



ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR
2012



MISSION

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

Illinois Department of
DCFS
Children & Family Services

SUBMITTED TO:

The Honorable Pat Quinn,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

JUNE 2014

Illinois Child Death Review Teams

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May 2014

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

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2012. In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All of the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

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

We want to thank DCFS Director Bobbie Gregg 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

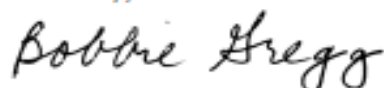
Dear Readers,

It is my privilege to present the 2014 Illinois Child Death Review Teams Annual Report. The information in the report includes the data for the child deaths that occurred during calendar year 2012.

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. I take these recommendations very seriously, and I appreciate the opportunity to 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,



Bobbie Gregg
Acting Director
Illinois Department of Children and Family Services

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 CDRTS 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, Tamara Skube, Bernadette Emery, and Sherry Barr provided the data analyses from the Child Death Review Team database and suggestions to Dr. Saijun Zhang. Children and Family Research Center staff Dr. Saijun Zhang and Dr. Tamara Fuller wrote the report, and Gail Title also provided editing help for the report.

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Table of Contents

List of Tables	7
List of Figures.....	7
Executive Summary	8
Introduction.....	10
Chapter 1: Child Death Review in Illinois	11
Chapter 2: Child Death Review Recommendations to Prevent Child Deaths	19
Chapter 3: Illinois Child Deaths 2012.....	27
Chapter 4: Child Deaths by Category	39
Premature Birth	40
Illness	42
Suffocation	44
Vehicular Accident.....	47
Firearm.....	50
Injuries	53
Sudden Infant Death Syndrome (SIDS) and unknown Infant Deaths (SUID).....	55
Undetermined	57
Drowning.....	58
Fire.....	60
Poisoning/Overdose	62
Uncommon Death Categories: Other, Scalding Burn and SUCD.....	64
Chapter 5: Trends in Illinois Child Deaths	65
Appendices	
A - Child Death Review Team Regional Map.....	68
B - List of CDRTs by Region.....	69
C - Illinois Child Deaths by County.....	72

List of Tables

Table 1. 2012 Recommendations and Responses	20
Table 2. Child Deaths by Category of Death	32
Table 3. Manner of Death – Total Child Deaths and Deaths Reviewed by CDRTs	33
Table 4. Total Child Deaths – Manner of Death by Category of Death.....	34
Table 5. Homicide Deaths.....	36

List of Figures

Figure 1. The Child Death Review Process in Illinois	15
Figure 2. Child Death Reviews	16
Figure 3. Illinois Child Deaths by Gender	28
Figure 4. 2010 Illinois Child Population by Age	29
Figure 5. Illinois Child Deaths by Age Group	30
Figure 6. Illinois Child Deaths by Race/Ethnicity.....	31
Figure 7. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs	33
Figure 8. Child Deaths Due to Prematurity	41
Figure 9. Child Deaths Due to Illness	42
Figure 10. Child Deaths Due to Illness by Age.....	43
Figure 11. Child Deaths Due to Suffocation.....	45
Figure 12. Child Deaths Due to Suffocation by Age	46
Figure 13. Child Deaths Due to Vehicular Accidents	48
Figure 14. Child Deaths Due to Vehicular Accidents by Age.....	49
Figure 15. Child Deaths Due to Firearms	51
Figure 16. Child Deaths Due to Firearms by Gender.....	52
Figure 17. Child Deaths Due to Firearms by Age	52
Figure 18. Child Deaths Due to Injuries	53
Figure 19. Child Deaths Due to Injuries by Age.....	54
Figure 20. Child Deaths Due to SIDS and Unknown Causes	56
Figure 21. Child Deaths with Undetermined Cause of Death	57
Figure 22. Child Deaths Due to Drowning	58
Figure 23. Child Deaths Due to Fire	60
Figure 24. Child Deaths Due to Poisoning/Overdose	62
Figure 25. Total Child Deaths Reported to DCFS and IDPH, 2003-2012.....	65
Figure 26. Total Child Deaths (reported to DCFS) by Age Group, 2003-2012.....	66
Figure 27. Total Child Deaths (reported to DCFS) by Manner of Death, 2003-2012.....	66
Figure 28. Total Child Deaths (reported to DCFS) by Category, 2003-2012.....	67

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 2012

In 2012, 1,540 children under 18 died in Illinois. This number represents the death information received by CDRTs.

Of the total child deaths reported to DCFS in 2012:

- 57% were boys and 43% were girls;
- 58% were infants under one year, 17% were young children between 1 and 4 years, 6% were older children between 5 and 14 years, and 12% were youth between 15 and 17 years.

When Illinois child deaths in 2012 were examined by the manner of death:

- 70% were attributable to natural causes;
- 12% were accidental;
- 7% were homicides;
- 2% were suicides;
- 9% were undetermined.

When deaths occurring in 2012 were examined by the category of death:

- 34% were related to illness;
- 36% were related to premature birth;
- 1% were related to Sudden Infant Death Syndrome (SIDS) and 3% were related to other types of sudden unexpected infant deaths;
- 21% were related to various types of injuries, such as vehicular accidents (4%), firearms (5%), drowning (2%), fires (1%), suffocations (5%), and other types of injuries (3%);
- 4% were due to undetermined causes.

2012 Child Deaths Reviewed by the CDRTs

In 2012, 188 child deaths were reviewed by the CDRTs, including 185 mandatory and 3 discretionary reviews. The reviews were mandated for one of several reasons, including 110 where death was indicated, 20 for indicated reports, 43 had an investigation in the year before the child's

death, 12 had an open case at the time of death, and 3 had a pending investigation at the time of death.

Reviewed Deaths in 2012 occurred in all CDRT's regions (see Appendix A for map of region):

- Aurora – 21 of the 203 deaths (10%) were reviewed.
- Champaign – 15 of the 71 (21%) were reviewed.
- Cook – 88 of the 857 (10%) were reviewed.
- East St. Louis – 7 of the 41 deaths (17%) were reviewed.
- Marion – 16 of the 54 deaths (30%) were reviewed.
- Peoria – 21 of the 149 deaths (11%) were reviewed.
- Rockford – 7 of the 52 deaths (13%) were reviewed.
- Springfield – 5 of the 57 deaths (9%) were reviewed.

Of the deaths reviewed by CDRT's in 2012:

- 57% were boys and 43% were girls;
- 39% were infants under one, 39% were young children between one and four years, 15% were older children between 5 and 14 years, and 6% were youth between 15 and 17 years.

When reviewed deaths occurring in 2012 were examined by manner of death:

- 34% were attributed to accidents;
- 19% were due to natural causes;
- 18% were homicides;
- 2% were suicides;
- 28% were undetermined.

When reviewed deaths occurring in 2012 were examined by category of death:

- 17% were related to illness;
- 2% were related to premature birth;
- 1% were related to Sudden Infant Death Syndrome (SIDS) ;
- 59% were related to various types of injuries, such as suffocations (23%), injuries (14%); vehicular accidents (5%), drowning (6%), fires (4%), poisoning/overdose (4%), and firearms (3%);
- 12% were due to undetermined causes.

INTRODUCTION

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations, and safety policies that have led to a decline in infant and child mortality, too many Illinois children are still dying. In 2012 there were 1,540 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 CDRTs produced the 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 hopes of furthering understanding of how we can make Illinois a safer and healthier state for children.

Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998 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 Services (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 CDRTs sub-regions is located in Appendix A.

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

- Pediatrician or other physician knowledgeable about child abuse and neglect,
- Representative 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 CDRTs see Appendix B.

Child Death Review Team Executive Council

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

In the past year, the Illinois Child Death Review Teams (CDRTs) 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 2012 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.
- Child Death Review Teams began using an electronic document sharing system in 2013. This application, termed Document Transfer System, was programmed by DCFS OITS division. The Document Transfer System allows for convenient and highly secure information sharing. This system allows team members to sign onto a secure website and obtain child death information related to DCFS investigations, hospital records, medical records, coroner reports and police reports. Team members can review relevant information on a child's death, thus attaining a thorough understanding of the entire case prior to a CDRT meeting. This new system allows the multidisciplinary members of a team access to all relevant information.
- The 17th Annual Child Death Review Teams Symposium was held April 11-12, 2013 at the Hilton in Springfield. The presentations included: 1) Failure to Thrive – JPA Individualized Growth Chart by Stephen Budde, Ph.D., LCSW; 2) Felony Review Process as it Relates to Child Death Cases by John Brassil, Cook County Assistant State's Attorney, Lawrence Solava, Champaign County Assistant State's Attorney; 3) Profiling Mothers Who Kill Their Children by Barbara Kirwin, Ph.D.; 4) DCFS Hotline by Nora Harms-Pavelski, DCFS Hotline Administrator; and 5) Changes in DCFS by Denise Gonzales, DCFS Chief of Staff. The symposium was well attended with 100 members present.

DCFS Roles and Responsibilities

The Illinois DCFS Division of Chief of Staff provides essential administrative support and assistance to the CDRTs (i.e., the CDRT Coordinator). In addition, the Department serves as a direct link between the review teams and the State's child protection policy makers. The Director of DCFS must review and reply to recommendations made by the CDRTs within 90 days of receipt.

Illinois Child Death Review Process

The Illinois child death review process is outlined in the CDRT *Protocol for the Multi-disciplinary Review of Child Deaths*. This protocol provides a practical manual for CDRT members and ensures

comparability of CDRT reviews and findings among the teams by defining: 1) the types of cases to be reviewed, 2) the procedures used to review cases, and 3) the confidentiality parameters of review findings and recommendations.

Purpose of Child Death Review

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

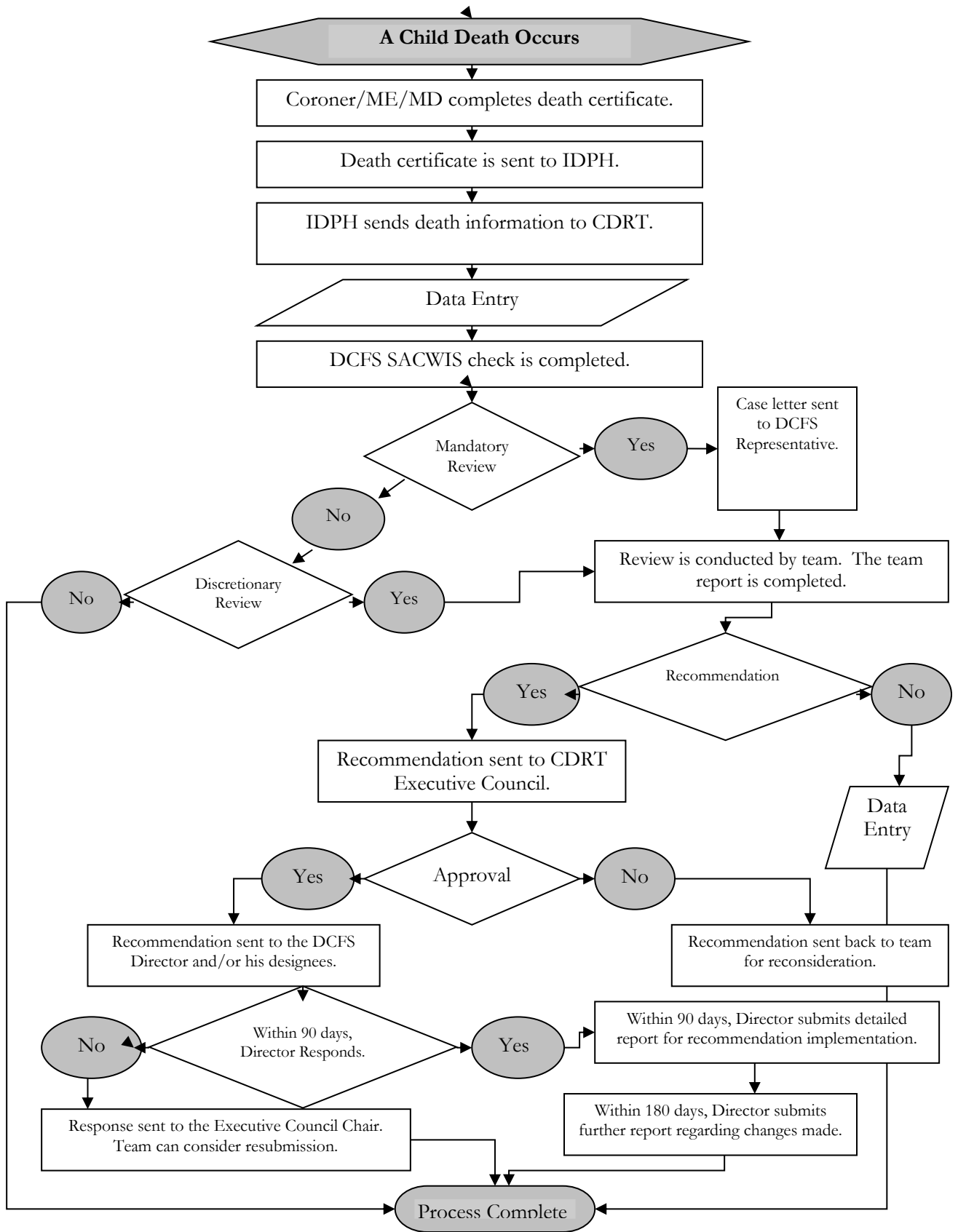
Other responsibilities of the CDRTs are to:

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

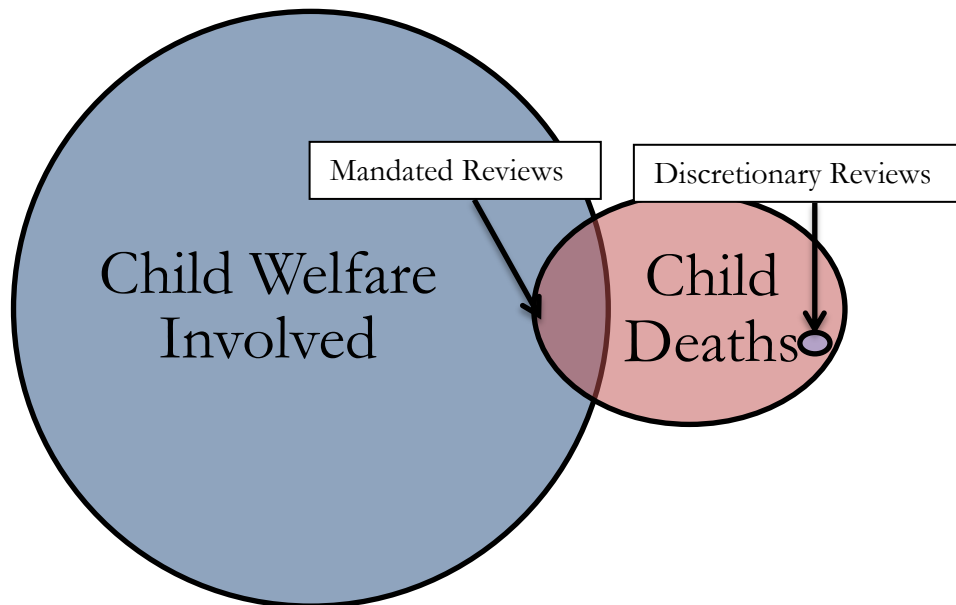


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the death certificate to the Illinois Department of Public Health (IDPH). IDPH electronically provides the Child Death Review Office with the information. The death information is added to the Child Death Review Database.

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

- a 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 the Child Death Review Office as the result of indicated child abuse or neglect.

Figure 2. Child Death Reviews



CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18, as well as cases of serious or fatal injuries to a child identified under the Child

Advocacy Center Act.¹ These reviews are called discretionary reviews (Figure2). Information from the death certificates received by the CDRTs is electronically entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is completed at the CDRT meeting.

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

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

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

CDRT Access to Information

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

¹ 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 2012.

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 26 system recommendations made by the CDRTs on deaths occurring in 2012 (See Table 1). The majority of the recommendations (24) focused on DCFS policy and procedures. The DCFS recommendations resulted from 4 types of reviews including: death indicated (17), indicated report at time of death (5), open child case at time of death (1), and discretionary review (1). There was 1 recommendation for other system and 1 primary prevention recommendation on deaths occurring in 2012.

There were 14 case specific recommendations in 2012. Ten of the case specific recommendations resulted from cases where death was indicated, 1 was from a case that had an indicated report at the time of death, 2 were from cases that had an investigation in the year before the death, and 1 of the case specific recommendations was from an open child case at the time of death.

Key:

PP = Primary Prevention recommendation

DCFS = DCFS recommendation

OS = Other System recommendation

Table 1. 2012 Recommendations and Responses

Number	CDRT Recommendation	Response
DCFS-1	Team recommends that at the time of handoff or prior to the handoff, the receiving worker and supervisor should be paralleled into the case so that the case can be reviewed and information can be clarified. Currently, the receiving worker has to rely on what is being orally reported by the current worker.	Awaiting additional information.
DCFS-2	Team recommends that the physical case transfer be done no later than the time of the transitional visit or the case cannot be accepted. This would allow the receiving worker to review relevant documents, client contacts, ask clarifying questions, and be better prepared to work on the case effectively.	Awaiting additional information.
DCFS-3	Team recommends DCFS critical incident debriefing for staff that has death cases in addition to the SPS program where supervisors in addition to staff themselves can request that the services be made available.	DCFS disagrees with this. This is a union issue.
DCFS-4	Team recommends that DCFS intact and POS intact workers be reminded of the importance of grief counseling for children and the impact death has on children. Clarification should be given that it is not necessary for parents to complete services prior to commencing services to surviving siblings.	DCFS agrees.
DCFS-5	Team recommends that DCFS implements 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 were educated on safe sleeping arrangements and they have chosen not to follow the recommendation. Team recommends that DCFS implement the policy that was previously agreed to by the Department to indicate unsafe sleep deaths for allegation 51 when drugs or alcohol is involved.	DCFS is re-writing Procedure 300 and will include what will be indicated. Deputy Director of Policy and Advocacy stated that DCFS is in the process of gathering all of the recommendations from CDRT and OIG for review and discussion regarding inclusion in Procedure 300.

DCFS-6	Team recommends that DCFS implements the policy that was previously agreed to by the Department to indicate unsafe sleep deaths.	DCFS is re-writing Procedure 300 and will include what will be indicated.
DCFS-7	Team would like to re-visit a previous CDRT recommendation that DCFS has a protocol in place for consistent findings for unsafe sleeping conditions.	DCFS is re-writing procedure 300 and will include what will be indicated.
DCFS-8	DCFS should look at policy to ensure that when a family care plan is created for a minor, background checks are completed on all household members 13 years old and over. A home visit and the home safety checklist should be completed to assess the home environment. Approval of the family case plan along with rationale for approval should be a critical decision made by the supervisor.	DCFS agrees with this recommendation.
DCFS-9	Team recommends that phone testimony not be allowed at administrative hearings.	DCFS disagrees with this recommendation. Department Rule 336.170 stated that, "for good cause shown, the Administrative Law Judge may, on the judges own motion or the motion of any party allow a witness to testify at the administrative hearing by telephone. Live testimony is preferred. However, telephone testimony may be allowed because doctors and professionals are not always able to come in person and wait at an all-day hearing for their opportunity to offer relevant testimony. Telephone is not frequent or the norm at the Administrative Hearing unit."

DCFS-10	Team recommends that there be refresher training for intact and child protection staff, as well as child protection supervisors and intact supervisors, on creating family care plans and death investigations. Specifically, training should focus on how to determine if a family care plan is appropriate (factors to be considered). As well, training should focus on improving practice in death investigations. This should be a multidisciplinary presentation of information and interagency approach to training (ex. learning the DHS system to access records, such as WIC, Family Case Management, APORS system and how to access records used in making inculpatory and exculpatory evidence).	DCFS agrees. DCFS will update and train on appropriate use of Safety Planning in investigations.
DCFS-11	DCFS should review and reinforce the existing protocol regarding Integrated Assessment. DCFS should make sure that recommendations from the Integrated Assessment are included in the service plan and the service plan is followed.	DCFS agreed. The Department released SACWIS 5.0 November 20, 2013 which included that initial service recommendations from the Integrated Assessment automatically populate the service plan.
DCFS-12	Daycare centers and homes licensed by DCFS must ensure that children are wearing coastguard approved, properly fitted personal flotation devices for children swimming in public pools/water parks unless otherwise waived in writing by the parent or guardian.	DCFS rejected this recommendation. The American Red Cross does not have a policy on how and if flotation devices should be used in pools. The cost parents will incur relative to the purchase may be a deterrent for some children's participation.
DCFS-13	Team would like DCFS to change policy to include that when one or more minor residents of the household are found to be seriously abused or killed, that the other minor residents of the household are accompanied by a DCFS investigator to the hospital for a thorough medical exam, and the other minor residents not be left in an in-home safety plan with a mere recommendation to take the minor residents for a medical exam.	DCFS disagrees that the investigator should be mandated to accompany the family and child to the hospital because it may not always be feasible. When possible, they do accompany the family and child. The Procedures 300 workgroup will include that the investigator contact the hospital and provide details of the case prior to the family's arrival and when possible and appropriate, the worker will attempt to go to the medical facility.

DCFS-14	Team would like DCFS to add to policy that when minor residents are taken to a hospital, they be taken to a hospital with a child abuse team when possible.	Currently, investigators are instructed to take the minors to the nearest hospital emergency room or medical facility to ensure that the minors receive immediate medical attention.
DCFS-15	Team requests that when DCFS knows there is methadone usage in a home, the intact worker at every visit should discuss safe methadone storage. As long as the case is open, the intact worker should check where the methadone is kept.	DCFS agrees to conduct training for intact workers on methadone mixing, storage and monitoring/checking where the methadone is stored.
DCFS-16	Team recommends that DCFS collect all information on deaths of wards and includes this information in the DCFS file before closing the case. This should include autopsy report, coroner report, police report and fire report if applicable.	DCFS agrees.
DCFS-17	Team requests that DCFS provides specific training to Henry County first responders about calling neglect cases into the hotline, including sleep death cases.	Mandated Reporter Training was held on September 13, 2013 at the Kewanee Hospital.
DCFS-18	Team would like DCFS to revise the mandated reporter training to include examples and explanation of neglect including unsafe sleep death cases with a reminder not to assume someone else has already called.	DCFS agrees.
DCFS-19	Team requests that in DCFS investigations of cases of bruising, tears or broken bones in children under the age of one, DCFS should request a second opinion from a second radiologist and/or doctor who specializes in child abuse.	DCFS disagrees. DCFS will consult with a specialist when available. If there is a reason to question the diagnosis, for example, during the investigation, if information obtained leads the investigator to suspect that the diagnosis is incorrect, then it will be at the discretion of DCFS to consult with another physician.
DCFS-20	DCFS create a protocol that when a hospital or doctor makes a mistake and misses child abuse, someone in DCFS, either legal department or supervisor should make contact with that hospital and doctor to notify them of the missed diagnosis of child abuse and document such contact in the case file.	DCFS disagrees. Our investigators are not trained to make judgment about the medical competence of a medical physician.

DCFS-21	Team requests that DCFS Quality Assurance and Medical Director complete an audit of DCFS cases that have gone to this hospital within the last 2 years. Any acute care institution should practice evidence based guidelines in evaluations of physical abuse cases.	During our investigation of this case, DCFS discovered that the deceased minor was seen at this Hospital in the Emergency Room as a result of reported signs of head trauma. This Hospital performed a CT on the brain and found multiple skull fractures. A skeletal survey was also performed. It appears that CDRT was not provided with all the information regarding the various tests performed. Audit is not necessary because this Hospital performed the appropriate medical tests.
DCFS-22	Team requests DCFS adds one line to the home safety checklist. After it states "call poison control," add "do not induce vomiting prior to calling poison control." Team would like to have this in bold letters.	The Home Safety Checklist was revised in October 2013 as suggested.
DCFS-23	Team recommends that DCFS gets the free magnets offered by National Center for Poison Control to pass out while doing investigation, intact services, and permanency. Team suggests that DCFS contact Poison Control to find out what language to use.	The magnets are not free. The poison control center charges \$225.00 for 2500 magnets, \$20.81 tax and \$5.00 shipping and handling for a total of \$250.81. DCFS is asking Council to pay for this out of CDRT funds. Council made the decision not to spend the money on this.
DCFS-24	Team recommends that CDRT and DCFS together sponsor training for DCFS investigators and intact including POS on incidence and prevalence in death related to unsafe sleeping including the distinction between SIDS and SUDI.	DCFS agrees that they need to give some guidance on this. DCFS asked CDRT to assist in creating guidelines and once CDRT has developed the guidelines, DCFS will work with them to ensure both sides are satisfied with the guidelines. DCFS agreed that this training could be web-based training.
PP-1	DCFS considers a prevention campaign for young mother's leaving their children with their paramours, and the brochure would add alternative care options.	DCFS previously developed a brochure but discontinued its use because the word "lover" was used. DCFS agreed to revise the brochure and change the word "lover" to "partner" and make additional revisions if needed. DCFS

		developed the "How Well Do You Know Your Partner" brochure which was distributed in January, 2014.
OS-1	Team recommends that a letter be written to the Consumer Product Safety Commission recommending that gas water heaters be preset to 120 degrees in an attempt to avoid scalding burns.	A letter was drafted, approved and mailed to the Consumer Product Safety Commission.
CS-1	Team recommends that the Director be notified of the great job staff did in preparing and presenting this case, with special thanks to the intact worker.	No response needed from DCFS.
CS-2	Team recommends that the children be offered grief counseling immediately since some of them witnessed a very traumatic/gruesome death and tried to stop the mother. The 16-year old expressed that he feels responsible because he should have been there to stop it.	The children received grief counseling from October 2012 to March 2013. The 16-year old participated in counseling at school. Family therapy started 9 months later. They could not participate in family therapy until mom was ready.
CS-3	Team recommends that this case be used as part of refresher training for intact and child protection staff.	DCFS agrees.
CS-4	Team recommends that DCFS looks at this POS agency and how they handled this entire case.	DCFS agrees.
CS-5	Team would like DCFS to look at how this investigation was handled by both the investigator and supervisor. Team would like the Department to look at the decision to return the child home.	DCFS agrees. The Director said the Department would take a look at how to handle treating physicians that may not know the child.
CS-6	Team requests DCFS look at this case. Integrated assessment was not reviewed carefully and should have been followed through within a timely manner. Some of the key recommendations were not pursued for close to a year. In the case review process, all participating should ensure that the integrated assessment is and has been reviewed thoroughly, implemented in detail and in a timely manner.	DCFS agrees. DCFS conducted a clinical review of this case. All recommendations from the Integrated Assessment were included in the initial Service Plan. Psychiatric services were not offered timely. The natural mother completed the full psychiatric evaluation 1 year and 3 months after the death of her child. The lack of timely psychiatric services and importance of addressing psychiatric concerns timely was discussed with the worker and agency administration.

CS-7	Team requests DCFS looks at this case and how it was handled. In home safety plan was used. Look at how safety was assessed and ensured on the minors in this case. No one accompanied the family to the hospital to be sure they got there. Time delayed.	DCFS agrees.
CS-8	Team would like a commendation letter sent to DCFS investigator.	No response needed from DCFS. Team Chairperson will write the letter.
CS-9	Team would like DCFS to use this case as a training tool for SCR. Team is concerned that this was not taken as a risk of harm allegation due to the aunt's history as well as mom's history with the Department.	DCFS disagrees. The babysitter had children removed. However, it was noted that she had her 4 youngest children in her care. Mother had unfounded reports and still had children in her care. Medical examiner noted no signs of abuse/neglect. Medical examiner reported a blanket in the crib but felt it was not a factor in the death. County sheriff only added information regarding the number of children the babysitter had lost and had currently with her. County sheriff reported they were investigating.
CS-10	Team recommends that a trauma focused treatment assessment should be completed on the other 4 children and treatment provided if needed.	DCFS agrees. A trauma focused treatment assessment was conducted on all 4 children. Three of the children are currently participating in therapy.
CS-11	Team would like DCFS to make a hotline call if dad does not get convicted for the safety of his natural child.	The dad was convicted for the child death.
CS-12	Team would like the initial investigator who was on call and the next investigator who took the case to be reminded about adding allegations regarding additional victims.	DCFS agrees.
CS-13	Team would like a commendation letter written to the Winnebago County Police Department complimenting them on a job well done on this case.	No response needed from DCFS. Team will write the commendation letter.
CS-14	Team would like a letter written to the Director and supervisor commending the investigator for excellent work on this case.	No response needed from DCFS. Team Chairperson will write the letter.

Chapter 3: Illinois Child Deaths in 2012

What do we know about the child deaths that occurred in Illinois during 2012?

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 who died differ from those in the general child population in Illinois.

The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths (98% in 2012) are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children involved with child welfare in Illinois is more likely to be younger and 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 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.

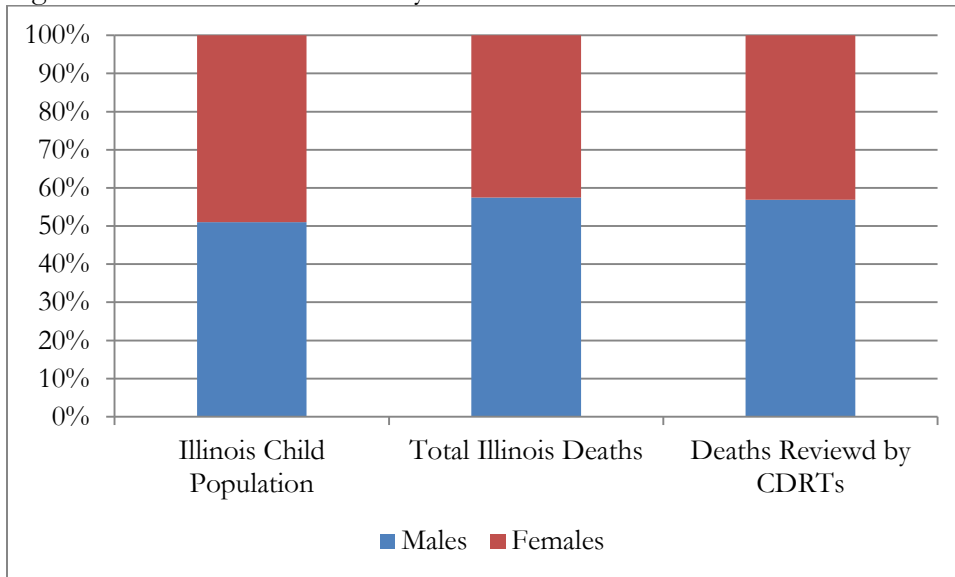
With this information in mind, the following provides a brief look at the three groups:

- 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 2012, there were 1,540 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.
- There were 188 child deaths that occurred in 2012 that were reviewed by the CDRTs – 185 of these were mandated for review and 3 were discretionary reviews.

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 57% of both total child deaths and reviewed deaths in 2012 (see Figure 3).

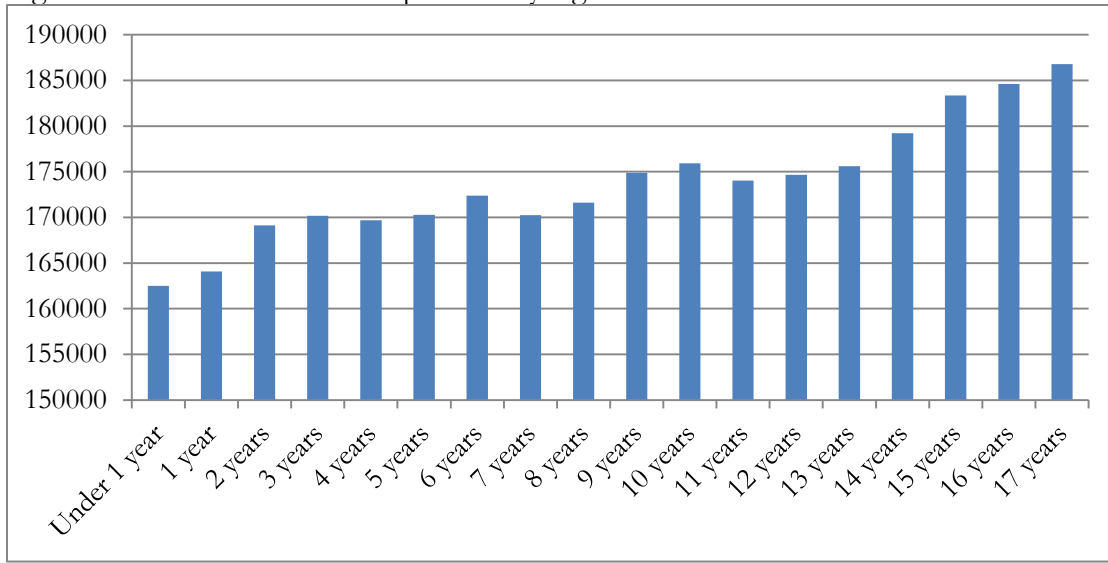
Figure 3. Illinois Child Deaths by Gender



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% were less than one year of age, 22% were between 1 and 4 years, 27% were between 5 and 9 years, 28% were between 10 and 14 years, and 18% were between 15 and 17 years.²

Figure 4. 2010 Illinois Child Population by Age

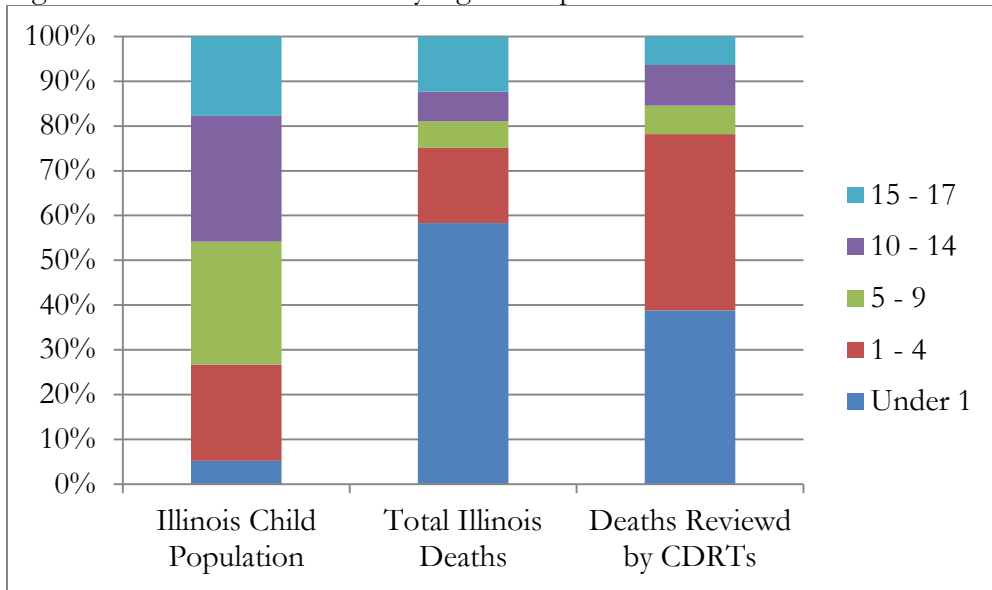


However, when the total Illinois child deaths reported to CDRTs are examined by age (see Figure 5), it becomes clear that infants less than one year old are especially vulnerable – 58% of the total deaths in 2012 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Older children are less likely to die: in 2012, 17% 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 12% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group (see Figure 5), infants under one year are again over-represented; they comprised 39% of reviewed deaths in 2012. Children between 1 and 4 years made up 39% of reviewed deaths in 2012. Older children make up a smaller portion of reviewed deaths: 6% of reviewed deaths were for children aged 5 to 9 years old, 9% of reviewed deaths were for children aged 10 to 14, and 6% of reviewed deaths were for children aged 15 to 17.

² 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

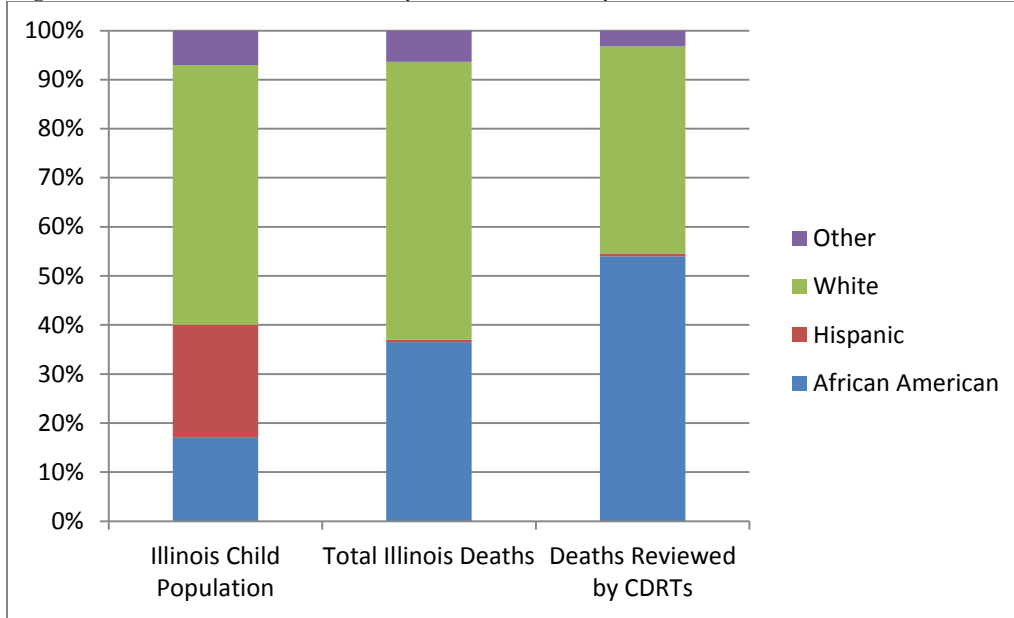
In 2010, there were 3.1 million children 17 and younger in Illinois, including 53% White, 23% Hispanic, 17% African American, and 7% other race/ethnicity (see Figure 6).³

Among the 1,540 total child deaths reported to CDRTs in 2012, 57% were White, 37% were African American, less than 1% were Hispanic, and 6% were other race/ethnicity (see Figure 6).

Among the 188 child deaths reviewed by the CDRTs in 2012, 54% were African American, 42% were White, 1% were Hispanic, and 3% were other race/ethnicity (see Figure 6).

³ Annie E. Casey Foundation. Kids Count Data Center. Retrieved on May 9, 2014, from <http://datacenter.kidscount.org/>.

Figure 6. Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

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

Categories of death for child deaths that occurred in Illinois in 2012 are shown in Table 2. The majority of total child deaths were related to either premature birth (36%) or illness (34%). The other categories accounted for the remaining 30% of the total child deaths and included suffocation (5%), firearms (5%), vehicular accidents (4%), undetermined (4%), injury (3%), SUID (3%), drowning (2%), fire (1%), poisoning/overdose (1%), and SIDS (1%).

Table 2. Child Deaths by Category of Death

	Total Deaths*		Reviewed Deaths*	
	N	%	N	%
Prematurity	547	36%	4	2%
Illness	529	34%	31	17%
Suffocation	82	5%	43	23%
Firearms	78	5%	5	3%
Vehicular	65	4%	10	5%
Undetermined	58	4%	22	12%
Injury	51	3%	27	14%
SUID	50	3%	15	8%
Drowning	27	2%	11	6%
Fire	15	1%	7	4%
Poison/Overdose	15	1%	7	4%
SIDS	11	1%	1	1%
Other	3	<1%	3	2%
SUCD	2	<1%	0	0%
Scalding burn	1	<1%	1	1%
Total	1534		187	

*Note: there were 6 “pending” cases in total deaths and 1 “pending” case in reviewed deaths at the time of the report.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 2). In 2012, deaths reviewed by CDRTs were most likely to be related to suffocation (23%), illness (17%), injury (14%), undetermined (12%), and SUID (8%). A detailed analysis of all the categories of deaths is included in chapter 4 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
- 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

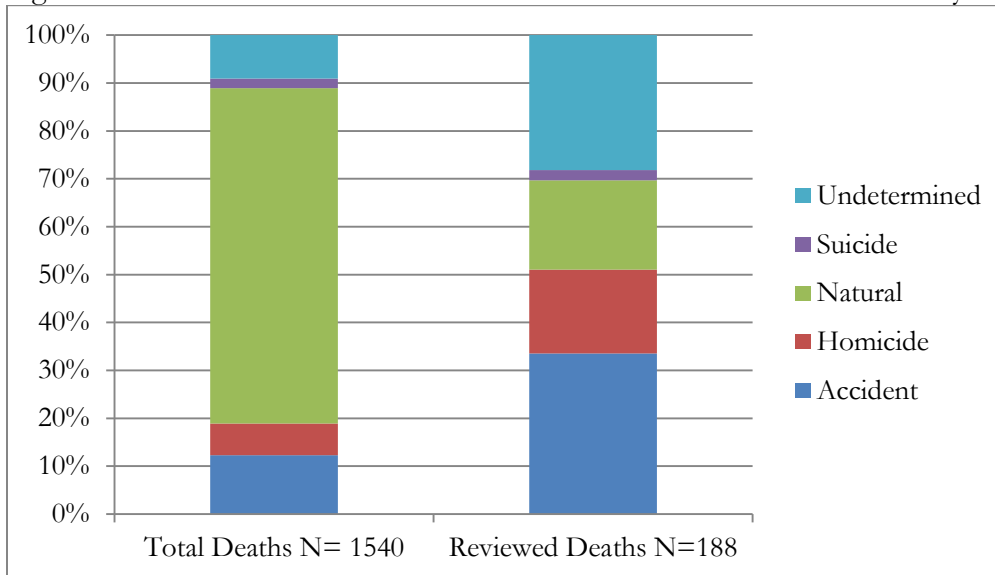
- Undetermined – information pointing to one manner of death is no more compelling than one or more other competing manners of death when all available information is considered

The majority of total child deaths were attributable to natural causes (70%). Accidents accounted for 12% of the total child deaths, 7% were homicides, 2% were suicides, and 9% were undetermined. When compared to total child deaths, deaths reviewed by CDRTs are much more likely to be accidents, undetermined, natural, and homicides, and much less likely to be due to suicides (see Table 3 and Figure 7).

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

	Total Deaths		Reviewed Deaths	
	N	Percent	N	Percent
Accident	189	12%	63	34%
Homicide	102	7%	33	18%
Natural	1078	70%	35	19%
Suicide	31	2%	4	2%
Undetermined	140	9%	53	28%
Total	1540		188	

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



Child Deaths by Category and Manner

Finally, it is interesting to examine the manner of child death juxtaposed with the categories of death (see Table 4). For instance, the majority of accidental child deaths are due to 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, followed by firearms. Almost all child deaths due to natural causes are the result of premature birth, illness, 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	
Prematurity	0	0	544	0	3	547
Illness	5	0	516	0	8	529
Suffocation	54	3	1	15	9	82
Firearms	3	63	0	12	0	78
Vehicular	61	3	0	1	0	65
Undetermined	0	0	0	0	58	58
Injury	18	24	0	3	6	51
SUID	4	0	8	0	38	50
Drowning	21	1	0	0	5	27
Fire	13	2	0	0	0	15
Poison/Overdose	10	1	0	0	4	15
SIDS	0	0	9	0	2	11
Other	0	3 ¹	0	0	0	3
SUCD	0	0	0	0	2	2
Scalding burning		1	0	0	0	1
Total	189	101	1078	31	135	1534

Note: 6 cases are still pending - manner is undetermined.

¹malnutrition; seizure disorder due to hyponatremia; hypothermia – exposure to the cold

Child Deaths by Review Type

There are multiple reasons that the death of a child would be reviewed, including 5 different types for 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 111 of the 188 cases that were reviewed. In the death indicated review type:

- Slightly over half (56%) of decedents in this type of review were males.
- The majority was very young, 64% were infants and 29% were 1 to 4 years old, and the remaining 7% were 5 years and older.
- The majority of deaths were the result of three categories: suffocation (31%), injury (21%), and undetermined reasons (12%). All other categories of death comprised a total of 36%.
- The largest category of deaths was accidental (41%), followed by homicides (29%), undetermined (26%), and natural causes or suicides (5%).

Indicated Report at Time of Death: DCFS has a founded allegation on the guardian of the child.

There were 20 deaths that were mandated for review because there was an indicated report at the time of death.

- The proportion of males and females in this type of reviewed deaths was equal.

- Nearly all deaths in this type (95%) were infants, and only one child (5%) was 1-4 years old.
- Most of these deaths occurred from unknown infant deaths (previously termed as SUID, 35%), suffocation (20%), or were due to undetermined causes (35%).
- The manner of death included 65% undetermined, 25% accidental, and 10% natural causes.

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 42 children who died in 2012 had been investigated in the year before their death.

- The majority (62%) of the deaths in this type were males.
- 45% of the deaths in this type were 4 years old and younger, 41% were 5 to 14, and the remaining 14% were 15 to 17 years old.
- The largest proportions of the deaths in this type were due to illness (45%) and vehicular accidents (14%). Other categories were all below 10%.
- Half of the deaths in this type were due to natural causes, 26% were accidental, 17% were undetermined, and 7% were suicides and homicides.

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 12 child deaths in 2012 of children who had an open DCFS case.

- The proportion of males and females was equal.
- Half of the deaths were children 4 years old and younger, and half were children 5 to 14 years old.
- The majority of deaths were the result of illness (58%). Deaths within other categories were each less than 10%.
- Most children who died with an open case died from natural causes (67%), followed by undetermined causes (25%), and suicides (8%).

Discretionary: These deaths were not mandated for review.

There were 3 deaths that were reviewed but not mandated.

- All deaths in this type of review were males.
- Two deaths (67%) were infants, and one death (33%) was a child 1 to 4 years old.
- Deaths that were discretionarily reviewed occurred from drowning, suffocation, and infant death from unknown causes.
- Two deaths in this type were accidental deaths, and one death was due to undetermined causes.

Special Analysis: Homicide Deaths

There were 102 homicide deaths in 2012. 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 58% of homicides are youth age 15 to 17 and that 75% of the victims are male. Additional information

	16	Gunshot wound to head	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to back	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to neck	Unknown
	16	Gunshot wound to head	Unknown
	16	Gunshot wound to thigh	Unknown
	17	Gunshot wound to buttock	Unknown
	17	Gunshot wound to chest	Unknown
	17	Gunshot wound to chest	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wounds to head and extremity	Unknown
	17	Gunshot wound to abdomen while attacking an officer	Unknown
	17	Multiple gunshot wounds while attempting robbery	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
Injury	Infant	Abusive closed head injuries	17-year-old paramour
	Infant	Blunt head trauma; child abuse	Father & mother
	Infant	Cerebral injuries; multiple blunt force injuries; child abuse	Father
	Infant	Hypoxic ischemic	Father
	Infant	Skull fracture cause by blunt force trauma; abusive head trauma; child abuse	33-year-old female babysitter
	Infant	Cerebral injuries; subdural & subarachnoid hemorrhage; blunt head trauma	Father
	Infant	Multiple injuries; child abuse	Father
	Infant	Closed head injury	Father
	Infant	Skull fracture; soft tissue damages; child abuse	Mother
	Infant	Cranio-cerebral injuries; blunt head trauma; child abuse	Father
	Infant	Closed head injury; fracture of rib	Father & mother
	1	Blunt force trauma to head, liver and	9-year-old child

		kidneys	
	1	Craniocerebral injuries; blunt head trauma	32-year-old male babysitter
	1	Blunt trauma due to child abuse	25-year-old female paramour
	1	Sepsis and bronchopneumonia traumatic encephalopathy	Father
	1	Blunt head trauma; child abuse	39-year-old male paramour
	1	Hemorrhagic shock; multiple hepatic lacerations; blunt force abdominal trauma	Unknown; father indicated
	2	Cerebral injuries due to blunt head trauma	25-year-old male paramour and 19-year-old mother
	2	Multiple injuries due to child abuse (including cuts, bruises, welts, abrasions and human bite injuries)	23-year-old male paramour
	2	Multiple injuries from child abuse	24-year-old male paramour
	3	Blunt force trauma of skin and soft tissue	22-year-old male paramour
	5	Slashed and stabbed to death	40-year-old female family friend babysitter
	10	Multiple traumatic injuries power boat versus swimmer	Unknown
	11	Complications of blunt head trauma; child abuse	31-year-old male paramour
	16	Blunt head trauma from assault	Unknown
Other	Infant	Newborn baby placed in a dumpster and exposed to the cold hypothermia	Unknown
	Infant	Malnutrition emaciation	Parents
	1	Seizure disorder due to hyponatremia; child neglect	Mother
Poison/Overdose	4	Carbon monoxide intoxication from car running in enclosed garage	Unknown
Scalding Burn	Infant	Scalding burns	Mother
Suffocation	Infant	Suffocation by mother	14-year-old mother and 39-year-old grandmother
	Infant	Suffocation by mother	21-year-old mother
	1	Suffocation by mother	Mother
Vehicular	1	Diffuse axonal injury and severe traumatic brain injury due to motor vehicle crash	Unknown
	7	Multiple injuries due to motor vehicle crash	Unknown
	16	Cardiopulmonary arrest and	Unknown

		cerebrovascular episode due to motor vehicle crash	
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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 2012 so that the most common categories of death are first. For each category section, the following information is presented:

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

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

Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature (or preterm) birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as “very preterm” (less than 32 weeks gestation) and moderately preterm (32 – 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 11.7% in 2011.⁴

In Illinois, about 1 in 8 babies (12.0% of live births) was born preterm in 2012.⁵ Between 2002 and 2012, the rate of infants born preterm in Illinois declined nearly 5%. The rate of preterm birth in Illinois is highest for African American infants (17.0%), followed by Native Americans (13.0%), Hispanic (12.1%), whites (10.7%), and Asians (10.6%).⁶ 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.⁷ Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

Illinois Data – Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death and has either been the second largest or the largest category in the past 10 years (ranging from 431 to 620 deaths per year). Although there was a decreasing trend in deaths due to prematurity during 2004-2009, deaths due to prematurity have increased after 2009 (see Figure 8).

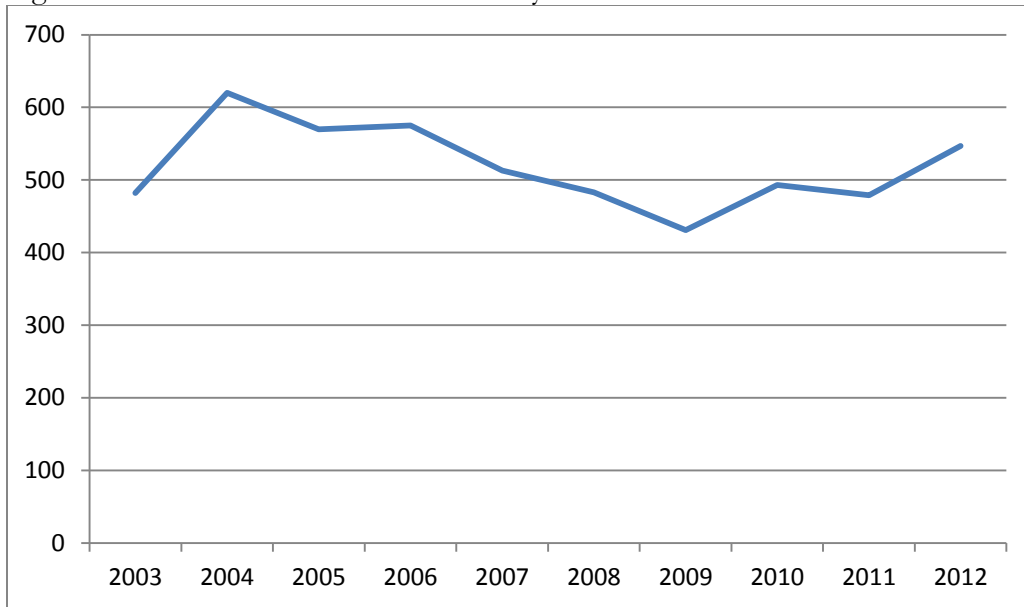
⁴ Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2013*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://childstats.gov>.

⁵ National Center for Health Statistics. *Illinois prematurity data*. Retrieved from <http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4>.

⁶ National Center for Health Statistics. *Illinois prematurity data*. Retrieved from <http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4>.

⁷ Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America's health: State rankings, 2004 Edition*. United Health Foundation.

Figure 8. Child Deaths Due to Prematurity



Of the 1,540 total child deaths in 2012, 547 (36%) were related to premature birth.

- Over 99% of the deaths in this category (544) were the result of natural causes, and 3 were undetermined.
- The majority of children who died from prematurity were boys (57%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 4 of the 188 child deaths reviewed by CDRTs (2%) were related to premature birth.

- All 4 of the premature deaths reviewed by the CDRTs were the result of natural causes.
- All 4 of the premature deaths reviewed by the CDRTs were females.

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).

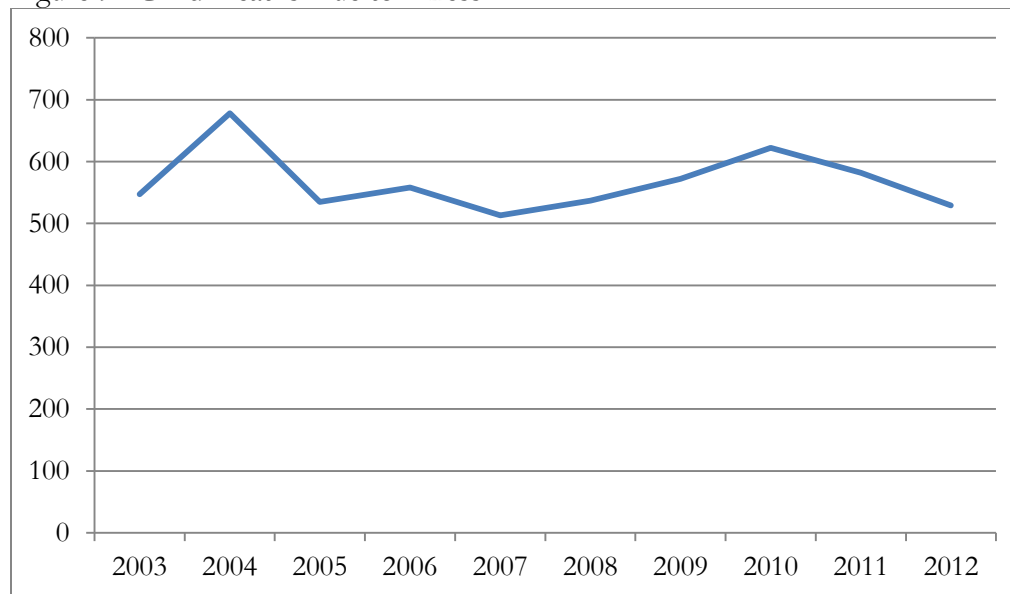
Background

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 CDRTs

For the past decade, illness has been one of the largest causes of child death. The number of deaths from illness has ranged from 513 in 2007 to 678 in 2004 (see Figure 9).

Figure 9. Child Deaths Due to Illness



In 2012, 529 of the 1,540 total child deaths (34%) reported to CDRTs were related to illness.

- The vast majority of these deaths (over 98%) were attributable to natural causes, and the others were undetermined.

- A majority of children who died from illness were male (53%).
- A little less than half of deaths from illness were among children under the age of one (44%); 23% of deaths from illness occurred among children between 1 and 4 years, and 11% occurred among 5 to 9 year olds, 10 to 14 years old, and 15 to 17 year olds, respectively.

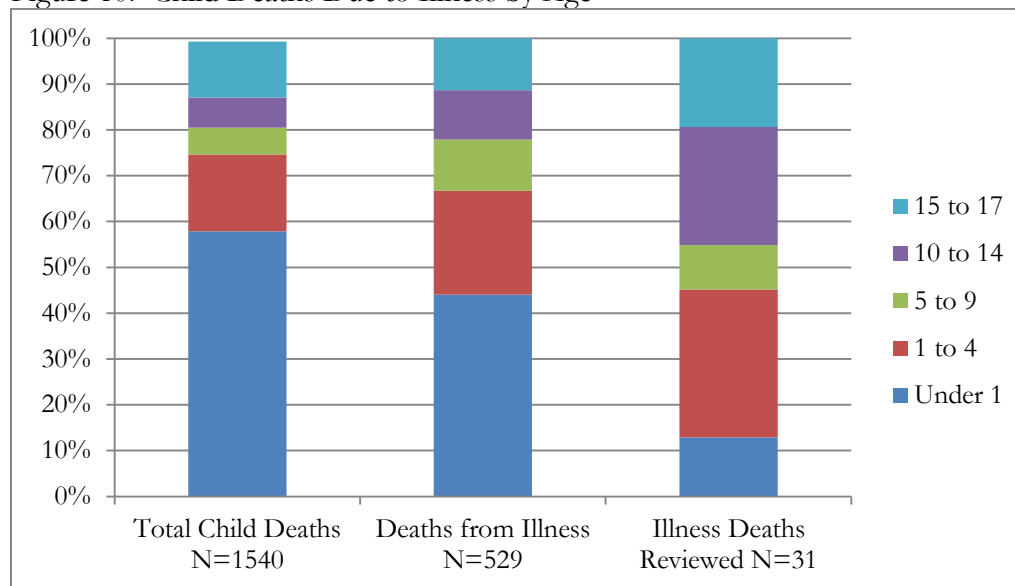
Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 31 of the 188 child deaths reviewed by the CDRTs (17%) were related to illness.

- More boys (65%) than girls who had deaths related to illness were reviewed.
- Children aged 1 to 4 years represent the largest percentage of deaths from illness reviewed by CDRTs (32%). Reviewed deaths from illness also included 13% of children under 1, 10% of children 5 to 9 years old, 26% of children 10 to 14 years old, and 19% of children 15 to 17 years old.
- Nearly all deaths that are categorized as illness were natural (2 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 2012 are presented in Figure 10. When comparing total child deaths and child deaths due to illness across age groups, infants less than 1 year old were the largest proportions in both the total child deaths and child deaths from illness, but infants had a lower proportion in child deaths from illness than their proportion in total child deaths. Instead, children 1 to 14 years old had a higher proportion in child deaths from illness than their proportion in the total deaths. Infant deaths from illness are also disproportionately less likely to be reviewed.

Figure 10. Child Deaths Due to Illness by Age



Suffocation

Definition

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

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

When examining the information on child deaths due to suffocation, it is important to note that many medical examiners or coroners will not list an infant death as suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eyewitness account. If there is no such evidence, these types of suffocation deaths may be listed as 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 suffocation (the latest year for which data are available).⁸ 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).⁹

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.¹⁰

⁸ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2013). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

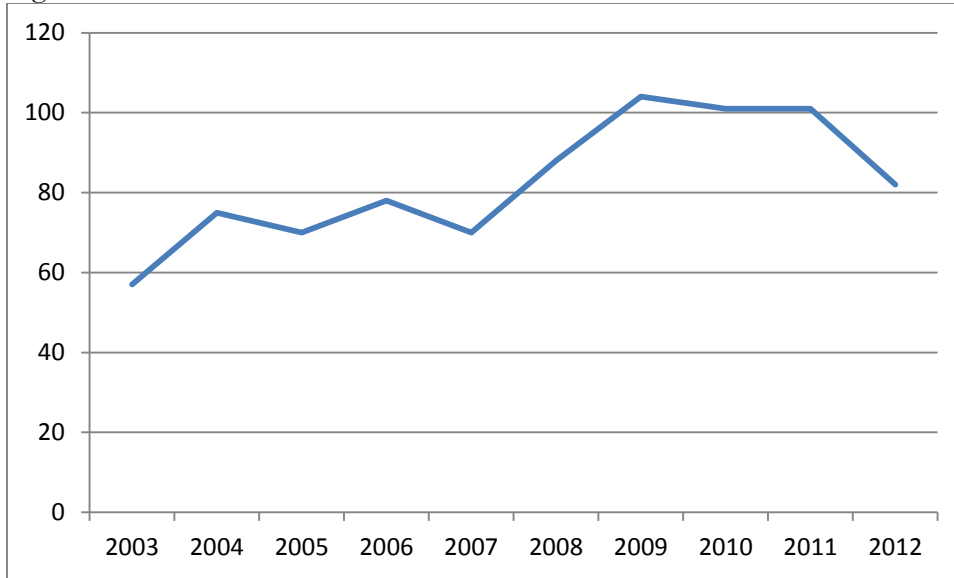
⁹ Safe Kids Worldwide. (2013). *Suffocation and choking safety*. Retrieved from <http://www.safekids.org/fact-sheet/home-safety-fact-sheet-pdf>.

¹⁰ Ibid.

Illinois Data – Total Child Deaths Reported to the CDRTs

There has been a rise in deaths from suffocation in the past 10 years from 57 in 2003 to 101 in 2011, but the number dropped in 2012 (see Figure 11).

Figure 11. Child Deaths Due to Suffocation



In 2012, 82 of the 1,540 total child deaths reported to the CDRTs (5%) were related to suffocation.

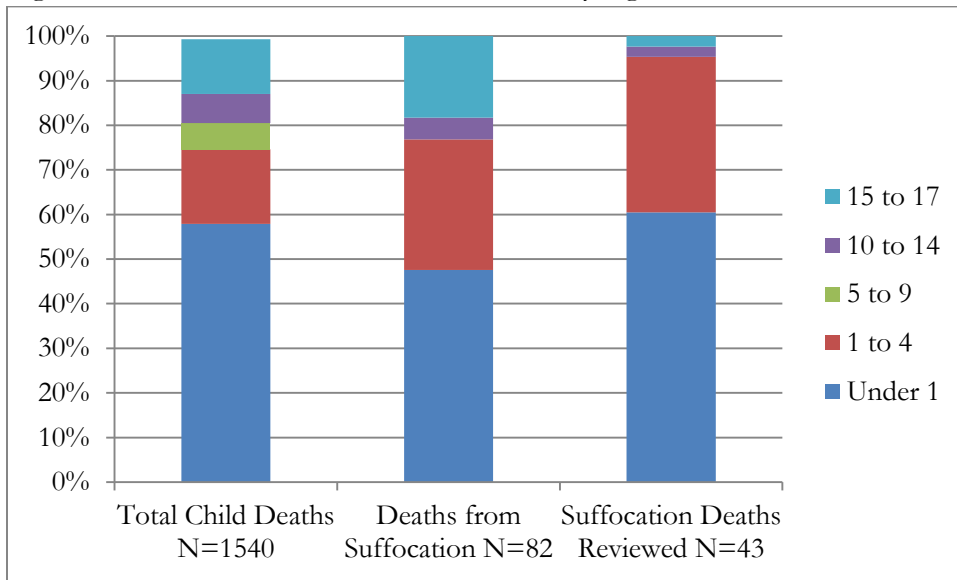
- The manner of the suffocation deaths was varied: 66% were accidental, 18% were suicides, 11% were undetermined, and 4% were homicides.
- The majority of children who died from suffocation were boys (62%).
- Infants under one year were the largest group in this category, accounting for 48% of the deaths.

Illinois Data – Deaths Reviewed by CDRTs

In 2012, 43 of the 188 deaths reviewed by CDRTs (23%) were related to suffocation.

- The slight majority (53%) of the reviewed suffocation deaths were male.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (60%). Infant deaths were over represented in the reviewed child deaths due to suffocation, when compared to the proportion of total infant deaths due to suffocation in 2012 (see Figure 12).

Figure 12. 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 952 children (under the age of 13) died in motor vehicle crashes in 2012.¹¹ The rate of motor vehicle crash deaths per million children under 13 has decreased 77% since 1975. In 2012, 67% of child motor vehicle crash deaths were passenger vehicle occupants, 22% were pedestrians, and 4% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 89% and 92%, respectively. Passenger vehicle child occupant deaths in 2012 were 46% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Fourteen percent of the passenger vehicle child occupant deaths in 2012 occurred in front seats, down from 46% in 1975. Seventy-eight percent were in the rear, and the rest occurred in cargo or unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about 1 of every 4 unintentional injury deaths among children younger than 13. Most crash deaths occur among children traveling as passenger vehicle occupants, and 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.¹²

A total of 2,823 teenagers ages 13 to 19 died in motor vehicle crashes in 2012. This is 68% fewer than in 1975 and 7% fewer than in 2011. About 2 out of every 3 teenagers killed in crashes in 2012 were males. In 2012, teenagers accounted for 8% of motor vehicle crash deaths. They comprised 10% of passenger vehicle (cars, pickups, SUVs, and vans) occupant deaths among all ages, 6% of pedestrian deaths, 3% of motorcyclist deaths, 11% of bicyclist deaths, and 13% of all-terrain vehicle rider deaths.¹³

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 to 19 year-olds is nearly 3 times the rate for drivers ages 20 and over. Risk is highest at ages 16 to 17. In fact, the fatal crash rate per mile driven is nearly twice as high for 16 to 17 year-olds as it is for 18 to 19 year-olds. Crash rates for teenagers are high largely because of their immaturity combined with driving inexperience.¹⁴

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 riding

¹¹ Insurance Institute for Highway Safety. (2012). *Fatality facts 2012: Children*. Retrieved from <http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety>.

¹² Ibid.

¹³ Insurance Institute for Highway Safety. (2012). *Fatality facts 2012: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

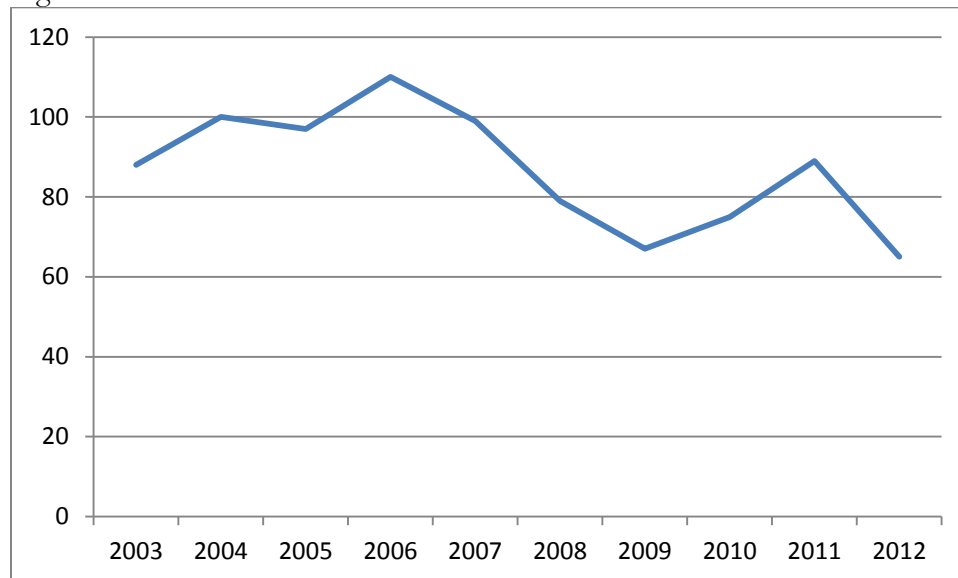
¹⁴ Ibid.

with peers and drowsiness.¹⁵ 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%.¹⁶

Illinois Data – Total Child Deaths Reported to the CDRTs

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 rose between 2009 and 2011, but then dropped again in 2012 (see Figure 13).

Figure 13. Child Deaths Due to Vehicular Accidents



In 2012, 65 of the 1,540 total child deaths reported to the CDRTs (4%) were related to vehicular accidents.

- A large majority (94%) of these deaths were accidental, and small portions were homicides (5%) and suicides (1%).
- Slightly more boys (51%) had deaths related to vehicular accidents.
- Older children (15 to 17) made up the largest proportion of vehicular accident deaths (48%). Children under the age of one made up the smallest proportion of vehicular deaths (2%). This is a sharp contrast to the age composition of total child deaths. Children in other age groups included 14% of 1 to 4 years old, 20% of 5 to 9 years old, and 17% of 10 to 14 years old (see Figure 14).

¹⁵ Child Trends. (2014). *Distracted driving*. Retrieved from www.childtrendsdatabank.org/?q=node/376 on April 18, 2014.

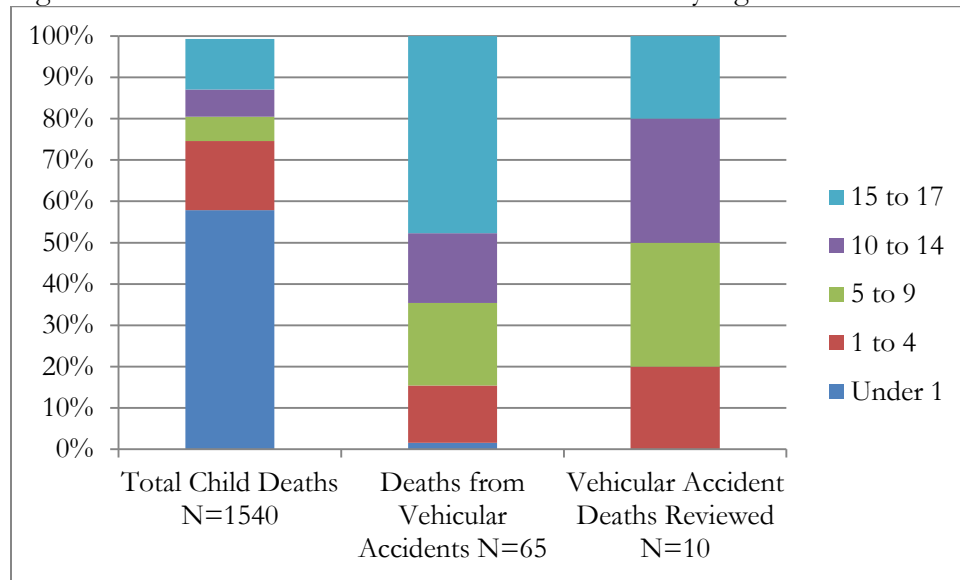
¹⁶ Insurance Institute for Highway Safety. (2012). *Fatality facts 2012: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 10 of the 188 deaths reviewed by the CDRTs (5%) were related to vehicular accidents.

- 40% of the reviewed deaths in this category were males.
- The proportions of reviewed deaths related to vehicular accidents ranged from 20-30% in all age groups except for infants under 1 year (see Figure 14).

Figure 14. Child Deaths Due to Vehicular Accidents by Age



Firearm

Definition

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

Background

According to data from the Center for Disease Prevention and Control, 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.¹⁷ The vast majority (72%) of these deaths were youth between the ages of 15 and 17. However, race of decedent is also 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.¹⁸

Firearms include several manners of deaths. Homicides and suicides are the second and third leading causes of death, respectively, among teens age 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 18.¹⁹ 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. 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.²⁰

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from firearms steadily increased from 2005 to 2008 and have remained fairly level each year since then (between 79%-84%, see Figure 15).

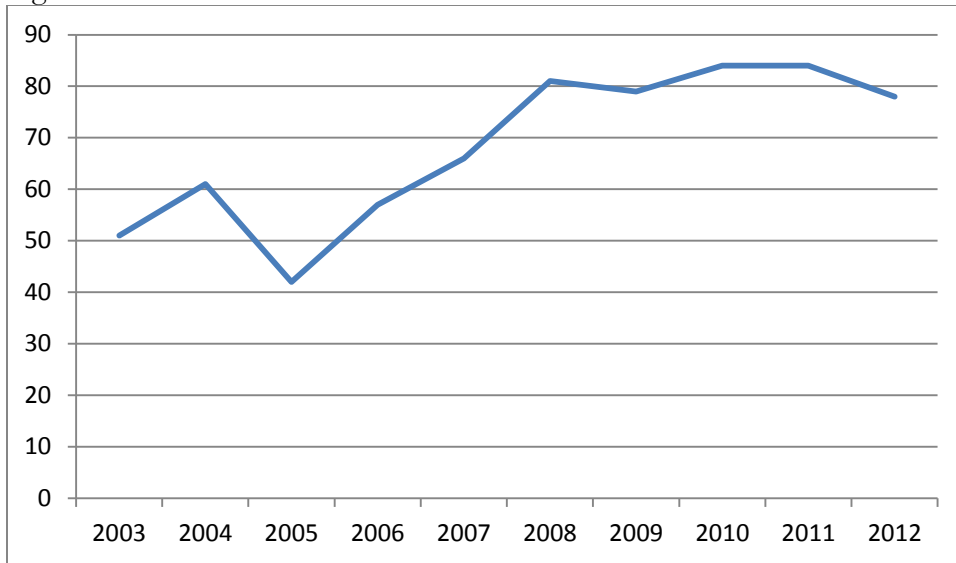
¹⁷ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

¹⁸ Child Trends. (2014). *Teen homicide, suicide, and firearm deaths*. Retrieved from <http://www.childtrendsdatabank.org/?q=node/124>.

¹⁹ Ibid.

²⁰ 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.

Figure 15. Child Deaths Due to Firearms



In 2012, 78 of the 1,540 total deaths (5%) were related to firearms.

- Homicides accounted for 81% of the firearm deaths, suicides accounted for 15%, and accidents accounted for 4%.
- As shown in Figure 16, deaths due to firearms overwhelmingly occurred among boys (86%).
- Children between 15 and 17 years of age were largely over-represented in firearm deaths when compared to total child deaths (see Figure 17). In 2012, 79% of firearm deaths occurred in children aged 15 to 17.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 4 of the 188 deaths reviewed by the CDRTs (3%) were related to firearms.

- In 2012, the firearm deaths reviewed by CDRTs were in three age groups: 1 to 4 years (25%), 10 to 14 years (50%), and 15 to 17 years (25%) (see Figure 17).

Figure 16. Child Deaths Due to Firearms by Gender

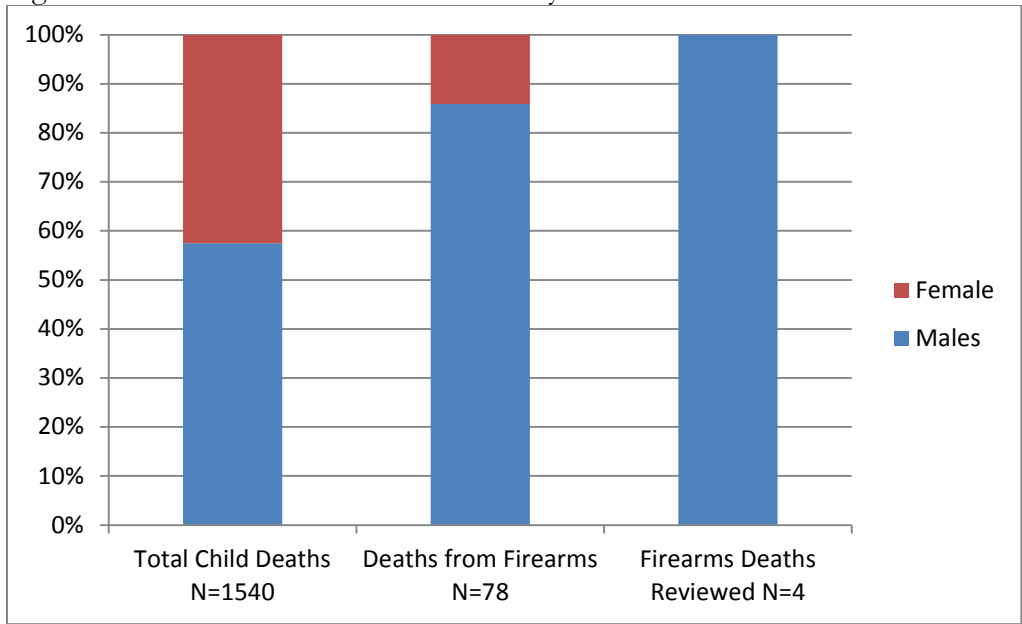
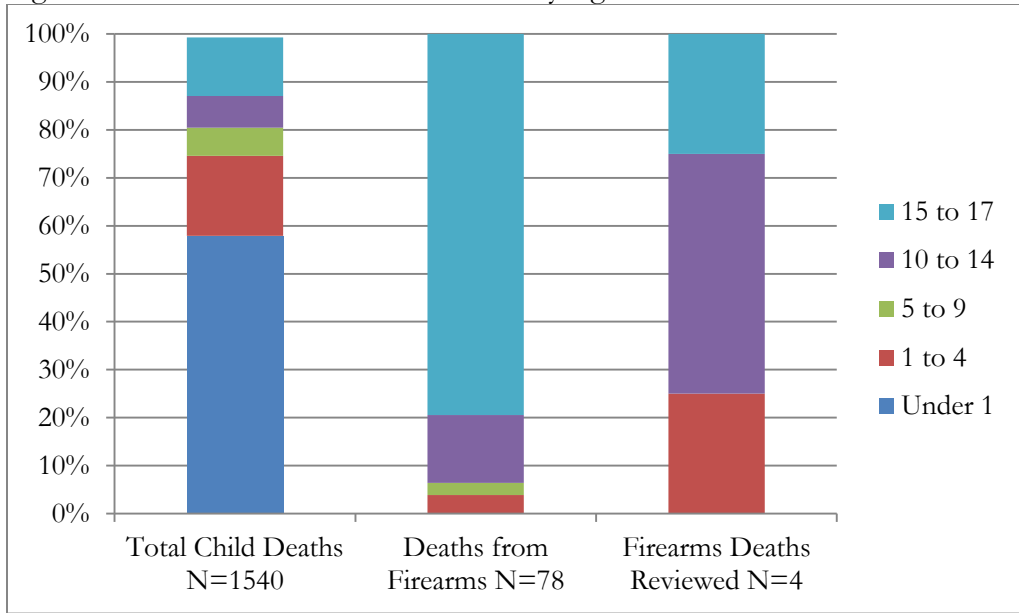


Figure 17. Child Deaths Due to Firearms by Age



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 2012, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,640 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. Nearly three-quarters (70.3%) of all child fatalities were younger than 3 years, and in general, the child fatality rate decreased with age. Four-fifths (80.0%) of child fatalities were caused by one or more parents.²¹ Of the children who died, 69.9% suffered neglect either exclusively or in combination with an additional maltreatment type and 44.3% suffered physical abuse either exclusively or in combination with another maltreatment type.²²

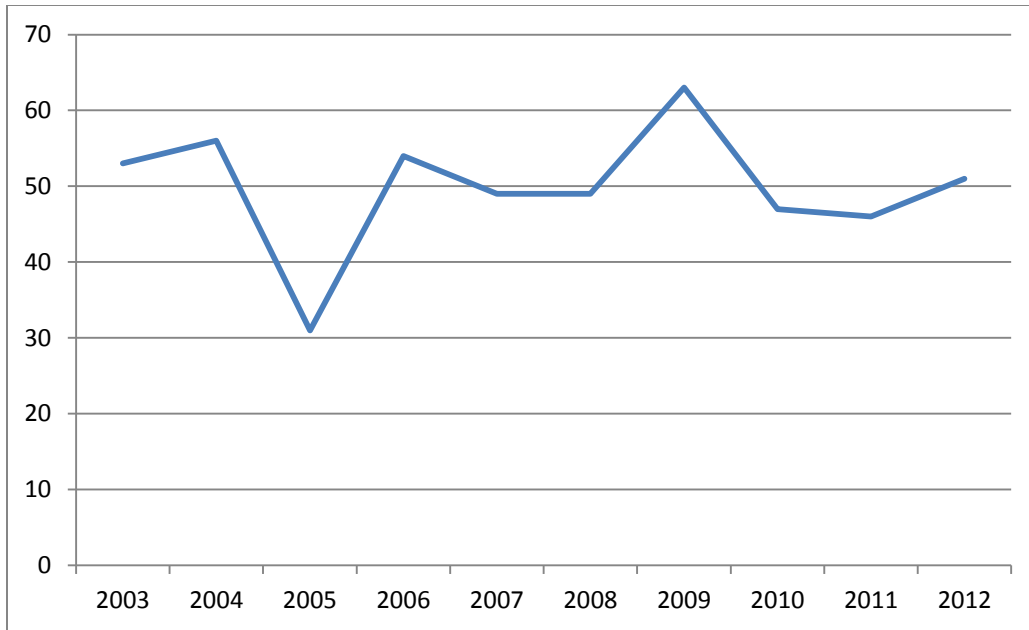
Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths due to injuries have largely surrounded a mean of 50 over the decade between 2003-2012, with an unusual low of 31 in 2005 and high of 63 in 2009 (see Figure 18).

Figure 18. Child Deaths Due to Injuries

²¹ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2012). *Child maltreatment, 2012*. Washington, DC: Government Printing Office. Retrieved from <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>.

²² Ibid.



In 2012, 51 of the 1,540 total child deaths reported to the CDRTs (3%) were related to injuries.

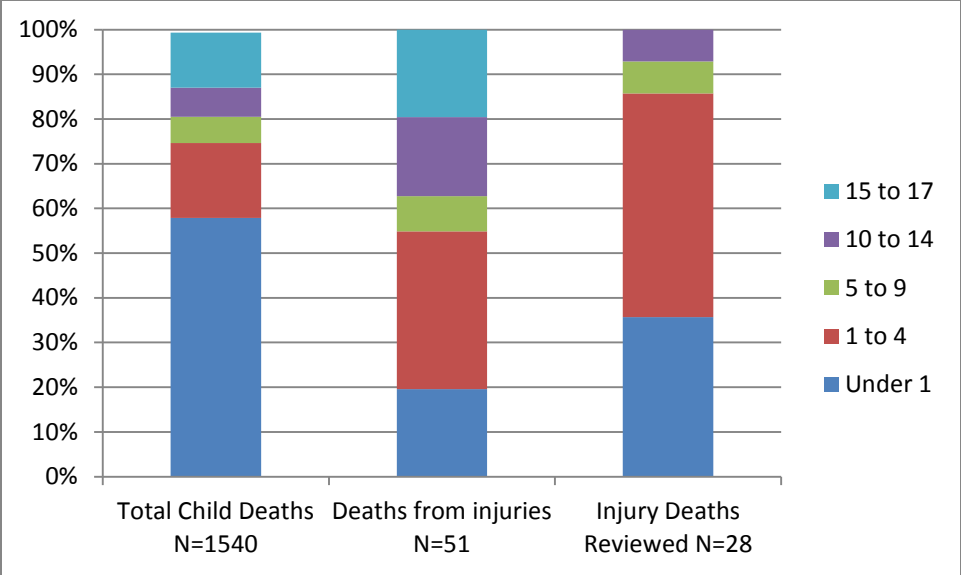
- 35% of these injury deaths were classified as accidents, 47% were homicides, 6% were suicides, and 12% were undetermined.
- 67% of decedents from injuries in 2012 were male.
- Younger children were more vulnerable to death from injuries: 20% of injury deaths were among infants under the age of one, and an additional 35% were among children between the ages of 1 and 4. Children 5 to 9 years had a comparatively lower rate of 8%, but the rates increased again for older children: 18% among those 10 to 14 years, and 20% among those between 15 and 17 years of age.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 28 of the 188 (15%) deaths reviewed by the CDRTs were related to injuries (see Figure 19).

- The vast majority of the reviewed cases involved young children 4 years and under (86%).
- 64% of the reviewed injury deaths were male.

Figure 19. Child Deaths Due to Injuries by Age



Sudden Infant Death Syndrome (SIDS) and Unknown Infant Deaths²³

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 needs to be completed, 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.²⁴ 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 death among infants aged 1 to 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.²⁵ 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 to 6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, the percentage of children ages 0 to 6 living in homes where someone smoked regularly was 6%, compared with 27% in 1994.²⁶

²³ In previous CDRT reports SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Center for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained. 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.

²⁴ Center for Disease Control and Prevention. (2011). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved from <http://www.cdc.gov/sids/>.

²⁵ Ibid.

²⁶ Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2013*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://childstats.gov>.

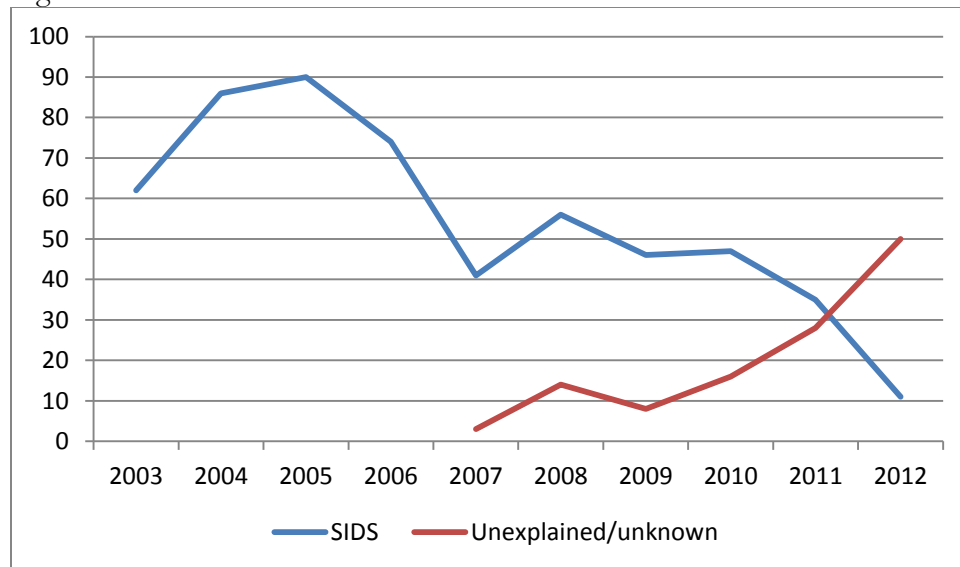
Background

SIDS is the leading cause of death among infants aged 1 to 12 months. A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.²⁷

Illinois Data – Total Child Deaths Reported to the CDRTs

During 2003–2005, child deaths from SIDS increased from 62 to 90. However, since the peak of 2005, there has generally been a sharp decline, with the lowest number of SIDS deaths of 11 in 2012 (see Figure 20). Infant deaths from unknown causes (called SUID in previous reports) were added as a category in 2007, and child deaths due to unknown causes have increased from 11 in 2007 to 50 in 2012, with the largest increase occurring from 2010 to 2012.

Figure 20. Child Deaths Due to SIDS and Unknown Causes



In 2012, 11 of the 1,540 total child deaths reported to the CDRTs (1%) were related to SIDS, and 50 deaths (3%) were categorized as “unknown infant deaths”.

- More boys (55%) than girls (45%) had deaths related to SIDS.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, only 1 of the 188 (1%) deaths reviewed by the CDRTs was related to SIDS and 15 were from unknown/unexplained causes.

²⁷ Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, 163, 762-769.

- The one SIDS death reviewed by the CDRTs was a girl.
- 67% of the unknown/unexplained causes of death cases reviewed by the CDRTs were boys.

Undetermined Deaths

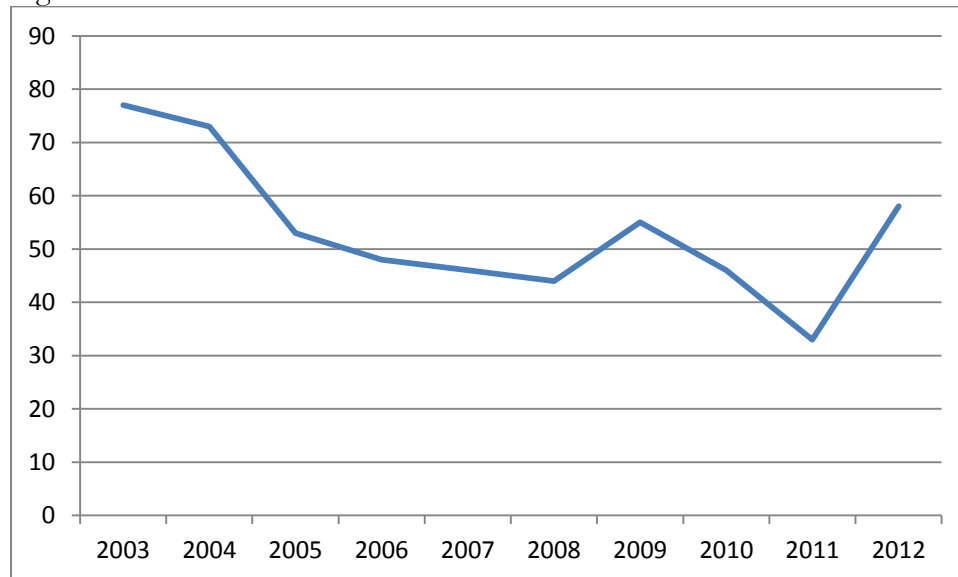
Definition

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

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of undetermined deaths for children dropped from 77 in 2003 to 33 in 2011, but there was an increase in 2012 to 58 (see Figure 21).

Figure 21. Child Deaths with Undetermined Cause of Death



In 2012, 58 of the 1,540 total child deaths reported to the CDRTs (4%) had an undetermined cause of death.

- Deaths due to undetermined causes were more common for boys (54%).
- Children under the age of 1 represent 62% of deaths in this category; and 34% of decedents from undetermined causes were between 1 and 4 years.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 22 of the 188 deaths reviewed by CDRTs (12%) had an undetermined cause of death.

- 59% of reviewed deaths due to undetermined causes occurred among children under 1 year of age, and 36% occurred among children 1 to 4 years old.

Drowning

Definition

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

Background

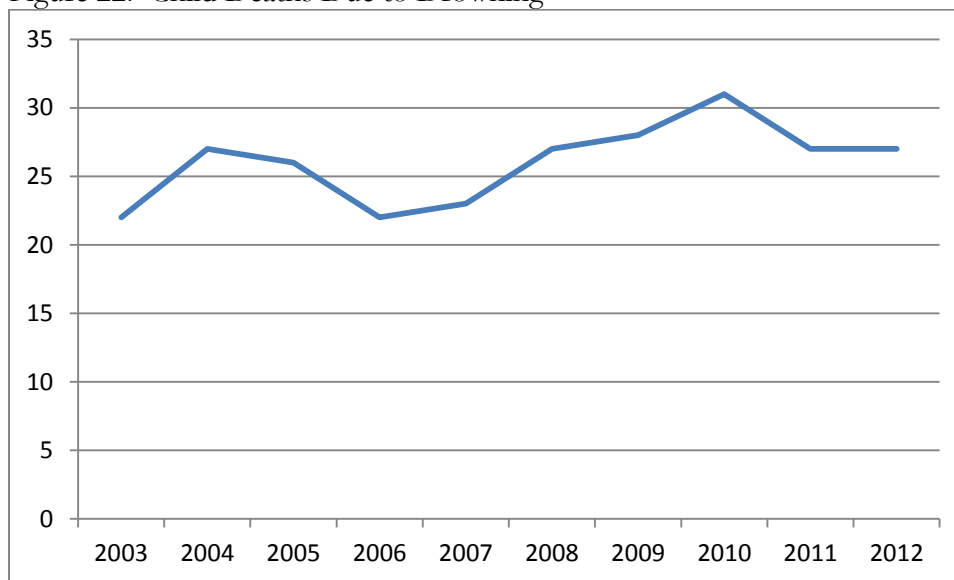
In 2010, 886 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 54% of these deaths.²⁸

The majority of infant 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 of 1 and 4 years, and about 3/4 of pool submersion deaths occur at a home. African American children ages 5 to 14 years old have a drowning rate 2.7 times greater than that of white children.²⁹

Illinois Data – Total Child Deaths Reported to the CDRTs

Since 2003, there have been between 22 and 31 deaths from drowning per year (see Figure 22).

Figure 22. Child Deaths Due to Drowning



In 2012, 27 of the 1,540 total child deaths reported to the CDRTs (2%) were related to drowning.

- Most of the drowning deaths were accidental (78%), and the rest were undetermined (19%) and homicide (3%).

²⁸ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

²⁹ 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>.

- More boys (74%) died from drowning than girls.
- Children aged 1 to 14 had a roughly equal risk of drowning deaths, accounting for a total of 64% of deaths due to drowning. Children under age 1 (11%) and 15 to 17 (15%) had a comparatively lower proportion.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 11 of the 188 reviewed deaths (6%) were related to drowning.

- 73% of the reviewed drowning deaths were male.
- Most of the reviewed deaths related to drowning occurred among young children: 72% were among children 4 years and younger.

Fire

Definition

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

Background

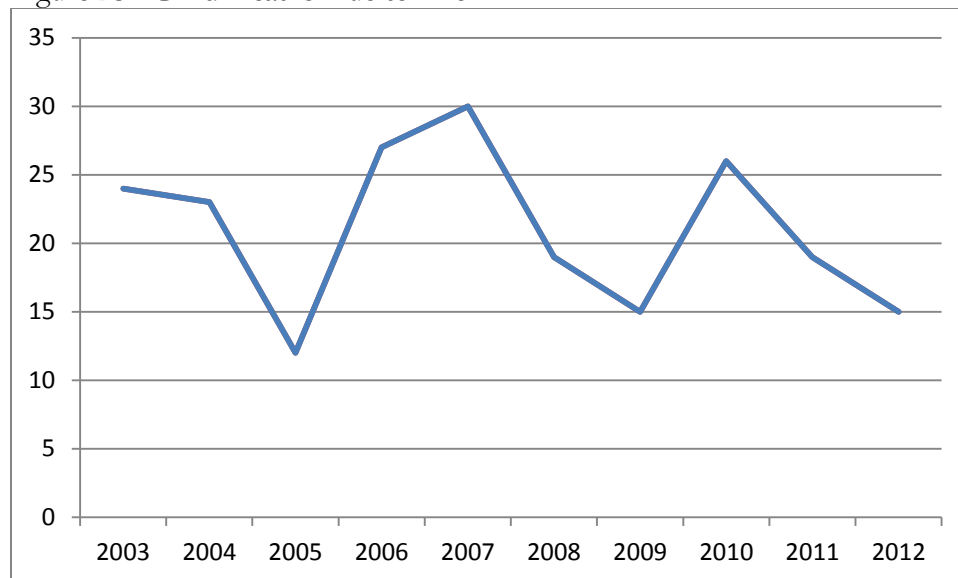
In the United States, fire and burns were the cause of 389 deaths among children between 1 and 17 years in 2010.³⁰ Fifty-four percent of fire deaths occurred in children 4 and under. Death rates per million among children 14 and under has decreased 41% from 2001-2010.³¹

Home fires account for nearly 90% of all fire-related fatalities. Home cooking equipment is the leading cause of injuries from residential fires. Working smoke alarms reduce the chances of dying in a fire by nearly 50%.³²

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from fire have fluctuated substantially over the decade from 2003–2012, ranging from 12 in 2005 to 30 in 2007. The number in 2012 is comparatively low (see Figure 23).

Figure 23. Child Deaths Due to Fire



³⁰ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

³¹ U. S. Fire Administration, (2014). Child Fire Death Rates and Relative Risk (2001-2010) Retrieved from http://www.usfa.fema.gov/statistics/estimates/trend_child.shtm.

³² Safe Kids Worldwide. (2011). *Fire safety*. Retrieved from <http://www.safekids.org/fire>.

In 2012, 15 of the 1,540 total child deaths reported to the CDRTs (1%) were related to fires.

- The majority of deaths (87%) attributable to fire were accidental, and 13% were homicides.
- There were more girls (53%) that died from fire.
- Young children were most at risk of fire-related deaths: 60% were under the age of 5, 20% were age 5 to 9 and the remaining 20% were among children 10 to 14 years. No youth aged 15 to 17 died from fires in Illinois in 2012.

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 7 of the 188 deaths reviewed by CDRTs (4%) were related to fires.

- 71% of the reviewed deaths from fire were for children aged 1 to 4 years; 1 reviewed death was an infant and 1 was a child between 10 and 14.

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

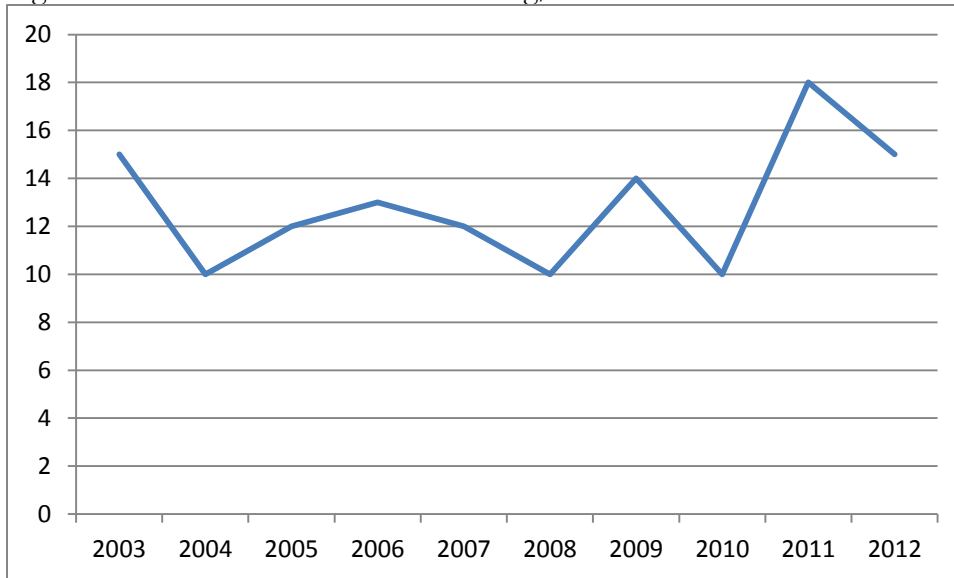
In 2012, 459 children under 18 years died of poisoning in the United States.³³ The majority of these deaths occurred in children 15 to 17 years of age (63%). The age group with the second most frequent number of deaths by poisoning was children under 4 (20%), with children between 4 and 15 accounting 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.³⁴ The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

Illinois Data – Total Child Deaths Reported to the CDRTs

Between 10 and 18 children died from poisoning per year since 2003 (see Figure 24).

Figure 24. Child Deaths Due to Poisoning/Overdose



³³ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

³⁴ 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 2012, 15 of the 1,540 total child deaths reported to the CDRTs (1%) were related to poisonings or overdoses.

- 10 of the 15 deaths (67%) were determined to be accidents, 1 death was a homicide, and 4 were undetermined.
- Boys (60%) were more likely to die from poisoning or overdose than girls.
- Children 4 years and younger accounted for about half of the poisoning/overdose deaths (46%), and youths 15 to 17 accounted for one third (33%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2012, 7 of the 188 deaths reviewed by the CDRTs (4%) were related to poisoning/overdose.

- 43% of the reviewed cases were male.
- 4 of the cases reviewed by CDRTs were among children aged 0 to 4 (57%), 2 cases were among children 5 to 9, and 1 reviewed case involved an adolescent between 15 and 17.

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 2012, 3 deaths fell in this category and all of them were reviewed.

Scalding Burn

There was one scalding burn death in 2012.

SUCD (Sudden Unexplained Child Death)

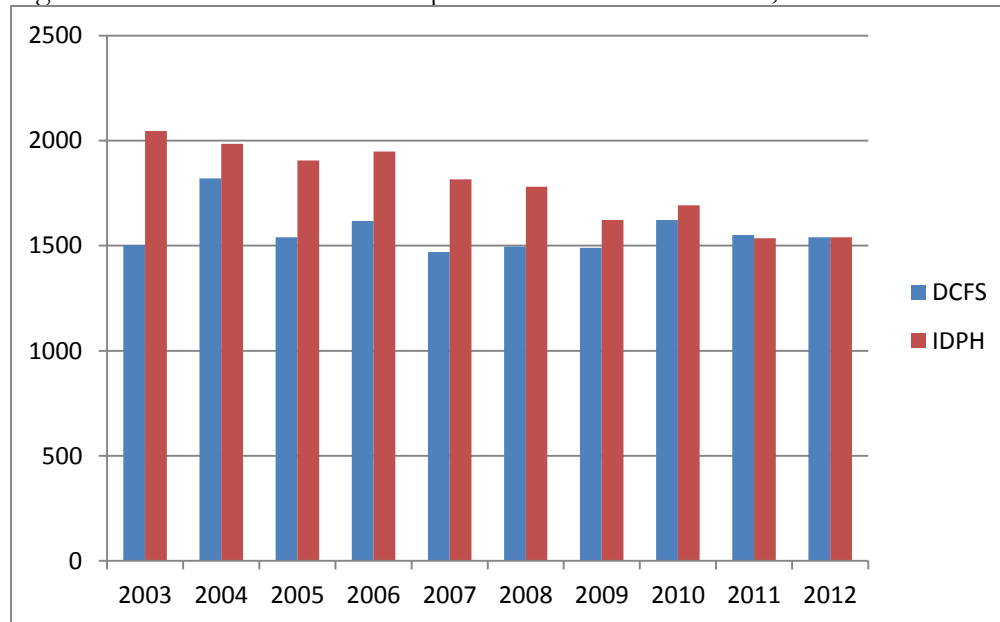
There were 2 SUCD in 2012 and neither was reviewed.

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.

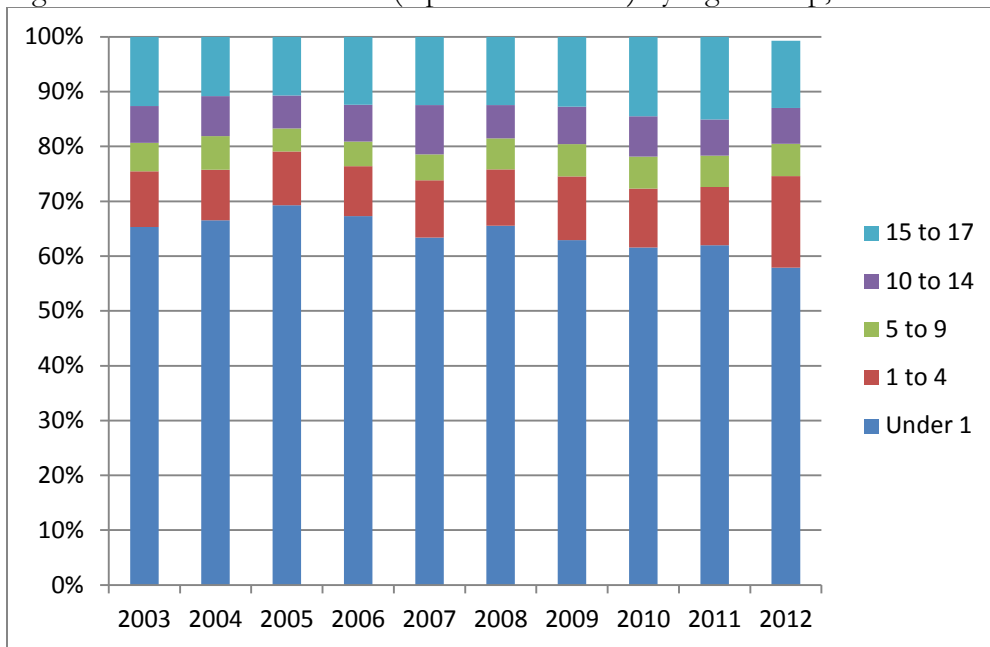
The total number of deaths the CDRTs have tracked has been relatively stable since 2005 (between 1,470 and 1,622). This is partially due to capturing more accurately the total number of child deaths. The total number of child deaths (reported by IDPH) in Illinois has been generally decreasing from 2,045 in 2003 to 1,540 in 2012 (see Figure 25).

Figure 25. Total Child Deaths Reported to DCFS and IDPH, 2003–2012



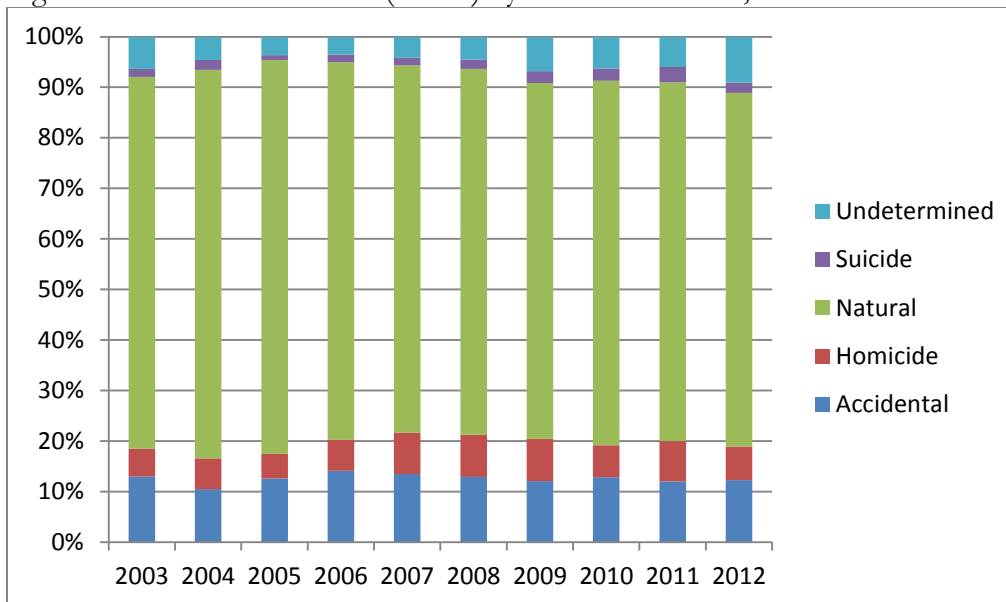
The total child deaths reported to DCFS from 2003 to 2012 is broken down by age group in Figure 26. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another, so that the sum 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 26 shows, the percentage of total deaths in each age group is generally stable over the 10 year period: infants under 1 year comprise 58-69% of all child deaths, children between 1 and 4 years comprise 9-17%, 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%.

Figure 26. Total Child Deaths (reported to DCFS) by Age Group, 2003–2012



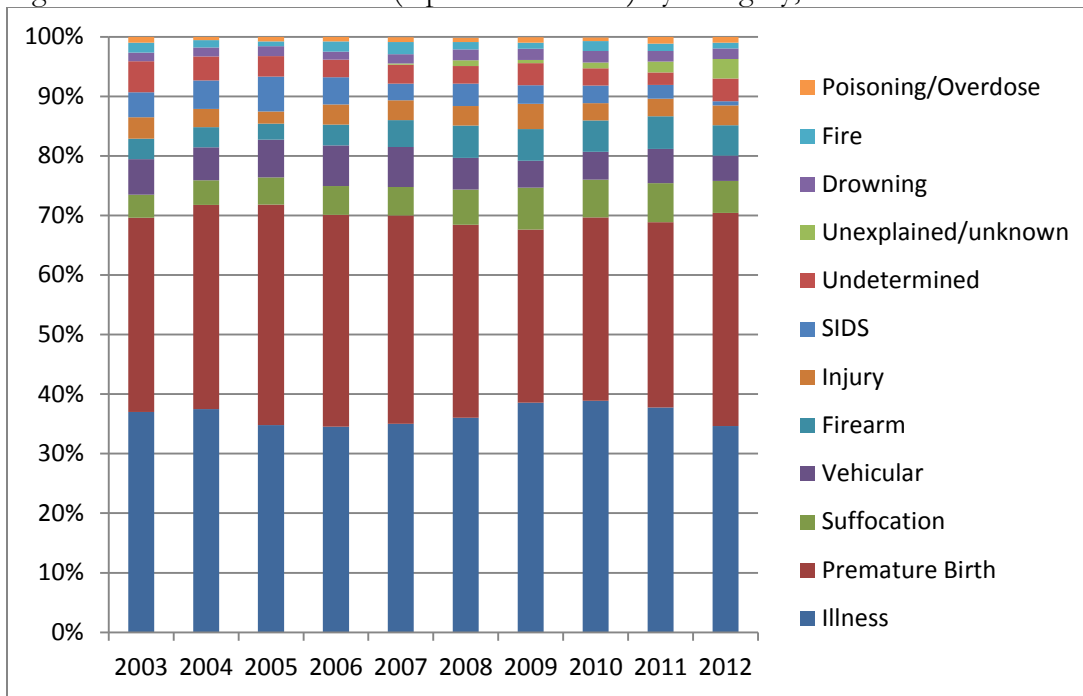
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 70-78% natural, 1-3% suicide, and 4-9% undetermined (see Figure 27).

Figure 27. Total Child Deaths (DCFS) by Manner of Death, 2003–2012



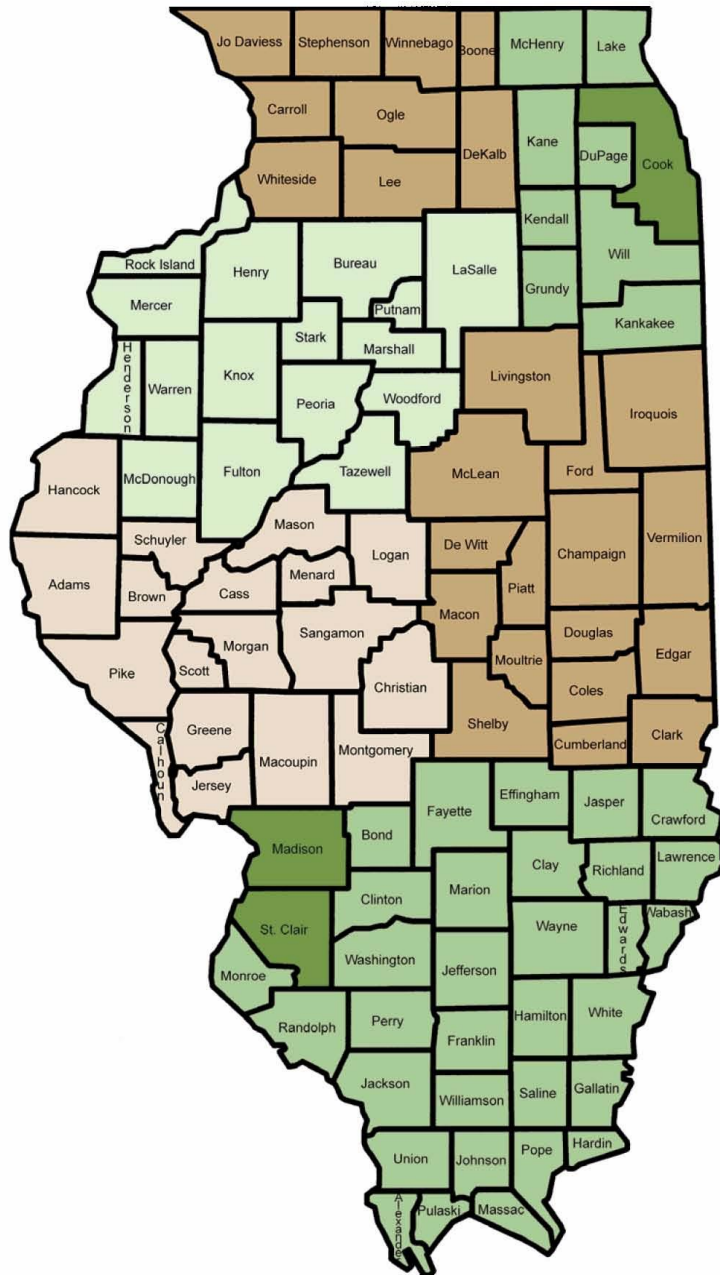
A similar analysis was done for category of death (see Figure 28). The overall percentage of child deaths related to each category of death remained relatively stable across the time periods. In order to see changes within category, please refer to charts for specific categories in Chapter 4.

Figure 28. Total Child Deaths (reported to DCFS) by Category, 2003–2012³⁵



³⁵ 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

Aurora

Myra D. West, Psy.D, **Chairperson**
Mitra Kalelkar, M.D., **Vice Chairperson** Victoria
M. Anderson
Susan Fackler, MSW, LCSW, CADC
Jody Gleason
Christina Hintze-Symoniak
Mary E. Jones MD, MPH
Kathryn Juzwin, Psy.D
Gregory A. Krantz., RN
Dawn Livorsi, LCSW
Gwendolyn Messer, M.D.
Jonathan Parker, Special Agent
Christine Schmidt, Psy.D.
Glendean Sisk, RN, BSN, CRADC, MPH
DCFS Staff- Frank Navarro

Champaign

Lawrence Solava, **Chairperson**
Kimberly Cessna, **Vice Chairperson** Adelaide
Aimé
Kathleen Carney Buetow, M.D.
Donald F. Davison, Jr. M.D.
Kimberly S. Fitton
Adam Ghrist
Lise Jankowski, RN
Patricia Metzler, RN, TNS, SANE-A & P
Sergeant Alex F. Meyer
Susan Elaine Minyard, PhD
Barbara Nafziger
Duane Northrup
Judy Osgood, PhD
James Owens
Cindy Patterson
Cathie Reynolds
Julie Runyon
Bryant Seraphin, Lt.
DCFS Staff- Maria Miller

Cook Team A

Anne Devaud, PsyD, **Chairperson**
Joan M. Pernecke, Chief, **Vice-Chairperson**
Barry Bennett, LCSW, ACSW
Kristen Bilka, MMS, PA-C
John Brassil
Danielle Butts
Anne Chambers, Sgt.
Felicia Clark
Debra DeYoung, Sgt.
Renee Dominguez, Ph.D.
Kristin Escobar-Alvarenga, M.D.
Joel Feinstein, M.D.
Amanda Fingarson, DO
Emalee Flaherty, M.D.
Kristine Fortin, MD, MPH
Jan Fowler, RN, M.A.
Jill Glick, M.D.
Kelly Liker, MD
Sandra L. Martell, R.N.
Kevin O'Connell
Eileen Payonk, Special Agent
Adrienne Segovia, M.D.
Kimberly Souder
Kelley Thornton
Dion Trotter
Yvonne M. Zehr, Chief Deputy
Virginia Zic-Schlomas, Sgt
DCFS Staff- Ann Marakis

Cook Team B

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Karla M. Chaplin, Sgt., **Vice Chairperson**
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James R. Burton
George Canellis
Stephen J. Cina, M.D., FCAP
Suzanne R. Dakil, M.D.
Eric Eason, M.D.
Angela Evans, MPH, RN, BSN
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Tamara Girtten, Sgt.
Kathy Grzelak, MA, LCPC
Mary Joly Stein
Michele Lorand, MD
Frank J. Marek
Mattie McLaurin, M.Ed
Theresa Olson
Evelyn Polk-Green, M.S.Ed.
Norell Rosado, MD
Benjamin Soriano, M.D.
Sandy Stavropoulos
Cindy Weatherspoon
Valencia Williams, Psy.D.
DCFS Staff- James Robinson

East St. Louis

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Carole A. Presson, Lt. **Vice Chairperson**
David Bivens, Sgt.
Jennifer M. Coffin
Cathy Daesch, ATR-BC, LCPC, ICDVP
Joseph Edwards, Chief
Alison Hebrank
Beth Horner, Ph.D.
Carolyn Hubler, Director
Gilda Johnson, Det.
Francis Jones, RN
David C. Norman, M.D.
Kelly Rogers
Curtis L. Schildknecht
Lynn Shelton RN
Cory Smith
Paula E. Wills, Dir.
DCFS Staff- Valda Haywood

Marion

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Mary Louise Cashel,, **Vice Chairperson**
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Leah Brown
Tambra Cain
Jessica Cullum
Scott Deming, Sgt.
Christy Guy, R.N.
Frederica Nanni, MD
Michael S. O'Leary, Lt.
Jamie Penrod
Melissa Presser
Linda Reiss
Kathy Swafford, MD
Steve Webb, PhD
L. Patrick Windhorst
Sheryl L. Woodham, MSW, LCSW
DCFS Staff- Don Rose

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Janis Benson RN, MS
Jerry Brady
Susan Bordenave-Bishop, MD
Walter Bradley, MD
Gregg M. Cavanaugh, M/Sgt.
Stefanie Clarke, BSN, RN, CPEN
Cindy Fisher
Judy Guenseth
Brian Gustafson, RN
Ruth Lane, Exec.Dir.
Emily McDonnell, RN
Marcy O'Brien, Det.
Channing Petrak, MD
Mark Thomas
Michele Verda, Ph.D.
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John Hayes, Det.
Clairice Hetzler
Jeffrey Lair
Lorinda Lamken
Mary Frisk Loken, Ph. D.
Tracy Lower, M.D.
Bette Ann MacIntosh, MD
Nathaniel Patterson, M.D.
James Stone
Amy C. Calvert Winans
DCFS Staff- James Craven

Appendix C – Illinois Child Deaths by County

County	2004 Deaths		2005 Deaths		2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH*	DCFS	IDPH*	DCFS	IDPH*	CDRTs**
Adams	0	5	0	6	1	8	8	11	1	10	6	5	6	5	4	3	9
Alexander	0	0	0	0	0	1	0	1	0	1	1	1	0	2	0	0	1
Bond	2	2	1	1	0	0	0	0	1	1	0	0	0	1	2	2	4
Boone	0	1	0	3	0	0	0	0	0	3	3	3	1	1	4	2	3
Brown	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Bureau	9	8	4	4	2	4	2	2	1	2	5	5	6	5	1	1	2
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	0	0	1	1	0	0	0	1	1	1	2	2	0	0	1
Cass	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Champaign	44	45	52	53	32	47	3	39	21	36	42	36	36	33	43	37	29
Christian	2	2	9	10	2	2	0	0	3	4	4	4	4	3	3	2	2
Clark	0	0	1	1	1	1	0	0	1	1	0	0	0	1	2	2	1
Clay	1	1	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1
Clinton	2	5	0	2	0	3	0	3	3	4	1	1	3	3	2	1	1
Coles	1	1	0	6	0	8	0	3	0	4	3	5	5	2	5	6	4
Cook	1150	1162	878	1,116	1,014	1,141	926	1,066	908	1,010	768	832	887	920	857	824	857
Crawford	0	2	0	0	0	1	0	1	1	1	0	0	2	1	2	1	4
Cumberland	0	0	0	2	1	1	0	0	3	2	2	3	2	2	0	0	1
DeKalb	5	10	2	4	1	14	4	5	3	3	5	3	4	3	5	5	4
Dewitt	0	0	0	1	0	2	0	1	0	0	2	2	0	0	1	1	0
Douglas	2	2	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1
Dupage	111	111	112	116	93	95	97	99	76	81	65	62	89	76	73	68	66
Edgar	1	1	1	1	2	3	0	1	1	2	0	0	0	0	1	1	1
Edwards	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Effingham	5	5	1	6	3	4	0	7	5	6	1	1	0	1	8	7	2
Fayette	1	3	1	1	0	1	0	1	0	0	0	0	1	0	1	1	0
Ford	0	1	2	2	1	1	1	1	3	3	1	0	1	1	0	0	1
Franklin	3	2	3	0	1	0	3	3	3	3	4	4	5	3	2	1	0
Fulton	4	4	0	0	2	2	5	5	0	0	3	4	4	4	0	0	3
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Greene	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0
Grundy	2	5	1	3	2	3	0	5	3	4	3	4	5	5	3	2	3
Hamilton	1	1	0	0	3	3	1	1	3	3	0	0	1	1	1	1	1
Hancock	1	2	0	0	0	1	0	0	0	2	2	1	0	0	1	1	0
Hardin	0	1	1	1	0	0	0	1	0	0	0	0	2	2	1	2	1
Henderson	0	0	0	0	0	3	0	0	0	0	0	1	0	0	0	0	0
Henry	3	3	3	3	1	1	4	4	2	2	2	3	4	4	4	2	2
Iroquois	1	2	1	1	0	0	0	2	0	1	0	0	3	3	1	1	1
Jackson	0	3	0	8	0	4	3	4	8	8	9	8	4	5	8	6	16
Jasper	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0
Jefferson	0	0	0	1	1	2	0	3	1	4	1	1	9	9	7	6	2
Jersey	0	2	0	1	0	1	1	3	0	2	0	0	1	2	2	3	4

Jo Daviess	0	0	2	2	3	3	0	1	0	0	0	0	0	0	4	4	0
Johnson	0	2	0	0	0	1	1	0	0	0	2	0	3	0	3	2	
Kane	32	38	50	56	44	61	37	46	59	57	55	53	44	41	45	42	42
Kankakee	16	16	15	15	14	14	9	9	8	13	5	5	8	8	8	8	12
Kendall	0	2	3	3	1	1	6	6	6	6	2	2	1	1	1	1	2
Knox	3	2	4	4	5	5	3	3	4	4	2	2	7	8	10	10	3
Lake	33	57	17	34	35	58	17	37	26	38	34	47	31	47	35	40	33
LaSalle	0	14	0	8	0	9	0	8	0	9	7	7	8	9	9	8	11
Lawrence	1	1	1	1	1	1	0	0	1	3	1	1	6	4	4	2	1
Lee	1	1	2	1	0	1	0	2	0	1	3	5	1	1	2	2	2
Livingston	0	7	0	3	0	4	0	5	2	5	2	2	3	3	5	2	3
Logan	2	1	0	0	0	0	0	7	8	6	5	0	0	2	2	3	
Macon	12	12	14	14	18	18	15	16	18	21	15	15	11	10	13	13	7
Macoupin	3	3	0	1	0	1	0	1	0	0	2	2	2	3	0	0	0
Madison	5	29	6	22	8	20	14	19	21	25	16	20	15	13	13	11	8
Marion	0	2	2	7	2	2	4	4	4	3	3	6	3	9	5	9	2
Marshall	0	1	0	0	0	1	0	0	0	0	3	2	2	1	0	0	0
Mason	1	1	0	1	0	3	0	0	0	0	0	0	2	1	0	0	0
Massac	2	3	1	2	1	1	1	1	1	1	4	2	0	0	0	0	2
McDonough	1	2	0	4	0	2	0	0	0	1	1	2	2	2	1	1	1
McHenry	17	17	15	15	9	10	23	24	14	19	11	11	7	6	11	9	12
McLean	10	11	14	18	12	16	11	10	14	14	5	6	9	10	13	12	9
Menard	0	1	0	3	0	0	0	0	0	1	1	1	1	1	0	0	0
Mercer	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2
Monroe	1	1	1	1	1	1	1	1	0	0	2	2	0	1	1	1	1
Montgomery	1	1	1	3	2	2	3	3	0	1	1	0	3	3	3	2	1
Morgan	1	2	2	2	0	1	1	1	0	2	1	1	2	2	0	1	2
Moultrie	0	0	2	2	1	1	0	0	3	3	0	0	1	1	4	4	1
Ogle	2	3	3	4	2	2	3	3	4	4	3	3	2	1	1	1	0
Peoria	106	107	86	87	92	97	51	77	49	86	76	93	81	80	76	75	109
Perry	0	0	0	0	2	3	1	4	2	3	0	0	4	4	0	0	1
Piatt	0	1	0	0	0	0	0	1	0	2	0	0	0	0	1	1	1
Pike	0	2	0	0	0	2	0	0	0	0	0	0	2	2	0	0	0
Pope	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Pulaski	0	1	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0
Putnam	1	1	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0
Randolph	1	1	1	2	0	0	1	4	0	0	1	1	1	1	1	1	6
Richland	3	3	4	4	1	3	0	0	1	3	1	1	1	1	2	2	1
Rock Island	8	8	17	17	4	4	19	19	12	12	18	17	12	9	12	11	11
Saline	1	2	1	1	3	3	2	2	2	2	4	2	4	3	1	1	3
Sangamon	68	71	57	58	45	52	48	54	32	46	51	48	46	43	38	46	33
Schuyler	0	0	0	0	0	3	0	0	0	0	0	0	4	0	6	0	1
Scott	0	0	0	0	0	0	0	1	0	1	0	2	0	0	0	0	0
Shelby	0	0	0	0	3	3	1	1	3	3	2	5	1	2	0	0	0
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21
St. Clair	29	26	22	29	23	35	14	29	7	26	26	28	18	16	18	15	0
Stephenson	8	9	5	5	1	2	3	4	4	5	4	4	5	4	2	2	1
Tazewell	3	4	9	10	6	9	3	5	4	7	2	2	2	3	3	2	3
Union	0	1	0	1	0	0	2	2	0	0	2	2	3	3	1	1	1

Vermillion	4	4	8	9	3	4	9	12	1	6	13	14	7	6	8	6	11
Wabash	0	1	0	2	0	0	0	1	0	2	3	2	0	0	0	0	1
Warren	0	1	0	1	0	1	0	0	0	1	0	1	1	1	1	1	1
Washington	0	1	0	1	0	1	0	1	0	0	0	0	2	2	1	1	0
Wayne	0	0	0	0	1	1	1	2	0	1	1	1	1	1	1	1	2
White	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	1
Whiteside	2	5	1	5	1	4	0	6	0	3	7	6	3	5	4	3	1
Will	49	50	35	36	40	41	42	43	42	38	44	47	38	35	28	26	33
Williamson	6	6	8	1	6	2	4	9	8	9	6	5	5	5	10	9	6
Winnebago	31	57	54	57	61	75	58	65	71	78	59	48	61	49	51	43	40
Woodford	0	0	1	1	1	2	0	0	1	1	1	2	2	2	3	3	1
Unknown	5	0	3	0	0	0	0	0	0	0	18	0	1	0	0	1	0
Out of State	-	-	-	-	1	0	4	0	13	0	27	81	53	117	46	97	47
Out of country	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9
Total	1,820	1,985	1,540	1,906	1,617	1,948	1,470	1,815	1,495	1780	1490	1622	1622	1692	1551	1535	1540

***Death numbers for IDPH are for facility of death**

****Death numbers for DCFS and IDPH have been consolidated since 2012**

*****The total number of child deaths is based on the number of death certificates that DCFS received from HFS as of 1/23/14.**