Every death of a child in Hamilton County matters. This report is dedicated to the children, and their families, friends and communities whose lives were forever changed.

The Hamilton County Child Fatality Review Annual Report was made possible through the collaboration, and commitment of the numerous individuals who are members of the Hamilton County Child Fatality Review Board. This report mirrors the endeavors of the individuals who strive to enhance the lives of children living in Hamilton County.
Dear Friends of Hamilton County Children:

There are few health outcomes more tragic than the loss of a child, but the fact remains that child deaths are an important indicator of the general health of a community. As you will read in this report, a great number of child deaths could have been prevented.

A state-wide Child Fatality Review (CFR) program was developed by the Ohio General Assembly in 2000. This program mandates that CFR boards be implemented in every county in Ohio in order to review the deaths of children under 18 years of age.

Once again this year, Hamilton County's infant mortality rates are higher than the national average. While this report covers child deaths for all children under 18 years of age, the vast majority of child deaths in the County occur in children before their first birthday.

The CFR annual report looks at the causes of child fatalities throughout the County. The report focuses on child deaths from 2010 to 2014.

Creating a strategy to reduce the number of preventable child deaths is a complicated endeavor that requires collaboration between many stakeholders. Hamilton County Public Health partners with individuals, healthcare systems, physicians, clinics and other support sources affecting social determinants of health in order to reduce these numbers.

It is my sincere hope that you examine the information in this report closely. It will require the collective effort of many to bring the rates of child mortality to levels representative of the quality of our great communities.

Sincerely,

Tim Ingram
Health Commissioner
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This report was prepared by Hamilton County Public Health, Department of Community Health Services.

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Special thanks to the Hamilton County Child Fatality Review Team for their commitment to the prevention of child deaths in Hamilton County, for without whom this report would not be possible.

All material appearing in the CFR Annual Report may be reproduced and copied without permission; citation to Hamilton County Public Health, however, is appreciated. Due to the sensitive and confidential manner of CFR data, data are only reported in aggregate.

Suggested Citation
Executive Summary

The Hamilton County Child Fatality Review Team (CFRT), which currently operates under the auspices of Hamilton County Public Health, officially began reviewing cases on January 1\textsuperscript{st}, 1996. The following report represents the eighteenth full year of the child fatality reviews by the Hamilton County Team. The Hamilton County Child Fatality Review Annual Report presents an in-depth analysis of child deaths that occurred between 2010 and 2014.

In 2000, the Ohio General Assembly established the Ohio Child Fatality Review program in response to the need to better understand why children in Ohio are dying\textsuperscript{1}. The law mandates that every Ohio county create a CFR board to review all deaths of children under 18 years of age\textsuperscript{1}. An online CFR data system was developed by the National Center for Prevention and Review of Child Deaths that allows for a thorough capture of factors that impacted the death of the child\textsuperscript{1}.

The online data system has allowed for the in-depth analysis of the types of death presented within this report. The report is broken out into 10 sections: introduction, deaths due to medical conditions, motor vehicle deaths, homicides, suicides, drownings, asphyxia deaths, sleep-related deaths, “other types of child death”, and a conclusion. Each section contains an in-depth look regarding the circumstances and factors related to the deaths. Where applicable, the number of child deaths (N) is displayed on each corresponding chart/figure. Maps will be presented throughout the report to highlight the inequities throughout the County as they relate to child deaths.

The purpose of CFR is to prevent child deaths by examining the causes of deaths in the aggregate, making policy recommendations from the review of child deaths in Hamilton County and increasing coordination and communication between agencies and systems. Each section of this report concludes with the recommendations made by the Hamilton County CFRT.

The main goals of the CFRT are to:

- Compile uniform statistics on all deaths among children under 18 years of age in Hamilton County.
- Accurately identify and document the causes of death of all Hamilton County children.
- Identify trends among child deaths in Hamilton County.
- Identify causes of death that may be preventable, and make subsequent recommendations about policy changes in public health and public safety for Hamilton County.
- Develop uniform protocols and procedures for investigating child deaths.

This report is intended to describe the trends and patterns found across child deaths, identify areas of child death inequities and make meaningful recommendations that improve the outcomes for all children in Hamilton County. It is hoped that the recommendations provided throughout this report will result in continued collaboration across the various agencies whose focus is on improving the health of children in Hamilton County. It is through this collaborative effort that we can strive to protect the health of the children living in Hamilton County.
Limitations

The CFR data system collects information surrounding the death of the child. However, not all information is available during the review of the child death and pieces of information can be missing or unknown. Missing or unknown data is identified in the data tables beginning on page ii of the Appendix.

Calculation of rates is not appropriate with Hamilton County’s CFR data because not all child deaths undergo a full team review by the Hamilton County CFRT. The overall child fatality rate is the only rate appropriate to calculate using Hamilton County’s CFR data as it takes into account all child deaths regardless if the child death received a full team review. CFR statistics are reported as proportions (percentages) of all child deaths in Hamilton County from 2010 to 2014. This can make analysis of trends over time difficult, as an increase in the percentage of one factor will result in a mathematical decrease in the percentage of other factors. Percentages presented throughout this report may not equal 100 percent due to rounding.

Since the origin of the statewide data collection, the CFR data system has undergone improvements and revisions. Due to the differences in data elements and classifications, the data presented within this report may not be comparable to previous reports. The in-depth evaluation of factors that contributed to and impacted the child deaths in Hamilton County is limited by a small number of cases and/or lack of pertinent information. Some statistics regarding child death in Hamilton County throughout this report are based on a small number of cases and should be interpreted with caution, as it may be difficult to distinguish random fluctuation/changes in the incidence from true changes in the underlying risk.
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Child Fatality Review Team Membership

Regular Child Fatality Review Team members are representatives of the following agencies:

- Hamilton County Public Health
- Children’s Services Division of Hamilton County Department of Job and Family Services
- Cincinnati Children’s Hospital Medical Center
- Hamilton County Coroner
- Cincinnati Health Department
- Cincinnati Fire Department
- Cincinnati Police Department
- Hamilton County Prosecutor
- Hamilton County Sheriff
- Hamilton County Juvenile Court
- Hamilton County Mental Health and Recovery Service Board
- UC Health

Meetings are closed to the general public and media, and all discussion and work products are confidential. Only CFRT members and invited guests are permitted to attend CFR meetings. Representatives of other agencies and organizations are occasionally invited to attend when a relevant case is being discussed.
Cases Reviewed

The Hamilton County CFRT screens all deaths of children under 18 years of age who are residents of Hamilton County at the time of death. The CFRT limits death reviews to residents of Hamilton County and does not review deaths of non-residents who die in Hamilton County.

Death certificates of all Hamilton County residents under 18 years of age are sent to Hamilton County Public Health by each of the health departments in Hamilton County. Hamilton County Public Health records all demographic data about all child deaths into the CFR data system developed by the National Center for Prevention and Review of Child Deaths. The Hamilton County Coroner’s Office reviews each death certificate to categorize the cause of death and determine whether it qualifies for a review by meeting any of the following criteria:

- Homicide
- Suicide
- Unintentional injuries (accidents)
- Undetermined, including presumed Sudden Infant Death Syndrome (SIDS)
- Unexpected outcomes (e.g., unexpected death from identified medical causes)
- Unexpected clusters (e.g., unusual frequency of deaths from identified medical causes)
- All cases investigated by law enforcement

If the coroner’s office determines that the case meets any of the criteria, the case is scheduled for a full CFRT review. Case names are also sent to Hamilton County Job and Family Services (JFS) to determine if there has been any involvement with Child Services at any time. Additionally, any CFRT member can request a full-team review of any case they feel would benefit from a full-team review, whether or not it meets the criteria for full review.

Full-team reviews involve an in-depth examination of the death by the entire CFRT, with members reporting on relevant information they might have about the death. The CFRT tries to reach conclusions about whether or not the death was preventable, based on the information available on the circumstances leading up to the death. The information about the factors related to the death of the child is recorded into the CFR data system. The following report is based on the analysis of the data between 2010 and 2014 from the CFR data system for Hamilton County.
Introduction

The death of a child is the most profound loss a parent can experience. In order to reduce the number of these tragic losses, we must understand why, how and where the children in our community are dying, along with the social determinants that influence the health of children.

To understand why our children are dying and the inequities in child deaths, we must first understand a little about the children living in Hamilton County. Children, throughout this report, are defined as Hamilton County residents under 18 years of age.

Demographics: Age, Race/Ethnicity, Sex

In 2010, there were 189,640 children who called Hamilton County home. This means that nearly a quarter of the total Hamilton County population in 2010 were children. The percent of male children (51 percent) was nearly equal to that of female children (49 percent) living in Hamilton County in 2010. The largest percentage of children (59 percent) in Hamilton County in 2010, were white children. Thirty-two percent of Hamilton County children in 2010 were black children, representing the second largest racial group of children. Five percent of Hamilton County children were multi-racial, or identified with two or more races. Other races, such as Pacific Island or Alaskan Native, represented four percent of children in Hamilton County. The majority of children in Hamilton County were non-Hispanic, however, four percent of children living in Hamilton County in 2010 were of Hispanic or Latino descent.

In 2010, the majority of children were between five and 14 years of age. Infants, those children younger than one year of age, accounted for six percent of the Hamilton County child population in 2010. Twenty-three percent of children in Hamilton County were between one to four years of age. Children who were between five and nine and 10 and 14 years of age each accounted for 27 percent of Hamilton County children in 2010. Older children, who were 15 to 17, represented the remaining 18 percent of Hamilton County children.
Overall Annual Trends
From 2010 to 2014, Hamilton County witnessed 719 of its child residents die from various causes, many of which could have been prevented. Over the five years during 2010 to 2014, the annual number of children who died in Hamilton County fluctuated. From 2010 to 2011, the number of child deaths increased from 149 to 156, the highest number of child deaths in the five year time period. In 2012, the number of child deaths decreased to the lowest number of child deaths (131) during the five-year time period. Since 2012, the number of child deaths in Hamilton County increased. In 2014, Hamilton County witnessed the third highest number of child deaths (138) during 2010 to 2014.

Another way to monitor child deaths is to look at the child fatality rate. The child fatality rate is a specific type of mortality rate that measures the number of child deaths over a specified time frame. The child fatality rate in Hamilton County from 2010 to 2014 was 7.7 per 10,000 children. This means that for every 10,000 children who were living in Hamilton County from 2010 to 2014, there were nearly eight child deaths. Much like the number of child deaths, the child fatality rate has fluctuated during 2010 to 2014. In 2011, the child fatality rate was the highest (8.3 per 10,000) over the five-year time period. After decreasing in 2012 to 7.0, the lowest rate from 2010 to 2014, the rate has been steadily increasing. The child fatality rate is the only rate appropriate to calculate using Hamilton County’s CFR data as it takes into account all child deaths regardless if the child death received a full team review.

DID YOU KNOW?
Between 2010-2014:

1 Hamilton County child died
Child Death Disparities: Demographic Sub-populations

Within the child population in Hamilton County, there are sub-populations that are disproportionately affected by child deaths. From 2010 to 2014, male children in Hamilton County were affected by higher numbers of child deaths than their female counterparts. In the five-year time span of 2010 to 2014, male children have consistently accounted for over 50 percent of child deaths in Hamilton County. Sixty-one percent of child deaths from 2010 to 2014 were to male children, while female children accounted for 39 percent. Male children are not the only population that is disproportionately affected by higher percentages of child deaths. When race is taken into account, larger disparities among the child population emerge.

Race/Ethnicity

Race and ethnicity presented throughout this report are the combined race and ethnicity of the child that is reported at the time of death on his/her death certificate. Race and ethnicity are classified into one of five different categories:

- non-Hispanic white
- non-Hispanic black
- non-Hispanic multi-racial
- non-Hispanic other race
- Hispanic

Hamilton County children who identify with two or more racial groups are classified as being multi-racial. If a child identifies with another race (e.g., Asian, Alaskan Native, Native American, etc.), the race is classified as “other”. Anytime a child is identified as being of Hispanic or Latino descent, regardless of race, they are classified as Hispanic. As shown previously, the majority of the child population in Hamilton County are non-Hispanic, and the majority of child deaths in Hamilton County are to non-Hispanic children. Fifty-five percent of child deaths from 2010 to 2014 were to non-Hispanic black children. Historically, non-Hispanic black children in Hamilton County have seen inequalities when it comes to child deaths. Child deaths to non-Hispanic black children have consistently accounted for over 50 percent of child deaths in Hamilton County. However, since 2011, the percent of child deaths to non-Hispanic black children has begun to trend downwards.

Thirty-four percent of child deaths from 2010 to 2014 were to non-Hispanic white children. Child deaths to non-Hispanic white children in Hamilton County witnessed a decrease from 2011 to 2013. However, in 2014 the percent of child deaths to non-Hispanic white children began to increase.

Hamilton County children who were non-Hispanic multi-racial had a consistent amount of child deaths from 2010 to 2014. The percent of child deaths to non-Hispanic multi-racial children had a slight increase from 2010 to 2011, but then began to decrease from 2012 to 2014.

Hispanic children, regardless of race, accounted for 10 percent of child deaths from 2010 to 2014 in Hamilton County. The percent of child deaths to Hispanic children has consistently trended downwards from 2010 to 2014.

Non-Hispanic other race children accounted for 10 percent of child deaths from 2010 to 2014 in Hamilton County. The percent of child deaths to non-Hispanic other race children has consistently trended downwards from 2010 to 2014.

Hamilton County Child Deaths by Race/Ethnicity, 2010-2014
racial accounted for five percent of child deaths from 2010 to 2014. Since 2012, the percent of deaths to non-Hispanic multi-racial children has been slowly increasing. Prior to 2012, the percent of child deaths to non-Hispanic multi-racial children in Hamilton County had accounted for only one percent of deaths in 2010 and 2011. Two percent of deaths from 2010 to 2014 were to children who were non-Hispanic and identified with another racial group. The percent of deaths to children who were non-Hispanic and identified with another racial group also witnessed an increase in the percent of child deaths since 2012. Child deaths to Hispanic children in Hamilton County remained relatively stable from 2010 to 2014. Over the five years of 2010 to 2014, three percent of child deaths were to Hispanic children in Hamilton County.

**DID YOU KNOW?**

Between 2010-2014:

3 out of every 5 Child deaths in Hamilton County were to non-Hispanic black children.

**Race/Ethnicity and Sex**

As illustrated previously, male children and non-Hispanic black children in Hamilton County represented the largest percentage of child deaths. When sex and race/ethnicity are coupled together, further inequalities in child deaths emerge. Non-Hispanic black male children accounted for the largest percentage of child deaths from 2010 to 2014. Thirty-two percent of child deaths in Hamilton County between 2010 and 2014 were to non-Hispanic black males. The percent of deaths to non-Hispanic black male children was nearly 1.5 times higher than non-Hispanic white male children and nearly seven times higher than non-Hispanic multi-racial, non-Hispanic other races, and Hispanic male children combined. Non-Hispanic white male children represented the second highest percentage of child deaths from 2010 to 2014 (24 percent). However, the percent of child deaths to non-Hispanic white males was nearly equal to the percent of child deaths to non-Hispanic black females.

Between 2010 and 2014, 23 percent of child deaths in Hamilton County were to non-Hispanic black females. The percent of child deaths to non-Hispanic black females was 1.5 times higher than non-Hispanic white females, and nearly nine times higher.
than non-Hispanic multi-racial, non-Hispanic other races, and Hispanic female children combined.

Two percent of child deaths in Hamilton County between 2010 and 2014 were to non-Hispanic multi-racial male children. Male children who were non-Hispanic and identified with another racial group comprised one percent of child deaths in Hamilton County from 2010 to 2014. Hispanic male children accounted for two percent of child deaths in Hamilton County from 2010 to 2014. Female children who were non-Hispanic and multi-racial accounted for one percent of child deaths in Hamilton County from 2010 to 2014. Female children who were non-Hispanic and identified with another racial group comprised the smallest percentage of child deaths in Hamilton County from 2010 to 2014, accounting for less than one percent (0.6 percent). Hispanic female children accounted for the second smallest percentage of child deaths in Hamilton County (0.7).

**Age**

Race/ethnicity and sex are not the only inequities in child deaths in Hamilton County, when the age of the child is taken into account, further inequities among child deaths in Hamilton County emerge. Child deaths throughout this report are classified into one of six different age groups:

- **<28 Days**
- **28 Days - 1 Year**
- **1-4 Years**
- **5-9 Years**
- **10-14 Years**
- **15-17 Years**

As illustrated previously, infants (children who are less than one year of age) accounted for the smallest percentage of the child population in Hamilton County. However, infants accounted for the largest percentage of child deaths in Hamilton County from 2010 to 2014. Seventy-three percent of child deaths from 2010 to 2014 were to infant children. Infants’ ages are further broken down into children who are <28 days old (neonates) and children who are between the ages of 28 days and one-year-of-age (post-neonates). Historically, infants in Hamilton County have seen inequalities when it comes to child deaths. From 2010 to 2014, infants have consistently accounted for over 60 percent of child deaths. However, the overall number of infant deaths in Hamilton County has been trending downwards.

Since 2010, the percent of neonatal deaths has been slowly trending downwards. However, these children accounted for 36 percent of all child deaths from 2010 to 2014. Post-neonatal deaths accounted for an additional 36 percent of the child deaths in Hamilton County from 2010 to 2014. After a decrease in deaths in 2013, the percentage of child deaths post-neonates began to increase in 2014.

For children one-year-of-age, and older, the percent of child deaths in Hamilton County drops drastically. The percentage of deaths to children who were between one and four remained relatively stable from 2010 to 2014, accounting for nine percent of child deaths in Hamilton County. The smallest percent
of child deaths, four percent, were to children between five and nine. However, while these children represent the smallest percentage of child deaths in Hamilton County, the percent of deaths each year to children between five and nine has been increasing since 2010. The second smallest percent of child deaths from 2010 to 2014, six percent, were to children between 10 and 14. After a decrease from 2010 to 2011, the percent of child deaths to children between 10 and 14 has been increasing. Mid-teenage children in Hamilton County, those between 15 and 17, accounted for eight percent of child deaths from 2010 to 2014. After an increase in the percent of child deaths from 2010 to 2011, the percent of child deaths to children between 15 and 17 has remained relatively stable. An increase in the percent of child deaths to children in other age groups could be due to the decrease in the number of infant deaths.

**DID YOU KNOW?**
Between 2010-2014:

2 out of every 3 Child deaths in Hamilton County were to children less than 1 year of age.

**Geography**
Inequities in child deaths also exist between communities in Hamilton County. Within Hamilton County, there are 49 communities comprised of cities, villages, and townships. As illustrated by the map below, the majority of the communities in Hamilton County have witnessed child deaths within their communities. The urban core of Hamilton County, the City of Cincinnati, experienced the largest number

*Hamilton County Child Deaths by Community, 2010-2014*

N=719
of child deaths from 2010 to 2014. Hamilton County communities to the north also witnessed a large number of child deaths from 2010 to 2014. To determine the location of your community, please refer to the map on page i of the Appendix.

The child fatality rate, much like an infant mortality rate, is also an important indicator of community health. While it is expected that an infant mortality rate may increase when a community experiences more births, a child fatality rate is not necessarily as sensitive relative to the number of child residents in a community.

As illustrated by the map above, communities in the western part of the County and north of the City of Cincinnati have some of the highest child fatality rates. However, these communities have fewer numbers of child deaths and smaller child populations than the City of Cincinnati. The largest burden of child fatality in terms of the number of child deaths, however, lies within the City of Cincinnati.

**Sociodemographics**

Child deaths and, child health can be influenced by sociodemographic factors, such as poverty, and the community in which the child lives. One way to look at how multiple sociodemographic factors interact to influence the health of children, and ultimately child deaths, is to look at the level of concentrated disadvantage in the community where the child resided. Concentrated disadvantage is an indicator that shows areas of a community that are at an economic disadvantage. Communities that have higher levels of concentrated disadvantage often times have less mutual trust and willingness among community members to intervene for the common good, often known as collective efficacy. Collective efficacy is a critical way that communities inhibit the perpetration of violence. Children who live and grow in disadvantaged areas are more likely to experience violence. Communities with high levels of concentrated disadvantage are also at an increased risk for higher rates of infant mortality.
Concentrated disadvantage is calculated using five indicators:

1. Percent of individuals living below the poverty line;
2. Percent of individuals on public assistance;
3. Percent of female-headed households;
4. Percent of the population who are unemployed;
5. Percent of the population who are less than 18 years of age

The map below shows communities that had low, medium, and high levels of concentrated disadvantage in Hamilton County in 2012.

The urbanized areas in Hamilton County (City of Cincinnati and to the north), along with pockets of residents in the western portion of the County, tend to have the highest levels of concentrated disadvantage. Correspondingly, the child fatality rate in neighborhoods with high levels of concentrated disadvantage is nearly double the child fatality rate in neighborhoods with medium levels of concentrated disadvantage and triple the child fatality rate in neighborhoods with low levels of concentrated disadvantage.

It is important to identify the areas
that have the largest inequities in child deaths so that targeted interventions may be implemented that can improve child health and reduce deaths. However, in order to implement these targeted interventions, we must further understand why and how our children are dying.

**Manner and Cause of Death**

Every child death is assigned both a manner and cause of death. The manner of death is how the death of the child is classified based on the surrounding circumstances of the cause of death and how the cause was brought about. The manner of death is reported as it is listed on the child's death certificate. There are five categories in which the manner of death is classified as:

- Accident
- Homicide
- Suicide
- Natural
- Undetermined

Between 2010 and 2014, 74 percent of child deaths that occurred in Hamilton County were deaths due to natural causes. Child deaths due to natural causes can be caused by one or more of many serious health conditions such as congenital anomalies, genetic disorders, cancer, and preterm birth. During 2010 to 2014, child deaths due to natural causes consistently accounted for over 70 percent of child deaths. The percent of child deaths due to natural causes has remained relatively stable during this period. However, in 2014 the percent of child deaths due to natural causes began to increase.

Child deaths in which the manner of death was deemed undetermined accounted for 10 percent of child deaths from 2010 to 2014. A death is classified as being undetermined when the information surrounding the death (that was available at the time to authorities completing the investigation) was insufficient to determine the manner of death. Undetermined child deaths have consistently accounted for over 10 percent of child deaths in Hamilton County. However, since 2011, the percent of child deaths that were deemed as undetermined have began to trend downward. Accidental deaths accounted for eight percent of child deaths from 2010 to 2014.

Accidental deaths are deaths in which “there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional.” Accidental deaths remained relatively stable from 2010 to 2014. In 2014, the percent of accidental child deaths slowly began to trend downward.

Child homicides in Hamilton County accounted for six percent of child deaths from 2010 to 2014. Between 2010 and 2013, the percent of child deaths that were due to homicides slowly increased in Hamilton County. In 2014, the percent of child deaths due to homicides began to slowly decrease.
Suicides represent the smallest percentage of child deaths in Hamilton County. Two percent of child deaths from 2010 to 2014 were due to suicides. From 2010 to 2013, the percent of child deaths that were due to suicides slowly increased, and in 2014 the percent of suicide child deaths began to decrease.

The cause of death is the actual mechanism by which the death occurred. There are four different categories into which a cause of death can be classified:

- A medical condition
- Undetermined if injury or medical condition
- External causes due to injury
- Unknown

If a cause of death was due to a medical condition, the deaths are further classified by the specific medical condition or disease that contributed to the death of the child. If a child death was from external causes due to injury, the nature of the injury is further classified and how the injury occurred is also detailed. Injury is defined as being “any unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy that exceeds a threshold of tolerance in the body from the absence of such essentials as health or oxygen.” If a cause of death is unable to be classified as a death due to a medical condition or from external causes, the death is classified as being undetermined if injury or a medical condition caused the child’s death. There are instances in which no information on the primary cause of death is available or known. In these types of cases, the cause of death is deemed unknown. There were no deaths in Hamilton County from 2010 to 2014 in which the cause of death was unknown.

The most common cause of death for children in Hamilton County was due to a medical condition (74 percent). Child deaths due to a medical condition have historically accounted for over 70 percent of child deaths. Between 2010 and 2013, the percent of child deaths due to a medical condition remained relatively stable. In 2014, the percent of child deaths due to a medical condition increased. Child deaths in which the cause of death was due to external causes accounted for 16 percent of child deaths from 2010

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**DID YOU KNOW?**

Between 2010-2014:

3 out of every 4 Child deaths in Hamilton County were due to natural causes.

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**Hamilton County Child Deaths by Cause of Death, 2010-2014**

Note: There were no child deaths in Hamilton County between 2010 and 2014 where a cause of death was unknown.
to 2014. The percent of child deaths due to external causes remained relatively stable from 2010 to 2012 at 15 percent. In 2013, there was an increase in the percent of child deaths caused by external causes. However, in 2014, the percent of deaths decreased to 2012 levels. The percent of child deaths whose cause was unable to be determined if the death was the result of an injury or medical condition accounted for 10 percent of child deaths from 2010 to 2014. Since 2011, the percent of child deaths whose cause was unable to be determined has been trending downwards.

**Preventability Classification**
Death rates for children are widely recognized as a valuable measure of the health and well-being of children in a community. The Hamilton County CFRT works to reduce the number of child deaths in Hamilton County, and to improve the health and wellbeing of children living in Hamilton County. Each death is reviewed to determine if the death of the child was considered to have been a preventable death. A child death is considered to have been preventable if the circumstances that caused the death of the child could have been changed by either the parent, individual, or the community. Once the CFRT reviews the death, it is classified as either “Yes, Probably Preventable,” “No, Probably Not Preventable” or “Team Could Not Determine.” Oftentimes, a case may be deemed as not being able to have been prevented, or based on the circumstances surrounding the case, it was unable to be determined as to whether the child death was preventable. These cases are nonetheless important, as the CFRT is able to identify areas where there are gaps in care, and community factors that could influence health outcomes. Recommendations for these types of cases are still given by the CFRT as a way to work toward improving health and wellness, and preventing the deaths of children in the future.

**Report Sections**
To prevent our children from dying, we must understand more about how and why our children are dying. This report analyzes the following types of death in-depth to better understand child deaths in Hamilton County:

- Deaths due to a medical condition
- Motor vehicle deaths
- Homicides
- Suicides
- Sleep-related deaths
- Drownings
- Asphyxia deaths
- “Other types of child death”

Each section will conclude with the preventability of each type of death along with the recommendations made by the Hamilton County CFRT on how communities can work at preventing these types of death.
Medical Deaths

As illustrated previously, the majority of child deaths in Hamilton County are caused by a medical condition. When a death is due to a medical condition it is the result of the natural progression of a disease, ailment, disorder, or prematurity. A death due to a medical condition is further identified and classified into one of 17 medical conditions that contributed to the death of a child:

- Asthma
- Cancer
- Cardiovascular
- Congenital Anomaly
- HIV/AIDS
- Influenza
- Low Birth Weight
- Malnutrition/Dehydration
- Neurological/Seizure Disorder
- Pneumonia
- Prematurity
- SIDS
- Other Infection
- Other Perinatal Condition
- Other Medical Condition
- Undetermined Medical Cause
- Unknown

Seventy-four percent of all child deaths in Hamilton County from 2010 to 2014 were due to a medical condition. From 2010 to 2012, the percent of child deaths in Hamilton County due to a medical condition remained relatively stable. In 2013, the percent of child deaths due to a medical condition was the lowest during the 2010 to 2014 period (70 percent). However, in 2014 the percent of child deaths due to a medical condition sharply increased to the highest percent over the five year period (81 percent).

Age

While medical conditions can affect everyone, child deaths due to a medical condition in Hamilton County disproportionately impact infants younger than one year of age. Eighty-three percent of all child deaths due to a medical condition were to infants (children less than one year of age).

When age is further broken out, disparities begin to emerge. Children who are less than 28 days of age (neonates) accounted for 49 percent of child deaths due to a medical condition from 2010 to 2014. Post-neonates (infants who are between 28 days of age and one year of age) accounted for the second largest percentage of child deaths due to a medical condition (34 percent).

As a child gets older, the percent of deaths due to a medical condition drastically drops. Children who are between one and four years of age accounted for six percent of child deaths due to a medical condition. Children who are between five and nine accounted for five percent of child deaths due to a medical condition. Four percent of child deaths due to a medical condition were to children who were between 10 and 14, while older children who are between 15 and 17, accounted for the smallest percent
(three percent) of child deaths due to a medical condition in Hamilton County.

**Sex**
Child deaths that are due to a medical condition not only are disproportionately higher in infants in Hamilton County, the percent of deaths due to a medical condition are higher among male children. Fifty-nine percent of child deaths due to a medical condition in Hamilton County from 2010 to 2014 were to male children.

**Race/Ethnicity**
Sex and age are not the only inequities in child deaths due to a medical condition in Hamilton County; when the race/ethnicity of the child is taken into account, further inequities emerge. As illustrated previously, non-Hispanic black children account for the largest percent of all child deaths in Hamilton County. Non-Hispanic black children also account for the highest percentage of child deaths that were due to a medical condition. From 2010 to 2014, 54 percent of child deaths that were due to a medical condition were to non-Hispanic black children. The percent of child deaths to non-Hispanic black children that were due to a medical condition was nearly 1.5 times higher than for non-Hispanic white children and 6 times higher than for non-Hispanic multi-racial, non-Hispanic other races, and Hispanic children combined.

Non-Hispanic white children accounted for the second highest percentage (38 percent) of child deaths that were due to a medical condition in Hamilton County from 2010 to 2014. Children who were non-Hispanic multi-racial accounted for three percent of child deaths that were due to a medical condition. Children who were non-Hispanic and identified with another racial group accounted for the smallest percentage of child deaths due to a medical condition (two percent). Hispanic children accounted for three percent of child deaths that were due to a medical condition from 2010 to 2014 in Hamilton County.

Prematurity, congenital anomalies and other types of medical conditions, not listed on page 18 of this report, were the top three leading medical conditions that caused a child’s death from 2010 to 2014 in Hamilton County.
The largest percentage (60 percent) of child deaths due to a medical condition in Hamilton County were caused by prematurity. Prematurity, also known as preterm birth, is the birth of a baby that is at least three weeks prior to the baby’s due date (<37 weeks gestation)\(^8\). Preterm birth can cause many health complications for the child later in life, such as long-term motor, cognitive, visual, behavioral, and growth problems\(^9\).

Congenital anomalies accounted for 14 percent of child deaths due to a medical condition. A congenital anomaly, more commonly known as a birth defect, is a serious condition that changes the structure of one or more parts of the body that can affect almost any part of the body (e.g., heart, brain)\(^10\). Other types of medical conditions that are not captured by the CFR online data system accounted for six percent of the child deaths due to a medical condition.

**Preventability**

Many health conditions can result in the death of a child, and it is believed that many of the medical conditions cannot be considered to be preventable in the same way an accident or homicide is deemed preventable. However, there are some instances in which the illness, disorder or deaths may have been prevented. Early screening and detection, consistent and early prenatal care and counseling that may aid in the prevention of some medical conditions\(^1\). Not all medical conditions can be prevented, however, early and appropriate detection and treatment can aid in the prevention of the death of a child due to a medical condition.

The Hamilton County CFRT deemed that 53 percent of child deaths between 2010 and 2014 that were due to a medical condition were probably not preventable. The Hamilton County CFRT could not determine, based on the circumstances surrounding the case, if the death of the child could have been prevented in 46 percent of child deaths due to a medical condition. One percent of child deaths due to a medical condition between 2010 and 2014 could have been prevented by changing various circumstances that led to the death of the child.

**Recommendations to prevent child deaths due to medical conditions.**

**Community Awareness**

- Community awareness around the seriousness of asthma
- Community awareness on the seriousness of medical situations (i.e. if diagnosed with a condition stress importance of keeping up with appointments and treatment plans).

**Physician Awareness**

- Physician awareness on the importance of educating parents on the signs/symptoms of Type I and Type II diabetes.
- Physician awareness on the importance of doing diabetes and blood sugar level testing at annual check-ups.
Motor Vehicle Deaths

Motor vehicle injuries are a leading cause of death among children in the United States\(^\text{11}\). However, many of these deaths can be prevented. Between 2010 and 2014, three percent of all child deaths in Hamilton County were due to motor vehicle accidents. Child deaths due to motor vehicle accidents have remained relatively stabled, accounting for less than five percent of child deaths during 2010 to 2014.

**Age**

Motor vehicle accidents can happen to anyone, however, new teen drivers are at a high risk for causing a motor vehicle accident\(^\text{12}\). The majority of child deaths that were due to motor vehicle accidents in Hamilton County were among older children. Forty-one percent of child deaths due to motor vehicle accidents between 2010 and 2014 were children between 15 and 17 years of age. Younger children, between one and four-years-of-age, accounted for the second highest percent (32 percent) of child deaths due to motor vehicle accidents during 2010 to 2014. Fourteen percent of child deaths that were due to motor vehicle accidents were to children who were between 10 and 14. Children who were between five and nine also accounted for 14 percent of child deaths that were due to motor vehicle accidents between 2010 and 2014.

**Sex**

Child deaths that are due to motor vehicle accidents not only are disproportionately higher in older children in Hamilton County, but the percent of deaths due to motor vehicle accidents are higher among male children. Seventy-three percent of child deaths that were due to motor vehicle accidents between 2010 and 2014 in Hamilton County were to male children. Female children accounted for 27 percent of child deaths due to motor vehicle accidents in Hamilton County.

**Age/Sex Combined**

When sex and age of the child are coupled together, further inequalities in
child deaths due to motor vehicle accidents emerge. Male children who were between 15 and 17 years of age accounted for the largest percentage of child deaths due to motor vehicle accidents from 2010 to 2014. Thirty-two percent of child deaths due to a motor vehicle accident were to male children between 15 and 17. The percent of child deaths due to motor vehicle accidents to male children between 15 and 17 was 3.5 times higher than their female counterparts in the same age group. Female children who were between 15 and 17 accounted for nine percent of child deaths due to motor vehicles accidents in Hamilton County between 2010 and 2014. Male children who were between one and four accounted for the second largest percent of child deaths due to motor vehicles, 18 percent. Female children between one and four accounted for 14 percent of child deaths due to motor vehicle accidents. Male children who were between 10 and 14 also accounted for 14 percent of child deaths due to motor vehicle accidents. Nine percent of child deaths between 2010 and 2014 that were due to motor vehicle accidents in Hamilton County were to male children between five and nine-years-of-age. Female children who were between five and nine accounted for the smallest percentage of child deaths due to motor vehicle accidents; five percent.

Race/Ethnicity
As illustrated previously, non-Hispanic black children in Hamilton County represented the largest percentage of child deaths. Non-Hispanic black children also accounted for the largest percentage of child deaths that were due to motor vehicle accidents. Fifty-five percent of child deaths due to motor vehicle accidents from 2010 to 2014 in Hamilton County were to non-Hispanic black children. Non-Hispanic white children accounted for a slightly smaller percentage of the child deaths due to motor vehicle accidents, 45 percent.

**DID YOU KNOW?**
Between 2010-2014:

1 Car accident involving a child as a driver, occupant, or pedestrian occurs in Hamilton County
**Geography**

As shown by the map to the right, inequities in child deaths due to motor vehicle accidents appear by Hamilton County community. Not all communities witnessed a child death due to a motor vehicle accident between 2010 and 2014. The urban core of Hamilton County, the City of Cincinnati, experienced the largest number of child deaths due to motor vehicle accidents from 2010 to 2014. However, the areas with the largest number of child deaths due to motor vehicle accidents were not the Hamilton County communities that had the largest percentage of motor vehicle accidents that involved children (either as the driver, occupant or pedestrian).

**Vehicle Position**

In 23 percent of child deaths in Hamilton County from 2010 to 2014 that were due to motor vehicle accidents, the child was the driver. In 36 percent of child deaths due to motor vehicle accidents in Hamilton County from 2010 to 2014 the child was the passenger in the vehicle. Children who were pedestrians (which include those children who were on bicycles and struck by a car) accounted for 36 percent of child deaths due to motor vehicle accidents from 2010 to 2014. In five percent of child deaths due to motor vehicle accidents the position of the child at the time of the accident was unknown.

**Passenger Location**

As illustrated previously, in over one-third of all child deaths due to motor vehicle accidents in Hamilton County from 2010 to 2014 the child was a passenger in the vehicle at the time of the accident. In 63 percent of child deaths due to motor vehicle accidents in which the child was a passenger, the child was sitting in the back seat of the car at the time of the accident. In 38 percent of child deaths in which the child was a passenger, the child was sitting in the front seat of the car at the time of the accident.
Seatbelt/Car Seat/Booster Seat Use
One of the most effective ways individuals can prevent injury or death due to a motor vehicle crash is by using a seatbelt or booster/car seat for small children. In the State of Ohio every driver and front seat passenger must wear a seatbelt. In 27 percent of child deaths from 2010 to 2014 in Hamilton County that were due to a motor vehicle accident, the child was properly restrained using a seatbelt/car seat/booster seat. In five percent of child deaths due to motor vehicle accidents the child was restrained using a seatbelt/car seat/booster seat, however, it was not used properly. Children who were not using a seatbelt/car seat/booster seat accounted for 18 percent of child deaths due to motor vehicle accidents. For the majority of child deaths due to motor vehicle accidents, 41 percent, a seatbelt/car-seat/booster-seat was not needed. In these instances the child was not in a motor vehicle at the time of the accident. In nine percent of child deaths due to motor vehicles it was unknown whether the child was restrained using a seatbelt/car seat/booster seat.

Children in the State of Ohio are required to use booster seats once they outgrow their car seat and until they are either eight years old or at least four feet nine inches tall. Eighteen percent of child deaths due to motor vehicle accidents in Hamilton County from 2010 to 2014 involved a child passenger who was younger than 10 years of age. In 25 percent of child deaths due to motor vehicle accidents that involved a child as a passenger that was 10 years of age and younger, the child was in a car seat/booster seat that was not properly used. This could mean that the child was not properly restrained in the seat, or the incorrect type of car seat/booster seat was used for the child’s age and/or height and weight. In 75 percent of child deaths due to motor vehicle accidents that involved a child as a passenger that was 10 years of age and younger did not have a car seat/booster seat, but based on the child’s age and/or height and weight needed one.

Contributing Factors
There are many factors that can cause a car accident. From 2010 to 2014, in 32 percent of child deaths that were due to motor vehicle accidents, speeding over the posted speed limit was a factor in the car accident. Drugs and/or alcohol was a factor in 32 percent of child deaths due to motor vehicle accidents.
in Hamilton County. In 23 percent of child deaths due to motor vehicle accidents reckless driving was a factor. Running a red light or stop sign was a factor in 14 percent of child deaths due to motor vehicle accidents. Distracted drivers were a factor in five percent of child deaths due to motor vehicle accidents. Drivers can be distracted by multiple things such as cell phones, radios, and other passengers. Rollovers were a factor in five percent of deaths due to motor vehicle accidents. Thirty-two percent of child deaths had other factors that contributed to the death. These are factors such as darting/walking across a road and not yielding to traffic, and running from the police.

Preventability

Motor vehicle accidents are a public health problem, and many deaths due to motor vehicle accidents can be prevented. The Hamilton County CFRT deemed that 95 percent of child deaths between 2010 and 2014 that were due to motor vehicle accidents could have been prevented. The Hamilton County CFRT could not determine, based on the circumstances surrounding the case, if the death of the child could have been prevented in five percent of child deaths due to a motor vehicle accident.

Recommendations to prevent child deaths due to motor vehicle accidents.

Community Awareness

- Community awareness around the importance that proper restraints (car seat/booster seat) for the age and/or height and weight of a child be used while they are in a vehicle.
- Community awareness on the importance of wearing your seatbelt.
- Community awareness on the importance of driving cautiously in and around a school zone.
- Community awareness on safe driving practices, do not drive distracted, and if you cannot make it, or think you cannot make it in time, do not pull out into traffic, wait until there is room.
- Community awareness on the importance of not letting your children play in or around streets/roadways.
- Community awareness on the importance of knowing where your children are during all times of the night regardless of age.

Policy Change

- Change in policy that courts should order mandatory drug treatment after an individual has been arrested on drug related charges more than twice.

Continued Education

- Make literature (advertise brochures, posters, flyers) available that indicate which fire department and/or location can help check to ensure that a car-seat is fastened properly.
- Continued education to high school children on the importance of not drinking, doing drugs and driving, and not getting into a vehicle with someone who is under the influence.
Homicides are a serious public health problem and can have lasting effects on communities. Homicide is an extreme outcome of the broader public health problem of interpersonal violence\textsuperscript{15}. Child homicides can have profound long-term emotional consequences on families and friends of victims and witnesses to the violence\textsuperscript{16}. They can also cause excessive economic costs to residents of affected communities\textsuperscript{16}. Between 2010 and 2014, six percent of all child deaths in Hamilton County were due to homicides. In 2010, the percent of child deaths due to homicides was the lowest in the five year time period of 2010 to 2014 (four percent). From 2010 to 2013, the percent of child deaths that were due to homicides slowly increased to seven percent, the highest in five year time period of 2010 to 2014.

### Age

Homicides of children are most often murders of teens by other teens\textsuperscript{17}. The majority of child homicides in Hamilton County were to older children. Thirty-four percent of child homicides were to children who were between 15 and 17 years of age. Children who were between one and four accounted for the second largest percentage of child homicides (24 percent). Twenty-percent of child homicides were to children between 10 and 14. Infant children who were between 28 days and one year of age accounted for 17 percent of child deaths that were due to homicides. Children who were between five and nine accounted for the smallest percentage (five) of homicides to Hamilton County children from 2010 to 2014.

### Sex

Child homicides are not only disproportionately higher in older children in Hamilton County, but the percent of homicides are also higher in male children. Sixty-six percent of child homicides between 2010 and 2014 in Hamilton County were to male children. Female children accounted for 34 percent of child homicides in Hamilton County between 2010 and 2014.
Race/Ethnicity
When the race/ethnicity of the child is taken into account, inequities in child homicides in Hamilton County emerge. Non-Hispanic black children, as illustrated previously, account for the largest percentage of all child deaths in Hamilton County. Non-Hispanic black children also accounted for the highest percentage of child deaths that were due to homicides. From 2010 to 2014, 73 percent of child deaths that were due homicides were to non-Hispanic black children. The percent of homicides to non-Hispanic black children was three times higher than the homicides to non-Hispanic white children and 30 times higher than homicides to Hispanic children. Non-Hispanic white children represent the second highest percentage of child homicides in Hamilton County from 2010 to 2014 (24 percent). Hispanic children represented the smallest percentage (2 percent) of child homicides in Hamilton County.

Sex and Race/Ethnicity Combined
When sex and race/ethnicity are coupled together, further inequities in child homicides in Hamilton County emerge. Non-Hispanic black male children accounted for the largest percentage of child homicides from 2010 to 2014. Forty-six percent of child homicides in Hamilton County between 2010 and 2014 were to non-Hispanic black males. The percent of homicide deaths to non-Hispanic black male children was nearly three times higher than homicides to non-Hispanic white children and 19 times higher than homicides to Hispanic male children in Hamilton County. Non-Hispanic black females represented the second highest percentage of child homicides from 2010 to 2014 (27 percent). The percent of deaths to non-Hispanic black females is nearly four times higher than homicides to non-Hispanic white female children, and 1.5 times higher than homicides to non-Hispanic white male children in Hamilton County. Seventeen percent of child homicides in Hamilton County from 2010 to 2014 were to non-Hispanic white male children. Non-Hispanic white female children accounted for seven percent of child homicides in Hamilton County.

### Hamilton County Child Homicides by Race/Ethnicity, 2010-2014

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic white</td>
<td>24%</td>
</tr>
<tr>
<td>non-Hispanic black</td>
<td>73%</td>
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<tr>
<td>Hispanic, Any Race</td>
<td>2%</td>
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</tbody>
</table>

### Hamilton County Child Homicides by Race/Ethnicity and Sex, 2010-2014

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<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>46%</td>
<td>27%</td>
</tr>
<tr>
<td>Hispanic, Any Race</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hispanic female children are not shown as there were no child homicides to Hispanic female children in Hamilton County between 2010 and 2014.

N=41

### DID YOU KNOW?

Between 2010-2014:

1 Child homicide occurred in Hamilton County

EVERY 45 Days
from 2010 to 2014. Hispanic male children accounted for the smallest percentage of child homicides (two).

**Sociodemographics**

There are many community factors that can contribute to youth violence and child homicide. Diminished economic opportunities, high concentrations of poor residents, and low levels of community participation are some of the risk factors that can contribute to child homicide. Communities that have high levels of concentrated disadvantage oftentimes have less mutual trust and collective efficacy. Collective efficacy is critical for communities to inhibit the perpetuation of violence. Children who live and grow in disadvantage areas are more likely to experience violence. The urbanized areas in Hamilton County (City of Cincinnati and to the north) tend to have the highest levels of concentrated disadvantage as illustrated by the map above. Correspondingly, the majority of child homicides occurred within the communities that have high levels of concentrated disadvantage. Sixty-one percent of child homicides occurred in communities that had high levels of concentrated disadvantage. The percent of child homicides in communities with high levels of concentrated disadvantage is double the percent of child homicides that occurred in communities with medium levels of concentrated disadvantage (29 percent) and six times higher than the percent of child homicides that occurred in communities with low levels of concentrated disadvantage (10 percent).

**Alcohol and Substance Use**

Individual risk factors, such as involvement with drugs, alcohol or tobacco, poor behavior control, and exposure to violence, can also contribute to youth violence and child homicide. Ninety-percent of all child homicides in Hamilton County received a toxicology screen at the time of death. A toxicology screen refers to various tests that determine the type and approximate amount of legal and illegal drugs a person has taken. In 34 percent of child homicides, the child tested positive at the time of death for marijuana. In five percent of child homicides, the child tested positive for alcohol. In five percent of.
child homicides, the child tested positive for another drug/substance that is not captured by the CFR online data system. In 49 percent of child homicides, the child had a negative toxicology screen.

In 24 percent of child homicides in Hamilton County from 2010 to 2014, the child had a drug/substance abuse problem. In two percent of child homicides, the child did not have a drug/substance abuse problem. It was unknown if the child had a drug/substance abuse problem in 29 percent of child homicides in Hamilton County. In the majority of child homicides, 44 percent, having a drug/substance abuse problem was not applicable to the child. The instances in which a drug/substance abuse problem was not applicable it was due to the age of the child. This means that the child was too young (e.g., infant or toddler) to begin to use drugs to develop a drug/substance abuse problem.

**Juvenile Delinquency**

Delinquency is often associated with the perpetration of violence, however, delinquent youth are also at risk for early violent deaths. In 34 percent of child homicides in Hamilton County from 2010 to 2014, the child had a delinquent or criminal history. In 12 percent of child homicides the child did not have a delinquent or criminal history. It was unknown if the child had a delinquent or criminal history in five percent of child homicides from 2010 to 2014. In the majority of child homicides, 49 percent, having a delinquent or criminal history was not applicable to the child. In these instances, the child was too young (e.g., infant or toddler) to have a delinquent or criminal history.

Of the child homicides where the child had a delinquent or criminal history, 50 percent had a history of committing assaults. In 29 percent of child homicides, the child had a delinquent or criminal history of committing robberies. In 57 percent of child homicides, the child had a delinquent or criminal history of using and/or abusing drugs. In 93 percent of child homicides, the child had some other type of delinquent or criminal acts not captured by the CFR online data system. These delinquent or criminal acts include:
- Carrying a concealed weapon
- Criminal mischief
- Criminal damaging
- Criminal trespassing
- Unauthorized use of a motor vehicle
- Chronic truancy
- Obstruction
- Violation of court orders

A child who commits delinquent or unruly acts...
Criminal and antisocial parents often tend to have delinquent and antisocial children. Family risk factors such as parental substance abuse or criminality can contribute to youth violence and child homicide. In 37 percent of child homicides, the primary caregiver of the child had a delinquent or criminal history. The primary caregiver is defined as the person who had responsibility for the care, custody and control of the child the majority of the time. In 27 percent of child homicides, the primary caregiver of the child did not have a delinquent or criminal history. It was unknown if the primary caregiver had a delinquent or criminal history in 37 percent of child homicides.

**Preventability**

Child homicides are a public health problem, and many child homicides could have been prevented. The Hamilton County CFRT deemed that 93 percent of child homicides between 2010 and 2014 could have been prevented. Two percent of child homicides the Hamilton County, the CFRT deemed that the child homicide could not have been prevented. The Hamilton County CFRT could not determined, based on the circumstances surrounding the case, if the death of the child could have been prevented in five percent of child homicides.
Recommendations to prevent child homicides.

Community Awareness

- Community awareness on the safe practices of handling children (e.g., a child should never be shaken, no matter how much the child is crying or being fussy).
- Community awareness on the importance of knowing with whom you are leaving your children (such as knowing the individual's background and whether the individual has a criminal history or history of abuse).
- Community awareness on the importance of being careful with whom you associate with (e.g., if a person has a history of criminal activity and being a drug dealer you become guilty by association).
- Community awareness on the dangers of guns (e.g., why they should be properly stored and locked and kept out of the reach of children).
- Community awareness on what constitutes criminal activity and how children should stay away from any and all criminal activity.
- Community awareness that marijuana is still illegal in Ohio and is considered a narcotic even though other states have legalized it.
- Community awareness on the importance of educating youth on building healthy relationships, and good decisions/behavior.

Policy Change

- Policy change where domestic violence and abuse/neglect screening should be followed through in hospital settings.
- Policy change to provide access to counseling for mothers and fathers who are experiencing mental health problems.
- Policy change where schools teach and talk about bullying and its effects from elementary school through high school.
- Delinquency and truancy policy changes in school systems where children with delinquent and truancy concerns are kept in the school system as opposed to suspensions/expulsions.
- Policy change where the caseworker for the parent(s) involve daycares and schools to alert the caseworker to sudden changes in the demeanor, speech and mannerisms of the child's parent(s) to get the parent entered into counseling.
- Policy change that ensures all internal protocol, are met/followed to ensure that all associated parties are at the table when following up with case involvement.

Systems Change

- Systems change to enhance the utilization of the school system to address gun violence towards others.
- Systems change to enhance school follow-up for children with delinquent and truancy concerns.
- Systems change in school systems where children with delinquent and truancy concerns are kept in the school system as opposed to suspensions/expulsions.
- Systems change where domestic violence education/training and resources should be made available to help children recognize domestic violence and what to do when it is encountered.
- Systems review of the internal processes for child services to strengthen/build upon the social aspects of the family for the assigned social/case worker.
- Child Fatality Review system change where if an incident occurred in another county that caused the child to become disabled and the child subsequently moved to another county and died as a result of complications associated with the incident; the county where the incidence occurred should also review the case as information about the incident may not be available to the review board in the county in which the child died.
Suicides

Suicides are a serious public health problem and can have lasting effects on communities. Suicide rates vary by age group, and reasons for suicide are often complex. A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Suicide is the tenth leading cause of death in the United States, and it is estimated that more than 1 million people reported making a suicide attempt in 2012.

Between 2010 and 2014, two percent of all Hamilton County child deaths were suicides. In 2011, the percent of child suicides was the lowest in the five year time period of 2010 to 2014 (one percent). Since 2011, however, the percent of child suicides in Hamilton County increased to the highest percentage (five) in 2013. Suicide can impact all children, however, there are some groups that are at a higher risk than others.

Age

All child suicides in Hamilton County were to older children who were 10 years of age and older. A majority of child suicides, 65 percent, in Hamilton County from 2010 to 2014 were to children who were between 15 and 17. Thirty-five percent of child suicides in Hamilton County were to children between 10 and 14.

Sex

Suicide deaths are more likely to occur in male children than female children. In Hamilton County male children were disproportionately affected by a higher percentage of child suicides than their female counterparts. Eighty-two percent of child suicides in Hamilton County between 2010 and 2014 were to male children. Female children accounted for 18 percent of child suicides in Hamilton County for the same time period.
Sex and Age Combined
When sex and age are coupled together, further inequities in child suicides emerge. Male children who are between 15 and 17 years of age accounted for the largest percentage of child suicides in Hamilton County from 2010 to 2014. Fifty-three percent of child suicides were to male children between 15 and 17. The percent of child suicides to male children between 15 and 17 was nearly double the percent of male children who were between 10 and 14. Male children who were between 10 and 14 accounted for 29 percent of child suicides in Hamilton County between 2010 and 2014. Female children who were between 10 and 14-years-of-age accounted for the lowest percentage of child suicides, six percent. The percent of child suicides to female children between 15 and 17 (12) was double the percent of child suicides to female children between 10 and 14.

Race/Ethnicity
As illustrated previously, non-Hispanic black children accounted for the largest percentage of child deaths in Hamilton County between 2010 and 2014. However, non-Hispanic black children accounted for the smallest percentage of child suicides in Hamilton County. Thirty-five percent of child suicides were to non-Hispanic black children. Non-Hispanic white children accounted for the majority of child suicides (65 percent).

Child Maltreatment
Several factors can place children at an increased risk for suicide, such as stressful life events, history of depression or other mental illness, and a history of previous suicide attempts. However, just because a child has a risk factor for suicide does not mean that suicide will occur. One stressful life event a child may experience is being a victim of child maltreatment. Child maltreatment is any act or series of acts of child abuse or child neglect by a parent or caregiver that results in harm, potential for harm, or threat of harm to a child. In the majority of the child suicides (47 percent) in Hamilton County between 2010 and 2014, the child was not a victim of child maltreatment. It was unknown if the child was a victim of child maltreatment in 18 percent of child suicides. In 35 percent of child suicides, the child was a victim of child maltreatment. Of the child suicides where the child was a victim of child maltreatment, 67 percent were victims of physical abuse. Child neglect was the type of child maltreatment in 50 percent of child suicides. In 17 percent of child suicides, the child was a victim of sexual abuse. Emotional and/or psychological abuse was the type of child maltreatment in 17 percent of child suicides where the child was a victim of child maltreatment.
Depression and mental Illness

Having a history of depression or mental illness can increase the risk of child suicide. A mental illness is a condition that impacts a person's thinking, feeling, mood and may affect his or her ability to relate to others and function on a daily basis. In 35 percent of child suicides in Hamilton County from 2010 to 2014, the child had been diagnosed with a mental illness. Mental illnesses, such as depression and anxiety, can impact an individual's ability to participate in healthy behaviors, and can decrease an individual's ability to engage in treatment and recovery for their mental illness.

In 83 percent of child suicides in Hamilton County from 2010 to 2014 where the child had been diagnosed with a mental illness, the child had received professional treatment for a mental health problem either near the time of death or in the past. In 67 percent of child suicides where the child was diagnosed with a mental illness, the child was currently receiving mental health services. Children currently receiving mental health services, were in treatment which includes seeing a psychiatrist, psychologist, medical doctor, therapist or other counselor for a mental health or substance abuse problem; receiving a prescription for an antidepressant or other psychiatric medication, or residing in an inpatient or halfway house facility for mental health problems. In 50 of child suicides where the child was diagnosed with a mental illness, the child was on medications for a mental illness. This means that the child had an active prescription for psychiatric medication at the time of death.

Risk/Contributing Factors

The reasons a child commits suicides are often complex, and may have many risk/contributing factors that led to suicide. In 41 percent of all child suicides in Hamilton County from 2010 to 2014, the child had made prior suicide attempts. The child talked about suicide in 35 percent of child suicides. If a child talked about suicide, they only expressed that they thought about suicide, however, they never mentioned or described a plan for committing suicide. Prior suicide threats were made in 35 percent of child suicides in Hamilton County. When a child made a threat of suicide, they expressed their intent to kill themselves verbally.

There may be many reasons a child would commit suicide. In some instances, a suicide note may answer why the child committed suicide. In 24 percent of child suicides the child left a note that may provide some insight into why the child committed

<table>
<thead>
<tr>
<th>Hamilton County Child Suicides by Risk/Contributing Factor(s), 2010-2014</th>
</tr>
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<tbody>
<tr>
<td>Prior suicide attempts were made</td>
</tr>
<tr>
<td>Child talked about suicide</td>
</tr>
<tr>
<td>Prior suicide threats were made</td>
</tr>
<tr>
<td>Unknown personal crisis</td>
</tr>
<tr>
<td>Suicide note was left</td>
</tr>
<tr>
<td>Victim of bullying</td>
</tr>
<tr>
<td>Breakup with boyfriend/girlfriend</td>
</tr>
<tr>
<td>Self-mutilation/Cutting oneself</td>
</tr>
<tr>
<td>Parents divorced/separated</td>
</tr>
</tbody>
</table>

Note: Percentages do not equal 100 percent as multiple factors can contribute to child suicide
suicide. In 29 percent of child suicides, the child was going through some form of personal crisis, but it was unknown at the time of death what that crisis was that contributed to the child committing suicide. In 18 percent of child suicides, the child was a victim of bullying which contributed to the child committing suicide. Breaking up with one’s boyfriend/girlfriend was a contributing factor in 18 percent of child suicides. Repetition of deliberate self-harm (e.g., self-mutilation/cutting oneself) is a risk factor for suicide\(^29\). In 18 percent of child suicides in Hamilton County from 2010 to 2014, the child had a history of self-mutilation/cutting oneself. Divorce/separation of the parents can be a large challenge for not only the parents, but the children as well. Parents who are going through or currently are divorced/separated was a contributing factor in 12 percent of child suicides in Hamilton County.

**Preventability**

While these are a few of the risk/contributing factors, suicides are complex and no one risk/contributing factor can answer why the child committed suicide. Child suicides can have a lasting impact on family, friends and the community, however, most of these tragic deaths could have been prevented. The Hamilton County CFRT deemed that 88 percent of child suicides between 2010 and 2014 could have been prevented. The Hamilton County CFRT could not determine, based on the circumstances surrounding the case, if the death could have been prevented in 12 percent of child suicides.

**Recommendations to prevent child suicides.**

**Community Awareness**
- Increased presence of suicide awareness that highlights the signs to look for in children and if a child expresses suicidal ideations they should be taken seriously as this can be the child’s call for help.
- Community awareness on the importance of education to children on bullying and the effects it can have, and that you should seek help if you are being bullied.
- Community awareness on the importance of monitoring a child who is taking medication that can cause suicidal thoughts as a side effect to ensure a child does not act upon these thoughts.

**Systems Change**
- Systems change in schools that the school psychologists should be proactive and not reactive in their work; every student should have a “drop in” session with the school psychologist to normalize visits to talk about any problems they or their friends may have.

**Policy Change**
- Policy change to improve the linkage to mental health services and follow-up with children who have mental health issues.

**Program Development**
- Creation of a text messaging service in schools that if a child is having problems or is in distress they can send a text to a phone number and get linked to a school psychologist and counselor to help them through the situation.
- The creation of peer counseling groups in school where other students can help each other out through tough times, as it may be easier for some students to talk with their peers.
- The creation of a youth mental health first aid kit for non-mental health professionals. This would provide education to other professionals who interact with the children on a day-to-day basis (e.g., teachers, faculty) to identify signs and symptoms of when a child may be suffering and are unable to, or unwilling to, speak up for themselves.
- Creation of a program in which parents who are going through divorces/separation can bring their child to aid in the transition in order to have the least amount of impact on the child’s behavior and emotional state.
Sleep-Related Deaths

A sleep-related death is the death of a child that is related to the child sleeping or the sleep-environment of the child. The sleeping environment, sleeping position, sleeping location of the child, and co-sleeping all can contribute to a child suffering from a sleep-related death. Between 2010 and 2014, 11 percent of child deaths in Hamilton County were sleep-related deaths. From 2010 to 2013, the percent of sleep-related child deaths in Hamilton County remained relatively stable accounting for 12 to 13 percent of child deaths. In 2014, the percent of child deaths witnessed a decrease to the lowest percentage (five) in the five year time frame of 2010 to 2014. However, while the percentage of sleep-related child deaths decreased in 2014, recent preliminary data show an increasing trend in the sleep-related deaths in Hamilton County. These data will be analyzed in next year’s CFR Annual Report.

**Percent of Hamilton County Child Deaths that were Sleep-Related, 2010-2014**

![Graph showing the percentage of Hamilton County child deaths that were sleep-related, 2010-2014]

**Data**
- **Age**
  - Deaths attributed to the sleep-environment can impact a child of any age. In Hamilton County the majority of sleep-related deaths between 2010 and 2014 were to infants. Ninety-two percent of sleep-related deaths were to infants who were between 28 days and one year of age. Children who were between one and four years of age accounted for eight percent of sleep-related deaths in Hamilton County.

**Sex**
- Sleep-related deaths are not only disproportionately higher in infants in Hamilton County, but the percent of sleep-related deaths are also higher in male children. Sixty-one percent of sleep-related deaths in Hamilton County between 2010 and 2014 were to male children. Female children accounted for 39 percent of sleep-related deaths.

**DID YOU KNOW?**
- Between 2010-2014:
  - **1 Sleep-related death occurred in Hamilton County**
  - **EVERY 23 Days**
When the race/ethnicity of the child is taken into account, inequities in the sleep-related deaths in Hamilton County emerge. Over half (57 percent) of all sleep-related deaths in Hamilton County were to non-Hispanic black children. The percent of sleep-related deaths to non-Hispanic black children was nearly two times higher than the percent of sleep-related deaths to non-Hispanic white children, nearly eight times higher than the percent of sleep-related deaths to non-Hispanic multi-racial children, and 45 times higher than the percent of sleep-related deaths to Hispanic children. Non-Hispanic white children accounted for 34 percent of sleep-related deaths between 2010 and 2014 in Hamilton County. Eight percent of sleep-related deaths in Hamilton County were to non-Hispanic multi-racial children. Hispanic children accounted for the smallest percentage of sleep-related deaths in Hamilton County between 2010 and 2014 (one percent).

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic white</td>
<td>34%</td>
</tr>
<tr>
<td>non-Hispanic black</td>
<td>57%</td>
</tr>
<tr>
<td>non-Hispanic multi-racial</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic, Any race</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Sociodemographics**

The sleeping arrangements of infants and children, which can increase or decrease the risk of a sleep-related death, can be influenced by a combination of parental values, socioeconomic factors and cultural diversity. One way to look at how multiple sociodemographic factors interact to influence disparities in sleep-related deaths is to look at the level of concentrated disadvantage in the community where the child resides. Communities with high levels of concentrated disadvantage are at an increased risk for higher rates of infant mortality. The urbanized areas in Hamilton County (City of Cincinnati and to the north) tend to have the highest levels of concentrated disadvantage, as illustrated by the map above. Correspondingly, half of the sleep-related child deaths occurred within the communities that have high levels of concentrated disadvantage. Fifty-one percent of sleep-related child deaths occurred in communities that had high levels of concentrated disadvantage. The percent of sleep-related child deaths in communities with high levels of concentrated disadvantage is slightly higher than the percent of sleep-related child deaths in communities with medium levels of concentrated disadvantage (43 percent) and is nearly seven times higher than the percent of sleep-related child deaths that occurred in communities with low levels of concentrated disadvantage (eight percent).
Manner and Cause of Death
Oftentimes, no one sees sleep-related deaths occur, and there can be many questions as to what caused the death of the child. Identifying the manner and cause of death of the child can help to identify what may have caused the death of the child. Between 2010 and 2014, 14 percent of sleep-related child deaths in Hamilton County were due to asphyxia (i.e. suffocation). One percent of sleep-related deaths were caused by Sudden Infant Death Syndrome (SIDS). SIDS is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted. In the majority of sleep-related deaths (85 percent), it was undetermined if the death was a result of injury or a medical cause. These deaths are often considered to be Sudden Unexplained Infant Death (SUID).

There are no tests that can be done to distinguish SIDS from suffocation. It is through a thorough investigation to gain a better understanding of the circumstances and events involved with the sleep-environment associated with the sleep-related deaths that can help to reduce these types of deaths in the future. The appropriate safe sleep-environment (even during nap time) is to follow the ABCs of safe sleep; alone, back, crib.

Co-Sleeping
Sleeping alone means the child should be sleeping without an adult, other children, pillows, blankets or stuffed animals in the crib or bassinet. Between 2010 and 2014, over half (57 percent) of sleep-related deaths in Hamilton County, the child was co-sleeping with either their parent(s), sibling(s), or caregiver(s). Co-sleeping is when a parent, sibling, or caregiver sleeps on the same surface close enough to the child that they can see and hear the child. In 39 percent of sleep-related deaths in Hamilton County, the child was not co-sleeping at the time of death. It

DID YOU KNOW?
Baby sleeps safest alone, on their back, in a crib.

ALWAYS FOLLOW THE ABC’S OF SAFE SLEEP, EVEN DURING NAP TIME
was unknown, based on the investigation, if the child was co-sleeping at the time of death in four percent of sleep-related deaths.

**Items Present During Sleep**

Having items in the same crib/bassinette or around the child can increase the risk for a sleep-related death. In over half (53 percent) of the sleep-related deaths in Hamilton County from 2010 to 2014, an adult was sleeping with the child at the time of death, also known as co-sleeping. In 15 percent of sleep-related deaths, another child was sleeping in the same bed or crib with the child at the time of death. In 16 percent of sleep-related deaths, a pillow, whether under or next to the child, was present at the time of death. Having items such as pillows, blankets and sheets can increase the risk that a child, particularly an infant, can become entangled/trapped in the item and suffer from a sleep-related death. In 13 percent of sleep-related deaths a comforter/blanket was present in the sleep-environment at the time of death. Other items (e.g., food and hygiene products) were present on the sleep surface with the child at the time of death in 11 percent of sleep-related deaths. A thin sheet was present in 11 percent of sleep-related deaths. In eight percent of sleep-related deaths a mattress was present and contributed to the death of the child (e.g., entrapment under or between a mattress and another object). In four percent of sleep-related deaths, a wall was present in which it contributed to the death of a child (e.g., child wedged next to wall). A boppy pillow, a specific type of pillow used to support the child during breastfeeding and playtime, was present in the sleep environment in three percent of sleep-related deaths in Hamilton County. A cushion, such as couch cushion, was present in the sleep environment of three percent of sleep-related deaths. In one percent of sleep-related deaths in Hamilton County, bumper pads were present in the sleep environment. Clothing, whether it was the child’s or parent’s/caregiver’s, was present in the sleep environment in one percent of sleep-related deaths.

**Sleep Position**

The sleep position of the child is also part of the sleep environment. Placing a child on their back to sleep for every sleep, including nap time, can help to reduce the risk of the child suffering from SIDS and other sleep-related causes of death. In 44 percent of sleep-related deaths in Hamilton County between 2010 and 2014, the child was placed to sleep on their back. The child was placed to sleep on their stomach in 27 percent of sleep-related deaths. In eight percent of sleep-related deaths, the child was placed to sleep on their side. It was unknown in what position the child was placed to sleep in 22 percent of sleep-related deaths.
Of the sleep-related deaths where the child was placed on their back to sleep, 46 percent were co-sleeping with a parent, caregiver, or another child. It was unknown whether the child was co-sleeping in three percent of sleep-related deaths where the child was placed to sleep on their back. In the majority (54 percent) of sleep-related deaths where the child was placed on their back to sleep, they were not co-sleeping. However, not all children who were not co-sleeping and put to sleep on their back were in a safe sleep environment. Thirty-two percent of sleep-related deaths where the child was placed to sleep on their back and were not co-sleeping had other items, such as pillows, blankets, and/or bumper pads in their sleep environment at the time of death.

**Sleep Location**

A safe sleep environment includes the child sleeping in a crib and/or bassinet. In 41 percent of sleep-related deaths in Hamilton County between 2010 and 2014, the child was sleeping in an adult bed. In 19 percent of sleep-related deaths, the child was put to sleep in a crib. A bassinet was the sleeping location of nine percent of sleep-related deaths in Hamilton County. In three percent of sleep-related deaths, the child was put to sleep in a playpen or some other type of play structure. A couch was the sleeping location of 13 percent of sleep-related deaths in Hamilton County. The child was put to sleep in a chair in one percent of sleep-related deaths. A car seat was the location in which the child was put to sleep in three percent of sleep-related deaths. (Car seats should only be used during transportation of the child in a car and should not be used as sleeping areas outside of the car.) In one percent of sleep-related deaths, the child was put to sleep on a futon. Other sleeping locations such as a bouncy seat, or infant swing accounted for nine percent of sleep-related deaths in Hamilton County. It was unknown where the child was put to sleep in three percent of sleep-related deaths.
Many of the sleep-related deaths in Hamilton County possibly could have been prevented by following the ABCs of safe sleep. The Hamilton County CFRT determined that 63 percent of sleep-related deaths in Hamilton County between 2010 and 2014 could have been prevented. The Hamilton County CFRT determined that sleep-related death could not have been prevented in three percent of sleep-related deaths. The Hamilton County CFRT could not determine, based on the circumstances surrounding the case, if the death of the child could have been prevented in 34 percent of sleep-related deaths.

**Recommendations to prevent sleep-related child deaths.**

**Community Awareness**
- Community awareness about the importance of not using drugs or being under the influence of drugs when you are caring for your children.
- Community awareness that a car seat is not a safe sleep environment and that it should only be used to transport a child when in a car and should not to be used for their sleep location.
- Community awareness that the ABCs of safe sleep apply to anytime the child is sleeping, including nap time.
- Community awareness about the importance that the parent(s), caregiver(s), and/or babysitter(s) need to stay awake when they are watching the child.
- Community awareness that there is no safe way to co-sleep.
- Community awareness to parents of multiples (e.g., twins, triplets) that all children should be asleep in their own crib and should not be allowed to have the babies sleep in the same crib.

**Systems Change**
- Systems change where information is provided to all potential caregivers and care-takers not solely the mother of the child (e.g., family members, friends, boy/girlfriends and nannies).
- Systems change where any individual who reports the death (e.g., hospital or Coroner’s office) needs to report all deaths of children under 18 years of age to the appropriate child protective services agency.
- Systems change that all child protective services agencies have a standard set of screening processes and procedures they are required to do for every sleep-related death in their county to allow all child deaths to be screened equally so no case goes unreported to the appropriate agency.
- Change in safe sleep education that shows parents why it is important/good for the child to be put to sleep on their back through the use of pictures/illustrations.
- Standardized change back to sleep education that is targeted at fathers.
- Targeted approach to safe sleep education for those parents who have to use sedative medication for health ailments.

**Policy Change**
- Policy change that upon discharge from the hospital at the time of birth, the parent(s) has to sign a document that states they are now aware of safe sleep practices and if they are not followed there is an increased risk for an infant death.
- Policy change where birthing hospitals should not let the parent(s) leave until they can show proof that the home has a crib and/or pack’n’play and they have a properly installed car seat in which to transport the child home.
- A policy change where all child services agencies investigate all sleep-related deaths.
Drownings

Drowning is the fifth leading cause of unintentional injury death in the United States\(^3^5\). In Hamilton County, from 2010 to 2014, drownings are the tenth leading cause of unintentional injury death. One percent of all child deaths between 2010 and 2014 in Hamilton County were due to the child drowning. Historically, the percent of child deaths due to drowning in Hamilton County has accounted for less than two percent of child deaths. The highest percentage of child deaths due to drowning was two percent in 2011. The lowest percentage of child deaths in Hamilton County that were due to drowning was in 2012, in which there were no child deaths that were due to drowning.

**Age**
Children between the ages of one and four years of age have the highest rates of drowning in the United States\(^3^6\). In Hamilton County, 25 percent of child drownings were to children between one and four. Thirteen percent of child drownings were to children between five and nine. Children who were between 10 and 14 accounted for the majority (50 percent) of child drownings in Hamilton County. Older children between 15 and 17 accounted for 13 percent of child drownings.

**Sex**
Child drownings in Hamilton County are disproportionately higher in male children. Sixty-three percent of child drownings between 2010 and 2014 in Hamilton County were to male children. Female children accounted for 32 percent of child drownings.

**Race/Ethnicity**
In Hamilton County, non-Hispanic black children, as illustrated previously, account for the largest percentage of child deaths. However, when the race/ethnicity of the child is taken into account for child drownings in Hamilton County, the percent of child deaths to non-Hispanic white and non-Hispanic black children are equal. Fifty percent of child drownings in Hamilton County from 2010 to 2014 were to non-Hispanic white children. Non-Hispanic black children accounted for the remaining 50 percent of child drownings.
When sex and race/ethnicity are coupled together, inequities in child drownings in Hamilton County emerge. The majority of child drownings, 38 percent, in Hamilton County from 2010 to 2014, were to non-Hispanic black male children. The percent of child drownings to non-Hispanic black male children was 1.5 times higher than the percent of non-Hispanic white male children. Twenty-five percent of child drownings were to non-Hispanic white male children. The percent of child drownings to non-Hispanic white male children was equal to non-Hispanic white female children from 2010 to 2014. The percent of child drownings to non-Hispanic white female children was two times higher than the percent to non-Hispanic black female children. Non-Hispanic black females accounted for the smallest percentage (13 percent) of child drownings in Hamilton County from 2010 to 2014.

**Location**

Individuals can drown in many different locations, such as swimming pools, open water, and even in the bathtub. Twenty-five percent of child drownings in Hamilton County from 2010 to 2014, happened in open water. Open water includes ponds, lakes, and rivers. Fifty percent of child drownings in open water occurred in a pond, while the remaining 50 percent occurred in a creek. An in-ground swimming pool was the location of 50 percent of child drownings in Hamilton County. The remaining 25 percent of child drownings occurred in a bathtub.

**Flotation Device**

When an individual cannot swim or is a weak swimmer wearing a life jacket can help save their lives. In child drownings in Hamilton County from 2010 to 2014 that were in open water and swimming pools, 50 percent did not use a flotation device. It was unknown if a flotation device was used in 33 percent of child drownings in open water and swimming pools. The use of a flotation device was not applicable in 17 percent of child drownings in open water and swimming pools. A flotation device may be deemed as not being applicable to wear based on the information surrounding the case that the child didn’t need a flotation device at the time of death (e.g., were in a bathtub).
Preventability
Most deaths due to drowning are preventable. The Hamilton County CFRT deemed that 100 percent of child drownings in Hamilton County from 2010 to 2014 could have been prevented.

Recommendations to prevent child drownings.

Community Awareness
- Community awareness that you need to have a fence around your pool if you have small children.
- Community awareness that you should not leave toys in the pool as this can attract toddlers and small children to try to retrieve the toys and fall in.
- Community awareness that if children are playing in a pool there should always be at least one adult who can swim watching the children.
- Community awareness that if children cannot swim, or are weak swimmers they should not be in a pool without a life jacket.
- Community awareness that if you administer a prescription drug to a child, you should follow all of the doctor's orders.
- Community awareness that children with special medical conditions that can cause seizures should not be left alone in a bathtub.
- Community awareness that you should always know where your children are at all times, regardless of age.

Systems Change
- Systems change to not allow floats/flippers into a pool as this can cause a child to become trapped under the water.
- Systems change to restrict deep end swimming until a child reaches an appropriate age where they no longer require a life jacket.
- Systems change where in order for a child to enter a swimming pool they need to show some form of ID/proof that they are capable of swimming.
Asphyxia Deaths

Asphyxia is defined as the lack of oxygen in the body that results in unconsciousness and often death and is usually caused by interruption of breathing or inadequate oxygen supply. Asphyxia deaths captured by the CFR online data system include suffocation, strangulation and choking. Between 2010 and 2014, four percent of child deaths in Hamilton County were deaths due to asphyxia. In 2011, the percent of child deaths due to asphyxia was the lowest in the five year time period of 2010 to 2014 (two percent). Since 2011, however, the percent of child deaths due to asphyxia in Hamilton County increased to the highest percentage (seven) in 2013.

Age
Child deaths due to asphyxia can happen to children of any age. In Hamilton County, the majority of child deaths due to asphyxia (42 percent) between 2010 and 2014, were to children who were between 28 days and one year of age. Nineteen percent of child deaths due to asphyxia were to children who were between one and four years of age. Children who were between five and nine accounted for the smallest percentage of child deaths due to asphyxia, three percent. Sixteen percent of child deaths due to asphyxia in Hamilton County from 2010 to 2014 were to older children who were between 10 and 14 years old. Children who were between 15 and 17 accounted for nineteen percent of child deaths.

Sex
Child deaths due to asphyxia are not only disproportionately higher in infants in Hamilton County, but the percent of child deaths due to asphyxia are also slightly higher in male children. Fifty-two percent of child deaths due to asphyxia between 2010 and 2014 in Hamilton County were to male children. Female children accounted for 48 percent of child deaths due to asphyxia in Hamilton County between 2010 and 2014.

Race/Ethnicity
Inequities in child deaths due to asphyxia emerge when the race/ethnicity of the child is taken into account. The majority of the child deaths due to asphyxia in Hamilton County from 2010 to 2014, were to non-Hispanic black children. Sixty-five percent of child deaths due to asphyxia were to non-
Hispanic black children. The percent of child deaths due to asphyxia to non-Hispanic black children was two times higher than the percent of deaths due to asphyxia to non-Hispanic white children and 20 times higher than the percent of deaths due to asphyxia to non-Hispanic multi-racial children. Thirty-two percent of child deaths due to asphyxia were to non-Hispanic white children. Non-Hispanic multi-racial children accounted for three percent of child deaths due to asphyxia in Hamilton County from 2010 to 2014.

Sleep-Related Asphyxia
A child death due to asphyxia can occur at anytime, including when the child is sleeping. Thirty-five percent of child deaths due to asphyxia were sleep-related deaths. This means that the child had an unsafe sleep environment such as co-sleeping, or having pillows, blankets and/or toys in the crib/bassinette with the child. The majority of child deaths due to asphyxia (65 percent) were not sleep-related. These asphyxia deaths would represent those children who committed suicide by asphyxia, along with accidental asphyxia by choking on a foreign object.

Type of Asphyxiation
Child deaths due to asphyxia are further classified by the type of asphyxiation event. In nearly half of child deaths due to asphyxia (48 percent) in Hamilton County from 2010 to 2014, asphyxiation was caused by the suffocation of the child. Suffocation refers to the death of a child in which oxygen was deprived and can occur in multiple different ways (e.g., sleep-related, becoming wedged or confined into a tight space, or asphyxia by gas). Sixty-seven percent of child deaths where suffocation was the type of asphyxiation event were sleep-related. Twenty percent of suffocation deaths were ruled as a homicide. The suffocation of the child was ruled as accidental in seven percent of child deaths caused by suffocation. In seven percent of suffocation deaths the child became wedged into a tight space and

DID YOU KNOW?
Between 2010-2014:

1 Child died due to asphyxia in Hamilton County

2 Months
became unable to breath. Strangulation was the type of asphyxia in 35 percent of child deaths due to asphyxia in Hamilton County. Strangulation is caused by a compression of the neck, such as hanging or manual strangulation using one’s hands. The majority of strangulation deaths (73 percent) in Hamilton County between 2010 and 2014 were ruled as a suicide. In 27 percent of strangulation deaths, it was determined that the strangulation of the child was an accident. In 16 percent of child deaths due to asphyxia in Hamilton County between 2010 and 2014, asphyxiation was caused by choking. Choking can occur when food or an object becomes lodged in the airway of the child. One-hundred percent of deaths in which the child choked were deemed as being an accident.

**Preventability**

Child deaths due to asphyxiation oftentimes can have complex and multiple risk/contributing factors, that can determine the preventability of the death. The Hamilton County CFRT was unable to determine, based on the circumstances surrounding the case, if the death of the child could have been prevented in 10 percent of child deaths due to asphyxia. In three percent of child deaths due to asphyxia in Hamilton County from 2010 to 2014, it was deemed that the death probably could not have been prevented based on the circumstances surrounding the case. In the majority of child deaths due to asphyxia, 87 percent, the Hamilton County CFRT determined that the death could have been prevented.

**Recommendations to prevent child deaths due to asphyxia.**

**Community Awareness**

- Community awareness that when young children are eating it is important to ensure that the food is cut to the appropriate size, and if it is too large, it should be cut into smaller pieces to avoid choking.
- Community awareness on the importance of education to children on bullying and the effects it can have, and that you should seek help if you are being bullied.
- Increase in community awareness about co-sleeping and safe sleep education.

**Systems Change**

- Systems change in birthing hospitals that a video about CPR be added to the videos that new parents have to watch prior to being discharged from the hospital.
- Systems change to have increased presence in CPR literature available and given out by hospitals and physicians’ offices.

**Policy Change**

- Policy change where grief support and counseling services are offered to individuals/families after they experience the loss of a family member.

**Program Development**

- Community classes for parents/families/caregivers on the proper way to perform CPR.
- Creation of a program in which parents who are going through divorces/separation can bring their child to aid in the transition to have the least impact on the child’s behavior and emotional state.
- Creation of a text messaging service in schools that if a child is having problems or is in distress they can send a text to a phone number and get linked to a school psychologist and counselor to help them through the situation.
“Other Types of Child Death”

Other types of child death are the remaining types of child death in Hamilton County that have a small number of child deaths in which an in-depth analysis was unable to be completed. As such, these deaths are grouped into an “other types of child death” category for this report. The type of deaths included in this group are:

- Fire, burn or electrocution
- Fall or crush
- Poisoning, overdose or acute intoxication

Between 2010 and 2014, these other types of child death accounted for one percent of all child deaths in Hamilton County. Since 2010, the percent of child deaths to these “other types of child death” decreased from nearly three percent of child deaths in 2010 to no child deaths in 2014.

Age
Younger children in Hamilton County are disproportionately affected by a higher percentage of these “other types of child death”. Fifty-six percent of child deaths due to these “other types of child death” between 2010 and 2014 were to young children between one and five years of age. Forty-Four percent of child deaths in Hamilton County between 2010 and 2014 were to older children between 15 and 17.

Sex
Male children, as illustrated previously, suffer from a higher percentage of child deaths in Hamilton County than their female counterparts. Male children are also disproportionately affected by a higher percentage of child deaths due to these “other types of child death”. Seventy-eight percent of child deaths in Hamilton County between 2010 and 2014 were due to these “other types of child death” were to male children. Female children accounted for 22 percent of deaths due to “other types of child death”.

Race/Ethnicity
Non-Hispanic white children in Hamilton County are also disproportionately affected by a higher percentage of child deaths due to these “other types of child death”. Eighty-nine percent of child deaths due to these “other types of child death” were to non-Hispanic white children. Non-Hispanic black children accounted for 11 percent of child deaths in Hamilton County between 2010 and 2014 due to one these “other types of child death”.

---

The charts illustrate the distribution of child deaths by age, sex, and race/ethnicity for the years 2010-2014 in Hamilton County.
Manner of Death
While these three types of death are grouped together, the manner of death can differ based on the circumstances in which the death occurred. The majority (78 percent) of these other types of child death in Hamilton County between 2010 and 2014, were determined to be accidental deaths. Eleven percent of these other types of child deaths were children committing suicide. The manner of death was deemed undetermined in 11 percent of child deaths due to one of these other types of death. A death is classified as being undetermined when the information surrounding the death (that was available at the time to authorities completing the investigation) was insufficient.

Preventability
Many factors can contribute to a child dying from one these other types of death. The majority of child deaths in Hamilton County due to “other types of child death” could have been prevented. The Hamilton County CFRT determined that 89 percent of child deaths to “other types of child death” could have been prevented. The Hamilton County CFRT could not determine, based on the circumstances surrounding the case, if the death of the child could have been prevented in 11 percent of child deaths to “other types of child death”.

Recommendations to prevent child deaths due to “other types of child death”.

Community Awareness
- Community awareness on how to properly child proof one's house.
- Community awareness on the proper techniques on how to store potentially dangerous substances (e.g., gasoline tanks, prescription pills).
- Community awareness on the proper procedures of what to do in the event of a fire.
- Community awareness that you should not give alcohol to your underage children.
- Community awareness on the importance of not leaving your children unattended in areas that can be potentially hazardous/dangerous.
- Community awareness on illicit drugs such as heroin and the dangers these drugs pose.
- Community awareness on how family support during the treatment for addictions can impact the treatment.

Policy Change
- Policy change that education is provided to anyone picking up prescription drugs on how to safely store the drugs to keep them out of the reach of children.
- Policy change to improve family support during drug treatment for addictions.
Conclusion

The death of a child can impact both the family and community. The goal of the Hamilton County CFR is to decrease the number of child deaths in Hamilton County through prevention efforts. This is accomplished through identification of groups (e.g., sex, racial/ethnic, and age groups) within the population of Hamilton County that experience disparities in child deaths.

This report is intended to describe the trends, along with underlying risk factors, found across the child deaths in Hamilton County and make meaningful recommendations that can be used to engage the community of Hamilton County to work at improving the outcomes for all children. Collaboration is needed to develop and implement policy and systems changes, and programs that can improve the lives of children in Hamilton County, ultimately reducing the number of child deaths.

It is hoped this report will provide communities with the tools to make significant, lasting policy changes that will have a positive effect on the children in Hamilton County for generations to come.
Within Hamilton County there are 49 communities comprised of cities, villages, and townships. Below is a map that illustrates the location of each community in Hamilton County.

1. Addyston
2. Amberley Village
3. Anderson Township
4. Arlington Heights
5. Blue Ash
6. Cheviot
7. Cincinnati
8. Cleves
9. Colerain Township
10. Columbia Township
11. Crosby Township
12. Deer Park
13. Delhi Township
14. Elmwood Place
15. Evendale
16. Fairfax
17. Fairfield
18. Forest Park
19. Glendale
20. Golf Manor
21. Green Township
22. Greenhills
23. Harrison City
24. Harrison Township
25. Indian Hill
26. Lincoln Heights
27. Lockland
28. Loveland
29. Madeira
30. Mariemont
31. Miami Township
32. Montgomery
33. Mount Healthy
34. Newtown
35. North Bend
36. North College Hill
37. Norwood
38. Reading
39. Saint Bernard
40. Sharonville
41. Silverton
42. Springdale
43. Springfield Township
44. Sycamore Township
45. Symmes Township
46. Terrace Park
47. Whitewater Township
48. Woodlawn
49. Wyoming
### Data Tables

Please Note: Some percentages may not equal 100 percent due to rounding.

| Table 1: Number of Child Deaths by Year in Hamilton County, 2010-2014 |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2010 | 2011 | 2012 | 2013 | 2014 | 2010-2014 |
| Number of Deaths         | 149  | 156  | 131  | 138  | 145  | **719**     |

| Table 2: Child Fatality Rate, per 100,000 children by Year in Hamilton County, 2010-2014 |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2010 | 2011 | 2012 | 2013 | 2014 | 2010-2014 |
| Rate                    | 7.9  | 8.3  | 7.0  | 7.4  | 7.7  | **7.7**      |

| Table 3: Percent of Child Deaths by Sex in Hamilton County, 2010-2014 |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2010 | 2011 | 2012 | 2013 | 2014 | 2010-2014 |
| Male                    | 53%  | 64%  | 56%  | 66%  | 63%  | **61%**      |
| Female                  | 47%  | 36%  | 44%  | 34%  | 37%  | **39%**      |

| Table 4: Percent of Child Deaths by Race/Ethnicity in Hamilton County, 2010-2014 |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2010 | 2011 | 2012 | 2013 | 2014 | 2010-2014 |
| non-Hispanic White       | 39%  | 41%  | 40%  | 33%  | 35%  | **38%**      |
| non-Hispanic Black       | 56%  | 58%  | 52%  | 55%  | 52%  | **55%**      |
| non-Hispanic Multi-Racial| 1%   | 1%   | 5%   | 4%   | 6%   | **3%**       |
| non-Hispanic Other Race  | 1%   | 0%   | 2%   | 4%   | 3%   | **2%**       |
| Hispanic, Any Race       | 3%   | 1%   | 2%   | 4%   | 3%   | **3%**       |

| Table 5: Percent of Child Deaths by Age in Hamilton County, 2010-2014 |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                         | 2010 | 2011 | 2012 | 2013 | 2014 | 2010-2014 |
| <28 Days                 | 41%  | 37%  | 36%  | 37%  | 31%  | **36%**      |
| 28 Days - 1 Year         | 36%  | 39%  | 39%  | 32%  | 36%  | **36%**      |
| 1-4 Years                | 10%  | 7%   | 7%   | 11%  | 9%   | **9%**       |
| 5-9 Years                | 2%   | 3%   | 4%   | 5%   | 8%   | **4%**       |
| 10-14 Years              | 7%   | 4%   | 6%   | 6%   | 9%   | **6%**       |
| 15-17 Years              | 5%   | 9%   | 8%   | 9%   | 7%   | **8%**       |
### Table 6: Percent of Child Deaths by Manner of Death in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>74%</td>
<td>71%</td>
<td>74%</td>
<td>70%</td>
<td>80%</td>
<td><strong>74%</strong></td>
</tr>
<tr>
<td>Accident</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
<td><strong>8%</strong></td>
</tr>
<tr>
<td>Suicide</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
<td><strong>2%</strong></td>
</tr>
<tr>
<td>Homicide</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
<td><strong>6%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td>11%</td>
<td>14%</td>
<td>11%</td>
<td>10%</td>
<td>6%</td>
<td><strong>10%</strong></td>
</tr>
</tbody>
</table>

### Table 7: Percent of Child Deaths by Cause of Death in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>From an External Cause of Injury</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>21%</td>
<td>15%</td>
<td><strong>16%</strong></td>
</tr>
<tr>
<td>From a Medical Condition</td>
<td>74%</td>
<td>72%</td>
<td>74%</td>
<td>70%</td>
<td>81%</td>
<td><strong>74%</strong></td>
</tr>
<tr>
<td>Undetermined if Injury or Medical Cause</td>
<td>11%</td>
<td>13%</td>
<td>11%</td>
<td>9%</td>
<td>4%</td>
<td><strong>10%</strong></td>
</tr>
</tbody>
</table>

### Table 8: Percent of Child Deaths due to a Medical Condition by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;28 Days</td>
<td>55%</td>
<td>52%</td>
<td>48%</td>
<td>53%</td>
<td>38%</td>
<td><strong>49%</strong></td>
</tr>
<tr>
<td>28 Days - 1 Year</td>
<td>3%</td>
<td>36%</td>
<td>35%</td>
<td>29%</td>
<td>37%</td>
<td><strong>34%</strong></td>
</tr>
<tr>
<td>1-4 Years</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>9%</td>
<td>8%</td>
<td><strong>6%</strong></td>
</tr>
<tr>
<td>5-9 Years</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>8%</td>
<td><strong>5%</strong></td>
</tr>
<tr>
<td>10-14 Years</td>
<td>5%</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
<td>5%</td>
<td><strong>4%</strong></td>
</tr>
<tr>
<td>15-17 Years</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>1%</td>
<td>4%</td>
<td><strong>3%</strong></td>
</tr>
</tbody>
</table>

### Table 9: Percent of Child Deaths due to a Medical Condition by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Sex</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>52%</td>
<td>62%</td>
<td>57%</td>
<td>61%</td>
<td>63%</td>
<td><strong>59%</strong></td>
</tr>
<tr>
<td>Female</td>
<td>48%</td>
<td>38%</td>
<td>43%</td>
<td>39%</td>
<td>37%</td>
<td><strong>41%</strong></td>
</tr>
</tbody>
</table>

### Table 10: Percent of Child Deaths due to a Medical Condition by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>38%</td>
<td>43%</td>
<td>40%</td>
<td>30%</td>
<td>36%</td>
<td><strong>38%</strong></td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>56%</td>
<td>57%</td>
<td>51%</td>
<td>56%</td>
<td>50%</td>
<td><strong>54%</strong></td>
</tr>
<tr>
<td>non-Hispanic Multi-Racial</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>3%</td>
<td>8%</td>
<td><strong>3%</strong></td>
</tr>
<tr>
<td>non-Hispanic Other Race</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>6%</td>
<td>3%</td>
<td><strong>2%</strong></td>
</tr>
<tr>
<td>Hispanic, Any Race</td>
<td>5%</td>
<td>0%</td>
<td>3%</td>
<td>5%</td>
<td>3%</td>
<td><strong>3%</strong></td>
</tr>
</tbody>
</table>
### Table 11: Percent of Child Deaths due to Motor Vehicle Accidents by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Deaths</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Table 12: Percent of Child Deaths due to Motor Vehicle Accidents by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 Years</td>
<td>25%</td>
<td>20%</td>
<td>40%</td>
<td>25%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>25%</td>
<td>0%</td>
<td>20%</td>
<td>0%</td>
<td>25%</td>
<td>14%</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>25%</td>
<td>20%</td>
<td>0%</td>
<td>25%</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>25%</td>
<td>60%</td>
<td>40%</td>
<td>50%</td>
<td>25%</td>
<td>41%</td>
</tr>
</tbody>
</table>

### Table 13: Percent of Child Deaths due to Motor Vehicle Accidents by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Sex</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>75%</td>
<td>10%</td>
<td>60%</td>
<td>50%</td>
<td>75%</td>
<td>73%</td>
</tr>
<tr>
<td>Female</td>
<td>25%</td>
<td>0%</td>
<td>40%</td>
<td>50%</td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>

### Table 14: Percent of Child Deaths due to Motor Vehicle Accidents by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>100%</td>
<td>20%</td>
<td>40%</td>
<td>75%</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>0%</td>
<td>80%</td>
<td>60%</td>
<td>25%</td>
<td>100%</td>
<td>55%</td>
</tr>
</tbody>
</table>

### Table 15: Percent of Child Homicides by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Deaths</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

### Table 16: Percent of Child Homicides by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Days - 1 Year</td>
<td>17%</td>
<td>22%</td>
<td>0%</td>
<td>20%</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td>1-4 Years</td>
<td>50%</td>
<td>22%</td>
<td>43%</td>
<td>10%</td>
<td>11%</td>
<td>24%</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>17%</td>
<td>0%</td>
<td>14%</td>
<td>20%</td>
<td>44%</td>
<td>20%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>17%</td>
<td>56%</td>
<td>43%</td>
<td>40%</td>
<td>11%</td>
<td>34%</td>
</tr>
</tbody>
</table>

### Table 17: Percent of Child Homicides by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Sex</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
<td>67%</td>
<td>57%</td>
<td>90%</td>
<td>56%</td>
<td>66%</td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
<td>33%</td>
<td>43%</td>
<td>10%</td>
<td>44%</td>
<td>34%</td>
</tr>
</tbody>
</table>
Table 18: Percent of Child Homicides by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>17%</td>
<td>11%</td>
<td>29%</td>
<td>30%</td>
<td>33%</td>
<td>24%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>83%</td>
<td>89%</td>
<td>71%</td>
<td>70%</td>
<td>56%</td>
<td>73%</td>
</tr>
<tr>
<td>Hispanic, Any Race</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 19: Percent of Child Suicides by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Deaths</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 20: Percent of Child Suicides by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 Years</td>
<td>33%</td>
<td>0%</td>
<td>50%</td>
<td>29%</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>67%</td>
<td>100%</td>
<td>50%</td>
<td>71%</td>
<td>50%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Table 21: Percent of Child Suicides by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Female</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>14%</td>
<td>25%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Table 22: Percent of Child Suicides by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>33%</td>
<td>0%</td>
<td>100%</td>
<td>57%</td>
<td>100%</td>
<td>65%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>67%</td>
<td>100%</td>
<td>0%</td>
<td>43%</td>
<td>0%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Table 23: Percent of Sleep-Related Deaths by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Deaths</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>5%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Table 24: Percent of Sleep-Related Deaths by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Days - 1 Year</td>
<td>90%</td>
<td>89%</td>
<td>94%</td>
<td>94%</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>1-4 Years</td>
<td>10%</td>
<td>11%</td>
<td>6%</td>
<td>6%</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Table 25: Percent of Sleep-Related Deaths by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
<td>68%</td>
<td>47%</td>
<td>81%</td>
<td>57%</td>
<td>61%</td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
<td>32%</td>
<td>53%</td>
<td>19%</td>
<td>43%</td>
<td>39%</td>
</tr>
</tbody>
</table>
### Table 26: Percent of Sleep-Related Deaths by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>3%</td>
<td>47%</td>
<td>29%</td>
<td>31%</td>
<td>29%</td>
<td>34%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>65%</td>
<td>42%</td>
<td>59%</td>
<td>56%</td>
<td>71%</td>
<td>57%</td>
</tr>
<tr>
<td>non-Hispanic Multi-Racial</td>
<td>5%</td>
<td>5%</td>
<td>12%</td>
<td>13%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic, Any Race</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Table 27: Percent of Child Drownings by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>50%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>non-Hispanic Multi-Racial</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>Hispanic, Any Race</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Table 28: Percent of Child Drownings by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 Years</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>0%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>50%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>13%</td>
</tr>
</tbody>
</table>

### Table 29: Percent of Child Drownings by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Sex</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
<td>67%</td>
<td>0%</td>
<td>50%</td>
<td>100%</td>
<td>63%</td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>38%</td>
</tr>
</tbody>
</table>

### Table 30: Percent of Child Drownings by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>50%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Table 31: Percent of Child Deaths due to Asphyxia by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Days - 1 Year</td>
<td>50%</td>
<td>67%</td>
<td>60%</td>
<td>20%</td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td>1-4 Years</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>13%</td>
<td>33%</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
<td>16%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>13%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td>19%</td>
</tr>
</tbody>
</table>

### Table 32: Percent of Child Deaths due to Asphyxia by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Days - 1 Year</td>
<td>50%</td>
<td>67%</td>
<td>60%</td>
<td>20%</td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td>1-4 Years</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>13%</td>
<td>33%</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
<td>16%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>13%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td>19%</td>
</tr>
</tbody>
</table>
### Table 33: Percent of Child Deaths due to Asphyxia by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>38%</td>
<td>67%</td>
<td>40%</td>
<td>80%</td>
<td>20%</td>
<td>52%</td>
</tr>
<tr>
<td>Female</td>
<td>63%</td>
<td>33%</td>
<td>60%</td>
<td>20%</td>
<td>80%</td>
<td>48%</td>
</tr>
</tbody>
</table>

### Table 34: Percent of Child Deaths due to Asphyxia by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>13%</td>
<td>33%</td>
<td>60%</td>
<td>20%</td>
<td>60%</td>
<td>32%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>88%</td>
<td>67%</td>
<td>40%</td>
<td>70%</td>
<td>40%</td>
<td>65%</td>
</tr>
<tr>
<td>non-Hispanic Multi-Racial</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Table 35: Percent of Other Types of Child Deaths by Year in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Deaths</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Table 36: Percent of Other Types of Child Deaths by Cause of Death in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire, Burn or Electrocution</td>
<td>25%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>22%</td>
</tr>
<tr>
<td>Fall or Crush</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>33%</td>
</tr>
<tr>
<td>Poisoning, Overdose or Acute Intoxication</td>
<td>25%</td>
<td>67%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Table 37: Percent of Other Types of Child Deaths by Age in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 Years</td>
<td>50%</td>
<td>67%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>56%</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>50%</td>
<td>33%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Table 38: Percent of Other Types of Child Deaths by Sex in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>78%</td>
</tr>
<tr>
<td>Female</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>22%</td>
</tr>
</tbody>
</table>

### Table 39: Percent of Other Types of Child Deaths by Race/Ethnicity in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hispanic White</td>
<td>100%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>89%</td>
</tr>
<tr>
<td>non-Hispanic Black</td>
<td>0%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Table 40: Percent of Child Deaths by Preventability in Hamilton County, 2010-2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, Probably</td>
<td>17%</td>
<td>19%</td>
<td>21%</td>
<td>29%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>No, Probably Not</td>
<td>5%</td>
<td>4%</td>
<td>48%</td>
<td>69%</td>
<td>83%</td>
<td>40%</td>
</tr>
<tr>
<td>Team Could Not Determine</td>
<td>78%</td>
<td>78%</td>
<td>32%</td>
<td>3%</td>
<td>&lt;1%</td>
<td>39%</td>
</tr>
</tbody>
</table>
References


Images courtesy of:
"We owe our children - the most vulnerable citizens in any society - a life free from violence and fear."

-Nelson Mandela-
Contact Us

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250 William Howard Taft Road
2nd Floor
Cincinnati, Ohio 45219

Phone Number
(513) 946.7800

Fax Number
(513) 946.7943

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www.hamiltoncountyhealth.org

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