ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR 2019

MISSION

To reduce preventable child fatalities and serious injuries among Illinois children.

Illinois Department of
DCFS
Children & Family Services

SUBMITTED TO:

The Honorable JB Pritzker,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

July 2021

Illinois Department of
DCFS
Children & Family Services

JB Pritzker
Governor

Marc D. Smith
Director

August 2021

Dear Readers,

It is my honor to present to you the 2021 Illinois Child Death Review Annual Report. The information in the report includes the data for the child deaths that occurred in calendar year 2019.

Every single child death that occurs is tragic. When such deaths are preventable, it is beyond tragic. This report serves as a tribute to every child that died.

While many of the deaths were due to natural causes, others may have been prevented through alternative actions by parents and other caretakers, earlier intervention by public and/or private support systems or increased efforts of public safety campaigns.

The goal of the Child Death Review Teams is to gain greater understanding of the incidence and causes of child deaths in order to prevent future child deaths.

This report reflects the diligent efforts of these nine Child Death Review Teams throughout the state. These teams, in partnership with DCFS staff, reviewed 245 child deaths and made 85 recommendations for improving and saving the lives of our children. These teams comprise many professionals who volunteer their time and expertise to painstakingly review and discuss these tragedies, often spending many hours outside their busy schedules. They do this for the sake of our children throughout the state.

I am extremely grateful for the difficult work that they do.

Given our charge to ensure the safety of the children of Illinois, DCFS responded to the recommendations made by these teams and implemented many of them. I am confident that our ongoing partnership with these teams will serve to prevent more child deaths in the future.

Sincerely,

Marc D. Smith
Director
Illinois DCFS

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July 2021

The Honorable J.B. Pritzker, Governor of the State of Illinois:
The Honorable Members of the 102nd General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2019. In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All of the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department of Children and Family Services (DCFS). The CDRT Executive Council reviews all recommendations made by the nine Illinois Child Death Review Teams and submits them to DCFS. The CDRT Executive Council continues to value the time the Director of DCFS dedicates to meet with the Executive Council, in-person, to discuss the recommendations made by the child death review teams, the responses given by DCFS to these recommendations, and the implementation of these recommendations.

We want to thank DCFS Director Marc D. Smith for agreeing to meet with the CDRT Executive Council in person and continuing to work with child death review. We truly appreciate all of your extra time and efforts. We would also like to thank all of the DCFS staff that is currently working with child death review. Thank you for your cooperation and for providing the necessary resources for the nine Child Death Review Teams and the Executive Council.

We would also like to express our sincere appreciation to the almost two hundred professionals of multiple disciplines who are the members of the nine CDRTs. Thank you for volunteering your time, your expertise, and your experiences to this very important effort. A special thanks goes to our fellow members of the Executive Council who not only serve as the Chairpersons and Vice Chairpersons of their individual teams, but who also attend additional meetings to finalize teams' recommendations and discuss general child death review issues. All of you are invaluable to this process of protecting Illinois' children.

Lastly, we thank Governor Pritzker and the members of the General Assembly for the opportunity to protect and serve the welfare of the children of Illinois.

Respectfully submitted,

Daniel J. Cuneo, Ph .D.
Chairperson, Executive Council
Illinois Child Death Review Teams

ACKNOWLEDGEMENTS

This report would not be possible without the dedication and unwavering support of almost 140 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams. Members of the Child Death Review Team Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

The production of this report represents the ongoing collaboration between the Illinois CDRT Executive Council, the Illinois Department of Children and Family Services (DCFS) and the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign.

Illinois Child Death Review Teams staff Tamara Skube, Bernadette Emery, and John Schweitzer provided the data from the Child Death Review Teams database and suggestions to Dr. Steve Tran. Children and Family Research Center staff, Drs. Steve Tran and Tamara Fuller, wrote the report; Chapter 5 on sudden unexpected infant deaths during sleep was written by Bernadette Emery.

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EXECUTIVE SUMMARY

Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The primary goals of the Child Death Review Teams (CDRTs) are 1) to review the circumstances of child fatalities in order to gain a better understanding of their causes, and 2) to recommend changes in practice and policy that will *prevent* future injuries and deaths.

Illinois Child Deaths in 2019

In 2019, 1,214 children under 18 died in Illinois.[1] This number represents the death information received by DCFS as of March 24, 2021.

Of the total child deaths reported to CDRTs in 2019:

- 58% were boys and 42% were girls;
- 61% were infants under one year, 10% were young children between 1 and 4 years, 13% were older children between 5 and 14 years, and 16% were youth between 15 and 17 years;
- 49% were White, 36% were Black, 11% were Hispanic, 3% were Asian, and 1% were of other or unknown racial/ethnic origin.

When Illinois child deaths in 2019 were examined by the manner of death:

- 67% were attributable to natural causes;
- 13% were accidental;
- 8% were homicides;
- 5% were suicides;
- 8% were undetermined.

When deaths occurring in 2019 were examined by the category of death:

- 35% were related to illness;
- 32% were related to premature birth;
- less than 1% were related to Sudden Unexpected Infant Death (SUID);
- 27% were related to various types of injuries, such as suffocations (8%), firearms (8%), vehicular accidents (4%), drowning (3%), poisoning/overdose (1%), fire (<1%), scalding burns (<1%), other types of injuries (2%), and 4% were pending;
- 5% were due to undetermined causes.

[1] The Illinois Department of Public Health reports all death data to the Enterprise Data Warehouse that is managed by Healthcare and Family Services (HFS).

2019 Child Deaths Reviewed by the CDRTs

In 2019, 245 child deaths were reviewed by the CDRTs, consisting of 157 mandatory and 88 discretionary reviews. The mandatory reviews occurred for one of several reasons: 85 were indicated death cases, 42 cases had an investigation in the year before the child's death, 21 were indicated investigations, and 8 were DCFS youth in care and 1 was pending DCFS investigation at the time of death.

Reviewed deaths in 2019 occurred in all CDRTs regions (see Appendix A for the CDRT regional map), although there were regional differences in the percentages of child deaths that were reviewed:

- Aurora – 25 of the 169 deaths (15%) were reviewed.
- Champaign – 28 of the 75 deaths (37%) were reviewed.
- Cook – 103 of the 692 deaths (15%) were reviewed.
- East St. Louis – 9 of the 25 deaths (36%) were reviewed.
- Marion – 14 of the 35 deaths (40%) were reviewed.
- Peoria – 28 of the 104 deaths (27%) were reviewed.
- Rockford – 17 of the 62 deaths (27%) were reviewed.
- Springfield – 21 of the 52 deaths (40%) were reviewed.

Of the deaths reviewed by CDRTs in 2019:

- 62% were boys and 38% were girls;
- 60% were infants under 1, 18% were young children between 1 and 4 years, 12% were older children between 5 and 14 years, and 10% were youth between 15 and 17 years.

When reviewed deaths occurring in 2019 were examined by manner of death:

- 32% were attributed to accidents;
- 21% were due to natural causes;
- 16% were homicides;
- 4% were suicides;
- 28% were undetermined.

When reviewed deaths occurring in 2019 were examined by category of death:

- 3% were related to premature birth;
- 18% were related to illness;
- 3% were related to SUID;
- 54% were related to various types of injuries, such as suffocations (26%), firearms (9%), drowning (7%), poisoning/overdose (2%), fire (2%), vehicular accidents (1%), scalding burns (<1%), and other types of injuries (7%);
- 22% were due to undetermined and other types of causes.

Introduction

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations and safety policies that have led to a decline in infant and child mortality, too many children are still dying. In 2019, there were 1,214 child deaths in Illinois. Many of these deaths were preventable.

Nine regional Child Death Review Teams (CDRTs) were established by Illinois statute in 1994 and implemented throughout the state in 1995 in an effort to better understand the reasons for child deaths. In 1999, the CDRTs produced the first annual report summarizing team findings and recommendations for reducing preventable child deaths. The CDRT annual report is presented to the governor, the Illinois legislature, and other interested parties in a continued effort to understand and reduce preventable child deaths in Illinois.

Since the implementation of the child death review process, individuals and agencies responding to child deaths have come to understand the importance of a coordinated, multi-agency response. Recommendations from the CDRTs have helped to develop, streamline and implement better practices regarding child safety.

This report honors the memory of all children who have died in Illinois. The Child Death Review Teams present this report in the hopes of furthering understanding of how we can make Illinois a safer and healthier state for children.

Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998, P.A. 92-468 on August 22, 2001, P.A. 95-405 and P.A. 95-527 on June 1, 2008, P.A. 95-876 on August 21, 2008, P.A. 96-328 on August 11, 2009, P.A. 96-955 on June 30, 2010, P.A. 96-1000 on July 2, 2010, P.A. 98-558 on January 1, 2014, P.A. 100-159 on August 18, 2017, P.A. 100-397 on January 1, 2018, P.A. 100-1122 on November 27, 2018, and most recently P.A. 100-733 on January 1, 2019.[2] Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

The Illinois Child Death Review Team Act created a partnership among many agencies, organizations and professionals across the state that serve and advocate for children. In particular, it established a strong working relationship between the Child Death Review Teams (CDRTs) and the Illinois Department of Children and Family Services (DCFS) Division of Child Protection.

Purpose of Child Death Review

The overarching mission of child death review is to reduce the number of preventable child deaths in Illinois. CDRTs achieve this goal by fulfilling the objectives stated below:

- Evaluate how the death might have been prevented.
- Report findings and recommendations to appropriate agencies.
- Promote continuing education for professionals involved in investigating, treating and preventing child abuse and neglect.
- Make specific recommendations to the DCFS director and inspector general concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

Other responsibilities of the CDRTs are to:

- assist in identifying systemic barriers that reduce the effectiveness of child welfare and child protective services;
- assist in increasing the effectiveness of public health services, prevention efforts, intervention services and investigative and legal processes aimed at reducing child mortality;
- enhance and support cooperation and communication among agencies;
- share information about advances in the field of investigation, prevention, intervention and prosecution regarding child maltreatment and child fatalities;
- contribute to initiatives to improve public awareness of issues that affect the safety and well-being of children;

[2] The complete Act is available online at www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=244&ChapterID=5.

- collect data that will inform efforts to reduce child fatalities; and
- keep the governor and legislature apprised of the CDRTs' findings and recommendations and of legislation needed to reduce child fatalities and protect the lives of children.

Child Death Review Team Composition

The composition of CDRTs and the process for selecting members is outlined in the Child Death Review Team Act. There are nine CDRTs in Illinois, one in each of the seven DCFS administrative sub-regions outside Cook County and two within Cook County. A map of the CDRTs sub-regions is in Appendix A.

The Child Death Review Team Act requires that each CDRT includes at least one member from each of the following disciplines:

- Pediatrician or other physician knowledgeable about child abuse and neglect;
- Representative from DCFS;
- State's attorney or state's attorney's representative;
- Representative of a local law enforcement agency;
- Psychologist or psychiatrist;
- Representative of a local health department;
- Representative of a school district or other education or child care interests;
- Coroner or forensic pathologist;
- Representative of a child welfare agency or child advocacy organization;
- Representative of a local hospital, trauma center, or provider of emergency medical services;
- Representative of the Illinois State Police;
- Representative of the Department of Public Health.

Teams may make recommendations to the DCFS inspector general concerning additional professionals to serve on their team as needed. Team members, who are volunteers, are appointed to the team for two years and are eligible for reappointment upon expiration of their term. The inspector general must fill any vacancy in a team within 60 days after the vacancy occurs. Each team elects a chairperson and vice-chairperson from their members. For a list of all members of regional CDRTs, see Appendix B.

Child Death Review Team Executive Council

The CDRT Executive Council is the coordinating and oversight body for child death review activities in Illinois. It consists of the chairpersons and vice-chairpersons of each of the nine CDRTs. The Executive Council meets in-person quarterly and teleconferences monthly to review the procedures and recommendations made by the teams in the examination of child deaths. The Executive Council operates pursuant to Section 40 of the Illinois Child Death Review Team Act. 20 ILCS 515/40. Executive Council responsibilities include, but are not limited to:

- serving as the voice of child death review in Illinois;
- providing oversight of regional CDRTs to ensure that their work is coordinated and in compliance with legislation and the operating protocol;

- ensuring that the data, results, findings and recommendations of the teams are adequately used to make necessary changes in the policies, procedures and statutes to protect children;
- collaborating with the Illinois General Assembly, DCFS and others to develop legislation needed to prevent child fatalities and protect children;
- assisting in the development of quarterly and annual reports based on the work and the findings of the CDRTs;
- ensuring that the review processes of regional teams are standardized to convey data, findings and recommendations in a usable format;
- serving as a link with CDRTs throughout the country and participate in national child death review team activities;
- developing an annual statewide symposium to update the knowledge and skills of CDRT members and promote the exchange of information between teams;
- serving as a sub-committee of the DCFS Citizen's Review Panel;
- providing the CDRTs with the most current information and practices concerning child death review and related topics; and
- performing any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

During 2020, the Illinois Child Death Review Teams (CDRT) accomplished several goals including the following:

- In collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign, the Illinois Child Death Review Teams Annual Report for 2019 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.
- Due to COVID-19 there was no Annual Child Death Review Teams Symposium

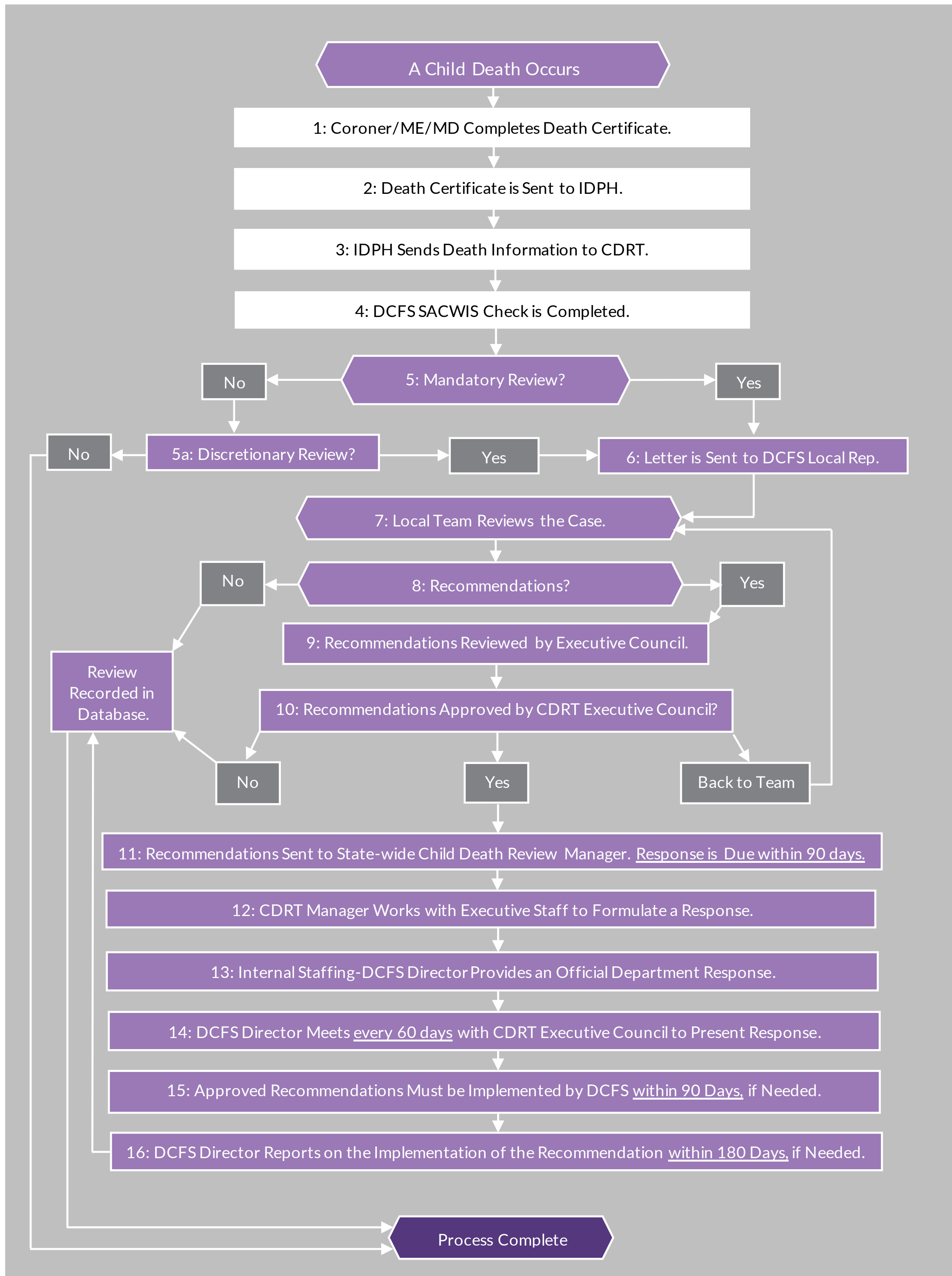
DCFS Roles and Responsibilities

The Illinois DCFS Office of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT manager). In addition, the department serves as a direct link between the review teams and the state's child protection policy makers. The DCFS director must review and reply to recommendations made by the CDRTs within 90 days of receipt.

Illinois Child Death Review Process

The Illinois child death review process is outlined in the CDRT Protocol for the Multi-Disciplinary Review of Child Deaths. This protocol provides a practical manual for CDRT members and ensures comparability of CDRT reviews and findings among the teams by defining: 1) the types of cases to be reviewed, 2) the procedures used to review cases and 3) the confidentiality parameters of review findings and recommendations. The CDRT process is outlined in a flow chart in Figure 1.

Figure 1: The Child Death Review Process in Illinois

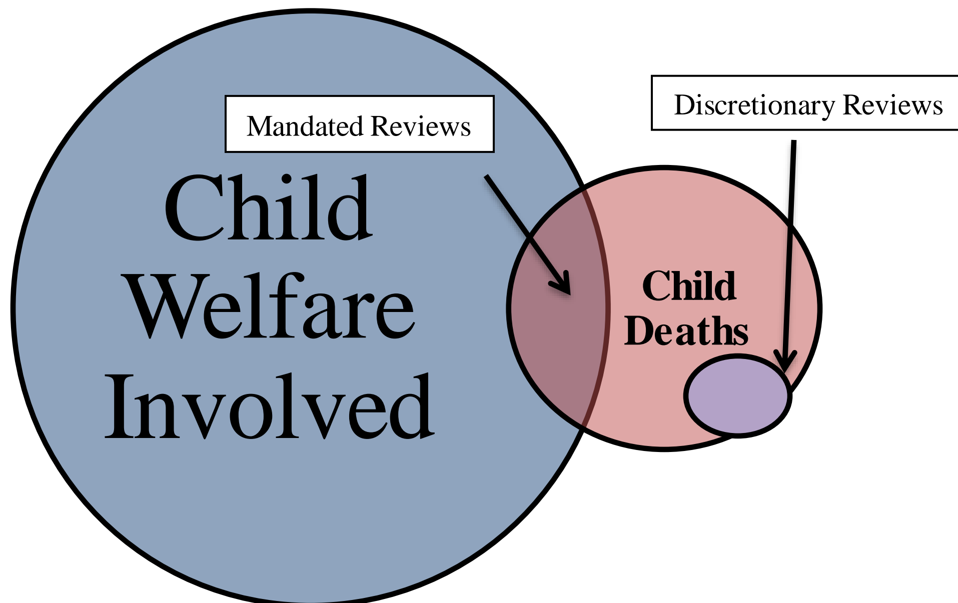


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the information to the Illinois Department of Public Health (IDPH). IDPH provides this information to the Illinois Department of Healthcare and Family Services (HFS) Enterprise Data Warehouse which then sends the death certificate information to the Child Death Review Office. The death information is added to the Child Death Review Database.

Once the death information is received by the Child Death Review Office, a search of the Statewide Automated Child Welfare Information System (SACWIS) for the child/family name is performed to identify those cases in which the child had prior involvement with DCFS. Child death review is required, or mandated, for all child deaths in which there was prior child involvement with DCFS within the prior year (see Figure 2). Specifically, CDRTs are required to review the deaths of all children aged 17 or younger if the deceased child was:

- a DCFS youth in care;
- not a DCFS youth in care, but the death occurred in a licensed foster home;
- the subject of an open DCFS service case;
- the subject of a pending child abuse or neglect investigation;
- the subject of an abuse or neglect investigation during the preceding 12 months; and/or
- a child whose death is reported to the Child Death Review Office as the result of indicated child abuse or neglect.

Figure 2: Child Death Reviews



CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18, as well as cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.[3] These reviews are called discretionary reviews (Figure 2). Information from the death certificates received by the CDRTs is electronically entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is completed at the CDRT meeting.

According to the Child Death Review Team Act, reviews must be timely. Specifically, each CDRT shall meet at least once in each calendar quarter. In addition, the CDRT must review a case as soon as is practical and not later than 90 days following the completion of an investigation by DCFS. When there has been no investigation by DCFS, the CDRT must review the case within 90 days of obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner or law enforcement agency.

All CDRTs use the same report form to collect information, record findings and list recommendations. This form details the circumstances of the child death. As a part of the child death review, a CDRT may submit recommendations to DCFS that are intended to prevent additional child fatalities through reasonable means. Recommendations are not always necessary in cases where the death was unpreventable through reasonable means or if no changes are needed to existing programs or practices.

After the Child Death Review Team Report is completed at the team meeting, the Child Death Review Office enters all information into the Child Death Review Database. All recommendations are sent to the executive council for approval. If the executive council approves a recommendation from a team, this recommendation is presented to the DCFS director for review at the bi-monthly director and executive council meeting. The director must review and reply to recommendations (except case-specific) within 90 days of receipt. The director shall submit his or her reply both to the chairperson of that team and to the chairperson of the executive council. The director's reply to each recommendation must include a statement as to whether he or she intends to implement the recommendation.

CDRT Access to Information

According to the Child Death Review Team Act, DCFS personnel are required to provide the CDRTs with all records and information in their possession that are relevant to the team's review of a child's death, including information concerning previous DCFS investigations and information gained through the Child Advocacy Center protocol for cases of serious or fatal injuries. In addition, a CDRT has access to all records and information in the possession of a state or local agency that are relevant to the team's review of a child's death. This includes, but is not limited to, birth

[3] In addition to mandated reviews and discretionary reviews, CDRTs are required to review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the mandated reporter may ask for a CDRT or other local multidisciplinary team to review the report. The team will review all pertinent information and make a recommendation to DCFS. There were no reviews of this nature requested in 2018.

certificates, relevant medical and mental health records, law enforcement agency records, Department of Correction parole records, probation and court services records and social service agency records regarding services to the child or family.

Confidentiality of CDRT Information

To ensure the confidentiality of the CDRT process, the Child Death Review Team Act mandates that information provided to and maintained by a CDRT is not subject to the Freedom of Information Act. In addition, these records are not subject to discovery or subpoena, and are not admissible in any civil or criminal proceeding. CDRT members cannot be subject to examination in any civil or criminal proceeding regarding information presented to members at a meeting or opinions shared in CDRT discussions. Furthermore, members of a CDRT are indemnified and held harmless for acts, omissions, decisions and other conduct arising out of the scope of their service on the team. Finally, CDRT meetings are exempt from the Open Meetings Act and therefore closed to the public.

In addition to these provisions outlined in the Child Death Review Team Act, guidelines for CDRT meetings ensure the confidentiality of the information reviewed. Each team member must sign a confidentiality statement at the time of his/her appointment. Only appointed members may regularly attend meetings; guests must be approved by the team chairperson and sign a confidentiality statement. No notes may be taken from the meeting or recorded by team members or non-members.

Chapter 2: Child Death Review Recommendations to Prevent Child Deaths

The purpose of CDRT recommendations is to prevent or reduce future child fatalities through reasonable means. The importance of CDRT recommendations—and their potential for preventing future child deaths—cannot be overstated. The DCFS director is required by the Child Death Review Act to respond to CDRT recommendations within 90 days.

There are four types of CDRT recommendations, although some recommendations will include elements of more than one type:

- Case-specific – immediate actions which must be taken on a specific child welfare case; usually related to siblings of the deceased or other children still in the home
- Primary prevention – focus on public awareness or public education issues (e.g., drowning prevention, firearm safety, seat belt/car seat campaigns)
- DCFS system – focus on the programs, policies and procedures of DCFS (e.g., safety and risk assessment, foster parent training)
- Other agency/system – focus on agencies or systems outside the parameter of DCFS (e.g. public health, state's attorney's office)

In 2019, there were 1,214 Illinois child deaths reported to Child Death Review. Child Death Review Teams reviewed 245 of these 1,214 child deaths. 85 recommendations were made by CDRT's on 57 of the 245 child death cases reviewed. Of the 85 recommendations, there were 38 recommendations which focused on DCFS policy and procedures. The DCFS recommendations resulted from five types of reviews including: death indicated (22), indicated report at time of death (4), investigation within a year of death (6), youth in care (1) and discretionary (5). There were 8 recommendations related to other agencies or systems. These recommendations came from three types of reviews including death indicated (4), indicated report at time of death (1) and discretionary (3). There were 39 case specific recommendations from five types of reviews: seventeen recommendations resulted from cases where death was indicated, seven recommendations resulted from cases that had an indicated report at time of death, seven were from discretionary reviews, five were from cases that had an investigation within a year of death and three recommendations resulted from youth in care cases. There were no primary prevention recommendations made on 2019 child deaths.

Table Key:
DCFS = DCFS recommendation
Other = Other System recommendation
PP = Primary Prevention recommendation
CS = Case-specific recommendation

Table 1: 2019 Illinois Child Deaths Recommendations and Responses

Type of Recommendation	Recommendation	Response
DCFS	The department review/revise its policy to ensure that other parents or regular caregivers are informed of allegations in a current investigation.	DCFS will consider this.
DCFS	DCFS staff should be reminded to do person searches on SACWIS for every adult caregiver in the home.	DCFS agrees.
DCFS	In the redesign of SACWIS, there should be some type of alert to help capture the need for follow up on issues such as screening with the ASA.	These suggestions will be forwarded to the Project Manager for CCWIS.
DCFS	Team recommends DCFS send a letter to the Illinois Chief of Police Association and police academy to remind and educate police that DCFS allegations 60 and 10 includes domestic violence. Police need to know that DCFS will take domestic violence calls.	DCFS agrees. The letter will also be sent to the Chicago Police and the State Police.
DCFS	DCFS should be consulted on any critical decisions made by the private pos agencies before they are presented to the court.	In cases where the family does not meet their service objectives (e.g. family fails to cooperate with services, does not achieve outcome, moves to an unknown location, moves out of state) the case cannot be closed without the Office of Intact Family Services review and approval. Consideration must be given to the risk and safety of the children. If there are active safety threats, an immediate call to police or new hotline report may be warranted. If the children are at high risk of repeat maltreatment, a referral to the appropriate States Attorney may be warranted. The Intact Utilization Unit is reviewing all unsuccessful intact case closures. The agencies that DCFS contracts with have full case management responsibility and are equipped to assist their own workers in making critical decisions. DCFS has a good partnership with private agencies that do the work and they are seeking to build this relationship further. The

		DCFS Clinical Unit is always available to provide consultation to agencies.
DCFS	DCFS Legal to clarify the circumstances and materials that should be released to others investigating the case (i.e. police, coroner, consulting physician, States Attorney, etc.). Specifically, what should be redacted in these cases and what can/should be released in a pending investigation.	Several laws and DCFS rules and procedures dictate how DCFS can share documents and which information must be redacted.
DCFS	Human trafficking training should remain part of the regular DCFS training curriculum. This case highlights that DCFS often intersects with minors who are either the victims of or vulnerable for human trafficking in scenarios where the case does not ultimately become a criminal or child protection court case. Given this unique opportunity to address this population specifically, DCFS should look into providing specialized intact services for minors who are victims of human trafficking or who exhibit signs of and are at risk for human trafficking.	DCFS agrees. Human trafficking will remain part of the training curriculum.
DCFS	There is a DCFS team in Cook county that reviews all cases where there is a history of DCFS investigations regardless of being indicated or unfounded to determine if the case should go to intact or to court for screening. This procedure should be expanded within Cook county as well as statewide.	DCFS has issued a "SOR" memo that addressed these recommendations and other related matters. The following summary of practice changes related to the assessment of Subsequent Oral Reports (SOR) are to be implemented by staff. Changes to P300 will be forthcoming. 1. Consider the total circumstance involving the new report, which includes a review of the family's history of involvement with the Department. This shall be documented in SACWIS as a case note and in a Supervisory note. This history will be weighed when considering a referral to the State's Attorney's Office. 2. When a decision to indicate a case for abuse or neglect is made, intact family services shall be offered. If a family declines these services, the facts of the case will be considered to determine if the case should be referred to the State's Attorney's Office to seek court ordered services.

		3. As has been policy, any second (or more) indicated abuse investigations require a referral to the State's Attorney's Office and a referral to intact services. 4. Area Administrators will be consulted when any of the following factors are present: a) children under the age of 7; b) paramour or domestic violence; c) a caregiver had previously failed to protect a child when the perpetrator has continued access to the child; d) a child has special needs such as medical complexities; e) when a caregiver presents with mental illness, developmental disabilities or cognitive disabilities; if there was a prior open intact or placement case, specifically those resulting in the termination of parental rights; if the caregiver is actively engaged in substance abuse; and if the family has 3 or more investigative contacts with the Department. 5. The Area Administrator shall be consulted whenever a family has 3 or more reports within a one-year time period as this may point to evolving risk of harm or physical injury to a child. 6. When a SOR is received on a parent with an open placement case, protective custody must be taken or ruled out. 7. If the parent had parental rights terminated previously, protective custody must be considered. 8. If the parent has an open intact case, the investigator must communicate with the intact worker within 48 hours. 9. If there are 2 or more SORs during an open intact case, the worker shall consult with the supervisor to determine the need for a referral to the State's Attorney. 10. Each of these aspects is to be documented in SACWIS. In general, in the event service needs are identified and the family refuses

		services, the Child Protection Specialist and Child Protection Supervisor shall consult to determine whether the case should be screened with the State's Attorney for court ordered services. If a case is referred to, or screened with the State's Attorney for court ordered services but the State's Attorney's Office declines to file a petition for court ordered services, then the Child Protection Specialist and Supervisor shall document the outcome of the referral to the State's Attorney's Office and consult with the DCFS Office of Legal Services consistent with DCFS Procedures 300.130 2) B).
DCFS	With the upcoming changes in the law regarding marijuana, the Department should come up with criteria for handling cases where marijuana is used.	A policy guide was issued related to this matter. DCFS will continue to address this on an ongoing basis. The key issue for DCFS to assess in all matters pertaining to substance use/abuse is the caretaker's capacity to parent. This issue is addressed in each of the allegations in DCFS Rule 300, Appendix B. Prior to this change in the law, DCFS did send out reminders related to this issue
DCFS	DCFS to send a general reminder to make sure pack and plays are given out whenever there is no safe sleep bed in the home.	DCFS agrees and will address this at the next operations meeting.
DCFS	DCFS should train staff that there is no such thing as "universal access to medical records" unless the child goes to the same facility. There was significant miscommunication on this.	DCFS agrees with the recommendation.
DCFS	DCFS Nurse and Medical Director should create a protocol to ensure that an agency receiving a medically complex child has specialized training in the area, and to ensure the smooth transition of medically complex children when placement changes or when children move to different medical providers.	DCFS agrees with the recommendation. The Medical Director composed the following: 1) Consider creating a policy specifically for youth returning home after a finding of allegation 79 – medical neglect (could be applied to all medically specialized youth): a. Mandate case to remain open for 12 months to monitor adherence to medical plan (medications, appointments etc.) b. Consider requiring case worker to attend medical appts (or other system

		to document communication with healthcare providers) c. Require continuation with medical providers upon return home if possible. If this is not possible due to geographic or other barriers, then formal written transition document must be completed and a warm hand-off between medical providers must be documented. Warm hand-off means providers speak directly by phone regarding transfer/acceptance of care for the youth. d. May begin transition to new providers if parents request after 3 months with use of written transition document and warm hand-off between medical providers e. Written transfer of care documentation that includes name and contact information of each provider (primary care, subspecialty, therapist) transferring care as well as receiving child for care. Document should also include: i. Medication dose, schedule ii. Diet plan iii. Equipment – e.g. wheelchair, feeding pump, nebulizer machine iv. Date of last appt with current provider and scheduled appt with new provider v. How transfer of medical records will be completed (paper, disc, EPIC) f. Recommendation that court require testimony or written opinion from the caring physician regarding current medical status and safety of returning to parent(s) care 2) Policy for assignment of "Medically Specialized" upon entry into care: a. Establish specific criteria and process to designate a child as medically specialized b. Add question on Comprehensive Health Evaluation completed by the physician "in your opinion, does this youth require designation as Medically Specialized?"

		3) Review role of POS nurse and DCFS nurse in following medically specialized youth a. DCFS nurses provide consultation but do not necessarily remain involved in following each youth b. POS agencies that serve medically specialized youth do not uniformly have a RN and not every medically specialized youth is followed by a POS nurse
DCFS	DCFS staff should be reminded that a forensic interview can be done on cases of physical abuse. These requests can be made by DCFS investigators and not just law enforcement.	DCFS agrees. DCFS will use a child's age and the nature of the allegation to determine the need for a forensic interview and if it is appropriate. DCFS will collaborate with the Statewide Director of the Children's Advocacy Center to provide clarity regarding the age and other circumstances connected to this.
DCFS	DCFS to add to the home safety checklist crib sharing/bed sharing questions regardless of age.	DCFS agrees that this is an ongoing issue. The Home Safety Checklist does ask if "the infant sleeps alone in a crib or bassinette." DCFS will discuss this matter further with staff to stress the importance of this.
DCFS	DCFS needs to have standard guidelines on safe sleep.	DCFS agrees and will be addressing this.
DCFS	If an invitee to CDRT is unable to access the records for their case, they should request that their supervisor access the records so they are able to adequately present at the meeting.	DCFS agrees. The CDRT Manager met with Cook Co. Administration and addressed this and other items.
DCFS	DCFS to look at caseloads and hire more investigators. Further, the complexity of a case needs to be considered in how cases are counted and assigned. The more complex a case, the more time it will take. Factors that make a case more complex include, but are not limited to: 1. Non-verbal victims; 2. Later sequence investigations; 3. Number of children in the family/household; 4. Corollary criminal investigation; 5. More serious injuries, and/or repeated injuries;	DCFS agrees. Caseloads are analyzed on an on-going basis and job postings are almost continual. These are frequently posted on the D-Net. Fortunately, the State Budget has allowed for DCFS to continue to expand its workforce. Numerous factors, including those listed in the recommendation, are considered when supervisors assign cases.

	6. Multiple risk factors (i.e. mental illness, domestic violence, substance and alcohol abuse, intergenerational abuse or neglect, lack of housing or income stability, etc.)	
DCFS	Under the new Family First legislation, DCFS should consider expanding service eligibility for families which include expectant mothers with no other children when there has been a prior report on the family. This would fall under preventative services. This would capture a previously unaddressed population such as is illustrated in this case where clear risk factors exist with a mother as to her neglect of a deceased child and she is due to have another child in her care in the near future.	Expectant parents are eligible for home visiting/preventative services through DHS. DCFS can only intervene once the child is born. As DCFS staff become aware of such needs by an expectant parent, the DCFS staff should be referring the family to HFS.
DCFS	DCFS to regularly send out D-Net notices of child products that are recalled. This should go to both licensed homes and caseworkers for unlicensed homes.	Licensing indicates that staff get regular updates on recalled products. When staff visit daycare and foster homes, the licensee is expected to have checked the Illinois Department of Public Health Website and sign the certification acknowledging that they reviewed and checked their inventory for unsafe products. The form is CFS583A-Certificate of Inspection for Unsafe Children's Products. DCFS will look into how notifications to unlicensed relatives can be completed.
DCFS	DCFS to standardize what is to be considered intoxicated levels of marijuana, research the state police protocols and pharm kinetics of blood levels so that it is universal that all DCFS workers should and can access. Marijuana is now legal for personal consumption in Illinois. Caretaking and marijuana use will likely be an ongoing issue that DCFS sees in abuse and neglect investigations. The question arises, at what level is a person too impaired to act as a caregiver. Executive Council researched whether Illinois has codified the amount of THC that would make a person "under the influence" in civil or criminal court. 625 ILCS 5/11-501.2(a)(6). The limits are 5 nanograms of THC per ml. of	Child Protection Specialists gather evidence of the alleged perpetrator's ability to care for the child victim during the time that they are in a caregiver role. The presence of THC in the system at the time of testing, while invaluable in our assessment, does not alone speak to the ability to care for the child during the time of the alleged incident. While this is valuable information to obtain, it is challenging to determine the exact levels at the time of the incident unless testing is done at that time. Unless the testing is done immediately, this then falls under Hearsay Evidence and is less useful in making a finding due to THC intoxication. Sometimes exact levels cannot be used but a care takers history

	blood, or 10 nanograms of THC per ml. of other bodily fluid (urine or saliva).	of drug/alcohol use or abuse does speak to the risk factors that are present. The Department will continue to support child protection specialists to assess the parenting capacity of alleged perpetrators by gathering all evidence (TCH levels included) regarding the environment of the child. There was the question as to whether or not the 5 nanograms of THC per liter of blood should be written into policy. Currently, the .08 blood alcohol level used to determine alcohol intoxication is not written into Procedure. The Department understands the point Executive Council makes but this does not need to be written into procedure. The Department will communicate to staff the point that 5 nanograms of THC per liter of blood is legally considered to be the intoxication level.
DCFS	DCFS to research most effective use of dolls and doll types for scene reenactment and provide them for staff in the field. Staff should be trained in the use of dolls for scene reenactment. A sufficient number of dolls should be available to each office.	DCFS agrees. The use of dolls is a critical part of scene reenactments. DCFS has explored the best options for dolls to be used in scene reenactments and has placed an order to ensure each office has a sufficient number of dolls available to staff. Staff are being trained in the use of the dolls.
DCFS	Staff to be reminded to document receipt of medical records (or other records) when they are received.	DCFS agrees. This is already in policy that receipt of such records is to be documented in SACWIS.
DCFS	All medical records and other hard file records be downloaded and made available to the CDRT Team.	DCFS agrees. The CDRT manager discussed this with Cook Co. Administration.
DCFS	DCFS should resume the Death Investigations statewide training as soon as possible, and to record the same so that it will be available remotely for incoming staff at any time in the future.	DCFS agrees.
DCFS	Procedures 300 should be amended to allow for a full investigation into an "unusual death" as opposed to a death where the hotline caller opines possible abuse or neglect as that would require a premature conclusion. Add the proposed wording from the ME's office to Procedure 300:	The Department agrees that this is a concern and is currently addressing this and other matters in its response to the Safe Sleep standing agenda item. Section 300.110 Special Types of Reports, Death of a Child, Notification of Child Deaths: The SCR

	SIDS should continue to be included to give historical context as most ME offices are discontinuing this term, however this term is still used frequently by coroners. Perhaps stating "SIDS is a term that is becoming replaced in the forensic pathology community due to the lack of signs, symptoms, or pathological findings to define it as an actual syndrome. Furthermore, some unnatural causes of death may remain undetected despite a thorough investigation and complete forensic autopsy." SUDI and SUID are not as easily defined. The terms are interchangeable and the "U" in each can be either "Unexpected" or "Unexplained" based on the preference of the forensic pathologist or coroner filling out the death certificate. It might be better to have a combined definition for these terms and state that "U" is meant to stand for "Unexpected" initially and transition to "Unexplained" only after a complete death investigation is performed and no cause of death can be determined. Undetermined cause and manner of death should also be mentioned as this is what the ME office uses. Cook County Medical Examiner's Office policy was updated to eliminate entirely the terms SIDS, SUID, and SUDI and instead classify infant deaths with negative scenes, autopsy, histology, and toxicology studies as Undetermined, with Undetermined manner of death. In cases where scene investigation elucidates cosleeping, or an unsafe sleep environment, certification as Asphyxia due to… (whatever the scene and autopsy elicits as the causal factor i.e. unsafe sleep environment, overlay, wedging, etc.), with manner being Accident, would be appropriate. Foster more collaboration between the ME and DCFS with the goal of establishing	Administrator shall ensure that the following, as appropriate, are notified of all child fatalities: The Director's office; The Deputy of Child Protection; The Office of the Inspector General; and The Senior Deputy of Operations. These notifications occur in real time and as such every death, including "unusual death" is reviewed by the Deputy of Child Protection. The Deputy of Child Protection informs SCR when review of an unusual incident should be classified as meeting criteria to become a Child Abuse/Neglect Report and assigned to the field. There is currently a workgroup working on possible changes to P300 and are looking at the material submitted by CDRT.

	joint follow up visits to prevent undue trauma to the parents.	
DCFS	To improve DCP/Hospital coordination and communication by: 1) DCFS, in partnership with the Illinois Hospital Association, will request each Illinois Hospital serving children to designate a point of contact at the hospital to ensure open lines of communication during an abuse and neglect investigation; and 2) DCFS shall create and maintain a database identifying the points of contact at each Illinois Hospital serving children. The point of contact at each hospital should serve to facilitate open lines of communication between the Department and the Hospital during the course of an active investigation.	DCFS disagrees. DCFS will continue to ensure there are open lines of communication during abuse and neglect investigations with hospitals in the service areas. The Department will continue communication with hospital social workers for any assistance.
DCFS	The team would like clarity on when such cases involving medically complex youth are screened right away vs. waiting until discharge given that it takes some time to prepare and train any prospective caretaker on how to properly care for such children.	DCFS should take protective custody as soon as the home environment is deemed "unsafe."
DCFS	DCFS to provide mandatory concrete support to its staff as it relates to secondary trauma in the death of a child. The following would be helpful: a. Establish a regular support group for staff. b. Provide some work relief for workers who have experienced ongoing traumatic cases. c. Provide additional training for secondary trauma and focus on self-care plans for workers. d. Better train supervisors to recognize signs of secondary trauma as all are impacted in some way. e. Provide paid time off for staff who have experienced a significant traumatic event.	DCFS agrees that staff need significant support as it relates to secondary trauma. A number of things are already in place to address this (i.e. Supervisory Model of Practice, support groups being piloted in the Central Region, allowing for administrative time off, and Union Support through the Personnel Support Program). The Department will routinely distribute this to staff.
DCFS	DCFS should work with law enforcement to address the issue of poor information sharing between DCFS and law enforcement.	AAs have been appointed to be liaisons with local law enforcement. A list of the liaisons will be provided to the Executive Council. "Buy in" by each individual is always a concern and this impacts effective collaboration. There was discussion

		that most professions have some type of training requirement. The Illinois Department of Professional Regulations sets this for many professions. The Illinois Law Enforcement Training and Standards Board sets this for law enforcement. At the local level, developing relationships between organizations is really the key.
DCFS	DCFS should continue efforts to engage the collaboration and assistance of state's attorneys' offices earlier on during the investigation phase of investigations such that there can be more thorough review of cases and whether they need to be screened into court or whether any valuable collaboration is possible. The Cook County State's Attorney's Office Division of Child Protection Unit has explored a pilot program with DCFS along these lines and this program and any written protocols should be reviewed for expansion and use throughout the state.	DCFS agrees and will continue to collaborate with the State's Attorney's Office and expand any protocols throughout the State as needed.
DCFS	There should be a written list of all equipment for medically complex children that is checked on a regular basis.	DCFS agrees that regular evaluation of equipment for medically complex youth should be completed. Some equipment required for children with complex medical needs (ventilators, feeding pumps, mobility devices etc.) will not be familiar to case workers who therefore may not be able to identify broken parts or other functional issues. DCFS will suggest a policy that requires case workers to ask foster parents at each visit if they have any concerns regarding the medical equipment for the youth(s) in their care. The case worker would then assist the foster parent in obtaining repair or replacement of the device.
DCFS	Agencies that work with medically complex children need to have extra training to check equipment. The managed care contract should also include checks of medical and other specialized equipment.	The agency nurse should be required to inspect the equipment on a quarterly basis and should also be available to assist in addressing any malfunction/repair needs when they occur.
DCFS	Procedure 300 should require workers to contact the school and if the child	DCFS agrees as much of this is already covered in procedure. Under P300,

	has an IEP, the records should be obtained. If a child is in a substance abuse or mental health facility or detention facility, these records should be obtained during the course of the investigation and factored into assessing the situation.	Appendix B(h) Contacts, Activities, and Documentation Required for ALL Allegations, Required Contacts, it lists: (1)(Q) "For those children enrolled in school or daycare, interview the children's school teachers, other school personnel and/or child care providers that have knowledge of the children and/or the level of care provided to the children." In the same section (W) states, "Interview any social service professionals who have or had involvement with or knowledge of the child and/or family." DCFS will remind staff to inquire about an IEP and if a child has one, they are to seek to obtain a copy of the IEP.
DCFS	There should be a separate allegation regarding unsafe sleep deaths. There are many of these cases and there is inconsistency in DCFS indicating/unfounding such cases.	The Department agrees that this is a concern and is currently addressing this and other matters in its response to the Safe Sleep standing agenda item.
DCFS	DCFS to look at visitation and reunification efforts when an egregious act has occurred on a sibling.	DCFS agrees and there was further discussion on egregious acts. There are several cases where there was a need for expedited termination and reunification should not be sought. This can also be addressed in simulation training.
DCFS	DCFS to review the EFS program to make sure the program is well-staffed, well-trained and well-funded. EFS providers should provide feedback to the referring source on whether the family is cooperative.	DCFS agrees. At the July DCP Meeting, EFS Staff will be invited to present and discuss their program.
DCFS	DCFS to remind staff that if they have concerns that the local State's Attorney is not filing a petition on behalf of children that the worker considers to be at high risk, the worker/supervisor should consult with legal staff and their administration to seek further action.	DCFS agrees. When the State's Attorney does not file and there is disagreement with that, staff should be involving DCFS Legal. Staff will be reminded of this at the upcoming in-person meeting for DCP. P300.130(a)(2)(B) states "In the event service needs are identified and the family refuses services, the Child Protection Specialist and Child Protection Supervisor shall consult to determine whether the case should be

		screened with the State's Attorney for court ordered services. If a case is screened with the State's Attorney for court ordered services but the State's Attorney declines to file a petition for court ordered services or consideration of a shelter care hearing, then the Child Protection Specialist and Supervisor shall consult with the DCFS Office of Legal Services. In addition, if consultation with another Department division (e.g., the Division of Clinical Practice and Development) is desired, the Child Protection Specialist and Supervisor shall make a request for such consultation thru the Area Administrator. The Area Administrator shall determine if the additional consultation is necessary."
DCFS	1. DCFS to seek birth and medical records in a death case from the ME or coroner when not received from provider or provider is unknown to DCFS; 2. DCFS to ask ME or coroner to obtain said records if DCFS hasn't received from the provider; 3. DCFS to use birth registry to find out where the child was born in order to seek birth records if the parents refuse to give that information. 4. DCFS hotline to specifically inquire if the caller knows where, or probably where, the child was born; 5. DCFS to use the "I-Care" system to determine where a child received immunizations, and then attempt to get birth location information from whoever did the immunizations; 6. DCFS to expand the Southern Illinois Regional Task Force to Central Illinois and other locations.	1 & 2. IDCFS agrees and recognizes the importance of obtaining birth records as they provide valuable information to gain a thorough assessment of the situation. Staff will be reminded that they can seek to obtain such records from the ME/coroner if they are unable to obtain records from other sources; 3. IDCFS agrees and will inquire further into the birth registry to seek where a child was born; 4. If the field addresses the rest of these recommendations, the information should be obtained and therefore there is no need for the hotline to add a question. 5. IDCFS agrees and will inquire further into the I-Care system to seek records and birth location information; 6. IDCFS agreed as this item has already been addressed and resolved at the October 2020 meeting between the Director and Executive Council.
Other	Team to send a letter to the Illinois Department of Health and Family Services to review the situation as to	Agreed. Letter pending.

	why the child did not get the needed equipment for his care.	
Other	Executive Council to seek changes in the law to allow for teams to report unsafe products to the Consumer Product Safety Division.	Agreed.
Other	CDRT could write a letter to the AG's office to review this matter and amend the order to allow for the release of information for SUID Registry purposes only.	Agreed. CDRT will compose the letter and transmit to the AG office.
Other	CDRT Executive Council to send a letter to the DCFS employee for her excellent work over the years with such challenging cases (she is retiring at the end of the month).	Approved. Letter sent.
Other	Team to write a letter to the Peoria Police about their practice of clearing crime scenes too soon.	Approved. Letter sent.
Other	The team to send a letter to the clinic for them to review this matter in regard to providing these medications to a mom with a young baby. With this dynamic, the doctor should have clearly warned the mom about the risks of bed-sharing.	Approved. Letter sent.
Other	The hospital should review this case internally to look at how this case was handled. They should get a copy of the autopsy. Hospital should have cooperated with the DCFS investigation as they did not release records. The team will write a letter and request that the hospital's risk management team review this matter further.	Approved. Letter sent.
Other	The team send a letter to the hospital, asking them to look at their discharge instructions regarding the instructions for child being placed on the stomach. The letter should include a review of all the risk factors that were present and for the hospital to look at how the case was handled. The letter will correct the information in the discharge instructions from the hospital regarding infants with symptomatic gastroesophageal reflux	Approved. Letter sent.

	disease (GERD) and placing an infant on their tummy for sleep. Are there any babies who should be placed on their tummy for sleep? The information below is correct: Virtually all babies are safer if they sleep on their backs (facing up). Sleeping face up reduces the risk of sudden infant death. Even babies who spit up frequently (reflux) should sleep on their back. When they spit up, their gag reflex protects them and babies turn their head to the side to let the milk out safely. Source: From The American Academy of Pediatrics –Healthychildren.org website: https://www.healthychildren.org/English/tips-tools/ask-the-pediatrician/Pages/What-is-the-safest-sleep-solution-for-my-baby-with-reflux.aspx	
CS	The Department to review this case as it appears as if there should have been further intervention given the child being substance abuse exposed, other kids being in foster care and the extensive history with DCFS.	DCFS agrees with the recommendation and will review this with the involved staff.
CS	DCFS to review the case addressing the key points, a) The primary part of the mom's supervision plan was to have the 8 & 9-year-old's as the primary caretaker of the younger kids. This plan did lead to the death of the infant. Upon closure of the case, it does not appear that this care plan significantly changed. These children may still be at risk. b) There appears to be no services in place to help the 9-year-old address the trauma of her brother's death as she was the primary caretaker. c) The case was not screened with the State's Attorney.	DCFS agrees and will review the case with the involved staff. Upon review, DCFS revised the care plan and the surviving children are in foster care.
CS	DCFS to look at the prior investigations and how they were handled as to why the State's Attorney was not cooperating with providing information. The children should have been examined more thoroughly by a	DCFS has already reviewed this matter. The case was also reviewed by the Inspector General.

	child abuse expert. The children should have had forensic interviews in at least the "G" Sequence. The full history on this family should have been considered when handling each individual report.	
CS	The ongoing placement case should be reviewed immediately. Given the case dynamics, history and dad's knowledge and consent of the abuse, visits between the dad and his surviving children should not be occurring. The Department should be seeking expedited termination of dad's parental rights, not reunification. The surviving kids should be receiving counseling services. It is not clear if they are receiving them at this time.	DCFS agrees and has reviewed this placement case.
CS	The worker should be commended for her excellent work.	DCFS agrees and has commended her.
CS	DCFS to review this case in regard to the private agency decision to have the kids returned without any confirmation that the mom's drug use was addressed.	DCFS agrees and will review this with staff.
CS	The investigator and supervisor should be commended for their work on this case and their diligent pursuit of the kids who moved away.	DCFS agrees and the investigator and supervisor will be commended for their work on this case.
CS	DCFS should consider termination of rights for the new child that is now in care.	This is already in process. Legal screening has passed for both children. The children are placed together and are doing well. In June the Permanency Goal was changed to Substitute Care Pending the Court Decision on Termination of Parental Rights. The current foster parents are willing to provide permanency for the children.
CS	When workers struggle with objectivity on a case, the supervisor probably should reassign the case. This case should be reviewed with the involved staff to discuss this matter further.	DCFS agrees and will review this case with the involved staff.
CS	DCFS should look at this case and how it was handled regarding the decision on the F and G sequence. In addition, the investigator was not allowed in the home on the E sequence.	DCFS agrees and will review this matter with the involved staff.

CS	CDRT will send a commendation letter to the DCFS Director regarding the investigator.	Executive Council agrees and a commendation letter will be sent.
CS	DCFS to review the case in that the scene reenactment was not done on this case. DCFS should consider adding "Scene Reenactment" as one of the required contacts in SACWIS.	DCFS will review this case with the involved staff as scene investigations should always occur when possible. A general reminder about this will be given at the In-Person DCP Meeting.
CS	DCFS should review this case and how it was handled. The A sequence appears to have merited further investigation into the health and well-being of the children, preferably with toxicology screens ordered for both children in addition to the parents since reporter (a school official) indicated the children were manifesting possible signs of direct methamphetamine exposure (e.g. possible consumption, not simply environmental risk). Similarly, during the B sequence, toxicology screens should have been requested for the child and his sibling, given that infant was born substance exposed, with closer evaluation of their health and well-being. The intact services provided and the service plan/safety plan subsequent to the B sequence should have required regular drug testing for the parents. The service plan/safety plan should have been re-evaluated immediately after the arrest of mother due to the chronic truancy and tardiness of the children. Drug testing should have been pursued as part of the C sequence with greater consideration given to the chronic neglect of the children.	DCFS agrees and has reviewed this case with the involved staff.
CS	The CDRT team to ask the Child Death Review Task Force to review this case regarding the lack of collaboration on this case.	Executive Council agrees. The letter has been sent to the Child Death Review Task Force.
CS	This case should be reviewed as to the accuracy of the finding.	DCFS agrees and will review the case.
CS	DCFS Nurse and Medical Director should look at this case to assess what may have been done differently and to enhance the oversight of cases involving medically complex children.	DCFS agrees with this recommendation.

CS	DCFS should review the case as to why dad was not indicated.	DCFS agrees.
CS	The DCFS Medical Director should review this case specifically as it pertains to the child's cause of death.	DCFS agrees.
CS	A letter should be sent to the doctors regarding the assessment of this child. Just because a child's hymen is still intact does not necessarily mean that the child has not been sexually abused.	DCFS agrees. DCFS Medical Director wrote and sent a letter stating: It is important that any medical provider who is evaluating a child for suspected sexual abuse to understand that the majority of children who have been victims of sexual abuse will have a completely normal examination. The finding of a normal external genital exam does not rule out sexual abuse. The hymen is a structure that varies widely in its appearance between individuals, and changes significantly with puberty. While it can show specific changes that are consistent with vaginal penetration (either acutely or with scarring from past injury), it may also appear completely normal after an acute assault or may heal without evidence of scarring. Rather than the use of "the hymen is intact" it is recommended that the examiner describe specifically the shape and appearance of the hymen as well as describe the other genital and anal structures. Additionally, with the concern for sexual assault in the day prior to presentation, completion of a sexual assault evidence kit and STI testing would have been indicated. While it may not have been possible in this child due to her critical condition, concern for intravaginal trauma in a prepubertal female should be evaluation by vaginoscopy under anesthesia.
CS	DCFS should look at this case and how it was handled as mother was not indicated on A sequence, child was dropped in a car seat and there were multiple incidents regarding domestic violence and mother did nothing to leave the relationship to protect her infant. There was lack of communication between DCFS and	DCFS agrees and will review this with the involved staff.

	POS agency regarding mom's substance abuse issues.	
CS	DCFS to commend the investigator for his good work on the investigation, especially photographing the condition of the scene, the sliding door and pool gate, as well as testing the door and whether a 2-year-old could have opened it.	DCFS agrees and will commend the investigator for this work.
CS	The Department to review this case and consider developing a separate "unsafe sleep" allegation. Situations like this should be indicated.	The Department agrees that this is a concern and is currently addressing this and other matters in its response to the Safe Sleep standing agenda item.
CS	DCFS to look at this case regarding the death and determine if the foster mom should remain a foster parent.	DCFS agrees and will look into this matter.
CS	DCFS should review the finding on this case as mom was impaired at the time of incident and had an available bassinette for safe sleep of the child.	DCFS agrees and will review this.
CS	Review the case as there was a mistake in that the 13yo uncle was indicated when he should not have been. The finding against the 13-year-old should be removed/expunged.	DCFS agrees. This matter was reviewed and the 13-year-old should not have been indicated on this case. The indicated finding against him will be expunged from the system.
CS	DCFS to review the B sequence related to the sexual abuse to help educate staff that a normal physical exam does not rule out that sexual abuse did not occur. A normal medical exam is evident in a large percentage (perhaps 97%) of confirmed sexual assault cases.	DCFS agrees and will review this with the involved staff.
CS	DCFS to review the case and how it was handled in that the mom's partner probably should have been indicated also.	DCFS has reviewed this case with the involved staff.
CS	Team recommends that Child Death Review write and send a letter to the guardian office in the care of this child.	Approved.
CS	DCFS to review this case as the two older kids do not appear to have been assessed regarding the lack of supervision allegation.	DCFS agrees and will review this with the involved staff.
CS	DCFS to review the case and how it was handled, specifically: 1) The new information regarding mother claiming later that the child fell twice, was not provided to the ME and the Chicago Police; and 2) It is unclear if a forensic	DCFS agrees and will review this investigation with the involved staff. DCFS agrees and the nursing division has followed up on this matter. Per the chief nurse, the nursing referral was completed and an addendum was done

	interview was done on the 6-year-old surviving sibling. This additional information is critical in helping determine autopsy results and if the case warrants further criminal investigation. DCFS should ensure that this information is forwarded to both the ME and the Chicago Police personnel who handled the case.	about a month prior to the child's death. The assigned nurse was in a staffing with the hospital staff and the child was improving. There was correspondence between the nurse and DCFS.
CS	DCFS to review the case with the involved staff as the child was in the hospital for some time and mom clearly showed an inability to care for her kids. The case probably should have been screened with the ASA much sooner.	DCFS agrees and will review the case with the involved staff.
CS	DCFS should review this case with the involved staff. It appears that the staff may have had preconceived ideas that the issue was the child's behavior and did not probe further into his medical, educational and behavioral concerns.	DCFS agrees.
CS	DCFS to review this case and determine if this case should move toward expedited termination given the egregious act to the sibling.	DCFS agrees and has reviewed the case related to expedited termination, visitation and reunification and met with the case management agency to outline next steps.
CS	The team would like to send a letter of commendation to the investigator for his good work on this case.	Approved. Letter sent.
CS	DCFS to review this case as it appears that the safety of the older two kids may not have been fully secured.	DCFS agrees and will review this with the involved staff for training purposes.
CS	The DCFS Medical Director should review this case specifically as it pertains to the child's cause of death	Pending.
CS	DCFS to look into the private agency's handling of this as they sought to support a guardianship transfer to relatives, one of which is an indicted perpetrator of sexual abuse and the other has extensive mental health history.	The Department will review this matter with the private agency to both serve as a learning opportunity and to provide monitoring and support.
CS	In this case, the death investigation resulted in an indicated finding which was based on the notion that mother did not check on her bundled infant presumably sleeping in a car seat during an approximately 3-hour drive from Springfield to Chicago. There were different reports given to this	DCFS agrees and will review this case further. AA's currently review all death cases prior to case closing. Any disagreements or changes to the finding are to be discussed with staff.

	team from the worker and supervisor as to whether mother did check on the baby with the investigator on the case specifically indicating that mother did check multiple times on the baby. The investigator's recommendation to unfound the case was declined and the case was indicated by supervisory staff with the investigator reporting she was confused by and not informed of the reasoning therefore. Based on this, it is recommended that: a. DCFS review the case and the ultimate disposition as to: i. even if the baby was not checked on, indicating someone for an arguably reasonable assumption does not seem in line with the purpose of indicated findings; and ii. the evidence as relayed to this team suggests that the baby was checked on multiple times during the trip. b. Review the process by which final decisions are made and then communicated back down to front line staff when there is discordance between the suggested recommendation of the investigator and the supervisor/AA. As this case illustrates, there was tension created when the worker felt like she was not provided with reasoning for the finding.	
CS	DCFS to review the placement case regarding: 1) the lack of follow up in ensuring the child had a primary care physician, 2) that the sleeping arrangements were appropriate, 3) this home should be placed on hold for placement of young children.	DCFS agrees. This matter has been reviewed with the involved staff. A Corrective Action Plan has been implemented regarding this home. Currently there are no children in this home due to the Corrective Action Plan. Once the Corrective Action Plan is completed, it is recommended that the foster parents age range for kids is to be ages 3-18.

Chapter 3: Illinois Child Deaths in 2019

What do we know about the child deaths that occurred in Illinois during 2019?

To answer this question, there are three sets of numbers we need to compare: 1) the total population of children in Illinois; 2) the population of total child deaths in Illinois; and 3) the child deaths that were reviewed by the CDRTs. By comparing the children who died with the general child population in Illinois, we can better understand how characteristics such as gender, age and race/ethnicity are associated with child deaths and how children who died differ from those in the general child population in Illinois. The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths (64% in 2019) are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children involved with child welfare in Illinois is more likely to be younger and Black than the total child population in Illinois. It is therefore likely that deaths reviewed by the CDRTs may over-represent these two characteristics. In order to compare 1) the total population of children; 2) the population of total child deaths; and 3) the child deaths reviewed by the CDRTs, these data are presented side by side throughout this report.

With this information in mind, the following provides a brief look at the three groups:

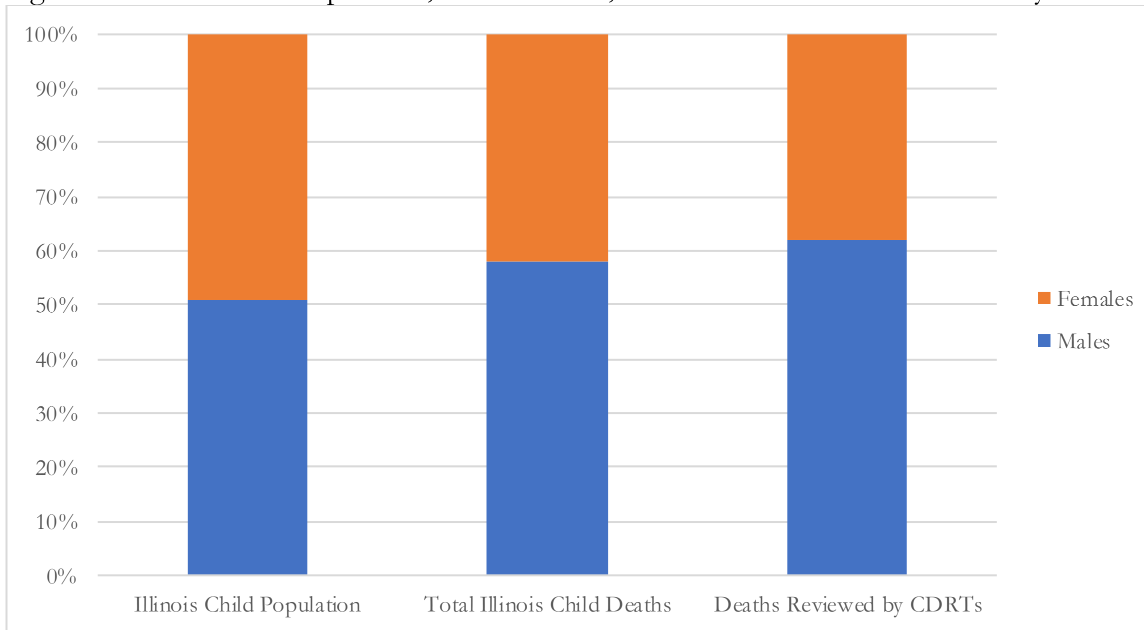
- The population of Illinois children was based on the 2019 Census estimates. According to the Census data, there were approximately 2.82 million children under the age of 18 in Illinois, which constituted about 22.2% of the total Illinois population.[4]
- In 2019, there were 1,214 child deaths reported to the Illinois CDRT database. This included deaths due to all causes, preventable and non-preventable.
- The CDRTs reviewed 245 child deaths that occurred in 2019: 157 of these were mandated for review and 88 were discretionary reviews.

Child Deaths by Gender

According to information from the 2019 Census estimates, 51% of the Illinois child population is male and 49% is female. Boys are more likely to die than girls based on CDRTs data: boys made up 58% of total child deaths and 62% of reviewed deaths in 2019 (see Figure 3).

[4] U.S. Census Bureau. (2021). State population by characteristic: 2010-2019. Retrieved from https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html.

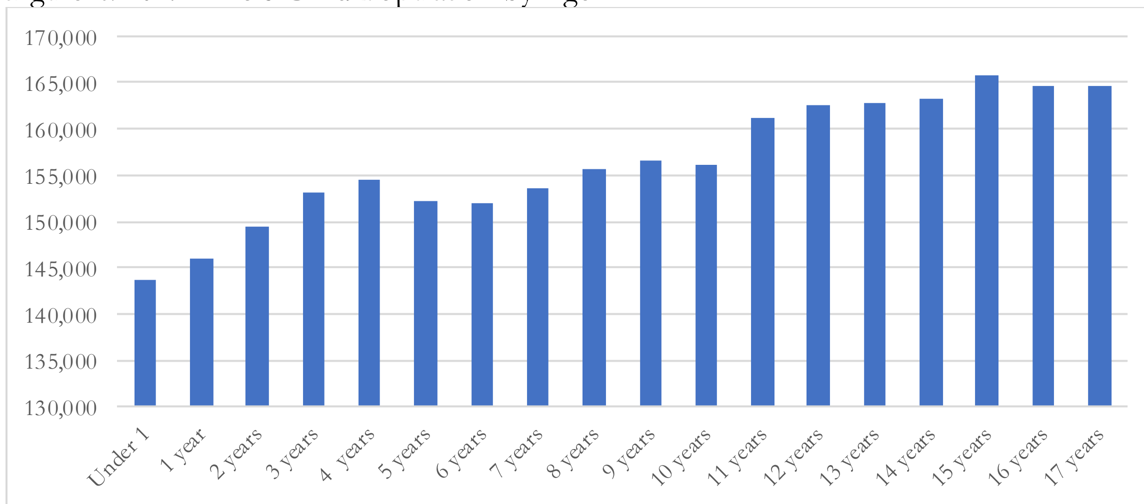
Figure 3: Illinois Child Population, Child Deaths, CDRT-Reviewed Child Deaths by Gender



Child Deaths by Age

In 2019, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 2.82 million children in Illinois under 18 years of age, 5% were less than one year, 21% were between 1 and 4 years, 27% were between 5 and 9 years, 29% were between 10 and 14 years and 18% were between 15 and 17 years.[5]

Figure 4: 2019 Illinois Child Population by Age

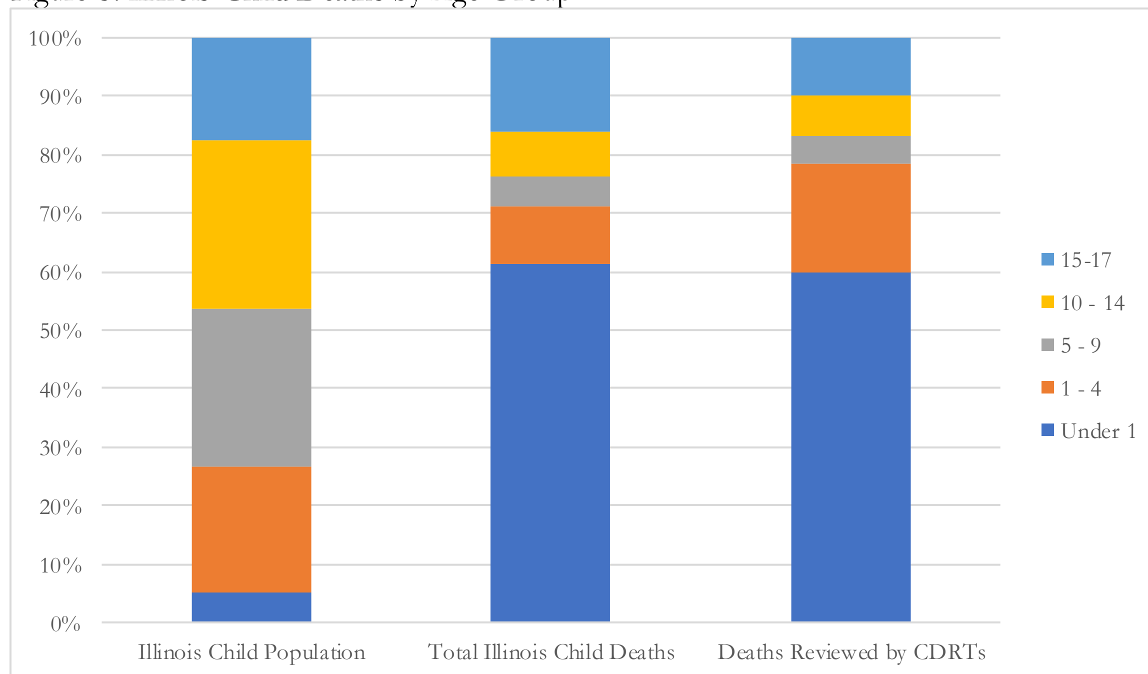


[5] U.S. Census Bureau. (2021). State population by characteristic: 2010-2019. Retrieved from https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html.

However, when we examine the total of Illinois child deaths reported to CDRTs by age (see Figure 5), infants less than one-year-old are especially vulnerable—61% of the total deaths in 2019 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). In 2019, 10% of the total deaths were children between 1 and 4 years, 5% were children between 5 and 9 years, 7% were children between 10 and 14 years, and 16% were between 15 and 17 years.

When we examine the deaths reviewed by the CDRTs by age group (see Figure 5), infants under one year are again over-represented; they comprised 60% of reviewed deaths in 2019. Children between 1 and 4 years make up 18% of reviewed deaths in 2019. Older children make up a smaller portion of reviewed deaths: 5% were for children aged 5 to 9-years-old, 7% were for children aged 10 to 14 and 10% were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race/Ethnicity

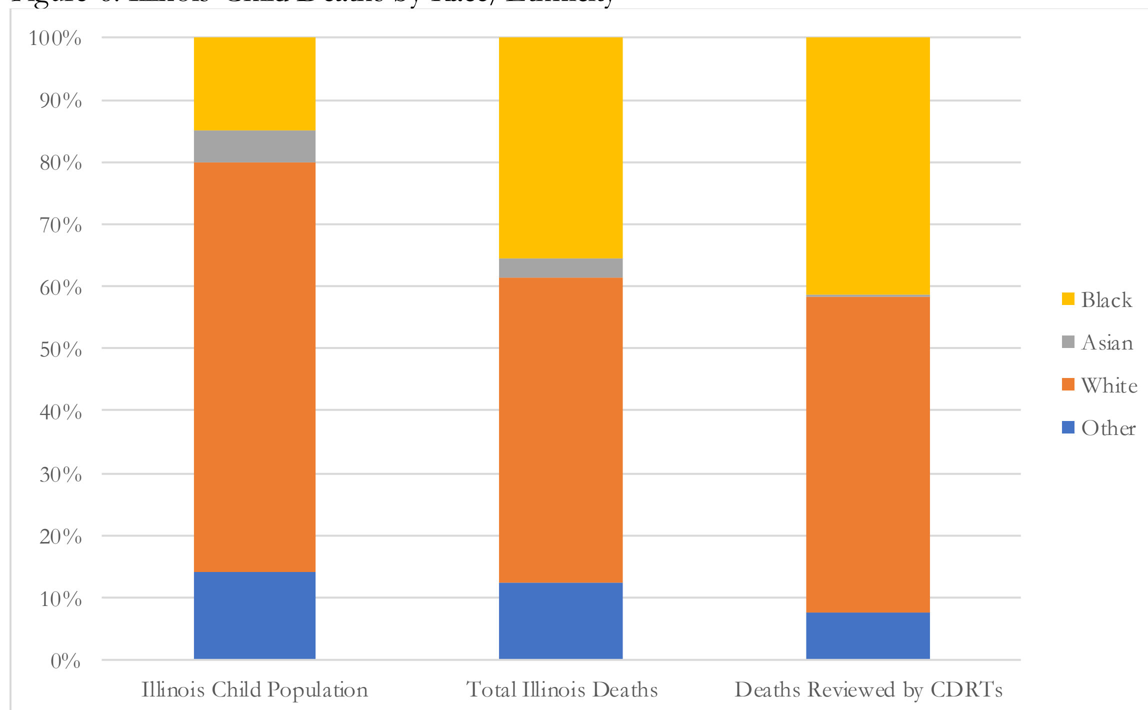
In 2019, 66% of children in Illinois were White, 15% were Black, 5% were Asian and the remaining 14% were of other races/ethnicities (see Figure 6).[6] For reports on ethnicity, 25% self-identified as Hispanic or Latino (of any race) and 51% were White (not Hispanic or Latino). The categories for racial/ethnic origin in the CDRT report are of the following: White, Black, Hispanic, Asian, and Other/Unknown.

[6] U.S. Census Bureau. (2021). 2019: ACS 5-Year Estimates Subject Tables. Retrieved from https://data.census.gov/cedsci/table?q=children%20under%2018%20illinois&tid=ACSST5Y2019.S0901&t=Children

When we examine the total Illinois child deaths by race, it is evident that Black children are at higher risk of death when compared to children in the general population: 36% of the children that died in 2019 were Black, yet they only comprise 15% in the general child population. The proportion of deaths among White children (49%) was lower when compared with their proportion in the general child population (66%). Asian children made up less than 3% of deaths, and children of other race/ethnicity accounted for 13% of child deaths.

Among the 245 child deaths reviewed by the CDRTs in 2019, 41% were Black children, which is larger than their proportion in the overall child population (15%) (see Figure 6).

Figure 6: Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and "other" deaths. In this classification system, the category of death can be different from the proximal cause of death. For example, a child may have died of pneumonia (cause of death) that was the result of an earlier gunshot wound (category of death). By reviewing this death as a firearm death, the CDRT examining the case would make recommendations related to firearms rather than the illness that resulted from the gunshot. The use of categories can be helpful in the development of strategies, systems and awareness campaigns to prevent child deaths.

Categories for child deaths that occurred in Illinois in 2019 are shown in Table 2. The majority of total child deaths were related to either illness (35%) or premature birth (32%). The other categories included suffocation (8%), firearms (8%), undetermined (5%), vehicular (4%), drowning (3%), injury

(2%), fire (1%), poison (1%), SUID (1%), and other types that accounted for less than 1% of the total deaths.

The CDRTs are far more likely to review certain categories of child deaths than others (see Table 2). In 2019, deaths reviewed by CDRTs were most likely to be suffocation (26%), undetermined (22%) and illness (18%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Illness	429	35%	43	18%
Premature Birth	383	32%	7	3%
Suffocation	93	8%	63	26%
Firearms	92	8%	22	9%
Undetermined	65	5%	55	22%
Vehicular	52	4%	3	1%
Drowning	32	3%	17	7%
Injury	21	2%	15	6%
Poison/Overdose	15	1%	4	2%
Fire	11	1%	4	2%
SUID	11	1%	8	3%
Other	5	<1%	3	1%
Scalding Burn	1	<1%	1	<1%
SIDS	0	0%	0	0%
SUCD	0	0%	0	0%
Pending	4	<1%	0	0%
Total	1,214	100%	245	100%

Child Deaths by Manner

It is important to distinguish between the "category of death" and the "manner of death," the latter being a classification used by medical examiners, coroners and physicians when completing a death certificate to clarify the circumstances of death and how the death arose. In most states, manner of death is classified into one of five categories:

- Natural – the death was a result of natural causes such as illness, disease and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm or death
- Suicide – the death was the result of an intentional, self-inflicted act committed to do self-harm or death
- Undetermined – information pointing to one manner of death is no more compelling than one or more other competing manners of death when all available information is considered

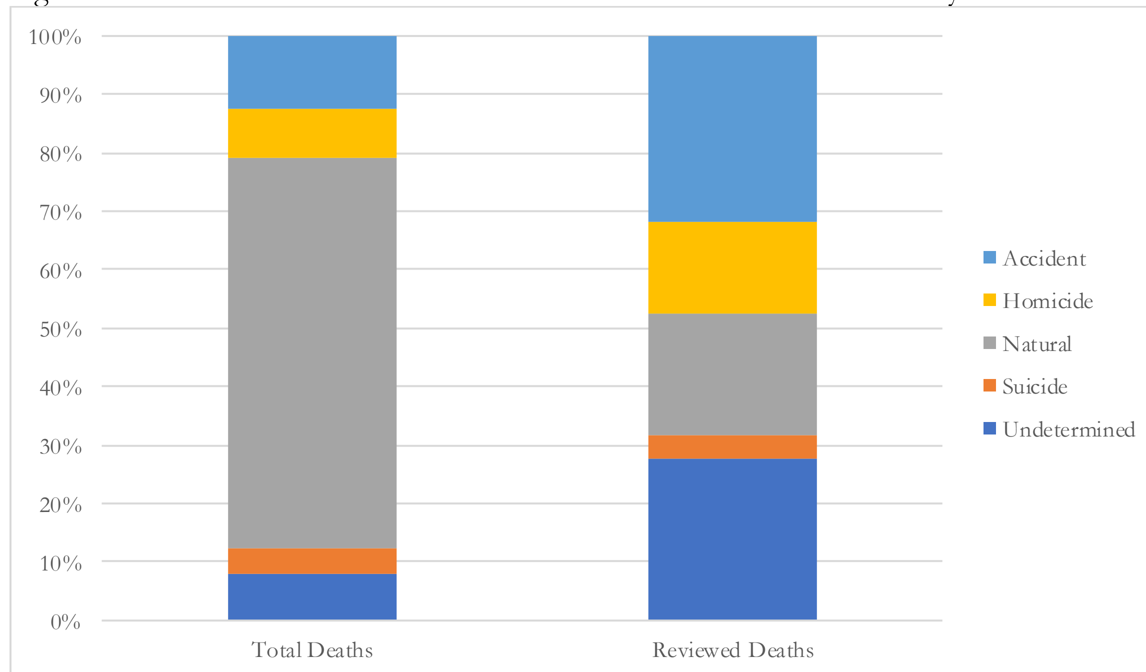
The majority of total child deaths in 2019 were attributable to natural causes (67%), and accidents accounted for 13% of the total child deaths. In addition, 8% were homicides, 5% were suicides and

8% were undetermined. The majority of deaths reviewed by CDRTs were due to accidents (32%), undetermined (28%) and natural causes (21%). The rates of reviewed deaths for homicides (16%) or suicides (4%) closely matched the proportions from all deaths reported in 2018 (see Table 3 and Figure 7).

Table 3: Manner of Death – Total Child Deaths Reviewed by CDRTs

	Total Deaths		Reviewed Deaths	
Accident	153	13%	78	32%
Homicide	101	8%	38	16%
Natural	809	67%	51	21%
Suicide	56	5%	10	4%
Undetermined	95	8%	68	28%
Total	1,214	100%	245	100%

Figure 7: Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs



Child Deaths by Category and Manner

It is important to examine the manner of child death juxtaposed with the categories of death (see Table 4). For instance, the majority of accidental child deaths are due to suffocation and vehicular accidents. Most homicides involve either firearms or other inflicted injuries. Suffocation (hanging) is the most frequent method of child/youth suicide, followed by firearms. Almost all child deaths due to natural causes are the result of illness and premature birth.

Table 4 Total Child Deaths – Manner of Death by Category of Death

Category of Death	Manner of Death					
	Accident	Homicide	Natural	Suicide	Undetermined	Totals
Illness	0	1	423	0	5	429
Premature Birth	1	0	380	0	2	383
Suffocation	60	5	0	22	6	93
Firearms	2	71	0	16	3	92
Undetermined	0	0	2	0	63	65
Vehicular	42	3	0	7	0	52
Drowning	25	2	0	1	4	32
Injury	6	14	0	0	1	21
Poison/Overdose	5	1	0	9	0	15
Fire	6	3	0	0	2	11
SUID	4	0	2	0	5	11
Other	1	1	2	1	0	5
Scalding Burn	1	0	0	0	0	1
SIDS	0	0	0	0	0	0
SUCD	0	0	0	0	0	0
Pending	0	0	0	0	4	4
Total	153	101	809	56	95	1,214

Special Analysis: Homicide Deaths

There were 101 homicide deaths out of the 1,214 deaths in 2019, and we know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. The majority (58%) of homicides were youth age 15 to 17-years-old. Additional information on homicide deaths, presented in Table 5, allows for a more complete understanding of the circumstances of these types of child deaths.

Table 4: Homicide Deaths

Category of Death	Age	Race/Ethnicity	Cause of Death
Drowning	1	Black	Drowning.
Drowning	1	Black	Drowning.
Fire	2	White	Carbon Monoxide intoxication.
Fire	2	White	Carbon Monoxide intoxication.
Fire	3	White	Carbon Monoxide intoxication.
Firearms	1	White	Multiple gunshot wounds to the head.
Firearms	1	Black	Air rifle pellet wound of chest shot by another person.
Firearms	2	Black	Gunshot wound of face.
Firearms	5	Black	Multiple gunshot wounds.
Firearms	7	Black	Gunshot wound of face.
Firearms	10	Black	Gunshot wound of head.

Firearms	12	White	Gunshot wound of head.
Firearms	12	Black	Gunshot wound of head.
Firearms	13	Black	Gunshot wound of chest.
Firearms	14	White	Gunshot wound of head
Firearms	14	White	Multiple gunshot wounds.
Firearms	14	Black	Gunshot wound of back.
Firearms	14	Black	Gunshot wound of right arm and bilateral chest shot by another person.
Firearms	14	Black	Gunshot wound of head.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Gunshot wound of chest.
Firearms	15	Black	Gunshot wound of chest.
Firearms	15	Black	Gunshot wound of head.
Firearms	15	Black	Gunshot wound of head.
Firearms	15	Black	Gunshot wound of right arm into chest.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Multiple gunshot wounds of head.
Firearms	16	Black	Gunshot wounds to torso and lower extremity with perforation of heart, lung, liver, stomach, spleen, and femoral artery.
Firearms	16	Black	Gunshot wound of head.
Firearms	16	White	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Gunshot wound of neck.
Firearms	16	White	Gunshot wound of head.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	White	Gunshot wound of head.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Gunshot wound to abdomen.
Firearms	17	Black	Gunshot wound of abdomen.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of back.
Firearms	17	Black	Complications of multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of chest.
Firearms	17	Black	Gunshot wound of head.
Firearms	17	Black	Gunshot wound of left arm into torso.
Firearms	17	Black	Gunshot wound of neck.
Firearms	17	Black	Gunshot wound to the abdomen.
Firearms	17	White	Gunshot wound to the head.
Firearms	17	White	Multiple gunshot wounds.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.

Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	White	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	White	Delayed complications of gunshot wound of head.
Firearms	17	Black	Gunshot wound of abdomen.
Firearms	17	White	Gunshot wound of groin.
Firearms	17	Black	Gunshot wound of head.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Hispanic	Gunshot wound of chest.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of torso.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of head.
Firearms	17	Black	Complications of multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of chest.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of chest.
Firearms	16	Black	Multiple gunshot wounds.
Illness	0	Hispanic	Complications of anoxic encephalopathy intrauterine hypoxia maternal assault and demise.
Injury	0	Black	Closed head injuries assault.
Injury	0	White	Blunt force injuries of head.
Injury	0	White	Skull fractures with epidural hemorrhage and severe edema of brain blunt force trauma of head struck by another person.
Injury	0	White	Blunt force head injuries child abuse.
Injury	1	Black	Subdural hematoma blunt force trauma of head.
Injury	1	White	Closed head injuries blunt force trauma.
Injury	1	Black	Complications of craniocerebral injuries inflicted head trauma.
Injury	1	Black	Craniocerebral injuries child abuse.
Injury	1	Hispanic	Multiple injuries child abuse.
Injury	1	Black	Hypoxic Ischemic Encephalopathy intracranial injuries blunt head trauma.
Injury	1	White	Craniocerebral injuries multiple blunt injuries of the head child abuse.
Injury	3	Black	Multiple injuries child abuse.
Injury	6	White	Craniocerebral trauma blunt force injuries.

Injury	9	Black	Peritonitis perforated ileum blunt force injury of abdomen.
Other	3	Black	Cold exposure environmental neglect.
Poison Overdose	1	Black	Diphenhydramine intoxication.
Suffocation	0	White	Asphyxia birth into a toilet.
Suffocation	0	White	Asphyxia unsafe sleep environment.
Suffocation	0	White	Suffocation.
Suffocation	1	Black	Asphyxia smothering and compression of neck.
Suffocation	17	White	Ligature strangulation.
Vehicular	13	White	Blunt force injuries motor vehicle crash.
Vehicular	17	White	Motor vehicle crash.

Chapter 4: Child Deaths by Category

To gain a more complete understanding of child deaths in Illinois, the following sections present detailed analyses for the categories of death identified by the CDRT Executive Council. By examining the characteristics of the children who die from each category of death, more explicit and useful recommendations for preventing future child deaths can be made.

Categories are presented in the order of frequency of occurrence for 2019 so that the most common categories of death are first. For each category section, the following information is presented:

- Category definition describes the types of deaths that are included. Background information provides national statistics or research findings, if available.
- Illinois data on total child deaths reported to the CDRTs.
- Numbers of deaths within each category over the past 10 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender, age and race/ethnicity of three groups: 1) the total child deaths; 2) deaths from a specific category; and 3) reviewed deaths from that category.

There is an important fact to remember about these analyses. The deaths reviewed by the CDRTs are not a representative sample of all child deaths in Illinois. It is mandatory that any death of a child involved with DCFS in the past 12 months must be reviewed. Since the child welfare system in Illinois over-represents Black children and young children, the cases reviewed by the CDRT are more likely to be of children who are younger or Black.

Illness

Definition

This category includes any death that was the result of a medical condition. The manner of death for this category is most often determined to be natural. On occasion, however, the manner of death may be determined to be accidental. An accidental determination would include children whose deaths were caused by an accident related to their illness, such as malfunctioning medical equipment or surgical error (for example, accidental removal of tracheotomy tubes).

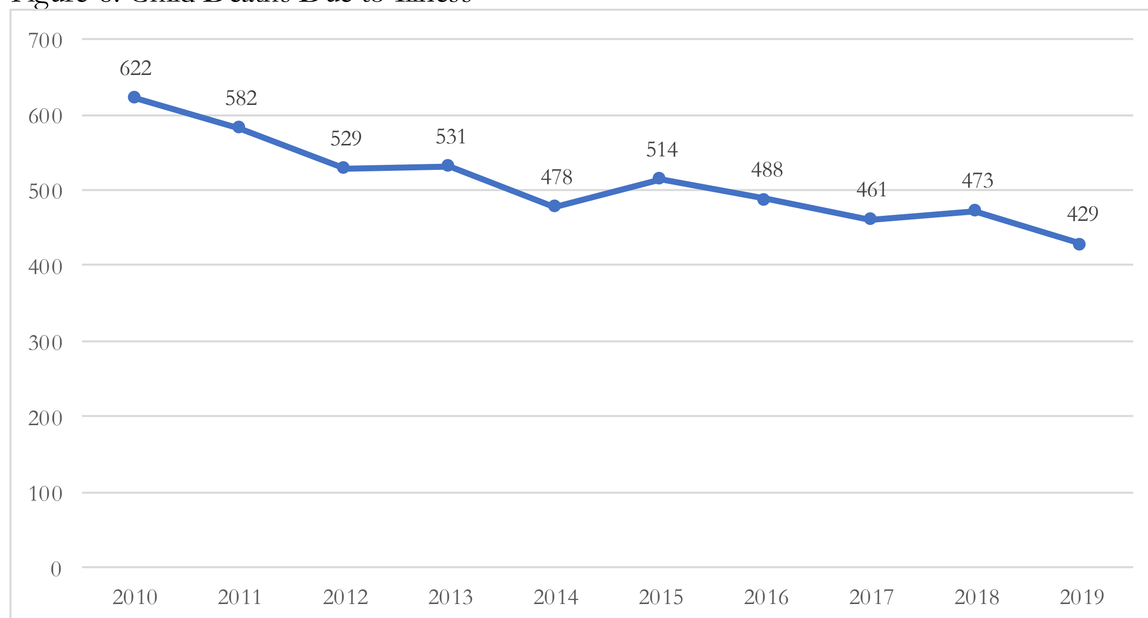
Background

A death due to illness can result from one of many serious health conditions, such as congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart or respiratory disorders and infections. Although many of these conditions are not believed to be preventable in the same way as accidents, homicides and suicides are preventable, deaths from certain illnesses, such as birth defects (e.g., neural tube defects), asthma, infectious diseases and some screen-able genetic disorders are now believed to have a preventable component.

Illinois Data—Total Child Deaths Reported to the CDRTs

For the past decade, illness has been one of the largest causes of child death. The number of deaths from illness peaked in 2010 at 622 and has been steadily decreasing over the years. In 2019, there were 429 deaths from illness, which is the lowest number of deaths in the observed period (see Figure 10).

Figure 8: Child Deaths Due to Illness



In 2019, 429 of the 1,214 total child deaths (35%) reported to CDRTs were related to illness.

- Boys (53%) were more likely to die from illness than girls (47%).
- Half of deaths from illness were among children under the age of 1 (50%), 16% of deaths from illness occurred among children 1 to 4 years old, 9% among children 5 to 9 years old, 13% among children 10 to 14 years old, and 12% among children 15 to 17 years old (see Figure 9).
- The majority (54%) of deaths from illness were White children, followed by Black children (32%), Hispanic children (10%), Asian children (4%), and children of Other/Unknown race/ethnicity (<1%) (see Figure 10).
- Nearly all deaths (99%) from illness were attributable to natural causes, and 1% of the remaining deaths were either homicides or undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 43 of the 245 child deaths reviewed by the CDRTs (18%) were related to illness.

- Girls (53%) were more likely to die from illness than boys (47%).
- Illness-related deaths were most common in infants under 1 year old (42%), while 21% of deaths from illness were of children age 1 to 4 years old, 7% of children 5 to 9 years old, 23% of children 10 to 14 years old, and 7% among children from 15 to 17 years old (see Figure 9).
- A little over half (53%) of the reviewed deaths from illness were Black children, 40% were White children, 5% were Hispanic children, and one case (2%) was an Asian child (see Figure 10).
- Nearly all (98%) of reviewed deaths that were categorized as illness were attributed to natural causes, and there was one case that was a homicide (2%).

Figure 9: Child Deaths Due to Illness by Age

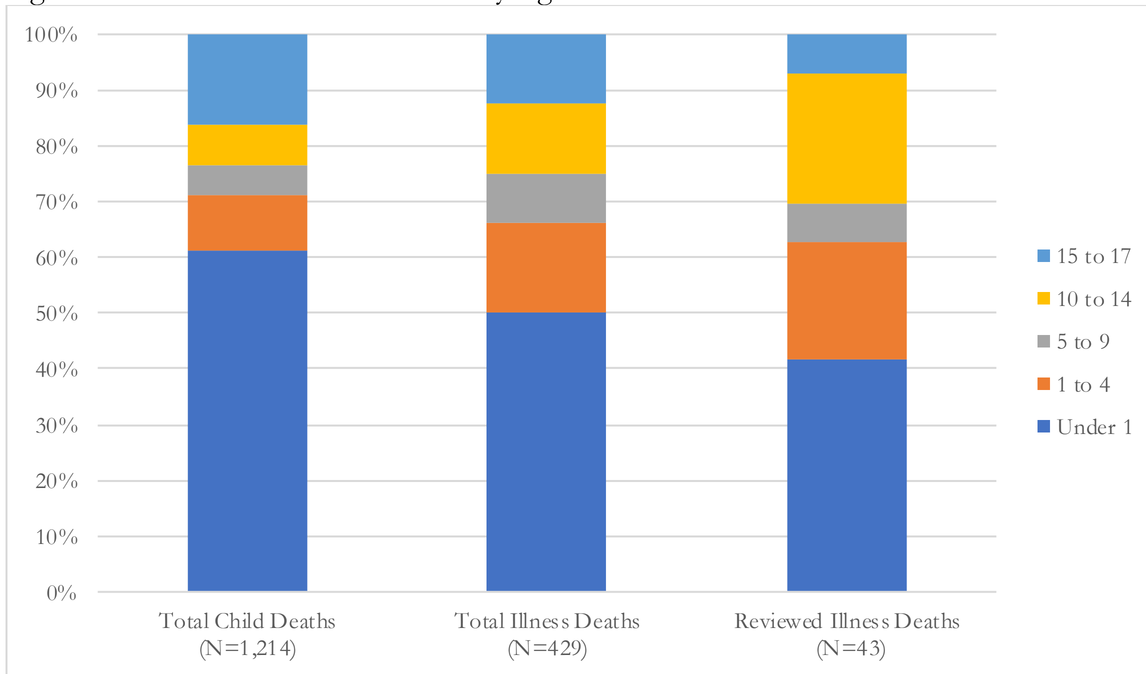
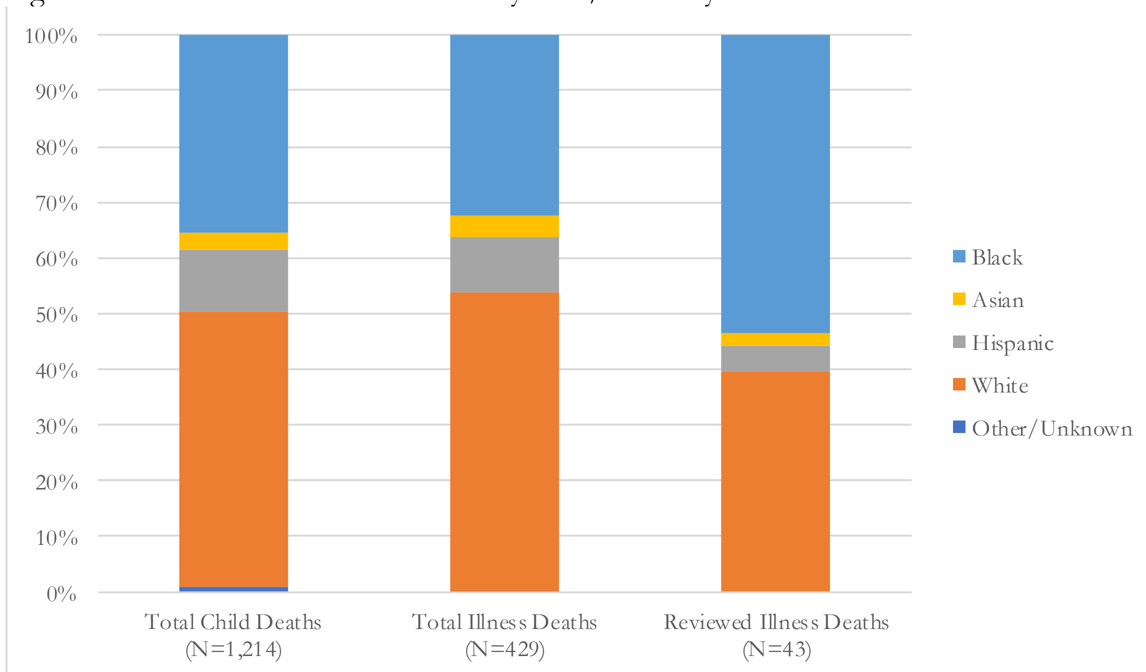


Figure 10: Child Deaths Due to Illness by Race/Ethnicity



Premature Birth

Definition

Although there is no single, agreed-upon definition of preterm birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as "very preterm" (less than 32 weeks of gestation) and "moderately preterm" (32-37 weeks of gestation). In Illinois, deaths in this category include aborted pregnancies where a death certificate was completed, but not fetal deaths. The manner of death associated with prematurity is most often determined to be natural. However, if an infant is born prematurely due to maternal injury, the manner of death may be ruled accidental or homicide.

Background

Premature birth is closely associated with low birth weight. Low birthweight (LBW), one of the five leading causes of infant mortality, is an indicator of child health (current and future) as well as maternal health. LBW babies are more likely to have health problems during the newborn period than babies of normal weight. LBW babies may be also at greater risk for serious physical and mental health illness throughout the lifespan.[7]

In Illinois, about 1 in 9 (10.7%) babies were born preterm in 2019, compared with 10.2% in the nation.[8] The rate of preterm birth in Illinois is highest for Black infants (14.6%), followed by American Indian/Alaska Natives (13.6%), Hispanics (10.2%), Whites (9.6%), and Asian/Pacific Islanders (9.4%).[9] A number of risk factors have been associated with preterm birth: maternal age, history of preterm birth, multi-fetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity and elevated blood pressure.[10] Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

Illinois Data—Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death in Illinois and has been either the largest or second largest category in the past decade (ranging between 383 to 572 deaths per year). The number of premature deaths decreased from 496 in 2018 to 383 in 2019, the lowest number of deaths being the lowest in the last decade.

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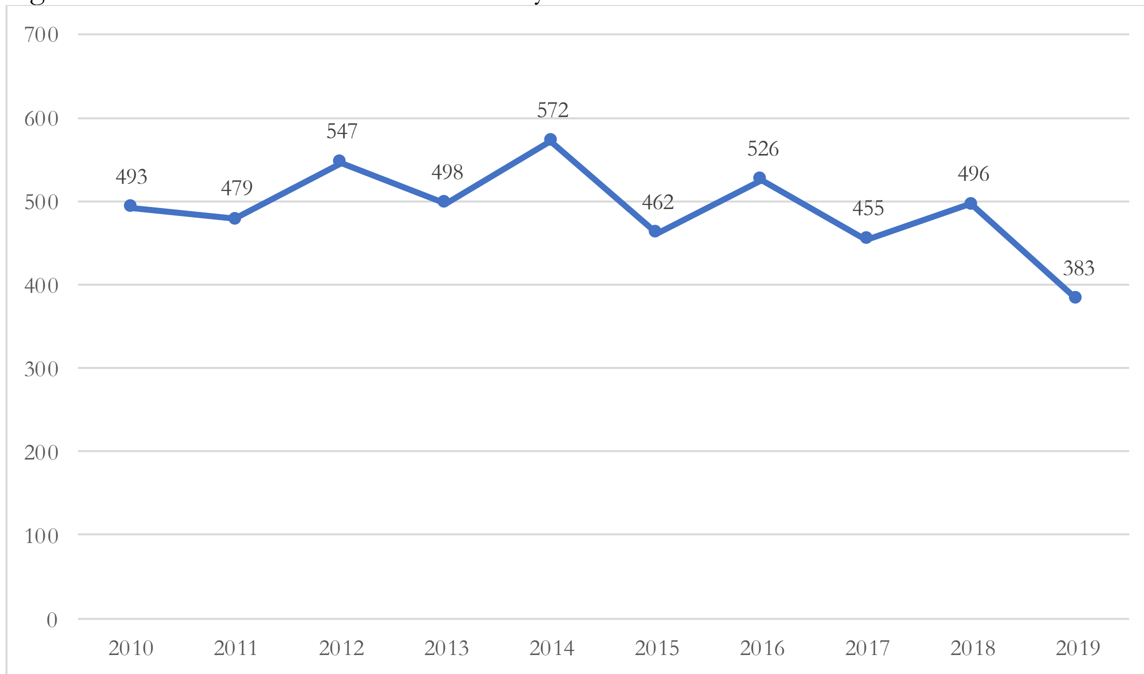
[7] America's Health Rankings (2020). 2020 Annual Report. United Health Foundation. Retrieved from https://assets.americashealthrankings.org/app/uploads/annual20-rev-complete.pdf

[8] March of Dimes (2021). Quick facts: *Preterm deaths*. Retrieved from https://www.marchofdimes.org/peristats/viewtopic.aspx?reg=17&top=3&lev=0.

[9] National Center for Health Statistics. Illinois prematurity data. Retrieved from http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4.

[10] Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America's health: State rankings, 2004 Edition*. United Health Foundation.

Figure 11: Child Deaths Due to Prematurity



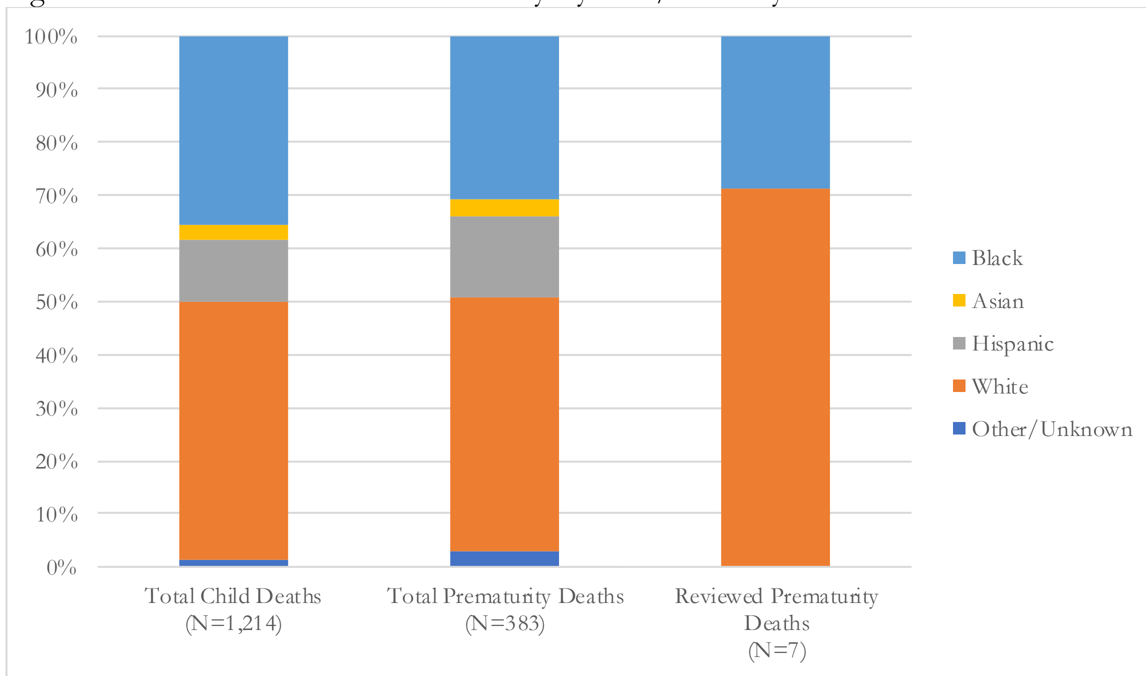
Out of 1,214 child deaths in 2019, 383 (32%) were related to premature birth.

- A majority of children who died prematurely were boys (54%).
- The largest proportion of deaths from prematurity were White children (48%), followed by Black children (31%), Hispanic children (15%), Asian children (3%) and children of other or unknown race/ethnicity (3%) (see Figure 9).
- Nearly all deaths (99%) in this category were the result of natural causes, 2 deaths were from undetermined causes, and 1 death was an accident.

Illinois Data – Deaths Reviewed by the CDRTs

- In 2019, 7 of the 245 child deaths reviewed by CDRTs (3%) were related to premature birth.
- All but one (86%) of premature deaths reviewed by the CDRTs were boys; one (14%) was a girl.
- The majority of premature deaths reviewed by the CDRTs were White children (71%), and Black children were 29%.
- All but one (86%) of premature deaths reviewed by the CDRTs were the result of natural causes, and one case (14%) was undetermined.

Figure 12: Child Deaths Due to Prematurity by Race/Ethnicity



Suffocation

Definition

Child deaths due to suffocation result from obstruction of the airway from a variety of causes. Deaths due to suffocation can be accidents, suicides or homicides. Most unintentional or accidental suffocations are caused by:

- Choking – food or another small object blocks the internal airway.
- Positional asphyxia – a child's external airway (i.e., nose and mouth) is blocked by objects or materials such as soft bedding, pillows, bumper pads, etc., or the child becomes wedged in a small space such as between a mattress and a wall or between couch cushions.
- Overlaying – a person sleeping with a child rolls onto the child and unintentionally suffocates the child.
- Confinement – a child is trapped in an airtight place such as an unused refrigerator.
- Strangulation – a rope, cord or other object becomes wrapped around a child's neck and restricts breathing.

When examining the information on child deaths due to suffocation, it is important to note that many medical examiners or coroners will not list an infant death as suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eyewitness account. If there is no such evidence, these types of suffocation deaths may be listed as unknown infant deaths, SIDS or undetermined deaths. Thus, the actual number of deaths due to suffocation may be under-reported.

Background

In 2019, 2,253 children ages 17 and under in the U.S. died from suffocation.[11] Of these children, 52% were less than one year of age and 59% were ages four and under. Unintentional suffocation is the leading cause of injury-related death among infants less than one year old.[12]

Illinois Data—Total Child Deaths Reported to the CDRTs

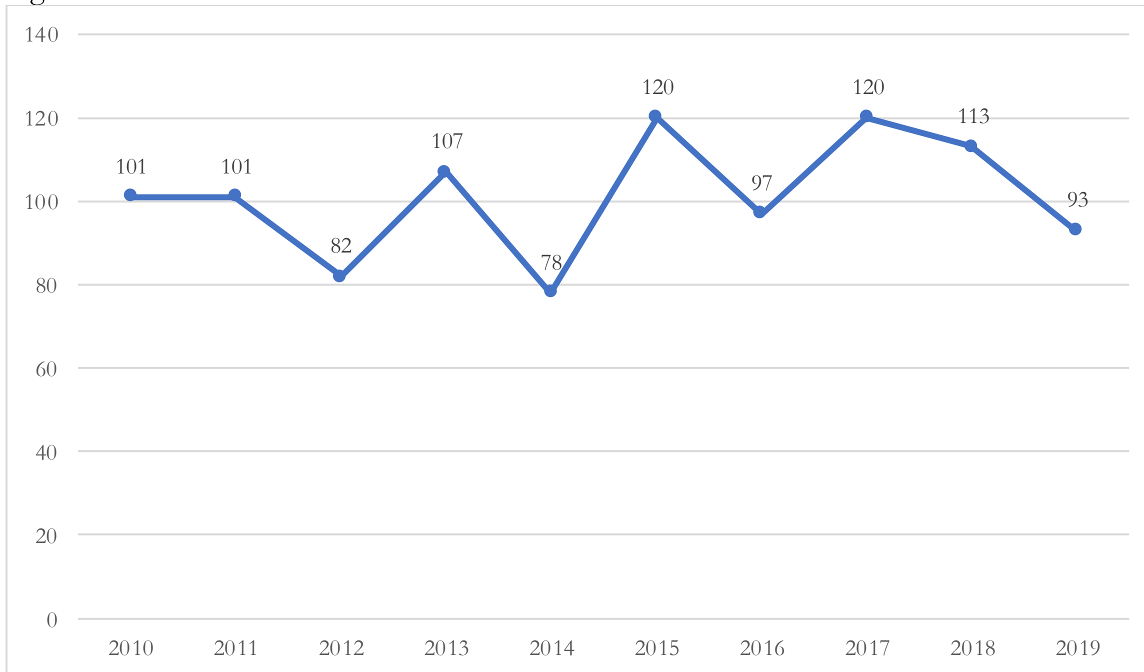
Suffocation deaths have fluctuated slightly in the past decade, ranging from a low of 78 to a high of 120. The number of suffocation deaths has dropped for the last two years, and there were 93 suffocation deaths in 2019 (see Figure 13).

---

[11] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.

[12] Safe Kids Worldwide. (2021). *Suffocation Prevention and Sleep Safety*. Retrieved from https://www.safekids.org/safetytips/field_risks/sleep-safety.

Figure 13: Child Deaths Due to Suffocation



In 2019, 93 of the 1,214 total child deaths reported to the CDRTs (8%) were categorized as suffocation.

- The majority of children who died from suffocation were boys (63%).
- Infants under one year made up over three-fifths (62%) of deaths in this category. Children ages 1 to 4, 5 to 9, and 10 to 14 accounted for 8%, 3%, and 4% of deaths in this category, respectively. Older children ages 15 to 17 accounted for the second largest proportion of suffocation deaths (23%).
- Over half (55%) of children who died from suffocation were White, 34% were Black, 8% were Hispanic, and 3% were Asian.
- Most suffocation deaths were accidental (65%) or suicides (24%); and the remaining suffocation deaths were homicides (5%) or undetermined (6%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 63 of the 245 child deaths reviewed by CDRTs (26%) were related to suffocation.

- The majority of reviewed suffocation deaths were boys (65%).
- Infants under one year made up the majority of reviewed suffocation deaths (78%). Children ages 1 to 4 accounted for 11% of reviewed suffocation deaths, children 5 to 9 for 5%, and

children 15 to 17 were 6%. There were no reviewed suffocation deaths of children 10 to 14 years old.

- The majority of reviewed suffocation deaths were White children (56%) and Black children (40%).

- Most reviewed suffocation deaths were accidental (76%). Homicides accounted for 8% of reviewed suffocation deaths, suicides were 6%, and 10% were undetermined.

Figure 14: Child Deaths Due to Suffocation by Age

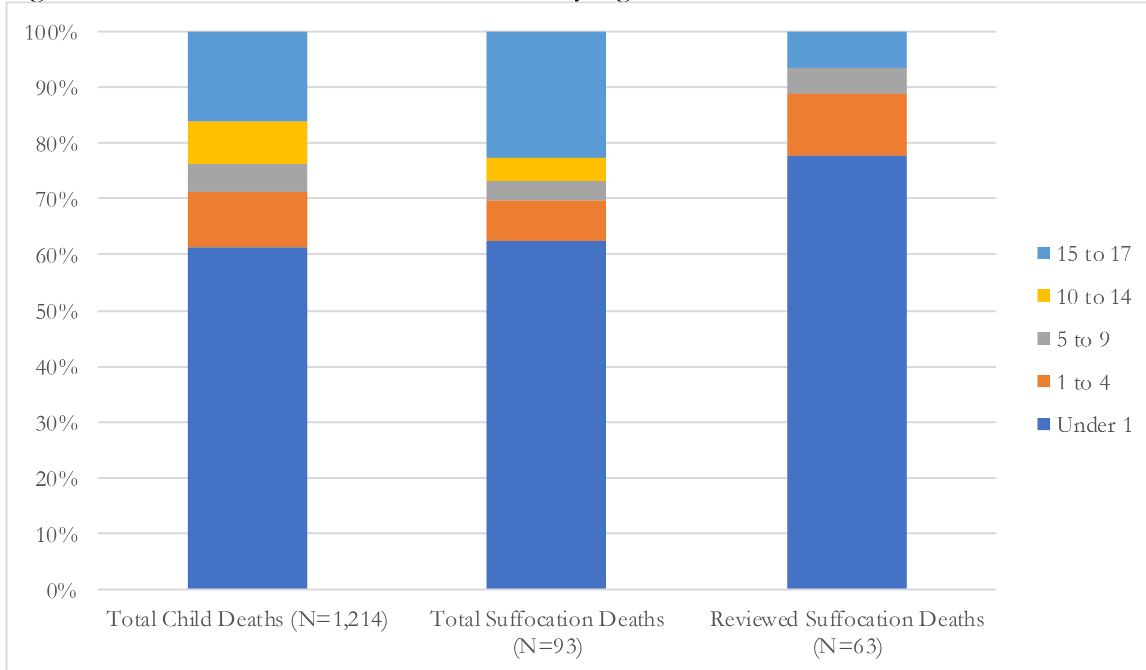
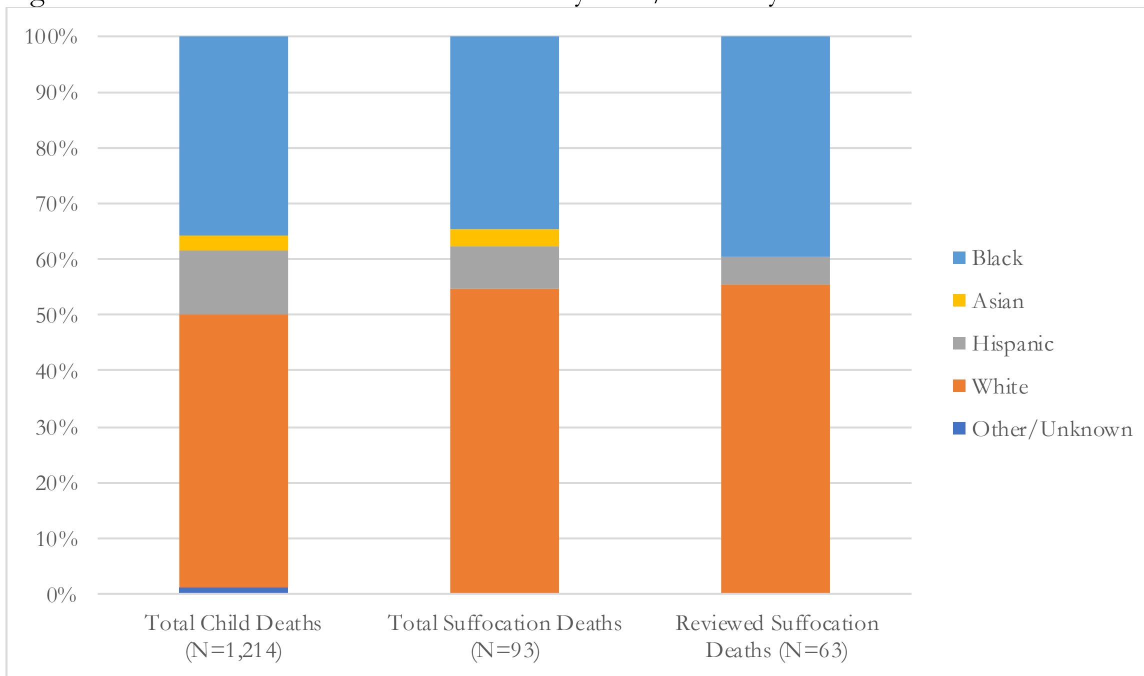


Figure 15: Child Deaths Due to Suffocation by Race/Ethnicity



Firearms

Definition

This category includes all deaths that are the result of gunshot wounds. The manner of death within this category may be determined to be homicide, suicide or accident.

Background

According to data from the Centers for Disease Control and Prevention, 1,732 firearm deaths occurred in 2019 among children under 18 years of age in the United States. The vast majority (71%) of these deaths were youth between the ages of 15 and 17. Race of decedent is also a factor. In 2019, the homicide rate with firearms for Black males 13 to 17 years old was nearly 10 times higher than the rate for White males of the same age group.[13] The proportion of teenage deaths due to firearms decreased dramatically over the span of nearly two decades. The rates were 27.8 per 100,000 in 1994 and fell down to 9.7 in 2013; however, rates have increased by nearly 30% to 13.8 per 100,000 in 2017.[14]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from firearms has fluctuated over the past several years. Firearms deaths ranged between 78 to 85 from 2010 through 2013, but there were over 100 child deaths from firearms in 2014, 2016, and 2017. There were 92 deaths from firearms in 2019 (see Figure 16).

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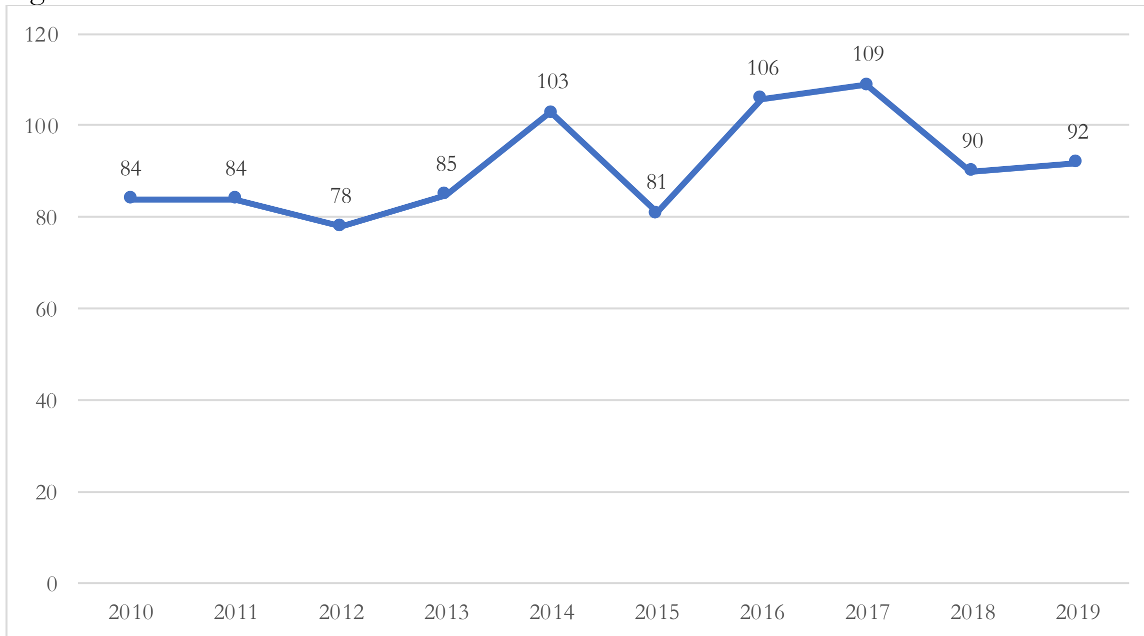
[13] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2021). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.

[14] Child Trends. (2017). *Teen homicide, suicide, and firearm deaths*. Retrieved from https://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths.

Figure 16: Child Deaths Due to Firearms



In 2019, 92 of the 1,214 total deaths (8%) were related to firearms.

- Deaths due to firearms overwhelmingly occurred among boys (91%).
- Over three-in-four firearm deaths occurred of children aged 15 to 17 (77%), and children age 10 to14 were the next largest group (16%) (see Figure 17).
- 64% of the children who died from firearms were Black, 28% were White, and 8% were Hispanic (see Figure 18).
- Homicides accounted for 77% of firearm deaths, suicides were 17%, accidents were 2%, and undetermined cases accounted for 3%.

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 22 of the 245 deaths reviewed by the CDRTs (9%) were related to firearms.

- The majority of reviewed firearm deaths were boys (82%).
- Youth 15 to 17 years old accounted for the majority of firearm deaths (59%), followed by children age 10 to 14 (27%). (see Figure 17).
- Over two-thirds (68%) of reviewed firearm deaths were Black children, slightly less than a quarter (23%) were White children, and 10% were Hispanic children (see Figure 18).

- The majority of firearms deaths reviewed by CDRTs were due to homicides (59%), and suicide cases (23%) were the second most common manner of death. Accidental and undetermined cases were each 9%.

Figure 17: Child Deaths Due to Firearms by Age

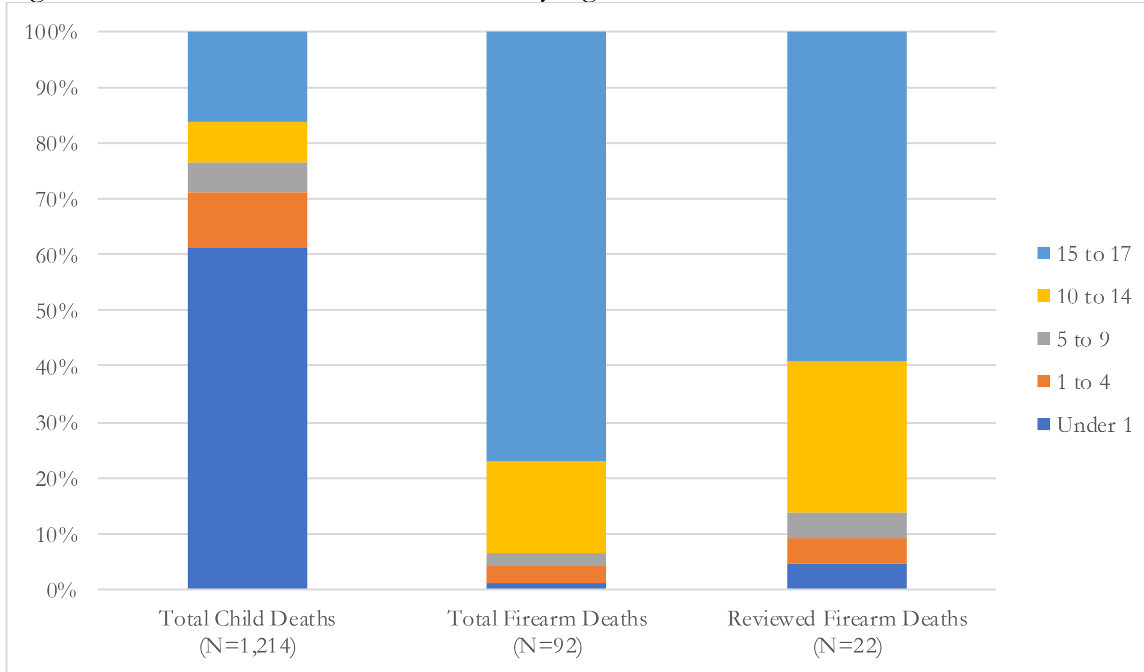
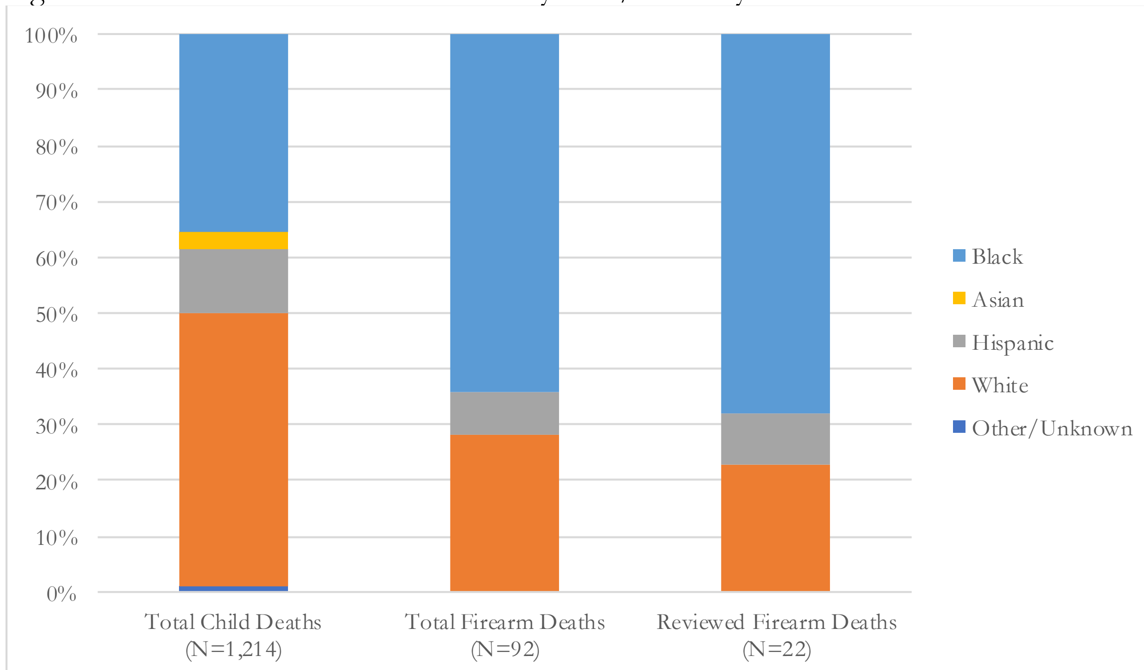


Figure 18: Child Deaths Due to Firearms by Race/Ethnicity



Undetermined Deaths

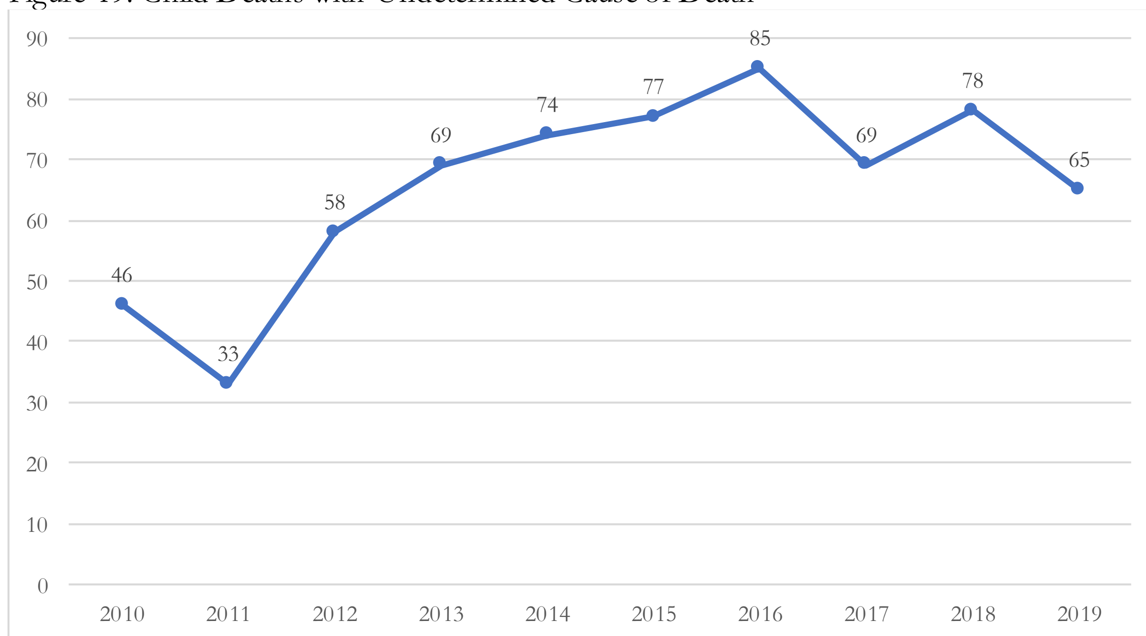
Definition

This category includes those deaths in which there was not enough evidence for the coroner or medical examiner to definitively determine the cause.

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of undetermined deaths in Illinois has been steadily increasing since the low of 33 in 2011 and peaked at 85 in 2016; there were 65 undetermined deaths in 2019 (see Figure 19).

Figure 19: Child Deaths with Undetermined Cause of Death



In 2019, 65 of the 1,214 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

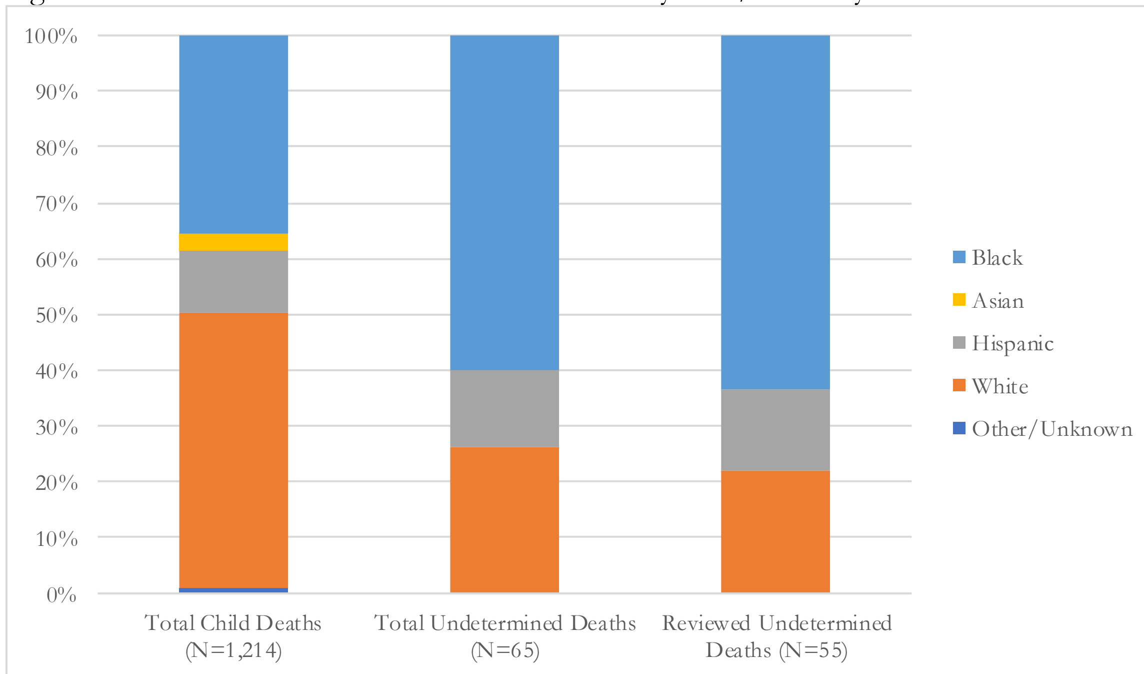
- Deaths due to undetermined causes were more common for boys (57%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (92%).
- The majority of undetermined deaths were Black children (60%), followed by White children (26%), and Hispanic children (14%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 55 of the 245 deaths reviewed by CDRTs (22%) had an undetermined cause of death.

- Reviewed deaths due to undetermined causes were more likely for boys (58%).
- 96% of reviewed undetermined deaths were children under age 1.
- The majority of undetermined deaths were Black children (64%), followed by White children (22%) and Hispanic children (15%) (see Figure 20).

Figure 20: Child Deaths with Undetermined Cause by Race/Ethnicity



Vehicular Accident

Definition

Included in this category are all deaths occurring to children who are drivers, passengers, pedestrians or occupants of other forms of vehicles such as bicycles, snowmobiles, motorcycles, ATVs, sleds, trains, etc. The manner of death is usually accidental but can include deaths ruled to be suicides or homicides as well.

Background

Nationally, a total of 844 children (under the age of 13) died in motor vehicle crashes in 2019.[15] There has been an 80% decrease in the rate of motor vehicle crash deaths per million children under 13 since 1975. In 2019, 73% of child motor vehicle crash deaths were passenger vehicle occupants, 16% were pedestrians, 4% were bicyclists, and the remaining 7% were other/unknown. Since 1975, child pedestrian and bicyclist deaths each year declined by 92% and 93%, respectively, and passenger child occupant deaths decreased by 56%. Children 12 and younger are recommended to ride in the rear seats of vehicles. Fourteen percent of passenger vehicle child occupant deaths occurred in front seats, continuing a downward trend that has spanned for several decades. Seventy-nine percent were in the rear seat, and 7% were in cargo/unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about a quarter of unintentional injury deaths among children younger than 13. The majority of deaths from crashes are among children traveling as passenger vehicle occupants, which could potentially be reduced through proper restraint use. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about 75% for children up to age 3, and almost 50% for children ages 4 to 8.[16]

In 2019, a total of 2,375 teenagers, ages 13 to 19, died in motor vehicle crashes. This is a decrease of 73% from 1975 and 5% from 2018. Males accounted for about two out of every three teenagers killed in crashes in 2019. Although males make up a larger number of crash deaths, their rates have decreased more for males (76%) than females (64%) since 1975. Teenagers accounted for 7% of motor vehicle crash deaths in 2019 and 8% of passenger vehicle (cars, pickups, SUVs and vans) occupant deaths among all ages, 4% of pedestrian deaths, 3% of motorcycle deaths, 6% of bicyclist deaths and 14% of all-terrain vehicle rider deaths.[17]

In the United States, teenagers drive less than most adults, yet their number of crashes and deaths from crashes are disproportionately high. The fatal crash rate per mile driven for 16- to 19-year-olds is about three times the rate of older drivers 20 and over, with the highest risk among teenagers ages 16 to 17.[18]

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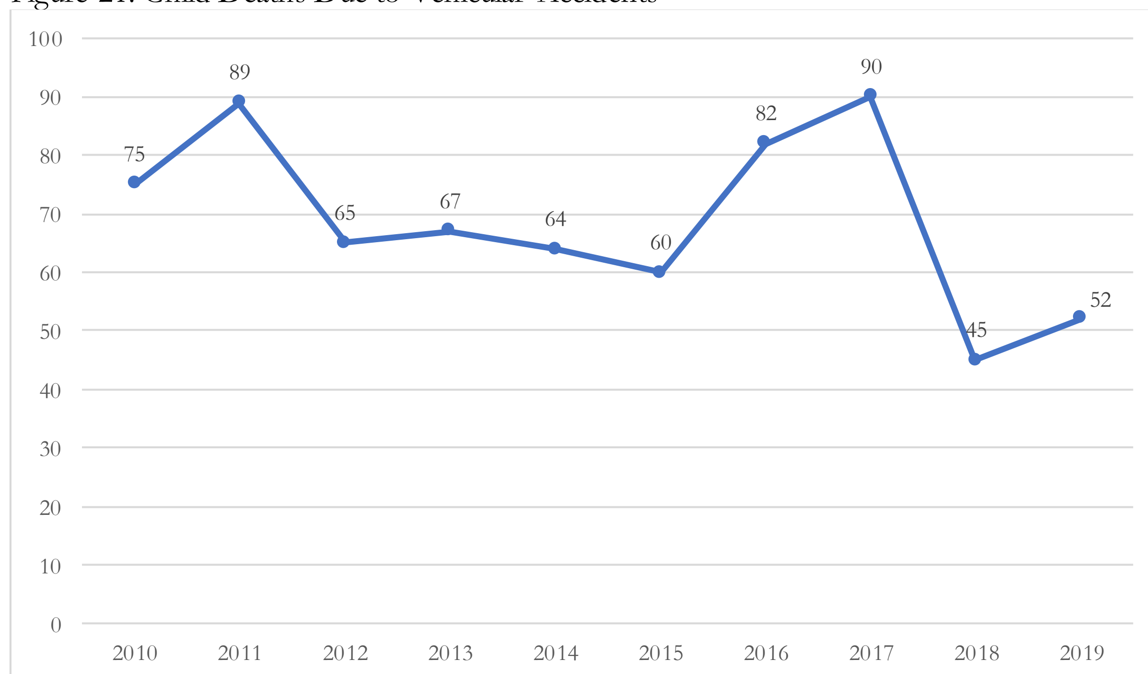
[15] Insurance Institute for Highway Safety. (2020). *Fatality facts 2019: Children*. Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/children#Age-and-gender.
[16] Ibid.
[17] Insurance Institute for Highway Safety. (2020). *Fatality facts 2019: Teenagers*. Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/teenagers.
[18] Ibid.

Distracted driving is often the cause of fatal accidents. The most common distraction for teen drivers is cell phone use. Other common sources of distraction for teen drivers are riding with peers and drowsiness.[19] Another factor that affects teenage vehicular fatalities is inexperience. To address this, all states have adopted graduated licensing systems, which phase-in full driving privileges. National studies of graduated licensing found that strong laws were associated with substantially lower fatal crash rates and substantially lower insurance claim rates among young teen drivers covered by the laws.[20]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of vehicle deaths had previously fluctuated between 60 to 90 between 2010 and 2017. However, in 2019 there were only 52 vehicle deaths (see Figure 21).

Figure 21: Child Deaths Due to Vehicular Accidents



In 2019, 52 out of the 1,214 total child deaths reported to the CDRTs (4%) were related to vehicular accidents.

- Boys accounted for 60% of vehicular accident deaths.
- Older children ages 15 to 17 made up the largest proportion of vehicular deaths (54%). Children in other age groups made up the following proportions of vehicular deaths—

[19] Children's Hospital of Philadelphia Research Institute (2019). Teen Driving Safety: Distracted Driving Research. Retrieved from https://injury.research.chop.edu/teen-driving-safety/distracted-driving-research.
[20] Insurance Institute for Highway Safety. (2018). *Fatality facts 2017: Teenagers*. Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/teenagers.

children under 1 were 2%, children 1 to 4 were 12%, 5 to 9 were 12%, and 10 to 14 were 21% (see Figure 22).

- The majority (69%) of vehicular deaths were White children, followed by Black children (23%), Hispanic children (6%) and one child was Asian (2%) (see Figure 22).
- The majority of vehicular deaths were accidental (81%). The remaining cases were suicides (13%) and homicides (6%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 3 of the 245 deaths reviewed by the CDRTs (1%) were related to vehicular deaths.

- Two out of the three reviewed vehicular deaths were girls (67%).
- All of the review vehicular deaths were between the ages of 1 to 4 (100%) (see Figure 22).
- Two of the three reviewed vehicular deaths were Black children (67%), and the other case was a White child (33%) (see Figure 23).
- All of the reviewed vehicular deaths were accidents (100%).

Figure 22: Child Deaths Due to Vehicular Accidents by Age

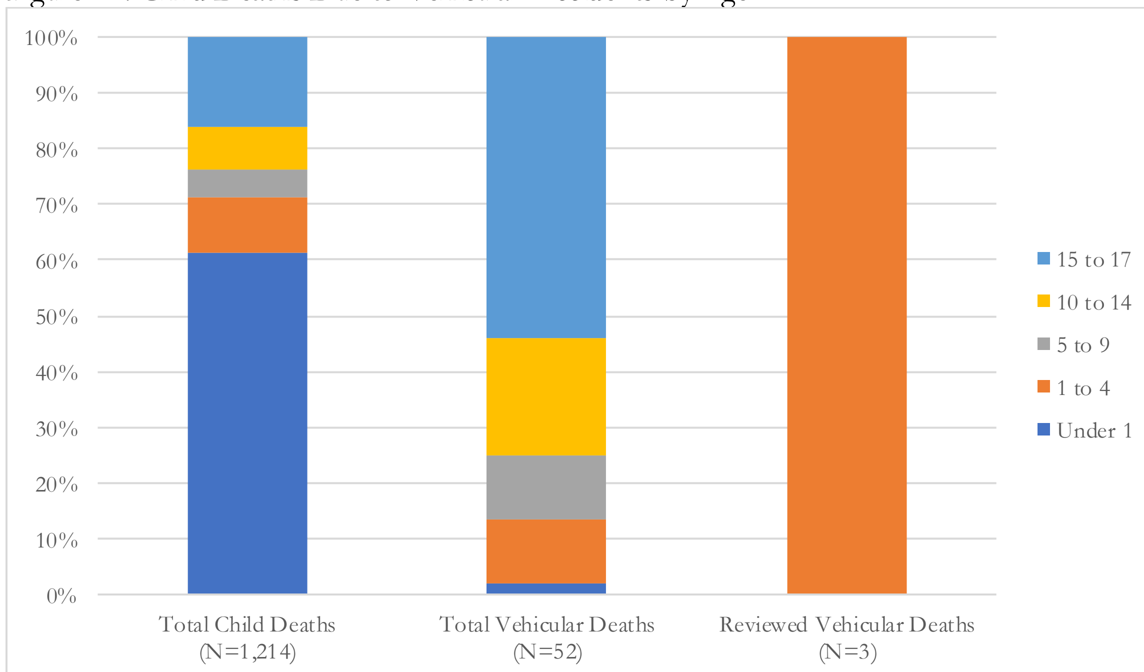
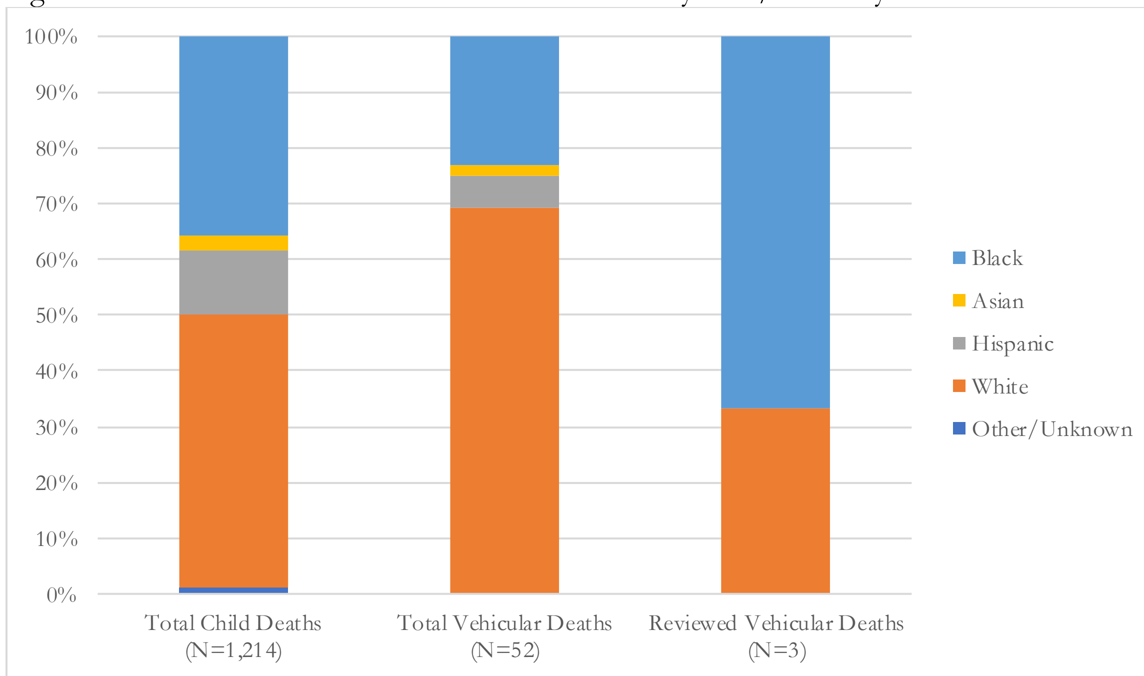


Figure 23: Child Deaths Due to Vehicular Accidents by Race/Ethnicity



Drowning

Definition

Drowning deaths occur from asphyxiation due to submersion in a liquid.

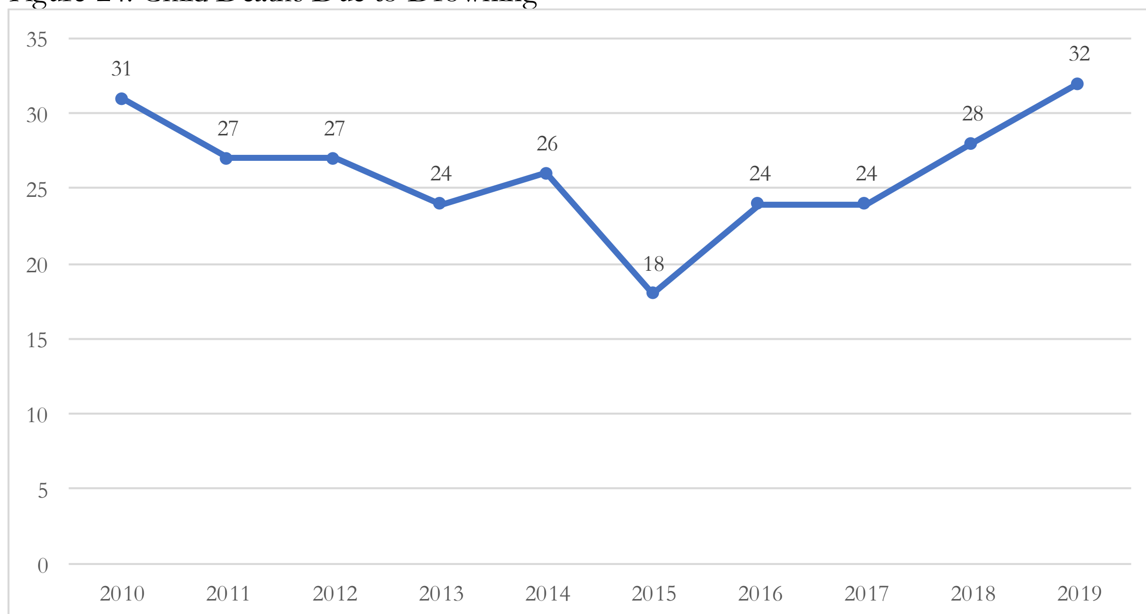
Background

In 2019, 756 children ages 17 and under died as a result of unintentional drowning in the United States. Children 4 and under accounted for 54% of these deaths,[21] and drowning is the leading cause of injury-related deaths among children in this age range and the third leading cause of unintentional injury-related death among children 19 and under. Black children ages 5 to 19 years old have a drowning rate 5.5 times higher than that of White children.[22, 23]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from drowning have ranged between a low of 18 in 2015 to a current high of 32 in the 2019 (see Figure 24).

Figure 24: Child Deaths Due to Drowning



[21] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2021). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.
[22] Safe Kids Worldwide. (2021). *Swimming*. Retrieved from https://www.safekids.org/poolsafety.
[23] Centers for Disease Control and Prevention. (2021). *Unintentional drowning: Get the facts*. Retrieved from https://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html

In 2019, 32 of the 1,214 total child deaths reported to the CDRTs (3%) were related to drowning.

- Boys made up three-quarters of reported drowning deaths (75%).
- Children under 4 years of age accounted for half of drowning deaths (50%). Children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 22%, 6%, and 22% of deaths due to drowning, respectively (see Figure 25).
- Over half of reported drowning deaths were White children (53%), Black and Hispanic children were each 22% of cases, and was a case with a child of unknown/other race/ethnicity (3%) (see Figure 26).
- The majority of drowning deaths were accidental (78%), and the rest were homicides (6%), suicides (3%), or undetermined (13%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 17 of the 245 reviewed deaths (7%) were related to drowning.

- Over three-quarters (76%) of the reviewed drowning deaths were boys.
- Children 4 and under accounted for 76% of reviewed drowning deaths, children 5 to 9 were 12%, children 10 to 14 and children 15 to 17 were each 6% (see Figure 25).
- The majority of reviewed drowning deaths were White children (65%), Black children were 29%, Hispanic children were 6% (see Figure 26).
- The majority of reviewed drowning deaths were accidents (82%), and the remainder of cases were homicides (12%) or undetermined (6%).

Figure 25: Child Deaths Due to Drowning by Age

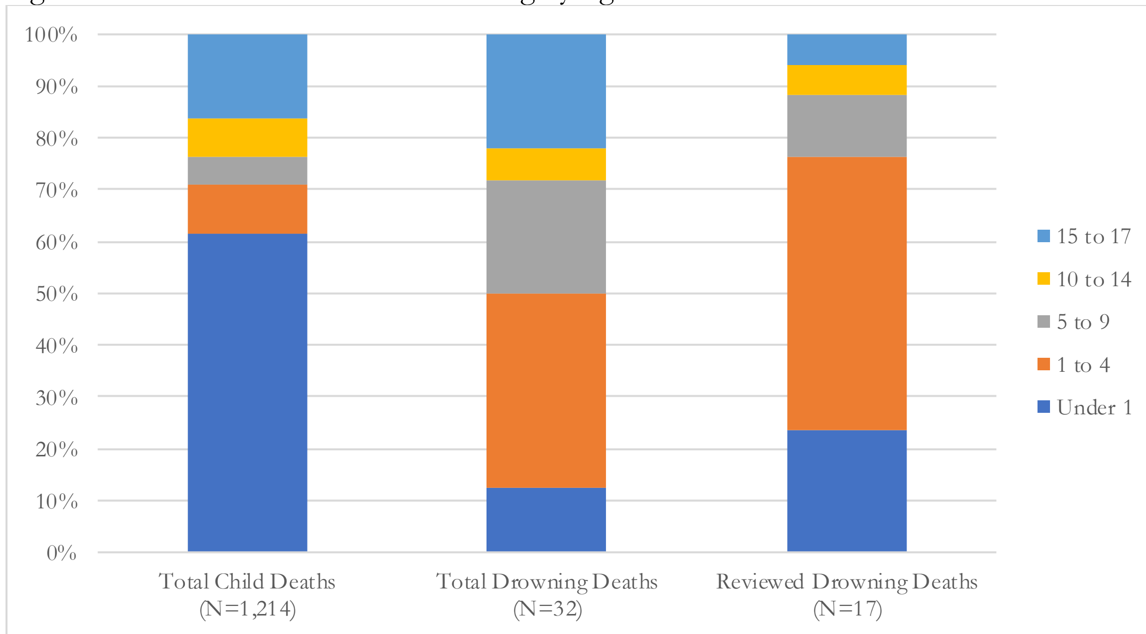
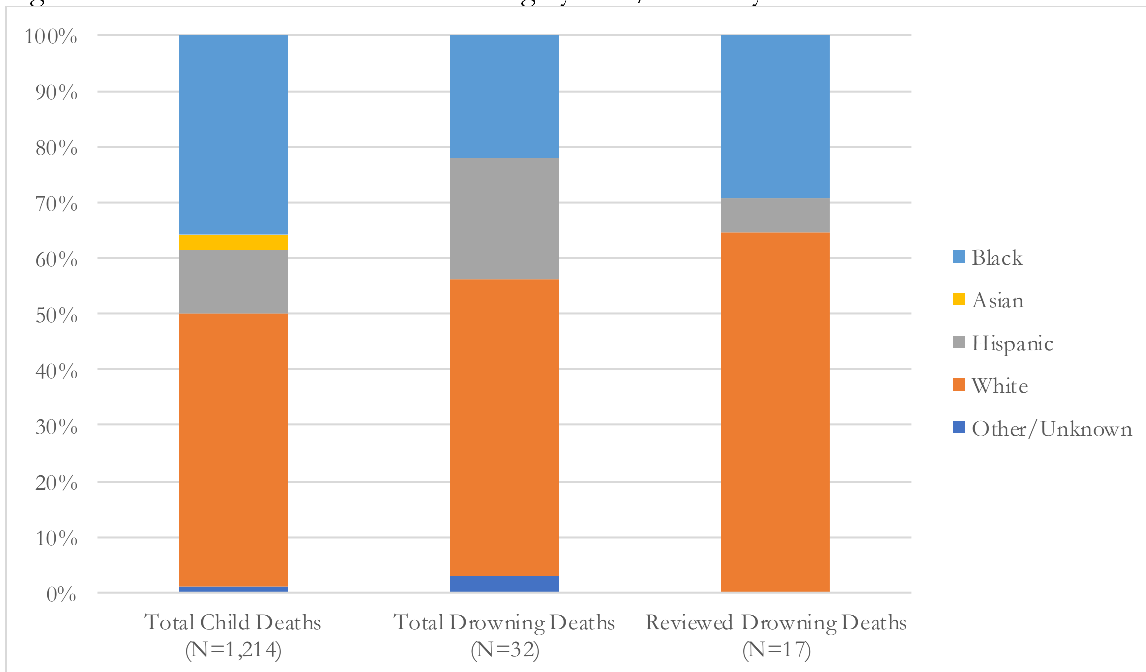


Figure 26: Child Deaths Due to Drowning by Race/Ethnicity



Injuries

Definition

This category includes deaths due to all types of injuries not covered in other categories of death. These injuries may be intentionally inflicted upon a child by him/herself (suicide), others (homicide) or may be unintentional (accidents). Child deaths due to injuries from fatal child maltreatment are included in this category.

Background

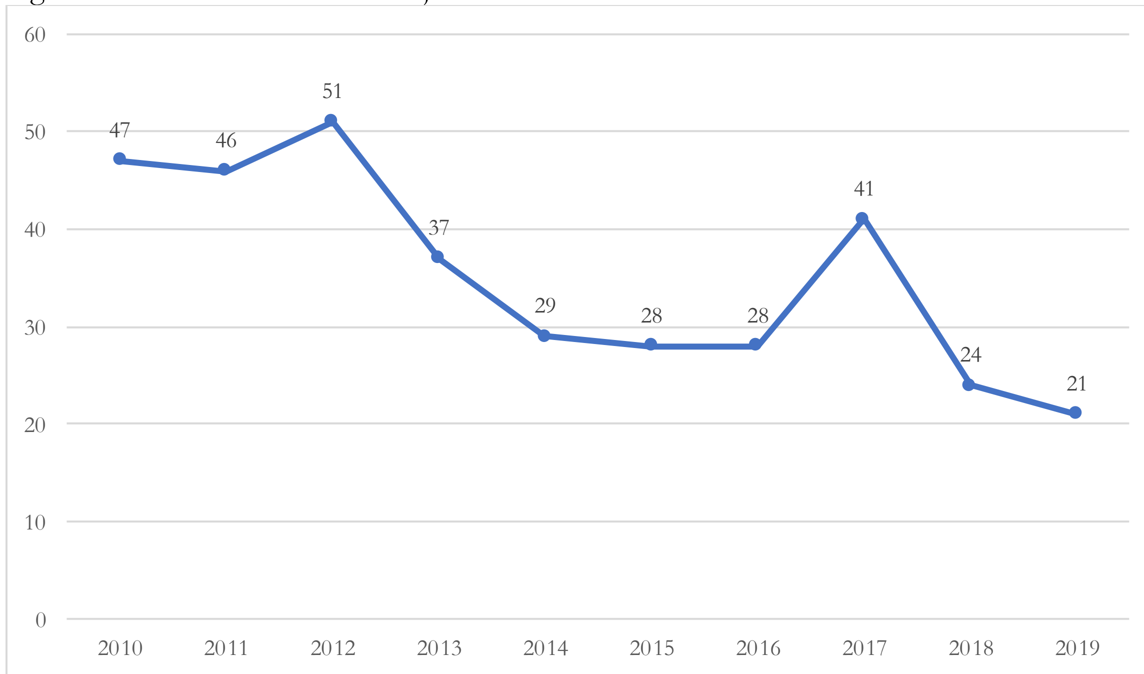
Child maltreatment (including abuse and neglect) is one cause of death from injuries. Based on 2019 data from the National Child Abuse and Neglect Data System (NCANDS), it is estimated that 1,840 children died from abuse and neglect at a rate of 2.50 deaths per 100,000 children. Younger children are the most vulnerable to die as a result of child abuse and neglect. Around seventy percent (70.3%) of child fatalities were children younger than 3 years old. In 2019, girls had higher victimization rates (9.4 per 1,000) than did boys (8.4 per 1,000); however, boys had a higher fatality rate (2.98 per 100,000) compared to girls (2.20 per 100,000). Black children had higher rates (5.06 per 100,000) compared to White children (2.18 per 100,000) and Hispanic children (1.89 per 100,000).[24] Of child maltreatment deaths, about three-quarters (72.9%) suffered neglect and 44.4% suffered physical abuse either exclusively or in combination with other maltreatment types (e.g., medical neglect, psychological abuse, sexual abuse).

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries has mostly declined after 2012, and 2019 had the lowest number of injury deaths in the last 10 years (see Figure 27).

[24] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2021). *Child maltreatment, 2019*. Washington, DC: Government Printing Office. Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf.

Figure 27: Child Death Due to Injuries



In 2019, 21 of the 1,214 total child deaths reported to the CDRTs (2%) were related to injuries.

- Two-thirds of injury deaths were boys (67%).
- Infants and children under 4 years made up the majority (71%) of injury deaths (see Figure 28).
- White and Black children each accounted for 43% of injurie deaths, Hispanic children were 10%, and one case was of an Asian child (5%) (see Figure 29).
- Two-thirds of deaths related to injuries were homicides (76%). Accidents accounted for 29% of injury deaths, and one case was undetermined (5%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 15 of the 245 deaths reviewed by the CDRTs (6%) were related to injuries.

- Two-thirds of injury deaths reviewed by CDRTs were boys (67%).
- Infants and children under 4 years of age made up the majority (80%) of reviewed injury deaths, and children 5 to 9 made up the remaining proportion of reviewed injury deaths (see Figure 28)
- The majority of reviewed injury deaths were Black children (60%), followed by White children (33%) and Hispanic children (7%) (see Figure 29).

- The majority of reviewed injury deaths were homicides (80%), accidents were 13%, and one case was undetermined (7%).

Figure 28: Child Deaths Due to Injuries by Age

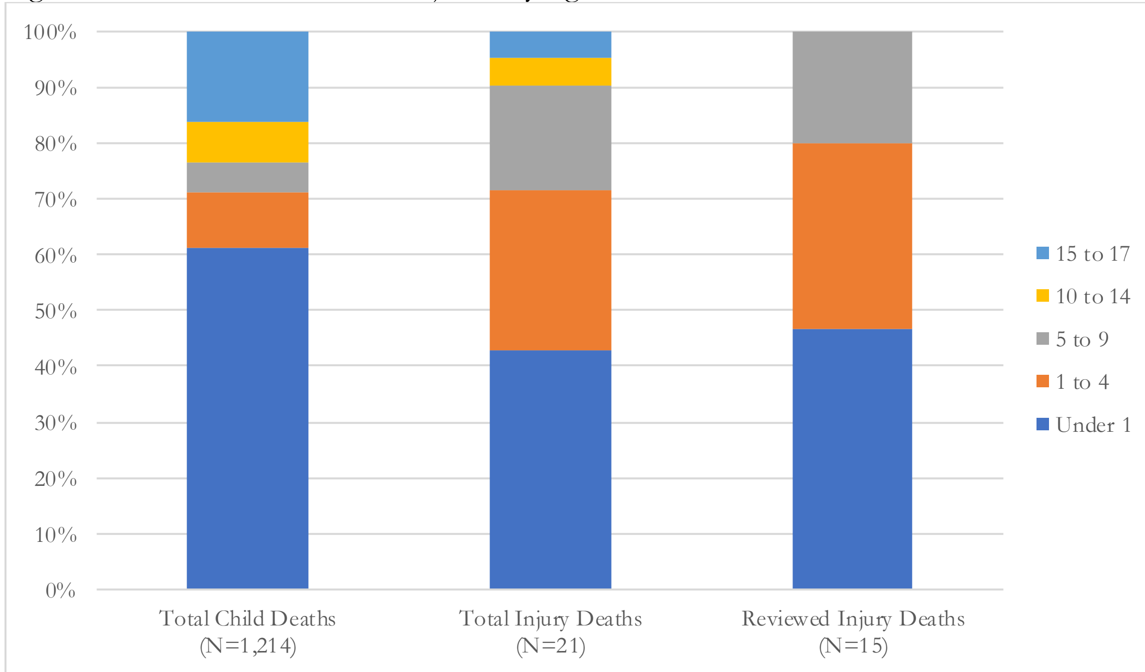
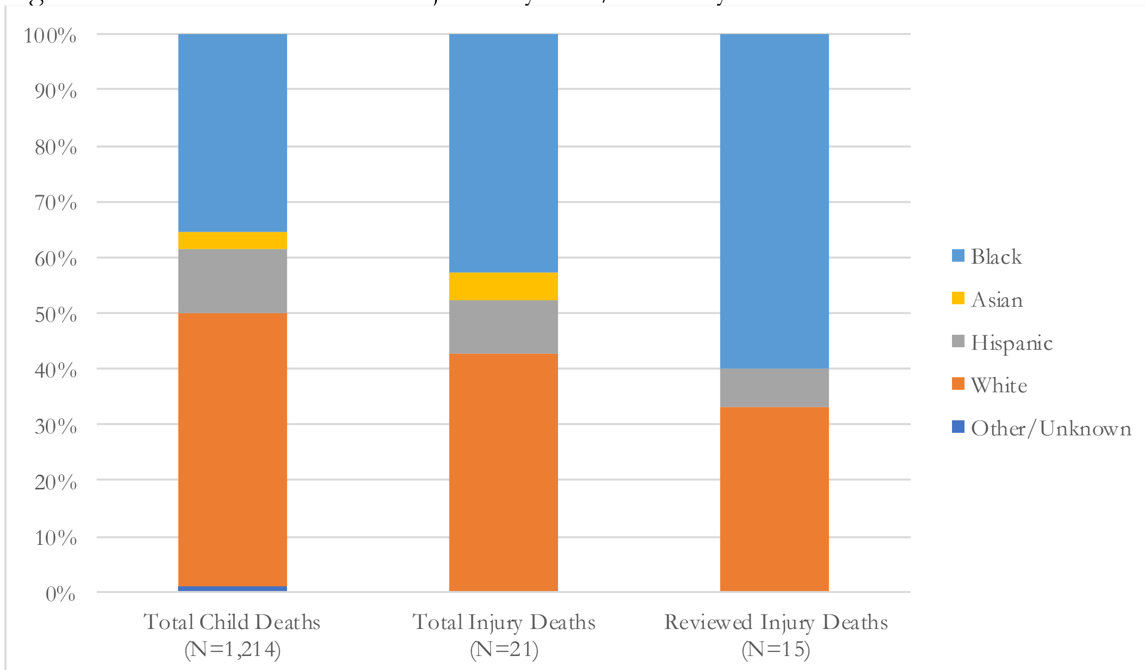


Figure 29: Child Deaths Due to Injuries by Race/Ethnicity



Poisoning/Overdose

Definition

Deaths due to poisoning result from the ingestion of a harmful substance, while deaths from overdose include the ingestion (either intentional or unintentional) of lethal amounts of harmful and non-harmful chemical substances (e.g., medicine, drugs).

Background

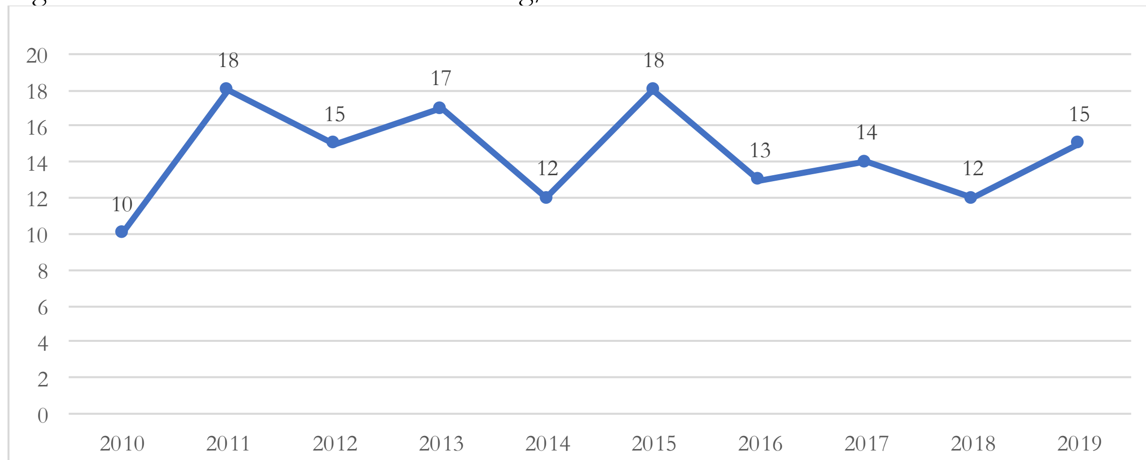
In 2019, 471 children under 18 years died of poisoning in the United States.[25] Nearly six in ten of these deaths occurred in children 15 to 17 years of age. Also, children 4 and under make up a large proportion of poisoning deaths (25%).

Each year, 60,000 children in the United States are treated in emergency departments for unintentional medication exposure or overdose. For children under five, 95% of these visits are caused by accidental ingestion of medications and 5% are dosing errors.[26] The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

Illinois Data—Total Child Deaths Reported to the CDRTs

Between 10 and 18 children died from poisoning per year in the past decade (see Figure 30).

Figure 30: Child Deaths Due to Poisoning/Overdose



[25] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2021). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.

[26] Baker J. M., & Mickalide, A.D. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on fare medication*. Washington, DC: Safe Kids Worldwide. Retrieved from https://www.safekids.org/sites/default/files/documents/ResearchReports/medicine-safety-study-2012.pdf.

In 2019, fifteen of the 1,214 total child deaths (1%) were related to poisonings or overdoses.

- There were slightly more poisoning or overdose deaths of girls (60%).
- All but one of the deaths were of children age 15 to 17 (93%), and the remaining case was of a child under 1 (7%).
- The majority the poisoning or overdose deaths were White children (60%), Black children were 27%, and there was one Hispanic child (7%) and one Asian child (7%).
- Suicides accounted for 60% of poison/overdose deaths, and the remaining cases were accidents (33%) or homicides (7%).

Illinois Data—Deaths Reviewed by the CDRTs

- In 2019, four of the 245 deaths reviewed by CDRTs (2%) were related to poisoning/overdose.
- Three of the four reviewed poisoning/overdose deaths were girls (75%).
- Three of the four deaths reviewed were of older children age 15 to 17 (75%), and one death was of a child under 1 (25%).
- Two of the reviewed poison deaths were Black children (50%), and there was a case with a White child (25%) and a Hispanic child (25%).
- Two of the deaths were accidentals (50%), and there was one homicide (25%) and one suicide (25%).

Fire

Definition

This category includes deaths that are the result of burns and smoke inhalation.

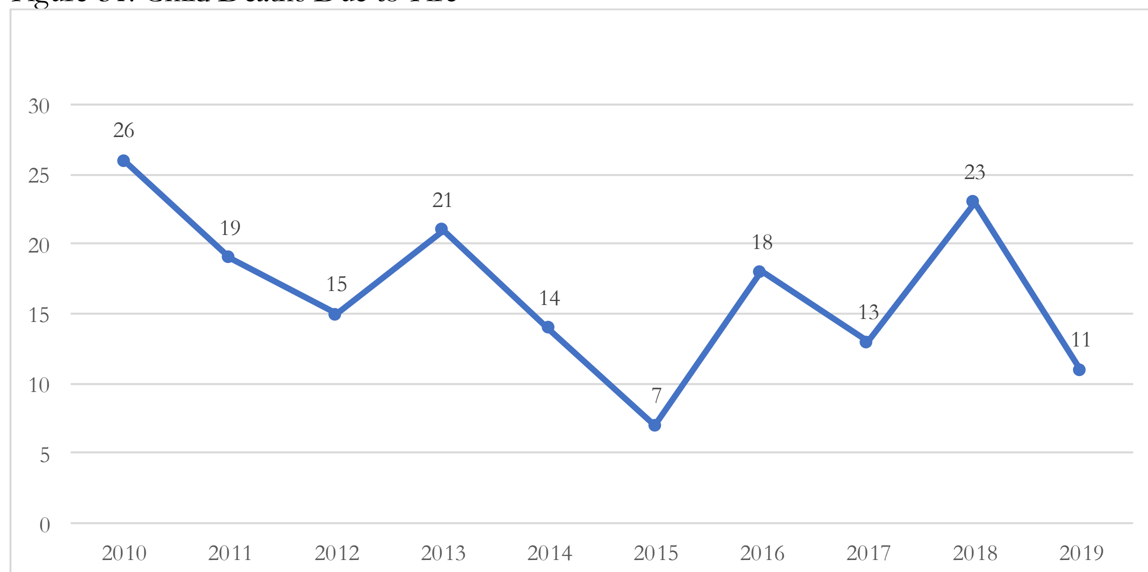
Background

In the United States, fire and burns were the cause of 259 deaths among children between 0 and 17 years in 2019. Forty-one percent of fire deaths occurred in children age 4 and under.[27] Death rates per million among children age 14 and under has decreased 14% from 2000-2018.[28] A large proportion (nearly 87%) of fire-related fatalities are due to home fires, but functioning smoke alarms can reduce the chances of dying by almost 50%.[29]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to fire has ranged between a low of 7 to a high of 26 in the past decade. There were 11 deaths due to fire in 2019 (see Figure 31).

Figure 31: Child Deaths Due to Fire



[27] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2021). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.
[28] U. S. Fire Administration. (2020). *U.S. fire deaths, fire death rates, and risk of dying in a fire*. Retrieved from https://www.usfa.fema.gov/data/statistics/fire_death_rates.html.
[29] Safe Kids Worldwide. (2020). *Fire safety*. Retrieved from https://www.safekids.org/fire.

In 2019, 11 of the 1,214 total child deaths reported to the CDRTs (<1%) were related to fires.

- The majority of fire related deaths were girls (64%).
- Over half of the deaths from fires were of children age 1 to 4 (55%). Children 5 to 9 and children 10 to 14 each made up 18%, and there was one death due to fire of a child age 15 to 17 (9%).
- The majority of deaths due to fire were White children (64%), followed by Black children (27%) and Hispanic children (9%).
- The majority of deaths attributable to fire were accidental (55%). The remaining cases were homicides (27%) and undetermined (18%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, 4 of the 245 deaths reviewed by the CDRTs were related to fire (2%).

- Reviewed fire deaths were evenly split between girls and boys (50% each).
- All four reviewed fire deaths were of children age 1 to 4 (100%).
- All four reviewed fire deaths were White children (100%).
- All but one of the cases were homicides (75%), and the remaining case was accidental (25%).

Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)[30]

Definition

According to Centers for Disease Control and Prevention (CDC),[31] there are about 3,400 Sudden Unexpected Infant Deaths (SUID) each year in the United States. SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation. In 2019, 12,500 of the SUID deaths were due to Sudden Infant Death Syndrome (SIDS), which is defined as the sudden death of an infant that cannot be explained after a thorough investigation is conducted that includes a complete autopsy, examination of the death scene and review of the clinical history. Another type of SUID is of unknown cause, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted and the cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of "suffocation" in the report.

Background

The CDC launched an initiative in 2004 to improve the investigation and reporting of SUID. A pilot program of the SUID Case Registry (SUID-CR) began in Colorado, Georgia, Michigan, New Jersey and New Mexico in 2009. It is designed to provide more detailed data about case investigation findings so that medical, environmental and behavioral facts associated with SUID can be described in greater detail.

A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.[32]

Exposure to secondhand smoke is a factor that increases the probability of SIDS. Since 2005, the percentage of children ages 0 to 6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, the percentage of children ages 0 to 6 living in homes where someone smoked regularly was 6%, compared with 27% in 1994.[33]

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[30] In previous CDRT reports (2007-2008) SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Center for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained.

[31] Center for Disease Control and Prevention. (2018). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Data and Statistics*. Retrieved from https://www.cdc.gov/sids/data.htm.

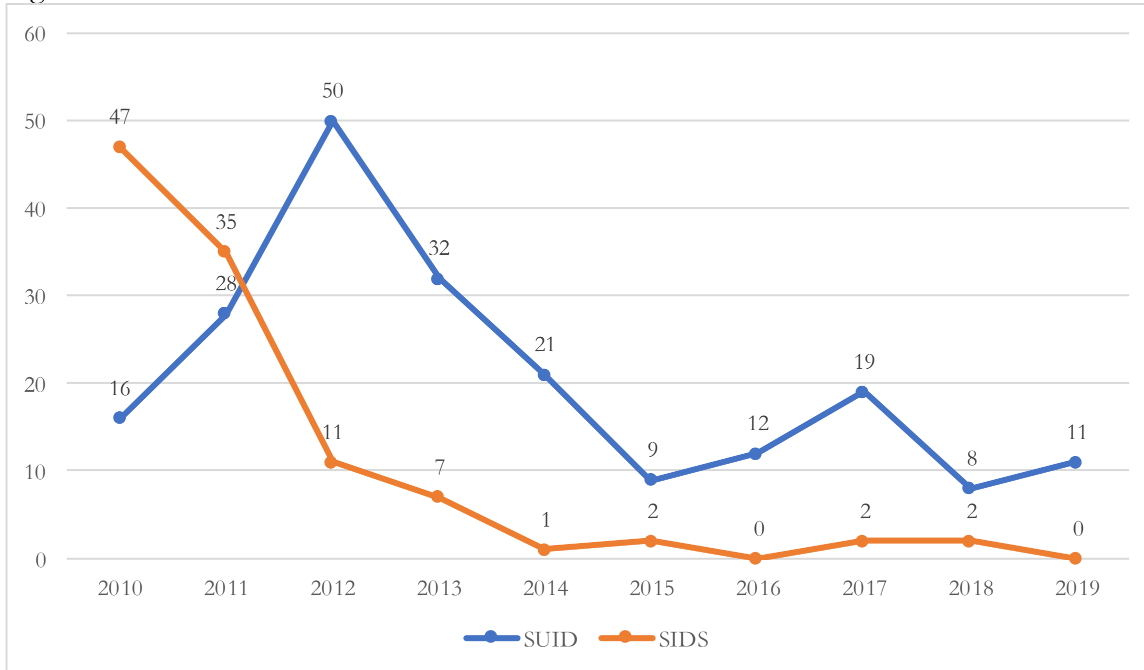
[32] Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology, 163*, 762-769.

[33] United States Environmental Protection Agency (2019). America's Children and Environment. Retrieved from https://www.epa.gov/ace/key-findings-ace3-report.

Illinois Data—Total Child Deaths Reported to the CDRTs

Since the peak of 47 cases in 2010, SIDS has experienced a sharp decline, with a very low number of deaths occurring in recent years (see Figure 32). Infant deaths from SUID were added as a category in 2007. Child deaths due to SUID reached a peak of 50 in 2012, but since then also have a large decline.

Figure 32: Child Deaths due to SIDS and SUID



In 2019, 11 of the 1,214 child deaths were categorized as SUID (<1%), and there were no deaths from SIDS (0%).

- The majority of SUID deaths were boys (73%).
- All SUID deaths were infants under 1 year (100%).
- The majority of SUID deaths were White children (64%), and Black children were 36%.
- Nearly half of the SUID deaths were undetermined (46%), and the remainder were accidental (36%) or natural (18%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2019, eight of the 245 deaths reviewed by the CDRTs were related to SUID (3%).

- Boys made up the majority of reviewed SUID deaths (75%).
- All of the reviewed SUID cases were infants under 1 year of age (100%).
- Reviewed SUID deaths were evenly split between White and Black children (50% each).
- Half of the reviewed SUID deaths were accidental (50%), and the remainder were either or natural (25%) or undetermined (25%).

Uncommon Death Categories: Scalding Burn and Other

There are several less-common categories of deaths. Each account for less than 1% of child deaths per year.

Scalding Burn

There was one scalding burn death in 2019, and it was a reviewed by a CDRT. The child was a Black three-year-old boy. The manner of death was deemed accidental.

Other

As implied by this label, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism and malnourishment). In 2019, five deaths fell in this label, and three were reviewed by a CDRT.

Chapter 5: Sudden Unexpected Infant Deaths During Sleep

Since the inception of Illinois Child Death Review Teams in the mid 1990's, the CDRTs have reviewed countless deaths of infants that died during sleep. The question arose, why were babies dying while sleeping?

Definition

Sudden Unexpected Infant Deaths During Sleep is the death of an infant less than one year of age that occurs suddenly and unexpectedly while sleeping. This classification captures all the deaths that are certified as unintentional asphyxia. SUID during sleep also encompasses those deaths certified as Undetermined, SIDS and SUID. For all deaths certified as Asphyxia, the sleep environment was unsafe and the infant died because of the unsafe environment. For infants certified with a cause of death of Undetermined, the Medical Examiner/Coroner has assigned that determination for one of several possible reasons including: there were multiple competing causes of death, or the family refused to allow a thorough investigation of the death perhaps by not allowing a doll re-enactment by an investigator (thus hampering the investigation of the death), or because unsafe sleep conditions may have caused the death. The ME/Coroner is essentially stating "maybe the unsafe sleep environment caused death or maybe it didn't."

Background

For many years, infant sleeping deaths were assigned a classification Sudden Infant Death Syndrome (SIDS). In time, fewer deaths were classified as SIDS and the classification of SUID (Sudden Unexpected Infant Deaths) came into use. Many studies were initiated to determine what was happening to the babies during sleep. Researchers found that an infant's sleep environment was critically important to the safety of the child.[34] The findings upended prevailing beliefs of where and how a baby should sleep. Unknowingly, caretakers were endangering the lives of their babies by simply following what had been done for decades, how their mothers and grandmothers had put a baby to sleep. For years, parents were told to place the baby on their stomach for sleep and to use blankets to keep the baby warm. Pillows, bumper pads and stuffed animals were welcome additions to the sleep environment. If the baby was fussy, comfort the baby in the caretaker's bed. <u>But the studies found that when babies slept alone, in a crib, on their back without pillows, blankets, toys and bumper pads, fewer babies were dying during sleep.</u> The Safe to Sleep (Back to Sleep) Campaign was started to educate the public on safe sleep practices.[35] Bed sharing, sleeping prone, sleeping in an adult bed, the use of blankets, pillows, secondhand smoke, caretaker inebriated or high all became unsafe sleep conditions. The Safe to Sleep Campaign has had success with educating the public on safe infant sleep. However, traditions and cultural customs are slow to change. There are some

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[34] Kemp, J.S., Unger, B., Wilkins, D., Psara, R.M., Ledbetter, T.L., Graham, M.A., Case, M., & Thach, B.T. (2000). Unsafe sleep practices and an analysis of bedsharing among infants dying suddenly and unexpectedly: Results of a four-year, population-based, death-scene investigation study of sudden infant death syndrome and related deaths, *Pediatrics, 106*, e41.

[35] U.S. Department of Health and Human Services National Institutes of Health (n.d.). *Safe to sleep public education campaign*. Retrieved from https://safetosleep.nichd.nih.gov/activities/campaign.

professionals that still advocate bed sharing. Many caretakers still sleep with their infants, place the baby on their stomach for sleep and use blankets and pillows. As a sad consequence of unsafe sleep practices, there still are many infants that die during sleep.

A Review of Sudden Unexpected Infant Deaths During Sleep for 2019

Sudden unexpected infant death while sleeping was the **3rd leading cause of death** of children in Illinois for calendar year 2019. As recorded by Child Death Review Teams, 121 infants died unexpectedly while sleeping in 2019. The sleep related deaths are represented by sections of the Suffocation, Undetermined, SIDS and SUID categories. Suffocation while sleeping caused the death of 56 infants. Undetermined (while sleeping) category accounted for 52 infants. SUID had 9 infant deaths. Illness with unsafe sleep conditions caused 4 infant deaths. This represents 9.95% of the 1,214 child deaths of 2019. Each infant sleep death had at least one unsafe sleep condition. Some had multiple unsafe sleep conditions.

Table 5. Summary Statistics and Sleeping Conditions of the 121 Sleep Related Deaths

CAUSE OF DEATH	Number
# of Deaths specified as Suffocation or Asphyxia by Coroner or ME	56
# of Deaths specified as Undetermined by Coroner or ME	52
# of Deaths specified as SUID by Coroner	9
# of Deaths specified as Pneumonia with unsafe sleep conditions by Coroner	4
INFANTS DIED WHILE SLEEPING IN 2019 (as reported to Child Death Review Database)	**121**
RACE / ETHNICITY	Number
Black	62
White	49
Hispanic	9
Arabic	1
GENDER	Number
Male	83
Female	38
LOCATION OF INFANT	Number
Adult Bed	66 (all beds had pillows and blankets)
Couch	11 (3 had a blanket/bedding items)
Crib	5 (3 had a blanket)
Bassinet	11 (10 had a blanket, 1 had a pillow)
Pack n Play	10 (7 had a blanket, 3 had a pillow)
Car Seat	3 (2 with a blanket)
Floor	5 (5 with bedding)
Air Mattress	4 (3 with bedding)
Futon	1 (1 with comforter)

Unknown location	2 (1 with pillow)
Trundle Bed	1 (bedding)
Bouncy Seat	1 (blanket)
Baby Carrier	1
INFANT POSITIONS	
Prone	58
Supine	33
Side	13
Sitting	2
Unknown position	8
Crook of Arm	4
Upside down	2
Facing moms front	1
ALCOHOL OR DRUG USE INVOLVEMENT	
Alcohol or drugs YES	24
Alcohol or drugs NO	95
Alcohol or drugs Unknown if used	2
INFANT SLEEPING ALONE OR WITH OTHERS	
Bed-sharing YES	74
Infant sleeping ALONE	46
Unknown	1
AGE OF INFANT AT DEATH	
Under 1 month	10
1 month	25
2 months	20
3 months	19
4 months	13
5 months	14
6 months	6
7 months	3
8 months	1
9 months	3
10 months	4
11 months	2
12 months	1

Infant Sleep Deaths Reviewed by Child Death Review

114 of the 121 sudden unexpected infant deaths during sleep were reviewed by Child Death Review Teams. When looking at the total number of reviews of 2019 deaths, 114 of the 245 deaths reviewed by the CDRTs were infant sleep deaths.

- 76 of the 114 reviews were boys (67%); 38 were girls (33%).

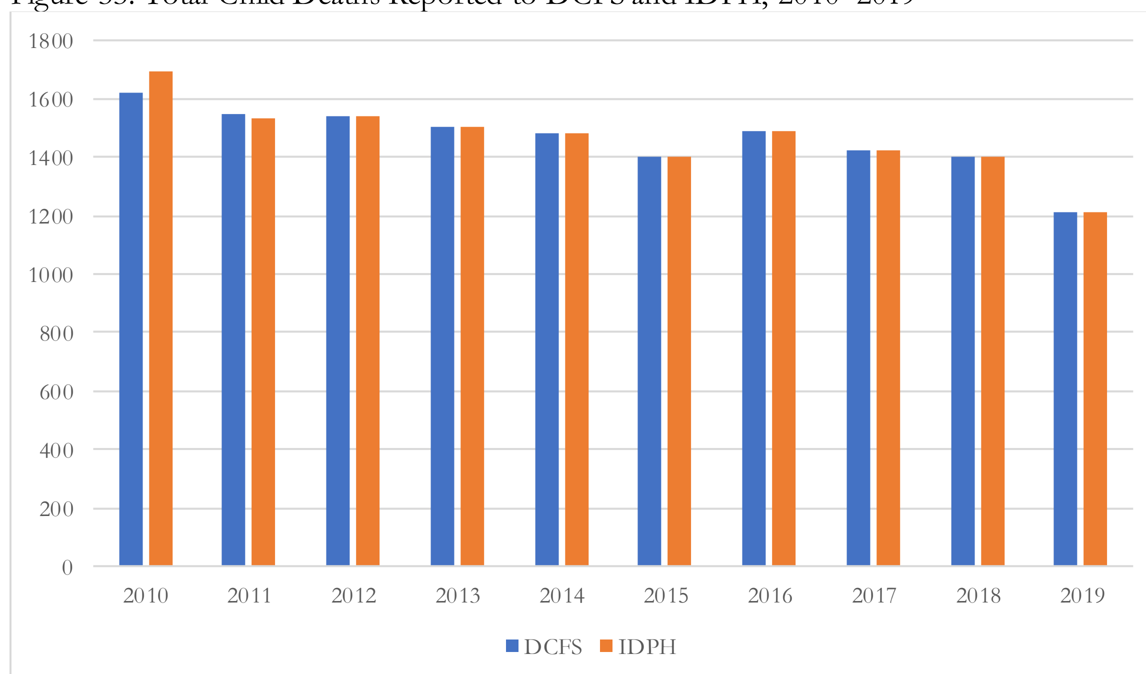
- 44 of the 114 reviews were White children (39%), 59 were Black children (52%), 8 were Hispanic (7%), 1 was Arabic (<1%).

Chapter 6: Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths since 2000, which allows for an analysis of the trends in Illinois child deaths over time. Since 2012, the deaths reported to DCFS come from the HFS Enterprise Data Warehouse. The EDW receives the deaths from IDPH. Thus, from 2012 forward, the DCFS deaths and IDPH deaths are consolidated.

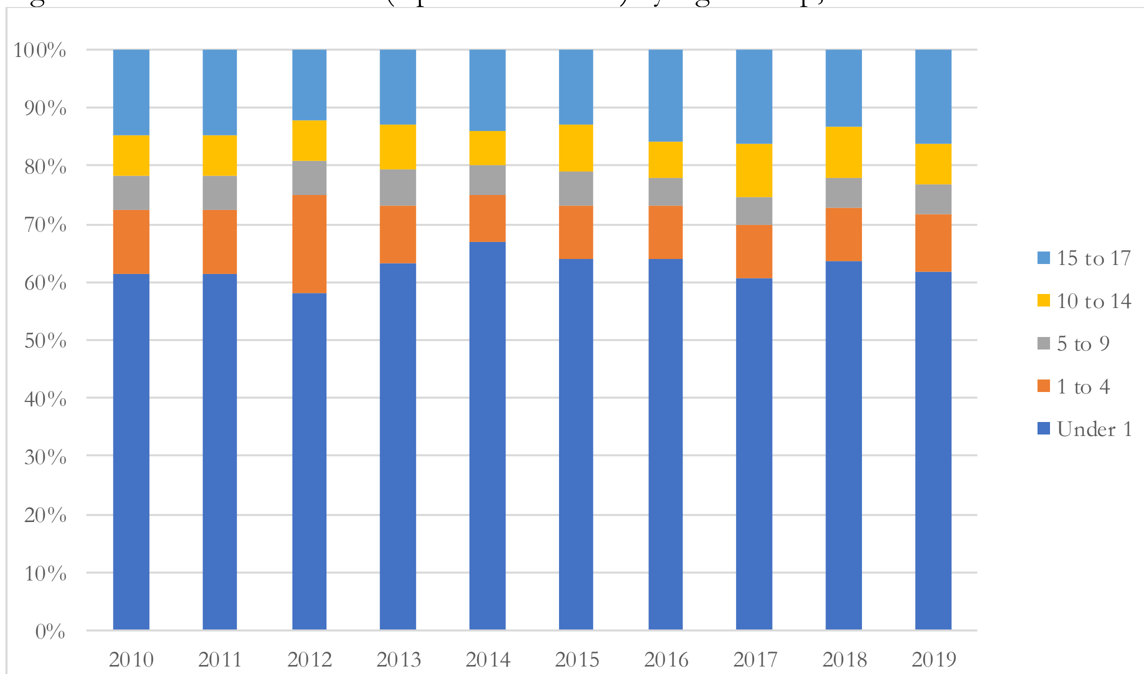
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1,622 (DCFS data) in 2010 to a current low of 1,214 in 2019 (see Figure 33).

Figure 33: Total Child Deaths Reported to DCFS and IDPH, 2010–2019



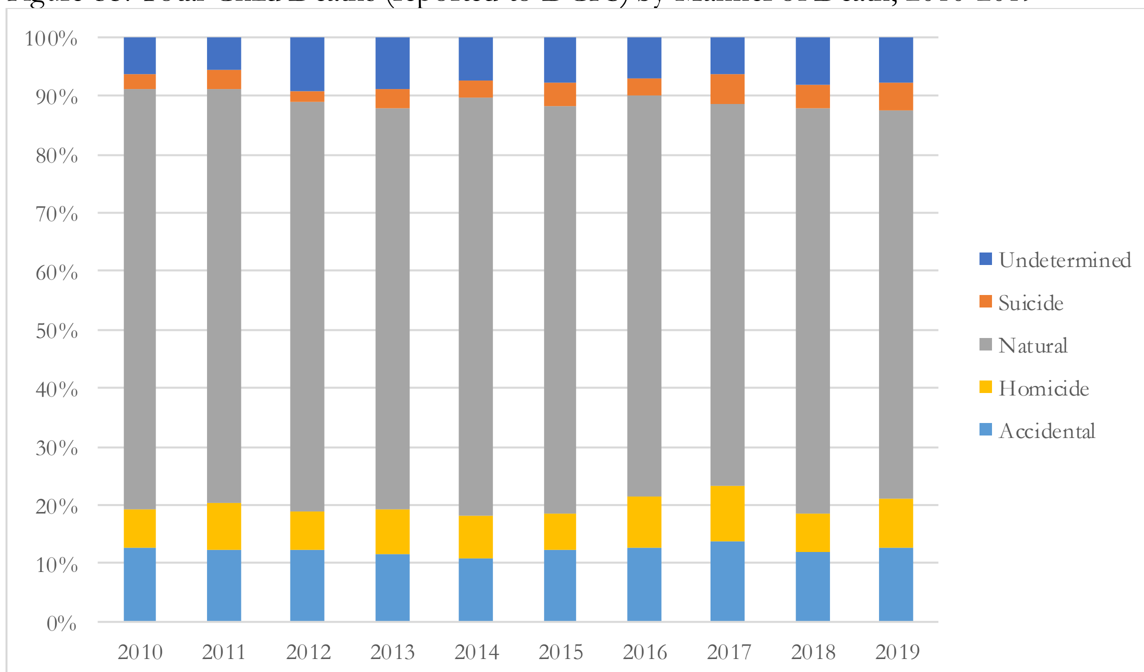
The total child deaths reported to the Child Death Review Team Unit from 2010 to 2019 is broken down by age group in Figure 34. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another, so that the sum for each year is 100%. This type of graph allows us to compare the percentages of each category across multiple years, so that we can determine, for example, if the percentage of infant deaths is increasing, decreasing or staying the same. As Figure 34 shows, the percentage of total deaths in each age group is generally stable over the 10-year period: infants under 1 year comprise 58-67% of all child deaths, children between 1 and 4 years comprise 8-17%, children between 5 and 9 years add another 5-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are about 12-16%. The percentage of infant deaths (58%) was slightly lower in 2012 than other years, while the percentage of deaths of 1 to 4 years (17%) was higher in 2012 than other years.

Figure 34: Total Child Deaths (reported to DCFS) by Age Group, 2010-2019



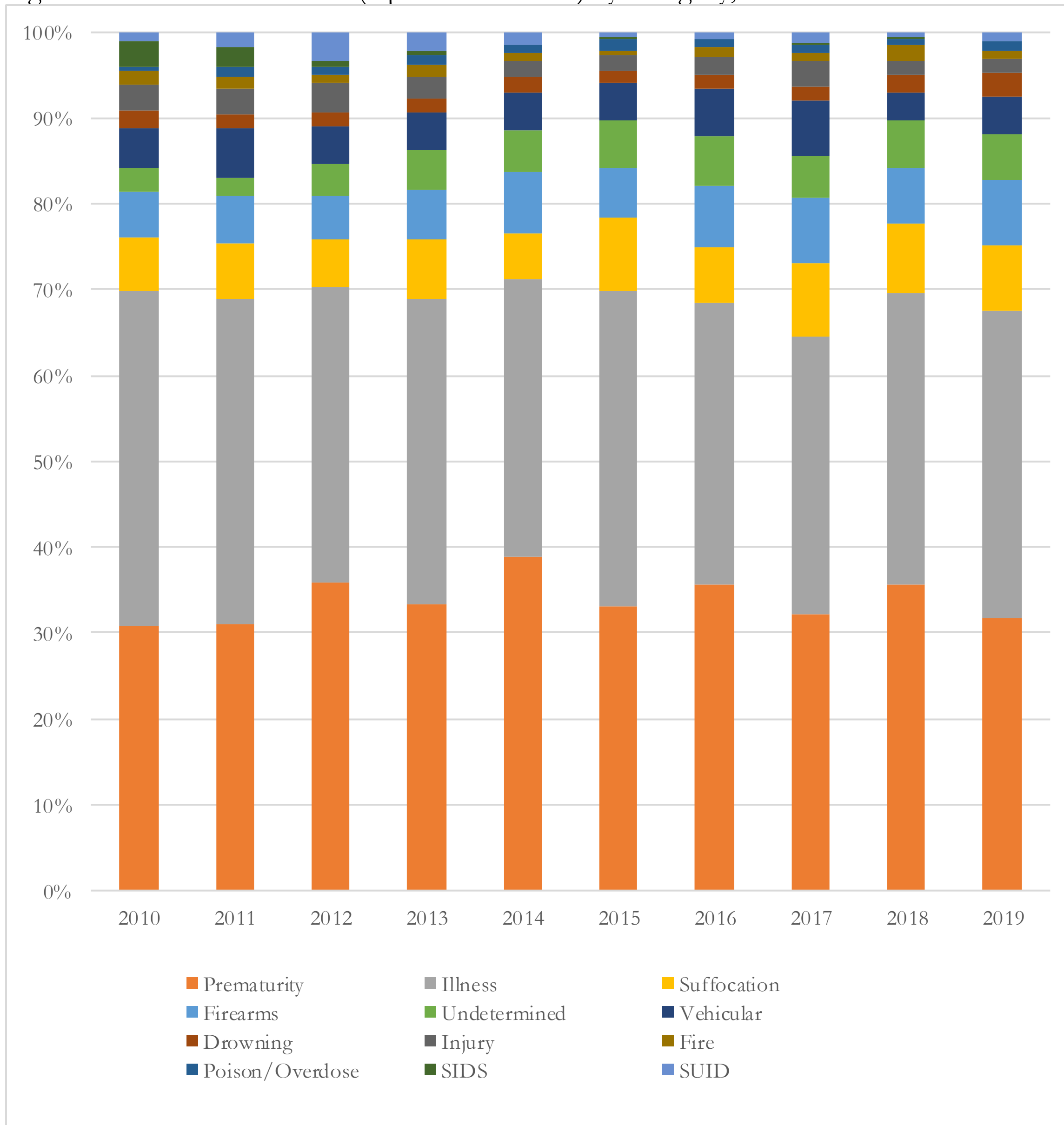
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-14% accidental, 6-10% homicide, 65-72% natural, 2-5% suicide, and 6-9% undetermined (see Figure 35).

Figure 35: Total Child Deaths (reported to DCFS) by Manner of Death, 2010-2019



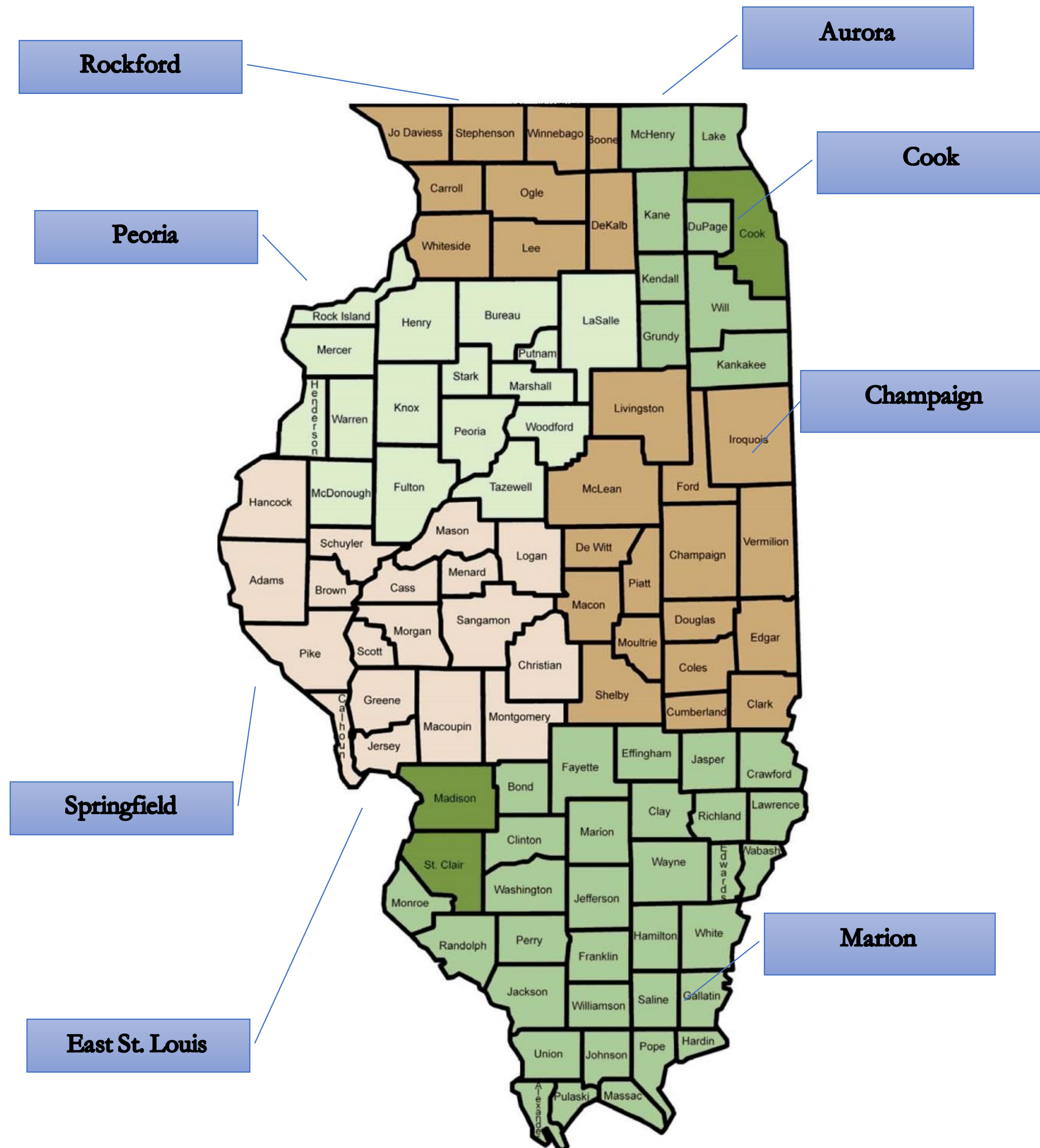
A similar analysis was done for category of death (see Figure 36). The percentage of child deaths related to each category of death across the time period varies. The major categories of deaths from prematurity (31-39%) and illness (32-39%) fluctuated over time. There was an increasing trend for deaths from firearms (5% before 2013 to 6-8% since 2013) and undetermined causes (2-4% before 2013 to 5-6% since 2013); and there was a declining trend for deaths from SIDS (2-3% from 2010 to 2012 to less than 1% since 2013). For more detailed changes within each category, please refer to the charts for specific categories in Chapter 4.

Figure 36: Total Child Deaths (reported to DCFS) by Category, 2010-2019[36]



[36] Notice that four rare categories are not included in this chart: pending, other, scalding burn and SUCD.

Appendix A – Child Death Review Team Regional Map



Appendix B – List of CDRT Members by Region

Aurora
Mary E. Jones MD, MPH, **Chairperson**
Dan Thomas, **Vice Chairperson**
Donna Bredrup
Patrick Dempsey
Joshua Fourdyce
Jennifer Hess
Jennifer Hillgoth
Nydia Molina
Orson Morrison
Wendy Payne
Loren Richardson Carrera
Jennifer Samartano
Anne Strickland
DCFS Staff – Rhonda Laye

Champaign
Donald F. Davison, Jr. MD, **Chairperson**
Brent Reifsteck, MD, **Vice Chairperson**
Kathleen Carney Buetow, MD
Carol Carlton
Jackie Dever
Jennifer Doege
Kimberly S. Fitton
Duane Northrup
Judy Osgood, PhD
Cindy Patterson
Eliza Rudin, RN, BSN, TNS, CEN
Windy Westfall

Cook Team A
Daniela Silaides, **Chairperson**
Joan M. Pernecke, **Vice Chairperson**
Janet Barnes
Kristen Bilka, MMS, PA-C
Kristine Caraballo
Felicia Clark
Margaret Conway
Anne Devaud
Dr. Kristin Escobar-Alvarenga
Jeana Friday, BSN, RN
Jill Glick, MD

Cook Team A (cont.)
Mary Henderson
Nicole Jackson, MD
Sharon Koc
Eileen Payonk, Special Agent, **Vice Chairperson**
Kyran Quinlan, MD, MPH
Karen Pitroda
Char Rivette
Jennifer Seo, MD, JD
Kelley Thornton
Dion Trotter
Syed Zaheer
Virginia Zic-Schlomas, Sgt.
DCFS Staff – Tanya Carriere

Cook Team B
Mary Joly Stein , **Chairperson**
Kim King, **Vice Chairperson**
Sweety Agrawal, PsyD
Shawnte Alexander
Ellen Chiocca
Dr. Michael Eckhardt
Craig Engebretson
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Kathy Grzelak, MA, LCPC
Nicole Johnson, MD
William Leen, Commander (Retired)
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Veena Ramaiah, MD
Kevin Scott
Dr. Benjamin Soriano
Demetra Soter, MD
Annie Torres, MD
Jason Wynkoop

East St. Louis
Daniel Cuneo, PhD, **Chairperson**
David C. Norman, **Vice Chair**
Emily Bell
Jamie Brunnworth
Cathy Daesch, ATR-BC, LCPC, ICDVP
Judy Dalan
Carolyn Hubler, Director
Francis Jones, RN
Michael O'Neill
Zachary Patterson
James Piper
Sakina Vernor
DCFS Staff – Stacy Short

Marion
Mary Louise Cashel, **Chairperson**
Shalynn Malone, **Vice Chairperson**
Lukasz Dabrowski, MD
Connie Edgar
Robin Hopper
Lisa Irvin
Jennifer Lindsey
Betti Mucha
Joe Murphy
Brittany Pierce
Kathy Swafford, MD
Tammy Turner
Steve Webb, PhD
Sheryl Woodham, MSW, LCSW

Peoria
Judy Guenseth, **Chairperson**
Special Agent Timothy Wilkins, **Vice Chairperson**
Dr. Susan Bordenave-Bishop
M/Sgt. Gregg M. Cavanaugh
Stefanie Clarke, BSN, RN, CPEN
Jacqueline Diediker
Erik Gibson
Brian Gustafson
Umair Iqbal, MD, MPH
Ann Lading-Ferguson
Emily McDonnell, MSN
Mark McLaughlin
Marcy O'Brien
Channing Petrak, MD
Michele Verda, PhD

Peoria (cont.)
Melissa Watkins
DCFS Staff – Jim Marmion

Rockford
Joanna Deuth, **Chairperson**
Holly Peifer, **Vice Chairperson**
Rebecca Anderson
Pamela A. Borchardt
Amy Buchenau
Raymond Davis, Jr., MD
David Glessner
Terry Inman
Rebecca Wigget
DCFS Staff – Patrice Thomas

Springfield
Dan Wright, **Chairperson**
Betsy Goulet, **Vice Chair**
Jim Allmon
Careyana Brenham MD
Ginger Darling, MD
Heather Hofferkamp
Rebecca Howard, APRN, CPNP-PC
Denise McCaffrey
Eric Weston, Special Agent
DCFS Staff – Amie Holzmacher

*** CDRT Executive Director Tamara Skube and DCFS staff John Schweitzer (CDRT Coordinator) are members included in each region.**

Appendix C – Illinois Child Deaths by County

	2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths	2014 Deaths	2015 Deaths	2016 Deaths	2017 Deaths	2018 Deaths	2019 Deaths
County	DCFS	IDPH *	DCFS	IDPH *	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **
Adams	6	5	4	3	9	5	9	9	8	6	6	2
Alexander	0	2	0	0	1	0	0	0	1	1	0	2
Bond	0	1	2	2	4	1	0	2	0	2	0	0
Boone	1	1	4	2	3	0	1	0	1	2	2	0
Brown	0	0	0	0	1	1	0	0	0	0	0	0
Bureau	6	5	1	1	2	1	3	0	2	1	0	0
Calhoun	0	0	0	0	0	0	0	0	0	0	1	0
Carroll	2	2	0	0	1	0	1	0	1	1	0	0
Cass	0	0	0	0	1	0	0	0	0	0	0	2
Champaign	36	33	43	37	29	49	38	30	45	44	44	39
Christian	4	3	3	2	2	1	1	4	2	3	1	1
Clark	0	1	2	2	1	3	0	1	1	1	1	0
Clay	1	1	0	0	1	1	0	0	3	0	2	1
Clinton	3	3	2	1	1	3	0	0	1	3	1	2
Coles	5	2	5	6	4	4	4	2	5	6	3	2
Cook	887	920	857	824	857	775	815	818	831	766	781	692
Crawford	2	1	2	1	4	4	0	1	0	4	1	1
Cumberland	2	2	0	0	1	0	0	0	1	0	0	0
DeKalb	4	3	5	5	4	9	7	3	6	7	4	8
Dewitt	0	0	1	1	0	0	3	1	0	1	3	3
Douglas	1	1	1	1	1	0	1	0	1	2	0	0
DuPage	89	76	73	68	66	70	80	63	76	56	70	67
Edgar	0	0	1	1	1	1	1	2	1	0	2	0
Edwards	0	0	0	0	1	0	1	0	0	0	0	0
Effingham	0	1	8	7	2	7	5	5	4	3	4	1
Fayette	1	0	1	1	0	2	3	1	1	1	0	2
Ford	1	1	0	0	1	2	1	0	0	1	1	2
Franklin	5	3	2	1	0	2	4	6	3	1	1	0
Fulton	4	4	0	0	3	0	0	2	2	2	2	1
Gallatin	0	0	0	0	1	0	0	0	0	0	0	0
Greene	0	1	0	1	0	0	1	0	0	4	1	1
Grundy	5	5	3	2	3	2	1	2	1	3	1	0
Hamilton	1	1	1	1	1	2	0	1	2	0	0	0
Hancock	0	0	1	1	0	1	3	0	0	1	0	1
Hardin	2	2	1	2	1	1	1	1	1	1	1	3
Henderson	0	0	0	0	0	0	0	0	0	0	0	1
Henry	4	4	4	2	2	3	3	2	5	3	1	1
Iroquois	3	3	1	1	1	1	0	0	2	2	2	2
Jackson	4	5	8	6	16	2	5	9	4	9	8	7
Jasper	2	1	0	0	0	0	0	0	1	0	0	0
Jefferson	9	9	7	6	2	6	4	2	4	2	6	0
Jersey	1	2	2	3	4	2	0	4	2	3	0	0
Jo Daviess	0	0	4	4	0	1	0	0	2	0	0	2
Johnson	0	3	0	3	2	0	0	0	0	0	0	0
Kane	44	41	45	42	42	42	44	51	46	39	45	25
Kankakee	8	8	8	8	12	10	10	6	16	9	13	7
Kendall	1	1	1	1	2	3	2	0	0	2	1	1
Knox	7	8	10	10	3	4	6	6	6	4	3	5
Lake	31	47	35	40	33	37	36	36	34	36	35	31
LaSalle	8	9	9	8	11	8	7	11	5	4	7	8
Lawrence	6	4	4	2	1	2	0	1	0	1	1	1
Lee	1	1	2	2	2	3	3	2	1	6	1	2
Livingston	3	3	5	2	3	0	4	2	3	2	2	3
Logan	0	0	2	2	3	3	1	0	3	3	1	2

Macon	11	10	13	13	7	4	12	11	7	11	7	9
Macoupin	2	3	0	0	0	5	4	2	0	2	0	1
Madison	15	13	13	11	8	12	14	18	21	18	23	15
Marion	3	9	5	9	2	5	5	10	3	4	3	3
Marshall	2	1	0	0	0	0	0	1	1	0	0	0
Mason	2	1	0	0	0	3	1	2	1	0	0	1
Massac	0	0	0	0	2	1	0	1	3	1	1	2
McDonough	2	2	1	1	1	2	0	1	0	1	3	1
McHenry	7	6	11	9	12	17	9	9	9	11	9	9
McLean	9	10	13	12	9	12	13	14	8	11	8	6
Menard	1	1	0	0	0	0	0	0	0	0	0	0
Mercer	1	1	1	1	2	6	0	1	0	1	2	0
Monroe	0	1	1	1	1	1	0	1	0	0	0	1
Montgomery	3	3	3	2	1	0	4	2	3	0	2	3
Morgan	2	2	0	1	2	3	3	0	2	4	2	2
Moultrie	1	1	4	4	1	0	0	0	0	1	0	1
Ogle	2	1	1	1	0	0	2	3	0	4	0	1
Peoria	81	80	76	75	109	72	82	63	76	83	68	65
Perry	4	4	0	0	1	3	2	1	2	0	1	1
Piatt	0	0	1	1	1	0	0	0	0	2	0	1
Pike	2	2	0	0	0	0	0	0	1	0	3	2
Pope	0	0	0	0	1	0	0	0	0	1	0	0
Pulaski	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	0	1	0	0	1	0
Randolph	1	1	1	1	6	7	2	1	3	0	4	1
Richland	1	1	2	2	1	1	2	1	2	2	1	1
Rock Island	12	9	12	11	11	9	12	8	9	10	8	10
Saline	4	3	1	1	3	0	3	3	0	1	5	2
Sangamon	46	43	38	46	33	46	39	36	45	38	53	33
Schuyler	4	0	6	0	1	1	1	0	0	2	0	1
Scott	0	0	0	0	0	2	0	0	1	0	0	0
Shelby	1	2	0	0	0	2	0	2	1	2	0	0
St. Clair	18	16	18	15	21	31	26	15	15	31	17	10
Stark	0	0	0	0	0	0	0	0	0	1	0	1
Stephenson	5	4	2	2	1	2	4	3	2	5	5	3
Tazewell	2	3	3	2	3	2	7	5	3	6	7	4
Union	3	3	1	1	1	2	1	3	0	9	1	0
Vermillion	7	6	8	6	11	10	7	4	12	5	5	7
Wabash	0	0	0	0	1	0	1	0	1	0	0	1
Warren	1	1	1	1	1	1	1	1	1	1	1	4
Washington	2	2	1	1	0	1	1	0	1	0	1	0
Wayne	1	1	1	1	2	1	1	3	1	0	0	0
White	1	1	1	1	1	0	1	0	2	0	0	0
Whiteside	3	5	4	3	1	4	3	1	6	3	5	1
Will	38	35	28	26	33	34	38	24	36	34	38	29
Williamson	5	5	10	9	6	6	13	6	3	5	8	3
Winnebago	61	49	51	43	40	36	43	46	59	57	47	45
Woodford	2	2	3	3	1	4	1	2	1	0	0	3
Unknown	1	0	0	1	0	0	0	0	0	3	0	0
Out of State	53	117	46	97	47	81	12	11	12	6	0	0
Out of country	–	–	–	–	9	0	0	0	0	0	0	0
Total	1,622	1,692	1,551	1,535	1,540	1,503	1,479	1,402	1,487	1,424	1,398	1,214

***Death numbers for IDPH are for facility of death**
****Death numbers for DCFS and IDPH have been consolidated since 2012**

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