Deaths by Age

- In Montgomery County, most (69%) child deaths were infants (<1 year of age), which is similar to the state (68%). More than half (57%) of Montgomery County’s infant deaths were to babies less than seven days of age.
- Montgomery County had a higher percentage of deaths to children 1-9 years of age (18%) compared to the state (15%).

### Child Deaths by Race and Sex

- The number of Black and White child deaths was nearly the same (270 vs. 275).
- In Montgomery County, 24% of the general child population were Black, however Black children accounted for 46% of the total deaths reviewed.
- In Montgomery County, 51% of the general child population were males, however male children accounted for 58% of the total deaths reviewed.

**Child Deaths by Race 2009-2016 (n=593)**

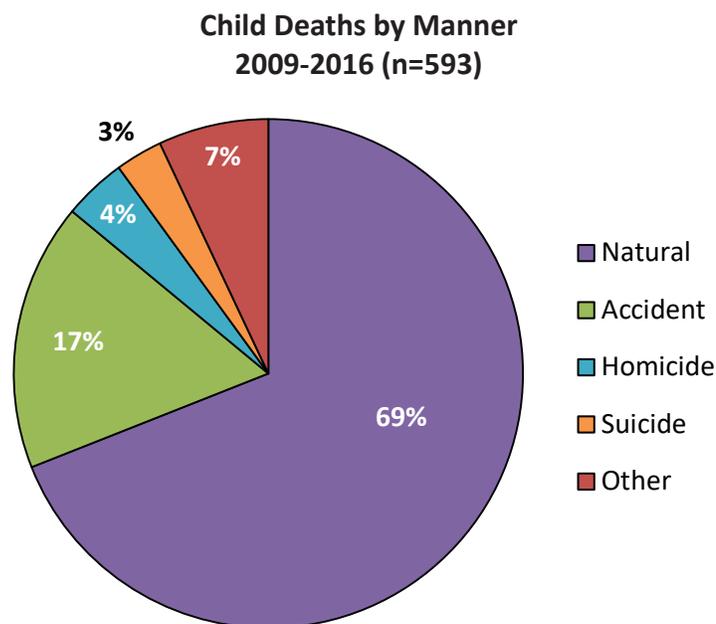


## Child Deaths by Manner and Cause of Death

### Manner of Death

Manner of death is a classification of deaths based on the circumstances surrounding a cause of death and how the cause came about. The five manner of death categories on the Ohio death certificate are natural, accident, homicide, suicide, and undetermined/unknown/pending. For deaths being reviewed, CFR boards report the manner of death as indicated on the death certificate. The 593 deaths that occurred in 2009-2016 were classified as follows:

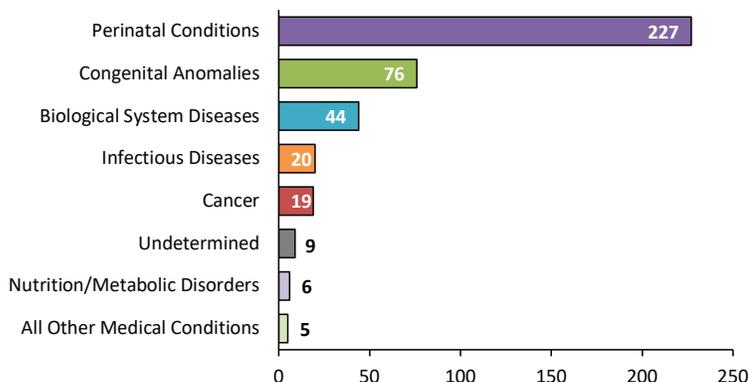
- Sixty-nine percent (406) were natural deaths.
- Seventeen percent (103) were accidents.
- Seven percent (41) were of an undetermined or unknown manner or pending review (labeled “other” in the chart to the right).
- Four percent (26) were homicides.
- Three percent (17) were suicides.



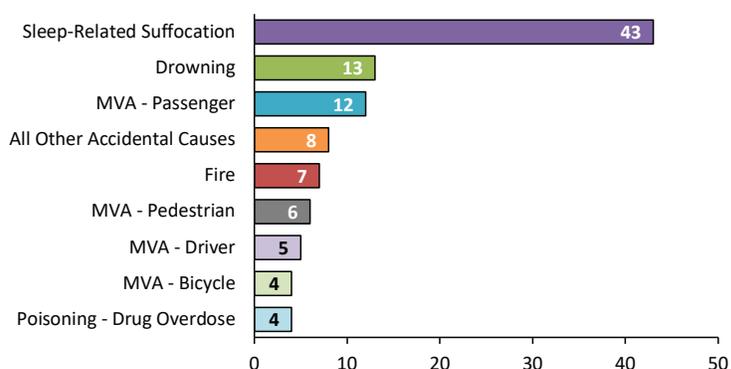
### Manner and Cause of Death

CFR boards select the cause of death category that allows the most information about the circumstances of the death to be recorded in the data system, with a focus on prevention. The cause of death category selected may not match the death certificate. For 2009-2016, the causes of death have been classified by their manner of death.

**Natural Child Deaths  
2009-2016 (n=406)**



**Accidental Child Deaths  
2009-2016 (n=103)**



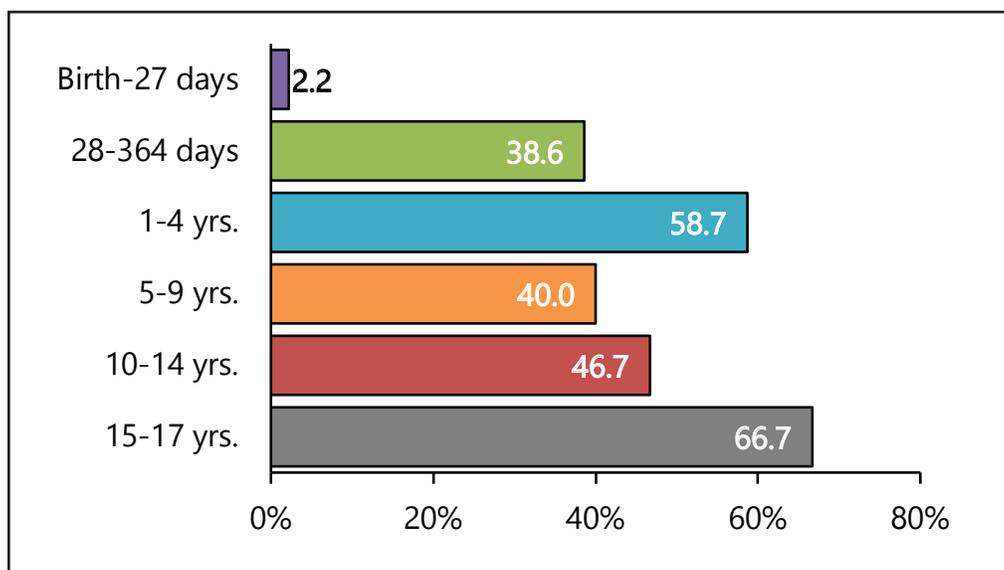
Perinatal conditions accounted for the largest number (227 cases, 56%) of natural child deaths. Sleep-related suffocation deaths accounted for the largest proportion (42% of cases) of accidental child deaths.

## Child Deaths by Preventability

The Ohio Administrative Code defines preventable as, “the degree to which an individual or community could have reasonably done something that would have changed the circumstances that led to the child’s death.”

- In general, deaths are more often ruled preventable as the child’s age increases.
- Two out of three deaths to children 15 to 17 years of age were preventable.

**Preventable Child Deaths by Age  
Montgomery County, 2009-2016**



## Key Findings and Recommendations

### **Demographics**

- Most (69%) child deaths for Montgomery County were deaths to infants (<1 year of age). Of the infant deaths, more than half (57%) were less than seven days of age.
- Across comparison counties and Ohio, infants (<1 year) represented the largest portion of child deaths. Montgomery County had a higher percentage of child deaths 1 to 9 years of age than comparison counties and the state.
- Black children die at a disproportionately higher rate than White children.

### **Manner**

- Most child deaths for Montgomery County and Ohio were natural deaths.

### **Cause of Death**

- Most (79%) infant (<1 year) deaths were due to medical causes; prematurity/low birth weight accounted for half (50%) of all medical causes of death.
- External causes of death were higher among children 1 to 4 years (52%) and 15 to 17 years of age (70%).
- Medical causes of death were higher among children 5 to 9 years (65%) and 10 to 14 years of age (59%).

### **Preventability**

- At least one out of every four child deaths in Montgomery County could have been prevented.

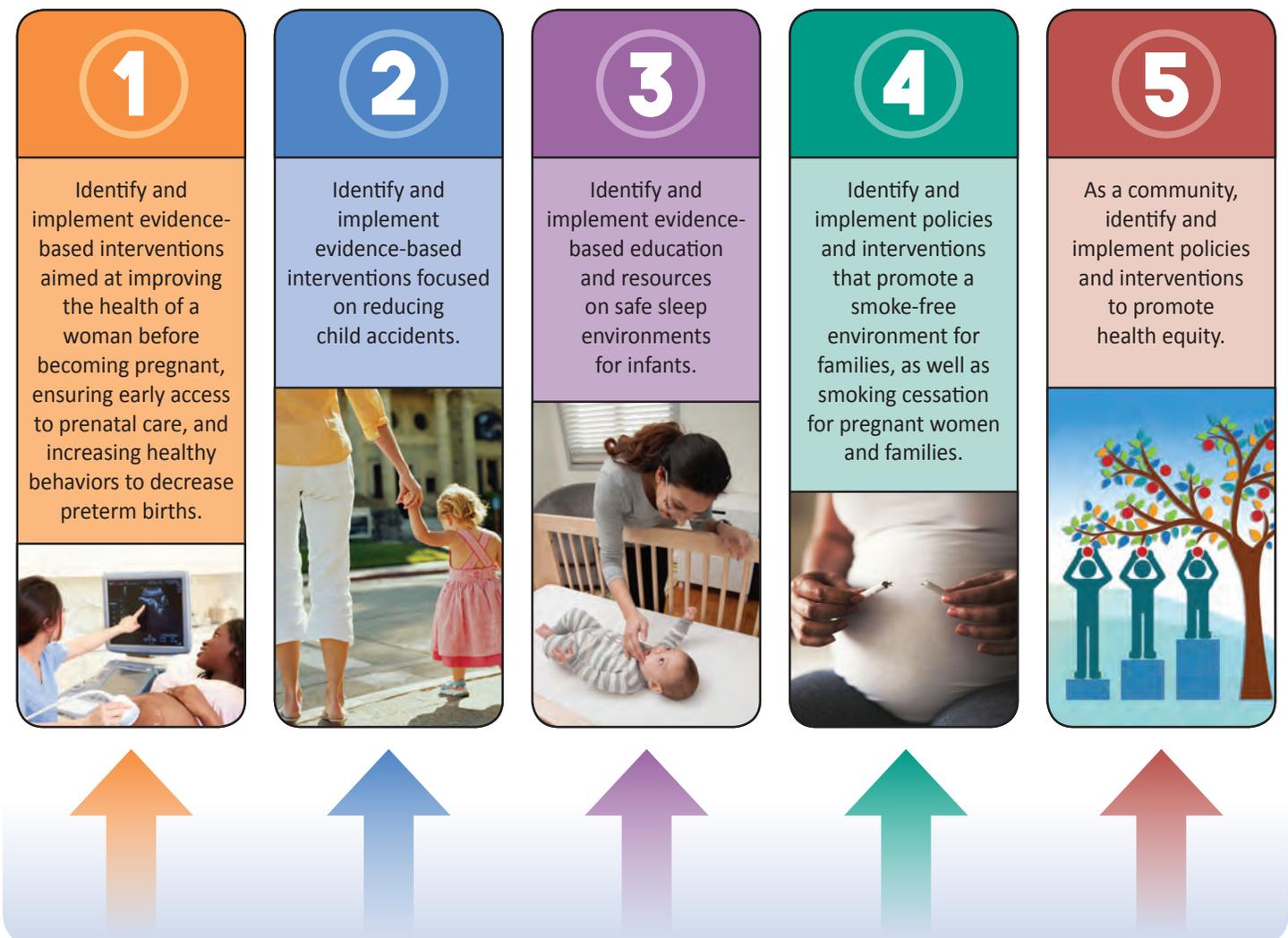
### Review of Comparison Data

- Overall, Montgomery County's child death rates are consistent with state and comparison counties. Montgomery County had a higher percentage (18%) of child deaths 1 to 9 years of age than other comparison counties (Cuyahoga: 11%, Franklin: 14%, Mahoning: 6%) and the state (15%).
- Montgomery County had a lower percentage of White child deaths (42%) compared to the state (60%).
- Montgomery County had the third highest percentage (6%) of child deaths due to homicide compared to other counties (Mahoning: 9%, Franklin: 7%, Cuyahoga 6%) and the state (3%).

### Key Recommendations

The purpose of Child Fatality Review (CFR) is to reduce the incidence of preventable child deaths. Through the process of local reviews, communities acknowledge that the circumstances involved in most child deaths are too complex and multidimensional for responsibility to rest within a single agency. This report acknowledges the collaborative work that has been done to prevent child deaths, and encourages more. It is only through continued collaborative work that we can hope to improve the health and lives of our children.

Based on the findings from this report, the CFRB identified four areas of focus – prematurity, preventable child deaths, tobacco use, and health equity. In addition, the CFRB is making the following key recommendations:



## Dedication and Acknowledgments

The death of a child is a tragic loss for a family, as well as the community. Child Fatality Review reflects the work of many dedicated professionals in the community who have committed themselves to gaining a better understanding of how and why children die, with an overall desire to improve the lives of children in Montgomery County. It is with deepest sympathy and respect that we dedicate this Report to the memory of those children and families represented within these pages.

This report is made possible by the support and dedication of the community leaders who serve on the Child Fatality Review Board (CFRB). Acknowledging that the death of a child is a community problem, members of the Child Fatality Review (CFR) give their time and expertise to examine all circumstances that lead to child deaths. We thank them for taking on this task with reverence and compassion, working with a commitment to preventing future fatalities.

We acknowledge the contributions of other agencies in facilitating the CFR program including the Ohio Department of Health's Office of Health Improvement and Wellness, the Ohio Children's Trust Fund, state and local vital statistics registrars, and the National Center for Fatality Review and Prevention (NCFRP).

The collaborative efforts of all these individuals and their organizations will help ensure a safer and healthier future for our most precious resource, our children.

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This executive summary report was produced by



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To view or download the full *Child Fatality Review Board Report, 2009-2016*, visit  
<https://www.phdmc.org/child-fatality-review>

