



# Child Deaths in Illinois 2011

Illinois Child Death  
Review Teams 2013  
A Partnership for Protecting Children

In cooperation with

Illinois Department of  
**DCFS**  
Children & Family Services

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

**ANNUAL REPORT ON CHILD DEATHS  
THAT OCCURRED IN CALENDAR YEAR 2011**

MISSION

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

SUBMITTED TO:

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

**JUNE 2013**

# Illinois Child Death Review Teams

Daniel J. Cuneo, Ph.D. – Chairperson

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April 2013

The Honorable Pat Quinn, Governor of the State of Illinois:  
The Honorable Members of the 98<sup>th</sup> General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2011. 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 involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

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

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

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

Lastly, we thank Governor 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

Dear Readers,

I am honored to present the 2013 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 calendar year 2011. During that time, 1,551 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 (CDRT) play an important role in the effort to reduce preventable child deaths. Since 1994, CDRT and the CDRT Executive Council have made hundreds of recommendations to the Department of Children and Family Services. As Director, I take these recommendations very seriously. I meet regularly with the Child Death Review Teams Executive Council to discuss the recommendations and how we can work together to more effectively serve and protect children in Illinois.

The child death review process is an example of all of us sharing the responsibility of advocating for children and working together to keep them safe. This process would not be possible without the commitment and support of hundreds of caring professionals across the state who volunteer their time and expertise to case review and discussions of prevention strategies to reduce child injury and death. I thank the CDRT for their efforts and look forward to continue working with these dedicated individuals in the future.

Sincerely,



Richard H. Calica  
Director

Illinois Department of Children and Family Services

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## **ACKNOWLEDGEMENTS**

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 Team Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

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

Illinois Child Death Review Teams Staff, Sherry Barr, Tamara Skube, and Bernadette Emery provided the data analyses from the Child Death Review Team database to Dr. Jill Schreiber. Dr. Schreiber and Dr. Saijun Zhang, Research Specialists for the Children and Family Research Center, wrote the report.

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# EXECUTIVE SUMMARY

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

## Illinois Child Deaths in 2011

In 2011, 1,551 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 2011:<sup>1</sup>

- 58% were boys and 41% were girls;
- 62% were infants under one year, 11% were young children between 1 and 4 years, 13% were older children between 5 and 14 years, and 15% were youth between 15 and 17 years.

When Illinois child deaths in 2011 were examined by the manner of death:

- 71% were attributable to natural causes;
- 12% were accidental;
- 8% were homicides;
- 3% were suicides;
- 6% were undetermined.

When deaths occurring in 2011 were examined by the category of death:

- 38% were related to illness;
- 31% were related to premature birth;
- 2% were related to Sudden Infant Death Syndrome (SIDS) and 2% were related to other types of sudden unexpected infant deaths;
- 24% were related to various types of injuries, such as vehicular accidents (6%), firearms (5%), drowning (2%), fires (1%), suffocations (7%), and other types of injuries (3%);
- 2% were due to undetermined causes.

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<sup>11</sup> Note that data on the race of the decedents was missing in a large portion of the cases and was unable to be analyzed for 2011. This problem has been remedied and data for 2012 should include race.

## 2011 Child Deaths Reviewed by the CDRTs

In 2011, 177 child deaths were reviewed by the CDRTs, including 160 mandatory and 17 discretionary reviews. The reviews were mandated for one of several reasons, including 85 where death was indicated, 14 for indicated reports, 32 had an investigation in the year before the child's death, 25 had an open case at time of death, and 4 had a pending investigation at the time of death.

Reviewed Deaths occurred in all CDRT regions (see Appendix A for map of region):

- Aurora – 26 of the 203 deaths (13%) were reviewed.
- Champaign – 19 of the 98 (19%) were reviewed.
- Cook – 64 of the 858 (7%) were reviewed.
- East St. Louis – 12 of the 77 deaths (16%) were reviewed.
- Marion – 15 of the 61 deaths (25%) were reviewed.
- Peoria – 20 of the 121 deaths (17%) were reviewed.
- Rockford – 13 of the 74 deaths (18%) were reviewed.
- Springfield – 10 of the 59 deaths (17%) were reviewed.

Of the deaths reviewed by CDRTs in 2011:

- 60% were boys and 40% were girls;
- 53% were infants under one, 25% were young children between one and four years, 14% were older children between 5 and 14 years, and 9% were youth between 15 and 17 years.

When reviewed deaths occurring in 2011 were examined by manner of death:

- 29% were attributed to natural causes;
- 23% were due to accidents;
- 27% were homicides;
- 4% were suicides;
- 18% were undetermined.

When reviewed deaths occurring in 2011 were examined by category of death:

- 16% were related to illness;
- 6% were related to premature birth;
- 6% were related to Sudden Infant Death Syndrome (SIDS) and 5% were other types of unexpected infant deaths;
- 54% were related to various types of injuries, such as suffocations (19%), injuries (18%); vehicular accidents (6%), drowning (6%), firearms (3%), fires (2%), and poisoning/overdose (1%);
- 9% were due to undetermined causes.

## Recommendation Highlights

The CDRT made several recommendations after reviewing the deaths. For a full list of all recommendations, see Chapter 2. The most important of these recommendations as determined by the Executive Board:

1. Team would like for a risk assessment to be done by DCFS after a foster child's psychiatric hospitalization to determine if the foster parent has the capability and desire to continue to care for the child. Psychiatric information regarding foster children should be verified by third party sources and not rely only on the foster parent's information.
2. Team recommends that DCFS implement the policy that was previously agreed to by the Department to indicate unsafe sleep deaths for allegation 60 when it can be proven that the parents/caregiver was educated on safe sleeping arrangements and they have chosen not to follow the recommendation and to indicate for allegation 51 when drugs or alcohol is involved.
3. The team recognizes there are many experienced DCP investigators who understand the critical questions that must be asked of primary care physicians in abuse and neglect investigations. The team recommends that DCFS utilize their experience and input to create a list of questions that should be posed to primary care physicians during investigations that could be a resource to less experienced DCP investigators.
4. Team would like for DCFS to modify the wording of Allegation 21 sexual molestation to read: Sexual molestation is sexual conduct with a child when the contact, touching or interaction is used for arousal or gratification of sexual needs or desires. Arousal and gratification of sexual need may be inferred from the act itself and surrounding circumstances. The absence of evidence of arousal or gratification should in no way preclude a full investigation into the matter. Parts of the body, as used in the example below, refer to the parts of the body described in the definition of sexual conduct found in the Illinois Criminal Sexual Assault Act (720 ILCS 5/12-12) as quoted above under Allegation 18, Sexually Transmitted Diseases. Examples include, but are not limited to:
  - A) DCFS should update sexual abuse training and train all investigative staff and supervisors;
  - B) All investigators investigating sexual abuse cases should be mandated to consult with DCFS specialized teams and/or CAC

# INTRODUCTION

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations, and safety policies that have led to a decline in infant and child mortality, too many Illinois children are still dying. In 2011 there were 1,551 child deaths. 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 understanding of how we can make Illinois a safer and healthier state for children.

# Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998 and more recently by P.A. 95-0405 on August 24, 2007 and P.A. 95-0527 on August 28, 2007. It is available online at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=244&ChapterID=5>. 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 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 A.

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 of the department,
- State's attorney or state's attorney's representative,
- Representative of a local law enforcement agency,
- Psychologist or psychiatrist,
- Representative of a local health department,
- Representative of a school district or other education or child care interests,
- Coroner or forensic pathologist,
- Representative of a child welfare agency or child advocacy organization,
- Representative of a local hospital, trauma center, or provider of emergency medical services, 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. For a list of all members of regional CDRT teams, see Appendix B.

## **Child Death Review Team Executive Council**

The CDRT Executive Council is the coordinating and oversight body for child death review activities in Illinois. It consists of the chairpersons and vice-chairpersons of each of the nine CDRTs. The Executive Council meets 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:

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

During 2012, The Illinois Child Death Review Teams (CDRT) accomplished several goals including the following:

- In collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign, the Illinois Child Death Review Teams Annual Report for 2011 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.
- Illinois updated the Illinois Child Death Review Teams Protocol and Best Practices for the Multidisciplinary Review of Child Deaths in January 2012.
- The 16<sup>th</sup> Annual Child Death Review Teams Symposium was held April 12-13, 2012 at the Marriott in Bloomington. The presentations included: 1) Project Skipper by Karen Kaiser; 2) DCFS Investigations: Allegations 1, 11, 16, 51, and 60 by Lori Gray, Public Service Administrator, Anganetta Terry, Child Protection Advanced Specialist, Marnita Martin-Harris, Public Service Administrator, Angela Scott-Watkins, Child Protection Advanced Specialist, Nancy West, Child Protection Supervisor, Stevie Jackson, Child Protection Investigator, Tara Gilman, Public Service Administrator, Barbara Traylor, Child Protection Advanced Specialist; 3) Abusive Head Trauma: The Controversies, the Realities, and Bumblebees by Jill Glick, M.D., Associate Professor University of Chicago, Medical Director, Child Protective Services, Comer Children's Hospital; 4) Children Exposed to Domestic Violence by Roger Canaff, JD. The symposium was well attended with over 100 members present.

## **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 Multidisciplinary 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 the objectives stated below:

- 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.
- 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.

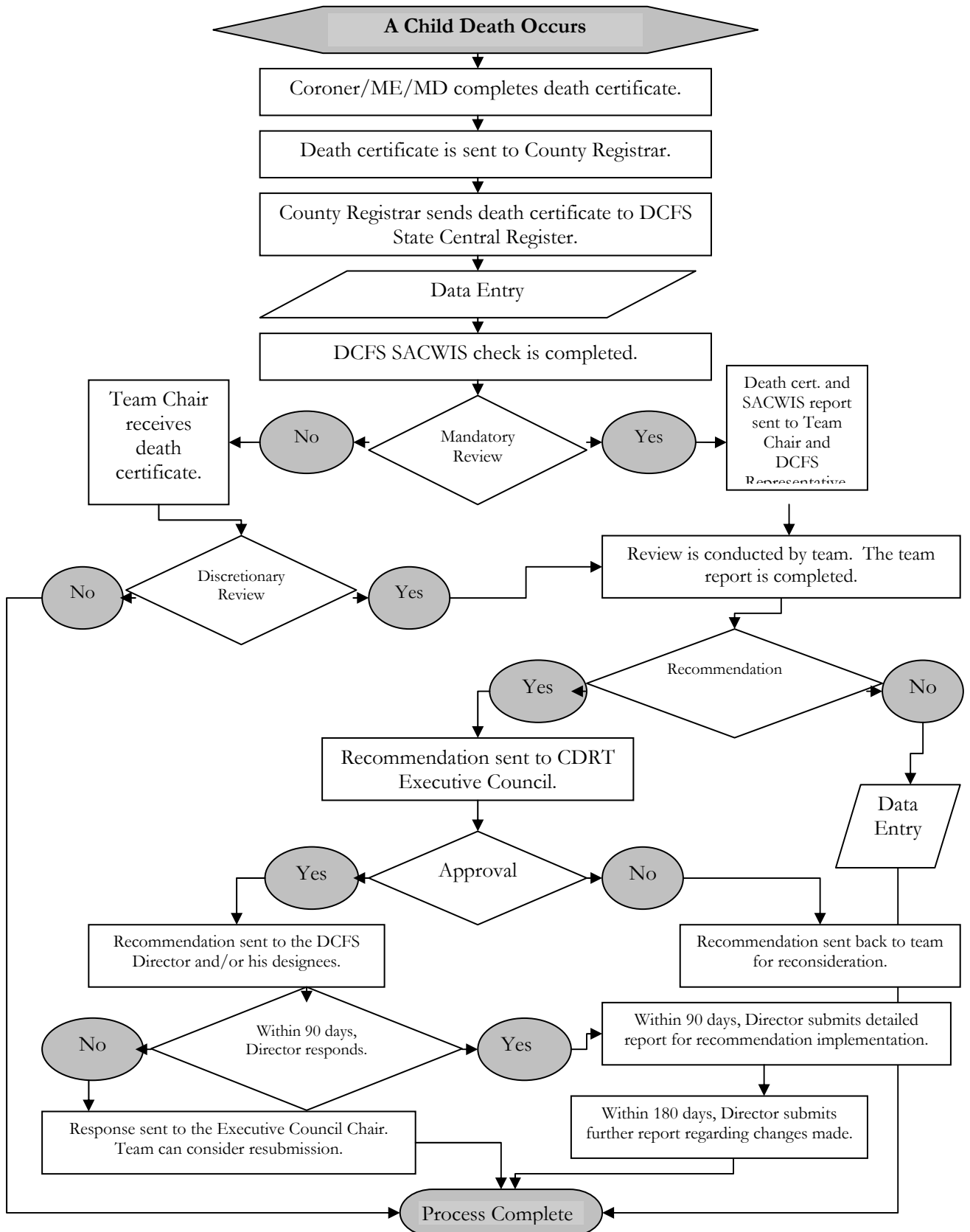
Other responsibilities of the CDRT are to:

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

The Child Death Review Team process is outlined in a flow chart in Figure 1.

# Child Death Review Procedures

Figure 1. The Child Death Review Process in Illinois.

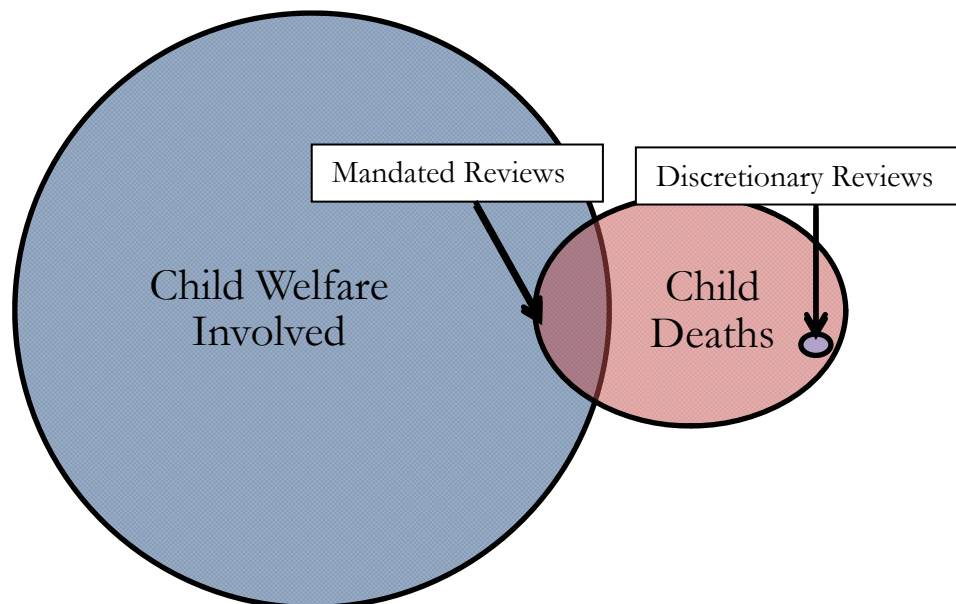


After a child's (age 17 or younger) death occurs, a coroner, medical examiner, or other physician/pathologist completes the death certificate. At this point, the county registrars are required by the Illinois Vital Records Act to send a copy of the death certificate to the DCFS State Central Register (SCR)<sup>2</sup>. 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 to 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 (Figure 2). Specifically, CDRTs are required to review the deaths of all children aged 17 or younger if the deceased child was:

- a ward of DCFS,
- a non-ward, when death occurs in a licensed foster home,
- the subject of an open DCFS service case,
- the subject of a pending child abuse or neglect investigation,
- the subject of an abuse or neglect investigation during the preceding 12 months, and/or
- any other child whose death is reported to DCFS's State Central Register as the result of indicated child abuse or neglect.

Figure 2. Child Death Reviews



<sup>2</sup> See section 8 of Act online at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1573&ChapterID=35>

CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18, as well as cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.<sup>3</sup> These reviews are called discretionary reviews (Figure 2).

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 team report form is 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.

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

After the CDRT report form is completed, it is sent back to DCFS for entry into the CDRT database. All recommendations are sent to the Executive Council for approval and then approved recommendations are sent to the Office of Inspector General and 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

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<sup>3</sup> 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 2011.

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: Child Death Review Recommendations to Prevent Child Deaths

The purpose of CDRT recommendations is to prevent or reduce future child fatalities through reasonable means. The importance of CDRT recommendations – and their potential for preventing future child deaths – cannot be overstated. The 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, firearm safety, seat belt/car seat campaigns)
- DCFS system – focus on the programs, policies, and procedures of DCFS (e.g., safety and risk assessment, foster parent training)
- Other agency/system – focus on agencies or systems outside the parameter of DCFS (e.g. public health, state’s attorney’s office)

There were 28 system recommendations made by the CDRTs on deaths occurring in 2011 (See Table 1). The majority of the recommendations (26) focused on DCFS policy and procedures. The DCFS recommendations resulted from all types of reviews including: death indicated (7), discretionary reviews (7), open cases (5), investigated in the year before death (4), indicated report at time of death (2) and pending investigation (1). There were 2 recommendations for other systems and no primary prevention recommendations on deaths occurring in 2011.

There were 18 case specific recommendations in 2011. In previous reports case specific recommendations were not included in order to protect confidentiality. This year the identifying information was redacted and the case specific recommendations were added to the list of recommendations. Eight of the case specific recommendations resulted from cases where death was indicated and 8 were from the cases that had an investigation in the year before the death. Two of the case specific recommendations were from discretionary reviews.

Key:

PP = Primary Prevention recommendation

DCFS = DCFS recommendation

OS = Other System recommendation

Table 1. 2011 Recommendations and Responses

Number	CDRT Recommendation	DCFS Response
DCFS-1	Team recommends that DCFS build onto what is already in place for medically complex children ensuring that this is practicable and feasible for all areas of the state and not just Cook County.	DCFS agrees to look at the hotline protocol for medically complex children and parents/caregivers ability to care for them and will examine what hotline uses as screens to alert high risk case. These cases can be referred to the Division of Specialized Care for Children.
DCFS-2	The team recommends that DCFS revise the SACWIS system to include a type of flag to alert SACWIS users when an individual is in the process of applying for a daycare license, or has applied for a daycare license at any time, even if the individual withdrew from the process or was denied the license.	DCFS disagrees. DCFS does not believe that having this in SACWIS will make any difference and it will not help the investigator. DCFS believes that the prevention piece is to keep parents from using unlicensed daycares. DCFS questioned their regulatory services. Question was asked: Does licensing have tracking/monitoring when someone applies for license and pulls request? Is there a way to check to see if they are still watching children? DCFS stated that they should have turned over to the Attorney General and let licensing know in place of just telling them to get a license. DCFS agreed to send out reminder to staff.
DCFS-3	Team recommends that DCFS provide Interview training for DCFS and POS initial responders both at initial DCFS training and annual refresher training in developmentally appropriate interviewing.	DCFS disagrees. DCFS will not retrain yearly. DCFS already does training in interviewing but the Department agrees to look at the training that is in place and determine if it is adequate.
DCFS-4	Team would like DCFS to consider doing higher level of monitoring for first time placement foster parents.	DCFS disagrees with a higher level of monitoring for first time foster parents. The Director discussed that DCFS is in the process of revamping many things in the Dept.
DCFS-5	Team recommends that all deaths of DCFS wards that are unexpected deaths be investigated by DCFS, even those that are	DCFS is already mandated by law and OIG by rule to do investigations for deaths of

	not suspected neglect or abuse.	wards. Rule 430.30
DCFS-6	Team would like DCFS to do a risk assessment after a foster child's psychiatric hospitalization to determine if the foster parent has the capability and desire to continue to care for the child.	Director said the Dept. should look at the process of discharge planning. The Department should look at what the needs of the children are and ask the question, Can this parent handle the situation? The Dept. is not disagreeing but will not develop another form and will not do a risk assessment. Director agreed that common sense should be used when returning the child where they came from when the likelihood of staying is low. DCFS agreed that clinical would take a look at foster care and begin to collect stats.
DCFS-7	Team requests that DCFS send out the Get Water Wise Supervise drowning prevention campaign materials out to all licensed day care providers every May along with a cover letter that reminds providers of the regulation regarding water safety.	DCFS will look into how to do this. Discussed whether a website could be utilized along with certification and re-certification.
DCFS-8	Psychiatric Information regarding foster children should be verified by third-party sources, and investigators should not rely only on the foster parent's information.	DCFS agrees and will look at a system-wide general rule.
DCFS-9	Team would like to make the same recommendation as other teams have made on Safe Sleep.	No response at this time.
DCFS-10	When DCFS investigates the death of a child and there is a child in the home under 2 years of age, a thorough physical examination should be performed and imaging for occult injuries (including skeletal survey and neuroimaging) should be considered within the first 48 hours of initiating the investigation. Medical providers should be informed of the circumstances of the death of the sibling child as this may guide the medical evaluation.	DCFS agrees to check with the DCFS legal division on whether this can be completed.
DCFS-11	Team recommends that DCFS strive to improve the communications among the Department Investigators and Case Workers and Law Enforcement Agencies, especially during DCP investigations. Interagency information sharing is	DCFS agrees. Clinical will do this.

	invaluable to multi-disciplinary case investigations involving child deaths.	
DCFS-12	Team recommends DCFS reinforce its policy that when the DCFS safety plan includes Guardianship being pursued through the probate court, workers make a timely referral to Extended Family Services.	DCFS agrees.
DCFS-13	Team felt contacting primary and other physicians involved in a child case is critical to a thorough investigation and therefore should not be allowed to be waived.	DCFS agrees.
DCFS-14	When a case is indicated for medical neglect and referred to intact services, follow up must include documentation of medical visits. A calendar of necessary appointments should be kept and follow-up to ensure appointments were kept.	DCFS agrees.
DCFS-15	Team recommends DCFS take steps to re-enforce requirements of checking IDs.	DCFS agrees with this recommendation.
DCFS-16	Team recommends DCFS re-establish protocols to facilitate better communication between law enforcement and DCFS.	Director stated that the Department is attempting to have better communication with police but that this had nothing to do with the death of this child. This child was in the hospital at the time of death. Director did agree to look into ICLEAR. Director agreed to discuss this with CPD.
DCFS-17	On cases of any allegation of neglect on children ages 0-5 years of age, DCFS should ensure that the primary care physician is contacted regarding the care of the child. If no primary care physician is identified, DCFS investigator will secure a medical exam for the child.	DCFS will take this into consideration. There was discussion that it may take doctors a long time to get back with the investigator and may hold the case from being closed. There are different kinds of neglect. It was discussed that this may be more workable for infants than for ages 0-5.

DCFS-18	Team would like DCFS to modify the wording of Allegation 21 sexual molestation to read: Sexual molestation is sexual conduct with a child when the contact, touching or interaction is used for arousal or gratification of sexual needs or desires. Arousal and gratification of sexual need may be inferred from the act itself and surrounding circumstances. The absence of evidence of arousal or gratification should in no way preclude a full investigation into the matter. Parts of the body, as used in the example below, refer to the parts of the body described in the definition of sexual conduct found in the Illinois Criminal Sexual Assault Act (720 ILCS 5/12-12) as quoted under Allegation 18, Sexually Transmitted Diseases.	Director agreed to talk to DCFS attorneys and look at modifying the wording.
DCFS-19	Team would like DCFS to reaffirm that in the DCP investigation process, all mental health records be obtained. It is also recommended that verification of any DSM IV diagnoses including ADHD, if mentioned, be verified by documentation from the mental health provider.	The Director said that the greater issue is what is DCFS protocol? The Director agreed to get back to Council regarding what DCFS protocol is when the perpetrator is a child. This will stay on recommendation to be answered section until it is determined what DCFS protocol is. Director said he would check with Legal and Policy to find out if we have policy.
DCFS-20	DCFS should update sexual abuse training and train all investigative staff and supervisors.	DCFS is in the process of changing many things in the Department and staff will be trained. The Director said they will not do state-wide training on one issue.
DCFS-21	All investigators investigating sexual abuse cases should be mandated to consult with specialized teams and/or CAC.	Director agreed to look at the current policy and if revision is needed.
DCFS-22	Team recommends that DCFS send out safe sleep brochures again. Team would like DCFS to send brochures to University of Illinois & Southern Illinois University Pediatric residency programs. The team would like DCFS to work with DHS and IDPH and local health departments to educate on safe sleep.	DCFS agrees to send out safe sleep brochures to University of Illinois & Southern Illinois University Pediatric Residency programs and to work with DHS and IDPH and local health departments to educate on safe sleep. DCFS also agrees to look

		at the Public Service Announcement for safe sleep.
DCFS-23	Team recommends that if the OIG is not already handling these issues, the team would like DCFS to look at the system to find out if the failure of the previous investigator and supervisor in this case is an isolated problem or is it a system problem (case load, training, etc.) and is it just in this region or is it state-wide problem.	DCFS agrees.
DCFS-24	Team recommends that DCFS provide Interview training for DCFS and POS initial responders both at initial DCFS training and annual refresher.	DCFS disagrees. DCFS will not retrain yearly. DCFS already does training in interviewing but the Department agrees to look at the training that is in place and determine if it is adequate training.
DCFS-25	Team would like to re-visit a previous CDRT recommendation that DCFS have a protocol in place for consistent findings for unsafe sleeping conditions where DCFS previously agreed to indicate for allegation 60 when it was documented that the parents/caregivers have been told of the safety hazards of unsafe sleeping and allegation 51 when the parents/caregiver have been drinking or using drugs.	DCFS is re-writing procedure 300 and will include what will be indicated.
DCFS-26	The differential response records that are not accessible should be made accessible to a DCFS investigator when a subsequent investigation comes in regarding the family.	DCFS no longer employs differential response.
OS-1	The Exec Council recommends that the Dept of Human Services promulgate rules related to licensing of substance abuse treatment facilities and halfway houses to ensure that infants under 1 year of age sleep in a safe sleep environment; alone, in their own sleeping space with no other people in the crib or bassinet; on their backs on a firm sleep surface; and in a crib or bassinet free of pillows, blankets, bumpers, sleep positioners, and other objects, as recommended by the National Institute of Child Health and Human Development; and further, that staff at these facilities and halfway houses are required to visually confirm at regular intervals that these safe	No response necessary.

	sleep requirements are being met whenever an infant under one year of age is present.	
OS-2	The team recommends that the CCME office and the DCFS head of the hotline have a teleconference to discuss CCME calling the hotline back on cases when CCME first told the hotline that it was not suspicious of neglect or abuse and after autopsy discovered that it was abuse or neglect.	DCFS agreed to hold a teleconference between the manager of the hotline and the CCME office. The teleconference was held on February 5th. CCME office agreed to call back on cases when they first told the hotline that it was not suspicious of neglect or abuse and after autopsy discovered that it was abuse or neglect.
CS-1	Team would like DCFS to use this case as a case study since no one talked to anyone else to see if child exhibited behavior problems.	DCFS agreed and will talk to training.
CS-2	Team would like DCFS to look at this case and how they are looking at TA supervisors. In this case, the TA supervisor was both supervisor and investigator. When supervisor came back, she had a large stack and signed off on the case. In course of investigation in children ages 0-6, investigator should qualify what seeing the child includes and this should include an unclothed physical exam.	DCFS re-staffed protective services and made an 80% improvement. 173 protective service staff will be hired. DCFS agrees.
CS-3	The team wants a letter to go to a POS Agency letting them know the seriousness of bruising in infants. If infants are not bruising they should not have bruising. POS agency personnel should be reminded that they are mandated reporters of suspicion of abuse.	No DCFS response required.
CS-4	Team would like DCFS to change the allegation of 60 from unfounded to indicated.	DCFS cannot do this. They did agree to talk to workers and supervisors and conduct training for all investigative staff on death cases on when to indicate and when to unfound cases.
CS-5	Team would like DCFS to look at this case and how POS agency handled the case.	DCFS agrees.
CS-6	Team would like a commendation letter to go to the investigator and supervisor of the death investigation.	No response needed from DCFS.
CS-7	Team would like a letter of praise to go out	No DCFS response required.

	to this POS Agency for the good job that they did on this case.	
CS-8	A commendation letter should go to the Task Force for a job well done and thank the Task Force for their coordination of this case. Their coordination allowed the most accurate data available to be reviewed by CDRT. Council decided this should come from State's Attorney in that County.	No DCFS response necessary.
CS-9	Team recommends that DCFS Administration see that this Manager and Supervisor are trained in allegation 60, substantial risk of physical injury-neglect, and allegation 51, death by neglect, and the circumstances that these allegations should be used. The team was concerned about the Manager and Supervisor choosing to indicate allegation 60 over allegation 51 in this case.	DCFS agrees. DCFS administration will see that this Manager and Supervisor are trained in allegations 60 and 51 and under what circumstances these allegations should be used.
CS-10	Team requests that the supervisor and manager on this case look at this interview and how it was handled.	DCFS agrees. DCFS will look at this case and how it was handled.
CS-11	Team would like to request that intact manager look at this case. Team wants another level of monitoring.	DCFS agrees. DCFS will have a staffing on this case. The RA will be informed.
CS-12	Team would like DCFS to review this case and how it was handled. Team is concerned that this case was not referred to intact. Team also concerned about the investigative report having personal feelings in place of being objective.	DCFS agrees and will look at this case and how it was handled.
CS-13	Team recommended that this death be called into the hotline. At time of review, DCFS had not investigated the death.	No DCFS response required. This case was called into the hotline and was taken as an investigation after the CDRT meeting. This death was indicated for allegation 51.
CS-14	Due to this child's medical complexity, the team would like DCFS to look at this case and how it was handled due to neither the primary physician nor any other physicians involved in the child case being contacted. The supervisor gave a waiver for the investigation to be closed without these contacts.	DCFS agrees.
CS-15	Team concerned that on this case, assumptions were possibly made by DCFS based on the fact that the ME's office found this to be accidental.	DCFS agrees.

CS-16	Intact supervisor contacted to ensure mom is being counseled about Domestic Violence and the fact that father will be out of jail in a short time and may be looking for her and ensuring order of protection. Screen 5 year old for risk.	DCFS agrees.
CS-17	Team requests that DCFS look at this case. Team is concerned that Mom was indicated for death by abuse and for broken bones and the 5-year-old child is still with her and DCFS was not willing to take this to screening.	DCFS agrees. They will do a staffing on this case and will have clinical report on the case.
CS-18	This case was not thoroughly investigated. The investigator on the case was not prepared for the meeting and was unable to answer any questions or clearly recollect any information about the case. The team recommends that the case be reviewed by DCFS management. There is a great concern regarding the quality of the investigation and documentation.	DCFS agrees to look at this case and how it was handled.

## Chapter 3: Illinois Child Deaths in 2011

What do we know about the child deaths that occurred in Illinois during 2011?

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 population 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 has historically based its analysis on the total child deaths reported to DCFS by county registrars and coroners. Although all deaths certificates were required by law to be submitted to DCFS, not all counties complied with this requirement, so the number of child deaths reported to DCFS was 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. Midway through the 2010 year, DCFS started receiving death certificates in an electronic format from the Illinois Department of Public Health. This new method of gathering data should improve the accuracy of the overall child death counts. However, having more complete data could also affect the trends. It is possible that increases between 2009 and 2011 could be due to the new way of accessing data rather than actual increases in deaths. Note that calendar Year 2011, the focus of the current report, is the first year that all the data is from the new method of getting death certificates.

The third group includes child deaths reviewed by the CDRTs. The majority (90% in 2011) of reviewed deaths are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children in child welfare in Illinois is more likely to be younger and African-American than the total child population in Illinois. It is, therefore, likely that deaths reviewed by the CDRTs may over-represent these two characteristics. In order to compare the norms of 1) the total population of children, 2) the population of total child deaths, and 3) the child deaths that were reviewed by the CDRTs, these data are presented side by side throughout this report.

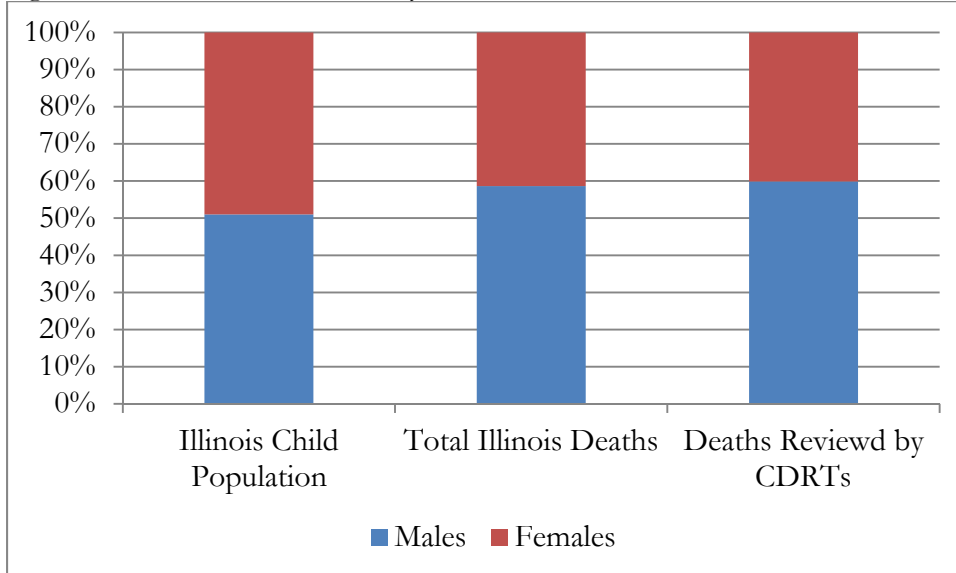
With this information in mind, the following provides a brief look at the three groups:

- The population of Illinois children was based on the 2010 Census. According to Census 2010 data, there were approximately 3.13 million children under the age of 18 in Illinois, which constitutes about 24.4% of the total Illinois population.
- In 2011, there were 1,551 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.
- There were 177 child deaths that occurred in 2011 that were reviewed by the CDRTs – 160 of these were mandated for review and 17 were discretionary reviews. Discretionary reviews included 2 or 3 cases in the following categories: illness, injury, SIDS, suffocation, unknown/unexplained infant deaths, and 6 cases where the cause was undetermined.

## Child Deaths by Gender

According to information from the 2010 Census, 51% of the Illinois child population is male and 49% is female. However, boys are more likely to die than girls: boys made up 58% of child deaths and 60% of reviewed deaths in 2011 (Figure 3).

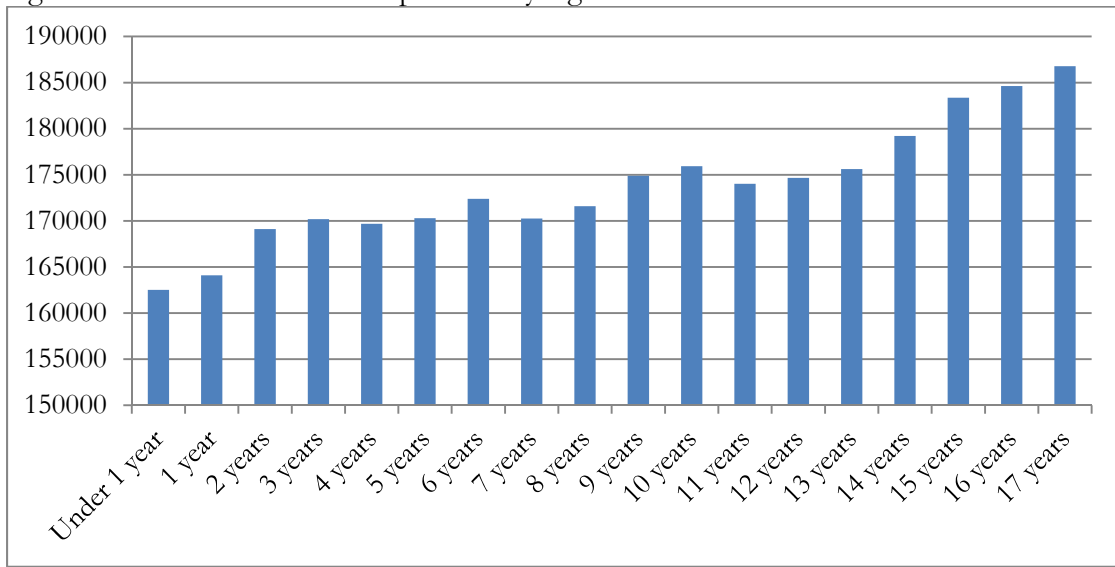
Figure 3. Illinois Child Deaths by Gender



## Child Deaths by Age

In 2010, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 3.13 million children in Illinois under 18 years, 5% are less than one year of age, 22% are between 1 and 4 years, 27% are between 5 and 9 years, 28% are between 10 and 14 years, and 18% are between 15 and 17 years.<sup>4</sup>

Figure 4. Illinois 2010 Child Population by Age

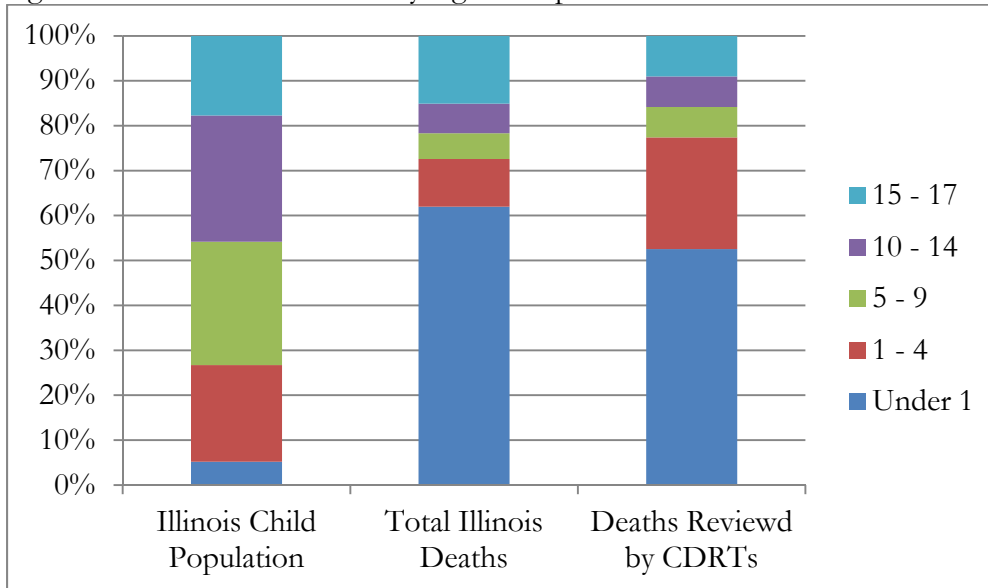


However, when the total Illinois child deaths reported to DCFS are examined by age (Figure 5), it becomes clear that infants less than one year old are especially vulnerable – 62% of the total deaths in 2011 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Older children are less likely to die; in 2011 11% of the total deaths were children between 1 and 4 years, 6% were children between 5 and 9 years, 7% were children between 10 and 14 years, and 15% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group (Figure 5), infants under one year are again over-represented; they comprised 53% of reviewed deaths in 2011. Children between 1 and 4 years made up 25% of reviewed deaths in 2011. Older children make up a smaller portion of reviewed deaths, 7% of reviewed deaths were 5 to 9 years old, 7% of reviewed deaths were aged 10 to 14, and 9% of reviewed deaths were for children aged 15 to 17.

<sup>4</sup> U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from [http:// www. factfinder2.census.gov](http://www.factfinder2.census.gov).

Figure 5. Illinois Child Deaths by Age Group



## Child Deaths by Race

Earlier reports have included analysis of child deaths by child race. However, due to a new online reporting system, race was not recorded for a large portion of the deaths that occurred between 2009 and 2011. This problem has been corrected and information on child race will be included in future reports.

In previous reports, African-American children were at increased risk of death when compared to their numbers in the general population. Conversely, deaths among Hispanic children were infrequent compared to their numbers in the general population. The portion of deaths among Caucasian children was roughly equivalent to their proportion in the general child population.

## Child Deaths by Category

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and “other” deaths. Three new categories were added in 2007: scalding burn, sudden unexplained infant death which is now called unknown/unexplained infant death and sudden unexplained child death (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 2011 are shown in Table 2.<sup>5</sup> The majority of total child deaths were related to either illness (38%) or premature birth (31%). The other categories accounted for the remaining 31% of the total child deaths and included suffocation (7%), vehicular accidents (6%), firearms (5%), injuries (3%), SIDS (2%), drowning (2%), fire (1%), and poisoning/overdose (1%).

Table 2. Child Deaths by Category of Death

	Total Deaths*		Reviewed Deaths	
	N	percent	N	percent
Illness	582	38%	29	16%
Prematurity	479	31%	11	6%
Suffocation	101	7%	34	19%
Vehicular	89	6%	11	6%
Firearms	84	5%	6	3%
Injury	46	3%	31	18%
SIDS	35	2%	10	6%
Undetermined	33	2%	16	9%
SUID	28	2%	9	5%
Drowning	27	2%	11	6%
Fire	19	1%	3	2%
Poison/Overdose	18	1%	2	1%
Other	5	<1%	4	2%
SUCD	4	<1%	0	0%
Total	1550		177	

\* There was 1 “pending” death in 2011 at the time of this report. There were no deaths due to scalding burns in 2011.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 2). In 2011, deaths reviewed by CDRTs were most likely to be related to suffocation (19%), injury (18%), and illness (16%). A detailed analysis of all the categories of deaths is included in chapter 3 of this report.

## Child Deaths by Manner

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

<sup>5</sup> 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.

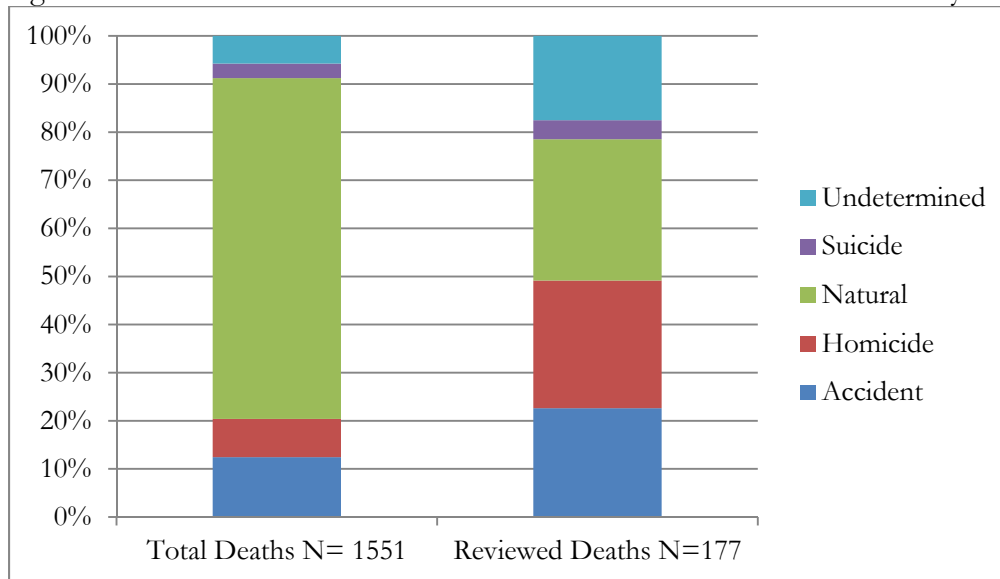
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death
- Suicide – the death was the result of an intentional, self-inflicted act committed to do self-harm or death
- Undetermined – information pointing to one manner of death is no more compelling than one or more other competing manners of death when all available information is considered

The majority of total child deaths were attributable to natural causes (71%). Accidents accounted for 12% of the total child deaths, 8% were homicides, 3% were suicides, and 6% 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 (See Table 3 and Figure 6) .

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

	Total Deaths		Reviewed Deaths	
	N	Percent	N	Percent
Accident	193	12%	40	23%
Homicide	123	8%	47	27%
Natural	1099	71%	52	29%
Suicide	47	3%	7	4%
Undetermined	89	6%	31	18%
Total	1551		177	

Figure 6. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs



Although there are a higher percentage of males in all manners of deaths, they constitute the highest proportion of Suicides (79%) and Homicides (72%). See Figure 7. Males also make up the majority of all manners of reviewed deaths, but the proportions are smaller. For example, of the suicides that were reviewed, only 57% were male and of the homicides that were reviewed, only 51% were male (Figure 8).

Figure 7. Total Deaths – Manner of Death by Gender

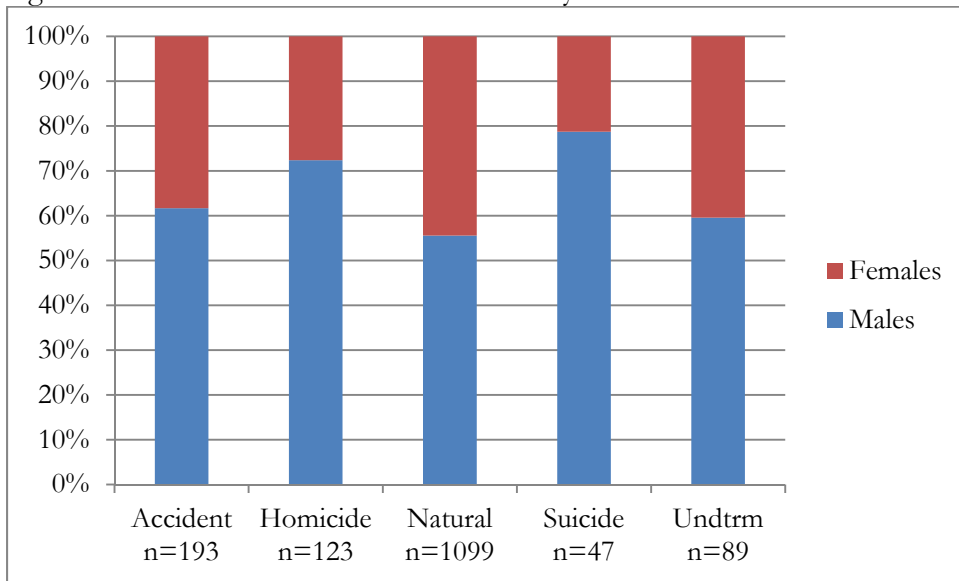
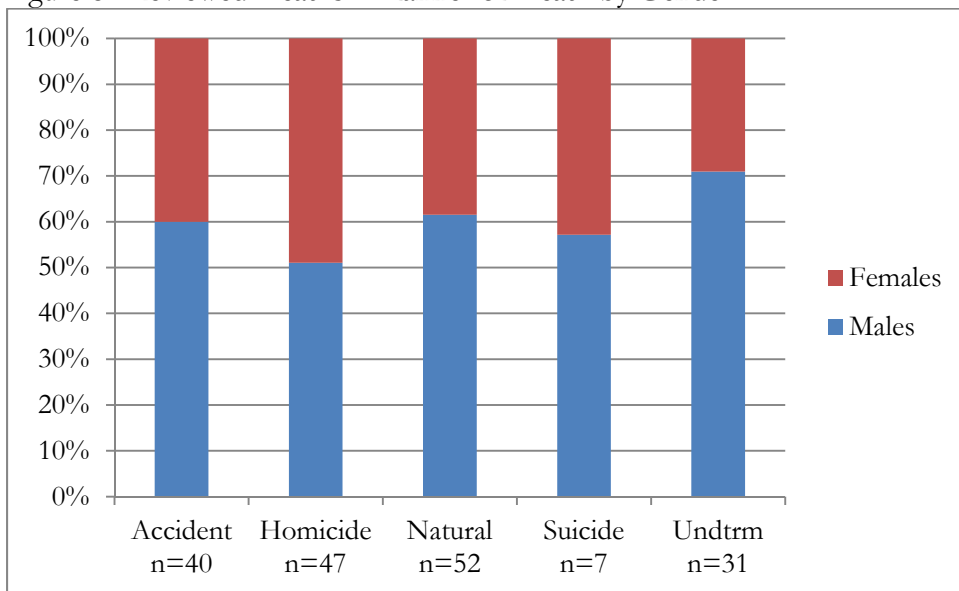
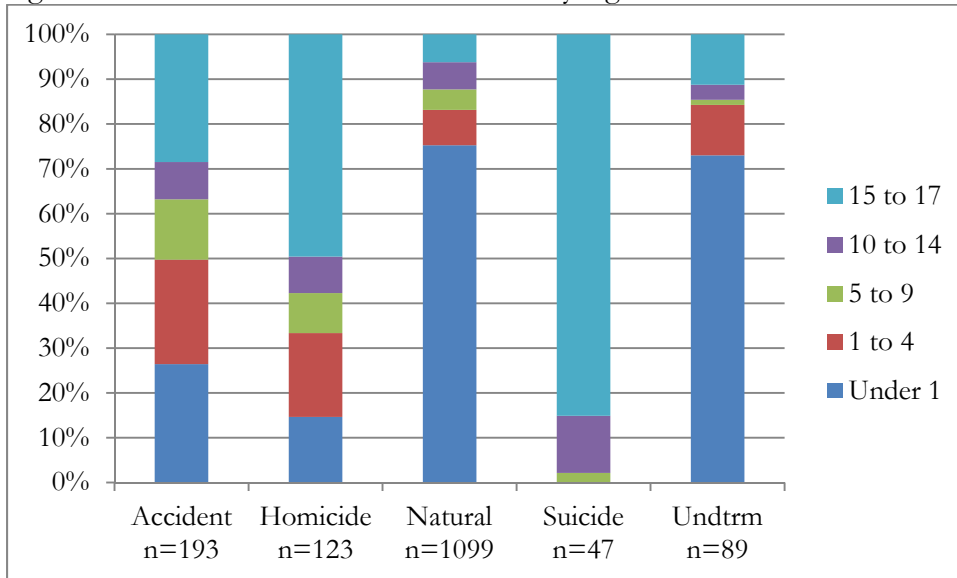


Figure 8. Reviewed Deaths – Manner of Death by Gender



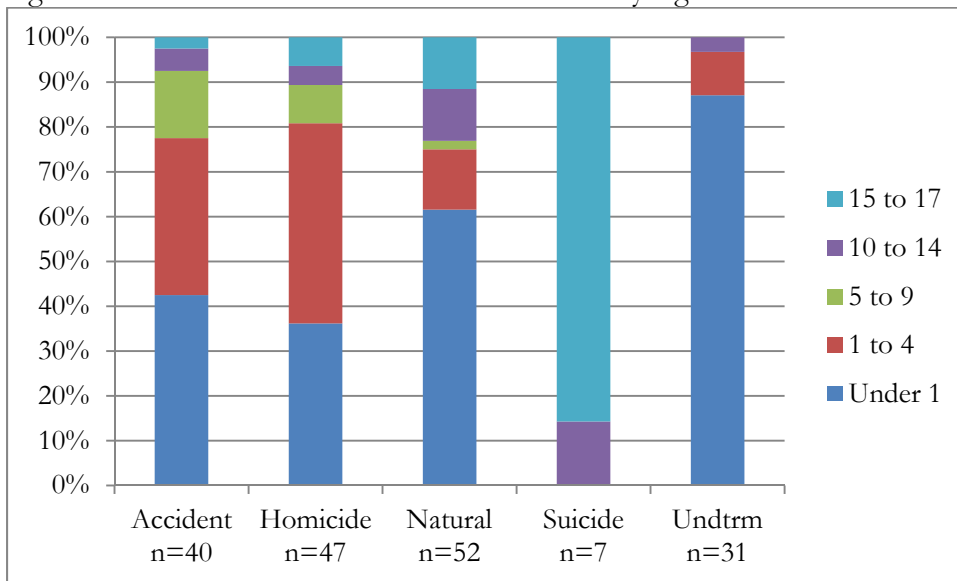
Manners are also correlated with age. Infants under 1 make up the highest percentage of natural deaths (75%) and undetermined manner (73%), whereas youth from 15-17 make up the highest percentage of suicides (85%) and homicides (50%). However, youth of all ages experience death by all manners, with the exception of suicides, which only occurred for youth 9 and over in 2011 (Figure 9).

Figure 9. Total Deaths – Manner of Death by Age



Reviewed deaths have a higher portion of younger children than total child deaths for all manners (except for natural causes). Suicide deaths only occur in older children, 75%-97% of deaths that are reviewed in all other manners of death are for children under 4 (Figure 10).

Figure 10. Reviewed Deaths – Manner of Death by Age



## Child Deaths by Category and Manner

Finally, it is interesting to examine the manner of child death juxtaposed with the categories of death (Table 4). For instance, the majority of accidental child deaths are due to vehicular accidents and suffocations, followed by drowning, injury, and fire related causes. Most homicides involve either firearms or other inflicted injuries. 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 4. Total Child Deaths – Manner of Death by Category of Death

Category of Death	Manner of Death					Totals
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	0	0	577	0	5	582
Prematurity	0	0	474	0	5	479
Suffocation	53	6	3	28	11	101
Vehicular	71	8	0	5	5	89
Firearms	3	66	0	12	3	84
Injury	12	33	0	0	1	46
SIDS	0	0	35	0	0	35
Undetermined	0	0	0	0	33	33
SUID	0	0	7	0	21	28
Drowning	24	1	0	0	2	27
Fire	17	2	0	0	0	19
Poison/Overdose	12	4	0	2	0	18
Other	1 <sup>1</sup>	3 <sup>2</sup>	1 <sup>3</sup>	0	0	5
SUCD	0	0	2	0	2	4
Totals	193	123	1099	47	89	1551

Note: 1 case is still pending - manner is undetermined. The findings for this case should be complete by end of May according to DCFS documentation.  
<sup>1</sup>clinical hyperthermia, high environmental temperature.  
<sup>2</sup>failure to thrive due to parental neglect; malnutrition; hypothermia.  
<sup>3</sup>aspiration of gastric content

## Child Deaths by Review Type

There are multiple reasons that the death of a child would be reviewed, including 5 different types under which the review is mandated, as well as some cases that were discretionary.

**Death Indicated:** The allegation of death is indicated for the child’s guardian.

This was the largest mandatory review type, comprising 85 of the 177 cases that were reviewed. In the death indicated review type:

- Slightly over half (55%) of decedents in this type of review were males.
- The majority was very young, 48% were under the age of 1 and 34% were 1 to 4 years old, 8% were 5-9, 7% were 10-14 and only 2% were aged 15-17.
- The majority of deaths were the result of two categories, injury (35%) and suffocation (22%). All other categories of death comprised less than 10%.
- The majority of deaths were homicides (53%), 26% were accidental, 15% were undetermined, and less than 5% died from natural causes or suicide.

**Indicated report at time of death:** DCFS has a founded allegation on the guardian

of the child.

There were 14 deaths that were mandated for review because there was an indicated report at the time of death.

- The majority of decedents in this type of review were males (71%).
- All but one (97%) were under the age of 1. One decedent was 17.
- Deaths occurred from the following categories: SIDS (36%), suffocation (29%), illness (14%), undetermined (14%) and SUID (7%).
- The manner of death included 50% natural causes, 36% undetermined and 14% accidental.

**Investigation within year of death:** DCFS had done an investigation in the year before the child's death.

This is the second largest type of mandated review, and 32 children who died in 2011 had been investigated in the year before their death.

- There were similar portions of males and females in this type (53% and 47%).
- There was a wide range of ages represented in this type; 38% were under 1, 19% were 1-4, 3% were 5-9, 13% were 10-14, and 28% were 15-17.
- The majority of these deaths occurred from injuries (41%), suffocation (22%) or prematurity (9%).
- Most children died from natural causes (53%), 19% were accidental, 13% were suicides, 13% were undetermined and one case (3%) was a homicide.

**Open Case:** There was an open case at the time of death. The child may be a ward of the state or the family may have an open case.

There were 25 child deaths in 2011 of children who had an open DCFS case.

- Slightly over half (59%) of decedents in this type of review were males.
- Slightly more than half (56%) were under the age of 1, 16% were 1 to 4 years old, 4% were 5-9, 8% were 10-14 and 16% were aged 15-17.
- The majority of deaths were the result of two categories, illness (36%) and prematurity (32%). All other categories of death comprised less than 10%.
- Most children who died with an open case died from natural causes (76%), 12% were accidental, 8% were suicides and 1 was homicide (4%)

**Pending Investigation:** At the time of the death there was an investigation in process.

This is a relatively small category of mandatory reviews; 4 children who died in 2011 had an investigation pending at the time of their death.

- Three were males (75%).
- Two were under the age of one and 2 were between the ages of 5 and 9.
- Two died from fire, one was undetermined and one has the category of death pending at the time this report was written.
- Two (50%) were accidental deaths and 2 (50%) were undetermined.

**Discretionary:** These deaths were not mandated for review.

There were 17 deaths that were reviewed but not mandated.

- The majority of decedents in this type of review were males (76%).
- The majority (65%) were under the age of 1, 29% were 1 to 4 years old, and 6% were 5-9. There were no discretionary reviews of children 10 or older.
- Deaths that were discretionarily reviewed occurred from the following categories: undetermined (29%), suffocation (18%), SIDS (18%), illness (12%), injury (12%) and SUID (12%).
- There were about equal portions of accidental deaths (33%), deaths from natural causes (28%) and undetermined (39%)

## Special Analysis: Homicide Deaths

There were 123 homicide deaths in 2011. We know from the above tables that the majority of homicides involve either firearms or inflicted injuries of some kind. In addition we know that 50% of homicides are youth age 15-17 and that 72% of the victims are male. Additional information on homicide deaths allows for a more complete understanding of the circumstances of these types of child deaths. The deaths are presented by frequency of homicide category.

Table 5. Homicide Deaths

<b>Category of Death</b>	<b>Child Age</b>	<b>Circumstances</b>	<b>Perpetrator</b>
<b>Firearms</b>	Unknown	Unknown	Unknown
	10 mo	Gunshot wound to head	Mother
	2 yrs	Gunshot wound	Unknown
	4 yrs	Gunshot wound to head	Mother
	5 yrs	Multiple gunshot wounds	Unknown
	5 yrs	Gunshot wound to head	Mother
	5 yrs	Gunshot wound to head	Gang Related – Child in car with father
	6 yrs	Gunshot wound to arm	Drive-by shooting
	7 yrs	Gunshot wound to head	Mother
	8 yrs	Gunshot wound to head	Unknown
	8 yrs	Gunshot wound to head/back	Mother
	12 yrs	Gunshot wounds	Unknown
	13 yrs	Multiple gunshot wounds	Unknown
	13 yrs	Gunshot wound to back	Drive-by shooting
	13 yrs	Gunshot wound to head	Unknown
	14 yrs	Multiple gunshot wounds	Unknown
	15 yrs	Multiple gunshot wounds	Unknown
	15 yrs	Multiple gunshot wounds to back	Drive-by shooting
	15 yrs	Gunshot wound in right armpit	Gang-related
	15 yrs	Gunshot wound to back	Unknown
	15 yrs	Gunshot wound to chest	Unknown
	15 yrs	Gunshot wound to back	Police Officer/ Robbery

	15 yrs	Gunshot wound to back	Unknown
	15 yrs	Gunshot wound to head	Unknown
	15 yrs	Gunshot wound to head	Unknown
	15 yrs	Multiple gunshot wounds	Unknown
	16 yrs	Gunshot wound	Unknown
	16 yrs	Gunshot wound to back	Unknown
	16 yrs	Gunshot wound to left shoulder	Unknown
	16 yrs	Gunshot wound to the chest	Unknown
	16 yrs	Multiple gunshot wounds	Unknown
	16 yrs	Gunshot wound to neck	Unknown
	16 yrs	Gunshot wound to chest	Unknown
	16 yrs	Gunshot wound to head	Unknown
	16 yrs	Multiple gunshot wounds	Unknown
	16 yrs	Gunshot wound to head	Altercation between 2 teen groups
	16 yrs	Gunshot wound to back	Unknown/Shot while committing robbery
	16 yrs	Multiple gunshot wounds	Unknown
	16 yrs	Multiple gunshot wounds	Drive by shooting
	16 yrs	Multiple gunshot wounds	Unknown
	16 yrs	Gunshot wound to head	Unknown
	17 yrs	Gunshot wound to head	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Gunshot wound to head and back	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds to chest and left arm	Gang-related
	17 yrs	Multiple gunshot wounds/ 6 mo. pregnant	Unknown
	17 yrs	Gunshot wound to flank	Unknown
	17 yrs	Gunshot wound to back	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Gunshot wound to chest	Unknown/Robbery
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Gunshot wound to head	Gang-related
	17 yrs	Gunshot wound to chest	Unknown
	17 yrs	Gunshot wound to chest	Gang-Related
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Gunshot wound to back	Unknown
	17 yrs	Gunshot wound to back	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds	Unknown
	17 yrs	Multiple gunshot wounds to head	Unknown

<b>Injury</b>	3 mo	Multiple injuries; blunt force trauma; child abuse	Mother/Father
	3 mo	Blunt head trauma; child abuse	Father
	3 mo	Subdural hematoma; blunt head trauma; child abuse	Mother
	3 mo	Multiple injuries; child abuse	Father
	9 mo	Craniocerebral injuries; blunt trauma of head	Mother/ Male Paramour
	11 mo	Intracranial injury by abuse	Daycare Owner
	1 yrs	Subdural hematoma; child abuse	Male Paramour
	1 yrs	Craniocerebral injuries; blunt head trauma; child abuse	Unknown
	1 yrs	Multiple blunt force injuries; suffocation; child abuse	Mother/Male Paramour
	1 yrs	Multiple injuries; child abuse	Male Paramour
	1 yrs	Cerebral injuries; child abuse	Mother/Father
	1 yrs	Blunt force trauma to abdomen	Mother
	1 yrs	Bronchopneumonia; cerebral injuries; blunt head trauma	Mother/Father
	1 yrs	Abusive head trauma	Grandmother
	2 yrs	Blunt trauma to head	Male Paramour
	2 yrs	Multiple blunt force injuries; child abuse	Mother
	2 yrs	Head trauma due to child abuse	Father/Mother
	2 yrs	Non-accidental traumatic head injuries; secondary complications	Mother
	3 yrs	Repeated physical abuse	Mother/Male Paramour
	3 yrs	Multiple blunt injuries of the head and abdomen	Male Paramour
	3 yrs	Multiple stab and incised wounds	Father
	3 yrs	Blunt force trauma; child abuse	Male Paramour
	4 yrs	Craniocerebral injuries; blunt trauma of head	Father/ Female Paramour
	4 yrs	Blunt force trauma to abdomen	Mother/Father
	4 yrs	Subdural hematoma; cerebral injuries; blunt trauma of the head	Foster Mother
	4 yrs	Multiple blunt force injuries; child abuse	Mother/ Male Paramour
	5 yrs	Multiple stab wounds	Grandfather
	7 yrs	Multiple medical problems; blunt trauma of the head	Father/Stepmother
	14 yrs	Multiple stab and incised wounds	Unknown
	16 yrs	Cerebral infarct; cranioerebral injuries; blunt head trauma	Unknown
	16 yrs	Multiple stab wounds	Unknown
	17 yrs	Diabetic ketoacidosis; respiratory	Mother

		syncytial virus pneumonia; anoxic encephalopathy due to blunt head trauma	
	17 yrs	Massive blunt force trauma	Unknown
<b>Vehicular</b>	7 yrs	Multiple injuries due to SUV striking a fixed object; passenger in vehicle; driver intoxicated	Father
	10 yrs	Multiple traumatic injuries; motor vehicle collision	Father
	14 yrs	Multiple injuries; motor vehicle striking subject in residence	Gang-related
	15 yrs	Craniocerebral injuries; driver intoxicated; rollover in field	Unknown
	15 yrs	Exsanguinating hemorrhage; right traumatic hemipelvectomy; unrestrained passenger in car accident	Mother's Friend
	15 yrs	Blunt trauma of the chest and abdomen; motor vehicle crash	Unknown
	16 yrs	Blunt force cranioerebral injuries; partly ejected passenger; rollover car accident	Unknown
	17 yrs	Multiple injuries; passenger in automobile crash; skid into tree; rolled & thrown from vehicle	Unknown
<b>Suffocation</b>	0 mo	Suffocation/plastic bag	Mother
	0 mo	Strangulation	Mother
	3 mo	Ligature strangulation	Mother
	3 mo	Asphyxiation/overlay	Father
	8 mo	Suffocation	Mother
<b>Poison/ Overdose</b>	0 mo	Necrotizing enterocolitis in presence of premature birth; maternal cocaine use	Mother
	0 mo	Preterm labor 18 weeks prematurity; spontaneous rupture of membranes; maternal cocaine abuse	Mother
	15 yrs	Complications of heroin intoxication	Unknown
	17 yrs	Alcohol intoxication	20-year-old and 50-year-old males who purchased alcohol
<b>Other</b>	0 mo	Hypothermia; maternal neglect	Mother
	1 mo	Malnutrition without evidence of natural disease	Mother/Male Paramour
	10 mo	Dehydration; febrile illness; failure to thrive due to parental neglect	Mother

<b>Fire</b>	9 yrs	Thermal injuries, house fire, multiple stab wounds	Unknown
	11 yrs	Thermal injuries, house fire, multiple stab wounds	Unknown
<b>Drowning</b>	8 yrs	Drowning	Mother

## Chapter 4: Child Deaths by Category

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

Categories are presented in the order of frequency of occurrence for 2011 so that the most common categories of death are first. For each category section, the following information is presented:

- Category definition describes the types of deaths that are included.
- Background information provides national statistics or research findings, if available.
- Illinois data on total child deaths reported to the State Central Register (SCR/DCFS).
- Numbers of deaths from categories over the past 12 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender and age of three groups: 1) the total child deaths,<sup>6</sup> 2) deaths from a specific category, and 3) reviewed deaths from that category. Previous reports have included comparisons by child race, but due to a lack of data, race is not included in the analysis this year.

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. It is mandatory that any death of a child involved with DCFS must be reviewed. Since the child welfare system in Illinois over-represents African-American children and young children, the cases reviewed by the CDRT are more likely to be younger or African-American.

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<sup>6</sup> Previous reports had used the population of Illinois as the comparison group in the charts, rather than total child deaths. The advantage of using the total child deaths as a comparison is that it allows for a finer distinction to be made based on category influence. For example, males are overrepresented in total child deaths, but the gender distribution in specific category of death (like suffocation) may or may not contribute to the gender disparity in total child deaths.

# Illness

## Definition

This category includes any death that was the result of a medical condition. The manner of death for this category is most often determined to be natural. On occasion, however, the manner of death may be determined to be accidental. An accidental determination would include children whose 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).

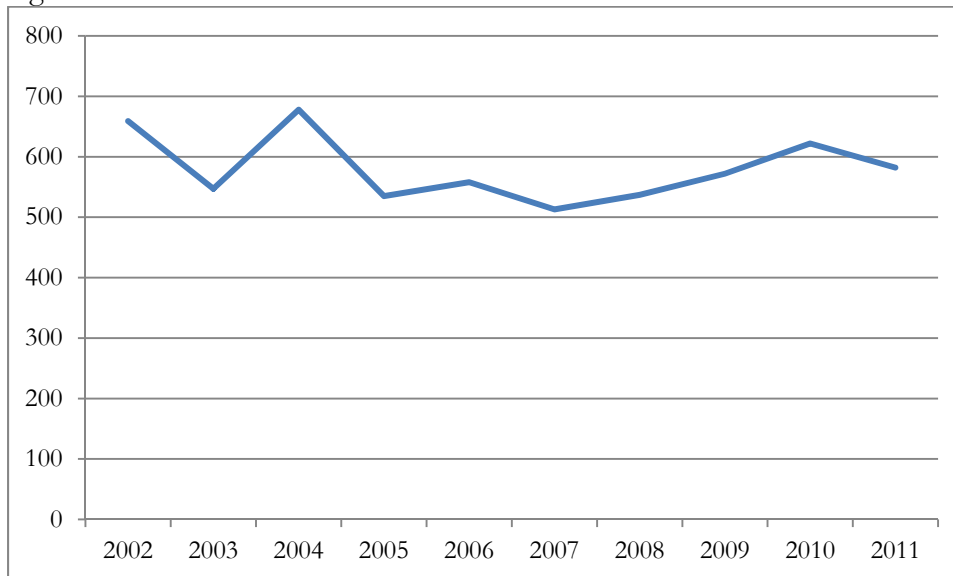
## Background

The majority of all child deaths are due to natural causes, and the majority of all illness deaths occur during the first year of life.<sup>7</sup> 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

For the past decade, illness has been the largest or nearly the largest cause of child death (in 2005 and 2006 prematurity was slightly larger). The number of deaths from illness has ranged from 513 in 2007 to 678 in 2004 (See Figure 11).

Figure 11. Child Deaths Due to Illness



<sup>7</sup> 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.

In 2011, 582 of the 1,551 total child deaths (38%) reported to the SCR were related to illness.

- The vast majority of these deaths (over 99%) were attributable to natural causes, the others were undetermined.
- A majority of children who die from illness are male (55%).
- A majority of deaths from illnesses were among children under the age of one (53%); 15% of the illness deaths occurred among children between 1 and 4 years, 9% among the 5 to 9 year olds, 12% among those 10 to 14 years old, and 12% among 15 to 17 year olds.

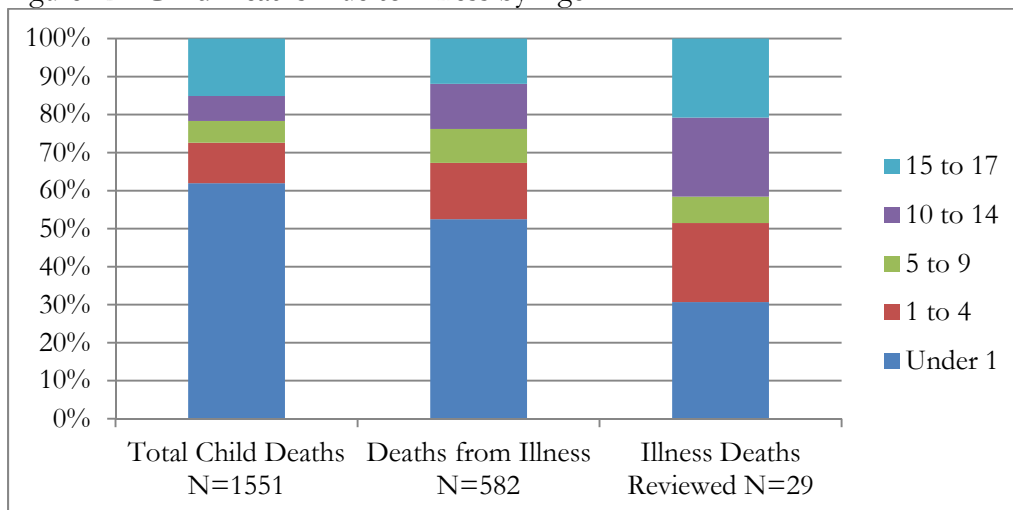
## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 29 of the 177 child deaths reviewed by CDRTs (16%) were related to illness.

- More boys (62%) than girls who had deaths related to illness were reviewed.
- Children under the age of one represent the largest percentage of the illness deaths reviewed by CDRTs (31%). Reviewed illness deaths also included 21% of 1 to 4 year olds, 7% of children aged 5-9, 21% of children aged 10 to 14, and 21% of children aged 15 to 17.
- Nearly all deaths that are categorized as illness are natural (5 were undetermined).

The age distributions of the total child deaths, deaths resulting from illness, and deaths resulting from illness that were reviewed by the CDRTs in 2011 are presented in Figure 12. Although deaths from illness are most likely to occur for infants under the age of one, it is clear when comparing deaths from illness to the total deaths, that children aged 1-14 have a higher proportion of death from illness than from other causes.

Figure 12. Child Deaths Due to Illness by Age



# 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 37<sup>th</sup> week of gestation. Preterm births are sometimes classified as “very preterm” (less than 32 weeks gestation) and moderately preterm (32 – 37 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. Infants born at the lowest birth weights and gestational ages have a large impact on infant mortality. Following many years of increases, the national preterm birth rate declined for the fourth straight year, from 12.8% in 2006 to 12.0% in 2010 <sup>8</sup>.

In Illinois, about 1 in 8 babies (12.2% of live births) was born preterm and 2.2% were very preterm in 2010.<sup>9</sup> After a rise in preterm births earlier in the decade, the rate has slowly and steadily decreased from 13.3% to 12.2% between 2006 and 2010. The rate of preterm birth in Illinois is highest for African American infants (17.6%), followed by Native Americans (13.9%), whites (11.4%), and Asians (10.6%).<sup>10</sup> A number of risk factors have been associated with preterm birth: maternal age, history of preterm birth, multi-fetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity, and elevated blood pressure.<sup>11</sup> Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

## Illinois Data – Total Child Deaths Reported to the SCR

Prematurity has been a leading cause of child death and has either been the second largest or the largest category in the past 10 years (ranging from 431 to 620 deaths per year). There has

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<sup>8</sup> Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2012*. Washington, DC: U.S. Government Printing Office. Retrieved from [Hhttp://childstats.gov](http://childstats.gov)

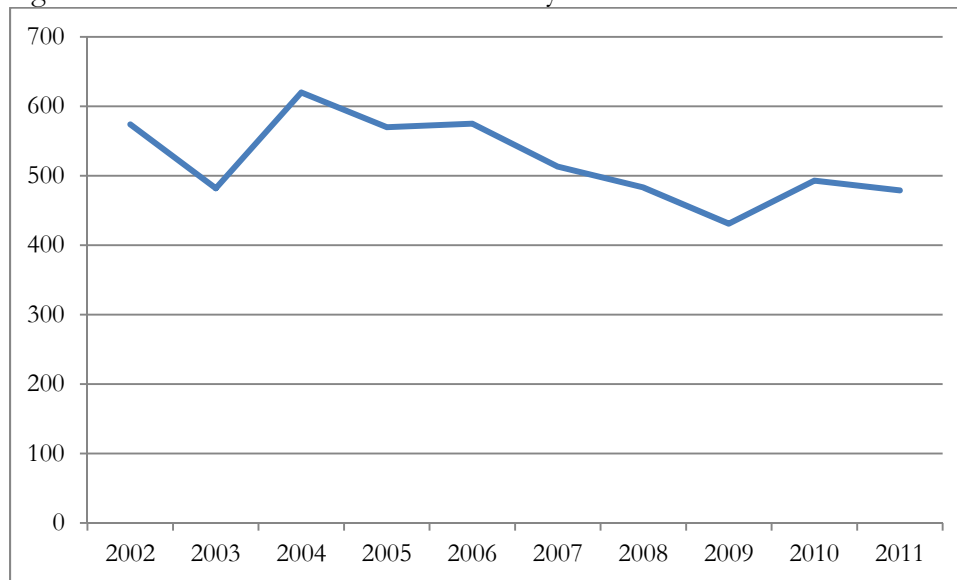
<sup>9</sup> National Center for Health Statistics. *Illinois prematurity data*. Retrieved from [Hhttp://www.marchofdimes.com/peristats/tlanding.aspx?dv=lt&reg=17&top=3&lev=0&slev=4](http://www.marchofdimes.com/peristats/tlanding.aspx?dv=lt&reg=17&top=3&lev=0&slev=4)

<sup>10</sup> National Center for Health Statistics. *Illinois prematurity data*. Retrieved from [Hhttp://www.marchofdimes.com/peristats/tlanding.aspx?dv=lt&reg=17&top=3&lev=0&slev=4](http://www.marchofdimes.com/peristats/tlanding.aspx?dv=lt&reg=17&top=3&lev=0&slev=4)

<sup>11</sup> Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America's health: State rankings, 2004 Edition*. United Health Foundation.

been a general decrease in prematurity in the past decade with the lowest number in 2009 (Figure 13).

Figure 13. Child Deaths Due to Prematurity



Of the 1,551 total child deaths in 2011, 479 (31%) were related to premature birth.

- Over 99% of the deaths in this category (454) were the result of natural causes, and 5 were undetermined.
- The majority of children who die from prematurity were boys (55%).

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 11 of the 177 child deaths reviewed by CDRTs (6%) were related to premature birth. Of the premature deaths reviewed, 64% were male.

# Suffocation

## Definition

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

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

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

## Background

In 2010, 1,818 children ages 17 and under in the U.S. died from accidental airway obstruction.<sup>12</sup> Of these children, 53% were less than one year of age and 62% were ages four 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).<sup>13</sup>

Toddlers and preschoolers are also at high 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.<sup>14</sup>

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<sup>12</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

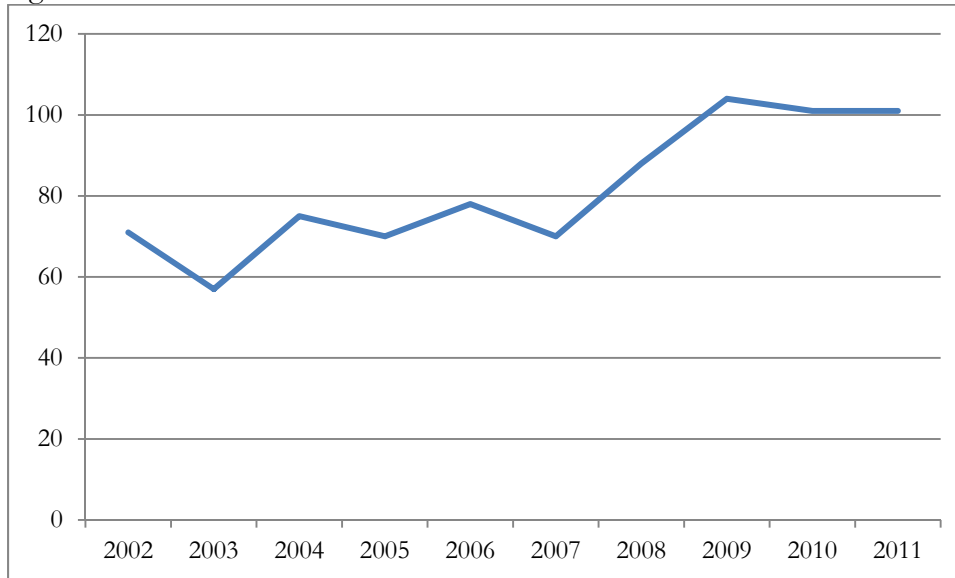
<sup>13</sup> Safe Kids Worldwide. (2012). *Suffocation and choking safety*. Retrieved from <http://www.safekids.org/our-work/research/fact-sheets/choking-and-suffocation-prevention-fact-sheet.html>

<sup>14</sup> Ibid.

## Illinois Data – Total Child Deaths Reported to the SCR

There has been a rise in deaths from suffocation in the past 10 years from 71 in 2002 to 101 in 2011 (Figure 14).

Figure 14. Child Deaths Due to Suffocation



In 2011, 101 of the 1,551 total child deaths reported to the SCR (7%) were related to suffocation.

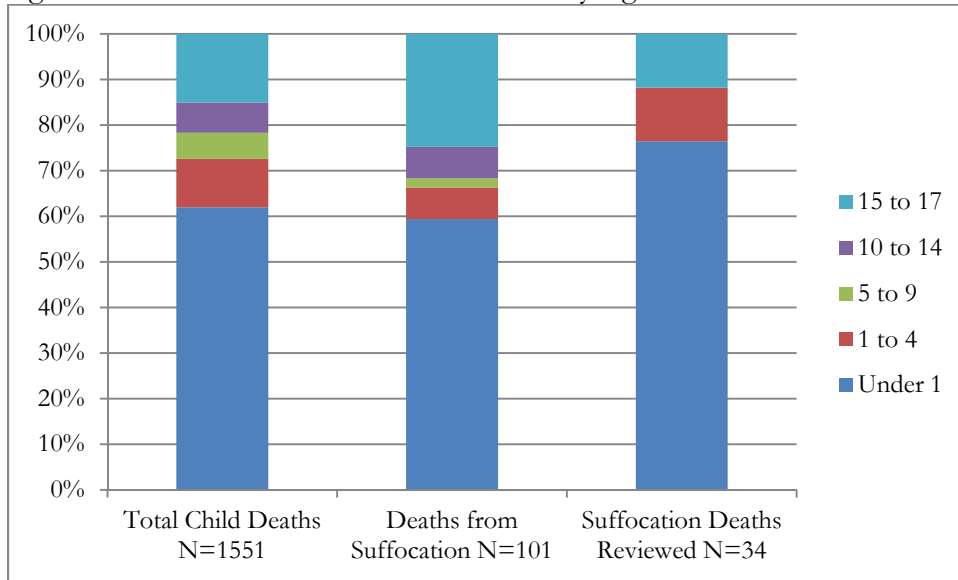
- The manner of the suffocation deaths was varied: 53% were accidental, 28% were suicides, 6% were homicides, and 11% were undetermined.
- The majority of children who died from suffocation were boys (62%).
- Infants under one year are the largest group in this category, accounting for 59% of the deaths.

## Illinois Data – Deaths Reviewed by CDRT's

In 2011, 34 of the 177 deaths reviewed by CDRT's (19%) were related to suffocation.

- The slight majority (56%) of the reviewed suffocation deaths were male.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (76%). The proportion of reviewed suffocation deaths was higher than the proportion of deaths from suffocation for children under the age of one in 2011 (Figure 15).

Figure 15. Child Deaths Due to Suffocation by Age



# Vehicular Accident

## Definition

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

## Background

Nationally, a total of 910 children (under the age of 13) died in motor vehicle crashes in 2011.<sup>15</sup> This has declined 78% since 1975. In 2011, 72% of child motor vehicle crash deaths were passenger vehicle occupants, 19% were pedestrians, and 4% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 91% and 92%, respectively. Passenger vehicle child occupant deaths in 2011 were 46% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Eighteen percent of the passenger vehicle child occupant deaths in 2011 occurred in front seats, which is down from 46% in 1975. Even though child deaths in motor vehicle crashes have declined since 1975, crashes still cause about 1 of every 4 unintentional injury deaths among children younger than 13. Since most crash deaths occur among children traveling as passengers, proper restraint use can reduce these fatalities. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about a third.<sup>16</sup>

A total of 3,023 teenagers ages 13 to 19 died in motor vehicle crashes in 2011. This is 65% fewer than in 1975 and 3% fewer than in 2010. About 2 out of every 3 teenagers killed in motor vehicle crashes in 2011 were males. In 2011, 80% of teenage motor vehicle crash deaths were passenger vehicle occupants. The others were pedestrians (10%), motorcyclists (5%), bicyclists (2%), riders of all-terrain vehicles (2%), and people in other kinds of vehicles (2%).<sup>17</sup>

In the United States, teenagers drive less than most adults (only drivers who are over the age of 70 drive less), but their numbers of crashes and crash deaths are disproportionately high. In the United States, the fatal crash rate per mile driven for 16-19 year-olds is nearly 3 times the rate for drivers ages 20 and over. Risk is highest at ages 16-17. In fact, the fatal crash rate per mile driven is nearly twice as high for 16-17 year-olds as it is for 18-19 year-olds. Crash rates for teenagers are high largely because of their immaturity combined with driving inexperience.<sup>18</sup>

Distracted driving is often the cause of fatal accidents. For teen drivers, the most common distraction is using a cell phone. Other common sources of distraction for teen drivers are

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<sup>15</sup> Insurance Institute for Highway Safety. (2011). *Fatality facts 2011: Children*. Retrieved from [Hhttp://www.iihs.org/research/fatality.aspx?topicName=Child-safety](http://www.iihs.org/research/fatality.aspx?topicName=Child-safety)H

<sup>16</sup> *ibid*

<sup>17</sup> Insurance Institute for Highway Safety. (2011). *Fatality facts 2011: Teenagers*. Retrieved from [Hhttp://www.iihs.org/research/fatality.aspx?topicName=Teenagers](http://www.iihs.org/research/fatality.aspx?topicName=Teenagers)H

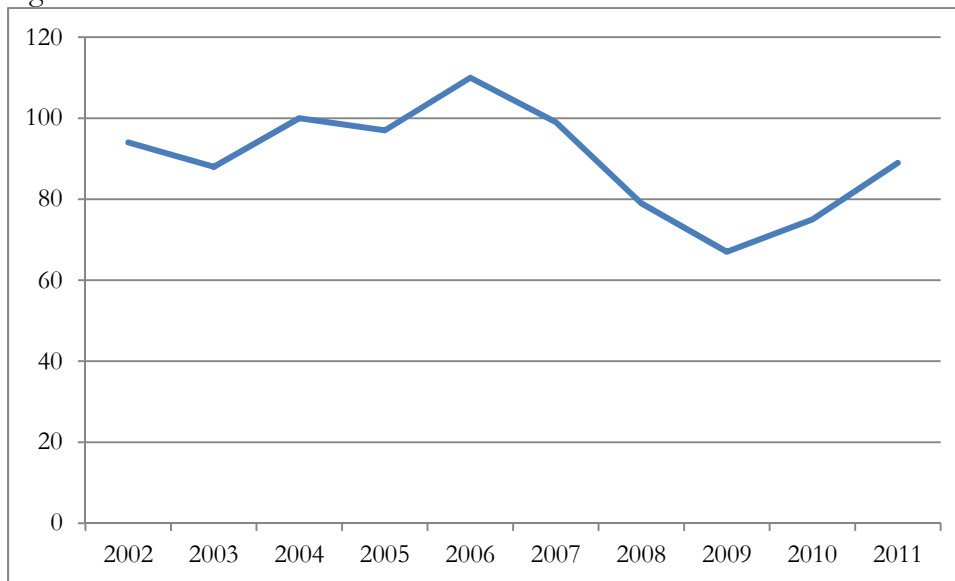
<sup>18</sup> *ibid*

riding with peers and drowsiness.<sup>19</sup> Another factor that affects teenage vehicular fatalities is inexperience. In order to address this, all states have adopted graduated licensing systems, which phase in full driving privileges. In states that adopted elements of graduated licensing, the crash rates among teenage drivers declined about 10-30%.<sup>20</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

After dropping from a high of 110 vehicular deaths in 2006 to a low of 67 in 2009, the number of child deaths from vehicular accidents has risen in the past 2 years to 89 in 2011 (see Figure 16).

Figure 16. Child Deaths Due to Vehicular Accidents



In 2011, 89 of the 1,551 total child deaths reported to the SCR (6%) were related to vehicular accidents.

- A large majority (80%) of these deaths were accidental, and a small portion were homicides (9%), suicides (6%), and 6% were undetermined.
- Slightly more boys (56%) had deaths related to vehicular accidents.
- Older children (15-17) made up the largest proportion of vehicular accident deaths (58%). Children under the age of one made up the smallest proportion of vehicular deaths (3%). The percentage of children in other age groups was between 8% and 17% (see Figure 17).

<sup>19</sup> Child Trends. (2010). *Distracted driving*. Retrieved from [Hwww.childtrendsdatabank.org/?q=node/376](http://www.childtrendsdatabank.org/?q=node/376)H on March 7, 2010.

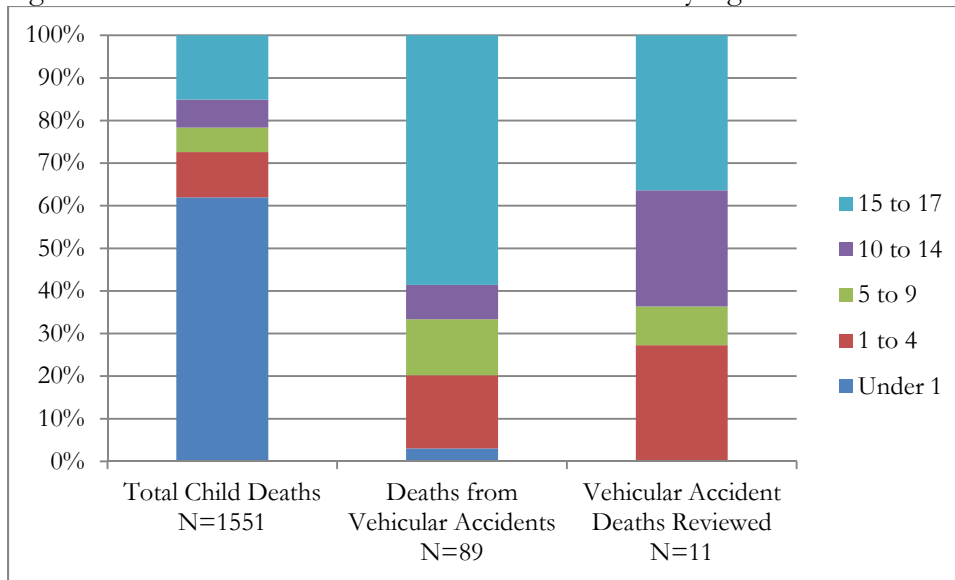
<sup>20</sup> Insurance Institute for Highway Safety. (2011). *Fatality facts 2011: Teenagers*. Retrieved from [Hhttp://www.iihs.org/research/fatality.aspx?topicName=Teenagers](http://www.iihs.org/research/fatality.aspx?topicName=Teenagers)

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 11 of the 177 deaths reviewed by CDRTs (6%) were related to vehicular accidents.

- 45% of the reviewed deaths in this category were males.
- A large proportion (58%) of vehicular decedents is from the 15-17 year olds, but only 36% of the reviewed deaths were from this group (Figure 17).

Figure 17. Child Deaths Due to Vehicular Accidents by Age



# 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 Centers for Disease Control and Prevention, 1,337 firearm deaths occurred in 2010 (the latest year for which data are available) among children under 18 years of age in the United States.<sup>21</sup> The vast majority (72%) of these deaths are youth between the ages of 15 and 17. However, race of decedent also is a factor. In 2010, the homicide rate for African American male teens was more than 22 times higher than the rate for white male teens.<sup>22</sup>

Firearms include several manners of deaths. Homicides and suicides are the second and third leading causes of death, respectively, among teens ages 15 to 19 (after unintentional injury). Firearms were the instrument of death in 85% of teen homicides and 40% of teen suicides in 2010. In two-thirds of the homicides, the murderer was over 18.<sup>23</sup> A recent national study from the *Journal of Pediatrics* found that the most-rural counties have virtually identical pediatric firearm mortality compared with the most-urban counties.<sup>24</sup> The most-rural counties had higher rates of pediatric firearm suicide and unintentional firearm death but lower homicide rates when compared with the most-urban counties.<sup>25</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

After dropping in the first part of this decade, child deaths from firearms have steadily risen from 2005 to 2008 and have ranged between 79-84% since then (Figure 18). In 2011, there were 84 child deaths from firearms, which is the same as 2010. These are the highest numbers in the past 11 years.

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<sup>21</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>

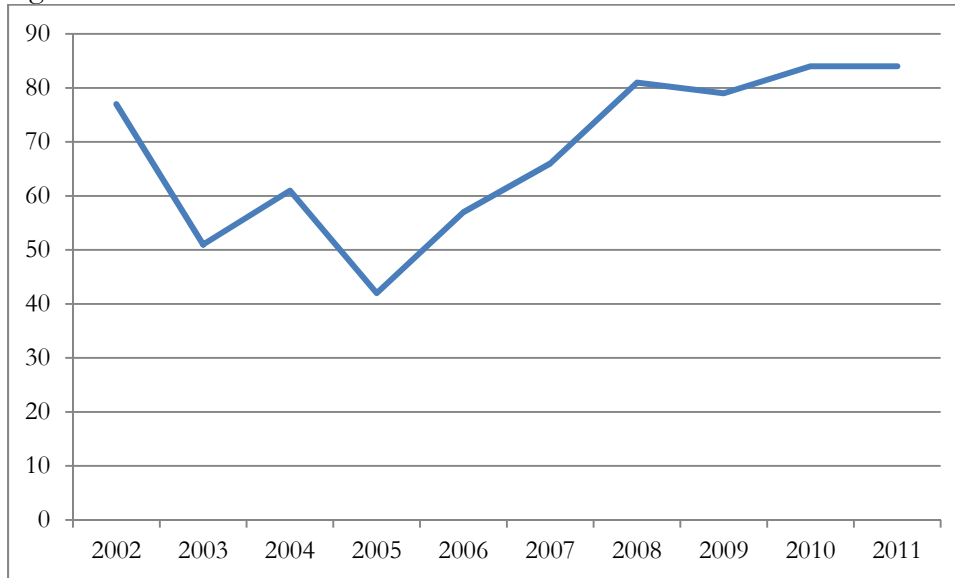
<sup>22</sup> Child Trends. (2012). *Teen homicide, suicide, and firearm deaths*. Retrieved from <http://www.childtrendsdatabank.org/?q=node/124>

<sup>23</sup> *ibid*

<sup>24</sup> Nance, M. L., Carr, B. G., Kallan, M. J., Branas, C. C., & Wiebe, D. J. (2010). Variation in pediatric and adolescent firearm mortality rates in rural and urban US counties. *Pediatrics*, 125, 1112 -1118.

<sup>25</sup> *ibid*.

Figure 18. Child Deaths Due to Firearms



In 2010, 84 of the 1,551 total deaths (5%) were related to firearms.

- Homicides accounted for 79% of the firearm deaths, suicides accounted for 14%, and accidents accounted for 4%.
- As shown in Figure 19, deaths due to firearms overwhelmingly occurred among boys (90%).
- Children between 15 and 17 years of age are largely over-represented in firearm deaths when compared to total child deaths (see Figure 20). In 2011, 76% of firearm deaths occurred in children aged 15 to 17.

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 6 of the 177 deaths reviewed by the CDRTs (3%) were related to firearms.

- In 2011, the firearm deaths reviewed by CDRTs were fairly evenly distributed among children of different age groups: 15-17 years (17%), 10-14 years (33%), 5-9 (33%), and 1-4 (17%). A smaller proportion of older teens were reviewed when compared to the proportion of 15 to 17 year olds who died due to firearms (see Figure 20).

Figure 19. Child Deaths Due to Firearms by Gender

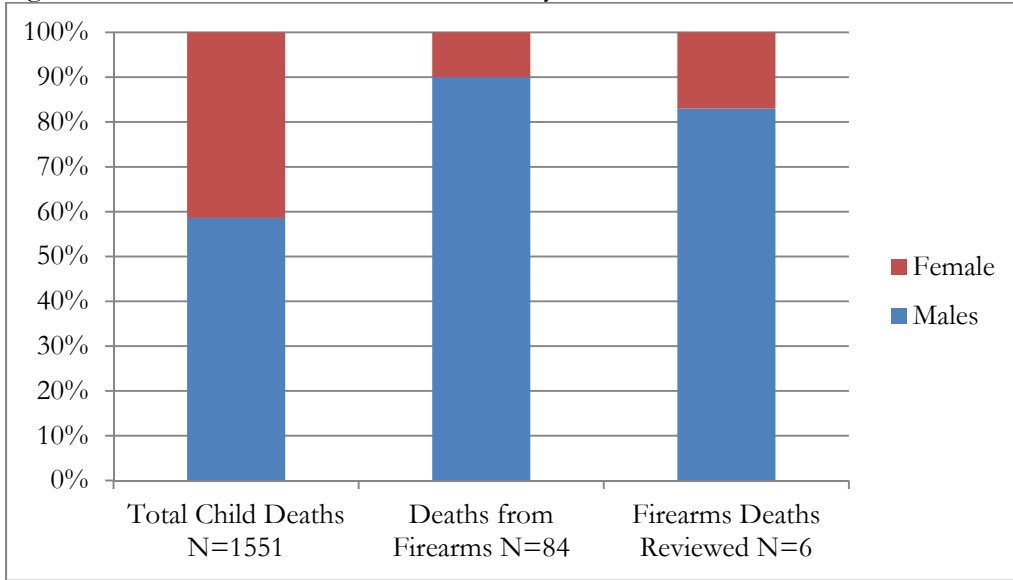
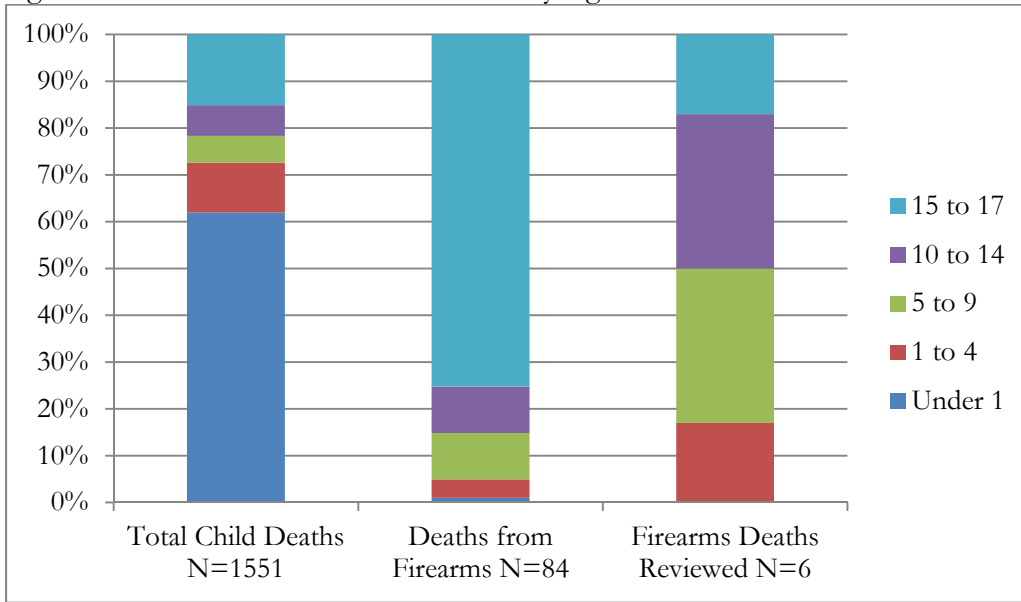


Figure 20. Child Deaths Due to Firearms by Age



# 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.

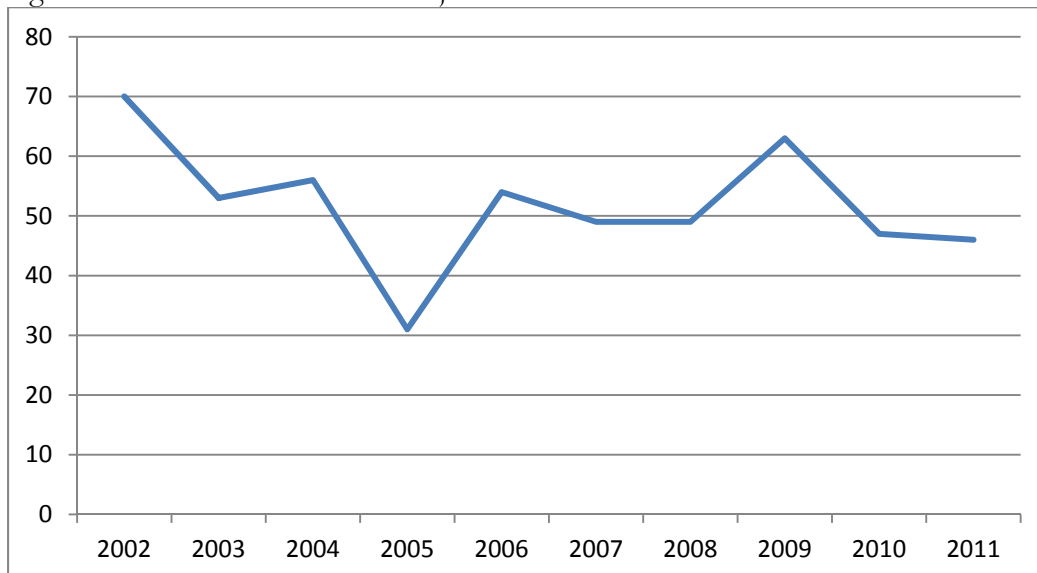
## Background

Child maltreatment (including abuse and neglect) is one cause of death from injuries. In 2011, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,570 fatalities from child maltreatment. The number of reported child fatalities due to child abuse and neglect has fluctuated during the past five years. Younger children are more vulnerable to death as the result of child abuse and neglect. Four-fifths (81.6%) of all child fatalities were younger than four years old. Four-fifths (78.3%) of child fatalities were caused by one or more parents.<sup>26</sup> Of the children who died, 71.1% suffered neglect either exclusively or in combination with an additional maltreatment type and 47.9% suffered physical abuse either exclusively or in combination with the physical abuse.<sup>27</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

There have been between 31 and 70 child deaths from injuries per year since 2002 in Illinois (Figure 21).

Figure 21. Child Deaths Due to Injuries



<sup>26</sup> U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2011). *Child maltreatment, 2011*. Washington, DC: Government Printing Office. Retrieved from [Hhttp://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf](http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf)H

<sup>27</sup> *ibid*

In 2011, 46 of the 1,551 total child deaths reported to the SCR (3%) were related to injuries.

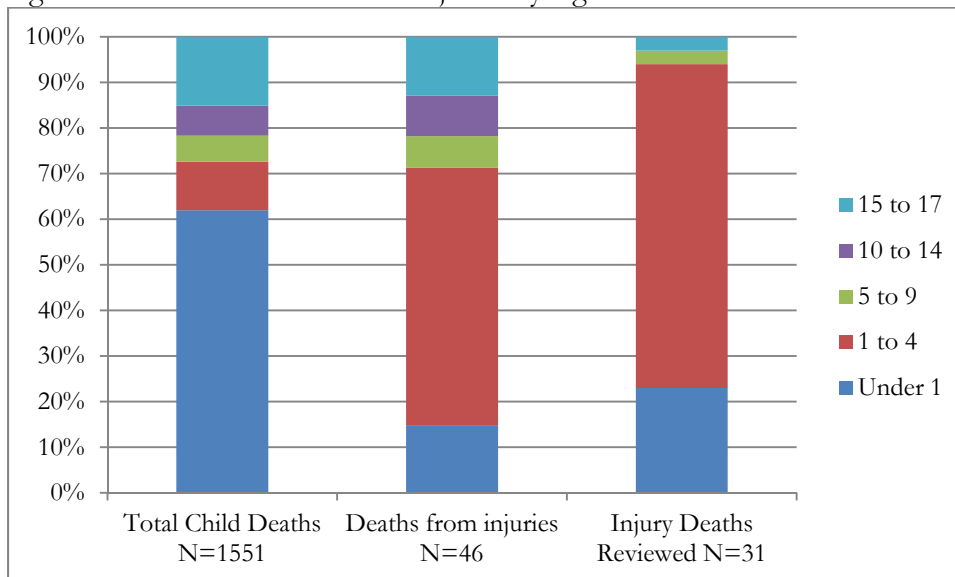
- 26% of these injury deaths were classified as accidents, 72% were homicides and one case was undetermined.
- Decedents from injuries in 2011 were half male and half female.
- Younger children are more vulnerable to death from injuries: 15% of injury deaths are among children under the age of one, and an additional 57% are among children between the ages of 1 and 4. Older children experienced injury-related deaths at lower, but not insignificant, rates: 7% among children 5 to 9 years; 9% among those 10 to 14 years; and 13% among those between 15 and 17 years of age.

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 31 of the 177 (18%) deaths reviewed by CDRTs were related to injuries (See Figure 22).

- The vast majority of the reviewed cases involved young children 4 years and under (94%).
- About half of the reviewed injury deaths were male (48%).

Figure 22. Child Deaths Due to Injuries by Age



# Sudden Infant Death Syndrome (SIDS) and Unknown Infant Deaths<sup>28</sup>

## Definition

Each year in the United States, more than 4,500 infants die suddenly of no immediately obvious cause. These deaths are called Sudden Unexpected Infant Deaths (SUID). Half of the SUID deaths are due to Sudden Infant Death Syndrome (SIDS). For a medical examiner or coroner to determine the cause of an SUID 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. After an investigation, some deaths are attributed to various causes such as suffocation, poisoning, or metabolic disorders.<sup>29</sup> Even after a thorough investigation, some unexpected deaths have an unexplained or unknown cause.

SIDS is the sudden death of an infant under age one that cannot be explained after a thorough investigation has been conducted. SIDS is the leading cause of deaths among infants aged 1–12 months. Sometimes the cause of death is unexplained and it is unknown whether the cause is SIDS or something else, these are labeled unknown.<sup>30</sup> Both explained and unexplained infant deaths can be associated with unsafe sleep environments.

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

Exposure to secondhand smoke increases the probability of lower respiratory tract infections, asthma, and sudden infant death syndrome (SIDS). Since 2005, the percentage of children ages 0–6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, 10% of children ages 0–6 living in poverty lived in a home where someone smoked regularly, down from 15% in 2005 and 37% in 1994<sup>31</sup>.

## Background

SIDS is the leading cause of death among infants aged one to twelve months. A decline in SIDS death has occurred since the 1990s largely because of the Back to Sleep Campaign,

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<sup>28</sup> In previous CDRT reports, SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Centers for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained. For this report, the category previously defined as SUID will be called Unknown Infant Death. Unknown is the description of the same category used by CDC.

<sup>29</sup> Centers for Disease Control and Prevention. (2011). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved from [Hhttp://www.cdc.gov/sids/](http://www.cdc.gov/sids/)

<sup>30</sup> Ibid.

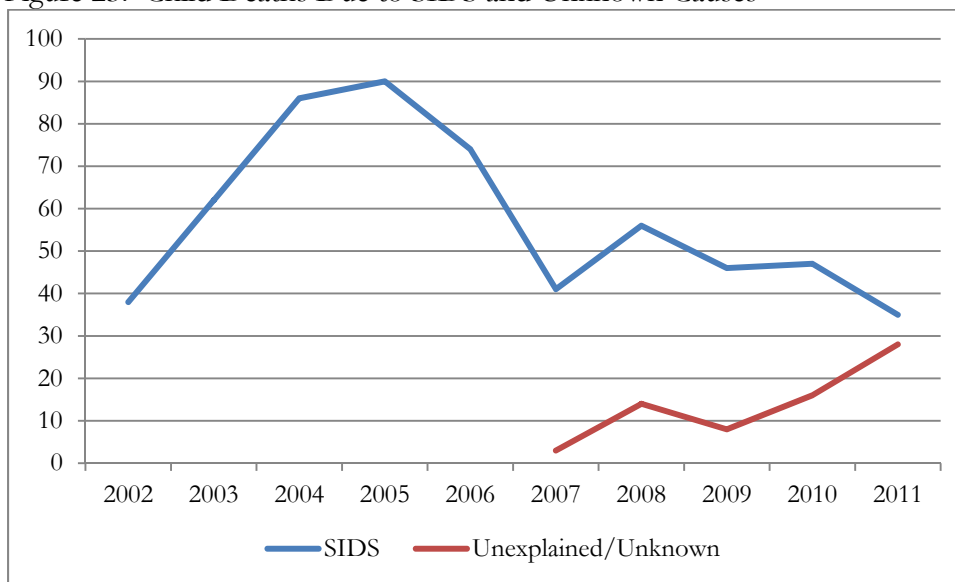
<sup>31</sup> Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2012*. Washington, DC: U.S. Government Printing Office. Retrieved from [Hhttp://childstats.gov](http://childstats.gov)

(now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.<sup>32</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

There have been between 35 and 90 child deaths from SIDS per year since 2002 with the lowest number occurring this year (2011) and the highest numbers (86-90) being in 2004 and 2005 (Figure 23). Infant deaths from unknown causes (called SUID in previous reports) were added as a category in 2007 and the highest number of unknown deaths (28) occurred in 2011.

Figure 23. Child Deaths Due to SIDS and Unknown Causes



In 2011, 35 of the 1,551 total child deaths reported to the SCR (2%) were related to SIDS, and 28 infant deaths (2%) were from unknown/unexplained causes.

- More boys (57%) than girls (43%) had deaths related to SIDS.

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 10 of the 177 (6%) deaths reviewed by CDRTs were related to SIDS and 9 were from unknown/unexplained causes.

- 50% of the SIDS deaths reviewed by the CDRTs were boys.
- 78% of the unknown/unexplained causes of death cases reviewed by the CDRTs were boys.

<sup>32</sup> 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.

# Undetermined

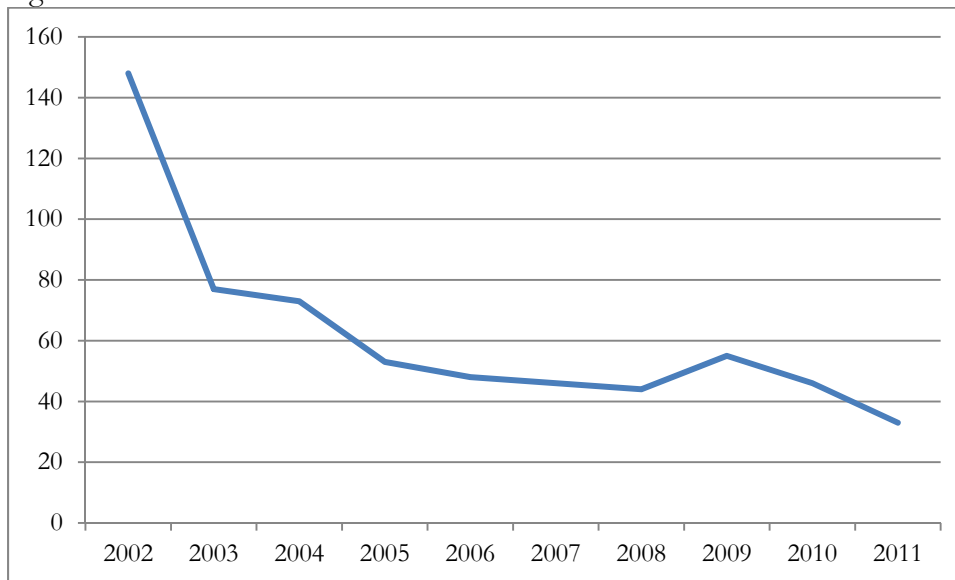
## Definition

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

The number of undetermined deaths for children has dropped from 148 in 2002 to 33 in 2011 (Figure 24).

Figure 24. Child Deaths with Undetermined Cause of Death



In 2011, 33 of the 1,551 total child deaths reported to the SCR (2%) had an undetermined cause of death.

- Deaths due to undetermined causes were more common for boys (64%).
- Children under the age of one represent 85% of deaths in this category; and 15% of decedents from undetermined causes were between one and four years.

## Illinois Data – Deaths Reviewed by CDRTs

In 2011, 16 of the 177 deaths reviewed by CDRTs (9%) had an undetermined cause of death.

- Seventy-five percent of the reviewed deaths due to undetermined causes occurred among children under one year of age.

# Drowning

## Definition

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

## Background

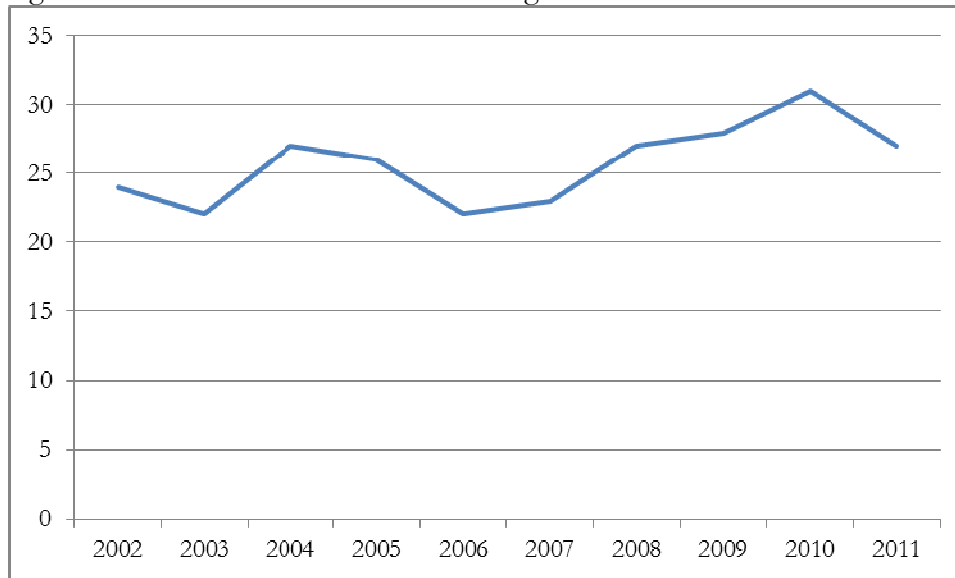
Drowning is the second major cause of unintentional injury death among children ages 0 to 17. In 2010, 886 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 54% of these deaths.<sup>33</sup>

The majority of infant (less than 1 year old) drowning deaths happen in bathtubs or large buckets. Swimming pools are the most common site for a drowning to occur among children between the ages 1 and 4 years, and about 3/4 of pool submersion deaths occur at a home. African American children ages 5-14 years old have a drowning rate 2.7 times greater than that of white children.<sup>34</sup> Drowning prevention should be especially heightened during the summer months. Drowning incidents can increase up to 89% during the summer as compared with the rest of the year.<sup>35</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

Since 2002, there have been between 22 and 31 deaths from drowning per year (Figure 25).

Figure 25. Child Deaths Due to Drowning



<sup>33</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from [http://www.cdc.gov/injury/wisqars/fatal\\_injury\\_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html)

<sup>34</sup> Safe Kids Worldwide. (2013). *Swimming and Boating Safety Fact Sheet 2013*. Retrieved from <http://www.safekids.org/fact-sheet/swimming-and-boating-safety-fact-sheet-pdf>.

<sup>35</sup> Safe Kids Worldwide. (2013). *Safety tips: swimming and water*. Retrieved from <http://www.safekids.org/poolsafety>.

The year with the most deaths due to drowning was 2010, in which 31 of the 1,622 total child deaths (2%) were related to drowning. In 2011, 27 of the 1,551 total child deaths reported to the SCR (2%) were related to drowning.

- Most of the drowning deaths were accidental (88%), and the rest were primarily undetermined.
- More boys (81%) died from drowning than girls.
- Children between the ages of 1 and 4 were at highest risk for drowning-related deaths. Forty four percent of drowning deaths were from this age group.

## **Illinois Data – Deaths Reviewed by CDRTs**

In 2011, 11 of the 177 reviewed deaths (6%) were related to drowning.

- In 2011, 64% of the reviewed drowning deaths were male.
- Most of the reviewed deaths related to drowning occurred among young children: 45% of decedents were between 1 and 4 years of age.

# Fire

## Definition

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

## Background

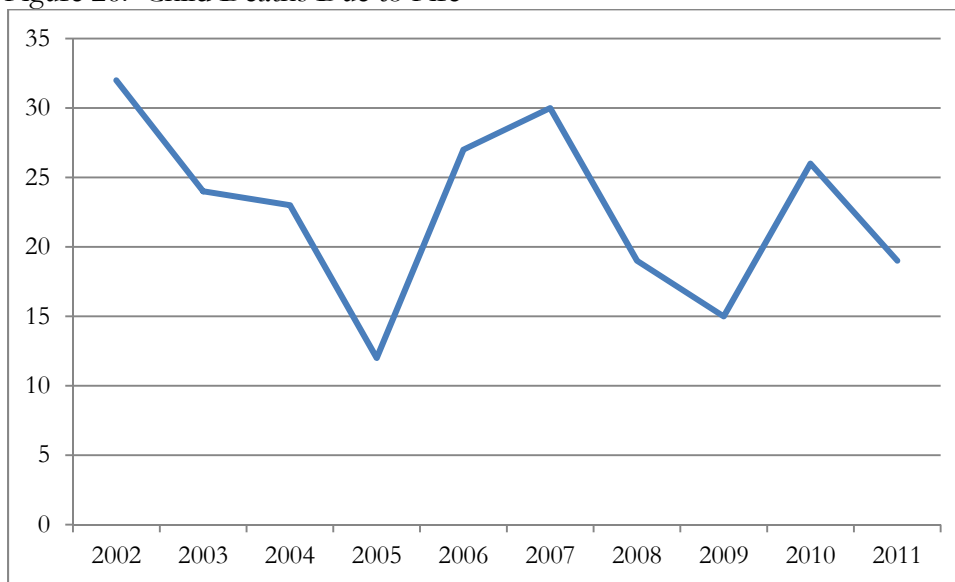
In the United States, fire and burns were the cause of 389 deaths among children between 1 and 17 years in 2011.<sup>36</sup> Fifty-four percent of fire deaths occurred in children 4 and under. Overall, the trend in the fire death rate per million population for children ages 14 and under decreased 41% from 2001-2010<sup>37</sup>.

Home fires account for nearly 90% of all fire-related fatalities. Home cooking equipment is the leading cause of residential fires and injuries from residential fires. Working smoke alarms reduce the chances of dying in a fire by nearly 50% .<sup>38</sup>

## Illinois Data – Total Child Deaths Reported to the SCR

There have been between 12 and 32 child deaths from fire per year since 2002 (Figure 26).

Figure 26. Child Deaths Due to Fire



<sup>36</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>

<sup>37</sup> U. S. Fire Administration, (2012). *Child Fire Death Rates and Relative Risk (2001-2010)* Retrieved from [http://www.usfa.fema.gov/statistics/estimates/trend\\_child.shtm](http://www.usfa.fema.gov/statistics/estimates/trend_child.shtm)

<sup>38</sup> Safe Kids Worldwide. (2011). *Fire safety*. Retrieved from <http://www.safekids.org/fire>

In 2011, 15 of the 1,551 total child deaths reported to the SCR (less than 1%) were related to fires.

- The majority of deaths (89%) attributable to fire were accidental and 11% were homicides in 2011.
- More boys (74%) died from fire in 2011.
- Young children were most at risk of fire-related deaths: 11% were under the age of 1, 32% of the deaths in this category were among children aged 1 to 4, 47% for children age 5-9 and the remaining 11% of fire-related deaths were children 10-14. No youth aged 15-17 died from fires in Illinois in 2011.

## **Illinois Data – Deaths Reviewed by CDRTs**

In 2011, 3 of the 177 deaths reviewed by CDRTs (2%) were related to fire.

- In 2011, all 3 of the reviewed deaths from fire were for children aged 5-9 years.

# Poisoning/Overdose

## Definition

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

## Background

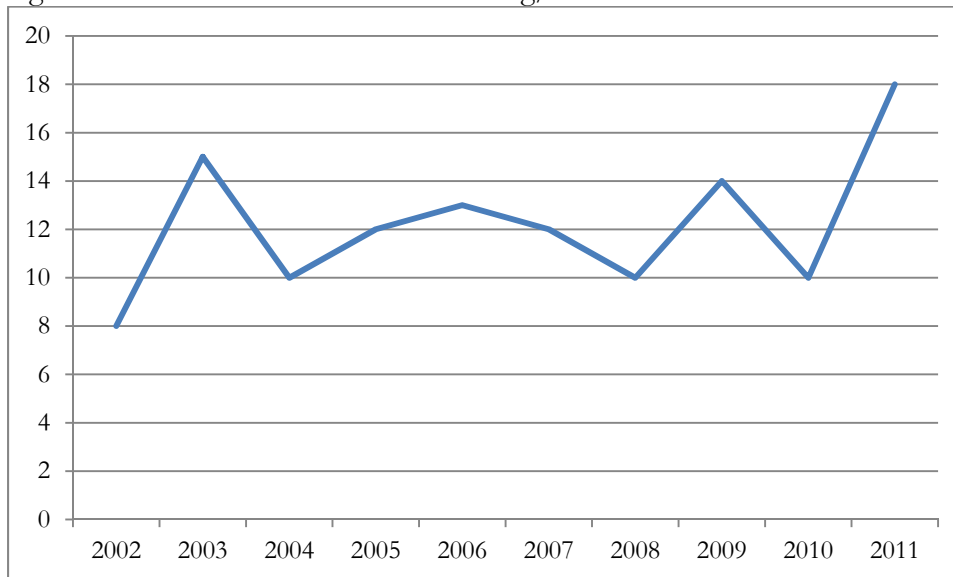
In 2011, 459 children under 18 years died of poisoning in the United States.<sup>39</sup> The majority of these deaths occurred in children 15 to 17 years of age (63%). The age group with the second most frequent number of deaths by poisoning was children under 4 (20%) with children between 4 and 15 accounting for 17% of poisoning deaths.

Each year 60,000 U.S. children are treated in emergency departments for unintentional medication exposure or overdose. For children under five, 95% of these visits are caused by accidental ingestion of medications and 5% are dosing errors.<sup>40</sup> The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

## Illinois Data – Total Child Deaths Reported to the SCR

Between 8 and 18 children died from poisoning per year since 2000 (Figure 27).

Figure 27. Child Deaths Due to Poisoning/Overdose



<sup>39</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>

<sup>40</sup> Baker JM, Mickalide, AD. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on fare medication*. Washington, DC: Safe Kids Worldwide.

In 2011, 18 of the 1,551 total child deaths reported to the SCR (1%) were related to poisoning or overdose.

- In 2011, 12 of the 18 deaths (67%) were determined to be accidents, 4 deaths were homicides, and 2 were suicides.
- Boys (50%) were equally likely to die from poisoning or overdose as girls.
- The majority of the deaths in this category (78%) were among youth between the ages of 15 and 17 years.

### **Illinois Data – Deaths Reviewed by CDRTs**

In 2011, 2 of the 177 deaths reviewed by CDRTs (1%) were related to poisoning/overdose.

- One of the reviewed cases was male and one was female.
- Both of the deaths reviewed in 2011 were infants under the age of 1.

## **Uncommon Death Categories: Other, Scalding Burn, SUCD**

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

### **Other**

As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2011, 5 deaths fell in this category and 4 of them were reviewed.

### **Scalding Burn**

There were no scalding burn deaths in 2011.

### **SUCD (Sudden Unexplained Child Death)**

There were 4 SUCD in 2011 and none of them were reviewed.

# Chapter 5: Trends in Illinois Child Deaths

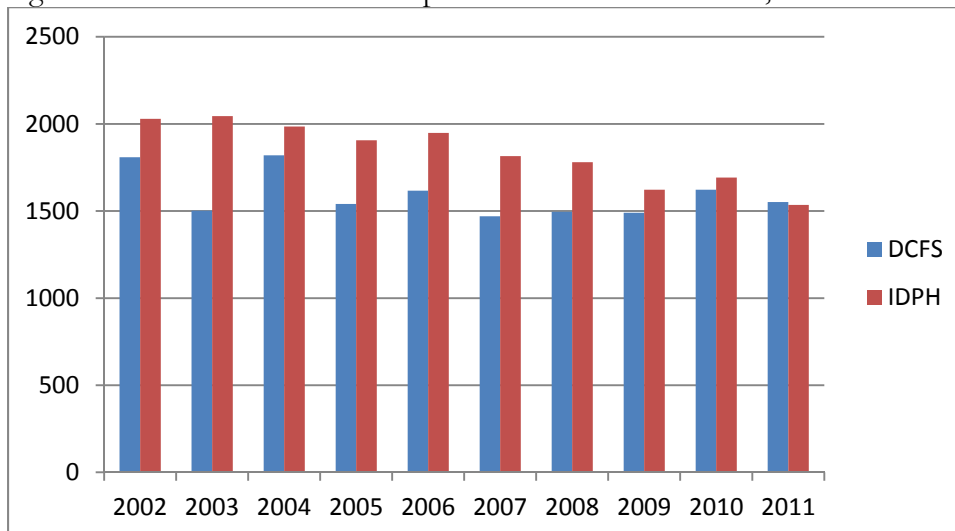
The Illinois CDRT database contains information on child deaths since 2000, which allows for an analysis of the trends in Illinois child deaths over time. As with the yearly analyses, it is important to remember that information on child deaths contained in the CDRT database is based on completed death certificates sent by county registrars and coroners to the Department of Children and Family Services. 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 section 8 of Act online at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1573&ChapterID=35>).

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 C for a breakdown of reported deaths by county).

In the past, only those child death certificates sent to the SCR were entered into the CDRT database and analyzed for this report. Since some child deaths were not included, it diminished the ability of the CDRTs to analyze and understand child death in Illinois and make sound recommendations for preventing future deaths. There were some counties which have never reported child deaths to CDRT, even though the Illinois Department of Public Health (IDPH) has records of child deaths occurring each year (see Appendix C). Other counties have regularly underreported child deaths.

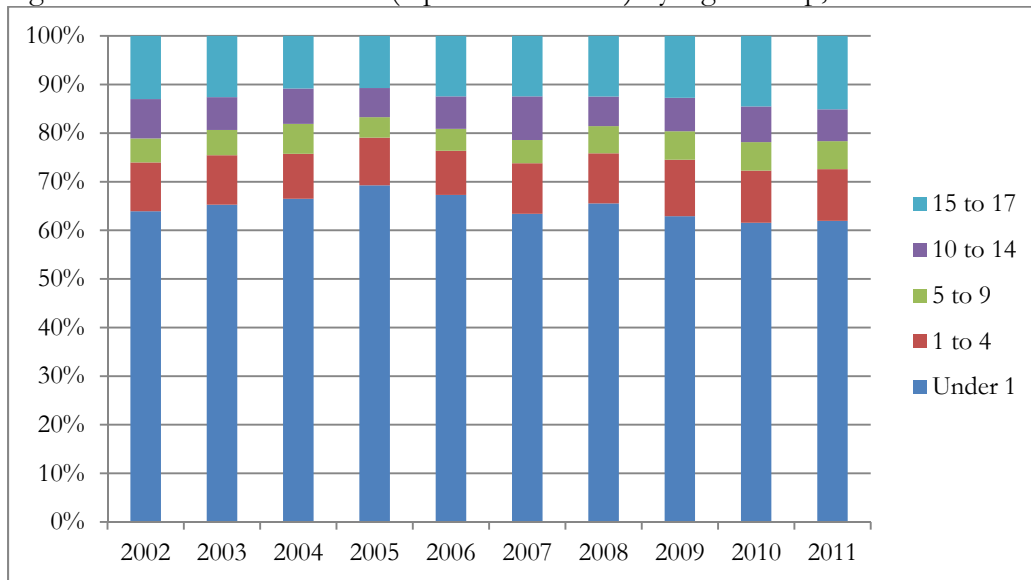
In order for CDRT to better capture all the child deaths which occur in Illinois, a new system was created so that they received the death certificate information on disk in an electronic format starting in the middle of 2010. Therefore, 2011 is the first year with a complete year of data using the new system. As a consequence of this new system, in 2011 there were more deaths reported to DCFS than to IDPH (Figure 28). The total number of deaths that CDRT has tracked have been relatively stable since 2005 (between 1470 and 1622) however this is partially due to capturing more accurately the total number of child deaths. The total number of child deaths (reported by IDPH) in Illinois has been generally decreasing from 2,029 in 2002 to 1,535 in 2011.

Figure 28. Total Child Deaths Reported to DCFS and IDPH, 2002 – 2011



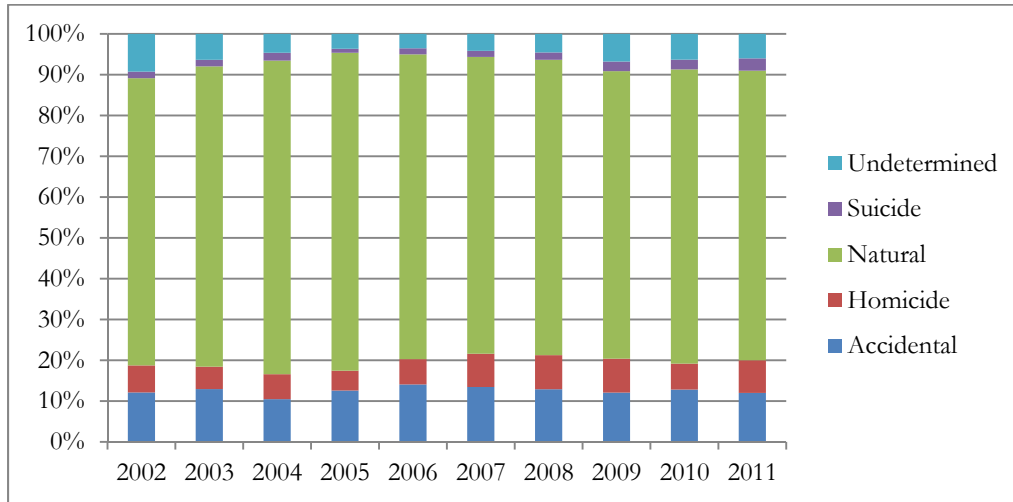
The total child deaths reported to DCFS from 2002 to 2011 is broken down by age group in Figure 29. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another, so that the sum for each year is 100%. This type of graph allows us to compare the percentages of each category across multiple years, so that we can determine, for example, if the percentage of infant deaths is increasing, decreasing, or staying the same. As Figure 29 shows, the percentage of total deaths in each age group is generally stable over the 11- year period: infants under 1 year comprise 62-69% of all child deaths, children between 1 and 4 years comprise 9-12%, children between 5 and 9 years add another 4-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are the final 11-15%. The age distribution for 2011 was the same as in 2010.

Figure 29. Total Child Deaths (reported to DCFS) by Age Group, 2002 – 2011



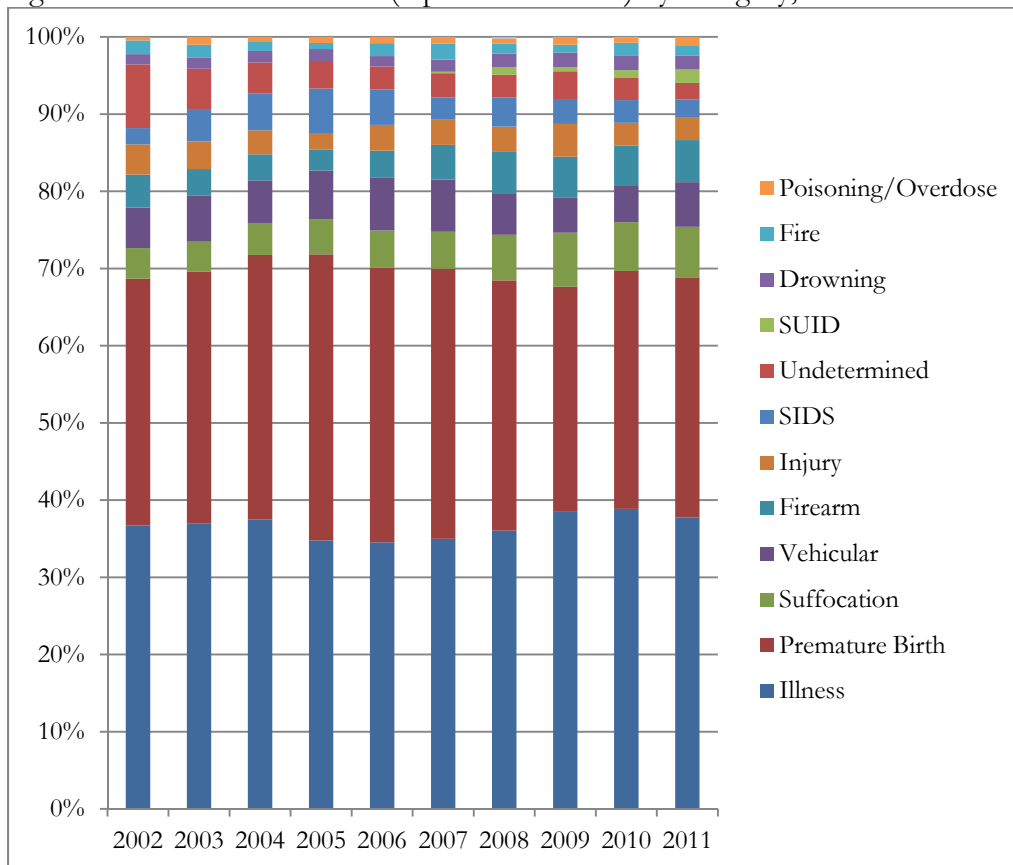
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 70-78% natural, 1-3% suicide, and 4-9% undetermined (see Figure 30).

Figure 30. Total Child Deaths (DCFS) by Manner of Death, 2002 – 2011



A similar analysis was done for category of death (see Figure 31). The overall percentage of child deaths related to each category of death remained relatively stable across the time periods. In order to see changes within category, please refer to charts for specific categories in Chapter 3.

Figure 31. Total Child Deaths (reported to DCFS) by Category, 2002 – 2011<sup>41</sup>



<sup>41</sup> Notice that 4 rare categories are not included in this chart: pending, other, scalding burn, and SUCD

# Appendix A – Child Death Review Team Regional Map



# Appendix B – List of CDRTs by Region

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## Aurora

Lori Chassee, **Chairperson**  
Susan Fackler, MSW, LCSW, CADC, **V.Chair**  
Victoria M. Anderson  
Steve J. Cardona  
Patrick Dowling, MD, FACEP  
Jody Gleason  
Mary E. Jones MD, MPH  
Mitra Kalelkar, MD  
Gregory A. Krantz., RN  
Dawn Livorsi, LCSW  
Judy Moss, RN  
Jonathan Parker, Special Agent  
Glendean Sisk, RN, BSN, CRADC, MPH  
Myra West, PsyD  
DCFS Staff - Thea Ford, Frank Navarro

## Champaign

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Mark Wichman, MS, LCPC, **Vice Chair**  
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Kimberly Cessna, Special Agent  
Donald F. Davison, Jr. MD  
Scott Denton, MD  
Kimberly S. Fitton  
Lise Jankowski, RN  
Beth C. Kimmerling  
Patricia Metzler, RN, TNS, SANE-A & P  
Alex F. Meyer, Sgt.  
Susan Elaine Minyard, PhD  
Barbara Nafziger  
Judy Osgood, PhD  
James Owens  
Cindy Patterson  
Cathie Reynolds  
Dana Rhoades  
Julie Runyon  
Bryant Seraphin, Lt.  
Lawrence Solava  
DCFS Staff - Maria Miller

## Cook Team A

Amanda Fingarson, DO, **Vice Chairperson**  
Alison Alstott  
Barry Bennett, LCSW, ACSW  
Kristen Bilka, MMS, PA-C  
John Brassil  
Donna L. Cervini, Hon.  
Anne Chambers, Det.  
Anne Devaud, PsyD  
Debra DeYoung, Sgt.  
Renee Dominguez, PhD  
Joel Feinstein, MD  
Emalee Flaherty, MD  
Kristine Fortin, MD, MPH  
Jan Fowler, RN, MA  
Jill Glick, MD  
Anne Grote, MSN, CNS  
Kelly Liker, MD  
Lee Ann Lowder  
Sandra L. Martell, RN  
Kevin O'Connell  
Eileen Payonk, Special Agent  
Joan M. Pernecke, Chief  
Adrienne Segovia, MD  
Kelley Thornton  
Barbara White, LCSW  
Yvonne M. Zehr, Chief Deputy  
Virginia Zic-Schlomas, Sgt  
DCFS Staff - Ann Marakis, Donna Steele

**Cook Team B**

Diane Scruggs, **Chairperson**  
Holly Robinson, **Vice Chairperson**  
Sweety Agrawal, PsyD  
James R. Burton  
Karla M. Chaplin, Sgt.  
Stephen J. Cina, MD, FCAP  
Suzanne R. Dakil, MD  
Angela Evans, MPH, RN, BSN  
Lindsay Forrey, LCSW  
Marjorie Fujara, MD, FAAP  
Tamara Girten, Sgt.  
Kathy Grzelak, MA, LCPC  
Mary Joly Stein  
Nancy Jones, MD  
Michele Lorand, MD  
Frank J. Marek  
Mattie McLaurin, M.Ed  
Okechukwu Jude Okeke, MD  
Revelle G. Peritz  
Evelyn Polk-Green, M.S.Ed.  
Norell Rosado, MD  
Emily Siffermann, MD, FAAP  
Demetra Soter, MD  
Sandy Stavropoulos  
Cindy Weatherspoon  
Valencia Williams, PsyD  
DCFS Staff - Steven Minter, Yolanda Jordan

**East St. Louis**

Daniel Cuneo, PhD, **Chairperson**  
Carole A. Presson, Lt. **Vice Chairperson**  
David Bivens, Sgt.  
Jennifer M. Coffin  
Thomas Coppotelli, Maj.  
Cathy Daesch, ATR-BC, LCPC, ICDVP  
Joseph Edwards, Chief  
Alison Hebrank  
Carolyn Hubler, Director  
Gilda Johnson, Det.  
Francis Jones, RN  
David C. Norman, MD  
Kelly Rogers  
Curtis L. Schildknecht  
Lynn Shelton RN  
Cory Smith  
Vicki Vasileff  
Paula E. Wills, Dir.  
Anna Ackerman Young  
DCFS Staff - Valda Haywood

**Marion**

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Chad Brown, Sgt.  
Leah Brown  
Karen Brown, RN, BSN  
Mary Louise Cashel  
Leigh Hammer, RN  
Dustin Lingle  
Frederica Nanni, MD  
Michael S. O'Leary, Lt.  
Linda Reiss  
Melanie Sanders, RN  
Nancy Stewart  
Kathy Swafford, MD  
Margo Tesch, MSW  
Steve Webb, PhD  
Richard White  
L. Patrick Windhorst  
DCFS Staff - Don Rose

**Peoria**

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Paul Bauer  
Janis Benson RN, MS  
Jerry Brady  
Susan Bordenave-Bishop, MD  
Walter Bradley, MD  
Gregg M. Cavanaugh, M/Sgt.  
Stefanie Clarke, BSN, RN, CPEN  
Johnna Ingersoll  
Ruth Lane, Exec.Dir.  
Emily McDonnell, RN  
Marcy O'Brien, Det.  
Channing Petrak, MD  
Debra Phares  
Becky Rossman  
Julie Smith, MSW  
Mark Thomas  
DCFS Staff - Jane Norman, Mary Bowman

**Springfield**

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Roy Harley, **Vice Chairperson**  
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Nancy Brown  
Cinda Edwards  
John Garner, M/Sgt.  
John Hayes, Det.  
Clairice Hetzler  
Jeffrey Lair  
Lorinda Lamken  
Mary Frisk Loken, PhD  
Bette Ann MacIntosh, MD  
John C. Milhiser  
Faith Sanderson  
Amy C. Calvert Winans  
DCFS Staff - James Craven

**Rockford**

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Raymond Davis, Jr., MD  
David Glessner, Det/Sgt.  
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Leah Hantke, RNC, MS, WHNP  
Marilyn Hite Ross  
Julia Marynus, RN, BA  
Dennis Miller  
Lenore Sparapani, LCSW  
Joe Thiele, PhD  
Peter Thomas, PsyD  
Pam VanderVinne RN/CMC  
Dave Watson  
Rebecca Wigget  
DCFS Staff - Jim Marmion

## Appendix C – Illinois Child Deaths by County

County	2003 Deaths		2004 Deaths		2005 Deaths		2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths	
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH*	DCFS	IDPH*	DCFS	IDPH*
Adams	0	4	0	5	0	6	1	8	8	11	1	10	6	5	6	5	4	3
Alexander	0	1	0	0	0	0	0	1	0	1	0	1	1	1	0	2	0	0
Bond	0	1	2	2	1	1	0	0	0	0	1	1	0	0	0	1	2	2
Boone	0	1	0	1	0	3	0	0	0	0	3	3	3	1	1	4	2	
Brown	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Bureau	4	5	9	8	4	4	2	4	2	2	1	2	5	5	6	5	1	1
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	0	0	0	0	1	1	0	0	0	1	1	1	2	2	0	0
Cass	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Champaign	38	39	44	45	52	53	32	47	3	39	21	36	42	36	36	33	43	37
Christian	5	5	2	2	9	10	2	2	0	0	3	4	4	4	4	3	3	2
Clark	0	1	0	0	1	1	1	1	0	0	1	1	0	0	0	1	2	2
Clay	1	1	1	1	0	0	0	0	0	0	0	1	0	0	1	1	0	0
Clinton	3	4	2	5	0	2	0	3	0	3	3	4	1	1	3	3	2	1
Coles	1	2	1	1	0	6	0	8	0	3	0	4	3	5	5	2	5	6
Cook	907	1,261	1,150	1,162	878	1,116	1,014	1,141	926	1,066	908	1,010	768	832	887	920	857	824
Crawford	0	1	0	2	0	0	0	1	0	1	1	1	0	0	2	1	2	1
Cumberland	0	0	0	0	0	2	1	1	0	0	3	2	2	3	2	2	0	0
DeKalb	3	4	5	10	2	4	1	14	4	5	3	3	5	3	4	3	5	5
Dewitt	0	3	0	0	0	1	0	2	0	1	0	0	2	2	0	0	1	1
Douglas	0	1	2	2	0	0	0	0	0	0	0	0	0	0	1	1	1	1
DuPage	80	81	111	111	112	116	93	95	97	99	76	81	65	62	89	76	73	68
Edgar	3	3	1	1	1	1	2	3	0	1	1	2	0	0	0	0	1	1
Edwards	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	0	6	5	5	1	6	3	4	0	7	5	6	1	1	0	1	8	7
Fayette	0	1	1	3	1	1	0	1	0	1	0	0	0	0	1	0	1	1
Ford	0	4	0	1	2	2	1	1	1	1	3	3	1	0	1	1	0	0
Franklin	5	5	3	2	3	0	1	0	3	3	3	3	4	4	5	3	2	1
Fulton	6	6	4	4	0	0	2	2	5	5	0	0	3	4	4	4	0	0
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greene	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1
Grundy	6	6	2	5	1	3	2	3	0	5	3	4	3	4	5	5	3	2
Hamilton	1	1	1	1	0	0	3	3	1	1	3	3	0	0	1	1	1	1
Hancock	0	1	1	2	0	0	0	1	0	0	0	2	2	1	0	0	1	1
Hardin	0	1	0	1	1	1	0	0	0	1	0	0	0	0	2	2	1	2
Henderson	0	0	0	0	0	0	0	3	0	0	0	0	0	1	0	0	0	0
Henry	1	1	3	3	3	3	1	1	4	4	2	2	2	3	4	4	4	2
Iroquois	0	4	1	2	1	1	0	0	0	2	0	1	0	0	3	3	1	1
Jackson	0	5	0	3	0	8	0	4	3	4	8	8	9	8	4	5	8	6
Jasper	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0
Jefferson	0	3	0	0	0	1	1	2	0	3	1	4	1	1	9	9	7	6
Jersey	0	1	0	2	0	1	0	1	1	3	0	2	0	0	1	2	2	3

Jo Daviess	1	1	0	0	2	2	3	3	0	1	0	0	0	0	0	0	4	4
Johnson	0	0	0	2	0	0	0	1	1	0	0	0	2	0	3	0	3	
Kane	21	46	32	38	50	56	44	61	37	46	59	57	55	53	44	41	45	42
Kankakee	11	11	16	16	15	15	14	14	9	9	8	13	5	5	8	8	8	8
Kendall	1	4	0	2	3	3	1	1	6	6	6	6	2	2	1	1	1	1
Knox	4	5	3	2	4	4	5	5	3	3	4	4	2	2	7	8	10	10
Lake	24	39	33	57	17	34	35	58	17	37	26	38	34	47	31	47	35	40
LaSalle	0	7	0	14	0	8	0	9	0	8	0	9	7	7	8	9	9	8
Lawrence	2	2	1	1	1	1	1	1	0	0	1	3	1	1	6	4	4	2
Lee	3	3	1	1	2	1	0	1	0	2	0	1	3	5	1	1	2	2
Livingston	0	9	0	7	0	3	0	4	0	5	2	5	2	2	3	3	5	2
Logan	6	6	2	1	0	0	0	0	0	7	8	6	5	0	0	2	2	
Macon	21	21	12	12	14	14	18	18	15	16	18	21	15	15	11	10	13	13
Macoupin	0	2	3	3	0	1	0	1	0	1	0	0	2	2	2	3	0	0
Madison	10	21	5	29	6	22	8	20	14	19	21	25	16	20	15	13	13	11
Marion	1	4	0	2	2	7	2	2	4	4	4	3	3	6	3	9	5	9
Marshall	0	0	0	1	0	0	0	1	0	0	0	0	3	2	2	1	0	0
Mason	2	2	1	1	0	1	0	3	0	0	0	0	0	0	2	1	0	0
Massac	2	2	2	3	1	2	1	1	1	1	1	1	4	2	0	0	0	0
McDonough	3	3	1	2	0	4	0	2	0	0	0	1	1	2	2	2	1	1
McHenry	14	14	17	17	15	15	9	10	23	24	14	19	11	11	7	6	11	9
McLean	6	9	10	11	14	18	12	16	11	10	14	14	5	6	9	10	13	12
Menard	0	2	0	1	0	3	0	0	0	0	0	1	1	1	1	1	0	0
Mercer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Monroe	1	1	1	1	1	1	1	1	1	1	0	0	2	2	0	1	1	1
Montgomery	2	5	1	1	1	3	2	2	3	3	0	1	1	0	3	3	3	2
Morgan	1	2	1	2	2	2	0	1	1	1	0	2	1	1	2	2	0	1
Moultrie	1	1	0	0	2	2	1	1	0	0	3	3	0	0	1	1	4	4
Ogle	2	3	2	3	3	4	2	2	3	3	4	4	3	3	2	1	1	1
Peoria	103	104	106	107	86	87	92	97	51	77	49	86	76	93	81	80	76	75
Perry	0	2	0	0	0	0	2	3	1	4	2	3	0	0	4	4	0	0
Piatt	0	0	0	1	0	0	0	0	0	1	0	2	0	0	0	0	1	1
Pike	0	3	0	2	0	0	0	2	0	0	0	0	0	0	2	2	0	0
Pope	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Pulaski	0	0	0	1	0	0	0	0	0	0	0	0	2	2	0	0	0	0
Putnam	0	0	1	1	0	0	0	0	0	0	0	0	2	2	0	0	0	0
Randolph	1	4	1	1	1	2	0	0	1	4	0	0	1	1	1	1	1	1
Richland	0	0	3	3	4	4	1	3	0	0	1	3	1	1	1	1	2	2
Rock Island	13	15	8	8	17	17	4	4	19	19	12	12	18	17	12	9	12	11
Saline	0	1	1	2	1	1	3	3	2	2	2	2	4	2	4	3	1	1
Sangamon	55	58	68	71	57	58	45	52	48	54	32	46	51	48	46	43	38	46
Schuyler	0	1	0	0	0	0	0	3	0	0	0	0	0	0	4	0	6	0
Scott	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0	0	0	0
Shelby	4	4	0	0	0	0	3	3	1	1	3	3	2	5	1	2	0	0
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Clair	28	29	29	26	22	29	23	35	14	29	7	26	26	28	18	16	18	15
Stephenson	5	7	8	9	5	5	1	2	3	4	4	5	4	4	5	4	2	2
Tazewell	7	7	3	4	9	10	6	9	3	5	4	7	2	2	2	3	3	2
Union	0	5	0	1	0	1	0	0	2	2	0	0	2	2	3	3	1	1

Vermillion	0	2	4	4	8	9	3	4	9	12	1	6	13	14	7	6	8	6
Wabash	0	3	0	1	0	2	0	0	0	1	0	2	3	2	0	0	0	0
Warren	0	2	0	1	0	1	0	1	0	0	0	1	0	1	1	1	1	1
Washington	1	2	0	1	0	1	0	1	0	1	0	0	0	0	2	2	1	1
Wayne	1	1	0	0	0	0	1	1	1	2	0	1	1	1	1	1	1	1
White	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1
Whiteside	0	1	2	5	1	5	1	4	0	6	0	3	7	6	3	5	4	3
Will	26	28	49	50	35	36	40	41	42	43	42	38	44	47	38	35	28	26
Williamson	4	6	6	6	8	1	6	2	4	9	8	9	6	5	5	5	10	9
Winnebago	48	70	31	57	54	57	61	75	58	65	71	78	59	48	61	49	51	43
Woodford	1	1	0	0	1	1	1	2	0	0	1	1	1	2	2	2	3	3
Unknown	2	0	5	0	3	0	0	0	0	0	0	0	18	0	1	0	0	1
Out of State	–	–	–	–	–	–	1	0	4	0	13	0	27	81	53	117	46	97
Total	1,502	2,045	1,820	1,985	1,540	1,906	1,617	1,948	1,470	1,815	1,495	1,780	1,490	1,622	1,622	1,692	1,551	1,535

**\*Deaths for IDPH are for facility of death**

