



Child Deaths in Illinois 2007- 2008

Illinois Child Death
Review Teams 2011
A Partnership for
Protecting Children

In cooperation with



Illinois Department of Children & Family Services

**ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN**

**ANNUAL REPORT ON CHILD DEATHS
IN 2007 AND 2008**

MISSION

To reduce preventable child fatalities
among Illinois children.

SUBMITTED TO:

The Honorable Pat Quinn, Governor, State of Illinois
Illinois State Senate
Illinois House of Representatives

MARCH 2011

Illinois Child Death Review Teams

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February 2011

The Honorable Pat Quinn, Governor of the State of Illinois
The Honorable Members of the 95th General Assembly

It is our privilege to submit the Illinois Child Death Review Program Annual Report for 2007-2008. In accordance with the 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 known to the Department of Children and Family Services (DCFS) as well as the deaths of other children who 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 Department of Children Family Services (DCFS). The CDRT Executive Council reviews all recommendations made by the nine Illinois Child Death Review Teams and submits them to them to DCFS. The CDRT Executive Council is very excited that the Director of DCFS has recently decided to begin meeting with the Executive Council in-person to discuss the recommendations, the responses given by DCFS, and the implementation of the recommendations.

The CDRT Executive Council has made great strides in beginning to establish a Child Death Investigation Task Force for the Southern Region of Illinois. A Task Force Commander has been identified and trainings have begun that are introducing the task force to law enforcement agencies, coroners, DCFS, and state's attorneys in the Southern Region of the State. The task force will assist law enforcement in the southern region when a child death or a serious life threatening injury to a child occurs. The CDRT Executive Council is eager to get the task force started.

We want to thank DCFS Director Erwin McEwen 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. Lastly, 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 Quinn 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



Duane Northrup, Champaign County Coroner
Vice Chairperson, Executive Council
Illinois Child Death Review Teams

Pat Quinn
Governor



Erwin McEwen
Director

Illinois Department of Children & Family Services

Dear Readers:

We are pleased to present the *2010 Illinois Child Death Review Teams Annual Report, A Partnership for Protecting Children*. The information in the report includes the data for the child deaths that occurred during calendar year 2007-2008. In 2007-2008, over 2,965 children under the age of 18 died in Illinois. While many of these deaths were due to natural causes, others may have been prevented through alternative actions by parents and other caregivers, earlier intervention by public support systems, or increased efforts of public safety education campaigns.

In Illinois, the Child Death Review Teams were established by law in 1994 as a means to reduce preventable child deaths. 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 (CDRT) and the Department of Children and Family Services (DCFS) Division of Child Protection and the Division of Quality Assurance.

Since 1994, CDRT and the CDRT Executive Council have made hundreds of recommendations to the Department of Children and Family Services. The Department takes these recommendations very seriously. This year, as the DCFS Director, I decided to begin to meet with the Child Death Review Teams Executive Council myself, in-person to discuss the recommendations, the responses given by my staff, and the implementations that will take place. These recommendations that are made by the Child Death Review Teams have had a positive effect on the Department of Children and Family Services and I am excited about deciding to have taken such an active role in this process.

The child death review process is an example of sharing responsibility of resources to improve public health in our state. This process would not be possible without the dedication and support of hundreds of caring professionals throughout the state who volunteer countless hours for the case review and discussions of prevention strategies to reduce child injury and death. As we continue our work together, we hope this report furthers the awareness and action of state and local officials as well as the citizens of Illinois of how we can work together to keep children safe.

Respectfully submitted:

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ACCREDITED • COUNCIL ON ACCREDITATION FOR CHILDREN AND FAMILY SERVICES

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This report would not be possible without the dedication and unwavering support of almost 200 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams.

Members of the Child Death Review Teams Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

Members of the CDRT Executive Council Annual Report Subcommittee, including Daniel J Cuneo, Ph.D., Coroner Duane Northrup, Sgt. Holly Robinson, Tracy Lower, M.D., Kate Watson, Sherry Barr, and Dr. Tamara Fuller.

The production of this report represents the ongoing collaboration between the Illinois CDRT Executive Council, the Illinois Department of Children and Family Services, and the Children and Family Research Center at the University of Illinois at Urbana-Champaign. The report was written by Dr. Tamara Fuller, Director of the Children and Family Research Center, and designed by Jennifer Florent, DCFS Graphic Designer/Artist.

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List of Tables

- Table 1. Child Deaths by Category of Death 2007 – 2008
- Table 2. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRT's
- Table 3. 2007 Total Child Deaths – Manner of Death by Category of Death
- Table 4. 2008 Total Child Deaths – Manner of Death by Category of Death
- Table 5. 2007 and 2008 Homicide Deaths
- Table 6. 2007 DCFS-System Recommendations and DCFS Responses
- Table 7. 2007 Other Systems Recommendations and DCFS Responses
- Table 8. 2007 Primary Prevention Recommendations and DCFS Responses
- Table 9. 2008 DCFS-System Recommendations and DCFS Responses
- Table 10. 2008 Other Systems Recommendations and DCFS Responses

List of Figures

- Figure 1. Child Death Review Flowchart
- Figure 2. Illinois Child Deaths by Gender
- Figure 3. Illinois Child Deaths by Age Group
- Figure 4. Illinois Child Deaths by Race
- Figure 5. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRT's
- Figure 6. Child Deaths Due to Illness – by Age
- Figure 7. Child Deaths Due to Illness – by Race
- Figure 8. Child Deaths Due to Premature Birth – by Race
- Figure 9. Child Deaths Due to SIDS – by Gender
- Figure 10. Child Deaths Due to SIDS – by Race
- Figure 11. Child Deaths Due to Vehicular Accidents – by Gender
- Figure 12. Child Deaths Due to Vehicular Accidents – by Age
- Figure 13. Child Deaths Due to Vehicular Accidents – by Race
- Figure 14. Child Deaths Due to Suffocation – by Age
- Figure 15. Child Deaths Due to Suffocation – by Race
- Figure 16. Child Deaths Due to Firearms – by Age
- Figure 17. Child Deaths Due to Firearms – by Race
- Figure 18. Child Deaths Due to Injuries – by Age
- Figure 19. Child Deaths Due to Injuries – by Race
- Figure 20. Child Deaths Due to Fire – by Age
- Figure 21. Child Deaths Due to Fire – by Race
- Figure 22. Child Deaths Due to Drowning – by Age
- Figure 23. Child Deaths Due to Drowning – by Race
- Figure 24. Child Deaths Due to Poisoning/Overdose – by Age
- Figure 25. Child Deaths Due to Poisoning/Overdose – by Race
- Figure 26. Total Child Deaths Reported to DCFS and IDPH, 2001 – 2008
- Figure 27. Total Child Deaths (reported to DCFS) in Illinois by Age Group, 2000 – 2008
- Figure 28. Total Child Deaths (reported to DCFS) in Illinois by Racial Group, 2000 – 2008
- Figure 29. Total Child Deaths (reported to DCFS) in Illinois by Manner of Death, 2000 – 2008
- Figure 30. Total Child Deaths (reported to DCFS) in Illinois by Category of Death, 2000 – 2008

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 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 2007 and 2008

In 2007, 1,470 children under 18 died in Illinois. These numbers represent the death certificates received by the Department of Children and Family Services (DCFS) State Central Register (SCR) and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the SCR; therefore, this number is a low estimate of the actual number of child deaths that occurred in Illinois.

Of the total child deaths reported to DCFS in 2007:

- 57% were boys and 43% were girls;
- 63% were infants under one year, 10% were young children between 1 and 4 years, 14% were older children between 5 and 14 years, and 12% were youth between 15 and 17 years;
- 58% were Caucasian, 35% were African-American, 2% were Hispanic, 3% were Asian, and 2% were of other or unknown racial background.

When Illinois child deaths in 2007 were examined by the manner of death:

- 73% were attributable to natural causes;
- 13% were accidental;
- 8% were homicides;
- 1% were suicides;
- 4% were undetermined.

When deaths occurring in 2007 were examined by the category of death:

- 35% were related to illness;
- 35% were related to premature birth;
- 3% were related to Sudden Infant Death Syndrome (SIDS);
- 23% were related to various types of injuries, such as vehicular accidents (7%), firearms (4%), drowning (2%), fires (2%), suffocations (5%), and other types of injuries (3%);
- 3% were due to undetermined causes.

In 2008, 1,495 children under 18 died in Illinois. Of the total child deaths reported to DCFS in 2008:

- 60% were boys and 40% were girls;
- 65% were infants under one year, 10% were young children between 1 and 4 years, 12% were older children between 5 and 14 years, and 12% were youth between 15 and 17 years;
- 56% were Caucasian, 34% were African-American, 3% were Hispanic, 1% were Asian, and 6% were of other or unknown racial background.

When Illinois child deaths in 2008 were examined by the manner of death:

- 72% were attributable to natural causes;
- 13% were accidental;
- 8% were homicides;
- 2% were suicides;
- 5% were undetermined.

When deaths occurring in 2008 were examined by the category of death:

- 36% were related to illness;
- 32% were related to premature birth;
- 5% were related to Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID);
- 22% were related to various types of injuries, such as vehicular accidents (5%), firearms (5%), drowning (2%), fires (1%), suffocations (6%), and other types of injuries (3%);
- 3% were due to undetermined causes.

Child Deaths Reviewed by the CDRTs

There were 130 child deaths that occurred during 2007 that were reviewed by the CDRTs (either a mandatory or discretionary review). Of the deaths reviewed by CDRTs in 2007:

- 57% were boys and 43% were girls;
- 39% were infants under one, 29% were young children between one and four years, 22% were older children between 5 and 14 years, and 9% were youth between 15 and 17 years;
- 44% were Caucasian, 54% were African-American, and less than 1% were Hispanic.

When reviewed deaths occurring in 2007 were examined by manner of death:

- 27% were attributed to natural causes;
- 28% were due to accidents;
- 37% were homicides;
- Less than 1% were suicides;
- 7% were undetermined.

When reviewed deaths occurring in 2007 were examined by category of death:

- 19% were related to illness;
- 6% were related to premature birth;
- 2% were related to Sudden Infant Death Syndrome (SIDS);
- 63% were related to various types of injuries, such as vehicular accidents (5%), firearms (5%), drowning (5%), fires (11%), suffocations (12%), and other types of injuries (25%);
- 5% were due to undetermined causes.

There were 285 child deaths that occurred during 2008 that were reviewed by the CDRT's (either a mandatory or discretionary review). Of the deaths reviewed by CDRT's in 2008:

- 62% were boys and 38% were girls;
- 73% were infants under one, 15% were young children between one and four years, 9% were older children between 5 and 14 years, and 3% were youth between 15 and 17 years;
- 45% were Caucasian, 48% were African-American, and 3% were Hispanic.

When reviewed deaths occurring in 2008 were examined by manner of death:

- 36% were attributed to natural causes;
- 28% were due to accidents;
- 15% were homicides;
- 1% were suicides;
- 19% were undetermined.

When reviewed deaths were occurring in 2008 examined by category of death:

- 13% were related to illness;
- 3% were related to premature birth;
- 24% were related to Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID);
- 44% were related to various types of injuries, such as vehicular accidents (3%), firearms (less than 1%), drowning (4%), fires (1%), suffocations (23%), and other types of injuries (11%);
- 14% were due to undetermined causes.

CDRT 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 Director of DCFS 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, safe sleeping for infants, paramour safety)
- 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. Coroner Association, hospitals)

In 2007, there were 23 recommendations made by the CDRTs. Most of the recommendations (16) focused on DCFS policy and procedures, followed by recommendations for other agencies or systems (6) and primary prevention recommendations (1). There were no case specific recommendations in 2007.

In 2008, there were 27 recommendations made by the CDRTs. Most of the recommendations focused on DCFS policy and procedures (21), followed by case-specific recommendations (5), then recommendations for other agencies or systems (1). There were no primary prevention recommendations in 2008.

A complete list of CDRT recommendations (excluding case-specific recommendations¹) and the corresponding DCFS responses is provided in Chapter 4 and Appendix E.

¹ Case-specific recommendations do not require a response from DCFS and are not listed in the appendix.

INTRODUCTION

The death of a single child due to preventable causes serves as a powerful reminder that there is much to be done to protect children from harm. In 2007, there were 1,470 total child deaths in Illinois, and in 2008, there were 1,495 total child deaths in Illinois.² 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 CDRT produced its first annual report summarizing team findings and presenting 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 hope of furthering the understanding of how we can make Illinois a safer and healthier state for children.

² This represents the number of death certificates received by DCFS and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the CDRTs; therefore, this number does NOT represent the total number of child deaths that occurred in Illinois during 2007 and 2008.

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 and more recently by P.A. 95-0405 on August 24, 2007 and P.A. 95-0527 on August 28, 2007 (see Appendix A for copy of the amended Act). 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 Department of Children and Family Service (DCFS) Division of Quality Assurance and the Division of Child Protection.

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 child death review teams in Illinois, one in each of the seven DCFS administrative sub-regions outside Cook County and two within Cook County. A map of the CDRT sub-regions is located in Appendix B.

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

- Pediatrician or other physician knowledgeable about child abuse and neglect,
- Representative, manager or administrator from the DCFS Division of Child Protection,
- 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,
- Medical examiner, 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, and
- Representative of the Department of State Police.

Teams may make recommendations to the DCFS Director 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 Director 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.

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 quarterly to review the procedures common to the examination of child deaths throughout the state. According to P.A. 92-0468 (effective August 2002), Executive Council responsibilities include, but are not limited to:

- serve as the voice of child death review in Illinois,
- provide oversight of regional CDRTs to ensure that their work is coordinated and in compliance with legislation and the operating protocol,
- approve recommendations made by each regional team each month and send the finalized recommendations to the Director of DCFS and/ or his designees
- ensure that the data, results, findings, and recommendations of the teams are adequately used to make necessary changes in the policies, procedures, and statutes in order to protect children,
- collaborate with the Illinois General Assembly, DCFS, and others in order to develop legislation needed to prevent child fatalities and protect children,
- assist in the development of quarterly and annual reports based on the work and the findings of the CDRTs,
- ensure that the review processes of regional teams are standardized in order to convey data, findings, and recommendations in a usable format,
- serve as a link with CDRTs throughout the country and participate in national child death review team activities,
- develop an annual statewide symposium to update the knowledge and skills of CDRT members and to promote the exchange of information between teams,
- serve as a sub-committee of the DCFS Citizen's Review Panel,
- provide the CDRTs with the most current information and practices concerning child death review and related topics, and
- perform any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

In addition to these primary responsibilities, the CDRT Executive Council and CDRTs achieved a number of additional accomplishments during FY2009 and FY2010 (NOTE: Although this report includes information on child deaths that occurred in 2007-2008 information on CDRT policies, procedures, and activities are current):

- The Illinois Child Death Review Team Annual Report for 2007 and 2008 in collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign.
- Regular meetings (every other month) with the DCFS Director to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new ones developed.
- Initiation of the “Illinois Child Death Investigation Task Force” for the Southern Region of Illinois with a Board of Directors that includes a representative from all disciplines participating on the task force. Protocols, by-laws and an intergovernmental agreement are in place and a one-day introductory training was provided during July 2010. Law enforcement officers, coroners, state attorneys, child advocacy center directors, hospital and DCFS representatives, and Illinois Senators and Representatives were all invited to attend.
- The DCFS Abuse and Neglect Hotline taking all calls of bruising on infants younger than 6 months as allegations of abuse. The Child Death Review Teams Executive Council discussed the issue of bruising on children younger than 6 months of age with the Director of DCFS. The Director agreed with the CDRT Executive Council that these calls should all be taken as allegations of abuse until proven otherwise.
- DCFS adopting the term “abusive head trauma” in place of “shaken baby syndrome” in all policies, procedures, and reporting systems. The American Academy of Pediatrics released the following statement, “While shaking an infant can cause neurologic injury, blunt impact or a combination of shaking and blunt impact can also cause injury. In recognition of the need for broad medical terminology that includes all mechanisms of injury, the new AAP policy statement, “[Abusive Head Trauma In Infants and Children](#),” recommends pediatricians embrace the term “abusive head trauma” to describe an inflicted injury to the head and its contents.”
- The DCFS Abuse and Neglect Hotline taking calls from coroners as priority calls. DCFS agreed to make a coroner hotline call a priority and provide the coroner with necessary information concerning the family’s history with DCFS. DCFS also agreed to send a representative to the coroner’s conference to explain these new procedures.
- DCFS providing an in-service training and newsletter alert for their providers about the dangers of bottle propping and caring for infants and toddlers who have difficulty swallowing due to medical conditions. DCFS noted that according to licensing standards bottle propping is prohibited in day care homes and day care centers.

- The 14th Annual Illinois Child Death Review Teams Symposium on April 15 -16, 2010 at the Hilton in Springfield. The presentations included: 1) Evaluation of Neglect and Failure to Thrive in the Medical Setting by Kelley Staley, MD, Assistant Professor of Pediatrics at the University of Chicago and Associate Medical Director of Child Protective Services at Comer Children's Hospital; 2) The Still, Small Voice: Recognizing, Investigating, and Prosecuting Deadly Child Abuse by Kristina Korobov, J.D., Senior Attorney for the National Center for the Prosecution of Violence Against Women, a division of the National District Attorney's Association; 3) Accomplice Liability in Child Abuse Cases also presented by Kristina Korobov; 4) How Child Death Review Recommendations Shape Policy and Prevention by Shannon Stotenbur-Wing, State Director of Child Death Review in Michigan; 5) Error Reduction in Child Welfare by Denise Kane, Ph.D., Inspector General of the Illinois Department of Children and Family Services, Lisa Coconato, J.D., A.M., Head of Child Death Investigations, Office of the Inspector General, Diane Moncher, B.S., A.M., Investigator, Office of the Inspector General. The symposium was well attended with approximately 100 members present.
- Promotion of the statewide public awareness campaign on child drownings, *Get Water Wise – Supervise*. The campaign continues to be widely circulated throughout the state of Illinois. The posters and brochures have been written in both English and Spanish. The campaign carries a powerful message to parents and caregivers about the importance of adult supervision at all times when children are in and around water. The Child Death Review Teams staff serve on a Drowning Prevention Committee in collaboration with DCFS, Department of Human Services, Prevent Child Abuse Illinois, the Red Cross and the Illinois Department of Public Health.

- 1) "I told him to wait for me." In a moment a caregiver takes to run inside and answer the phone a curious child can slip silently into the water.*
- 2) "I left her in the bath for just a minute." A minute is all it takes for a child to slip silently underwater while her caregiver leaves the room to answer the phone.*
- 3) "I thought you were watching her." Children are quick and curious, and a day at the beach can quickly end in tragedy if you turn your back on a child for just a moment.*
- 4) "She went for a walk two minutes ago." Children are quick and curious, and a family cookout at the lake can quickly end in tragedy if you turn your back on a child for just a moment.*

*Drowning is the leading cause of accidental death for young children. The good news is that these tragedies can be prevented. Watch kids near water, and save a life.

- Promotion of infants sleeping safely. Teams continue to see many infant deaths related to the caregiver and infant bedsharing. DCFS workers currently distribute a safe sleeping brochure to families with infants receiving services. The brochure, *Safe Sleep for Your Baby*, from the National Institute of Child Health and Human Development, and, following the recommendations set forth by the American Academy of Pediatrics (AAP), urges caregivers

to room share and not bed share with infants. The Child Death Review Executive Council worked with SIDS of Illinois, Inc. to place billboards and bus cards with the following message.

Safe Sleep for Baby is:

1 *Baby on back*

2 *Alone*

3 *In a safe crib*

To learn more, call 1.800.432.7437 (SIDS of Illinois, Inc. number).

A total of 16 billboards were placed across the state including Bloomington, Carbondale, Champaign, Chicago (2), Decatur, Effingham, Joliet (2), Kankakee, Peoria, Quincy, Rockford (2), Springfield, and Vandalia. Due to the lack of billboards in the metro southeastern part of the state, one hundred bus cards were produced and placed in buses that travel the major routes of the East St. Louis area.

DCFS Roles and Responsibilities

The Illinois DCFS Division of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT Coordinator). In addition, the Department serves as a direct link between the review teams and the State's child protection policy makers. The Director of DCFS 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.

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 several objectives:

- evaluate the means by which 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; and
- make specific recommendations to the Director and Inspector General of DCFS concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

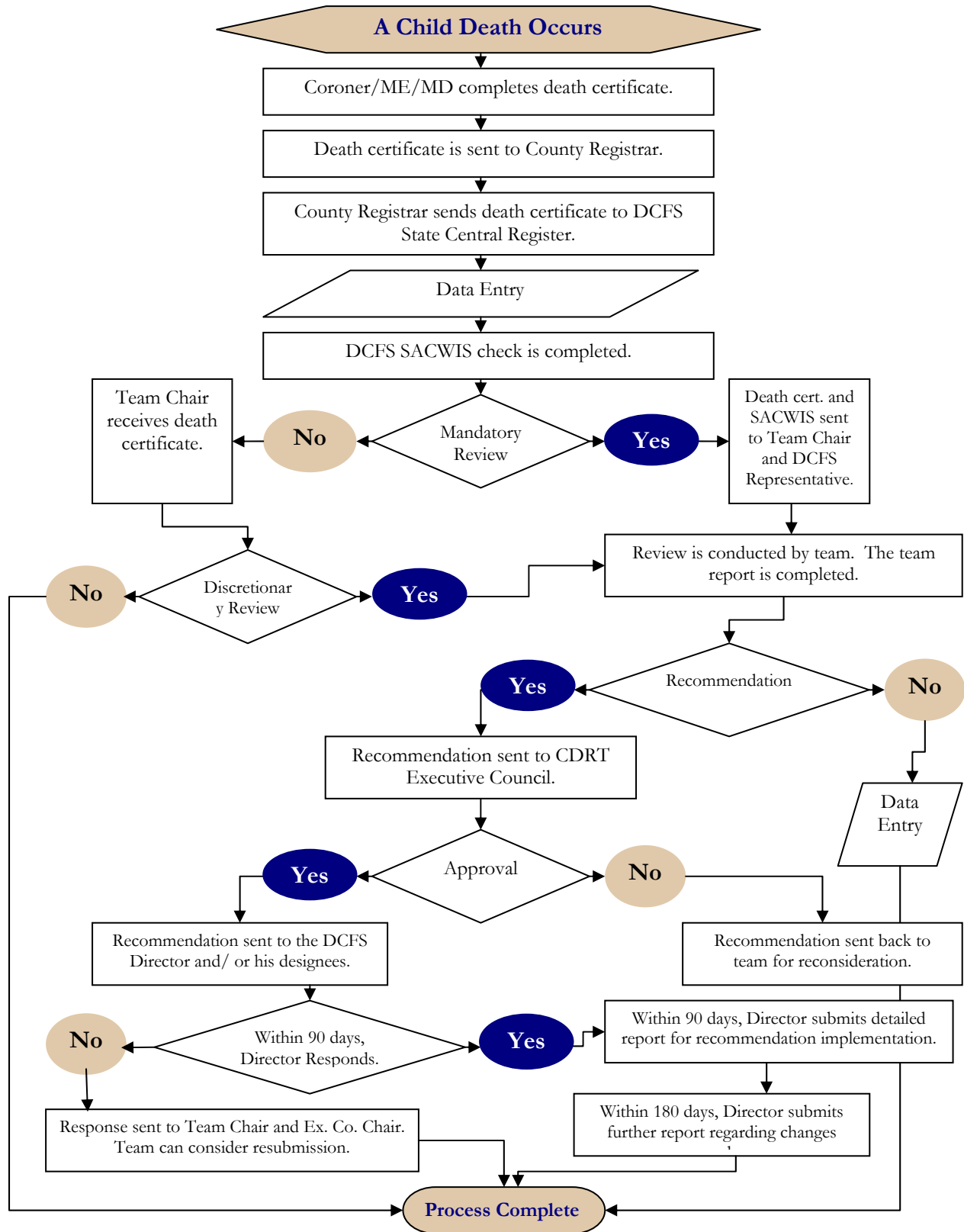
Other responsibilities of the CDRT include:

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

Child Death Review Procedures

Figure 1 delineates the child death review process in Illinois.

Figure 1. Child Death Review Flowchart



After a child's (under 18) death occurs, a coroner, medical examiner, pathologist, or physician completes the death certificate. At this point, the county registrars are required by the Illinois Vital Records Act (see Appendix C) to send a copy of the death certificate to the DCFS State Central Register (SCR). Unfortunately, although county registrars are required to submit copies of all child death certificates to the SCR, many do not. The importance of this requirement cannot be overstated, as only those child death certificates sent to the SCR are entered into the CDRT database and analyzed for this report. If significant numbers of child deaths are not included, it diminishes the ability of the CDRTs to analyze and understand child death in Illinois and make sound recommendations for preventing future deaths.

Once the death certificate is received by the SCR, 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 family involvement with DCFS within the prior year. Specifically, CDRTs are required to review the deaths of all children under 18 if the deceased child was:

- a ward of DCFS,
- 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
- any other child whose death is reported to DCFS's State Central Register as the result of indicated child abuse or neglect.

CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18 at their discretion, as well as cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.³

Information from the death certificates received by the SCR is 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 letter and the appropriate paperwork are sent to the appropriate CDRT for review and completion.

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.

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 2007 or 2008.

All CDRTs use the same report form to collect information, record findings, and list recommendations. This form details the circumstances of the child death, such as the time and location, witnesses to the death, and additional information specific to the category of 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 CDRT report form is completed, it is sent back to DCFS for entry into the CDRT database. All recommendations are sent to the Director of DCFS, who must review and reply to recommendations (except case-specific), within 90 days of receipt. Pursuant to the new legislation, 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 the Director intended to implement the recommendation.

In addition, the Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or non-implementation of the recommendations. Specifically, within 90 days after the Director submits a reply to the CDRT teams and Executive Council, he or she must submit an additional report that sets forth the way, if any, in which the recommendation will be implemented and the schedule for implementing the recommendation. The Director shall submit this report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. Within 180 days after the Director submits this report concerning the implementation of a recommendation, he or she shall submit a further report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to 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 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 are 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: Illinois Child Deaths 2007 and 2008

What do we know about the child deaths that occurred in Illinois during 2007 and 2008?

To answer this question, there are three important sets of numbers that need to be compared: 1) the total population of children in Illinois, 2) the number of total child deaths in Illinois, and 3) the child deaths that were reviewed by the CDRTs.

Comparing the children who died to the total child population in Illinois can add to our understanding of how characteristics such as gender, age, and race are associated with child deaths and how children that die differ from those in the general child population in Illinois. However, it is important to note that **this report bases its analysis on the total child deaths reported to DCFS** by county registrars and coroners. Although all death certificates are required by law to be submitted to DCFS, not all counties comply with this requirement, so the number of deaths reported to DCFS is typically a low estimate of the total number of deaths that occur in Illinois. Previous comparisons between the number of child deaths reported to DCFS and those reported to the Illinois Department of Public Health suggest that the child deaths reported to DCFS range from 73% to 92% of all child deaths that occur in Illinois in a given year. In 2007, 81% of the child deaths recorded by IDPH were also submitted to DCFS for entry into the Child Death Review Team database.⁴

Further analysis of the characteristics of children in the third group – child deaths reviewed by the CDRTs – can increase our understanding of the types of deaths experienced by children involved in the child welfare system in Illinois and how these might differ from the total child deaths. When making this comparison, it is very important to remember that the population of children in child welfare in Illinois differs from the total child population in Illinois on a number of characteristics.

According to recent analysis of children indicated for abuse and neglect in Illinois, almost half of the children indicated for abuse or neglect were five years of age or younger. This is much higher than the number of children in that age range in the total child population in Illinois. In addition, the “indication rate” (i.e., the number of children indicated for abuse or neglect per 1,000 children) among African-American children (13.5) was considerably higher than that of either white (6.1) or Hispanic children (2.7).⁵ Thus, the Illinois child welfare population is over-represented by young children and African-American children when compared to the total child population in Illinois. It is, therefore, likely that deaths reviewed by the CDRTs, which come from this population, will also be over-represented on these two characteristics.

⁴ The number of total child deaths reported to the Illinois Department of Public Health in 2008 was not available at the time of publication of this report.

⁵ Children and Family Research Center. (2008). *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, stability, continuity, permanence, and well-being*. Urbana, IL: Children and Family Research Center. Available online at www.cfr Illinois.edu

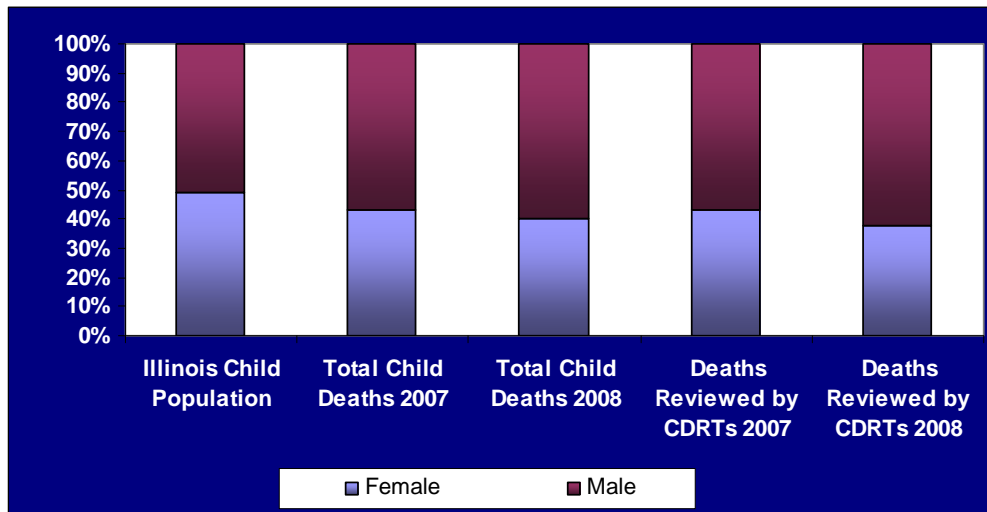
With this information in mind, the following provides a brief look at the three groups.

- According to Census 2000 data, there were approximately 3.2 million children under the age of 18 in Illinois, or about 26% of the total Illinois population.
- In 2007, there were 1470 child deaths reported to the Illinois CDRT database, and in 2008 there were 1495 child deaths reported. This includes deaths due to all causes, preventable and non-preventable.
- There were 130 child deaths that occurred in 2007 that were reviewed by the CDRTs – 127 of these were mandated for review and 3 were discretionary reviews. There were 285 child deaths that occurred in 2008 that were reviewed by CDRTs – 154 were mandated for review and 131 were discretionary reviews. The number of discretionary child death reviews in 2008 is much higher than in past years because the Executive Council asked all CDRTs to perform discretionary reviews of all SIDS, SUID, suffocation, and undetermined deaths.

Child Deaths by Gender

According to information from the 2000 Census, 51% of the Illinois child population is male and 49% is female. Figure 2 shows that boys were more likely to die than girls in both 2007 and 2008, and a greater percentage of reviewed deaths were males in 2007 and 2008.

Figure 2. Illinois Child Deaths by Gender



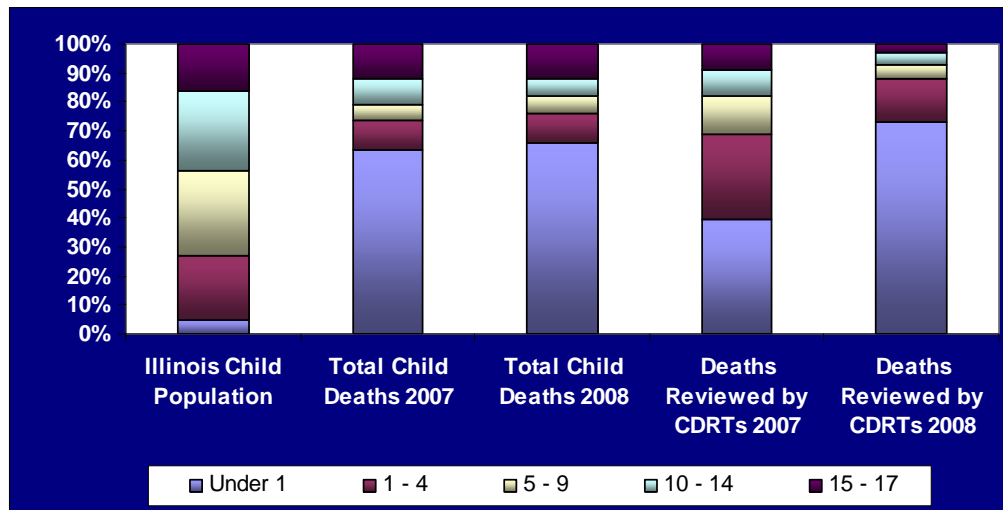
Child Deaths by Age

Of the 3.2 million children in Illinois under 18 years, 5% are less than one year of age, 22% are between 1 and 4 years, 29% are between 5 and 9 years, 28% are between 10 and 14 years, and 16% are between 15 and 17 years.⁶

However, when the total Illinois child deaths reported to DCFS are examined by age (Figure 3), it becomes clear that infants less than one year old are especially vulnerable – 63% of the total deaths in 2007 and 65% of the total deaths in 2008 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Children in other age groups are much less likely to die in 2007 and 2008: 10% of the total deaths were children between 1 and 4 years, 5-6% were children between 5 and 9 years, 6-9% were children between 10 and 14 years, and 12% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group, infants under one year are again over-represented, especially in 2008, when they comprised 73% of all reviewed deaths (the percentage in 2008 is much higher than in 2007 because of the higher number of discretionary reviews of SIDS, SUID, and suffocation deaths). There were comparatively fewer reviewed deaths among children between 1 and 4 years (29% in 2007 and 15% in 2008), 5 and 9 years (13% in 2007 and 5% in 2008), 10 and 14 years (9% in 2007 and 4% in 2008) and 15 through 17 years (9% in 2007 and 3% in 2008).

Figure 3. Illinois Child Deaths by Age Group



⁶ Numbers for the Illinois child population were obtained from the 2000 Census, available online at www.census.gov

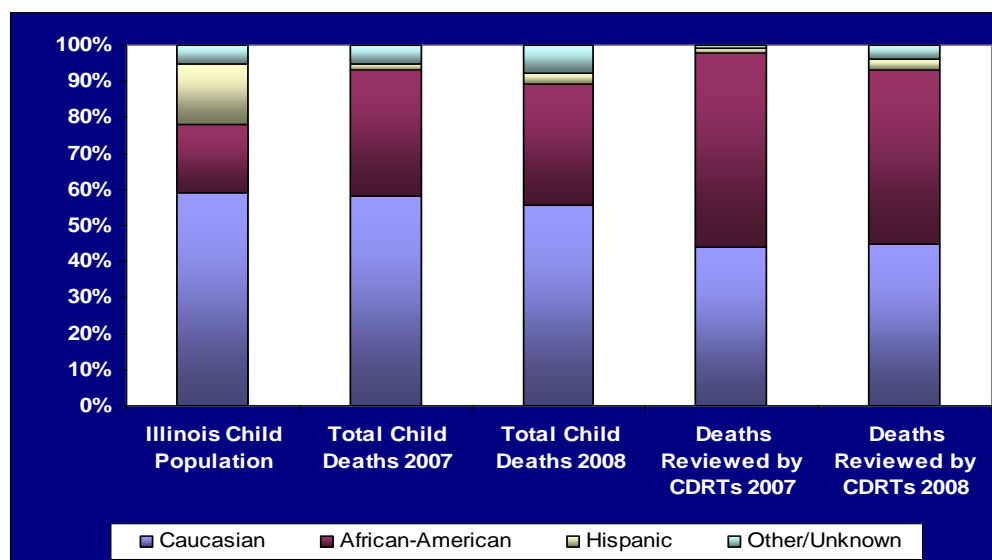
Child Deaths by Race

According to 2000 Census data, 59% of Illinois children are Caucasian, 18.7% are African-American, 17% are Hispanic/Latino, and 5% are of another racial background.

However, when the total Illinois child deaths reported to DCFS are examined by race, it is evident that African-American children are at increased risk of death when compared to their numbers in the general population: 34-35% of the children that died in 2007 and 2008 were African-American compared with roughly 19% in the general child population. Conversely, deaths among Hispanic children (2-3% of the total deaths in 2007 and 2008) were infrequent compared to their numbers in the general population (17%). The portion of deaths among Caucasian children (58% in 2007 and 56% in 2008) was roughly equivalent to their proportion in the general child population (59%).

When deaths reviewed by the CDRTs are examined by race, the disproportionate number of African-American children is even larger: 48-54% of the reviewed deaths were African-American children, 44-45% were Caucasian children, and 1-3% were Hispanic children (see Figure 4).

Figure 4. Illinois Child Deaths by Race



Child Deaths by Category and Manner

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and “other” deaths. Three new categories were added in 2007: scalding burn, sudden unexplained infant death (SUID) and sudden unexplained death in childhood (SUCD). 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 of death for child deaths that occurred in Illinois in 2007 and 2008 are shown in Tables 1.⁷ The majority of total child deaths were related to either illness (35-36%) or premature birth (32-35%). The other categories accounted for the remaining 30% of the total child deaths, ranging from vehicular accidents (5-7%), suffocation (5-6%), firearms (4-5%), SIDS (3-4%), injuries (3%), fire (1-2%), drowning (2%) and poisoning/overdose (1%).

Table 1. Child Deaths by Category of Death 2007 – 2008

CATEGORY OF DEATH	TOTAL CHILD DEATHS				DEATHS REVIEWED BY CDRTS			
	2007		2008*		2007		2008*	
	N	%	N	%	N	%	N	%
Illness	513	35	537	36	25	19	36	13
Premature Birth	513	35	483	32	8	6	9	3
Vehicular Accident	99	7	79	5	7	5	8	3
Suffocation	70	5	88	6	16	12	66	23
Firearm	66	4	81	5	7	5	2	<1
Injury	49	3	49	3	33	25	32	11
Undetermined	46	3	44	3	6	5	41	14
Sudden Infant Death Syndrome	41	3	56	4	3	2	54	19
Fire	30	2	19	1	14	11	3	1
Drowning	23	2	27	2	6	5	12	4
Overdose/Poisoning	12	1	10	1	2	2	2	<1
Sudden Unexplained Infant Death	3	<1	14	1	1	<1	14	5
Sudden Unexplained Child Death	1	<1	0	0	0	0	0	0
Scalding Burn	1	<1	3	<1	1	<1	3	1
Other	3	<1	2	<1	1	<1	2	<1
Total	1470		1495		130		285	

*There was one “pending” death in 2008 at the time of this report.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 1). In 2007, deaths reviewed by CDRTs were most likely to be related to injury (25%), illness (19%), suffocation (12%), and fire (11%). The number of reviewed deaths increased dramatically in 2008, after a decision was made for the CDRTs to perform discretionary reviews for all deaths related to suffocation, SIDS, SUID, and undetermined causes. Therefore, in 2008, deaths reviewed by CDRTs were most likely to be related to suffocation (23%), SIDS (19%), undetermined (14%), illness (13%), and injury (11%).

⁷ These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths.

It is important to distinguish between the “category of death” and the “manner of death,” 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, and
- 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.

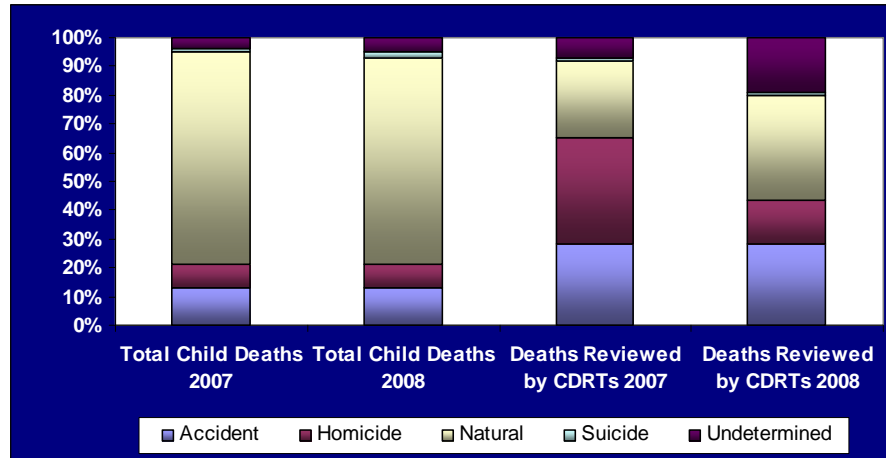
Child deaths that occurred in 2007 and 2008 are examined by manner of death in Table 2 and Figure 5. The majority of total child deaths were attributable to natural causes (72-73%). Accidents accounted for 13% of the total child deaths, 8% were homicides, 1-2% were suicides, and 4-5% were undetermined. When compared to total child deaths, deaths reviewed by CDRTs are much more likely to be homicides, accidents, and undetermined, and much less likely to be due to natural causes.

Table 2. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs

MANNER OF DEATH	TOTAL CHILD DEATHS*				DEATHS REVIEWED BY CDRTS			
	2007		2008		2007		2008	
	N	%	N	%	N	%	N	%
Accident	198	13	193	13	37	28	81	28
Homicide	120	8	25	8	48	37	42	15
Natural	1069	73	1082	72	35	27	104	36
Suicide	22	1	27	2	1	<1	3	1
Undetermined	61	4	68	5	9	7	55	19
Total	1470		1495		130		285	

*These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths.

Figure 5. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs



Finally, it is interesting to examine the manner of child death juxtaposed with the categories of death (Tables 3 and 4). For instance, the majority of accidental child deaths are related to vehicular accidents, followed by suffocations, drownings, and fires. Most homicides involve either firearms or other inflicted injuries, and hanging (suffocation) is the most frequent method of child/youth suicide. Almost all child deaths due to natural causes are the result of illness, premature birth, or sudden infant death syndrome (SIDS).

Table 3. 2007 Total Child Deaths – Manner of Death by Category of Death

Category of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	0	0	511	0	2	513
Premature Birth	1	0	512	0	0	513
Vehicular Accident	84	8	0	3	4	99
Suffocation	48	5	0	14	3	70
Firearm	2	59	0	4	1	66
Injury	12	36	0	1	0	49
Undetermined	0	0	2	0	44	46
Sudden Infant Death Syndrome	0	0	41	0	0	41
Fire	20	8	0	0	2	30
Drowning	21	14	0	0	1	23
Overdose/Poisoning	9	1	0	0	2	12
Sudden Unexplained Infant Death	0	0	2	0	0	2
Sudden Unexplained Child Death	0	0	1	0	0	1
Scalding Burn	0	0	0	0	1	1
Other	1	2	0	0	0	3
Total	198	120	1069	22	61	1470

Table 4. 2008 Total Child Deaths – Manner of Death by Category of Death

Category of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	0	1 ^a	536	0	0	537
Premature Birth	0	0	482	0	1	483
Vehicular Accident	74	3	0	1	1	79
Suffocation	60	4	1	17	6	88
Firearm	2	71	0	7	1	81
Injury	7	40	0	1	1	49
Undetermined	0	0	1 ^b	0	43	44
Sudden Infant Death Syndrome	0	0	56	0	0	56
Fire	17	0	0	0	2	19
Drowning	24	1	0	0	2	27
Overdose/Poisoning	6	0	0	1	3	10
Sudden Unexplained Infant Death	3 ^c	0	6	0	5	14
Sudden Unexplained Child Death	0	0	0	0	0	0
Scalding Burn	0	3	0	0	0	3
Other	0	2	0	0	0	2
Total	193	125	1082	27	68	1495

^aIllness/Homicide was sepsidecubitus Ulcers due to neglect

^bUndetermined/Natural is what Coroner ruled

^cSUDI/Accident is what the death certificate read

Special Analysis: Homicide Deaths in 2007 and 2008

There were 120 homicide deaths in 2007 and 125 in 2008. We know from the above tables that the majority of homicides involve either firearms or inflicted injuries of some kind. Additional information on homicide deaths allows for a more complete understanding of the circumstances of these types of child deaths.

Table 5. 2007 and 2008 Homicide Deaths

2007 Homicide Deaths			
Category of Death	Child Age	Circumstances	Perpetrator
Injury	2 mo	Subdural hematoma, cerebral injuries, assault	Father
	1 mo	Multiple injuries assault	Father and Mother
	4 mo	Subdural hematoma, blunt head trauma	Father
	5 yrs	Multiple injuries, blunt trauma, child abuse, failure to thrive due to parental	Mother

		neglect	
	2 yrs	Closed head injuries, multiple blunt force trauma to head	Male Paramour
	3 yrs	Complications of closed head injuries, blunt force trauma	Male Paramour
	13 yrs	Stab wound to chest	Brother (mutual combatants)
	14 yrs	Multiple stab wounds	Mother's Ex-boyfriend
	13 yrs	Craniocerebral injuries, blunt head trauma, assault	Multiple Offenders
	4 mo	Subdural hematoma, blunt head trauma	Father
	4 yrs	Multiple injuries, blunt trauma, child abuse	Male Paramour
	14 yrs	Multiple stab wounds	19-year-old male Self-defense
	12 yrs	Multiple stab wounds	Mother's Ex-boyfriend
	1 yr	Multiple injuries, blunt trauma of head, chest, abdomen	Unknown
	5 yrs	Cerebral injuries, blunt head trauma, child abuse	Mother
	10 mo	Complications of cranial cerebral injury, multiple blunt force trauma	Male Paramour
	2 mo	Multiple injuries, child abuse	Father
	10 mo	Subdural hematoma, blunt head trauma	Male Paramour
	1 mo	Subdural hematoma, blunt head trauma, child abuse	Father
	3 yrs	Multiple injuries, blunt trauma, assault	Babysitter
	4 mo	Multiple injuries, blunt trauma, child abuse	Male Paramour
	13 yrs	Multiple injuries, child abuse	Mother and Stepfather
	2 yrs	Blunt head trauma, assault	Babysitter
	3 yrs	Multiple injuries, assault	Mother
	1 yr	Multiple injuries, assault	Mother and Stepfather
	2 yrs	Cranial-cerebral injuries, multiple blunt force trauma	Male Paramour
	11 mo	Subdural hematoma, blunt head trauma, child abuse	Male Paramour
	2 yrs	Multiple injuries, blunt trauma, child abuse	Mother
	1 mo	Craniocerebral injuries, blunt head trauma	Father
	1 yr	Multiple injuries, child abuse	Babysitter
	1 yr	Multiple injuries, child abuse	Aunt
	9 days	Craniocerebral injuries, blunt head trauma	Mother
	4 days	Hypoxic ischemic encephalopathy hyaline membrane disease, abruption	Father

		placenta due to maternal blunt trauma	
	1 yr	Cerebral injuries, blunt trauma of the head	Male Paramour
	7 yrs	Subdural hematoma, child abuse	Mother
Drowning	11 mo	Asphyxia, drowning	Mother
Fire	10 yrs	Carbon monoxide poisoning	Parental Acquaintance
	5 yrs	Carbon monoxide poisoning	Parental Acquaintance
	5 mo	Carbon monoxide poisoning	Parental Acquaintance
	7 yrs	Carbon monoxide poisoning	Parental Acquaintance
	9 yrs	Carbon monoxide poisoning	Parental Acquaintance
	14 yrs	Inhalation injuries, fire in van	Gang-related
	1 yr	Thermal injuries, house fire	Mother
	4 yrs	Thermal injuries, house fire	Mother
Vehicular	16 yrs	Blunt chest trauma, automobile vs. fixed object mishap	Driver Intoxicated
	6 yrs	Pneumonia, motor vehicle crash	
	17 yrs	Due to blunt force injuries to the body, due to a 2 vehicular collision	
	16 yrs	Massive internal exsanguinations, blunt force injuries, 2 vehicular collision	
	9 yrs	Blunt head and chest trauma, SUV vs. minivan mishap	Reckless Driving by other driver
	14 yrs	Multiple injuries, automobile striking pedestrian	
	3 yrs	Pending	Father
	2 yrs	Pending	Father
Suffocation	4 mo	Suffocation	Father
	16 yrs	Strangulation	Stepfather
	1 day	Asphyxia, obstruction of the mouth and nose by placenta	Mother
	7 yrs	Asphyxia, undetermined etiology	Mother
	16 yrs	Asphyxia	17 –year-old male
Other	3 days	Hypothermia, cold exposure	Mother
	1 yr	Dehydration, parental neglect	Mother
Poison/ Overdose	4 yrs	Acute morphine toxicity	Aunt and Aunt's Paramour
Firearms	15 yrs	Multiple gunshot wounds	Drive-by
	15 yrs	Multiple gunshot wounds	Victim in Home Robbery
	17 yrs	Gunshot wound to the arm	Friend playing with gun
	14 yrs	Gunshot wound to back	Bystander at party when fight broke out
	16 yrs	Multiple gunshot wounds	Gang related
	17 yrs	Gunshot wound to hip	

	16 yrs	Gunshot wound of head	Teen playing with gun
	17 yrs	Gunshot wound of back thru chest	
	15 yrs	Gunshot wound to head	Bystander at party when fight broke out
	14 yrs	Multiple gunshot wounds	
	17 yrs	Gunshot wound to neck	
	15 yrs	Gunshot wound of the head	Drive-by
	15 yrs	Gunshot wound of arm	
	16 yrs	Bullet injuries of the brain, gunshot wound of the head	20-year-old male
	16 yrs	Multiple gunshot wounds	Police Officer/ Attempted Armed Robbery
	12 yrs	Multiple gunshot wounds	Father
	11 yrs	Multiple gunshot wounds	Father
	8 yrs	Multiple gunshot wounds	Father
	17 yrs	Multiple gunshot wounds	17-year-old male
	17 yrs	Gunshot wound of back, shot while being chased	
	16 yrs	Gunshot wound of chest	
	16 yrs	Multiple gunshot wounds	
	17 yrs	Multiple gunshot wounds	
	17 yrs	Multiple gunshot wounds	
	17 yrs	Gunshot wound of the abdomen	
	15 yrs	Gunshot wound to the chest	
	16 yrs	Gunshot wound to the chest	
	17 yrs	Bullet injuries of the lungs, gunshot wound of the back	
	17 yrs	Gunshot wound to chest	Gang related
	17 yrs	Gunshot wound of back	Gang related
	14 yrs	Multiple gunshot wounds, craniocerebral injuries trauma from assault	Gang related
	14 yrs	Multiple gunshot wounds	Drive-by; 20-year old male and 19-year-old male
	16 yrs	Gunshot wound of neck	
	14 yrs	Multiple (3) gunshot wounds of the chest and abdomen	Gang related
	17 yrs	Gunshot wound of chest	
	17 yrs	Gunshot wound of neck	
	17 yrs	Gunshot wound of chest	
	16 yrs	Multiple gunshot wounds	
	15 yrs	Multiple gunshot wounds	
	17 yrs	Multiple gunshot wounds	
	16 yrs	Hemoperitoneum, erosion of vascular anastomosis, multiple gunshot wounds	
	15 yrs	Gunshot wound to back	
	17 yrs	Multiple gunshot wounds	
	17 yrs	Gunshot wound to back	

	14 yrs	Shotgun wound to back	Gang related
	13 yrs	Multiple gunshot wounds	Carjacking
	17 yrs	Shotgun wound of back	Gang related
	14 yrs	Multiple gunshot wounds	Shooter in car next to car decedent was riding in
	17 yrs	Gunshot wound to back	Gang related
	17 yrs	Gunshot wound of back	
	17 yrs	Gunshot wound to head	
	17 yrs	Massive brain trauma projectile entry passage medial to left eye, single gunshot wound to the head	
	10 yrs	Multiple gunshot wounds	Gang related
	16 yrs	Gunshot wound of back	Drive-by
	14 yrs	Multiple gunshot wounds	
	17 yrs	Multiple gunshot wounds	
	15 yrs	Multiple gunshot wounds	
	4 yrs	Gunshot wound of chest	

2008 Homicide Deaths

Category of Death	Child Age	Circumstances	Perpetrator
Injury	7 mo	Subdural hematoma, blunt head trauma, child abuse	Mother
	9 mo	Hemoperitoneum, laceration of liver and mesentery, blunt abdominal trauma	Mother and Father
	16 yr	Sepsis, cerebral injuries, blunt head trauma	Caregiver
	16 yrs	Cranio cerebral injuries, multiple blunt head trauma, assault	Gang related
	6 yrs	Multiple stab and incised wounds	Mother
	16 yrs	Stab wound of chest	54-year-old male
	2 mo	Subarachnoid and subdural hemorrhage and diffuse axonal	Father
	5 mo	Blunt head injury, subarachnoid and subdural hemorrhage, brain swelling and herniation associated with multiple bilateral rib fractures (healing)	Father
	6 yr	Sharp and blunt force injuries to chest	52-year-old Male
	2 mo	Blunt trauma of the head	Father
	1 yr	Subdural hematoma, blunt head trauma	Male Paramour
	3 yr	Subdural hemorrhage due to multiple systematic contusions and abrasions due to multiple trauma due to beating	Father and Mother
	8 mo	Cranial cerebral injuries, multiple blunt force trauma to the head	Male Paramour
	1 yr	Multiple injuries, child abuse	
	3 mo	Multiple injuries, blunt trauma, child abuse	Father
	3 mo	Multiple injuries, blunt trauma of the abdomen, child abuse	Father

	17 yr	Hemorrhagic shock, sharp force injury to heart, stab wound to the chest	
	6 mo	Subdural hematoma, blunt head trauma, child abuse, violent assault	Male Paramour
	16 yr	Stab wound of back	18-year-old and 20-year-old Males
	1 yr	Subdural hematoma, blunt head trauma, child abuse	Father
	1 mo	Subdural hematoma, blunt head trauma, child abuse	Father
	1 yr	Subdural hematoma, blunt head trauma, child abuse	Male Paramour
	5 mo	Cerebral injuries, blunt head trauma, child abuse	Adopted Father
	9 yr	Multiple injuries, assault	
	11 mo	Multiple injuries, child abuse	Male Paramour
	1 yr	Hemoperitoneum, multiple injuries, blunt trauma	Father
	6 mo	Blunt head trauma, child abuse	Babysitter/ Daycare
	11 mo	Multiple injuries, blunt trauma	Male Paramour
	6 yr	Seizure disorder, blunt head trauma, child abuse	Male Paramour
	1 yr	Multiple injuries, blunt trauma, child abuse	Male Paramour
	17 yr	Multiple injuries, assault	Gang related
	2 mo	Cerebral injuries, blunt force trauma, assault	Father
	17 yr	Blunt head trauma, assault	
	5 yr	Close head injury	Male Paramour
	4 mo	Recent head injury with evidence of prior injury, multiple rib fractures of different duration in both R and L chest	Father
	1 yr	Cranio-cerebral injuries, blunt head trauma	Babysitter
	3 yr	Cranio-cerebral blunt trauma	Father
	5 mo	Closed head injury	Mother's Male Friend
	13 yr	Sepsis decubitus ulcers, due to neglect, cerebral palsy	Mother
	5 mo	Subdural hematoma, blunt head trauma, child abuse	Babysitter
Drowning	5 mo	Drowning	Mother
Scalding Burn	7 yr	Thermal burns, gasoline fire	Father
	2 yr	Scalding burns, immersed in scalding water	Male Paramour
	4 yr	Thermal burns, gasoline fire	Father
Suffocation	5 yr	Suffocation	Father
	15 yr	Strangulation	18-year-old Former Boyfriend

	3 yr	Smothering	Mother
	11 mo	Suffocation, old injuries, child abuse	Male Paramour
Vehicular	1 yr	Blunt force trauma to the head, motor vehicle collision	Mother
	17 yr	Multiple blunt force injuries	
	17 yr	Blunt trauma of the head, neck, and chest	Hit by Drunk Driver
Other	5 mo	Sepsis, dehydration, neglect	Father
	13 yr	Dehydration, parental neglect, multiple chromosome anomalies	Mother
Firearms	15 yr	Gunshot wound to chest	Gang related
	16 yr	Gunshot wound of chest	20-year-old Male Neighbor
	16 yr	Multiple gunshot wounds	Gang related
	17 yr	Multiple gunshot wounds	
	17 yr	Gunshot wound of chest	
	14 yr	Hemorrhagic shock, bullet injury of heart aorta and right lung, gunshot wound to chest	Home Invasion
	17 yr	Gunshot wound to back	
	17 yr	Gunshot wound of head	20-year-old Male
	7 yr	Multiple gunshot wounds	Father
	14 yr	Gunshot wound to head	Male on bicycle
	17 yr	Multiple penetrating gunshot wounds	Drive-by
	16 yr	Gunshot wound to the face	Drive-by
	17 yr	Multiple gunshot wounds	Police
	17 yr	Multiple gunshot wounds	
	17 yr	Multiple gunshot wounds	
	15 yr	Multiple gunshot wounds	
	16 yr	Gunshot wound to the back	
	12 yr	Gunshot wound to the head	27-year-old Male not intended victim
	15 yr	Multiple gunshot wounds	
	17 yr	Multiple gunshot wounds	Drive-by
	17 yr	Multiple gunshot wounds	
	16 yr	Gunshot wound of the back	
	17 yr	Gunshot wound of chest	
	15 yr	Gunshot wound of back	18-year-old Male
	15 yr	Gunshot wound to head	Gang related
	16 yr	Gunshot wound of head	
	17 yr	Gunshot wound of the face	
	15 yr	Gunshot wound right shoulder	
	17 yr	Multiple gunshot wounds	
	17 yr	Gunshot wound of head	Robbery
	16 yr	Multiple gunshot wounds	

	14 yr	Gunshot wound to the back	
	15 yr	Multiple gunshot wounds	
	16 yr	Multiple gunshot wounds	Drive-by
	15 yr	Gunshot wound abdomen	Gang related
	15 yr	Gunshot wound head	
	15 yr	Gunshot wound chest	
	16 yr	Multiple gunshot wounds	Gang related
	16 yr	Multiple gunshot wounds	
	17 yr	Gunshot wound to chest	
	17 yr	Multiple gunshot wounds	
	9 yr	Gunshot wound of head	Father
	16 yr	Shotgun wound of neck	16-year-old male, Accident
	16 yr	Gunshot wound of back	
	17 yr	Gunshot wound of abdomen	Altercation after party
	7 yr	Multiple gunshot wounds	Father
	16 yr	Multiple gunshot wounds	Argument with 2 others
	16 yr	Multiple gunshot wounds	
	17 yr	Multiple gunshot wounds	
	13 yr	Gunshot wound of the head	Gang related
	10 yr	Gunshot wound of chest	
	15 yr	Gunshot wound of head	
	17 yr	Multiple gunshot wounds	
	17 yr	Gunshot wound of head	31-year-old Male Convicted Murderer on Parole
	17 yr	Gunshot wound of eye	
	16 yr	Gunshot wound of chest	
	17 yr	Multiple gunshot wounds	
	16 yr	Gunshot wound of chest	
	15 yr	Gunshot wound of pelvis	19-year-old Male
	15 yr	Multiple gunshot wounds	
	17 yr	Multiple gunshot wounds	
	15 yr	Multiple gunshot wounds	
	7 yr	Multiple gunshot wounds	Stepfather
	16 yr	Gunshot wound of chest	
	17 yr	Multiple gunshot wounds	Drive-by
	16 yr	Gunshot wound of chest	
	17 yr	Multiple gunshot wounds	
	13 yr	Multiple gunshot wounds	15-year-old Male
	17 yr	Gunshot wound of chest	
	17 yr	Gunshot wound of face	Male shot at bus not intended victim
	15 yr	Multiple gunshot wounds	20-year-old Male

Chapter 3: Child Deaths Reviewed 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 that die by the specific cause of death, more explicit and useful recommendations for preventing future child deaths can be made.

For each category section, the following information is presented:

- category definition – describes the types of deaths that are included
- background information – information regarding national statistics or research findings, if available
- Illinois data on total child deaths – this includes deaths reported to the State Central Register (SCR/DCFS)
- Illinois data on child deaths reviewed by the CDRTs
- charts comparing the total Illinois child population, total child deaths, and deaths reviewed by the CDRTs by child gender (when noteworthy), age, and race

Once again, there are two important facts to remember about these analyses. The first is that not all child deaths in Illinois are reported to DCFS as required by statute. Thus, the number of total child deaths, and any analyses using this number, will be an estimate of the true number of child deaths in Illinois. Second, it is important to remember that the deaths reviewed by the CDRTs are not a representative sample of all child deaths in Illinois. The deaths reviewed by CDRTs include children involved with the child welfare system in Illinois, a population of children that is over-represented by African-American children and young children. Thus, any group of children selected from this population (such as child deaths) will be more likely to include young, African-American children than a similar group selected from the general Illinois child population.

Illness

Definition

This category of death 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 death was caused by an accident related to their illness, such as malfunctioning medical equipment or surgical error (for example, accidental removal of tracheotomy tubes).

Background

The majority of all child deaths are related to illness and other natural causes, and the majority of all illness deaths occur during the first year of life.⁸ 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 that accidents, homicides, and suicides are preventable, deaths from certain illnesses, such as neural tube defects, asthma, infectious diseases, and some screenable genetic disorders are now believed to have a preventable component.

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 513 of the 1,470 total child deaths (35%) reported to the SCR were related to illness; in 2008, 537 of the 1,495 total child deaths (36%) were related to illness.

- The vast majority of these deaths (over 99%) were attributable to natural causes.
- A larger percentage of boys than girls had deaths related to illness (54% in 2007 and 53% in 2008).
- A majority of deaths from illnesses were among children under the age of one (55-57%); 16% of the illness deaths occurred among children between 1 and 4 years, 7-10% occurred among the 5 to 9 year olds, 9-12% among those 10 to 14 years old, and 9-10% occurred among 15 to 17 year olds.
- Although more Caucasian children died from illness (59-61%) than African-American children (30-31%), African-American children are over-represented in this group compared to their numbers in the total Illinois child population (19%). Deaths from illness among Hispanic children (2%) are much lower than their numbers among the Illinois child population (17%).

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 25 of the 130 child deaths reviewed by CDRTs (19%) were related to illness; in 2008, 36 of the 285 child deaths reviewed by CDRTs (13%) were related to illness.

- Approximately equal numbers of boys and girls had deaths related to illness.
- Children under one represent the largest percentage of the illness deaths reviewed by CDRTs.
- 56-60% of the illness deaths reviewed by the CDRTs involved African-American children and 36-44% involved Caucasian children.

⁸ Missouri Department of Social Services. (2004). *Preventing Child Deaths in Missouri: The Missouri Child Fatality Review Program Annual Report for 2003*. Jefferson City, MO: Author.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 6 and 7.

Figure 6. Child Deaths Due to Illness – by Age

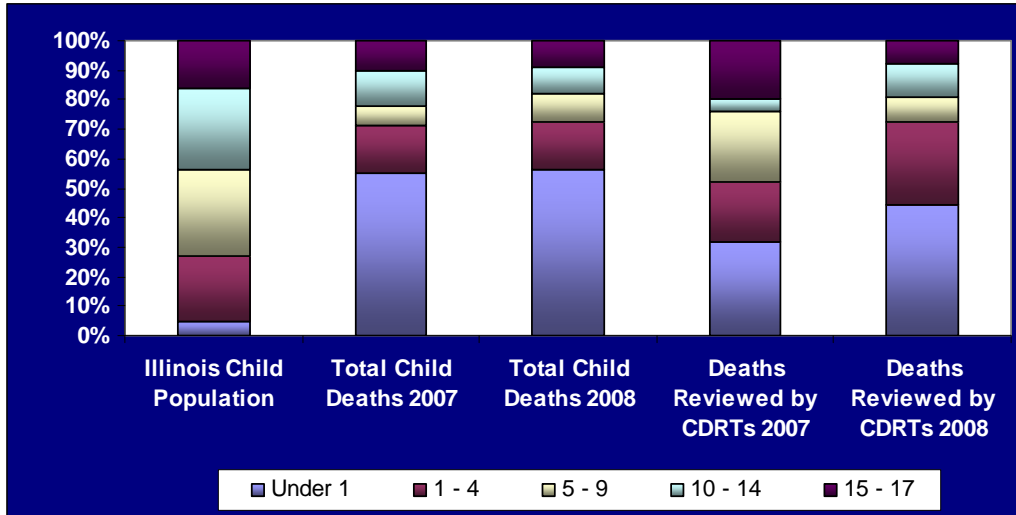
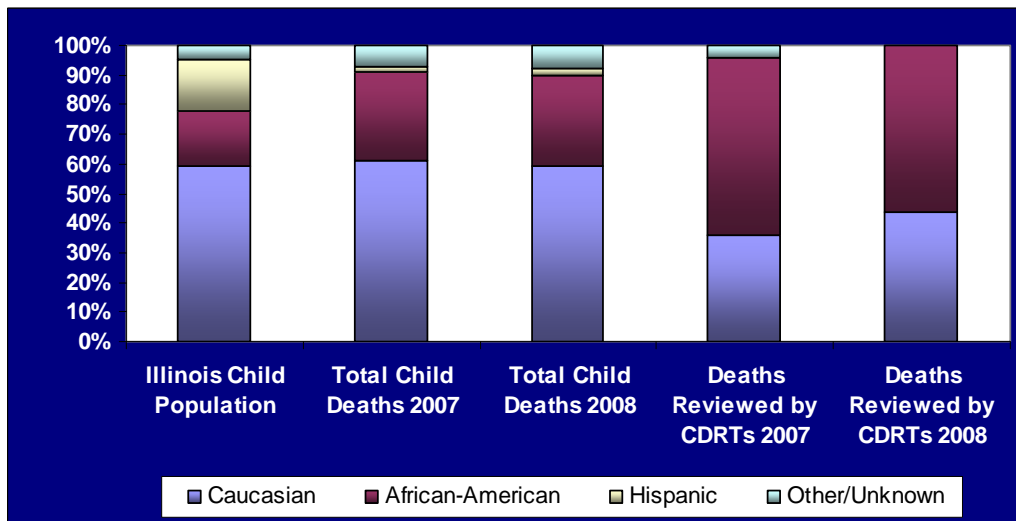


Figure 7. Child Deaths Due to Illness – by Race



Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature (or 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 gestation) and moderately preterm (32 – 36 weeks 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. According to the U.S. Department of Health and Human Services, period of gestation and birth weight are the two most important predictors of neonatal mortality. Low birth weight babies (less than 2,500 grams) and very low birth weight babies (less than 1,500 grams) are more likely to die during the first four weeks of life than babies weighing more than 2,500 grams. Because of their much greater risk of death, infants born at the lowest birthweights and gestational ages have a large impact on overall U.S. infant mortality. Only .8% of births in 2005 occurred at less than 28 weeks of gestation, but they accounted for nearly one-half (46.4%) of all infant deaths in the U.S. in 2005.⁹ Unfortunately, the percentage of preterm births has been steadily increasing in the U.S. since the mid-1980's.

While vast improvements have been made in treating premature infants, *preventing* pre-term and low birth weight babies is still a challenge. Several risk factors have been associated with preterm birth: maternal age, history of preterm birth, multifetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity, and elevated blood pressure.¹⁰ For reasons not fully understood, there are significant racial disparities in preterm birth: preterm-related infant mortality rate for non-Hispanic black mothers were 3.4 times higher than for non-Hispanic white mothers, and that for Puerto Rican mothers was 87% higher than for non-Hispanic white mothers.¹¹ Early access to quality prenatal care can prevent pre-term birth and increase the likelihood that babies are born at normal birth weights.

⁹ Matthews, T.J., & MacDorman, M.F. (July 30, 2008). Infant mortality statistics from the 2005 period linked birth/infant death data set. *National Vital Statistics Reports*, 57 (2). Available online: http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_02.pdf

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.

¹¹ Matthews, T.J., & MacDorman, M.F. (July 30, 2008). Infant mortality statistics from the 2005 period linked birth/infant death data set. *National Vital Statistics Reports*, 57 (2).

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 513 of the 1,470 total child deaths (35%) reported to the SCR were related to premature birth; in 2008, 483 of the 1,495 total child deaths (32%) were related to premature birth.

- Over 99% of the deaths in this category were the result of natural causes.
- Slightly more boys (52-57%) had deaths related to premature birth.
- Although more Caucasian children died from premature birth (58%) than either African-American children (29-34%) or Hispanic children (3%), African-American children are over-represented in this group because they comprise only 19% of Illinois children.

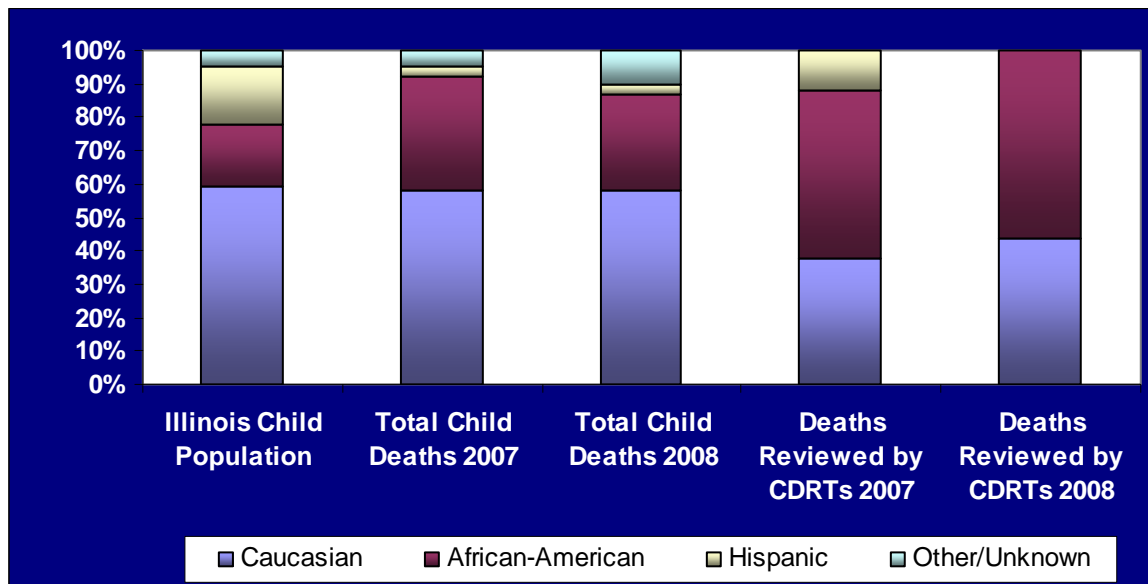
Illinois Data – Deaths Reviewed by CDRTs

In 2007, 8 of the 130 child deaths reviewed by CDRTs (6%) were related to premature birth; in 2008, 9 of the 285 child deaths reviewed by CDRTs (3%) were related to premature birth.

- African-American children accounted for approximately half of the reviewed deaths (50-56%) related to prematurity.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by race are presented in Figure 8.

Figure 8. Child Deaths Due to Premature Birth – by Race



Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Deaths (SUID)

Definition

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of an apparently healthy infant under one year of age that remained unexplained after a thorough investigation, which includes an autopsy, examination of the death scene and review of the clinical history. SIDS is characterized by the sudden death of an infant during the sleep period.

Sudden Unexplained Infant Deaths (SUID) are defined as deaths for which the cause of death is unknown. Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. Half of these SUIDs are due to SIDS, the leading cause of SUID.¹² Others are related to various causes such as suffocation, poisoning, and falls, and may not be easily distinguishable from one another. For a medical examiner or coroner to determine the cause of the death, an investigator needs to conduct a thorough investigation including examination of the death scene, a review of the infant's clinical history, and a complete autopsy needs to be performed. Even when a thorough investigation is conducted, it may be difficult to separate SIDS from other types of sudden, unexplained infant deaths.¹³

The Centers for Disease Control and Prevention (CDC) launched an initiative in 2004 to improve the investigation and reporting of SUID. As part of this effort, on March 1, 2007, the CDC released the Sudden, Unexplained Infant Death Investigation (SUIDI) Reporting Form for state and local use in infant death scene investigations. The CDC also developed a comprehensive training curriculum and materials for infant death scene investigations.

Background

Despite recent decreases in the incidence of SIDS, it is still the most common cause of death among normal birth-weight infants between one month and one year of age. According to a report from the National Center for Health Statistics, 2,234 infants in the U.S. died due to SIDS in 2005.¹⁴ Ninety percent of SIDS deaths occur within the first six months of life, peaking between two to four months.¹⁵ Largely because of the national Back to Sleep Campaign, SIDS rates have declined approximately 50% since the start of the campaign in 1994. 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.¹⁶

¹² National SIDS/Infant Death Resource Center. (2007, Summer). Sudden, Unexplained Infant Death Initiative (SUIDI). *Information Exchange*, 49, 2.

¹³ Center for Disease Control and Prevention. (2007). Sudden Infant Death Syndrome (SIDS): Risk Factors. Available online at <http://www.cdc.gov/SIDS/riskfactors.htm>

¹⁴ Matthews, T.J., & MacDorman, M.F. (July 30, 2008). Infant mortality statistics from the 2005 period linked birth/infant death data set. *National Vital Statistics Reports*, 57 (2).

¹⁵ American Medical Association. JAMA Patient Page: Sudden Infant Death syndrome. *JAMA Archives Journal*. Available online at <http://www.medem.com>.

¹⁶ 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.

The following have been consistently identified as risk factors for SIDS: prone (stomach) sleep position, sleeping on a soft surface, loose bedding, maternal smoking during pregnancy, infant exposure to smoke at home or daycare, overheating, late or no prenatal care, young maternal age, prematurity and/or low birth weight and male gender.¹⁷ Additionally, African-Americans and Native Americans have consistently higher rates of SIDS – two to three times the national average. The risk factors with the greatest potential for modification include prone sleep position, sleeping on a soft surface, maternal smoking and overheating.¹⁸ CDRTs have noted that the presence of bedsharing is also a factor in many SIDS cases.

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 41 of the 1,470 total child deaths reported to the SCR (3%) were related to SIDS; in 2008, 56 of the 1,495 total child deaths (4%) were related to SIDS. Less than 1% of the total child deaths in each year were related to SUID.

- More boys (63%) than girls (37%) had deaths related to SIDS
- SIDS deaths occurred about equally among Caucasian and African-American children. No SIDS deaths occurred among Hispanic children in 2007 and two occurred in 2008.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 3 of the 130 (2%) deaths reviewed by CDRTs were related to SIDS; in 2008, 54 of the 285 reviewed deaths (19%) were related to SIDS.

- 65-67% of the SIDS deaths reviewed by the CDRTs were boys.
- In 2007, 2 of the 3 reviewed deaths (67%) were African-American children. In 2008, almost all of the SIDS deaths were reviewed, so the racial breakdown for total deaths and reviewed deaths is very similar.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender and race are presented in Figures 9 and 10.

¹⁷ Center for Disease Control and Prevention. (2007). Sudden Infant Death Syndrome (SIDS): Risk Factors. Available online at <http://www.cdc.gov/SIDS/riskfactors.htm>

¹⁸ American Academy of Pediatrics. (2000). Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position. *Pediatrics*, 105, 650-656.

Figure 9. Child Deaths Due to SIDS – by Gender

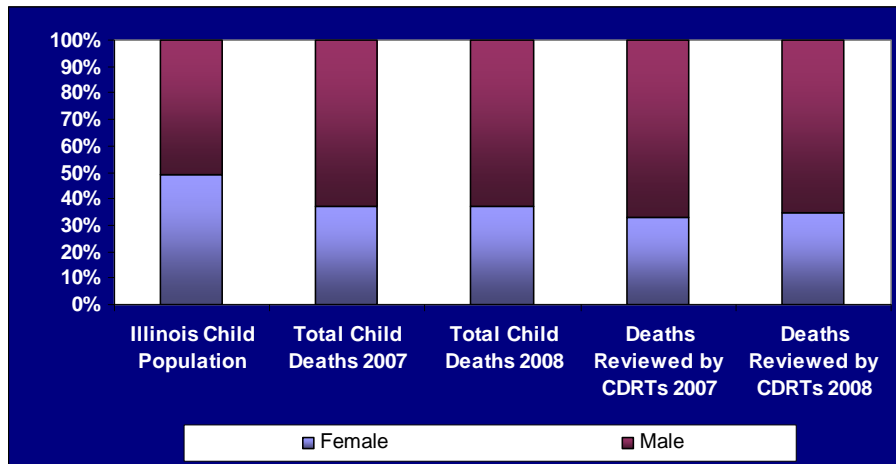
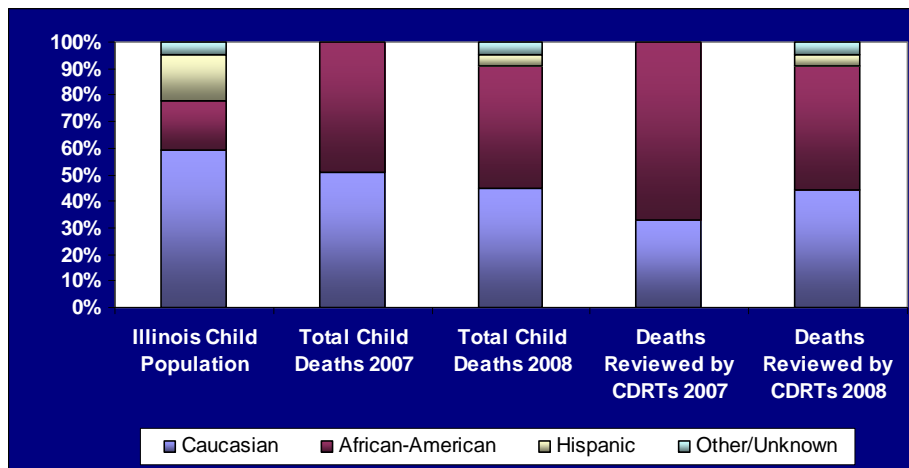


Figure 10. Child Deaths Due to SIDS – by Race



Vehicular Accident

Definition

Included in this category are all deaths occurring to children who are drivers, passengers, pedestrians, or occupants in 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, motor vehicle crashes remain the leading cause of unintentional injury-related deaths among children 1 to 14 years old. In 2007, 1,426 child occupants ages 13 and under died in motor

vehicle crashes in the United States. This is a 7% decline from 2005 and a 61% decline from 1975.¹⁹ Most of these deaths occur among children traveling as passenger vehicle occupants, and proper restraint use can reduce these fatalities. Placing children in rear seats instead of front seats reduces fatal injury risk by about a third among those 12 and younger.²⁰

Vehicular accidents are the leading cause of injury death among adolescents between 13 and 19 years old; 33% of all deaths among 13 to 19 year olds in 2005 were related to motor vehicles. In 2007, 5,156 teenagers ages 13 to 19 died in motor vehicle crashes in the U.S.; this is 41% fewer than in 1975 and 3% fewer than in 2005. About 2 out of every 3 teenagers killed in motor vehicle crashes in 2007 were male. Teenagers drive less than all but the oldest drivers, yet their numbers of crashes and related deaths are disproportionately high. Crash rates among teenage drivers are high because inexperienced drivers lack the perception, judgment, and decision-making skills acquired with practice. Crashes involving young drivers are typically single-vehicle, run-off-the-road crashes that involve driver error and/or speeding. These crashes often occur when other young people are in the vehicle with a young driver, so teenagers are disproportionately involved in crashes as passengers as well as drivers. Young drivers are less likely than adults to drive after drinking, but their crash risk is substantially higher when they do. An estimated 18% of fatally injured drivers ages 16 and 17 had a blood-alcohol concentration at or above .08 percent in 2007. This is down 57% since 1982.²¹

Finally, the majority of child pedestrian deaths and injuries are traffic-related. Children ages four and under are at the greatest risk from pedestrian death. Nearly two-thirds of child pedestrian deaths are males, and African-American children have a pedestrian death rate almost twice that of white children. One in four child pedestrian deaths occur between 6 – 9 p.m., and 83% occur in non-intersection locations.²²

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 99 of the 1,470 total child deaths reported to the SCR (7%) were related to vehicular accidents; in 2008, 79 of the 1,495 total child deaths (5%) were related to vehicular accidents.

- A large majority (85% in 2007 and 94% in 2008) of these deaths were accidental, a small portion were suicides (8% in 2007, 4% in 2008) and suicides (1-3%).
- More boys (66-70%) had deaths related to vehicular accidents.
- Children between 15 and 17 years represent the biggest group involved in deaths related to vehicular accidents (52% in 2007 and 39% in 2008), followed by children between 10 and 14 years (20%). The percentages of children in the other age groups varied in 2007 and 2008.

¹⁹ Insurance Institute for Highway Safety. *Fatality Facts 2007: Children*. Available online at: http://www.iihs.org/research/fatality_facts_2007/children.html

²⁰ *ibid*

²¹ Insurance Institute for Highway Safety. *Fatality Facts 2005: Teenagers*. Available online: http://www.iihs.org/research/fatality_facts_2007/teenagers.html

²² Safe Kids Worldwide. *Injury Fact Sheet: Pedestrian Safety*. Available online at: http://www.usa.safekids.org/content_documents/2007_Fact_Sheet_Pedestrian.doc

- Of children who died from vehicular accidents, 76% were Caucasian, 21% were African-American, 1% were Hispanic, and 2% were Asian.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 7 of the 130 deaths reviewed by CDRTs (7%) were related to vehicular accidents; in 2008, 8 of the 285 reviewed deaths (3%) were related to vehicular accidents.

- 62-71% of the reviewed deaths in this category were boys.
- Reviewed deaths related to vehicular accidents were fairly evenly distributed in 2007 and 2008.
- Over one half to three quarters of the vehicular deaths reviewed by CDRTs involved Caucasian children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender, age, and race are presented in Figures 11, 12, and 13.

Figure 11. Child Deaths Due to Vehicular Accidents – by Gender

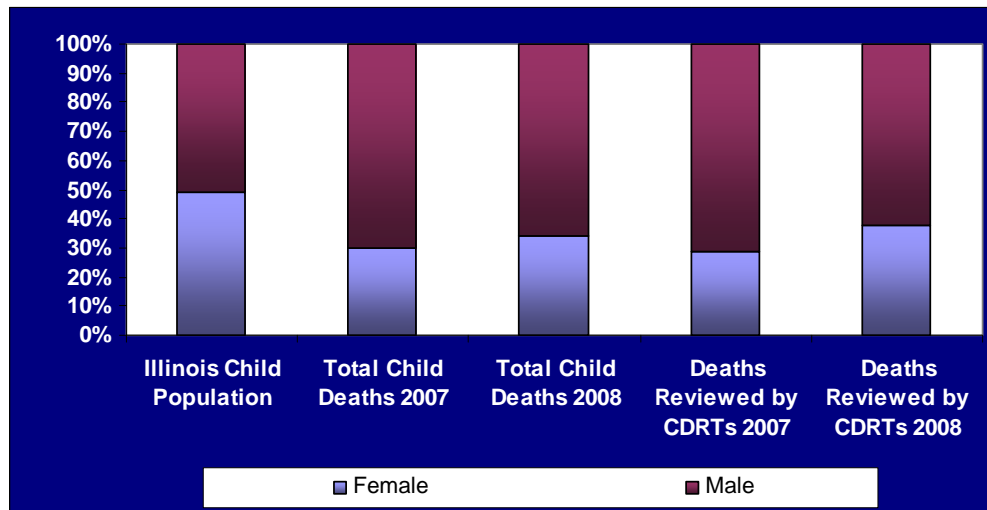


Figure 12. Child Deaths Due to Vehicular Accidents – by Age

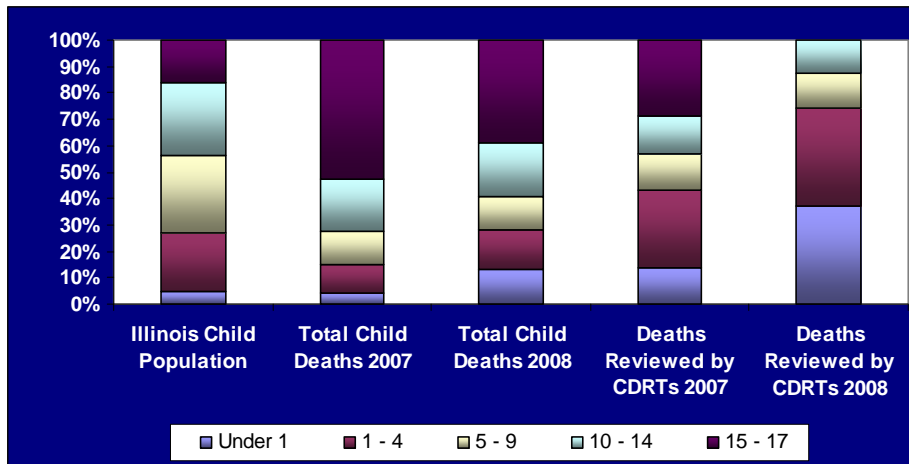
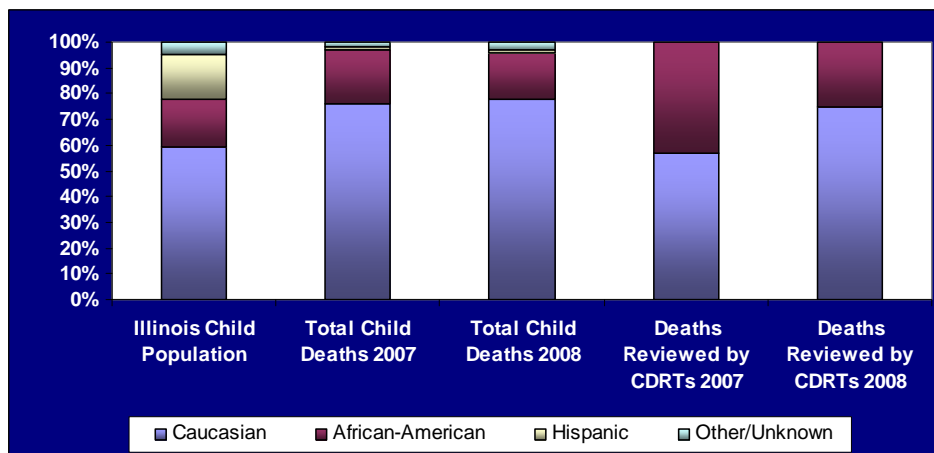


Figure 13. Child Deaths Due to Vehicular Accidents – by Race



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 – child’s external airway (i.e., nose and mouth) are 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 a suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eye witness account. If there is no such evidence, these types of suffocation deaths may be listed as SIDS deaths or undetermined. Thus, the actual number of deaths due to suffocation may be under-reported.

Background

In 2004, 963 children ages 14 and under in the U.S. died from accidental airway obstruction. Of these children, 88% were ages 4 and under. In fact, airway obstruction is the leading cause of accidental death among infants under one year. Young children are especially vulnerable to airway obstruction injury and death due to the small size of their upper airways, their relative inexperience with chewing, and their natural tendency to put small objects in their mouths. Additionally, infants’ inability to lift their heads or extricate themselves from tight places puts them at greater risk. Most infant deaths due to suffocation are directly related to an unsafe sleeping environment (e.g., soft bedding and pillows, infants sleeping on couches or adult beds).²³

Toddlers and preschoolers are at higher risk for choking and strangulation deaths. Because they are more active, they can more easily become tangled in cords and gain access to small objects. The majority of childhood choking injuries are associated with food.²⁴

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 70 of the 1,470 total child deaths reported to the SCR (5%) were related to suffocation; in 2008, 88 of the 1,495 total child deaths (6%) were related to suffocation.

- The manner of the suffocation deaths was varied: 68-69% were accidental, 19-20% were suicides, 5-7% were homicides, and 4-7% were undetermined.
- Deaths due to suffocation were slightly higher for boys (62-63%).
- Infants under one year are largely over-represented in this category, accounting for around 60% of the deaths. Youth over 10 are the next most frequent group (around 30% combined), followed by those between 1 and 4 years (8-9%), and 5 through 9 years (2-4%).
- Of children who died from suffocation, 60% were Caucasian and 36% were African-American.

²³ Safe Kids Worldwide. *Suffocation and choking safety*. Available online: http://www.usa.safekids.org/content_documents/2007_Fact_Sheet_Choking_Suffocation.doc

²⁴ Ibid.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 16 of the 130 deaths reviewed by CDRTs (12%) were related to suffocation; in 2008, this percentage was 23%.

- The slight majority (62-63%) of the reviewed suffocation deaths were male.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (75-82%).
- The reviewed suffocation deaths were about equally split between Caucasian and African-American children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 14 and 15.

Figure 14. Child Deaths Due to Suffocation – by Age

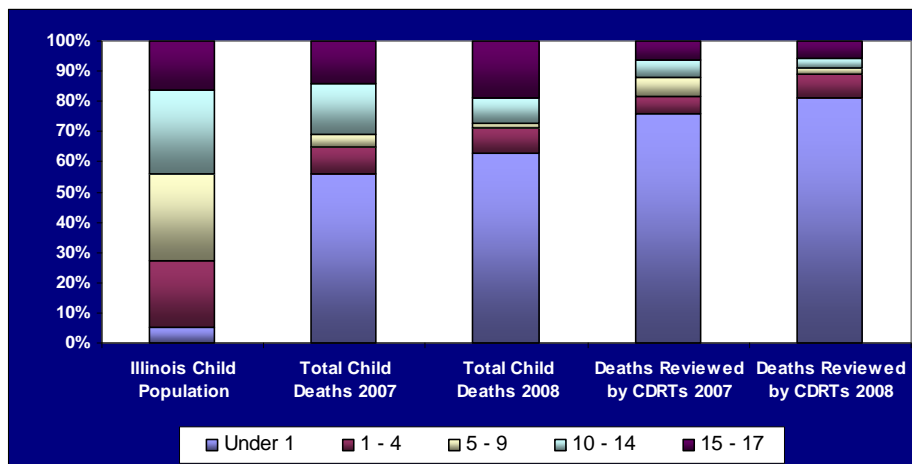
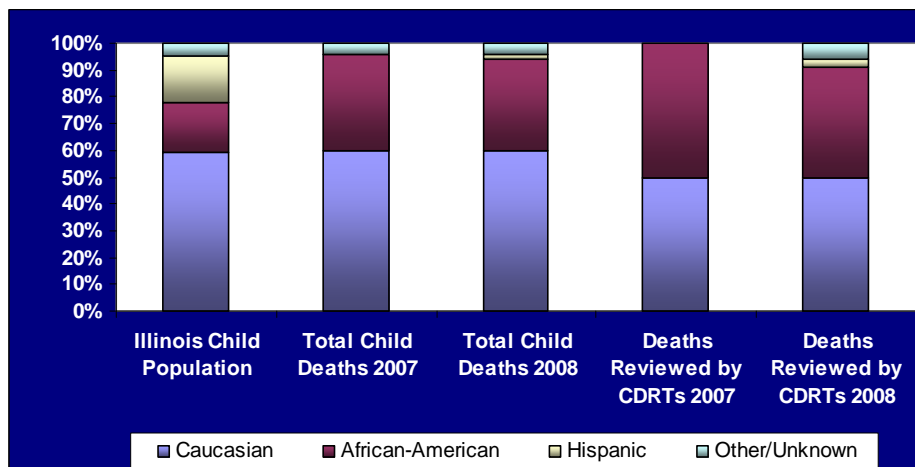


Figure 15. Child Deaths Due to Suffocation – by Race



Firearm

Definition

This category of death 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 Center for Disease Prevention and Control, 1,490 firearm deaths occurred in 2005 (the latest year for which data is available) among children under 18 years of age in the United States.²⁵

Homicide and suicide are the second and third leading causes of death among youth between 15 and 19, after accidental death. In 2004, firearms were the instrument of death in over 80% of teen homicides and about half of teen suicides in the U.S. National firearm-related deaths nearly doubles from 1980 (14.7 per 100,000) to their peak in 1994 (28.2 per 100,000); the rate has dramatically declined since then to 12 per 100,000 in 2004. Firearm deaths in 2004 (including homicides, suicides, and accidental deaths) were highest among African-Americans (55.1 and 5.9 per 100,000 for males and females, respectively) and lowest among non-Hispanic whites (10.8 and 2.3 per 100,000 for males and females, respectively), with Hispanics in between (28.0 and 2.7 per 100,000 for males and females, respectively).²⁶

Unintentional deaths from firearms disproportionately affect children under 14 years of age. Nearly all childhood unintentional shooting deaths occur in or around the home; the presence of a firearm in the home is associated with an increased risk of unintentional firearm fatalities among children. More than 70% of unintentional firearm shootings involve handguns. In the U.S., boys are far more likely to die from unintentional shootings than girls: over 80% of unintentional firearm deaths are boys. Unintentional shootings among children tend to most often occur when children are unsupervised and out of school: late in the afternoon, during the weekend and summer months. Eighteen states, including Illinois, have enacted child access protection and safe storage laws that may hold adults criminally negligent for failing either to store loaded firearms in a place inaccessible to children or to use safety devices to lock guns. Safe storage laws have been shown to reduce unintentional firearm-related deaths among children by an average of 23%.²⁷

²⁵ National Center for Injury Prevention and Control. *WISQARS Injury Mortality Report 1999-2005*. Available online: <http://www.cdc.gov/ncipc/wisqars/>

²⁶ Child Trends. *Teen Homicide, Suicide and Firearm Death*. Available online: http://www.childtrendsdatabank.org/pdf/70_PDF.pdf

²⁷ Safe Kids Worldwide *Gun safety*. Available online: http://www.usa.safekids.org/content_documents/2007_Fact_Sheet_Gun.doc

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 66 of the 1,470 total child deaths reported to the SCR (4%) were related to firearms. In 2008, 81 of the 1,495 total deaths (5%) were related to firearms.

- Homicides accounted for 88-89% of the firearms deaths, suicides accounted for 6-9%, and accidents accounted for 2-3%.
- Deaths due to firearms overwhelmingly occurred among boys (85-88%).
- Children between 15 and 17 years of age are largely over-represented in this category (71% in 2007 and 83% in 2008), with children between ages 10 to 14 years accounting for most of the remaining deaths.
- African-American children were over-represented among firearm deaths in 2007 (55%) and 2008 (65%) compared to white (44% and 28%) or Hispanic (2-6%) children.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 7 of the 130 deaths reviewed by the CDRTs (5%) were related to firearms; in 2008, only 2 of the 285 reviewed deaths (less than 1%) were related to firearms.

- In 2007, the firearm deaths reviewed by CDRTs were fairly evenly distributed among children of different age groups: 10-14 years (34%), 15-17 years (34%), 1-4 (17%) and 5-9 (17%). In 2008, there was one reviewed death of a 3 year old and one 15 year old.
- A little under half of the firearm deaths reviewed in 2007 were African-American. In 2008, both of the reviewed deaths were African-American.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 16 and 17.

Figure 16. Child Deaths Due to Firearms – by Age

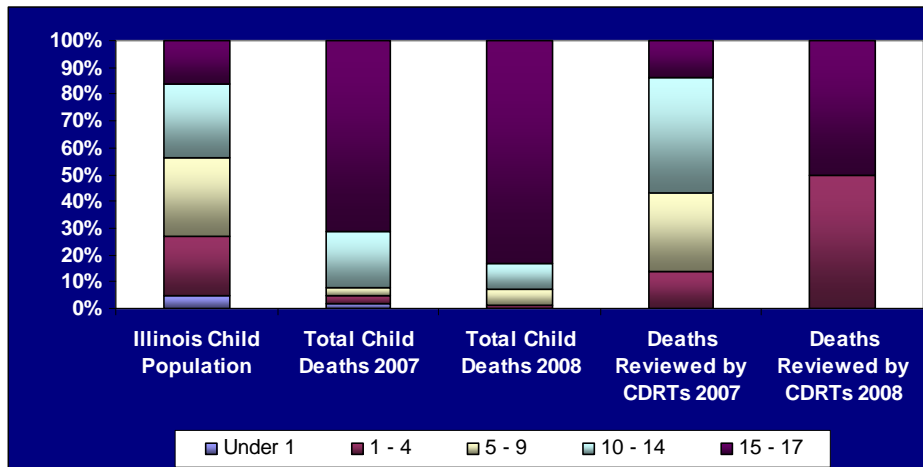
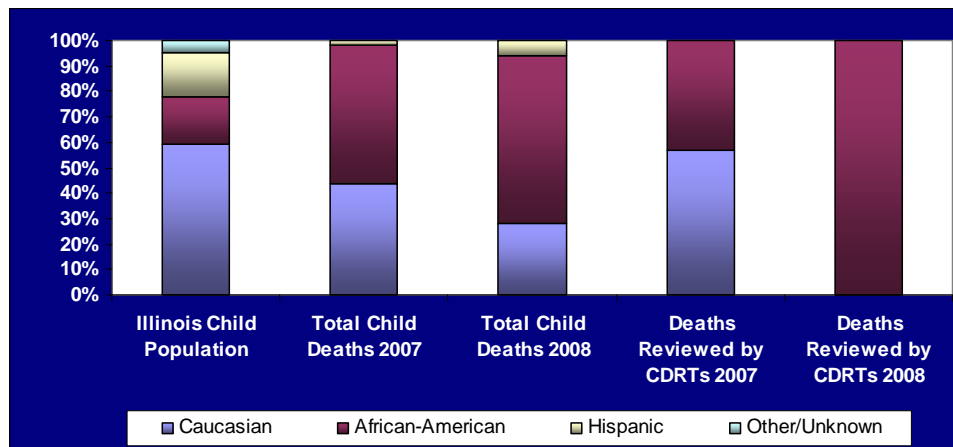


Figure 17. Child Deaths Due to Firearms – by Race



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) or others (homicide), or may be unintentional (accidents). Child deaths due to injuries from fatal child maltreatment are included in this category.

Background

Data collected through child protective services agencies through the National Child Abuse and Neglect Data System (NCANDS) suggest that an estimated 1,530 children died in 2007 from child maltreatment, defined as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect were contributing factors. The rate of child maltreatment fatalities reported to NCANDS increased in 2007 to 2.04 deaths per 100,000 children, up from 1.96 deaths per 100,000 children in 2005.²⁸ Young children are the most frequent victims of child maltreatment fatalities: children under one year accounted for 44% of the fatalities in 2007 and children less than 4 years accounted for 78% of fatalities. Three-quarters (75.9%) of the child fatalities in 2007 reported to NCANDS were caused by one or more parents. Non-parental perpetrators (e.g., other relatives, foster parents, legal guardians, etc.) accounted for 14.7% of child fatalities in 2007. Almost half (41%) of child maltreatment fatalities were associated with neglect alone. Physical abuse alone was the cause of 22.4% of reported fatalities, and 31.4% were the result of multiple maltreatment types.²⁹ Children whose families had received family preservation services in the past 5 years accounted for 13.7% of child fatalities in the U.S. in 2007.³⁰

²⁸ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2008). *Child Maltreatment 2007*. Washington, DC: Government Printing Office.

²⁹ Ibid.

³⁰ Ibid.

In the U.S., a large proportion of fatal inflicted injury deaths among children result from abusive head trauma, commonly known as Shaken Baby Syndrome (SBS), which involves the violent shaking of an infant or young child. Immediate consequences of abusive head trauma can range from vomiting and lethargy to seizures and coma; 25% of victims die from their injuries. The second most common type of physical abuse deaths involve punching or kicking the abdomen, resulting in massive internal injuries and bleeding.

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 49 of the 1,470 total child deaths reported to the SCR (3%) were related to injuries; and in 2008, 49 of the 1,495 total deaths (3%) were related to injuries.

- 14-25% of these injury deaths were classified as accidents, 74-82% were homicides, and 2% were suicides.
- Males were more likely to die from injuries (61-69%).
- Children four and under were the most vulnerable to death from injuries (62-64%), although children of all ages were represented in this category: 10-14% among those between 5 and 9 years, 2-16% among those 10 to 14 years, and 6-16% among youth between 15 and 17 years.
- Slightly less than half of the reviewed cases were Caucasian (47-49%), and about an equal percentage were African-American (41-47%).

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 33 of the 130 (25%) deaths reviewed by CDRTs were related to injuries; in 2008, 32 of the 285 reviewed deaths (11%) were related to injuries.

- 78-84% of the reviewed cases involved young children 4 years and under.
- Around half or slightly more (50-61%) of the reviewed cases were African-American and 36-38% were Caucasian.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 18 and 19.

Figure 18. Child Deaths Due to Injuries – by Age

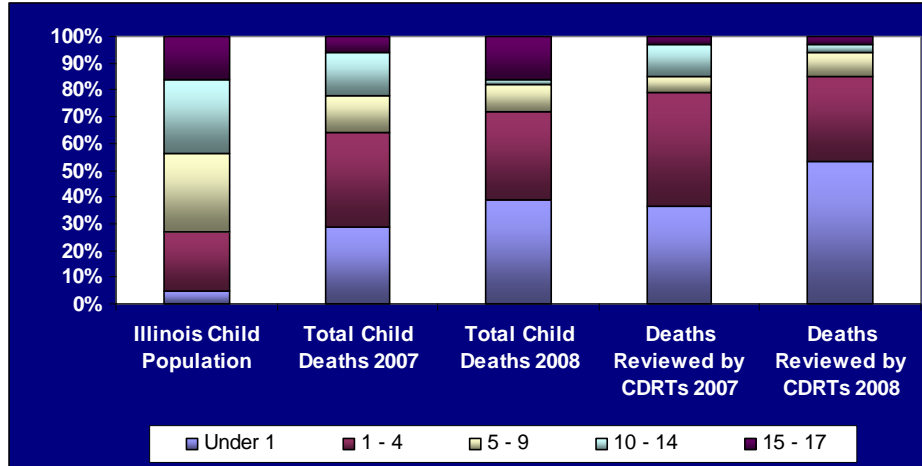
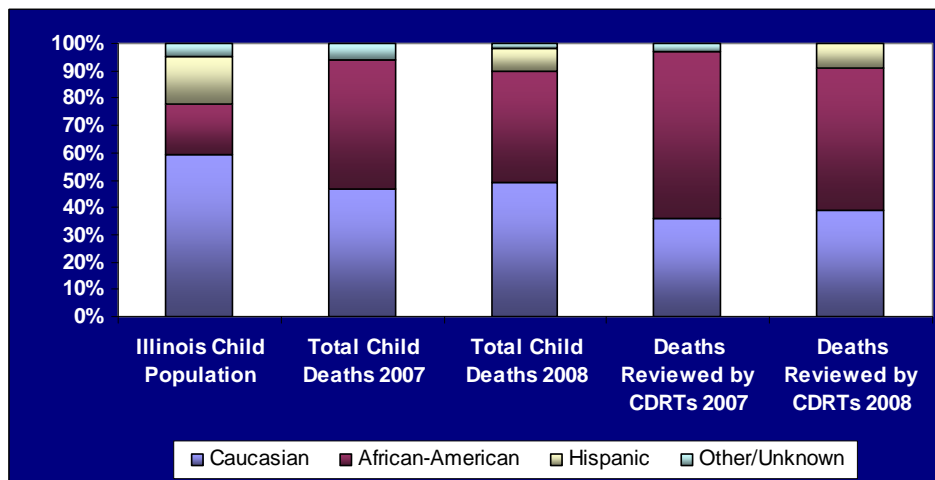


Figure 19. Child Deaths Due to Injuries – by Race



Fire

Definition

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

Background

According to national statistics, fire and burns are the third largest cause of unintentional injury deaths among children between 1 and 17 years in 2005.³¹

³¹ National Center for Injury Prevention and Control. *WISQARS Injury Mortality Report 1999-2005*. Available online: <http://www.cdc.gov/ncipc/wisqars/>

Younger children (birth – 4 years) are at a significantly higher risk than older children, with a fire/burn death rate more than two times that of children 5 to 14 years. Young children have a limited ability to react promptly and properly in a fire; they may hide or run from adults attempting to rescue them. Children from low-income families are at greater risk for fire-related deaths due to factors such as lack of working smoke alarms, substandard housing, use of alternative heating sources, and economic constraints on the provision of adult supervision.³²

The single most important factor in reducing child fire fatalities is the presence of a working smoke detector. Three-fifths of fire fatalities occur in the small number of homes (7%) that lack any detectors at all.³³

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 30 of the 1,470 total child deaths reported to the SCR (2%) were related to fires and in 2008, 19 of the 1,495 total deaths (1%) were related to fires.

- The majority of deaths (67-89%) attributable to fire were accidental; 27% were homicides (in 2007), and two deaths (7-11%) were undetermined.
- More boys (63-77%) had deaths related to fires.
- Young children were most at risk of fire-related deaths: 46-52% of the deaths in this category were among children four and under, 26-30% were among children 5 to 9 years, 16-17% were among children 10 to 14, and 5-7% were among youth between 15 and 17.
- Of the 30 children who died in fires in 2007, 12 were Caucasian (40%), 16 were African-American (53%), and two were Asian (6%). Of the 19 children that died in fires in 2008, 11 were Caucasian (58%) and 8 were African-American (42%).

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 14 of the 130 deaths reviewed by CDRTs (11%) were related to fires; in 2008, 3 of the 285 reviewed deaths (1%) were related to fires.

- In 2007, the reviewed deaths were scattered among children 14 and under, and in 2008, the 3 reviewed deaths were children between 1 and 9 years.
- In 2007, the reviewed deaths were about evenly split between Caucasian (43%) and African-American (57%) children. In 2008, all 3 of the reviewed deaths were Caucasian children.

³² Missouri Department of Social Services. (2004). *Preventing Child Deaths in Missouri: The Missouri Child Fatality Review Program Annual Report for 2003*. Jefferson City, MO: Author.

³³ Ahrens, M. (2002). U.S. experience with smoke alarms and other fire alarms. Quincy, MA: National Fire Protection Association.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 20 and 21.

Figure 20. Child Deaths Due to Fire – by Age

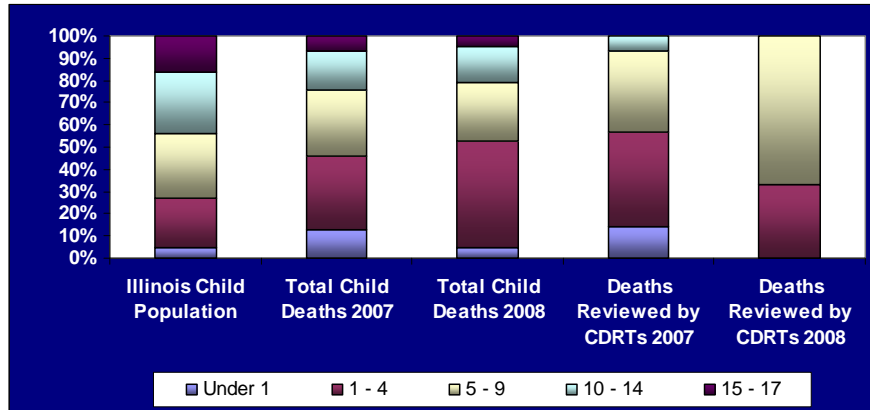
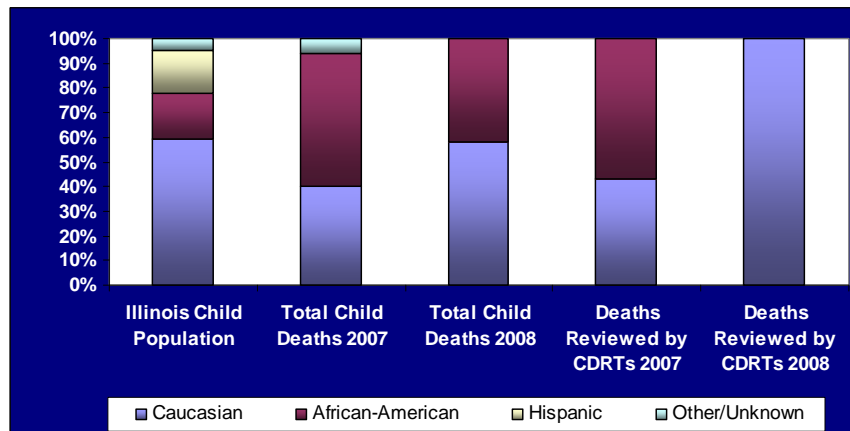


Figure 21. Child Deaths Due to Fire – by Race



Drowning

Definition

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

Background

Drowning is the leading cause of accidental death among children ages 1 to 4 and the second leading cause of accidental death among children ages 1 to 14. In 2005, 1,036 children ages 17 and under

died as a result of accidental drowning. Children ages 4 and under accounted for more than 50% of these deaths.³⁴

A child's age is closely related to the locations in which drowning deaths occur: Children under age one most often drown in bathtubs, children ages one to four years most often drown in residential swimming pools, hot tubs and spas, and older children more often drown in open bodies of water.³⁵ Toddlers are particularly vulnerable to accidental "bucket" drowning due to immature muscles in the upper body.

Teenagers are also at risk for drowning, especially in lakes and reservoirs, where there may be no supervision and where their swimming abilities may be challenged by environmental factors. Oftentimes, teen drownings involve alcohol or other substance abuse. Alcohol use has been determined as a major contributing factor in up to 50% of drownings among adolescent boys.³⁶

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 23 of the 1,470 total child deaths reported to the SCR (2%) were related to drowning. In 2008, 27 of the 1,495 total child deaths (2%) were related to drowning.

- Most of the drowning deaths were accidental (89-91%), 4% were homicides, and 4-7% were undetermined.
- More boys (65-74%) die from drowning than girls.
- Children between one and four were at highest risk for drowning-related deaths, followed by children between 15 and 17, children between 10 and 14, children between 5 and 9, and those under one.
- Of children who died from drowning in 2007, 78% were Caucasian and 22% were African-American. In 2008, 41% of the drowning deaths were Caucasian, 52% were African-American, and 7% were of other racial backgrounds.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 6 of the 130 deaths reviewed by CDRTs (5%) were related to drowning; in 2008, 12 of the 285 reviewed deaths (4%) were related to drowning.

- Most of the reviewed deaths related to drowning occurred among young children: in 2007, 83% were under one year, and in 2008, 67% were under five years.

³⁴ National Center for Injury Prevention and Control. *WISQARS Injury Mortality Report 1999-2005*. Available online: <http://www.cdc.gov/ncipc/wisqars/>

³⁵ Safe Kids Worldwide. *Drowning and water-related safety*. Available online: http://www.usa.safekids.org/content_documents/2007_Fact_Sheet_Drowning.doc

³⁶ National Safety Council. (1993). *Accident Facts, 1993 Ed*. Itasca, Illinois: Author.

- Most of the reviewed deaths in this category involved Caucasian children: 100% in 2007 and 67% in 2008.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 22 and 23.

Figure 22. Child Deaths Due to Drowning – by Age

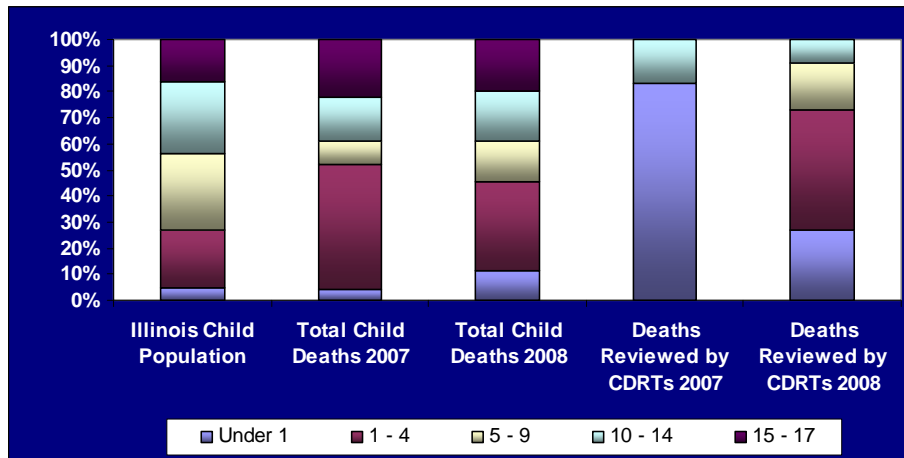
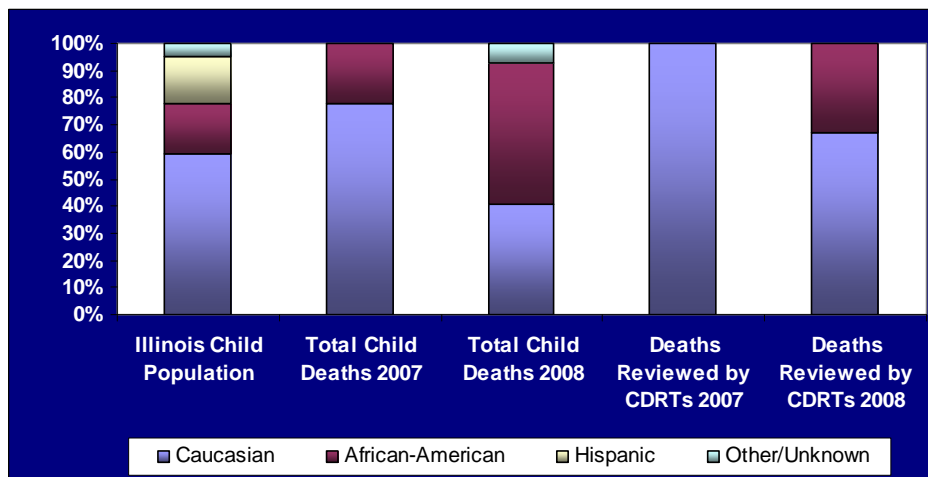


Figure 23. 2007 Child Deaths Due to Drowning – by Race



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

445/ 929 children under 18 years died of poisoning in the United States in 2005/ 2006.³⁷ More than 90% of poisoning cases occur in the home. Children, especially those under age 6, are more likely to have unintentional poisonings than older children and adults. The most common poison exposures for children are cleaning products, pain relievers, cosmetics, personal care products, plants and medicines. About half of all poisonings among teens are classified as overdoses due to suicide attempts.³⁸

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 12 of the 1,470 total child deaths reported to the SCR (1%) were related to poisonings or overdoses; in 2008, only 2 of the 1,495 total deaths were related to poisoning or overdose.

- In 2007, nine of the 12 deaths (75%) were determined to be accidents, one death was a homicide (8%), and two deaths were undetermined (17%). In 2008, 6 of the 10 deaths were accidents, one was a suicide, and three were undetermined.
- Boys (58-80%) were more likely to die due to poisoning or overdose than girls.
- The majority of the deaths in this category (50-70%) were among youth between the ages of 15 and 17 years.
- In 2007, children who died from overdose/poisoning were equally Caucasian (50%) and African-American (50%). In 2008, 70% were Caucasian.

Illinois Data – Deaths Reviewed by CDRTs

In both 2007 and 2008, there were 2 deaths reviewed by CDRTs related to overdose or poisoning (2%). Comparisons between the total child population and total child deaths by age and race are presented in Figures 24 and 25.

³⁷ National Center for Injury Prevention and Control. *WISQARS Injury Mortality Report 1999-2005*. Available online: <http://www.cdc.gov/ncipc/wisqars/>

³⁸ Centers for Disease Control and Prevention. (2005). *Poisonings: Fact sheet*. Available online: <http://www.cdc.gov/ncipc/factsheets/poisoning.htm>

Figure 24. Child Deaths Due to Poisoning/Overdose – by Age

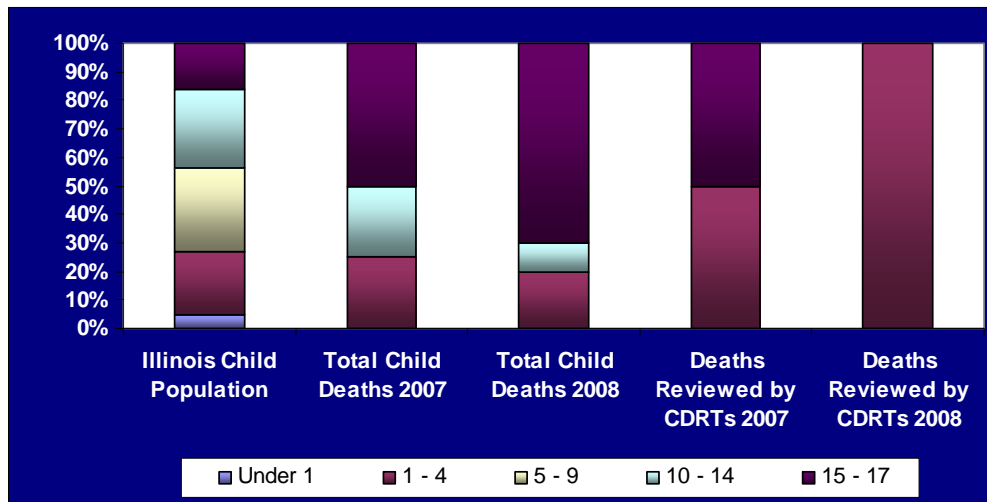
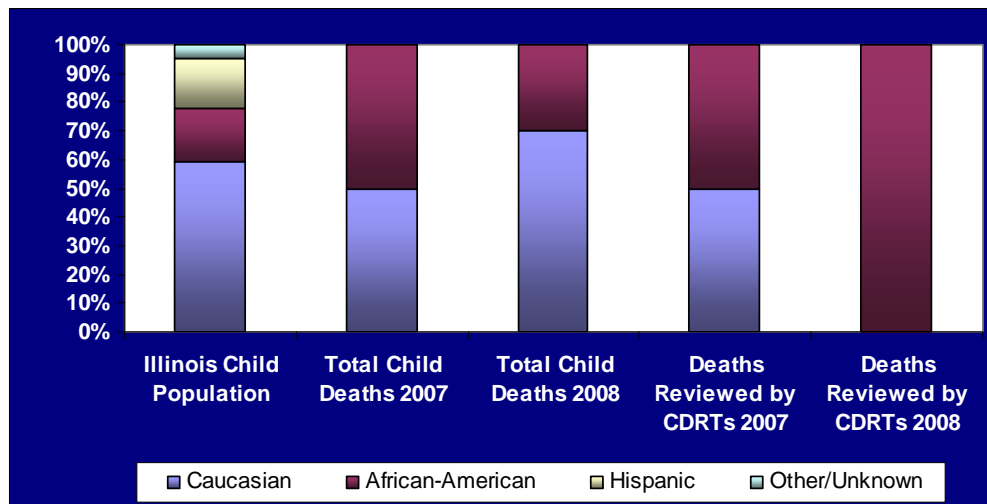


Figure 25. Child Deaths Due to Poisoning/Overdose – by Race



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 of death on the death certificate.

Illinois Data – Total Child Deaths Reported to the SCR

In 2007, 46 of the 1,470 total child deaths reported to the SCR (3%) had an undetermined cause of death. In 2008, 44 of the 1,495 total deaths (3%) had an undetermined cause of death.

- Deaths due to undetermined causes were roughly equivalent for boys and girls.
- Children under the age of one represent 78-89% of deaths in this category; an additional 9% were between one and four years.
- African-American children were slightly more likely to have an undetermined death (59-61%) than Caucasian children.

Illinois Data – Deaths Reviewed by CDRTs

In 2007, 6 of the 130 deaths reviewed by CDRTs (5%) had an undetermined cause of death, in 2008, 41 of the 285 reviewed deaths (14%) were related to undetermined causes.

- Almost all of the reviewed deaths due to undetermined causes occurred among young children – 83-88% were under one year.
- 59-67% of the reviewed deaths of undetermined causes were African-American children.

Chapter 4: Impact of Child Death Review

In Illinois, each CDRT submits recommendations for changes in procedures, programs, and policies based on their reviews of child deaths. These recommendations are submitted to the Director and Inspector General of DCFS, and the Director must respond to each recommendation (except for case-specific recommendations) within 90 days. Thus, the importance of CDRT recommendations – and their potential for preventing future child deaths – cannot be overstated.

Recommendations to DCFS may focus on establishing new policies and protocols, improving existing policies and protocols, raising public awareness, or increasing effectiveness of services provided to children and families. 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. Recommendations fall into four categories:

- 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, infant safe sleeping);
- DCFS system – focus on the programs, policies, and procedures of DCFS (e.g., safety and risk assessment, foster parent training); and
- Other agency/system – focus on agencies or systems outside the parameter of DCFS (e.g. Coroner Association, hospitals).

Recommendations often bridge more than one area, focusing on a specific case that has implications for preventing future fatalities through changes in DCFS policy, other system policy (e.g., law enforcement, coroners, state’s attorneys office, etc.), and public awareness.

CDRT Recommendations in 2007

In 2007, there were 23 recommendations made by the CDRTs (many of these had several components). The majority of the recommendations (16) focused on DCFS policy and procedures, followed by recommendations for other systems (6), and primary prevention strategies (1). There were no case specific recommendations in 2007.

DCFS System Recommendations

A DCFS system recommendation is specific to a DCFS policy, procedure, or program. Table 6 lists the 16 DCFS system recommendations submitted to the Department in 2007 by CDRTs, as well as the corresponding response from the Department.

Table 6. 2007 DCFS-System Recommendations and DCFS Responses

CDRT RECOMMENDATION	DCFS RESPONSE
<p>The Department of Children and Family Services should include welfare referral education and how to approach parents in a non-threatening way about making DCFS referrals in their mandated reporter training and on-line training. DCFS should immediately send out a notice to all current mandated reporters reminding them about the option of making a child welfare referral to the DCFS hotline.</p> <p>New recommendation made after response came back: Team recommends that DCFS take measures to revise the mandated reporter acknowledgement form emphasizing the importance of reporting the least suspicious threats of child welfare.</p>	<p>ANCRA limits the legal responsibility of mandated reporters. Mandated reporters do not determine the outcome of referrals to the child abuse hotline. The determination is made by the trained social workers at the DCFS hotline receiving the calls. Child welfare referral education is currently in the mandated reporter manual which is located on the DCFS website.</p> <p>Response to new recommendation: DCFS will explore revising the mandated reporter acknowledgement form and adding a definition of reasonable causes.</p>
<p>This is the 2nd case in a few months time this team has reviewed where DCFS indicated for 51 (death by neglect) when the death was ruled homicide. The team is going to make the same recommendation on this case as they did on the first case.</p> <p>If a child's death is ruled a homicide then the death should be indicated by DCFS as 01, death by abuse and not 51, death by neglect.</p>	<p>The Department will address the issue of correct case coding with staff and supervisors via on-going training and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.</p>
<p>The Department should educate workers on attorney general and State's Attorney victim witness assistance program in order to access maximum support of witness of violence especially children.</p>	<p>The victim witness assistance program comes into effect only if there is a prosecution. If there is prosecution the Attorney General and State's Attorney Office will educate the victim of their respective services.</p>
<p>The change in the statute regarding screening for orders needs to be out to intact and POS agencies through a policy transmittal.</p>	<p>We agree. A policy transmittal will be sent out to intact and POS agencies regarding PA 95-0405.</p>
<p>The current brochure for violence prevention should include information on web access to information on registered sex offenders.</p>	<p>At the next printing of DCFS paramour procedures DCFS will include information on web access to registered sex offenders.</p>
<p>All children less than 6 months of age reported with bruising should always be taken as an allegation of abuse by the hotline.</p>	<p>DCFS agrees. All children less than 6 months of age reported to the hotline with bruising will be taken as an allegation of abuse by the hotline.</p>
<p>DCFS change current web based training for mandated reporting to specify that all accidental children deaths should be called into the hotline.</p>	<p>It is not financially feasible to make any changes to the web based training at this time.</p>
<p>1. DCFS should develop a rule and procedure for dealing with the inability to find subjects of a report which would require a written plan that is placed in the investigative file and that is</p>	<p>1. This is already in DCFS Rules 300.60 (e) (3)</p> <p>3) Unable to Locate Subjects</p>

approved by the supervisor.

2. If there is a history of police involvement particularly domestic violence, as part of the opening of the case the follow-up worker has to establish a connection with the police department and check in with the police department quarterly during the span of the open case.

3. The team request the an audit be completed to determine the degree of compliance with the required phone call being made to a mandated reporter at the conclusion of the investigation.

In-person contact is not required when the investigative worker has taken all of the following steps to locate a subject, and is still unable to locate the subject:

- Request the local, county, and state law enforcement agencies to check their records for information which would locate the subject;

AND

- Conduct a records check of Department of Public Aid and Secretary of State, Division of Motor Vehicles (if a license number is known), records;

AND

- Ask the Reporter (if identity known) to provide as much additional information as possible to help locate the subjects;

AND

- Ask relatives and friends of the subject (if known) to provide information to help locate the subject;

AND

- Contact the local post office, DPA office, utility companies and school to request a check of their records.

The investigative worker shall document all efforts to locate the subject(s) and the reasons why those efforts were unsuccessful. All efforts shall be documented on the SACWIS Case Note.

2. DCFS agrees, Procedures 302.260, Domestic violence will be revised to include if there is a history of police involvement, particularly domestic violence, as part of the opening of the case the follow-up worker will establish a connection with the police department, along with quarterly contact with the policy department for the duration of the open case.

3. Due to budget restraints and lack of manpower it is not possible for the Dept. to do an audit. Procedures 300.100 (e) has been revised to include the following information.

e) Notify Mandated Reporters

The Investigation Specialists shall verbally notify the mandated reporter and guardian ad litem, if applicable, of the recommended determination after the finding has been approved by the Investigation Supervisor or Manager. If either person disagrees with the recommended determination, the Investigation Specialist shall

	<p>immediately notify his or her supervisor of the concerns raised by the reporter or guardian. The Investigation Supervisor shall contact the reporter or guardian to resolve their issues and/or to determine if there are additional investigation activities that need to be completed. When a resolution cannot be reached, the supervisor shall inform the reporter or guardian of their right to appeal the investigation finding. The supervisor and Investigation Specialist shall use SACWIS Contact Notes to document the notification of the recommended determination and all attempts to resolve any issues identified by the reporter or guardian.</p> <p>Revisions to Procedures 300 will be included in the CERAP training provided to Department and POS staff.</p>
<ol style="list-style-type: none"> 1. After the 2nd attempt to see the home for the 60 day evaluation is unsuccessful the daycare license should be suspended until the home is seen by DCFS. 2. DCFS licensing staff should be trained to identify if there is a risk of harm/danger present in the daycare. 3. The team request that rules and procedures be changed when there are environmental violations. The licensing worker should also complete a write up that would determine if there is risk to the child due to the environmental neglect. If there is risk of harm to the child a report should be made of suspected abuse or neglect. 	<ol style="list-style-type: none"> 1. We agree. This is currently already in policy. A policy transmittal will be sent out. 2. DCFS licensing staff are trained to identify if there are risk of harm present at daycare. They are child welfare specialists who have received 383 and 406 training. 3. The licensing monitoring record can document environmental issues in daycare. The Dept. at this time cannot afford too provide staff with cameras. All licensing staff are mandated reporters and are mandated to report suspicions of child abuse or neglect.
<p>If a mandated reporter calls in a hotline report regarding the death of a child caused by drugs, either before or after delivery, at minimum a CWS assessment should be initiated in regards to the safety of any surviving child(ren) remaining in the home. The team requests that DCFS make this standard procedure on how all cases such as this are handled.</p>	<p>DCFS took protective custody of these children. There was nothing else the Department could have done. There was a response to the hotline report.</p>
<ol style="list-style-type: none"> 1. If Southern Il Task force would have been in existence at the time of this death, a multi-disciplinary approach would have been done and meetings would have been held with the State's Attorney's Office. The team recommends DCFS's support in getting the task force started. 2. The DCFS investigator, law enforcement investigator and State's Attorneys Office need to have a sit down and face-to-face conference on this case 	<ol style="list-style-type: none"> 1. DCFS agrees. The child death review contract for the Southern Il task force given to SIDS of Illinois. 2. DCFS agrees No response required 3. The Department will address the issue of correct case coding with staff and supervisors via on going training and management meetings. This process will allow for our staff to consistently recognize incorrect case coding

<p>3. The team discussed the need for the indicated allegation of torture to help the State's Attorney Office.</p> <p>4. When consent decree is not followed it puts children at risk. DCFS needs to follow consent decree at all times.</p> <p>5. Team recommends that Director McEwen reinforce the willful failure to report policy to all investigators and investigator supervisors</p>	<p>during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ACRA the Department can only amend in the event we have an appeal.</p> <p>4. We agree. Furthermore, the importance of staff following the Consent Decree will be reinforced consistently at our weekly Administrator meeting(s).</p> <p>5. DCFS composed the following e-mail to send out to staff: This is a reminder to all Staff regarding the responsibility of Department staff as mandated reporters per Procedure 300.20 and section 4 of ANCRA, 325 ILCS 5 that all Department staff having reasonable cause to believe a child known to them in their professional or official capacity may be an abused child or a neglected child shall immediately report or cause a report to be made to the Department. Willful failure of a Department employee to report suspected incidents of child abuse or neglect known to them can face consequences of disciplinary action, up to and including discharge.</p>
<p>DCFS distribute the current Paramour brochure or create a new paramour brochure to distribute.</p>	<p>DCFS agrees. DCFS will continue to print and distribute current paramour brochures.</p>
<p>The team recommends that DCFS collect all information on deaths of wards and include this information in the DCFS file before closing the case. This should include autopsy report, Coroners report, police report and fire if applicable.</p>	<p>DCFS agrees to collect all information on deaths of wards and include this information in the DCFS file before closing the case. This will include autopsy report, Coroner's report, police report and fire if applicable.</p>
<p>DCFS train all investigators, intact, and case workers on the "Safe Sleep" for infants every three years.</p>	<p>DCFS currently train Investigators, Intact and Case Workers on the Safe Sleep for infants. It is covered in our Foundations and CPI portions of Training. We also distribute brochures, pamphlets, etc on an ongoing basis to our staff to refresh and remind our staff of the seriousness of safe sleep.</p>
<p>DCFS revise procedure 300, Allegations 10.60 to make more clearly of what definition of risk to children when there is a history of drug use of mental illness and care giver is not taking prescribed medication.</p>	<p>DCFS believes that procedure 300 is clear on the definition of risk to children when there is a history of drug use or mental illness and caregiver is not taking prescribed medication. The definition of the allegation includes the following statement under subheading of circumstances: Anyone in the home exposes child to an environment which significantly affects the health and safety based on the use, sale or manufacturing of illegal drugs</p>

	(NEGLECT). Parents/caretakers or anyone in the home whose mental illness and behavior pose a significant danger to the child's health and safety. (NEGLECT) To indicate an allegation based on this factor, the Investigation Specialist must rule out Dependency as defined in Juvenile Court Act as the presenting problem. (Abuse or Neglect)
The team request that DCFS change Procedure 302, Appendix A which deals with substance abuse services, to require all drug/alcohol drops be random and unannounced. The refusal or non-compliance with the drop should result in an indicated report	The recommendation to adopt a blanket policy to indicate for failure to comply or comply consistently with drug drops, in and of itself, violates one's rights and would probably not stand legal scrutiny.

Other Systems Recommendations

Other system recommendations concern the policies and procedures of agencies and organizations that are involved in child safety, health, and welfare. This includes medical examiners, coroners, medical professionals, state's attorneys, and other state agencies such as the Illinois Department of Public Health. In 2007, CDRTs submitted 6 recommendations concerning other systems (Table 7).

Table 7. 2007 Other Systems Recommendations and DCFS Responses

CDRT RECOMMENDATION	DCFS RESPONSE
Team will send a letter to hospital reminding them about mandated reporting. The team will include education about child welfare referrals through the DCFS hotline, the WIC program, and family case management through IDPH	No DCFS response necessary.
<ol style="list-style-type: none"> 1. DCFS send out "Care Enough to Call" brochures to Department of Human Services Child Care Nurse Consultants and request that they distribute them to daycares to give to parents and request that Child Care Nurse Consultants use them in their presentations. 2. DCFS send out "Care Enough to Call" brochures to all Head Start and Early Start childhood Programs with a request that they give them out with registration materials. 3. DCFS make an insert with Care Enough to Call brochure information on it and sent it to Secretary of State with a request that they send it out with license registration. 	<ol style="list-style-type: none"> 1. DCFS agrees. Care Enough to Call brochures will be sent to the DHS Child Care Nurse Consultants with a request that they distribute them to daycares to give to parents and request that Child Care Nurse Consultants use them in their presentations. 2. DCFS agrees. Care Enough to Call brochures will be sent to all Head Start and Early Start childhood Programs with a request that they give them out with registration materials. 3. DCFS will explore this recommendation with the Secretary of State and will implement it if compatible with their current mailing procedures.
DCFS seek a partnership with the Illinois Police Training Board and the Illinois State Police to update training on mandated reported.	IDCFS has a good relationship with the ISP, which has resulted in partnering with them on a number of statewide incentives. Therefore,

	IDCF will reach out to the IL Police Training Board and ISP to alert and remind them to view our mandated reporting website for possible training opportunities.
Southern IL Task Force should include this in their training.	DCFS will forward your recommendation to the Protocol Board and advise them of the web based training available.
Team will call State to report hospital did not complete form and send to APORS.	No response required.
Team will write a letter to the hospital and Health Department reminding them they are mandated to complete IDR form and send to APORS on high risk cases.	No response required.

Primary Prevention Recommendations

Prevention recommendations encourage strengthening of public awareness campaigns related to child health, safety, and welfare, and other mechanisms for preventing child deaths. In 2007, CDRTs made one prevention recommendation (Table 8).

Table 8. 2007 Primary Prevention Recommendations and DCFS Responses

CDRT RECOMMENDATION	DCFS RESPONSE
DCFS work with DHS Community Health and Prevention and Mental Health to create a community awareness campaign on prenatal and post-partum depression. This should include educating mother and family on the signs and symptoms including increase alcohol use and thoughts of harming your child. This campaign should also identify services in the community.	A representative from the Exec. Council accompanied by a DCFS staff person should meet with a representative from DHS to discuss a community awareness campaign on prenatal and post-partum depression.

CDRT Recommendations in 2008

In 2008, there were 27 recommendations made by the CDRTs (many of these had several components). The majority of the recommendations (21) focused on DCFS policy and procedures, followed by case-specific recommendations (5), and recommendations for other systems (1). There were no primary prevention recommendations in 2008.

DCFS System Recommendations

A DCFS system recommendation is specific to a DCFS policy, procedure, or program. Table 9 lists the 21 DCFS system recommendations submitted to the Department in 2008 by CDRTs, as well as the corresponding response from the Department.

Table 9. 2008 DCFS-System Recommendations and DCFS Responses

CDRT RECOMMENDATION	DCFS RESPONSE
<p>The team recommends that when there is evidence of previous serious injuries to an infant or child under the age of two and the primary care givers are alleged perpetrator, safety plans should not be used and protective custody should always be taken and/or at a minimum an order of protection should be obtained.</p>	<p>Protective Custody must be taken of young children with serious injuries determined to be the result of abuse. UNLESS the Decision Tree Serious Physical Injury has ruled out Protective Custody. If protective custody is rule out and the Department is unable to implement a safety plan consideration will be given to screening the case with the SA for a protective order (as referred in the memorandum dated 3/18/08 CA/N Investigation Errors/Guidelines in Youth Children.)</p>
<p>DCFS should change policy to include if DCFS has an open case and a child dies a hotline call shall be made by the caseworker (DCFS and POS) of the open case regardless of how the child dies.</p>	<p>Since all unexplained deaths are reportable it is very important to note that all child deaths do not fall under child abuse and neglect. Therefore, contacting the hotline regardless of how children die is out of the Departments scope. However, the Department has very clear and concise procedures/policies for casework staff (DCFS and POS) to follow (i.e. procedures 300.160, 302.220) regarding death of a child related to prior open service cases and/or current open service cases. In addition, an unusual incident report is required on all death cases and the caseworkers should contact the hotline if they suspect abuse or neglect. The UIR must be completed by field staff and this will serve as notice to the Dept.</p>
<p>The Team is very concerned about the repeated incidents where cases of homicide are being indicated by DCFS as death by neglect in place of death by abuse. When there is an allegation of injury and it is unclear in any way if it is abuse or neglect it should be coded as abuse by the hotline. The hotline should default to abuse and the investigator should change it to neglect if needed. The recommendation would apply not only to allegations of death but all allegations that could be coded abuse or neglect.</p>	<p>The Department will address the issue of correct case coding with staff and supervisors via on-going trainings and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.</p>
<p>When there is a Deputy of Child Protection investigation, DCP procedures should be amended to require that the investigator immediately contact the post adoption service provider and that there be a mutual sharing of information about issues that have the potential to affect the safety of the children. 2. When adoptive parents die, as part of the home study the post adoption services provider must contact collateral sources outside of family i.e. school counselors, health care providers, etc.</p>	<p>. The Department agrees that Procedure 300 and/or an informational transmittal should be amended/completed to require that the investigator immediately contact other involved Child Welfare Personnel. This information should be cited in 300.60 (g) under other required contacts. 2. DCFS agrees. When adoptive parents die, as part of the home study the post adoption services provider must contact collateral sources outside of family ie. school counselors, health care providers, etc</p>

<p>Team recommends that the Director of DCFS look at how (Agency X) handled this case. A waiver was done within their agency after they did not get placement from DCFS. Neither the Public Guardian office nor the court was given the information about the waiver or about the sexual perpetrator living in the home at the time the children were placed.</p>	<p>We agree. The Director agrees to look at how the case was handled.</p>
<p>Team requests that the Agency Performance Teams do a licensing evaluation with (Agency X) and take a random sample of cases to review for these types of issues in possible of other cases.</p>	<p>We agree. The Agency Performance Teams will do a licensing evaluation by taking a random sample of cases from (Agency X).</p>
<p>1. If a child's death is ruled a homicide then the death should be indicated by DCFS as a death by abuse and not death by neglect. 2. The team recommends that this case be reviewed and reclassified as death by abuse and not death by neglect.</p>	<p>The Department will address the issue of correct case coding with staff and supervisors via on-going trainings and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.</p>
<p>Team recommends that DCFS make it protocol that for cases involving an indicated death if the non offending parent's ability to care for the surviving children is in question the case should be referred to intact services to ensure ongoing monitoring.</p>	<p>Intact services are voluntary. The Department currently has a comprehensive procedure (302.388) that outlines(s) for our staff the necessary steps to take when cases should be referred to intact services. During the early investigative assessment (risk/safety) process the primary focus is on safety, permanency and the well being of the family which will include assessment of the non offending parent's ability to care for the surviving children</p>
<p>If a mandated reporter making a new report of a SEI inquires about prior DCFS involvement, SCR should share, in addition to prior indicated reports, if there has been a previously opened service case on the family, and specifically if there has been past court involvement with the family.</p>	<p>Due to confidentiality SCR would not be able to share prior information with the mandated reporters at the time of the new report. The Department can release prior information to those outlined in the Abuse and Neglected Child Reporting Act Sec. 11.1 (Access to Records). Prior information is released over the telephone to Doctors, Police Officers and IDCF/POS employees with a valid ID number. Other mandated reporters requesting prior information must submit a written request.</p>
<p>The team recommends that DCFS have a longer retention for drug exposed infants. Many times the allegation is expunged before the mother gives birth to another drug exposed infant and then it becomes A sequence again.</p>	<p>A substance exposed infant report may be restrained for twenty years depending on the seriousness of the injury. When the Department started investigating substance exposed infants, the Department determined that five years retention would be appropriate if the factors below were not present. To retain the reports for twenty years the</p>

	<p>factors must be present: P.300 Section 100 Extent of the injuries Long term effects of the injury medical treatment required pattern of chronicity of injuries</p>
<p>Change DCFS policy and procedures and reporting system to term of shaken baby to abusive head trauma to comply with the American Academy of Pediatrics guidelines.</p>	<p>DCFS agrees. DCFS will change policy, procedure and reporting system to replace shaken baby syndrome with abusive head trauma.</p>
<p>Team recommends that interstate compact should be respected, therefore, in cases where judges overrule it should be mandated for DCFS legal to be involved.</p>	<p>We agree. The purpose and policy of the Interstate Compact on the Placement of Children is for the party states to cooperate with each other in the interstate placement of children. Whenever a Judge orders the placement of a minor without an interstate compact being in placed, DCFS Legal will remind the court of the penalty for illegal placement of children and the risk factors associated with such a placement. However, the ICPC does not apply to relatives or guardians of the minor.</p> <p>45 ILCS 15/ 0.01 INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN</p> <p>ARTICLE IV. Penalty for Illegal Placement The sending, bringing, or causing to be sent or brought into any receiving state of a child in violation of the terms of this compact shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit, or other legal authorization held by the sending agency which empowers or allows it to place, or care for children.</p> <p>ARTICLE VIII. Limitations This compact shall not apply to: (a) The sending or bringing of a child into a receiving state by his parent, step parent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or non agency guardian in the receiving state. (b) Any placement, sending or</p>

	bringing of a child into a receiving state pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state are party, or to any other agreement between said states which has the force of law
Team recommends that DCFS develop a protocol for return home that must be followed by workers prior to returning children home and after children are returned home. Team gave 9 items to be included.(see recommendation sheet)	DCFS agrees to explore development of protocol that must be followed by workers prior to returning children home and after children are returned home.

Team recommends that DCFS develop guidelines for investigators for indicating or unfounding cases when a baby dies while bed sharing as well as guidelines for the hotline when calls are taken regarding a baby who dies while co-sleeping.	In addition to allegation 1 and 2, if there are surviving siblings in the home we would also be investigating allegation 10/60, risk of harm. It is important that DCP staff not just accept/rely on a coroner's report that finds the death to be accidental but look at Blatant disregard which is defined as incidents where the risk of harm to the child was so imminent and apparent that it is unlikely that a parent or caretaker would have exposed the child to such obvious danger without exercising precautionary measures to protect the child from harm.
The team would like for DCFS to create a designated line for Coroner's only so that the request to have all Coroner's call the hotline on all deaths would be more feasible. During this call DCFS can notify Coroner's of any history with the Department on this family.	DCFS met with Coroners on 1/21/10. It was agreed that DCFS would make Coroner's calls to the hotline a priority and if a call back is needed they would be called back first. It was also agreed that the Exec Council would create a protocol for Coroners of types of deaths to call the hotline for. The Coroners will be able to obtain DCFS prior history with families at the time the death is called in. XX will speak at Coroner's Conference in the spring
1. The team request a change in DCFS policy to include that when a ward of the state has a child and the ward is approaching a move into an independent living arrangement, DCFS must do an assessment on the safety and well-being of the ward's child. If risk is present the agency shall request from the SA a petition for wardship of the minor dependent. 2. Once a DCFS ward has a child and moves into an independent living arrangement, DCFS must do another assessment on the safety and well-being of the wards child within 5 days after the move into an independent living arrangement and again at every 30 days until the case closes.	We are working on the revised ILO/TLP policy where we will put language around the 2 recommendations outlined in the attachment. We have a goal of completing the draft by 9/11/09. We then will get it to Policy to post for the usual comment period. New Policy completed and given to CDRT Exec Council on 12/3/09.
Team request that Southern IL Task Force be implemented as soon as possible.	DCFS agrees. The child death review contract for the Southern Il task force given to SIDS of IL.

<p>The team discussed the importance of educating caregivers on the risk of bottle propping. Team request that DCFS include the risk of bottle propping in Foster parent training, foster parent newsletter, DCFS licensed daycares and training with intact and investigators to educate families with infants.</p>	<p>DCFS agrees. The issue of bottle propping is addressed specifically in the Day Care Home Standards, Part 406- specifically in the Day Care Home Standards, Part 406 - specifically 406.22 - d-2 and also in Day Care Centers, Part 407, specifically 407.210 f-24. Licensed day care homes and centers providers are alerted and aware of this issue, as the licensing standards prohibit bottle propping.</p> <p>We agree. An in-service training and a newsletter alert will be sent out for information sharing for all providers of infants and some toddlers who have difficulty swallowing due to a medical condition.</p> <p>This issue is not addressed in Part 402 foster home licensing standards but again it would be beneficial information sharing in an in-service training and/or newsletter</p>
<p>Team recommends that DCFS have a protocol in place for Follow-up for investigation of what to do when they receive an information only report.</p>	<p>CDRT and SCR are working together to obtain final autopsy reports. Upon receipt of final autopsy results the information provided is reassessed to determine if legal criteria for investigation is met.</p>
<ol style="list-style-type: none"> 1. Team recommends that DCFS change camera protocol to include that DCFS intact and placement teams also be provided a digital camera for documentation purposes. 2. DCFS include in contract agreements with POS agencies that they must provide digital cameras to all intact and placement teams. 3. DCFS include in the contract with POS agencies that pictures must be taken once a week upon closure of environmental cases. 4. Team recommends that protocol wording state that there is a minimum of quarterly unannounced visits to the home on all open cases. 	<ol style="list-style-type: none"> 1. The Department at this time cannot afford to provide staff with cameras. 2. The Department at this time cannot afford to provide staff with cameras. 3. Just prior to a case closing, POS agencies have to complete a safety assessment which would cover environmental issues. 4. Procedures 302.388(f) (1) (A), Worker Family Contacts, should be amended to, “Following the assessment period, contact with the family shall occur at a minimum of twice per month. Unannounced visits with the family shall occur at a minimum of once per quarter.”
<p>Team recommends that DCFS develop a protocol that list out circumstances for indicating investigations for children who die while bed sharing i.e. alcohol, drugs.</p>	<p>DCFS stated that they are working on modifying the allegation for Risk. DCFS agrees to share these changes made with the Exec Council. Exec Council agreed that this case can be completed once they see the changes made.</p>

Other Systems Recommendations

Other system recommendations concern the policies and procedures of agencies and organizations that are involved in child safety, health, and welfare. This includes medical examiners, coroners, medical professionals, state’s attorneys, and other state agencies such as the Illinois Department of Public Health. In 2008, CDRT’s submitted one recommendation concerning other systems (Table 10).

Table 10. 2008 Other Systems Recommendations and DCFS Responses

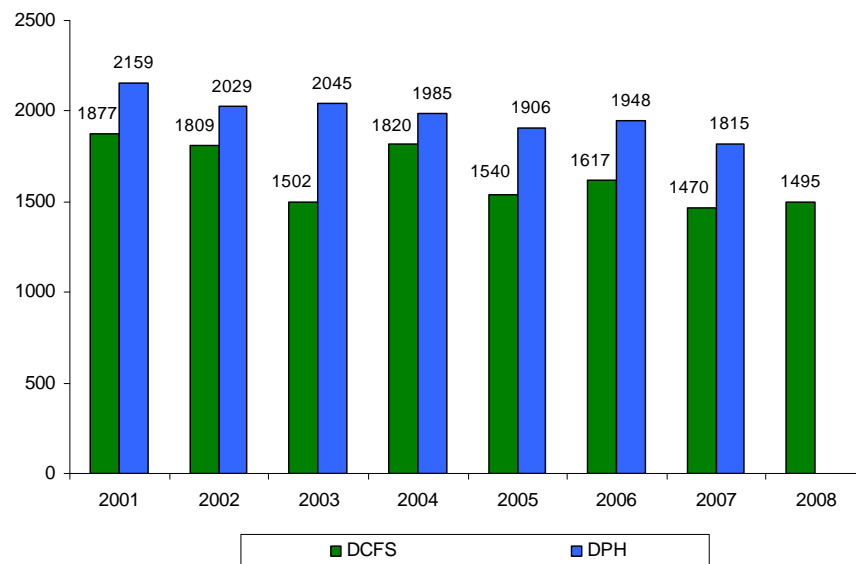
CDRT RECOMMENDATION	DCFS RESPONSE
Team recommends that DCFS work with the Coroner Association to request that Coroners call in deaths of all children under the age of 18.	DCFS agrees. A letter will be written to the Coroner's Association requesting that they report all deaths of all children less than 18 years of age to the DCFS hotline.

Chapter 5: Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths from 2000 to 2008, which allows for an analysis of the trends in Illinois child deaths over time. As with the yearly analyses, it is important to remember that information on child deaths contained in the CDRT database is based on completed death certificates sent by county registrars and coroners to the Department of Children and Family Services State Central Register. The Illinois Vital Records Act was amended in 1998 to state that local registrars shall transmit monthly a copy of all death certificates of persons under 18 years of age who have died within the month to the State Central Register (SCR) of the Department of Children and Family Services (see Appendix C). Unfortunately, many local registrars do not send child death information to the DCFS State Central Register as required by the Vital Records Act (see Appendix D for a breakdown of reported deaths by county). The importance of this requirement cannot be overstated, as only those child death certificates sent to the SCR are entered into the CDRT database and analyzed for this report. If large numbers of child deaths are not included, it diminishes the ability of the CDRTs to analyze and understand child death in Illinois and make sound recommendations for preventing future deaths.

A comparison between the total numbers of deaths reported to DCFS versus the total number of deaths reported to IDPH is shown in Figure 26.³⁹ These comparisons reveal that anywhere from 73% (in 2003) to 91% (in 2004) of the child deaths reported to the IDPH are also reported to DCFS; 81% were reported in 2007. Thus, the number of child deaths contained in the CDRT database for a given year should be considered a subset of the total deaths in that year. When looking at trends in child death over time, the general direction of the trends should be the focus rather than the exact number of deaths that occurred. The numbers presented in Figure 26 reveal that the total number of child deaths (reported by IDPH) in Illinois has been generally decreasing from 2001 to 2007, although there was a slight increase in 2006.

Figure 26. Total Child Deaths Reported to DCFS and IDPH, 2001 – 2008



³⁹ The number of deaths reported to IDPH in 2008 was unavailable at the time of this report.

The following two figures present the total child deaths reported to DCFS from 2000 to 2008 broken down by age group (Figure 27) and racial group (Figure 28). For each year of data, the number of children in each category (age or race) 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. Looking first at Figure 27, it becomes clear that although the *number* of deaths in each age group has fluctuated slightly from year to year, the percentage of total deaths in each age group is remarkably stable over the 9 year period: infants under one year comprise 63-69% of all child deaths, children between one and four years comprise 9-10%, children between five and nine years add another 4-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are the final 11-13%. This consistency across the years is also apparent among racial groups (see Figure 28): Caucasian children comprise 54-59% of all child deaths each year, African-American children make up 34-37%, Hispanic children comprise 2-6%, Asian children represent 1-3%, and children of other racial background represent 1-3% of child deaths. The one anomalous year was 2005, when there was a slightly higher percentage of Hispanic deaths and lower percentage of African-American deaths than usual.

Figure 27. Total Child Deaths (reported to DCFS) in Illinois by Age Group, 2000 – 2008

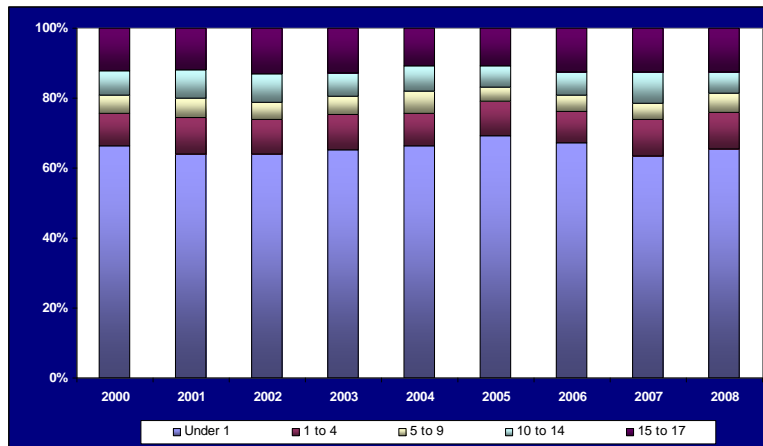
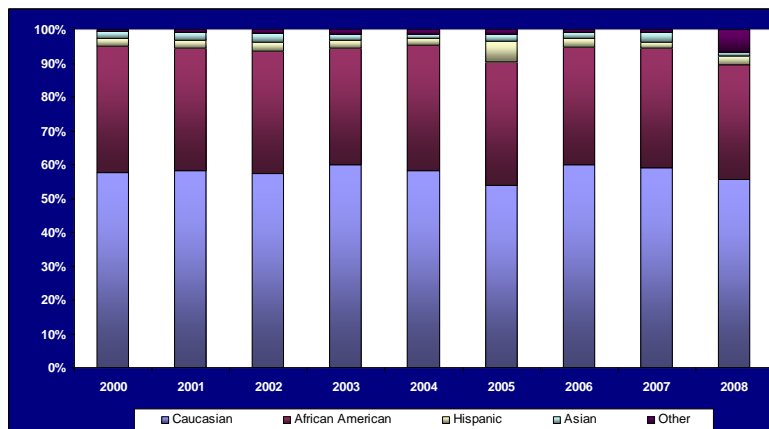
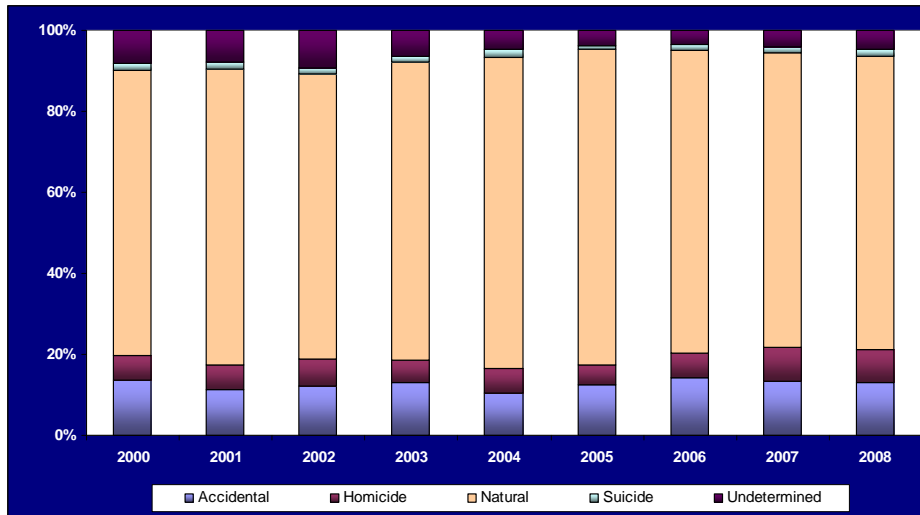


Figure 28. Total Child Deaths (reported to DCFS) in Illinois by Racial Group, 2000 – 2008



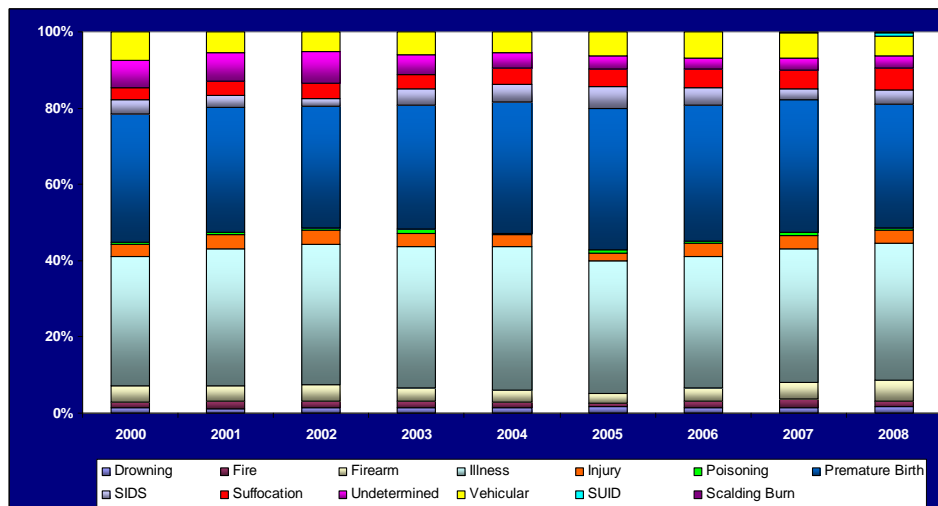
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 71-78% natural, 1-2% suicide, and 4-9% undetermined (see Figure 29). It appears as the percentage of homicides increased slightly in 2007 and 2008, a trend that bears further watching.

Figure 29. Total Child Deaths (reported to DCFS) in Illinois by Manner of Death, 2000 – 2008



A similar analysis was done for category of death; the results are presented in Figure 30. The percentage of child deaths related to each category of death remained fairly stable across the five year period.

Figure 30. Total Child Deaths (reported to DCFS) in Illinois by Category, 2000 – 2008



Appendix A – Child Death Review Team Act
Illinois Compiled Statutes
Executive Branch
Child Death Review Team Act
20 ILCS 515/

(20 ILCS 515/)

(20 ILCS 515/1)

Sec. 1. Short title. This Act may be cited as the Child Death Review Team Act.

(Source: P.A. 88-614, eff. 9-7-94.)

(20 ILCS 515/5)

Sec. 5. State policy. The following statements are the policy of this State:

(1) Every child is entitled to live in safety and in health and to survive into adulthood.

(2) Responding to child deaths is a State and a community responsibility.

(3) When a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death, the provision of services to surviving family members, and the development and implementation of measures to prevent future deaths from similar causes. The response may include court action, including prosecution of persons who may be responsible for the death and juvenile proceedings to protect other children in the care of the person responsible for the care of the child who died.

(4) Professionals from disparate disciplines and agencies who have responsibilities for children and expertise that can promote child safety and well-being should share their expertise and knowledge so that the goals of determining the causes of children's deaths, planning and providing services to surviving children and non-offending family members, and preventing future child deaths can be achieved.

(5) A greater understanding of the incidence and causes of child deaths is necessary if the State is to prevent future child deaths.

(6) Multidisciplinary and multi-agency reviews of child deaths can assist the State and counties in (i) investigating child deaths, (ii) developing a greater understanding of the incidence and causes of child deaths and the methods for preventing those deaths, and (iii) identifying gaps in services to children and families.

(7) Access to information regarding deceased children and their families by multidisciplinary and multi-agency child death review teams is necessary for those teams to achieve their purposes and duties.

(Source: P.A. 88-614, eff. 9-7-94.)

(20 ILCS 515/10)

Sec. 10. Definitions. As used in this Act, unless the context requires otherwise: "Child" means any person under the age of 18 years unless legally emancipated by reason of marriage or entry into a branch of the United States armed services.

"Department" means the Department of Children and Family Services.

"Director" means the Director of Children and Family Services.

"Executive Council" means the Illinois Child Death Review Teams Executive Council.

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/15)

Sec. 15. Child death review teams; establishment.

(a) The Director, in consultation with the Executive Council, law enforcement, and other professionals who work in the field of investigating, treating, or preventing child abuse or neglect in that sub-region, shall appoint members to a child death review team in each of the Department's administrative sub-regions of the State outside Cook County and at least one child death review team in Cook County. The members of a team shall be appointed for 2-year terms and shall be eligible for reappointment upon the expiration of the terms. The Director must fill any vacancy in a team within 60 days after the vacancy occurs.

(b) Each child death review team shall consist of at least one member from each of the following categories:

(1) Pediatrician or other physician knowledgeable about child abuse and neglect.

(2) Representative of the Department.

(3) State's attorney or State's attorney's representative.

(4) Representative of a local law enforcement agency.

(5) Psychologist or psychiatrist.

(6) Representative of a local health department.

(7) Representative of a school district or other education or child care interests.

(8) Coroner or forensic pathologist.

(9) Representative of a child welfare agency or child advocacy organization.

(10) Representative of a local hospital, trauma center, or provider of emergency medical services.

(11) Representative of the Department of State Police.

Each child death review team may make recommendations to the Director concerning additional appointments.

Each child death review team member must have demonstrated experience and an interest in investigating, treating, or preventing child abuse or neglect.

(c) Each child death review team shall select a chairperson from among its members. The chairperson shall also serve on the Illinois Child Death Review Teams Executive Council.

(d) The child death review teams shall be funded under a separate line item in the Department's annual budget.

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/20)

Sec. 20. Reviews of child deaths.

(a) Every child death shall be reviewed by the team in the sub-region which has primary case management responsibility. The deceased child must be one of the following:

(1) A ward of the Department.

(2) The subject of an open service case maintained by the Department.

(3) The subject of a pending child abuse or neglect investigation.

(4) A child who was the subject of an abuse or neglect investigation at any time during the 12 months preceding the child's death.

(5) Any other child whose death is reported to the State central register as a result of alleged child abuse or neglect which report is subsequently indicated.

A child death review team may, at its discretion, review other sudden, unexpected, or unexplained child deaths, and cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.

(b) A child death review team's purpose in conducting reviews of child deaths is to do the following:

(1) Assist in determining the cause and manner of the child's death, when requested.

(2) Evaluate means by which the death might have been prevented.

(3) Report its findings to appropriate agencies and make recommendations that may help to reduce the number of child deaths caused by abuse or neglect.

(4) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect.

(5) Make specific recommendations to the Director and the Inspector General of the Department concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

(c) A child death review team shall review a child death as soon as practical and not later than 90 days following the completion by the Department of the investigation of the death under the Abused and Neglected Child Reporting Act. When there has been no investigation by the Department, the child death review team shall review a child's death within 90 days after obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner, or law enforcement agency, depending on the nature of the case. A child death review team shall meet at least once in each calendar quarter.

(d) The Director shall, within 90 days, review and reply to recommendations made by a team under item (5) of subsection (b). With respect to each recommendation made by a team, 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 the Director intended to implement the recommendation.

The Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or non-implementation of the recommendations.

(e) Within 90 days after the Director submits a reply with respect to a recommendation as required by subsection (d), the Director must submit an additional report that sets forth in detail the way, if any, in which the Director will implement the recommendation and the schedule for implementing the recommendation. The Director shall submit this report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council.

(f) Within 180 days after the Director submits a report under subsection (e) concerning the implementation of a recommendation, the Director shall submit a further report to the chairperson of the team that made the

recommendation and to the chairperson of the Executive Council. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to the recommendation.

(Source: P.A. 90-239, eff. 7-28-97; 90-608, eff. 6-30-98.)

(20 ILCS 515/25)

Sec. 25. Team access to information.

(a) The Department shall provide to a child death review team, on the request of the team chairperson, all records and information in the Department's possession that are relevant to the team's review of a child death, including records and information concerning previous reports or investigations of suspected child abuse or neglect.

(b) A child death review team shall have access to all records and information that are relevant to its review of a child death and in the possession of a State or local governmental agency, including, but not limited to, information gained through the Child Advocacy Center protocol for cases of serious or fatal injury to a child. These records and information include, without limitation, birth certificates, all relevant medical and mental health records, records of law enforcement agency investigations, records of coroner or medical examiner investigations, records of the Department of Corrections concerning a person's parole, records of a probation and court services department, and records of a social services agency that provided services to the child or the child's family.

(Source: P.A. 91-812, eff. 6-13-00.)

(20 ILCS 515/30)

Sec. 30. Public access to information.

(a) Meetings of the child death review teams and the Executive Council shall be closed to the public. Meetings of the child death review teams and the Executive Council are not subject to the Open Meetings Act (5 ILCS 120), as provided in that Act.

(b) Records and information provided to a child death review team and the Executive Council, and records maintained by a team or the Executive Council, are confidential and not subject to the Freedom of Information Act (5 ILCS 140), as provided in that Act. Nothing contained in this subsection (b) prevents the sharing or disclosure of records, other than those produced by a Child Death Review Team or the Executive Council, relating or pertaining to the death of a minor under the care of or receiving services from the Department of Children and Family Services and under the jurisdiction of the juvenile court with the juvenile court, the State's Attorney, and the minor's attorney.

(c) Members of a child death review team and the Executive Council are not subject to examination, in any civil or criminal proceeding, concerning information presented to members of the team or the Executive Council or opinions formed by members of the team or the Executive Council based on that

information. A person may, however, be examined concerning information provided to a child death review team or the Executive Council that is otherwise available to the public.

(d) Records and information produced by a child death review team and the Executive Council are not subject to discovery or subpoena and are not admissible as evidence in any civil or criminal proceeding. Those records and information are, however, subject to discovery or a subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

(Source: P.A. 92-468, eff. 8-22-01)

(20 ILCS 515/35)

Sec. 35. Indemnification. The State shall indemnify and hold harmless members of a child death review team and the Executive Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the team or Executive Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act (5 ILCS 350/1 et seq.).

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/40)

Sec. 40. Illinois Child Death Review Teams Executive Council.

(a) The Illinois Child Death Review Teams Executive Council, consisting of the chairpersons of the 9 child death review teams in Illinois, is the coordinating and oversight body for child death review teams and activities in Illinois. The vice-chairperson of a child death review team, as designated by the chairperson, may serve as a back-up member or an alternate member of the Executive Council, if the chairperson of the child death review team is unavailable to serve on the Executive Council. The Inspector General of the Department, ex officio, is a non-voting member of the Executive Council. The Director may appoint to the Executive Council any ex-officio members deemed necessary. Persons with expertise needed by the Executive Council may be invited to meetings. The Executive Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year, renewable term. The Executive Council must meet at least 4 times during each calendar year. At each such meeting, in addition to any other matters under consideration, the Executive Council shall review all replies and reports received from the Director pursuant to subsections (d), (e), and (f) of Section 20 since the Executive Council's previous meeting. The Executive Council's review must include consideration of the Director's proposed manner of and schedule for implementing each recommendation made by a child death review team.

(b) The Department must provide or arrange for the staff support necessary for the Executive Council to carry out its duties. The Director, in cooperation and consultation with the Executive Council, shall appoint, reappoint, and remove team members. From funds available, the Director may select from a list of 2 or more candidates recommended by the Executive Council to serve as the Child Death Review Team Executive Director. The Child

Death Review Teams Executive Director shall oversee the operations of the child death review teams and shall report directly to the Executive Council.

(c) The Executive Council has, but is not limited to, the following duties:

(1) To serve as the voice of child death review teams in Illinois.

(2) To oversee the regional teams in order to ensure that the teams' work is coordinated and in compliance with the statutes and the operating protocol.

(3) To ensure that the data, results, findings, and recommendations of the teams are adequately used to make any necessary changes in the policies, procedures, and statutes in order to protect children in a timely manner.

(4) To collaborate with the General Assembly, the Department, and others in order to develop any legislation needed to prevent child fatalities and to protect children.

(5) To assist in the development of quarterly and annual reports based on the work and the findings of the teams.

(6) To ensure that the regional teams' review processes are standardized in order to convey data, findings, and recommendations in a usable format.

(7) To serve as a link with child death review teams throughout the country and to participate in national child death review team activities.

(8) To develop an annual statewide symposium to update the knowledge and skills of child death review team members and to promote the exchange of information between teams.

(9) To provide the child death review teams with the most current information and practices concerning child death review and related topics.

(10) To perform any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

(c-5) The Executive Council shall prepare an annual report. The report must include, but need not be limited to, (i) each recommendation made by a child death review team pursuant to item (5) of subsection (b) of Section 20 during the period covered by the report, (ii) the Director's proposed schedule for implementing each such recommendation, and (iii) a description of the specific changes in the Department's policies and procedures that have been made in response to the recommendation. The Executive Council shall send a copy of its annual report to each of the following:

(1) The Governor

(2) Each member of the Senate or the House of Representative whose legislative district lies wholly or partly within the region covered by any

child death review team whose recommendation is addressed in the annual report.

(3) Each member of each child death review team in the State.

(d) In any instance when a child death review team does not operate in accordance with established protocol, the Director, in consultation and cooperation with the Executive Council, must take any necessary actions to bring the team into compliance with the protocol.

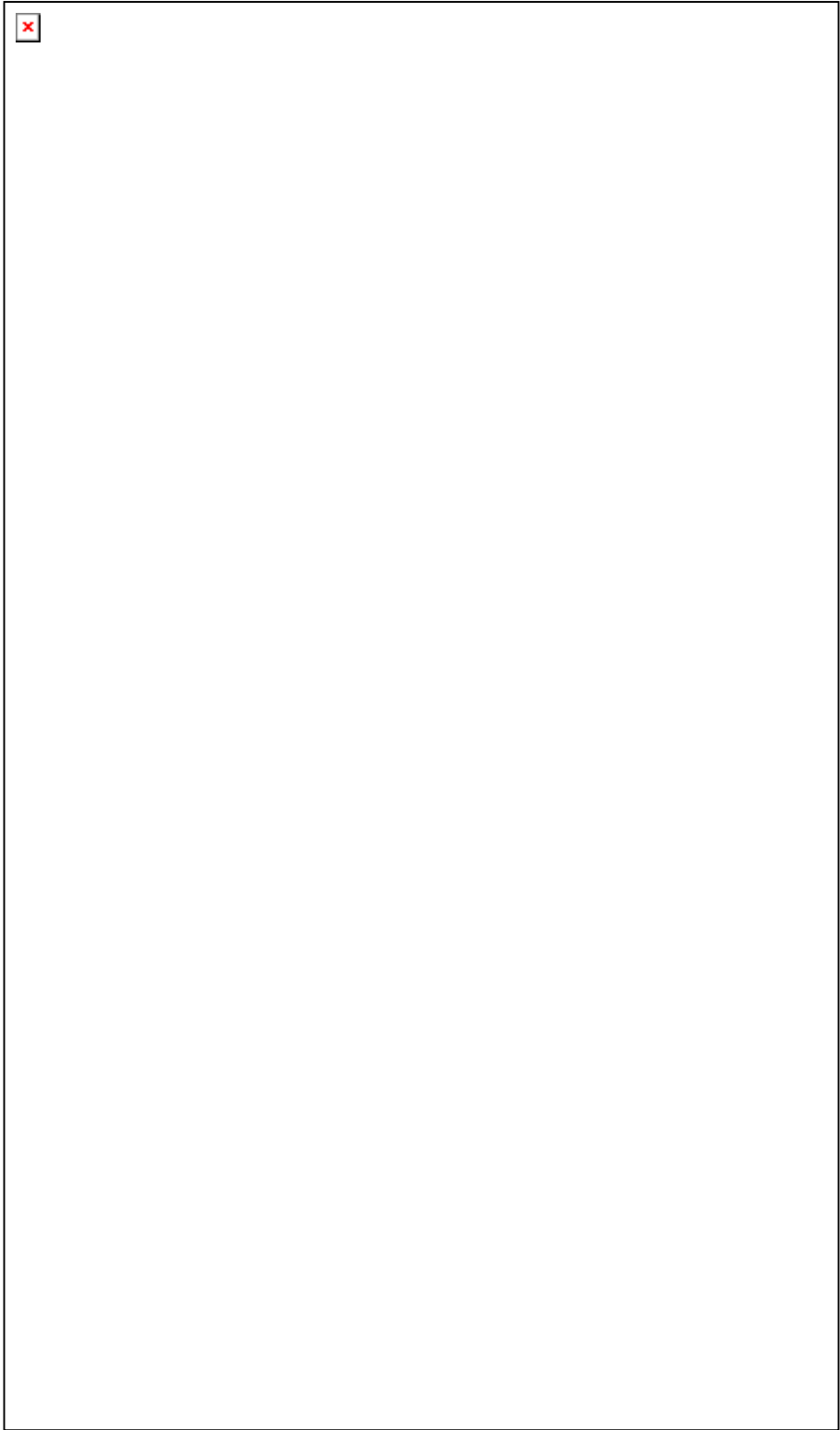
(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/45 new)

Sec. 45. Child Death Investigation Task Force; pilot program. The Child Death Review Teams Executive Council may, from funds appropriated by the Illinois General Assembly to the Department and provided to the Child Death Review Teams Executive Council for this purpose, or from funds that may otherwise be provided for this purpose from other public or private sources, establish a 3-year pilot program in the Southern Region of the State, as designated by the Department, under which a special Child Death Investigation Task Force will be created by the Child Death Review Teams Executive Council to develop and implement a plan for the investigation of sudden, unexpected, or unexplained deaths of children under 18 years of age occurring within that region. The plan shall include a protocol to be followed by child death review teams in the review of child deaths authorized under paragraph (a)(5) of Section 20 of this Act. The plan must include provisions for local or State law enforcement agencies, hospitals, or coroners to promptly notify the Task Force of a death or serious life-threatening injury to a child, and for the Child Death Investigation Task Force to review the death and submit a report containing findings and recommendations to the Child Death Review Teams Executive Council, the Director, the Department of Children and Family Services Inspector General, the appropriate State's Attorney, and the State Representative and State Senator in whose legislative districts the case arose. The plan may include coordination with any investigation conducted under the Children's Advocacy Center Act. By January 1, 2010, the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the pilot program together with any recommendations for statewide implementation of a protocol for the investigating all sudden, unexpected, or unexplained child deaths.

(Source: P.A. 95-527, eff. 6-1-08.)

Appendix B – Child Death Review Team Regional Map



Appendix C – Vital Records Act

Illinois Compiled Statutes

410 ILCS 535/

(410 ILCS 535/8) (from Ch. 111 1/2, par. 73-8)

Sec. 8. Each local registrar shall:

(1) Appoint one or more deputies to act for him in his absence or to assist him. Such deputies shall be subject to all rules and regulations governing local registrars.

(2) Appoint one or more subregistrars when necessary for the convenience of the people. To become effective, such appointments must be approved by the State Registrar of Vital Records. A subregistrar shall exercise such authority as is given him by the local registrar and is subject to the supervision and control of the State Registrar of Vital Records, and shall be liable to the same penalties as local registrars, as provided in Section 27 of this Act.

(3) Administer and enforce the provisions of this Act and the instructions, rules, and regulations issued hereunder.

(4) Require that certificates be completed and filed in accordance with the provisions of this Act and the rules and regulations issued hereunder.

(5) Prepare and transmit monthly an accurate copy of each record of live birth, death, and fetal death to the county clerk of his county. He shall also, in the case of a death of a person who was a resident of another county, prepare an additional copy of the death record and transmit it to the county clerk of the county in which such person was a resident. In no case shall the county clerk's copy of a live birth record include the section of the certificate which contains information for health and statistical program use only.

(6) (Blank).

(7) Prepare, file, and retain for a period of at least 10 years in his own office an accurate copy of each record of live birth, death, and fetal death accepted for registration. Only in those instances in which the local registrar is also a full time city, village, incorporated town, public health district, county, or multi-county health officer recognized by the Department may the health and statistical data section of the live birth record be made a part of this copy.

(8) Transmit monthly the certificates, reports, or other returns filed with him to the State Registrar of Vital Records, or more frequently when directed to do so by the State Registrar of Vital Records.

(8.5) Transmit monthly to the State central register of the Illinois Department of Children and Family Services a copy of all death certificates of persons under 18 years of age who have died within the month.

(9) Maintain such records, make such reports, and perform such other duties as may be required by the State Registrar of Vital Records.

(Source: P.A. 89-641, eff. 8-9-96; 90-608, eff. 6-30-98.)

Appendix D – Illinois Child Deaths by County

County	2002 Deaths		2003 Deaths		2004 Deaths		2005 Deaths		2006 Deaths		2007 Deaths		2008 Deaths	
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH ⁴⁰
Adams	2	4	0	4	0	5	0	6	1	8	8	11	1	
Alexander	1	2	0	1	0	0	0	0	0	1	0	1	0	
Bond	0	0	0	1	2	2	1	1	0	0	0	0	1	
Boone	0	1	0	1	0	1	0	3	0	0	0	0	0	
Brown	0	1	0	0	0	0	0	0	0	1	0	0	0	
Bureau	1	1	4	5	9	8	4	4	2	4	2	2	1	
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	
Carroll	1	1	0	0	0	0	0	0	1	1	0	0	0	
Cass	0	0	0	0	0	0	0	0	0	1	0	0	0	
Champaign	46	50	38	39	44	45	52	53	32	47	3	39	21	
Christian	2	2	5	5	2	2	9	10	2	2	0	0	3	
Clark	1	1	0	1	0	0	1	1	1	1	0	0	1	
Clay	0	0	1	1	1	1	0	0	0	0	0	0	0	
Clinton	0	0	3	4	2	5	0	2	0	3	0	3	3	
Coles	1	2	1	2	1	1	0	6	0	8	0	3	0	
Cook	1117	1211	907	1261	1150	1162	878	1,116	1,014	1,141	926	1,066	908	
Crawford	1	1	0	1	0	2	0	0	0	1	0	1	1	
Cumberland	1	1	0	0	0	0	0	2	1	1	0	0	3	
DeKalb	8	12	3	4	5	10	2	4	1	14	4	5	3	
Dewitt	0	0	0	3	0	0	0	1	0	2	0	1	0	
Douglas	0	0	0	1	2	2	0	0	0	0	0	0	0	
Dupage	104	109	80	81	111	111	112	116	93	95	97	99	76	
Edgar	1	1	3	3	1	1	1	1	2	3	0	1	1	
Edwards	0	1	0	0	0	1	0	0	0	0	0	0	0	
Effingham	0	2	0	6	5	5	1	6	3	4	0	7	5	
Fayette	0	2	0	1	1	3	1	1	0	1	0	1	0	
Ford	0	1	0	4	0	1	2	2	1	1	1	1	3	
Franklin	0	4	5	5	3	2	3	0	1	0	3	3	3	
Fulton	5	6	6	6	4	4	0	0	2	2	5	5	0	
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	0	
Greene	0	0	0	0	0	0	0	0	0	1	0	0	0	
Grundy	7	7	6	6	2	5	1	3	2	3	0	5	3	

⁴⁰ IDPH numbers for deaths occurring in 2008 were not available at the time of this report

Hamilton	1	1	1	1	1	1	0	0	3	3	1	1	3
Hancock	0	1	0	1	1	2	0	0	0	1	0	0	0
Hardin	0	0	0	1	0	1	1	1	0	0	0	1	0
Henderson	0	0	0	0	0	0	0	0	0	3	0	0	0
Henry	3	3	1	1	3	3	3	3	1	1	4	4	2
Iroquois	0	0	0	4	1	2	1	1	0	0	0	2	0
Jackson	0	14	0	5	0	3	0	8	0	4	3	4	8
Jasper	0	3	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	8	0	3	0	0	0	1	1	2	0	3	1
Jersey	0	0	0	1	0	2	0	1	0	1	1	3	0
Jo Daviess	2	2	1	1	0	0	2	2	3	3	0	1	0
Johnson	1	1	0	0	0	2	0	0	0	1	1	0	0
Kane	44	53	21	46	32	38	50	56	44	61	37	46	59
Kankakee	21	19	11	11	16	16	15	15	14	14	9	9	8
Kendall	1	2	1	4	0	2	3	3	1	1	6	6	6
Knox	0	2	4	5	3	2	4	4	5	5	3	3	4
Lake	35	43	24	39	33	57	17	34	35	58	17	37	26
LaSalle	0	12	0	7	0	14	0	8	0	9	0	8	0
Lawrence	3	3	2	2	1	1	1	1	1	1	0	0	1
Lee	4	2	3	3	1	1	2	1	0	1	0	2	0
Livingston	0	6	0	9	0	7	0	3	0	4	0	5	2
Logan	3	3	6	6	2	1	0	0	0	0	0	0	7
Macon	13	13	21	21	12	12	14	14	18	18	15	16	18
Macoupin	0	5	0	2	3	3	0	1	0	1	0	1	0
Madison	19	26	10	21	5	29	6	22	8	20	14	19	21
Marion	0	1	1	4	0	2	2	7	2	2	4	4	4
Marshall	0	0	0	0	0	1	0	0	0	1	0	0	0
Mason	0	1	2	2	1	1	0	1	0	3	0	0	0
Massac	1	1	2	2	2	3	1	2	1	1	1	1	1
McDonough	4	5	3	3	1	2	0	4	0	2	0	0	0
McHenry	6	6	14	14	17	17	15	15	9	10	23	24	14
McLean	10	12	6	9	10	11	14	18	12	16	11	10	14
Menard	0	0	0	2	0	1	0	3	0	0	0	0	0
Mercer	0	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	1	1	1	1	1	1	1	1	1	1	1	0
Montgomery	1	3	2	5	1	1	1	3	2	2	3	3	0
Morgan	2	2	1	2	1	2	2	2	0	1	1	1	0
Moultrie	0	0	1	1	0	0	2	2	1	1	0	0	3
Ogle	2	2	2	3	2	3	3	4	2	2	3	3	4

Peoria	94	95	103	104	106	107	86	87	92	97	51	77	49	
Perry	3	4	0	2	0	0	0	0	2	3	1	4	2	
Piatt	0	2	0	0	0	1	0	0	0	0	0	1	0	
Pike	0	0	0	3	0	2	0	0	0	2	0	0	0	
Pope	0	1	0	0	0	0	0	0	0	1	0	0	0	
Pulaski	0	1	0	0	0	1	0	0	0	0	0	0	0	
Putnam	0	0	0	0	1	1	0	0	0	0	0	0	0	
Randolph	2	2	1	4	1	1	1	2	0	0	1	4	0	
Richland	1	1	0	0	3	3	4	4	1	3	0	0	1	
Rock Island	12	14	13	15	8	8	17	17	4	4	19	19	12	
Saline	0	0	0	1	1	2	1	1	3	3	2	2	2	
Sangamon	44	46	55	58	68	71	57	58	45	52	48	54	32	
Schuyler	0	2	0	1	0	0	0	0	0	3	0	0	0	
Scott	0	0	0	0	0	0	0	0	0	0	0	1	0	
Shelby	0	0	4	4	0	0	0	0	3	3	1	1	3	
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	
St. Clair	29	27	28	29	29	26	22	29	23	35	14	29	7	
Stephenson	3	4	5	7	8	9	5	5	1	2	3	4	4	
Tazewell	4	4	7	7	3	4	9	10	6	9	3	5	4	
Union	0	2	0	5	0	1	0	1	0	0	2	2	0	
Vermillion	5	7	0	2	4	4	8	9	3	4	9	12	1	
Wabash	0	0	0	3	0	1	0	2	0	0	0	1	0	
Warren	0	1	0	2	0	1	0	1	0	1	0	0	0	
Washington	4	4	1	2	0	1	0	1	0	1	0	1	0	
Wayne	1	1	1	1	0	0	0	0	1	1	1	2	0	
White	1	1	0	1	0	0	0	0	0	0	0	0	0	
Whiteside	0	2	0	1	2	5	1	5	1	4	0	6	0	
Will	42	42	26	28	49	50	35	36	40	41	42	43	42	
Williamson	1	8	4	6	6	6	8	1	6	2	4	9	8	
Winnebago	80	78	48	70	31	57	54	57	61	75	58	65	71	
Woodford	1	1	1	1	0	0	1	1	1	2	0	0	1	
Unknown	6	0	2	0	5	0	3	0	0	0	0	0	0	
Out of State									1	0	4	0	13	
Total	1,809	2,029	1,502	2,045	1,820	1,985	1,540	1,906	1,617	1,948	1,470	1,815	1,495	

Appendix E – Child Death Review Team Recommendations and DCFS Responses

Key:

PP = Primary Prevention recommendation

DCFS = DCFS recommendation

OS = Other System recommendation

2007 Recommendations and Responses		
Number	CDRT Recommendation	DCFS Response
PP-1	DCFS work with DHS Community Health and Prevention and Mental Health to create a community awareness campaign on prenatal and post-partum depression. This should include educating mother and family on the signs and symptoms including increase alcohol use and thoughts of harming your child. This campaign should also identify services in the community.	A representative from the Exec. Council accompanied by a DCFS staff person should meet with a representative from DHS to discuss a community awareness campaign on prenatal and post-partum depression.
DCFS-1	<p>The Department of Children and Family Services should include welfare referral education and how to approach parents in a non-threatening way about making DCFS referrals in their mandated reporter training and on-line training. DCFS should immediately send out a notice to all current mandated reporters reminding them about the option of making a child welfare referral to the DCFS hotline.</p> <p>New recommendation made after response came back: Team recommends that DCFS take measures to revise the mandated reporter acknowledgement form emphasizing the importance of reporting the least suspicious threats of child welfare.</p>	<p>ANCRA limits the legal responsibility of mandated reporters. Mandated reporters do not determine the outcome of referrals to the child abuse hotline. The determination is made by the trained social workers at the DCFS hotline receiving the calls. Child welfare referral education is currently in the mandated reporter manual which is located on the DCFS website.</p> <p>Response to new recommendation: DCFS will explore revising the mandated reporter acknowledgement form and adding a definition of reasonable causes.</p>
DCFS-2	This is the 2nd case in a few months time this team has reviewed where DCFS indicated for 51 (death by neglect) when the death was ruled homicide. The team is going to make the same recommendation on this case as they did on the first case.	The Department will address the issue of correct case coding with staff and supervisors via on-going training and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and

	If a child's death is ruled a homicide then the death should be indicated by DCFS as 01, death by abuse and not 51, death by neglect.	document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.
DCFS-3	The Department should educate workers on attorney general and State's Attorney victim witness assistance program in order to access maximum support of witness of violence especially children.	The victim witness assistance program comes into effect only if there is a prosecution. If there is prosecution the Attorney General and State's Attorney Office will educate the victim of their respective services.
DCFS-4	The change in the statute regarding screening for orders needs to be out to intact and POS agencies through a policy transmittal.	We agree. A policy transmittal will be sent out to intact and POS agencies regarding PA 95-0405.
DCFS-5	The current brochure for violence prevention should include information on web access to information on registered sex offenders.	At the next printing of DCFS paramour procedures DCFS will include information on web access to registered sex offenders.
DCFS-6	All children less than 6 months of age reported with bruising should always be taken as an allegation of abuse by the hotline.	DCFS agrees. All children less than 6 months of age reported to the hotline with bruising will be taken as an allegation of abuse by the hotline.
DCFS-7	DCFS change current web based training for mandated reporting to specify that all accidental children deaths should be called into the hotline.	It is not financially feasible to make any changes to the web based training at this time.
DCFS-8	<p>1. DCFS should develop a rule and procedure for dealing with the inability to find subjects of a report which would require a written plan that is placed in the investigative file and that is approved by the supervisor.</p> <p>2. If there is a history of police involvement particularly domestic violence, as part of the opening of the case the follow-up worker has to establish a connection with the police department and check in with the police department quarterly during the span of the open case.</p> <p>3. The team request the an audit be completed to determine the degree of compliance with the required phone call being made to a mandated reporter at the conclusion of the investigation.</p>	<p>1. This is already in DCFS Rules 300.60 (e) (3)</p> <p>3) Unable to Locate Subjects</p> <p>In-person contact is not required when the investigative worker has taken all of the following steps to locate a subject, and is still unable to locate the subject:</p> <ul style="list-style-type: none"> • Request the local, county, and state law enforcement agencies to check their records for information which would locate the subject; <p>AND</p> <ul style="list-style-type: none"> • Conduct a records check of Department of Public Aid and Secretary of State, Division of Motor Vehicles (if a license number is known), records; <p>AND</p> <ul style="list-style-type: none"> • Ask the Reporter (if identity known) to provide as much additional information as possible to help locate the subjects; <p>AND</p> <ul style="list-style-type: none"> • Ask relatives and friends of the subject (if

		<p>known) to provide information to help locate the subject; AND</p> <ul style="list-style-type: none">• Contact the local post office, DPA office, utility companies and school to request a check of their records. <p>The investigative worker shall document all efforts to locate the subject(s) and the reasons why those efforts were unsuccessful. All efforts shall be documented on the SACWIS Case Note.</p> <p>2. DCFS agrees, Procedures 302.260, Domestic violence will be revised to include if there is a history of police involvement, particularly domestic violence, as part of the opening of the case the follow-up worker will establish a connection with the police department, along with quarterly contact with the policy department for the duration of the open case.</p> <p>3. Due to budget restraints and lack of manpower it is not possible for the Dept. to do an audit. Procedures 300.100 (e) has been revised to include the following information. e) Notify Mandated Reporters</p> <p>The Investigation Specialists shall verbally notify the mandated reporter and guardian ad litem, if applicable, of the recommended determination after the finding has been approved by the Investigation Supervisor or Manager. If either person disagrees with the recommended determination, the Investigation Specialist shall immediately notify his or her supervisor of the concerns raised by the reporter or guardian. The Investigation Supervisor shall contact the reporter or guardian to resolve their issues and/or to determine if there are additional investigation activities that need to be completed. When a resolution cannot be reached, the supervisor shall inform the reporter or guardian of their right to appeal the investigation finding. The supervisor and Investigation Specialist shall use SACWIS Contact Notes to document the notification of the recommended determination and all attempts to resolve any issues identified by the reporter or guardian.</p>
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		Revisions to Procedures 300 will be included in the CERAP training provided to Department and POS staff.
DCFS-9	<ol style="list-style-type: none"> 1. After the 2nd attempt to see the home for the 60 day evaluation is unsuccessful the daycare license should be suspended until the home is seen by DCFS. 2. DCFS licensing staff should be trained to identify if there is a risk of harm/danger present in the daycare. 3. The team request that rules and procedures be changed when there are environmental violations. The licensing worker should also complete a write up that would determine if there is risk to the child due to the environmental neglect. If there is risk of harm to the child a report should be made of suspected abuse or neglect. 	<ol style="list-style-type: none"> 1. We agree. This is currently already in policy. A policy transmittal will be sent out. 2. DCFS licensing staff are trained to identify if there are risk of harm present at daycare. They are child welfare specialists who have received 383 and 406 training. 3. The licensing monitoring record can document environmental issues in daycare. The Dept. at this time cannot afford too provide staff with cameras. All licensing staff are mandated reporters and are mandated to report suspicions of child abuse or neglect.
DCFS-10	<p>If a mandated reporter calls in a hotline report regarding the death of a child caused by drugs, either before or after delivery, at minimum a CWS assessment should be initiated in regards to the safety of any surviving child(ren) remaining in the home. The team requests that DCFS make this standard procedure on how all cases such as this are handled.</p>	<p>DCFS took protective custody of these children. There was nothing else the Department could have done. There was a response to the hotline report.</p>
DCFS-11	<ol style="list-style-type: none"> 1. If Southern II Task force would have been in existence at the time of this death, a multi-disciplinary approach would have been done and meetings would have been held with the State's Attorney's Office. The team recommends DCFS's support in getting the task force started. 2. The DCFS investigator, law enforcement investigator and State's Attorneys Office need to have a sit down and face-to-face conference on this case 3. The team discussed the need for the indicated allegation of torture to help the State's Attorney Office. 4. When consent decree is not followed it puts children at risk. 	<ol style="list-style-type: none"> 1. DCFS agrees. The child death review contract for the Southern II task force given to SIDS of Illinois. 2. DCFS agrees No response required 3. The Department will address the issue of correct case coding with staff and supervisors via on going training and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ACRA the Department can only amend in the event we have an appeal. 4. We agree. Furthermore, the importance of staff following the Consent Decree will be reinforced consistently at our weekly Administrator meeting(s).

	<p>DCFS needs to follow consent decree at all times.</p> <p>5. Team recommends that Director McEwen reinforce the willful failure to report policy to all investigators and investigator supervisors</p>	<p>5. DCFS composed the following e-mail to send out to staff: This is a reminder to all Staff regarding the responsibility of Department staff as mandated reporters per Procedure 300.20 and section 4 of ANCRA, 325 ILCS 5 that all Department staff having reasonable cause to believe a child known to them in their professional or official capacity may be an abused child or a neglected child shall immediately report or cause a report to be made to the Department. Willful failure of a Department employee to report suspected incidents of child abuse or neglect known to them can face consequences of disciplinary action, up to and including discharge.</p>
DCFS-12	<p>DCFS distribute the current Paramour brochure or create a new paramour brochure to distribute.</p>	<p>DCFS agrees. DCFS will continue to print and distribute current paramour brochures.</p>
DCFS-13	<p>The team recommends that DCFS collect all information on deaths of wards and include this information in the DCFS file before closing the case. This should include autopsy report, Coroners report, police report and fire if applicable.</p>	<p>DCFS agrees to collect all information on deaths of wards and include this information in the DCFS file before closing the case. This will include autopsy report, Coroner's report, police report and fire if applicable.</p>
DCFS-14	<p>DCFS train all investigators, intact, and case workers on the "Safe Sleep" for infants every three years.</p>	<p>DCFS currently train Investigators, Intact and Case Workers on the Safe Sleep for infants. It is covered in our Foundations and CPI portions of Training. We also distribute brochures, pamphlets, etc on an ongoing basis to our staff to refresh and remind our staff of the seriousness of safe sleep.</p>
DCFS-15	<p>DCFS revise procedure 300, Allegations 10.60 to make more clearly of what definition of risk to children when there is a history of drug use of mental illness and care giver is not taking prescribed medication.</p>	<p>DCFS believes that procedure 300 is clear on the definition of risk to children when there is a history of drug use or mental illness and caregiver is not taking prescribed medication. The definition of the allegation includes the following statement under subheading of circumstances: Anyone in the home exposes child to an environment which significantly affects the health and safety based on the use, sale or manufacturing of illegal drugs (NEGLECT). Parents/caretakers or anyone in the home whose mental illness and behavior pose a significant danger to the child's health and safety. (NEGLECT) To indicate an allegation based on this factor, the Investigation Specialist must rule out Dependency as defined in Juvenile Court Act as the presenting problem. (Abuse or Neglect)</p>
DCFS-16	<p>The team request that DCFS change Procedure 302,</p>	<p>The recommendation to adopt a blanket policy to indicate for failure to comply or comply</p>

	Appendix A which deals with substance abuse services, to require all drug/alcohol drops be random and unannounced. The refusal or non-compliance with the drop should result in an indicated report	consistently with drug drops, in and of itself, violates one's rights and would probably not stand legal scrutiny.
OS-1	Team will send a letter to hospital reminding them about mandated reporting. The team will include education about child welfare referrals through the DCFS hotline, the WIC program, and family case management through IDPH	No DCFS response necessary.
OS-2	<ol style="list-style-type: none"> 1. DCFS send out "Care Enough to Call" brochures to Department of Human Services Child Care Nurse Consultants and request that they distribute them to daycares to give to parents and request that Child Care Nurse Consultants use them in their presentations. 2. DCFS send out "Care Enough to Call" brochures to all Head Start and Early Start childhood Programs with a request that they give them out with registration materials. 3. DCFS make an insert with Care Enough to Call brochure information on it and sent it to Secretary of State with a request that they send it out with license registration. 	<ol style="list-style-type: none"> 1. DCFS agrees. Care Enough to Call brochures will be sent to the DHS Child Care Nurse Consultants with a request that they distribute them to daycares to give to parents and request that Child Care Nurse Consultants use them in their presentations. 2. DCFS agrees. Care Enough to Call brochures will be sent to all Head Start and Early Start childhood Programs with a request that they give them out with registration materials. 3. DCFS will explore this recommendation with the Secretary of State and will implement it if compatible with their current mailing procedures.
OS-3	DCFS seek a partnership with the Illinois Police Training Board and the Illinois State Police to update training on mandated reported.	IDCFS has a good relationship with the ISP, which has resulted in partnering with them on a number of statewide incentives. Therefore, IDCFS will reach out to the IL Police Training Board and ISP to alert and remind them to view our mandated reporting website for possible training opportunities.
OS-4	Southern IL Task Force should include this in their training.	DCFS will forward your recommendation to the Protocol Board and advise them of the web based training available.
OS-5	Team will call State to report hospital did not complete form and send to APORS.	No response required.
OS-6	Team will write a letter to the hospital and Health Department reminding them they are mandated to complete IDR form and send to APORS on high risk cases.	No response required.

2008 Recommendations and Responses

Number	CDRT Recommendation	DCFS Response
DCFS-1	The team recommends that when there is evidence of previous serious injuries to an infant or child under the age of two and the primary care givers are alleged perpetrator, safety plans should not be used and protective custody should always be taken and/or at a minimum an order of protection should be obtained.	Protective Custody must be taken of young children with serious injuries determined to be the result of abuse. UNLESS the Decision Tree Serious Physical Injury has ruled out Protective Custody. If protective custody is rule out and the Department is unable to implement a safety plan consideration will be given to screening the case with the SA for a protective order (as referred in the memorandum dated 3/18/08 CA/N Investigation Errors/Guidelines in Youth Children.)
DCFS-2	DCFS should change policy to include if DCFS has an open case and a child dies a hotline call shall be made by the caseworker (DCFS and POS) of the open case regardless of how the child dies.	Since all unexplained deaths are reportable it is very important to note that all child deaths do not fall under child abuse and neglect. Therefore, contacting the hotline regardless of how children die is out of the Departments scope. However, the Department has very clear and concise procedures/policies for casework staff (DCFS and POS) to follow (i.e. procedures 300.160, 302.220) regarding death of a child related to prior open service cases and/or current open service cases. In addition, an unusual incident report is required on all death cases and the caseworkers should contact the hotline if they suspect abuse or neglect. The UIR must be completed by field staff and this will serve as notice to the Dept.
DCFS-3	The Team is very concerned about the repeated incidents where cases of homicide are being indicated by DCFS as death by neglect in place of death by abuse. When there is an allegation of injury and it is unclear in any way if it is abuse or neglect it should be coded as abuse by the hotline. The hotline should default to abuse and the investigator should change it to neglect if needed. The recommendation would apply not only to allegations of death but all allegations that could be coded abuse or neglect.	The Department will address the issue of correct case coding with staff and supervisors via on-going trainings and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.
DCFS-4	When there is a Deputy of Child Protection investigation, DCP procedures should be amended to require that the investigator	. The Department agrees that Procedure 300 and/or an informational transmittal should be amended/completed to require that the investigator immediately contact other

	<p>immediately contact the post adoption service provider and that there be a mutual sharing of information about issues that have the potential to affect the safety of the children.</p> <p>2. When adoptive parents die, as part of the home study the post adoption services provider must contact collateral sources outside of family i.e. school counselors, health care providers, etc.</p>	<p>involved Child Welfare Personnel. This information should be cited in 300.60 (g) under other required contacts.</p> <p>2. DCFS agrees. When adoptive parents die, as part of the home study the post adoption services provider must contact collateral sources outside of family ie. school counselors, health care providers, etc</p>
DCFS-5	<p>Team recommends that the Director of DCFS look at how (Agency X) handled this case. A waiver was done within their agency after they did not get placement from DCFS. Neither the Public Guardian office nor the court was given the information about the waiver or about the sexual perpetrator living in the home at the time the children were placed.</p>	<p>We agree. The Director agrees to look at how the case was handled.</p>
DCFS-6	<p>Team requests that the Agency Performance Teams do a licensing evaluation with (Agency X) and take a random sample of cases to review for these types of issues in possible of other cases.</p>	<p>We agree. The Agency Performance Teams will do a licensing evaluation by taking a random sample of cases from (Agency X).</p>
DCFS-7	<p>1. If a child's death is ruled a homicide then the death should be indicated by DCFS as a death by abuse and not death by neglect.</p> <p>2. The team recommends that this case be reviewed and reclassified as death by abuse and not death by neglect.</p>	<p>The Department will address the issue of correct case coding with staff and supervisors via on-going trainings and management meetings. This process will allow for our staff to consistently recognize incorrect case coding during supervisions which will prompt our supervisors to immediately identify and document the appropriate coding on cases. Per ANCRA the Department cannot correct or change the coding on a closed investigation. The Department can only amend in the event we have an appeal.</p>
DCFS-8	<p>Team recommends that DCFS make it protocol that for cases involving an indicated death if the non offending parent's ability to care for the surviving children is in question the case should be referred to intact services to ensure ongoing monitoring.</p>	<p>Intact services are voluntary. The Department currently has a comprehensive procedure (302.388) that outlines(s) for our staff the necessary steps to take when cases should be referred to intact services. During the early investigative assessment (risk/safety) process the primary focus is on safety, permanency and the well being of the family which will include assessment of the non offending parent's ability to care for the surviving children</p>

DCFS-9	If a mandated reporter making a new report of a SEI inquires about prior DCFS involvement, SCR should share, in addition to prior indicated reports, if there has been a previously opened service case on the family, and specifically if there has been past court involvement with the family.	Due to confidentiality SCR would not be able to share prior information with the mandated reporters at the time of the new report. The Department can release prior information to those outlined in the Abuse and Neglected Child Reporting Act Sec. 11.1 (Access to Records). Prior information is released over the telephone to Doctors, Police Officers and IDCF/POS employees with a valid ID number. Other mandated reporters requesting prior information must submit a written request.
DCFS-10	The team recommends that DCFS have a longer retention for drug exposed infants. Many times the allegation is expunged before the mother gives birth to another drug exposed infant and then it becomes A sequence again.	A substance exposed infant report may be restrained for twenty years depending on the seriousness of the injury. When the Department started investigating substance exposed infants, the Department determined that five years retention would be appropriate if the factors below were not present. To retain the reports for twenty years the factors must be present: P.300 Section 100 Extent of the injuries Long term effects of the injury medical treatment required pattern of chronicity of injuries
DCFS-11	Change DCFS policy and procedures and reporting system to term of shaken baby to abusive head trauma to comply with the American Academy of Pediatrics guidelines.	DCFS agrees. DCFS will change policy, procedure and reporting system to replace shaken baby syndrome with abusive head trauma.
DCFS-12	Team recommends that interstate compact should be respected, therefore, in cases where judges overrule it should be mandated for DCFS legal to be involved.	We agree. The purpose and policy of the Interstate Compact on the Placement of Children is for the party states to cooperate with each other in the interstate placement of children. Whenever a Judge orders the placement of a minor without an interstate compact being in placed, DCFS Legal will remind the court of the penalty for illegal placement of children and the risk factors associated with such a placement. However, the ICPC does not apply to relatives or guardians of the minor. 45 ILCS 15/ 0.01 INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN ARTICLE IV. Penalty for Illegal Placement The sending, bringing, or causing to be sent or brought into any receiving state of a child in violation of the terms of this compact shall constitute a violation of the laws respecting the

		<p>placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit, or other legal authorization held by the sending agency which empowers or allows it to place, or care for children.</p> <p>ARTICLE VIII. Limitations This compact shall not apply to: (a) The sending or bringing of a child into a receiving state by his parent, step parent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or non agency guardian in the receiving state. (b) Any placement, sending or bringing of a child into a receiving state pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state are party, or to any other agreement between said states which has the force of law</p>
DCFS-13	<p>Team recommends that DCFS develop a protocol for return home that must be followed by workers prior to returning children home and after children are returned home. Team gave 9 items to be included.(see recommendation sheet)</p>	<p>DCFS agrees to explore development of protocol that must be followed by workers prior to returning children home and after children are returned home.</p>
DCFS-14	<p>Team recommends that DCFS develop guidelines for investigators for indicating or unfounding cases when a baby dies while bed sharing as well as guidelines for the hotline when calls are taken regarding a baby who dies while co-sleeping.</p>	<p>In addition to allegation 1 and 2, if there are surviving siblings in the home we would also be investigating allegation 10/60, risk of harm. It is important that DCP staff not just accept/rely on a coroner's report that finds the death to be accidental but look at Blatant disregard which is defined as incidents where the risk of harm to the child was so imminent and apparent that it is unlikely that a parent or caretaker would have exposed the child to such obvious danger without exercising precautionary measures to protect the child from harm.</p>
DCFS-15	<p>The team would like for DCFS to create a designated line for Coroner's only so that the request to have all Coroner's call the hotline on all</p>	<p>DCFS met with Coroners on 1/21/10. It was agreed that DCFS would make Coroner's calls to the hotline a priority and if a call back is needed they would be called back first.</p>

	deaths would be more feasible. During this call DCFS can notify Coroner's of any history with the Department on this family.	It was also agreed that the Exec Council would create a protocol for Coroners of types of deaths to call the hotline for. The Coroners will be able to obtain DCFS prior history with families at the time the death is called in. XX will speak at Coroner's Conference in the spring
DCFS-16	<p>1. The team requests a change in DCFS policy to include that when a ward of the state has a child and the ward is approaching a move into an independent living arrangement, DCFS must do an assessment on the safety and well-being of the ward's child. If risk is present the agency shall request from the SA a petition for wardship of the minor dependent.</p> <p>2. Once a DCFS ward has a child and moves into an independent living arrangement, DCFS must do another assessment on the safety and well-being of the wards child within 5 days after the move into an independent living arrangement and again at every 30 days until the case closes.</p>	We are working on the revised ILO/TLP policy where we will put language around the 2 recommendations outlined in the attachment. We have a goal of completing the draft by 9/11/09. We then will get it to Policy to post for the usual comment period. New Policy completed and given to CDRT Exec Council on 12/3/09.
DCFS-17	Team request that Southern IL Task Force be implemented as soon as possible.	DCFS agrees. The child death review contract for the Southern Il task force given to SIDS of IL.
DCFS-18	The team discussed the importance of educating caregivers on the risk of bottle propping. Team request that DCFS include the risk of bottle propping in Foster parent training, foster parent newsletter, DCFS licensed daycares and training with intact and investigators to educate families with infants.	<p>DCFS agrees. The issue of bottle propping is addressed specifically in the Day Care Home Standards, Part 406- specifically in the Day Care Home Standards, Part 406 - specifically 406.22 - d-2 and also in Day Care Centers, Part 407, specifically 407.210 f-24. Licensed day care homes and centers providers are alerted and aware of this issue, as the licensing standards prohibit bottle propping.</p> <p>We agree. An in-service training and a newsletter alert will be sent out for information sharing for all providers of infants and some toddlers who have difficulty swallowing due to a medical condition.</p> <p>This issue is not addressed in Part 402 foster home licensing standards but again it would be beneficial information sharing in an in-service training and/or newsletter</p>
DCFS-19	Team recommends that DCFS have	CDRT and SCR are working together to

	a protocol in place for Follow-up for investigation of what to do when they receive an information only report.	obtain final autopsy reports. Upon receipt of final autopsy results the information provided is reassessed to determine if legal criteria for investigation is met.
DCFS-20	<ol style="list-style-type: none"> 1. Team recommends that DCFS change camera protocol to include that DCFS intact and placement teams also be provided a digital camera for documentation purposes. 2. DCFS include in contract agreements with POS agencies that they must provide digital cameras to all intact and placement teams. 3. DCFS include in the contract with POS agencies that pictures must be taken once a week upon closure of environmental cases. 4. Team recommends that protocol wording state that there is a minimum of quarterly unannounced visits to the home on all open cases. 	<ol style="list-style-type: none"> 1. The Department at this time cannot afford to provide staff with cameras. 2. The Department at this time cannot afford to provide staff with cameras. 3. Just prior to a case closing, POS agencies have to complete a safety assessment which would cover environmental issues. 4. Procedures 302.388(f) (1) (A), Worker Family Contacts, should be amended to, "Following the assessment period, contact with the family shall occur at a minimum of twice per month. Unannounced visits with the family shall occur at a minimum of once per quarter."
DCFS-21	Team recommends that DCFS develop a protocol that list out circumstances for indicating investigations for children who die while bed sharing i.e. alcohol, drugs.	DCFS stated that they are working on modifying the allegation for Risk. DCFS agrees to share these changes made with the Exec Council. Exec Council agreed that this case can be completed once they see the changes made.
OS-1	Team recommends that DCFS work with the Coroner Association to request that Coroners call in deaths of all children under the age of 18.	DCFS agrees. A letter will be written to the Coroner's Association requesting that they report all deaths of all children less than 18 years of age to the DCFS hotline.
DCFS – 22	Team recommends that DCFS support an effort by the Office of Inspector General and the Child Death Review Teams to develop a program for parenting wards that will focus on lowering mortality rates especially homicide rates among wards' children.	DCFS disagrees with the recommendation. DCFS believes that this is a general public problem and not just a problem for children of wards. CDRT agreed to work with OIG regarding the TBSN Program.
PP – 1	Team request that the Domestic Violence brochures distributed to the jail, WIC Offices, Human Services and Physicians for education	DCFS disagrees with the recommendation. DCFS and CDRT agreed that brochures are not effective with today's youth. The media target for youth is text messages, face book etc.