



ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR
2015



MISSION

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

Illinois Department of
DCFS
Children & Family Services

SUBMITTED TO:

The Honorable Bruce Rauner,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

FEBRUARY 2017

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January 2017

The Honorable Bruce Rauner, Governor of the State of Illinois
The Honorable Members of the 100th General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2015. 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 George H. Sheldon 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 Rauner and the members of the General Assembly for the opportunity to protect and serve the welfare of the children of Illinois.

Respectfully submitted,



Joan Pernecke
Chairperson, Executive Council
Illinois Child Death Review Teams

Bruce Rauner
Governor



George H. Sheldon
Director

January 24, 2017

To the Citizens of Illinois:

I present to you the Illinois Child Death Review Team Annual Report for calendar year 2015. Members of the nine regional Child Death Review Teams through the state volunteer several hours each month to review and analyze child deaths with the goal of gleaned lessons to help us prevent future deaths. An important area of focus has been safe-sleep practices for infants and young children. No parent or caregiver intends that falling asleep with a young child will result in the child's death, but we have to continually improve our public awareness and education about safe-sleep practices and the dangers of unsafe practices. The teams have made several recommendations in this area, and we are hopeful that their work will save more lives.

Other recommendations throughout the year help us improve our work in the child-welfare system to better identify risks to the safety of children and better protect children from harm. The Child Death Review process ensures that we are vigilant in protecting children who are unable to protect themselves from harm. This process works because of the commitment of hundreds of caring professionals throughout our state who volunteer their time and expertise to protect children who cannot protect themselves from neglect or abuse.

On behalf of all of us in the Department of Children and Family Service, I express deep appreciation to the members of these teams for their work.

Sincerely,

A handwritten signature in blue ink, appearing to read "G. Sheldon".

George H. Sheldon
Director

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ACKNOWLEDGEMENTS

This report would not be possible without the dedication and unwavering support of almost 150 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams. Members of the Child Death Review Team Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

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

Illinois Child Death Review Teams staff Tamara Skube and Bernadette Emery provided the data from the Child Death Review Team database and suggestions to Dr. Saijun Zhang. Children and Family Research Center staff, Dr. Saijun Zhang, Gail Tittle, and Dr. Tamara Fuller wrote the report.

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EXECUTIVE SUMMARY

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

Illinois Child Deaths in 2015

In 2015, 1,402 children under 18 died in Illinois.¹ This number represents the death information received by CDRTs.

Of the total child deaths reported to CDRTs in 2015:

- 61% were boys and 39% were girls;
- 64% were infants under one year, 9% were young children between 1 and 4 years, 14% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years.²
- 58% were White, 36% were African American, 2% were Hispanic, and the remaining 3% were children of other races/ethnicities.

When Illinois child deaths in 2015 were examined by the manner of death:

- 69% were attributable to natural causes;
- 12% were accidental;
- 6% were homicides;
- 4% were suicides;
- 8% were undetermined.

When deaths occurring in 2015 were examined by the category of death:

- 37% were related to illness;
- 33% were related to premature birth;
- 1% were related to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID);
- 23% were related to various types of injuries, such as suffocations (9%), firearms (6%), vehicular accidents (4%), drowning (1%), fires (1%), poisoning/overdose (1%), and other types of injuries (2%);
- 5% were due to undetermined causes.

¹ The Illinois Department of Public Health reports all death data to the Enterprise Data Warehouse that is managed by Healthcare and Family Services (HFS). The total number of child deaths is based on the death information that DCFS received from HFS as of 1/3/2017. Out of state deaths are partial as all notifications from the Illinois Department of Public Health were not included.

² Due to rounding, some percentages in the report may not add up to 100%.

2015 Child Deaths Reviewed by the CDRTs

In 2015, 231 child deaths were reviewed by the CDRTs, including 131 mandatory and 100 discretionary reviews. The mandatory reviews occurred for one of several reasons: 74 were indicated death cases, 36 cases had an investigation in the year before the child's death, 13 were indicated investigations, 4 were DCFS youth in care, 2 were open DCFS cases, and 2 involved an open DCFS investigation at the time of death.

Reviewed deaths in 2015 occurred in all CDRTs regions (see Appendix A for the CDRT regional map), although there were regional differences in the percentages of child deaths that were reviewed:

- Aurora – 26 of the 191 deaths (14%) were reviewed.
- Champaign – 17 of the 69 deaths (25%) were reviewed.
- Cook – 108 of the 818 deaths (13%) were reviewed.
- East St. Louis – 12 of the 33 deaths (36%) were reviewed.
- Marion – 14 of the 59 deaths (24%) were reviewed.
- Peoria – 18 of the 104 deaths (17%) were reviewed.
- Rockford – 10 of the 58 deaths (17%) were reviewed.
- Springfield – 15 of the 59 deaths (25%) were reviewed.
- In addition, 11 of 11 deaths (100%) that were out of state were reviewed.

Of the deaths reviewed by CDRTs in 2015:

- 60% were boys and 40% were girls;
- 58% were infants under one, 19% were young children between 1 and 4 years, 17% were older children between 5 and 14 years, and 6% were youth between 15 and 17 years.
- 50% were White, 46% were African American, 1% were Hispanic, and the remaining 3% were children of other races/ethnicities.

When reviewed deaths occurring in 2015 were examined by manner of death:

- 34% were attributed to accidents;
- 22% were due to natural causes;
- 10% were homicides;
- 5% were suicides;
- 29% were undetermined.

When reviewed deaths occurring in 2015 were examined by category of death:

- 2% were related to premature birth;
- 21% were related to illness;
- 1% were related to SUID;
- 54% were related to various types of injuries, such as suffocations (27%), drowning (5%), firearms (4%), vehicular accidents (3%), poisoning/overdose (3%), fire (2%) and other types of injuries (10%);
- 22% were due to undetermined causes and other types of causes.

Introduction

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations, and safety policies that have led to a decline in infant and child mortality, too many children are still dying. In 2015 there were 1,402 child deaths in Illinois. Many of these deaths were preventable.

Nine regional Child Death Review Teams (CDRTs) were established by Illinois statute in 1994 and implemented throughout the state in 1995 in an effort to better understand the reasons for child deaths. In 1999, the CDRTs produced the first annual report summarizing team findings and 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, 2007.³ Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This Committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

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

Child Death Review Team Composition

The composition of CDRTs and the process for selecting members is outlined in the Child Death Review Team Act. There are nine CDRTs in Illinois, one in each of the seven DCFS administrative sub-regions outside Cook County and two within Cook County. A map of the CDRTs sub-regions is 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 from DCFS,
- State's attorney or state's attorney's representative,
- Representative of a local law enforcement agency,
- Psychologist or psychiatrist,
- Representative of a local health department,
- Representative of a school district or other education or child care interests,
- Coroner or forensic pathologist,
- Representative of a child welfare agency or child advocacy organization,
- Representative of a local hospital, trauma center, or provider of emergency medical services, and
- Representative of the Department of State Police.

³ The complete Act is available online at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=244&ChapterID=5>.

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.

During 2016-2017 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 2015 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 policies or procedures will be revised or new policies or procedures will be developed.
- The 20th Annual Symposium was held at the Crowne Plaza – Springfield, Illinois on April 21st-22nd, 2016. There were 63 attendees. The presentations included: 1) Assessing Allegations of Sexual Abuse in Pre or Non-verbal Children by Victor Vieth (Founder of Gundersen National Child Protection Training Center); 2) Unto the Third Generation: A Call to End Child Abuse in 120 Years by Victor Vieth; and 3) Case Specific Presentation by Denise Kane (DCFS Inspector General).

DCFS Roles and Responsibilities

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

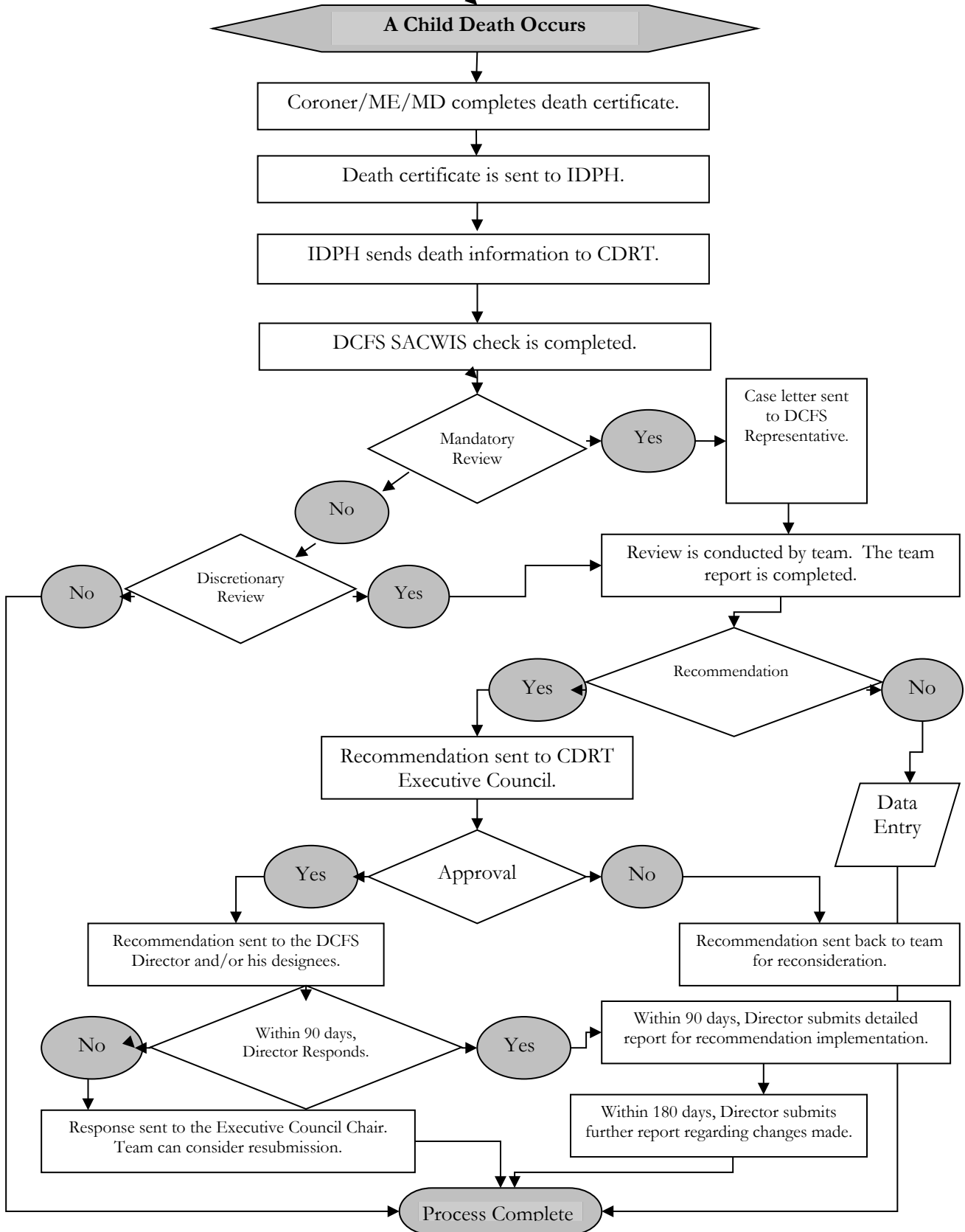
Other responsibilities of the CDRTs are to:

- 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

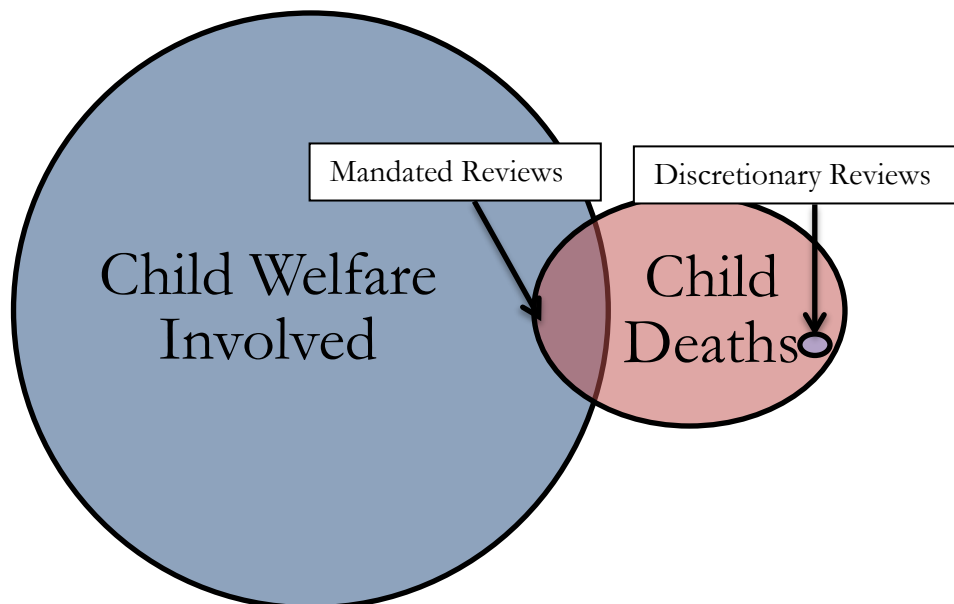


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the death certificate to the Illinois Department of Public Health (IDPH). IDPH electronically provides the Child Death Review Office with the information. 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 DCFS youth in care,
- a child was not a DCFS youth in care, but the death occurred in a licensed foster home,
- the subject of an open DCFS service case,
- the subject of a pending child abuse or neglect investigation,
- the subject of an abuse or neglect investigation during the preceding 12 months, and/or
- 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.⁴ These reviews are called discretionary reviews (Figure 2). Information from the death certificates received by the CDRTs is electronically entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is completed at the CDRT meeting.

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

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

After the Child Death Review Team Report is completed at the team meeting, the Child Death Review Office enters all information into the Child Death Review Database. All recommendations are sent to the Executive Council for approval. If the Executive Council approves a recommendation from a Team, this recommendation is presented to the 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

⁴ 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 2015.

review of a child's death. This includes, but is not limited to, birth certificates, relevant medical and mental health records, law enforcement agency records, Department of Correction parole records, probation and court services records, and social service agency records regarding services to the child or family.

Confidentiality of CDRT Information

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

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

Chapter 2: Child Death Review

Recommendations to Prevent Child Deaths

The purpose of CDRT recommendations is to prevent or reduce future child fatalities through reasonable means. The importance of CDRT recommendations – and their potential for preventing future child deaths – cannot be overstated. The 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 a total of 82 recommendations made by the CDRTs on deaths occurring in 2015, including 57 “system-level” recommendations and 25 case-specific recommendations. The majority (45) of the system-level recommendations focused on DCFS policy and procedures (see Table 1). The DCFS recommendations resulted from four types of reviews including: death indicated (15), discretionary (19), indicated report at time of death (5), and investigation within a year of death (6). There were 10 recommendations related to other systems made from three types of reviews, including death indicated (4), discretionary (5), and indicated report at time of death (1). There were two primary prevention recommendations from discretionary reviews in 2015.

Among the 25 case-specific recommendations in 2015 (see Table 1), 9 recommendations resulted from cases where death was indicated, 7 were discretionary reviews, 3 were from cases that had an indicated report at time of death, and 6 were from cases that had an investigation within a year of death.

Key:

DCFS = DCFS recommendation

OS = Other System recommendation

PP = Primary Prevention recommendation

CS = Case-specific recommendation

Table 1: 2015 Recommendations and Responses

	Recommendation	Response
DCFS-1	Team recommends DCFS implement a policy that on all death investigations and serious abuse allegation investigations, DCFS schedule a meeting coordinated through CAD with CAC, SA, Coroners, Law Enforcement, and DCFS prior to DCFS closing the case.	DCFS agreed. Procedures 300 outlines and directs the investigator to coordinate serious harms and death investigations through the local CAC. Part of this process would include discussion of the case as a multidisciplinary team which could include all the parties recommended. Coroners and law enforcement are welcome but not required to attend. Procedure also dictates the coroner is to be contacted for all death cases and a discussion held regarding the merits of the case.
DCFS-2	Team recommends DCFS put all UIR's in SACWIS so that information can be seen by investigators anywhere in the state.	DCFS is currently re-evaluating the UIR process. A company is looking at the current system and is making recommendations for a new system.
DCFS-3	Team recommends that on all death cases, even if the case is not taken through the hotline, DCFS is to check with law enforcement to determine if there are any unusual circumstances surrounding the death.	Currently, the DCFS hotline staff will call Coroner's/ME 30-60 days after the report of an unusual death to request a report to determine if the Department should investigate the death.
DCFS-4	Team requests DCFS send a reminder to all investigative staff that the primary care physician needs to be contacted in any medical neglect or physical abuse or death investigation. If the investigator is told the child has no primary care physician, document who told them that.	DCFS agreed and sent out a reminder to staff on May 20, 2015 to contact the primary care physician for all medical neglect, physical abuse, and death cases. New Procedures 300 better clarifies who is considered a primary care physician. As a result of recent CDRT recommendations from Cook County teams, Cook County Child Protection Supervisors should review this information with all child protection staff during their June team meetings. Required Contact with Victim's Primary Care Physician – Current Procedures 300 (and revised Procedures 300 upon release) requires the investigator to have contact with the child's primary care physician for allegations of death, physical abuse and medical neglect.

		Death Investigation Findings – Procedures 300, Death allegation requires the investigator to interview the Medical examiner/Coroner about the cause of death, and to obtain their report which should document the cause of death. That cause of death should inform our decision-making but does not prevent DCFS from making an independent finding of abuse/neglect.
DCFS-5	Team recommends that DCFS should increase the retention rate in unfounded child death cases.	DCFS disagreed. The vast majority of death cases are reported by mandated reporters, usually more than one, and are retained for 3 years. To increase the number of years for retention for an unfounded report would bring it to the same retention period as an indicated report, 5 years.
DCFS-6	Team requests DCFS remind all investigative staff that primary care physicians need to be contacted in any medical neglect or physical abuse or death investigation. If the investigator is told the child has no primary care physician, document who told them that.	DCFS agreed. Procedures 300 and medical neglect, death, and physical abuse allegations do require consult with child's primary care physician, unless a supervisor waives the contact. This information will be reviewed with all child protection staff as part of Procedures 300 revision training. A practice reminder will be issued to Cook County child protection teams in advance of the 300 training since this was a Cook County investigation. On May 20, 2015, the Regional Administrator sent out a practice reminder to all Cook Area Administrators and Child Protection Supervisors.
DCFS-7	Team recommends that when service needs are identified during the course of the preliminary investigation, the services should be provided in a timely fashion and not be delayed based on the completion of the Medical Examiner's report.	DCFS agreed. The field will be reminded that cases should be referred for services at the time the need is identified. If the case does not yet have a finding, there is a procedure already in place in which referrals can be requested and discussed with the Intact Utilization Administrator to ensure referrals and services are made timely.
DCFS-8	Team recommends that DCFS conduct a Quality Assurance review, such as a retrospective review, to track the time-line of services being offered (typically	DCP has requested as a metric, the date between when the family was last seen to date of referral in order to track this better. The Division of Quality Assurance and the Department

	with intact cases) and initiated for families with a child death.	acknowledges that this is an issue and therefore no current review is needed. Once the metrics are in place, this will be much easier to track. Supervisory practice is to focus on timeliness of service referrals.
DCFS-9	Team requests that DCFS review Procedures 300 as it relates to allegation 11 (cuts, bruises, welts, abrasions, & oral injuries) and the establishment of criteria for indicating cases. The child's age, location of bruising, culture and frequency should not be considered when parents/caregiver admits to using physical discipline and marks are left on a child. Also, existing conditions related to medical conditions and mental health difficulties should be taken into consideration for all ages of children.	DCFS agreed. A review of Procedures 300, Appendix B was conducted concerning the suitability of unfounding a report with a minor with visible marks as a result of physical discipline. The importance of following Procedures 300 was stressed to ensure final findings can be substantiated.
DCFS-10	Team recommends that DCFS conduct a full and complete investigation into the deaths of all youth in care.	All youth in care deaths are reviewed by DCFS to ensure rule and procedure were followed and the Department ensured the safety and well-being of the child at all times. Concerns or issues are addressed according to DCFS policy.
DCFS-11	Team requests that drug tests, where there is some level of drug found, be confirmed at a lab for the actual quantitative levels. There was some concern because mom did take a drug drop but the screen said she was negative because the levels were not high enough to be coded as positive.	DCFS canceled their lab-testing contract with the drug testing company X. One of our new testing labs will be testing opioid samples at lower cutoff levels on a pilot basis for the remainder of FY16. They will be using a cutoff threshold of 300 ng/ml rather than previous cutoff of 2000 ng/ml. This will give us the opportunity to evaluate the impact and effectiveness of use of the lower cutoff levels before making the decision to make the change system-wide.
DCFS-12	The drug testing company that DCFS has employed is not working for DCFS drug drops due to multiple issues. Team requests that the state come up with a better drug drop system.	DCFS canceled their lab-testing contract with Company X. One of our new testing labs will be testing opioid samples at lower cutoff levels on a pilot basis for the remainder of FY16. They will be using a cutoff threshold of 300 ng/ml rather than previous cutoff of 2000

		ng/ml. This will give us the opportunity to evaluate the impact and effectiveness of use of the lower cutoff levels before making the decision to make the change system-wide.
DCFS-13	Team recommends DCFS consider recording all contributing factors and add contributing factors to the database such as substance abuse.	DCFS is working on adding "drop down" boxes in SACWIS to identify types of death. In addition, we are in the process of refining the Child Fatality website to address this.
DCFS-14	Team requests DCFS use this case as a training tool to illustrate how older children not being raised by the parent should be considered when assessing risk, even if it is an A sequence.	Waiting on response.
DCFS-15	Team recommends MPEC educate child abuse teams and judges on child abuse and neglect investigations.	Waiting on response.
DCFS-16	Team recommends DCFS ensure that "unfounded" investigations are maintained according to ANCRA, which requires that any hotline call made by a mandated reporter shall be maintained, with no time limit. Further, all "unfounded" investigations should be available to DCP Investigators at any time. Here, there were two unfounded cases that were expunged. At least one of the hotline calls (Sequence E) was made by a mandated reporter, a police officer who stopped a drunk driver. Mom was a passenger and had very young, filthy, and urine soaked kids in the car. Mom kept passing out and the children were unrestrained in the car.	SCR adheres to retention codes contained within ANCRA and Rule 431. Edits exist within SACWIS based on the variables included in Rule 431. These edits are applied automatically by SACWIS. Child Protection staff have access to all priors that are maintained within the system based on retention code. Procedure has been updated to allow State's Attorneys to have access and review unfounded reports. In addition, the Department agrees this should have been screened with the State's Attorney for possible court involvement. The investigator(s) should always review a family's history as a whole and how the prior history impacts the current case to determine a need for services or court involvement. A reminder will be sent to all Cook investigators, supervisors, and AAs of the importance of this. It should be noted in this case that the family did receive services and the case was screened into court; however, the judge returned the children. It is important that all parties working with a family,

		legal, intact, and investigators, communicate with each other regarding issues and concerns surrounding a family.
DCFS-17	Team recommends that DCFS add to the home safety checklist that furniture be bolted to the wall. Team requests that straps be given out to families to help secure furniture to the wall.	DCFS agrees that it is always best practice to have heavy furniture bolted to the wall and can certainly instruct families regarding the dangers surrounding heavy furniture falling over on young children. However, the family's living arrangements may not allow them to perform such action. DCFS agrees to provide instruction about the dangers of heavy furniture and the need to bolt to the wall. This information will be placed on the home safety checklist. DCFS will help the family identify where they can obtain straps but is not able to provide them.
DCFS-18	Team recommends that DCFS look at consistency in the guidelines and policies regarding investigations when weapons (guns) are present in the home and a tragedy occurs.	DCFS has policies in place for youth in care. Each case or investigation is individually assessed, and gun safety measures are factored into a case and/or finding. DCFS will look at how other states address this.
DCFS-19	Team recommends that DCFS look at improving/overhauling SACWIS, as it is reportedly not user-friendly, is time-consuming, and is not reliable. DCFS should also look at improving the AP monitoring of cases so that there is a more qualitative, big picture review. Essentially it seems that it is a check-the-box type of review, not a holistic look at how the case was handled.	Waiting on response.

DCFS-20	Team recommends DCFS ensure that “unfounded” investigations are maintained according to ANCRA, which requires that any hotline call made by a mandated reporter shall be maintained, with no time limit. Further, all “unfounded” investigations should be available to DCP investigators at any time. At least a few of the unfounded reports were made by mandated reporters.	SCR adheres to retention codes contained within ANCRA and Rule 431. Edits exist within SACWIS based on the variables included in Rule 431. These edits are applied automatically by SACWIS. Child Protection staff have access to all priors that are maintained within the system based on retention code. Procedure has been updated to allow State's Attorneys to have access and review unfounded reports. DCFS stands behind their current interpretation that investigations are held in accordance with ANCRA. DCFS interprets report as an investigation and not just a call to the hotline.
DCFS-21	Team requests DCFS not close an intact case while a mother is pregnant, especially where there is a long history of abuse and neglect.	DCFS agreed. The extension request that was developed for cases over 6 months and over 12 months exclude from that review cases where mom is pregnant. It is an automatic approval to keep the case open if mom is pregnant.
DCFS-22	Team recommends DCFS take a report on mothers who have a second or repeat positive drug drop during their pregnancy. Recommend DCFS take these reports as a CWS report.	Current law (ANCRA) does not allow DCFS to take a report for investigation on a mother who is pregnant and has no other children, as there is no eligible child victim until a newborn is verified to have taken a breath. Child welfare referrals are not considered reports or investigations and must be called in by the family themselves or a professional in the community who is currently working with the family, identifying a possible need for services. There must be a viable child before law allows intervention by DCFS. DCFS will follow up with legal and legislative staff to discuss possible changes in the law that may allow for DCFS to pursue investigating situations of in utero harm to a child or "reckless endangerment of an unborn child".
DCFS-23	Team recommends that DCFS review the Home Safety Checklist and consider adding a discussion of the family’s	DCFS already has a fire safety-related brochure, "Love alone didn't save her: Practicing fire safety did". This brochure addresses emergency evacuation. DCFS

	emergency evacuation plan, and if necessary, assist the family in the development of such a plan.	staff are not qualified to create emergency evacuation plans.
DCFS-24	Team recommends that in cases of death by neglect, the parent be required to attend parenting classes when there is a surviving child under the age of 6.	In situations like this, DCFS needs to stress safe sleep practices more than parenting. DCFS is in the process of updating the parenting classes to include more "hands on" practice. DCFS can and does request parenting classes when necessary, but participation is voluntary outside of a court order. The home visiting program may be a good resource in situations like this.
DCFS-25	Team recommends that DCFS require daycare centers and homes to complete an assessment of the environment whenever they take a trip or field trip out of the facility or home.	Waiting on response.
DCFS-26	Team recommends that in cases of death by neglect, the parent be required to attend parenting classes when there is a surviving child under the age of 6.	In situations like this, DCFS needs to stress safe sleep practices more than parenting. DCFS is in the process of updating our parenting classes to include more "hands on" practice. DCFS can and does request parenting classes when necessary but participation is voluntary outside of a court order. The home visiting program may be a good resource in situations like this.
DCFS-27	Team recommends that DCFS collaborate with the Medical Examiners Office.	Waiting on response.
DCFS-28	Team recommends DCFS check status of partnering with Public Health about being aggressive with the literature with co-sleeping, such as "Back to sleep in a CRIB".	Waiting on response.
DCFS-29	Team requests DCFS pull data for the last 2.5 years on unsafe sleep deaths for unfounded and indicated cases so the decision-making that determines unfounded and indicated cases can be reviewed, as well as the consistency with decision-	Waiting on response.

	making. Cases that were unsafe sleeping, co-sleeping, asphyxia deaths, and undetermined deaths should be reviewed/ compared with Medical Examiner data.	
DCFS-30	Team recommends that DCFS develop a decision tree to delineate the extenuating circumstances where a co-sleeping report could be indicated, i.e., drugs, alcohol, substance affected, multiple children in a bed co-sleeping with an adult, demonstrating a pattern of co-sleeping where knowledge of the risk is documented, prior co-sleeping deaths.	DCFS Director sent an informational transmittal to all investigative staff regarding surrounding circumstances to assess child deaths due to unsafe sleep circumstances. Each death is to be assessed individually, and unsafe sleep practices, in and of themselves, are not a criteria to indicate a report at this time. Guidance is already provided to the investigator through Procedures 300, which was recently updated. The investigator is required to consult with his/her supervisor regarding his/her findings and review all inculpatory and exculpatory evidence obtained in order to make a final decision. Based on this, a decision tree is not necessary at this time.
DCFS-31	Team recommends DCFS implement, within a reasonable timeframe, a mandatory debriefing involving all individuals associated with the investigation and invite MDT members to participate. This recommendation is being made to assist employees with stress they may be experiencing and also as a learning opportunity for an internal review of how the case was handled.	Waiting on response.
DCFS-32	Team recommends DCFS send an email to all DCFS investigators, supervisors, and others who present at CDRT after the CDRT annual report is published that reads: "Thank you for participating in a child death review in (year participated). Each year, an annual report summarizing the recommendations made by the Illinois Child Death Review	Waiting on response.

	Teams is published. This report is now available at (web site) for your review."	
DCFS-33	Team recommends that DCFS list for investigation any foster parent, whether licensed or unlicensed, who is caring for a parenting minor when the parenting minor's child is injured or dies while in the foster parent's home or care.	Waiting on response.
DCFS-34	Team recommends DCFS take a report on mothers who have a second or repeat positive drug drop during their pregnancy. Recommends DCFS take these reports as a CWS report.	Current law (ANCRA) does not allow DCFS to take a report for investigation on a mother who is pregnant and has no other children, as there is no eligible child victim until a newborn is verified to have taken a breath. Child welfare referrals are not considered reports or investigations and must be called in by the family themselves or a professional in the community who is currently working with the family identifying a possible need for services. There must be a viable child before law allows intervention by DCFS. DCFS will follow up with legal staff and legislative staff to discuss possible changes in the law that may allow for DCFS to pursue investigating situations of in utero harm to a child or "reckless endangerment of an unborn child".
DCFS-35	Team recommends DCFS partner with Illinois Department of Public Health, to develop safe sleep education and policies that can be shared with shelters that care for infants.	Waiting on response.
DCFS-36	Team recommends that DCFS look into the safety of pack and play usage including bedding options for pack and play bedding.	DCFS continually reminds parents of safe sleep practices. Pack and plays are distributed but do not come with bedding. We will reiterate not to use soft bedding.
DCFS-37	Team recommends that Child Protection Teams be staffed at Consent Decree levels.	Child Protection teams are currently being staffed at 10:1, which is below consent decree levels. DCFS has faced challenges in obtaining qualified staff on

		lists for interview and hiring and is working closely with CMS to focus on grading child protection applications. In addition, the degrees have been changed for child protection to allow those with a law enforcement background to apply.
DCFS-38	Team recommends DCFS secure a consultation case review by a child abuse pediatrician or specialist on medically complex and failure to thrive cases.	A nursing referral is required for all cases involving children with special health care needs. In this case, the Primary Care physician was very much involved in the child's treatment. Procedures 300.100 allows for additional medical consultation whenever needed. Staff will be reminded to utilize the certified child abuse pediatricians for consult.
DCFS-39	Team recommends that DCFS utilize a more effective and timely drug screen process when a child death occurs.	Waiting on response.
DCFS-40	Team recommends that if there is no evidence of abuse or neglect, there should be a reassessment of the safety plan. DCFS should start collecting data on how many kids we have out of the home on a safety plan pending a final autopsy report, especially on co-sleeping and other cases where there are no initial signs of trauma or no aggravating factors.	Child Protection Administration, in conjunction with DCFS legal division, is addressing the use of safety plans and the need for them to be time-limited and specific. Meetings are in place to update appendix G CERAP procedures, and DCFS hopes to have clearer guidelines in place to direct staff regarding the use of safety plans by the end of December 2016. DCFS Administration then plans to follow up with training specific to safety planning in early 2017. Additionally, DCFS is trying to acquire data regarding out of home safety plans and is working with the IT division.
DCFS-41	Team recommends that DCFS have an identified medical resource that is knowledgeable about abuse, neglect, medical abuse, and medically complex children. Workers need to be sure to get information from good medical providers and greater medical expertise (institutionalized medical expertise, more than just the regional nurse). It needs to be a medical resource that is oriented to child welfare and readily available to staff.	DCFS currently has four medical resource networks across the state with medical experts (physicians) that staff are able to consult with when dealing with abused, neglected, and medically complex children. DCFS Administration is currently working with the Medical Director for MPEEC to enhance and possibly increase these networks so that staff has better and easier access to them for consultation. Child Protection Administration will also send a reminder to field staff regarding the networks in their areas.

DCFS-42	The team requests that DCFS explain what procedure is followed when their youth in care is the victim of sexual assault, other sexual crime, or trafficking, as was the mother of this deceased minor - mother was a youth in care and a minor (16/17) when impregnated by her 30 year old "boyfriend" and is impregnated by him again.	DCFS has a staff member specifically assigned to address human trafficking. She reviews these situations daily and consults with the field. The situations cited require that a UIR be completed. UIRs are data-entered and must be dispositioned within 14 days. Supervisors and AAs, in some situations, are involved in the UIR disposition process. In cases of sexual abuse, DCFS is to notify law enforcement. Often these cases may be worked in tandem with the local Child Advocacy Center, which will notify law enforcement. DCFS staff can advocate for prosecution as part of the MDT process, consult with our legal division for direction, and ultimately file a petition in court to protect a child. DCFS can assist the family in linking to victims' services for an order of protection. If the event does not qualify for an allegation of abuse, DCFS staff are required by policy to report criminal acts to local law enforcement. DCFS staff can advocate, but many of these decisions lie within law enforcement and the state's attorney office to charge and prosecute.
DCFS-43	The team requests that DCFS conduct an updated training for DCFS staff in which CDRT members and MEs participate with a focus on the MEs report not being dispositive in terms of making a finding.	There is already a formalized training regarding the coroner's 5 manners of death and the fact these findings do not preclude unfounding an investigation.
DCFS-44	The team requests that DCFS create an "unsafe sleep" allegation.	DCFS already has a death allegation which encompasses all types of child deaths. Appendix K is being updated to provide specific guidance to the investigator regarding sleep deaths.
DCFS-45	Team recommends that in cases of death by neglect, the parent should be required to attend parenting classes when there is a surviving child under the age of 6.	In situations like this, DCFS needs to stress safe sleep practices more than parenting. DCFS is in the process of updating our parenting classes to include more "hands on" practice. DCFS can and does request parenting classes when necessary, but participation is voluntary outside of a court order. The home visiting program may be a good resource

		in situations like this.
OS-1	Team recommends the development of a way for hospitals to track a parent that has had DCFS involvement.	Waiting on response.
OS-2	Team recommends a new law be created that requires caregivers be drug tested within 24 hours of the death of a child.	Investigative staff has the ability to drug test an alleged perpetrator if there are identified circumstances related to possible drug use to support this activity. DCFS understands the need to perform these timely and is working diligently to ensure this is possible. The Director stated he will follow up on this issue with our legal staff.
OS-3	Team will contact the hospital to determine why the hotline was not called immediately when the mother admitted to using cocaine during her pregnancy and the infant was suffering withdrawal; in this case, the hospital waited for the meconium test to come back, and mother and infant were released together before this happened.	The hospital was contacted and the situation was discussed with the hospital.
OS-4	Team will send a letter to the coroner to commend him for his wording on the autopsy report.	The letter was written and sent.
OS-5	Team recommends a letter be sent to the State's Attorney and Law Enforcement to remind them to contact DCFS right away by calling the hotline in all death cases.	The letter was written and sent.
OS-6	Team recommends referring this case to the OIG office.	Waiting on response.
OS-7	Team recommends a follow up with the State's Attorney on why charges were not filed. The safe sleep changes brought this situation to light, as the investigation turned up the drug and alcohol issues. The 1 year old would not have come into	Team followed up with the State's Attorney.

	care without this investigation and the change in safe sleep reporting.	
OS-8	Team recommends the Medical Examiner pull 1 - 2.5 years of data on co-sleeping deaths for cases that were unsafe sleeping, co-sleeping, asphyxia deaths, and undetermined deaths so that these can be reviewed/compared to DCFS data. This data should include findings (cause and manner of death) to compare.	
OS-9	Team will write a letter to the hospital to look at issues related to the mom leaving against medical advice and how they handled the case. After mother left the hospital, the hospital did not contact mom to ask her to come back nor call the hotline.	Letter written and sent.
OS-10	Team Chair will write a letter to the hospital and to the Police Department Chief to remind them that they are mandated reporters and required to call in all child deaths.	Letter written and sent.
PP-1	Team requests DCFS add boppy pillows to the safe sleep education material.	DCFS agreed. The safe use of boppy pillows is already being added to appendix K (Safe Sleep) of Procedures 300, which is being updated at this time.
PP-2	Team recommends DCFS revise "Get Waterwise, Supervise" content materials to state: If there is a near drowning experience, seek medical attention immediately for further evaluation.	Waiting on response.
CS-1	Team requests DCFS look at how this case was handled since the investigator did not talk to the primary care physician and did not investigate the mother's compliance to the child's treatment regimen.	DCFS agreed. Upon looking at this case, the finding was supported based upon the following: *Treating physician of South Suburban called the hotline to provide related information on the same day as the Initial Oral Report. The doctor stated that a report was made earlier on 11/10 regarding bruising on the child and that,

		<p>at this time, there is no trauma or abuse. The child is going to be admitted to the hospital in order to determine a diagnosis. The child is "bruising easily" due to a possible medical condition.</p> <p>*There is no information regarding how long the child was diagnosed with leukemia. If the diagnosis was a result of assessment of the bruises, that would have added additional investigation integrity regarding the finding. *No discussion with hospital regarding treatment plan resulting from diagnosis. There was a home health nurse with whom the worker did not speak. There is no documentation regarding if the nurse was in the home prior to the investigation. *We did not ask if child had a primary care physician and make efforts to contact the Primary Care Physician. The other children were also on medication and we did not explore that. * Issue of mother being "stressed" and her support system was not thoroughly explored. We should have assessed the additional stresses having a child with this diagnosis caused for her and the family. We should have attempted to contact the hospital social worker to determine if mother would be referred to agencies that work with and support families with children with leukemia. Perhaps we could have referred her to a FAC. There may have been some depression as a result of learning her child had leukemia, loss of the job etc., and she may have needed counseling. The mother never stated she hit the child with a belt. Her statement is documented, "She denies ever abusing her children, but states that she does whip them with a belt when disciplining her children." It was not specifically asked if the child (1 at the time) was also disciplined in this manner, but this should have been clarified. * Hospital social worker reported child was diagnosed with leukemia and the source of the bruises. The Area Administrator</p>
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		will review this investigation with the investigator, primary PSA, and acting PSA by July 3, 2015.
CS-2	<p>Team requests that DCFS and POS agency review this case and how it was handled for supervision and policy/procedure compliance.</p> <p>For POS agency:</p> <p>a) There were risk factors present for mother when she disclosed her pregnancy to the POS agency. When POS had contact with the mother in the Fall, it would have been critical to determine what, if any, medical care was being sought and where she was going for prenatal care. Further, it would have helped locate the mother when she delivered the baby, a missed opportunity.</p> <p>b) When the hotline was called regarding the disclosure of the birth of the baby, there should have been consistent communication between DCFS and POS. There was a lack of documentation from POS around efforts to locate mother.</p> <p>For DCFS:</p> <p>An all shift alert was not followed, although the child was under 6 years of age. There were attempts to contact on the 3rd, 4th, and 5th, but an all shift alert wasn't done on the 6th. Nothing was done again (no documentation) until the 29th. There was a lack of documentation from DCFS around efforts to locate mother.</p> <p>For both DCFS and POS:</p> <p>When efforts were unsuccessful, a warrant should be placed and the protocol of screening the case for an order of protection</p>	Awaiting DCFS response.

	should be done before closing the case. There was a lack of understanding surrounding the ability to screen cases.	
CS-3	Team recommends DCFS look at how this case was handled since the investigator did not talk to the primary care physician, did not look at the malnourished allegation, and there was not a nurse referral made.	This case was reviewed by the Regional Administrator. The AA thoroughly reviewed the investigation with the worker and the Temporary Assigned Supervisor, who is now at another site as a PSA on 6/15/15.
CS-4	Team recommends that DCFS review the case and how it was handled, addressing why there was such a delay in initiating services, and why there was a delay (approximately 9 weeks) in the investigator calling the sitter of the child, who may or may not have been involved with the child's death.	DCFS agreed. This case was sent to the Associate Deputy to review and address. The delay in contacting the sitter should not have occurred. The supervisor on the case is no longer in the Division of Child Protection. All other supervisors were reminded, in writing, that all service referrals are to be made right when a need is identified.
CS-5	Team requests DCFS look at this case and how it was handled. Team had lengthy discussion about whether Procedures 300 was followed. Team is also concerned because this mother was not referred to services to assist with her understanding of this child's ADHD and talking to the doctor was waived. In the case notes, the supervisor specified that the investigators should have a drug and alcohol assessment conducted due to the DUI. This was not done. In addition, notes from the supervisor stated that the investigator was to make contact with the teacher, and this was not done.	On 7/27/15, the Regional Administrator conducted a review of the investigation noting several major concerns. On 8/5/15 and 8/21/15, case was then reviewed with the supervisor and investigator, reviewing each concern. A review of Procedures 300, Appendix B was also conducted with the supervisor/investigator concerning the suitability of unfounding the report with a minor with visible marks as a result of physical discipline. Both agreed to follow Procedures 300 to ensure they can substantiate their final finding.
CS-6	Team requests DCFS look at how this case was handled, specifically regarding DCP#1 and LSSI, regarding: 1. the mother was allowed to have the baby in her care after being discharged from Haymarket due to having a weapon and stealing.	Waiting on response.

	<p>Even though this was an A sequence, mother had another child who she never cared for (10 year old) and this should have been a red flag to DCP#1 and taken into consideration for risk; 2. DCP#1 had unfounded B sequence; 3. the baby was not removed after A or B sequence – if baby had been, she'd likely still be alive; and 4. there was a 3 week gap in opening the Intact Case.</p>	
CS-7	<p>Team recommends that a service caseworker be brought in for services to the family.</p>	<p>Waiting on response.</p>
CS-8	<p>Team recommends DCFS look at this case and how it was handled. Despite mother being indicated multiple times in the past, for Inadequate Supervision, ASRI, Risk of Sex Abuse, NEI and another Inadequate Supervision, as well as multiple “unfounded” investigations, this case was never screened in. One of the indicated cases (Sequence D) involved mother allowing a known sex offender to have access to a 4-year-old girl. The sex offender raped the 4 year old.</p>	<p>DCFS reviewed this case. Mom was referred to domestic violence counseling, was to consent and follow through with urine screens, and obtain a substance abuse assessment. She was to cooperate with developmental screenings for the youngest children. She was to not allow contact with paramour and the children, as he is a registered sex offender. She completed all recommended services, including the Inpatient Haymarket Program, and was involved with the Family Recovery Program through Haymarket. Two children were with her and two children were with an aunt when the case closed. They were to assist with Housing Advocacy. Beds were provided before the case closed. Haymarket has a Housing Advocacy program and they were assisting her with finding housing. She cooperated with scheduling her mental health assessment and was waiting to get into the DV program at Circle of Family Care. As she became involved in the inpatient program at Haymarket, all of her service needs were addressed through the Haymarket Program. On 2/22/13, she was successfully discharged from the</p>

		<p>Haymarket program. She then moved into the Family Recovery Program. Case was closed as she had successfully completed all services and was connected to a program to support her and assist her with housing. One concern is that the case closed before she had stable housing, but Haymarket was assisting her with that process. The assistant regional administrator for Cook discussed the overall recommendations with the AA and with the team involved.</p>
CS-9	<p>Team requests DCFS review this case and how it was handled. Upon review of the records and in speaking with the investigator at our meeting regarding the investigation, the investigator did not state that she reviewed the file of records the grandparents/legal guardians had on the child and she did not make sufficient collateral phone calls to confirm the grandparents' statements. Records do not indicate that the investigator spoke with the hospital, the child's psychiatrist, staff at his interim school, Ombudsman, any possible pediatrician, or ensure grandparents were, indeed, being compliant with the child's substance abuse and mental health needs.</p>	<p>Regional administrator reviewed the case in-depth and then reviewed the case and concerns with the supervisor and investigator. Corrective action has been taken with the supervisor and investigator, and both agreed that a more thorough investigation should have been conducted.</p>
CS-10	<p>Team requests DCFS look at staffing levels at this office that may have impacted child's death.</p>	<p>DCFS is aware of current staffing issues and is seeking to address them.</p>
CS-11	<p>Team requests that DCFS look at how the intact case was managed and how that may have impacted the child's death.</p>	<p>The intact case was reviewed by the Intact Utilization Administrator and some issues related to worker visits to the home at differing times of the day. The APT reviewed the case with the POS. Those participating included APT Staff, Statewide Intact Family Service Coordinator and the POS Staff (Site Director, Program Director and Vice President). They discussed, and the POS acknowledged, the importance of</p>

		<p>ensuring that all assessment/risk assessments are completed on IFS cases on a timely basis and consistent with policy. The POS also acknowledged that both the assigned worker and supervisor at the time of the child's death were ultimately terminated, primarily due to poor performance in ensuring child safety. The POS continues to train IFS staff on the importance of assessing risk and documenting in a timely fashion. The POS has trained to ensure that supervision practice accounts for a regular discussion of child safety and risk assessment, including the ability of the worker to observe the child, as well as the interaction between the child and parent. This would include altering the in-home visit time in order to ensure the child is awake during the home visit.</p>
CS-12	<p>Team recommends DCFS look at this case and how it was handled: a) During the handoff meeting to the POS, there was no mention of father's paramour even being in the house, she hadn't been made "part of the household" much less assessed; b) there was no mention that a new hotline call had been made and was under investigation; c) once it was discovered that a new hotline call (B sequence on dad) was under investigation, calls by the POS to DCP Supervisor went unanswered and then the investigation was unfounded; d) no call/contact was made or attempted by DCP to the intact worker at the POS even though this is required; e) it appeared that DCP didn't interview the children separately from father/paramour or each other; f) information on the 8/14 and 10/14 unfounded allegations against father weren't available to the Intact agency for weeks, as they either hadn't been uploaded</p>	<p>Waiting on response.</p>

	to SACWIS, or SACWIS wasn't accessible to agency.	
CS-13	<p>Team recommends that DCFS look at this case and how it was handled. Despite the family being indicated multiple times in the past, for Inadequate Supervision, ASRI, Risk of Sex Abuse, a second ASRI, this case was never screened in. One of the Indicated cases (Sequence D) involved a minor being exposed to a sex offender. Further, the family had a long history of neglect, untreated mental illnesses, substance abuse, and domestic violence. Mother attacked father with a knife 3 times, yet he never pressed any charges.</p>	<p>DCFS agreed. This case should have been screened with the State's Attorney for possible court involvement. The investigator should always review a family's history as a whole and how the prior history impacts the current case to determine a need for services or court involvement. A reminder will be sent to all Cook investigators, supervisors, and AA's of the importance of this. The Assistant Regional Administrator has been directed to discuss the overall recommendations with the Area Administrators and review this case specifically with the team involved. A reminder will be sent to all staff regarding the need to screen high-risk cases with multiple sequences and allegations/conditions. This will be completed within the next 30 days. APT confirmed that they addressed the issues (court referral given the history of neglect, untreated mental illness, substance abuse and domestic violence) with the agency.</p>
CS-14	<p>Team requests DCFS look at this case and how it was handled, specifically regarding: the investigator never obtained medical records for any information and/or corroboration, especially given that the child was a medically complex child, and she never spoke with anyone besides the uncle for information and/or corroboration about the parents' functioning.</p>	<p>Waiting on response.</p>

CS-15	<p>Team recommends DCFS look at this case and how it was handled, given that the investigation for allegation #74, inadequate supervision against mom, was unfounded and the case was closed, despite the following facts: the 16-year-old daughter had a baby, was bringing her 24-year-old boyfriend into the house, was not attending school, and the deceased minor was killed in a car crash, in which he was a passenger, at 1:45 am with BAC at the MEO of .04. An adult was driving, and that individual fled the scene after crashing the car. The police had been called to the house repeatedly for various disturbances. Even though the 12 and 13 year old were attending school, the other factors were not considered. If it was founded and opened to Intact, at a minimum, services could have been offered to this family that may have prevented this death.</p>	<p>DCFS agreed. There was only one supervision note in the file and it did not provide any instructions. The report noted a number of issues, such as the death victim is barely at home, according to the mother; questions should have been asked "where is he?" He is a minor. There were no attempts to speak with the other school officials for the entire sibling group. There were no questions asked of the 16 year old regarding her baby nor was she seen or added to the report. The focus was on selling drugs out of the home and observed that children appeared old enough to care for themselves. Yes, this could have been a case referred for services. These issues were addressed with the Regional Administrator.</p>
CS-16	<p>Team requests that DCFS look at this case and how it was handled.</p>	<p>DCFS reviewed this case on 1/25. Discussions were held with Regional Administrator on 1/25, the AA on 1/29, the supervisor and investigator on 2/2. Numerous issues noted in the investigation included lividity questions, substance abuse, domestic violence, co-sleeping education, and inadequate supervision with other children. The issues were discussed with the AA, supervisor and investigator for learning purposes. The case will be redacted and presented to all Springfield investigative staff as a learning tool.</p>

CS-17	Team requests that DCFS look into this case and how it was handled. It was closed, with indications determined, prior to DCFS obtaining the ME's report that it was ruled a homicide. (Closing a case prior to receiving the ME report is not following policy.) The indications for the uncle (#s 51 and 52) are only for neglect, although he is being criminally charged with first-degree murder, and, given this 'new' information and the ME report, DCFS should revisit indications to be given.	DCFS agreed. This case will be shared with staff regarding the application of the correct allegation and the importance of waiting for the ME report. In this specific case, the finding was changed to an abuse indication. DCFS will be discussing with the IT division the ability to place acquisition of the ME report on the checklist. It will be set so that it requires an Area Administrator to waive no report. DCFS does not have a timeline yet on completion, as the focus with IT is to complete the mindshare dashboards. Estimation of time to completion is 90 days or more.
CS-18	Team requests DCFS review the case further. This was not a thorough investigation as the insights were more subjective than objective. There is no solid rationale for unfounding the case. The case should be reviewed with the supervisor and worker.	Waiting on response.
CS-19	Team requests that DCFS look at the case to see how it was handled, given that the notes were entered in an untimely manner.	DCFS agreed. Procedures clearly indicate that case notes are to be entered into SACWIS no later than 48 hours after the event or contact occurs. The staff involved in this case will be reminded of this requirement.
CS-20	Team recommends that DCFS look at the case and how it was handled. Parents admitted drinking and admitted practice of unsafe sleep in a bed that was barely big enough for the two of them, but the case was unfounded. Further, the babysitter was not contacted or interviewed. She could have shed light on the condition of the parents when they picked the minor up after 3:30 a.m.	Waiting on response.
CS-21	Team requests DCFS look at this case and how it was handled, specifically regarding: there were 7 previous Sequence A reports;	Waiting on response.

	and there was blatant disregard for the well-being of the children, given that the father left two toddlers in a motel room alone and he is currently being criminally charged. The team has concerns that the father was not indicated for Death by Neglect.	
CS-22	Team requests DCFS look at the case particularly in regards to interviewing the 15 year old about substance abuse.	Waiting on response.
CS-23	DCFS should look at this case and how it was handled: even though the agency did well to repeatedly instruct the mother/youth in care, the MGM, and the relative foster parent that there must be safe sleeping equipment wherever the baby slept, they did not assist in bringing either the crib or pack and play to the new relative foster parent's home.	Waiting on response.
CS-24	Team requests DCFS look at this case and how it was handled (supervisor overriding the recommendation to Indicate, based on the MEO's undetermined/undetermined finding).	DCFS Administration will review the case. According to the Director's memo of July 2015, investigations are not indicated merely related to an unsafe sleep practice.
CS-25	Team recommends that transfers between DCP and Intact workers be more effective with efficient communication. Intact workers are not aware that they can screen in cases; there seems to be hesitancy on their part. There needs to be education for the head of agencies. Team recommends DCFS review the case in respect to multiple system-level missed opportunities to include: 1. transitional visit communication/process between DCP and Intact agencies; 2. processes, knowledge, circumstances and duty for intact	DCFS agreed. There is to be a detailed discussion at the time of transition. Staff will be reminded of the importance to communicate and provide accurate information to intact and permanency partners at both the hand-off and transitional meetings. Both intact and child protection staff will be educated regarding the various specialty substance abuse programs in place for intact families in Cook. The Intensive Family Recovery program has met with teams in Cook. All intact referrals in Cook are screened through the intact utilization unit. If appropriate and there are openings, they will refer a case directly to the substance abuse specialty program. A quarterly statewide intact provider

	<p>workers and DCP to screen cases into court; 3. training for private agencies to discuss process for screening case with the State's attorney; 4. priority to refer families with extensive substance abuse to the specialized intact contracts and ability to extend Intact cases, especially when the family has a long history of substance abuse; and 5. review hotline process to understand why the hotline worker did not add an allegation for bruises as described by the doctor. This may have led to greater safety concerns with the investigation.</p>	<p>meeting is being scheduled for October. A topic for that meeting will be discussion around identifying services, the decision process in place when making a critical decision to close a case, and the need for court intervention and screening cases for court. Communication around intact referrals and court screenings will also be a topic at the Operations AA meeting in December. This case will be reviewed with the SCR Administrator to discuss with her staff and to use as a teaching moment. A script is utilized at the hotline to assist in gathering information. They will be reminded of the importance of using this tool and adding all allegations based on information obtained during the call. This will be completed within the next 30 days, by 10/15/16.</p>
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Chapter 3: Illinois Child Deaths in 2015

What do we know about the child deaths that occurred in Illinois during 2015?

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

By comparing the children who died with the total child population in Illinois, we can better understand 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 (57% in 2015) 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 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:

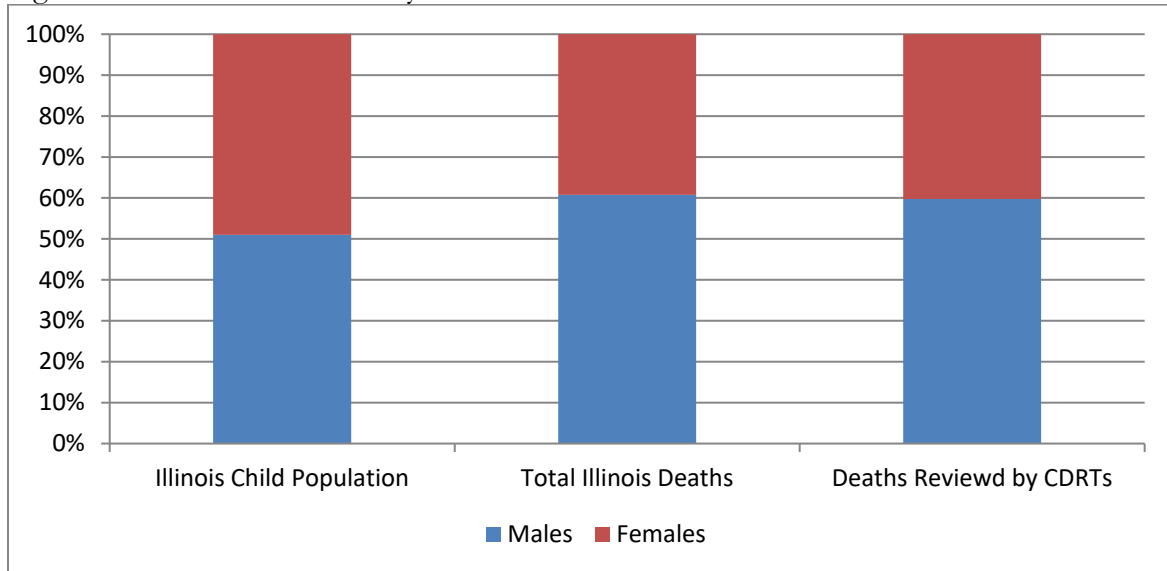
- The population of Illinois children was based on the 2010 Census. According to Census 2010 data, there were approximately 3.13 million children under the age of 18 in Illinois, which constitutes about 24.4% of the total Illinois population.⁵
- In 2015, there were 1,402 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.
- The CDRTs reviewed 231 child deaths that occurred in 2015: 131 of these were mandated for review and 100 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 61% of total child deaths in 2015. More deaths of boys were also reviewed: 60% of reviewed deaths were boys in 2015 (see Figure 3).

⁵ U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from [http:// www. factfinder2.census.gov](http://www.factfinder2.census.gov).

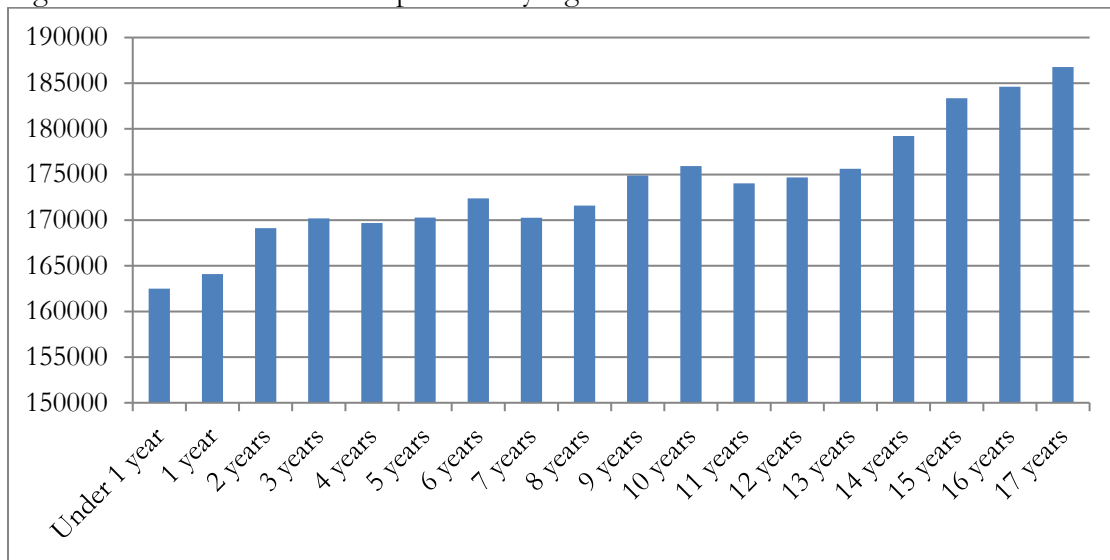
Figure 3: Illinois Child Deaths by Gender



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.⁶

Figure 4: 2010 Illinois Child Population by Age



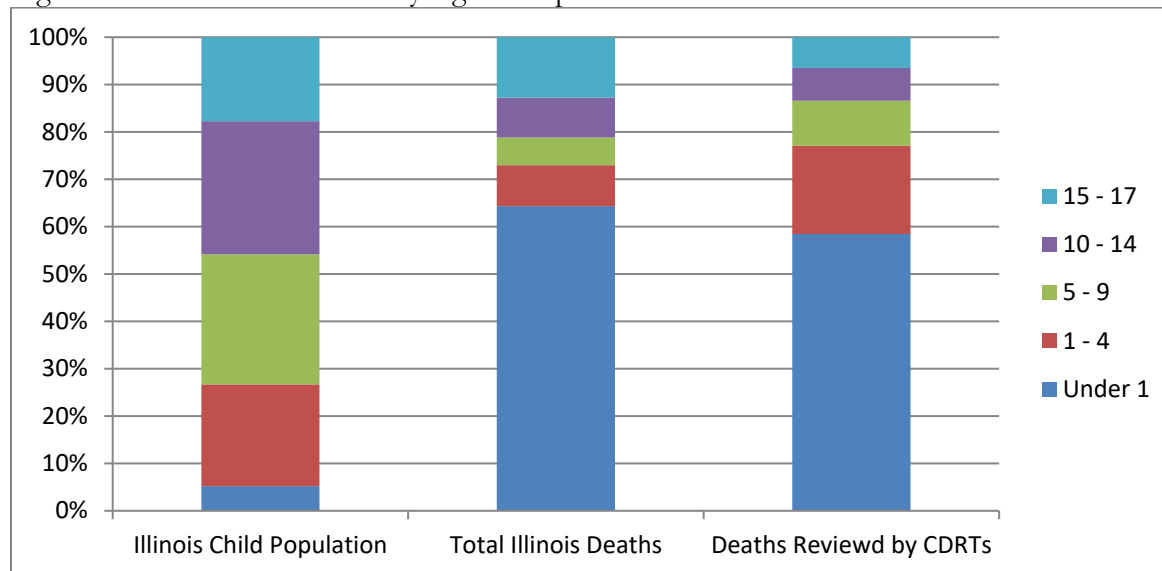
However, when we examine the total Illinois child deaths reported to CDRTs by age (see Figure 5), infants less than one year old are especially vulnerable – 64% of the total deaths in 2015 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Older children are less likely to die: in 2015, 9% of the

⁶ U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from <http://www.factfinder2.census.gov>.

total deaths were children between 1 and 4 years, 6% were children between 5 and 9 years, 8% were children between 10 and 14 years, and 13% were between 15 and 17 years.

When we examine the deaths reviewed by the CDRTs by age group (see Figure 5), infants under one year are again over-represented; they comprised 58% of reviewed deaths in 2015. Children between 1 and 4 years make up 19% of reviewed deaths in 2015. Older children make up a smaller portion of reviewed deaths: 10% of reviewed deaths were for children aged 5 to 9 years old, 7% of reviewed deaths were for children aged 10 to 14, and less than 6% of reviewed deaths were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race

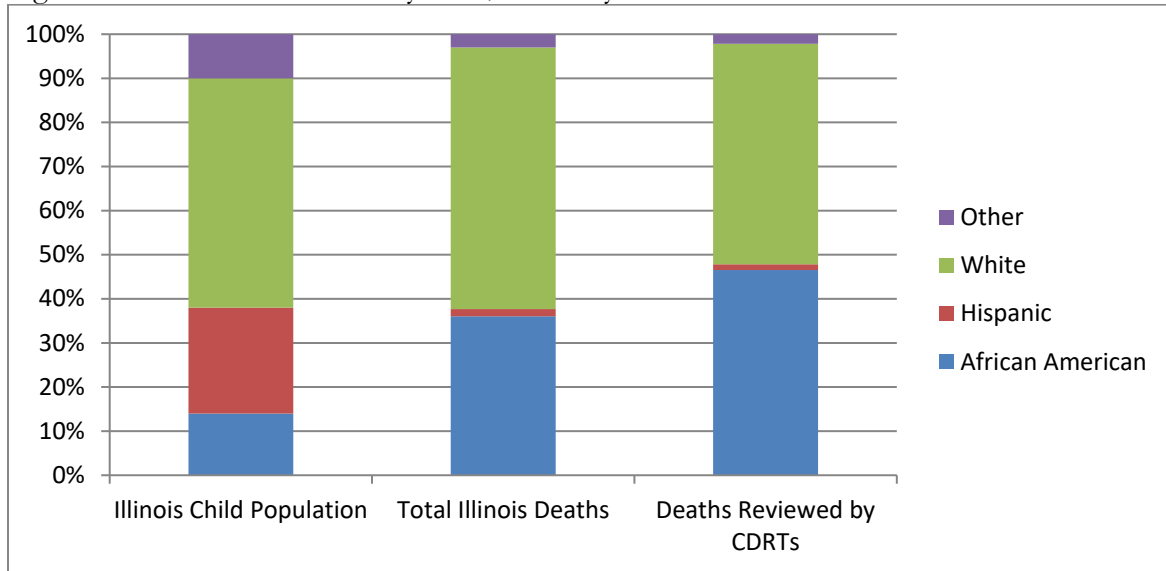
In 2015, there were 3 million children 17 and younger in Illinois, of whom 53% were White, 24% were Hispanic, 14% were African American, and the remaining 9% were of other races/ethnicities (see Figure 6).⁷

However, when we examine the total Illinois child deaths by race, it is evident that African-American children are at higher risk of death when compared to their numbers in the general population: 36% of the children that died in 2015 were African-American compared with roughly 14% in the general child population. The proportion of deaths among Caucasian children (59%) was slightly higher when compared with their proportion in the general child population (53%). Deaths among Hispanic children (2%) were infrequent compared to their numbers in the general population (24%) (see Figure 6).

Among the 231 child deaths reviewed by the CDRTs in 2015, 46% were African American children, which is larger than their proportion in the overall child population (14%) or the total child deaths that occurred in 2015 (36%) (see Figure 6).

⁷ U.S. Census Bureau. (2016). Children characteristics 2011 – 2015 American Community Survey 5-year estimates. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S0901&prodType=table

Figure 6: Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

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

Categories for child deaths that occurred in Illinois in 2015 are shown in Table 2. The majority of total child deaths were related to either illness (37%) or premature birth (33%). The other categories included suffocation (9%), firearms (6%), undetermined (5%), vehicular accidents (4%), injury (2%), drowning (1%), poisoning/overdose (1%), SUID (1%), fire (1%), and a few cases of SIDS, scalding burn, and other types that accounted for less than 1% of the total deaths respectively. There were no deaths due to Sudden Unexplained Child Death (SUCD) in 2015.

The CDRTs are far more likely to review certain categories of child deaths than others (see Table 2). In 2015, deaths reviewed by CDRTs were most likely to be related to suffocation (27%), undetermined (22%), and illness (21%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Illness	514	37%	49	21%
Prematurity	462	33%	5	2%
Suffocation	120	9%	63	27%
Firearms	81	6%	9	4%
Undetermined	77	5%	51	22%
Vehicular Accident	60	4%	7	3%
Injury	28	2%	19	8%
Drowning	18	1%	11	5%
Poison/Overdose	18	1%	8	3%
SUID	9	1%	2	1%
Fire	7	1%	4	2%
Other	4	<1%	1	<1%
Scalding burn	2	<1%	2	1%
SIDS	2	<1%	0	0%
SUCD	0	0%	0	0%
Total	1402	100%	231	100%

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:

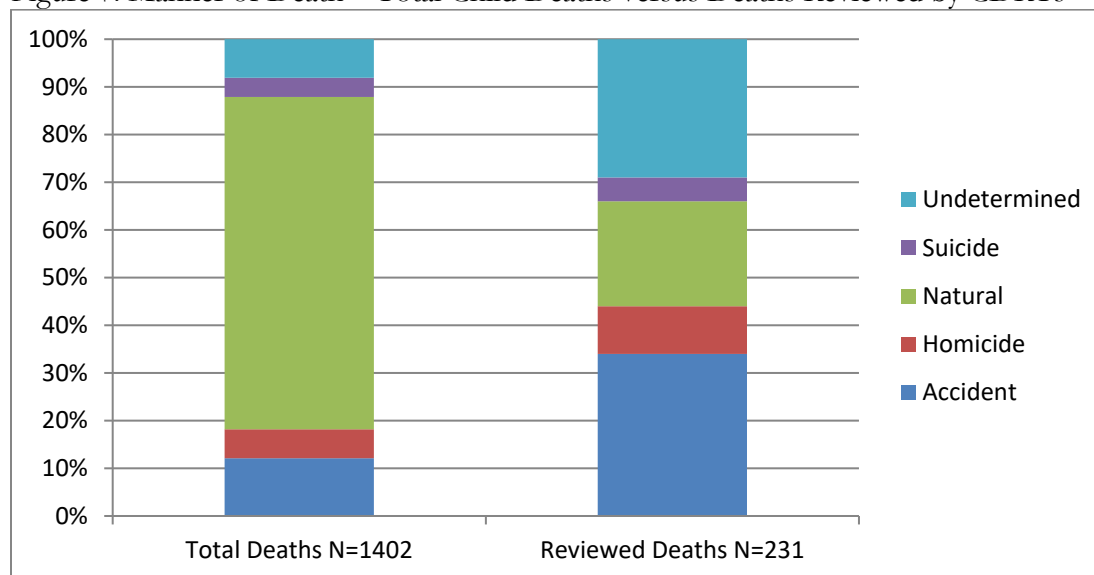
- Natural – the death was a result of natural causes such as illness, disease, and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death
- Suicide – the 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 in 2015 were attributable to natural causes (69%), and accidents accounted for 12% of the total child deaths. In addition, 6% were homicides, 4% were suicides, and 8% were undetermined. When compared to total child deaths, the CDRTs are much more likely to review deaths from accidents (34%), undetermined (29%), and natural causes (22%); and much less likely to review deaths from homicides (10%) or suicides (5%) (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	172	12%	79	34%
Homicide	90	6%	24	10%
Natural	973	69%	51	22%
Suicide	60	4%	11	5%
Undetermined	107	8%	66	29%
Total	1402	100%	231	100%

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



Child Deaths by Category and Manner

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

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

Category of Death	Manner of Death					Totals
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	2	0	509	0	3	514
Prematurity	0	0	459	0	3	462
Suffocation	76	2	0	34	8	120
Firearms	2	62	0	15	2	81
Undetermined	0	0	0	0	77	77
Vehicular	54	3	0	3	0	60
Injury	6	18	0	1	3	28
Drowning	16	0	0	0	2	18
Poison/Overdose	6	3	0	7	2	18
SUID	0	0	4	0	5	9
Fire	5	2	0	0	0	7
Other	3 ¹	0	0	0	1 ²	4
SIDS	0	0	1	0	1	2
Scalding burn	2	0	0	0	0	2
SUCD	0	0	0	0	0	0
Total	172	90	973	60	107	1402

Note: ¹Anoxic encephalopathy/probable anaphylactic reaction secondary to ingested allergen; acute chorioamnionitis with bilateral multicystic renal dysplasia and opiate exposure; anaphylaxis/ingestion of food allergen; ² Probable anaphylactic reaction of undetermined etiology.

Special Analysis: Homicide Deaths

There were 90 homicide deaths out of the 1,402 deaths in 2015 and we know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. In addition, we know that 60% of homicides were youth age 15 to 17 and that 83% of the victims were male. Additional information on homicide deaths, presented in Table 5, allows for a more complete understanding of the circumstances of these types of child deaths.

Table 5: Homicide Deaths

Category	Age	Circumstance	Perpetrator	Race
Firearms	3	Gunshot wound to head	6 yr. old brother	White
	7	Gunshot wound to back	Unknown	African American
	9	Multiple gunshot wounds	Unknown	African American
	11	Gunshot wound to abdomen	Uncle	African American
	12	Gunshot wound to head	Unknown	African American
	12	Gunshot wound to head	Unknown	African American
	13	Multiple gunshot wounds	Unknown	Hispanic
	13	Gunshot wound to head	Unknown	African American
	13	Gunshot wound to head	Unknown	African American
	14	Gunshot wound to torso	Unknown	African American
	14	Gunshot wound to head	Unknown	White
	14	Gunshot wound to head	Unknown	African American
	14	Gunshot wound to head	Unknown	African American
	14	Gunshot wound to head	Unknown	African American
	14	Multiple gunshot wounds	Unknown	African American
	15	Gunshot wound to back	Unknown	African American
	15	Multiple gunshot wounds	Unknown	African American
	15	Gunshot wound to head	Unknown	African American
	15	Multiple gunshot wounds	Unknown	African American
	15	Multiple gunshot wounds	Unknown	African American
	15	Gunshot wound to neck	Unknown	African American
	15	Multiple gunshot wounds	Unknown	African American
	16	Multiple gunshot wounds	Unknown	African American

	16	Multiple gunshot wounds	Unknown	African American
	16	Gunshot wound to face	Unknown	African American
	16	Multiple gunshot wounds to head	Unknown	White
	16	Gunshot wound to left shoulder into chest	Unknown	African American
	16	Gunshot wound to back	Unknown	White
	16	Gunshot wound to back	Unknown	African American
	16	Gunshot wound to head	Unknown	White
	16	Gunshot wound to head	Unknown	African American
	16	Gunshot wound of right arm into torso	Unknown	White
	16	Multiple gunshot wounds to torso	Unknown	Hispanic
	16	Multiple gunshot wounds	Unknown	African American
	16	Gunshot wound to back	Unknown	African American
	16	Multiple gunshot wounds	Unknown	African American
	16	Multiple gunshot wounds	Unknown	White
	16	Multiple gunshot wounds	Unknown	African American
	16	Multiple gunshot wounds to torso	Unknown	African American
	17	Multiple gunshot wounds	Brother	White
	17	Gunshot wound to chest	Unknown	African American
	17	Gunshot wound to chest	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound to chest	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound to head	Unknown	African American
	17	Gunshot wound to chest	Unknown	African

				American
	17	Gunshot wound to torso	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound to head	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound to torso	Unknown	African American
	17	Gunshot wound to chest	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound of left artificial rupture of membranes	Unknown	White
	17	Multiple gunshot wounds	Unknown	African American
	17	Gunshot wound to chest	Unknown	White
	17	Multiple gunshot wounds	Unknown	African American
Injury	Infant	Closed head injury	Unknown	White
	Infant	Complications of inflicted closed head injury	Uncle	White
	Infant	Craniocerebral injuries blunt force head trauma; child abuse	Grandmother	White
	Infant	Craniocerebral injuries blunt force head trauma and thermal burns; child abuse	Father	African American
	Infant	Multiple injuries; child abuse	Parents	African American
	Infant	Craniocerebral injuries blunt force head trauma	Babysitter	African American
	Infant	Multiple blunt force injuries	Unknown	African American
	1	Closed head injuries blunt force impacts to head	Mother's paramour	African American

	1	Multiple injuries; child abuse	Father	African American
	1	Multiple blunt force injuries; child abuse	Mother's paramour	White
	2	Multiple blunt force injuries	Mother	African American
	2	Multiple injuries	Mother and father	African American
	3	Closed head injury	Mother's paramour	White
	5	Complications of remote traumatic brain injury	Babysitter	African American
	5	Internal injuries from multiple blunt force impacts	Mother's Paramour	White
	14	Craniocerebral injuries from blunt force trauma assault	Stepfather	White
	16	Stab wound of the chest	Unknown	White
	16	Stab wound of the back	Unknown	African American
Poison/Overdose	Infant	Maternal methadone ingestion; premature birth	Parents	White
	15	Overdose of morphine alprazolam and amitriptyline	Unknown	White
	17	Heroin overdose	Babysitter	White
Suffocation	Infant	Suffocation	Mother	White
Vehicular	15	Multiple injuries due to motor vehicle collision	Unknown	White
	16	Multiple traumatic injuries due to motor vehicle accident	Unknown	African American
	17	Multiple injuries due to motor vehicle crash	Unknown	African American

Chapter 4: Child Deaths by Category

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

Categories are presented in the order of frequency of occurrence for 2015 so that the most common categories of death are first. For each category section, the following information is presented:

- Category definition describes the types of deaths that are included.
- Background information provides national statistics or research findings, if available.
- Illinois data on total child deaths reported to the CDRTs.
- Numbers of deaths within each category over the past 10 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender, age, and race 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 of children who are younger or African-American.

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).

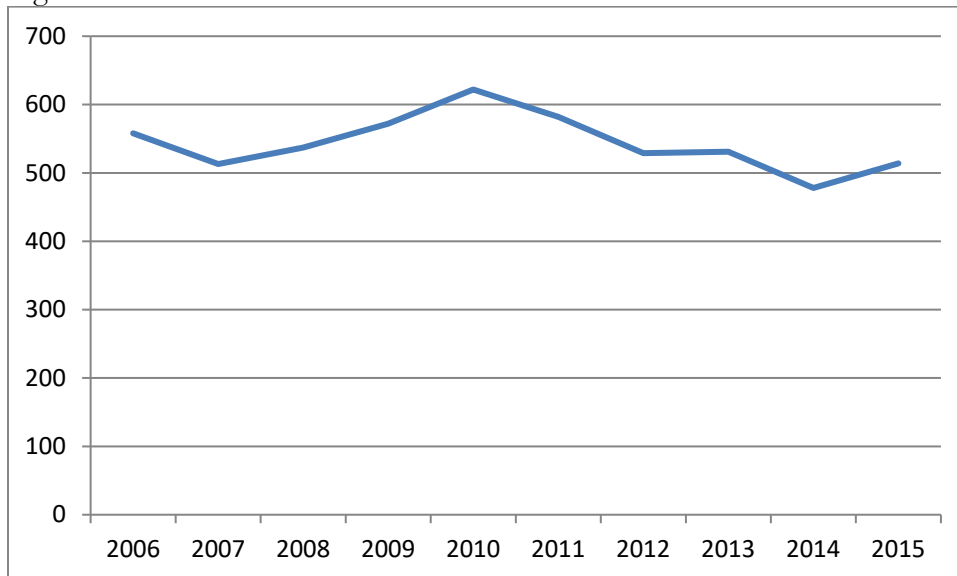
Background

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 peaked at 622 in 2010 and has since generally declined, although there was a slight increase in 2015 (see Figure 8).

Figure 8: Child Deaths Due to Illness



In 2015, 514 of the 1,402 total child deaths (37%) reported to CDRTs were related to illness.

- A slight majority of children who died from illness were male (58%).
- A little more than half of deaths from illness were among children under the age of one (53%); 15% of deaths from illness occurred among children 1 to 4 years old, 11% occurred among children 5 to 9 years old, 12% occurred among children 10 to 14 years old, and 9% occurred among children 15 to 17 years old (see Figure 9).
- The majority (63%) of deaths from illness were White children, followed by African American children (31%) and children of other races/ethnicities (6%) (see Figure 10).
- Over 99% of these deaths (509) were attributable to natural causes, except 2 deaths were due to accidents and 3 were due to undetermined causes.

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 49 of the 231 child deaths reviewed by the CDRTs (21%) were related to illness.

- Slightly more than half (55%) of the reviewed deaths related to illness were boys.
- Illness deaths among infants under 1 year old (39%) and children 1 to 4 (33%) were more likely to be reviewed, followed by children 5 to 9 years old (16%) and children 10 and older (12%) (see Figure 9).
- Over half (53%) of the reviewed deaths from illness were African American children, 45% were White children, and the remaining (2%) were children of other races/ethnicities (see Figure 10).
- Nearly all (94%) reviewed deaths that were categorized as illness were attributed to natural causes, except 2 were due to undetermined causes and 1 was due to accidents.

Figure 9: Child Deaths Due to Illness by Age

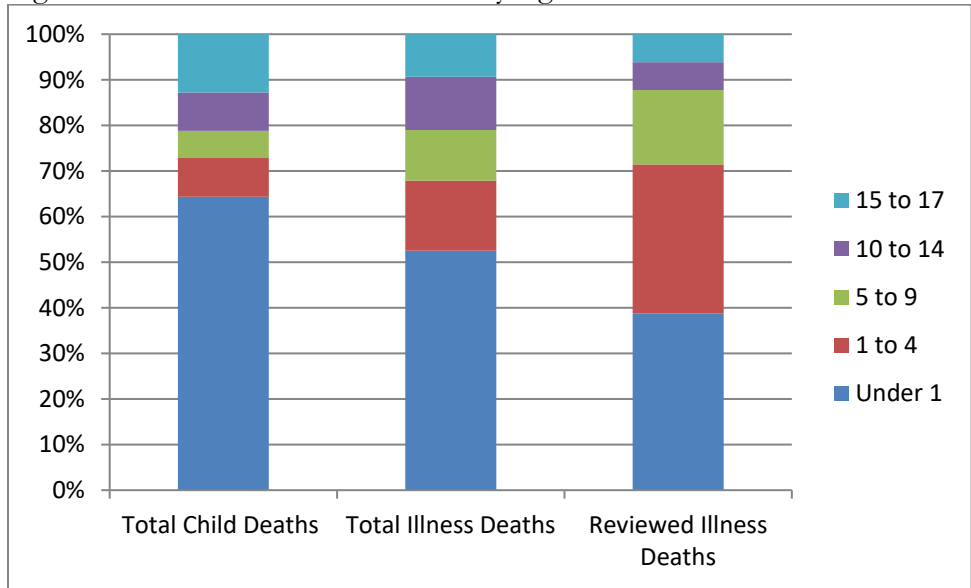
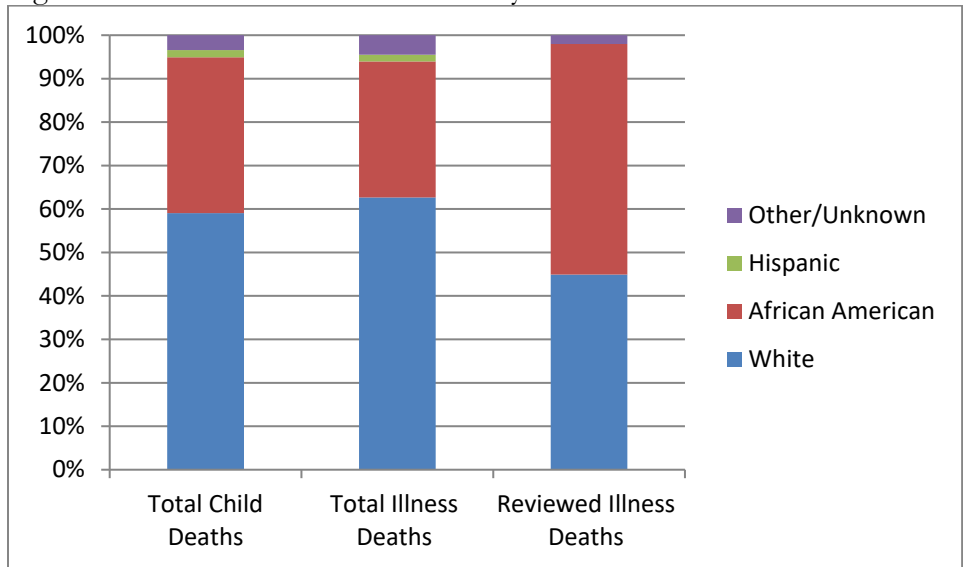


Figure 10: Child Deaths Due to Illness by Race



Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature (or preterm) birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as “very preterm” (less than 32 weeks gestation) and moderately preterm (32 – 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. Low birthweight (LBW), one of the five leading causes of infant mortality, is an indicator of child health (current and future) as well as maternal health. LBW babies are more likely than babies of normal weight to have health problems during the newborn period. LBW babies may be also at greater risk for health conditions such as diabetes and heart disease as adults.⁸

In Illinois, 10.1% babies were born preterm in 2014, compared with 9.6% in the nation.⁹ The rate of preterm birth in Illinois is highest for African American infants (13.6%), followed by Native Americans (10.3%), whites (9.4%), Hispanics (9.1%), and Asians (9.1%).¹⁰ 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.¹¹ Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

⁸ America’s Health Rankings (2017). A call to action for individuals and their communities. United Health Foundation (2015 Edition). Retrieved from <http://www.americashealthrankings.org/learn/reports/2016-annual-report>

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

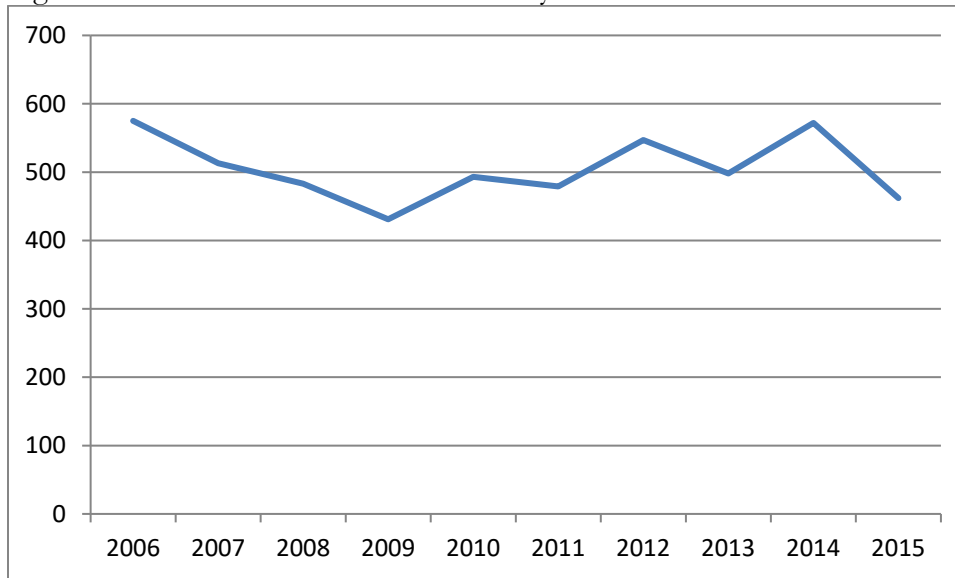
¹⁰National Center for Health Statistics. *Illinois prematurity data*. Retrieved from <http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4>.

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

Illinois Data – Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death in Illinois and has either been the second largest or the largest category in the past 10 years (ranging from 431 to 575 deaths per year). The number of prematurity deaths declined between 2006 and 2009, then demonstrated an upward trend until 2014. There was a noticeable decline from year 2014 to 2015 (see Figure 11).

Figure 11: Child Deaths Due to Prematurity



Of the 1,402 total child deaths in 2015, 462 (33%) were related to premature birth.

- A slight majority of children who died from prematurity were boys (58%).
- The majority (60%) of deaths from prematurity were White children, followed by African American children (35%) and children of Hispanic or other races/ethnicities (5%) (see Figure 12).
- Nearly all deaths (99%) in this category were the result of natural causes, and only 3 deaths were undetermined.

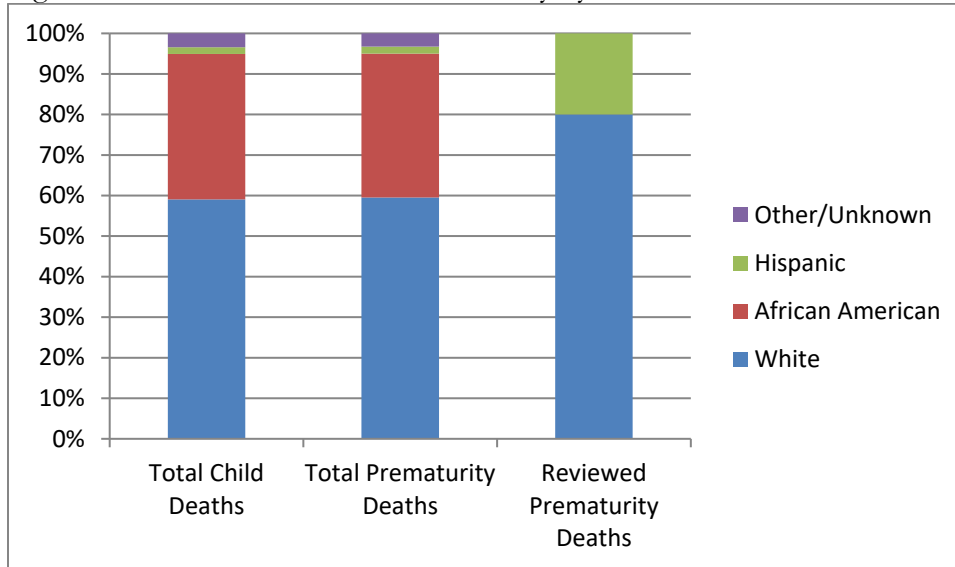
Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 5 of the 231 child deaths reviewed by CDRTs (2%) were related to premature birth.

- The majority (60%) of the premature deaths reviewed by the CDRTs were males.
- 80% of the premature deaths reviewed by the CDRTs were White children, and the other one (20%) was a Hispanic child (see Figure 12).

- 80% of the premature deaths reviewed by the CDRTs were the result of natural causes, and the other one (20%) was undetermined.

Figure 12: Child Deaths Due to Prematurity by Race



Suffocation

Definition

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

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

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

Background

In 2015, 2,142 children ages 17 and under in the U.S. died from suffocation.¹² Of these children, 56% were less than one year of age and 64% were ages four and under. Accidental suffocation is the leading cause of injury-related death among infants less than one year old, and 70% of suffocation deaths among infants are from accidental suffocation or strangulation in bed.¹³

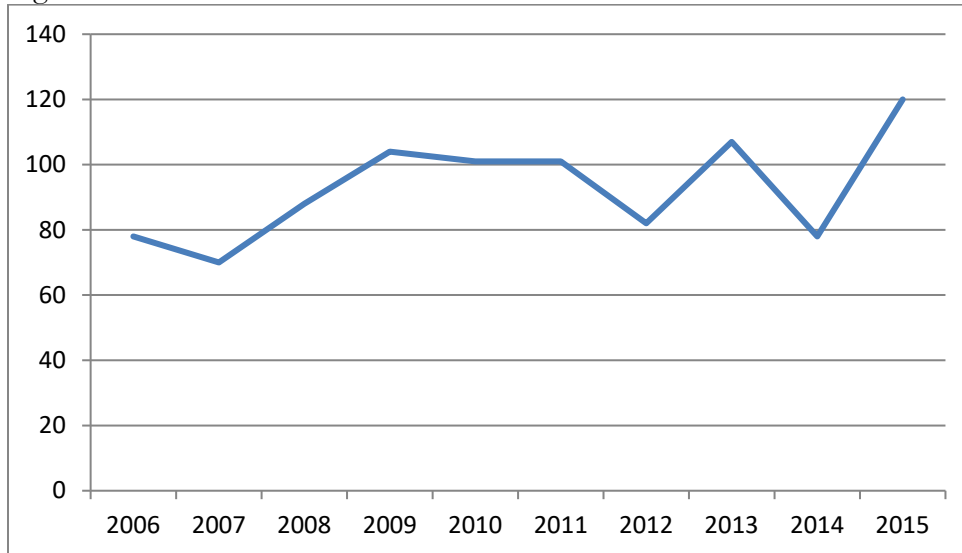
¹² Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

¹³ Safe Kids Worldwide. (2017). *Suffocation Prevention and Sleep Safety*. Retrieved from <http://www.safekids.org/suffocation-prevention-and-sleep-safety>

Illinois Data – Total Child Deaths Reported to the CDRTs

In the past decade there has been an upward trend in the number of Illinois deaths from suffocation, which reached a new high number in 2015 (see Figure 13).

Figure 13: Child Deaths Due to Suffocation



In 2015, 120 of the 1,402 total child deaths reported to the CDRTs (9%) were related to suffocation.

- The majority of children who died from suffocation were boys (63%).
- Infants under one year were the largest group in this category, accounting for 60% of the deaths (see Figure 14).
- The majority (64%) of children who died from suffocation were White, 32% of them were African American, and the remaining (5%) were children of Hispanic or other races/ethnicities (see Figure 15).
- The manner of the suffocation deaths primarily included accidents (63%) and suicides (28%), with the remaining suffocation deaths due to undetermined causes (7%) or homicides (2%).

Illinois Data – Deaths Reviewed by CDRTs

In 2015, 63 of the 231 deaths reviewed by CDRTs (27%) were related to suffocation.

- The majority (65%) of the reviewed suffocation deaths were boys.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (78%) (see Figure 14).

- The majority (59%) of children who died from suffocation were White, 37% of them were African American children, and the remaining (5%) were Hispanic children or other races/ethnicities (see Figure 15).
- Most (81%) of the reviewed deaths due to suffocation were accidental.

Figure 14: Child Deaths Due to Suffocation by Age

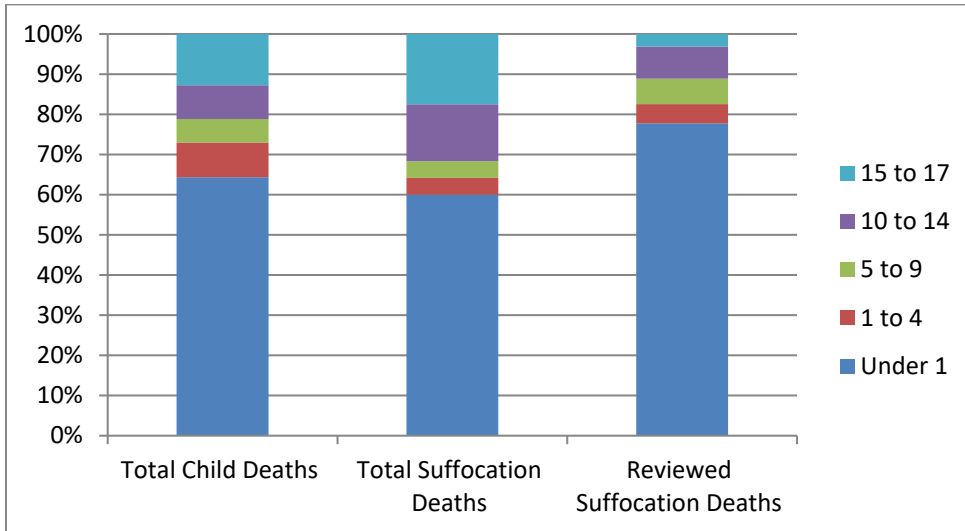
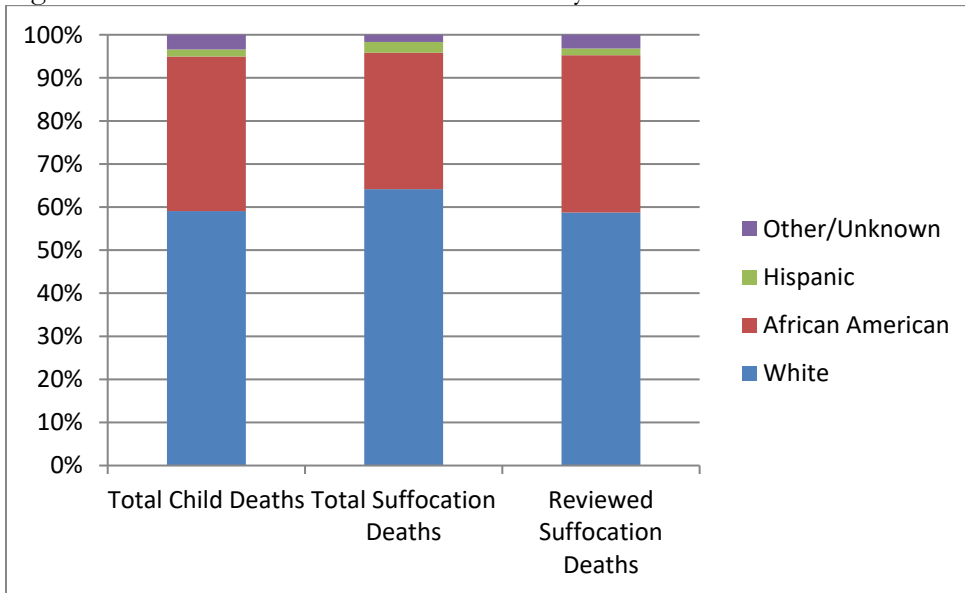


Figure 15: Child Deaths Due to Suffocation by Race



Firearms

Definition

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

Background

According to data from the Center for Disease Prevention and Control, 1,458 firearm deaths occurred in 2015 among children under 18 years of age in the United States. The vast majority (70%) of these deaths were youth between the ages of 15 and 17. Race of decedent is also a factor. In 2015, the homicide rate with firearms for African American male teens was 10 times higher than the rate for white male teens.¹⁴

Firearms include several manners of deaths. Firearms were the instrument of death in 88% of teen homicides and 41% of teen suicides in 2014. In two-thirds of the homicides, the murderer was over 18.¹⁵ 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.¹⁶

Illinois Data – Total Child Deaths Reported to the CDRTs

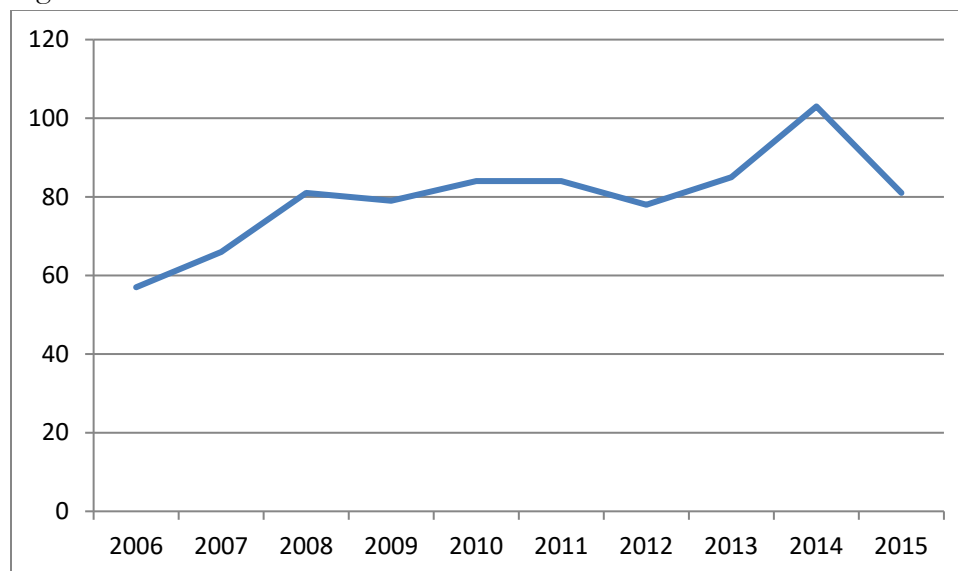
Child deaths from firearms steadily increased from 57 in 2006 to 83 in 2008 and have remained fairly level until 2012. There was a noticeable increase during 2013 and 2014, but the number declined substantially in 2015 (see Figure 16).

¹⁴ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

¹⁵ Child Trends. (2017). *Teen homicide, suicide, and firearm deaths*. Retrieved from <http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths>

¹⁶ 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 16: Child Deaths Due to Firearms



In 2015, 81 of the 1,402 total deaths (6%) were related to firearms.

- Deaths due to firearms overwhelmingly occurred among boys (95%).
- In 2015, 77% of firearm deaths occurred in children aged 15 to 17 (see Figure 17).
- 68% of the children who died from firearms were African American, 30% were White, and 2% were children of other races/ethnicities (see Figure 18).
- Homicides accounted for 77% of the firearm deaths, suicides accounted for 19%, and accidents and undetermined causes accounted for the remaining 4%.

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 9 of the 231 deaths reviewed by the CDRTs (4%) were related to firearms.

- Nearly all reviewed deaths due to firearms were boys (8 deaths).
- Most of the firearm deaths reviewed by CDRTs involved youth 10 to 14 (56%) and 15 to 17 years old (33%) (see Figure 17).
- White (44%) and African American (44%) children accounted for most of the reviewed child deaths due to firearms, and one reviewed death (11%) was a Hispanic child (see Figure 18).
- The firearm deaths reviewed by CDRTs were all due to homicides (67%) and suicides (33%).

Figure 17: Child Deaths Due to Firearms by Age

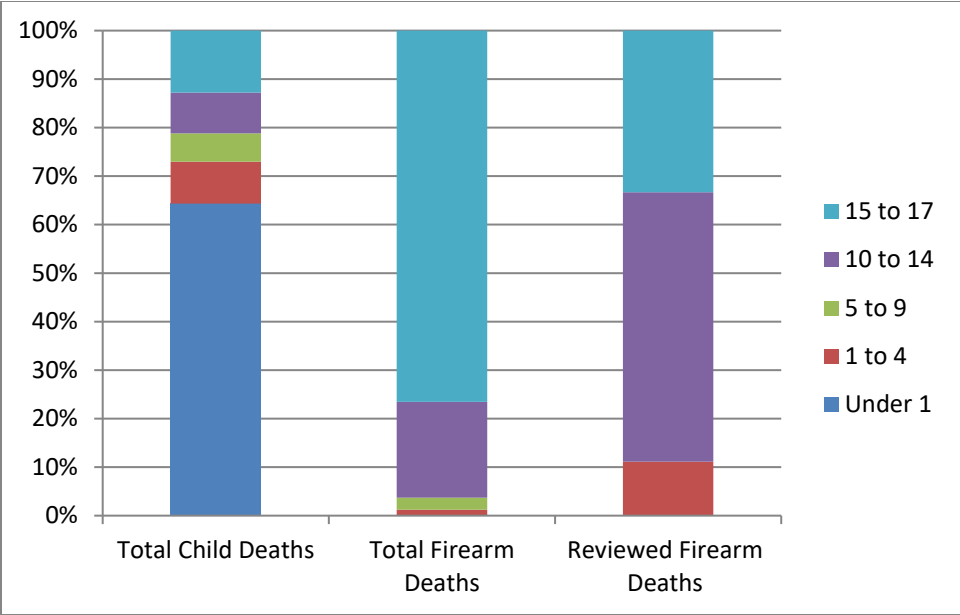
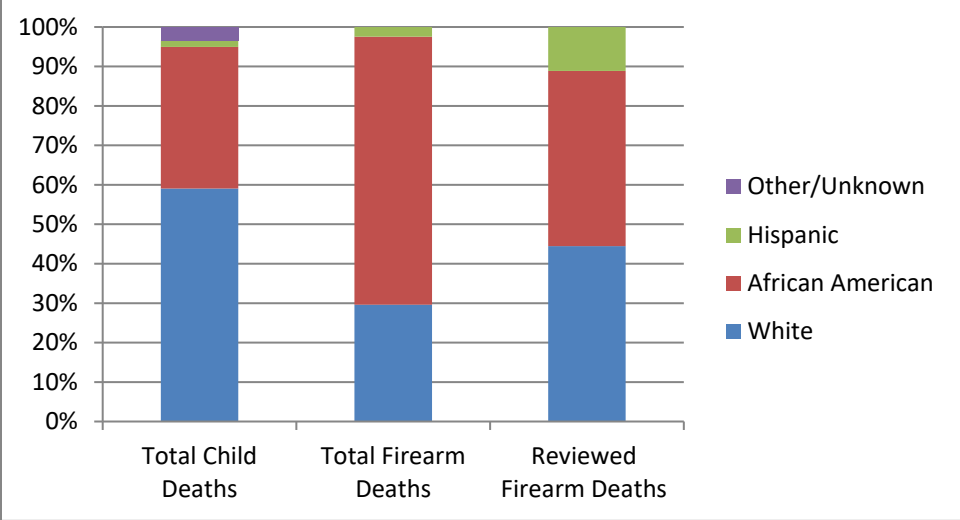


Figure 18: Child Deaths Due to Firearms by Race



Undetermined Deaths

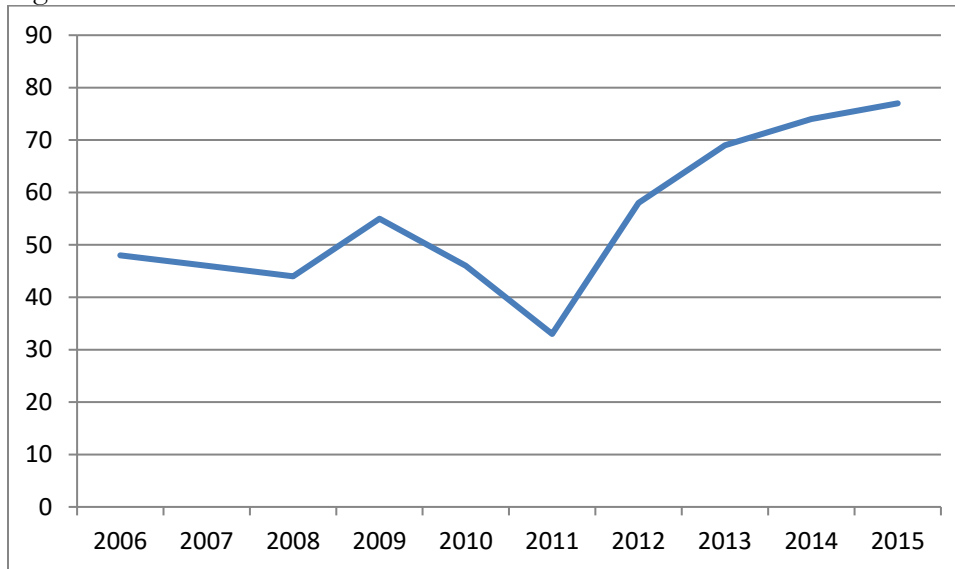
Definition

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

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of undetermined deaths among children in Illinois dropped from around 50 in the previous years to 33 in 2011, but has since steadily increased to its highest point in 2015 (see Figure 19).

Figure 19: Child Deaths with Undetermined Cause of Death



In 2015, 77 of the 1,402 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

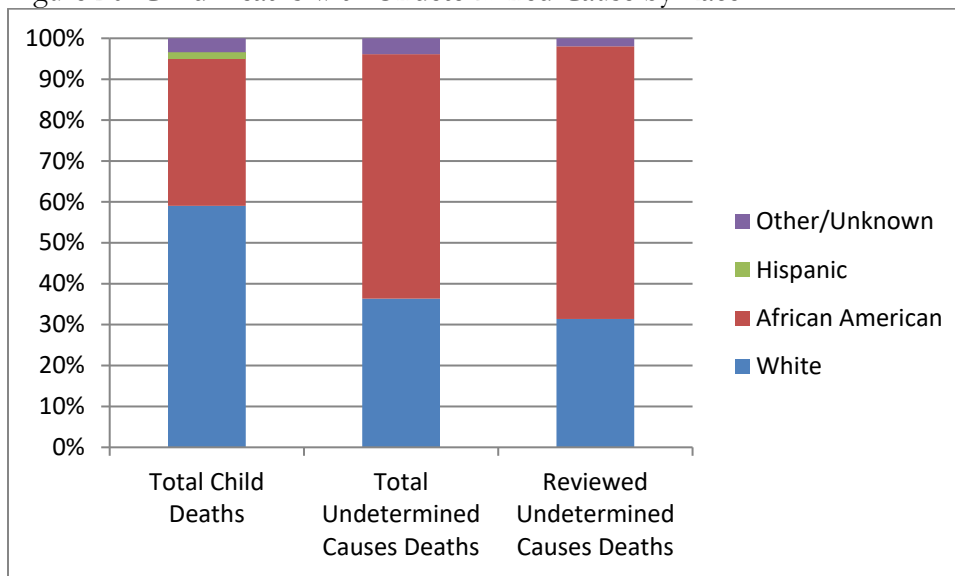
- Deaths due to undetermined causes were slightly more common for boys (64%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (96%), with the remaining being children 15 to 17 (3%) and 1 to 4 years old (1%).
- The majority (60%) of children who died due to undetermined causes were African American, 36% were White, and the remaining (4%) were children of other races/ethnicities (see Figure 20).

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 51 of the 231 deaths reviewed by CDRTs (22%) had an undetermined cause of death.

- The majority of reviewed deaths due to undetermined causes were boys (59%).
- 98% of reviewed deaths due to undetermined causes were children under the age of 1.
- The majority (67%) of reviewed children who died due to undetermined causes were African American, 31% were White, and the remaining death (2%) was a child of other race/ethnicity (see Figure 20).

Figure 20: Child Deaths with Undetermined Cause by Race



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 938 children (under the age of 13) died in motor vehicle crashes in 2015.¹⁷ The rate of motor vehicle crash deaths per million children under 13 has decreased 78% since 1975. In 2015, 71% of child motor vehicle crash deaths were passenger vehicle occupants, 20% were pedestrians, and 3% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 89% and 94%, respectively. Passenger vehicle child occupant deaths in 2015 were 52% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Thirteen percent of the passenger vehicle child occupant deaths in 2015 occurred in front seats, down from 46% in 1975. Eighty 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 three-quarters for children up to age 3, and almost half for children ages 4 to 8.¹⁸

A total of 2,715 teenagers ages 13 to 19 died in motor vehicle crashes in 2015. This is 69% fewer than in 1975 and 3% fewer than in 2014. About 2 out of every 3 teenagers killed in crashes in 2015 were males. In 2015, teenagers accounted for 7% of motor vehicle crash deaths. They comprised 10% of passenger vehicle (cars, pickups, SUVs, and vans) occupant deaths among all ages, 5% of pedestrian deaths, 3% of motorcyclist deaths, 8% of bicyclist deaths, and 13% of all-terrain vehicle rider deaths.¹⁹

In the United States, teenagers drive less than most adults but the oldest people, 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.²⁰

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

¹⁷ Insurance Institute for Highway Safety. (2017). *Fatality facts 2015: Children*. Retrieved from <http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety>.

¹⁸ Ibid.

¹⁹ Insurance Institute for Highway Safety. (2017). *Fatality facts 2015: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

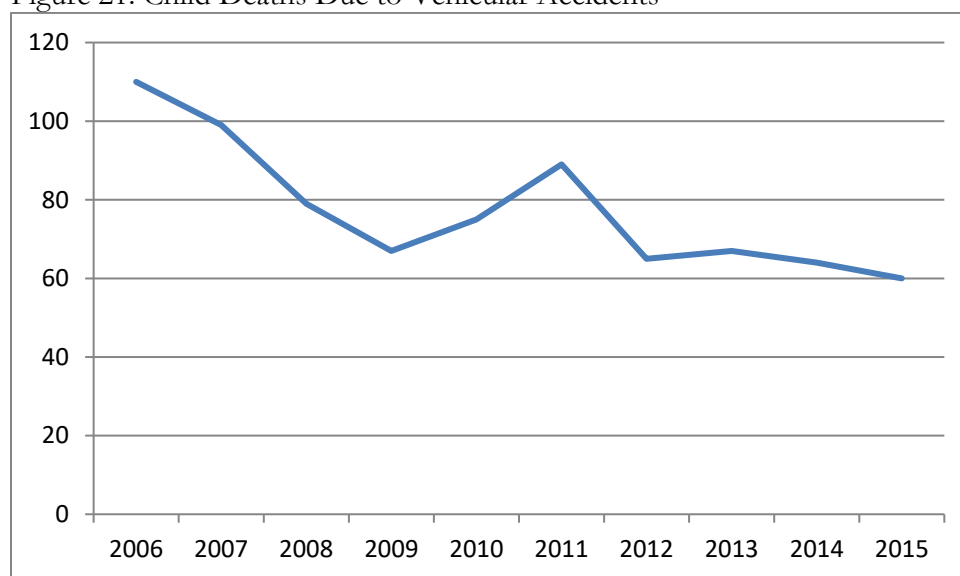
²⁰ Ibid.

riding with peers and drowsiness.²¹ 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. National studies of graduated licensing found that strong laws were associated with substantially lower fatal crash rates and substantially lower insurance claim rates among young teen drivers covered by the laws.²²

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of vehicular deaths has declined from the peak of 110 deaths in 2006 to its lowest level in 2015 (see Figure 21).

Figure 21: Child Deaths Due to Vehicular Accidents



In 2015, 60 of the 1,402 total child deaths reported to the CDRTs (4%) were related to vehicular accidents.

- More boys (63%) had deaths related to vehicular accidents.
- Older children (15 to 17) made up the largest proportion of vehicular accident deaths (47%). Children of 10 to 14 (22%) and 5 to 9 years old (17%) accounted for another major proportion, and the remaining 15% of the deaths were children 4 years old and younger (see Figure 22).
- The majority (72%) of deaths due to vehicular accidents were White children, followed by African American children (20%) and children of Hispanic or other races/ethnicities (8%) (see Figure 23).

²¹ Child Trends. (2017). *Distracted driving*. Retrieved from <http://www.childtrends.org/?indicators=distracted-driving>.

²² Insurance Institute for Highway Safety. (2017). *Fatality facts 2015: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

- A large majority (90%) of these deaths were accidental, and small portions were homicides (5%) and suicide (5%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 7 of the 231 deaths reviewed by the CDRTs (3%) were related to vehicular accidents.

- The majority (71%) of the reviewed deaths in this category were males.
- The reviewed deaths related to vehicular accidents include 71% of 1 to 9 years old, and 29% of 10 to 17 years old (see Figure 22).
- Most of the reviewed deaths related to vehicular accidents were White (43%) and African American (43%) children, and the remaining one (14%) was a child of other race/ethnicity (see Figure 23).
- All of the reviewed deaths in this category were accidental.

Figure 22: Child Deaths Due to Vehicular Accidents by Age

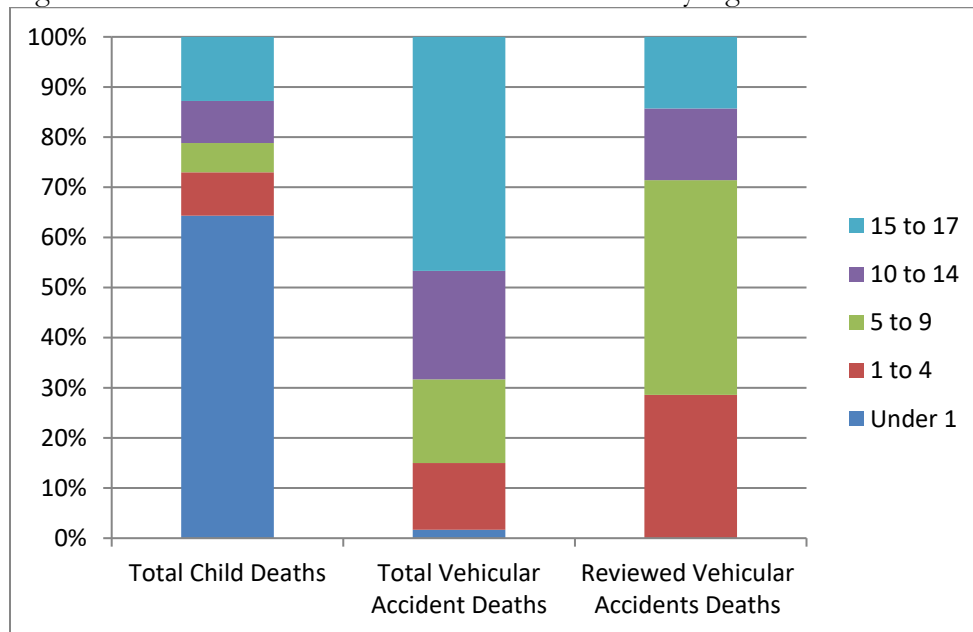
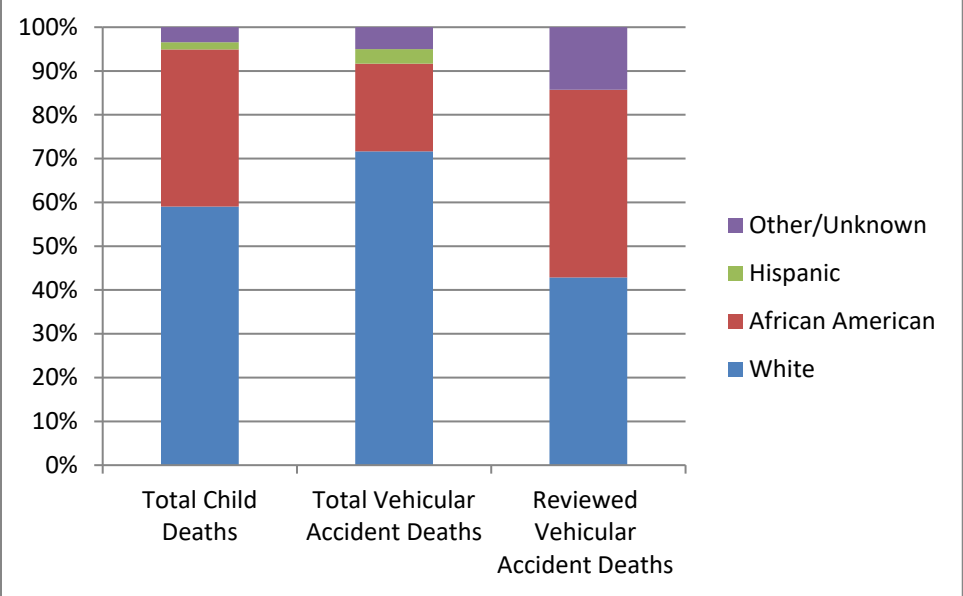


Figure 23: Child Deaths Due to Vehicular Accidents by Race



Injuries

Definition

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

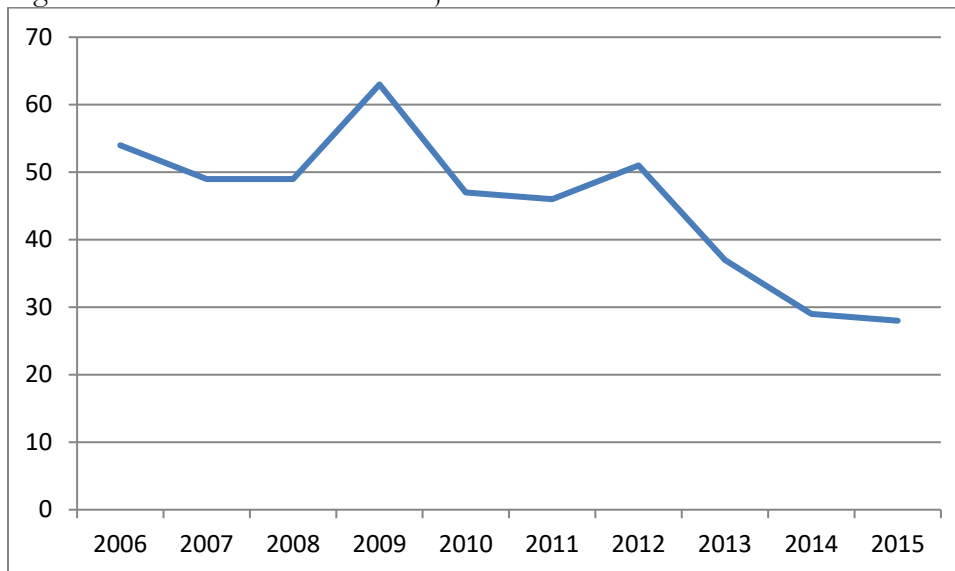
Background

Child maltreatment (including abuse and neglect) is one cause of death from injuries. In 2014, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,239 fatalities from child maltreatment. For FY 2014, a nationally estimated 1,580 children died from abuse and neglect at a rate of 2.1 per 100,000 children in the population. Younger children are the most vulnerable to death as the result of child abuse and neglect. Seventy-one percent of all child fatalities were younger than 3 years and the child fatality rate mostly decreased with age.²³ Of the children who died, 72.3% suffered neglect and 41.3% suffered physical abuse either exclusively or in combination with maltreatment type.²⁴

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries has declined over the past decade (see Figure 24).

Figure 24: Child Deaths Due to Injuries



²³ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2017). *Child maltreatment, 2014*. Washington, DC: Government Printing Office. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf>

²⁴ Ibid.

In 2015, 28 of the 1,402 total child deaths reported to the CDRTs (2%) were related to injuries.

- 64% of the child deaths from injuries in 2015 were male.
- Younger children were more vulnerable to death from injuries: 64% of injury deaths were among infants and children 1 to 4 years old (see Figure 25).
- Slightly more than half (54%) of the deaths due to injuries were White children, and the remaining were African American children (see Figure 26).
- The majority (64%) of the injury deaths were due to homicides, with the remaining due to accidents (21%), undetermined causes (11%) and suicides (4%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 19 of the 231 deaths reviewed by the CDRTs (8%) were related to injuries.

- 63% of the reviewed injury deaths were male.
- The vast majority (74%) of the reviewed cases involved young children 4 years and under (see Figure 25).
- Slightly more than half (53%) of the reviewed deaths due to injuries were African American children, and the remaining 47% were White children (see Figure 26).
- Most (79%) of the reviewed injury deaths were due to homicides, with the remaining due to accidents (11%), suicides (5%), and undetermined (5%).

Figure 25: Child Deaths Due to Injuries by Age

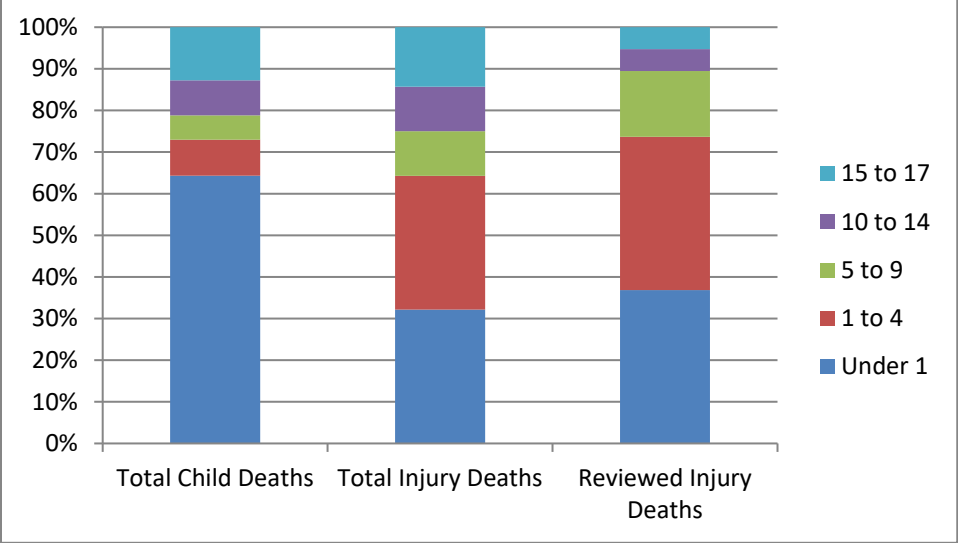
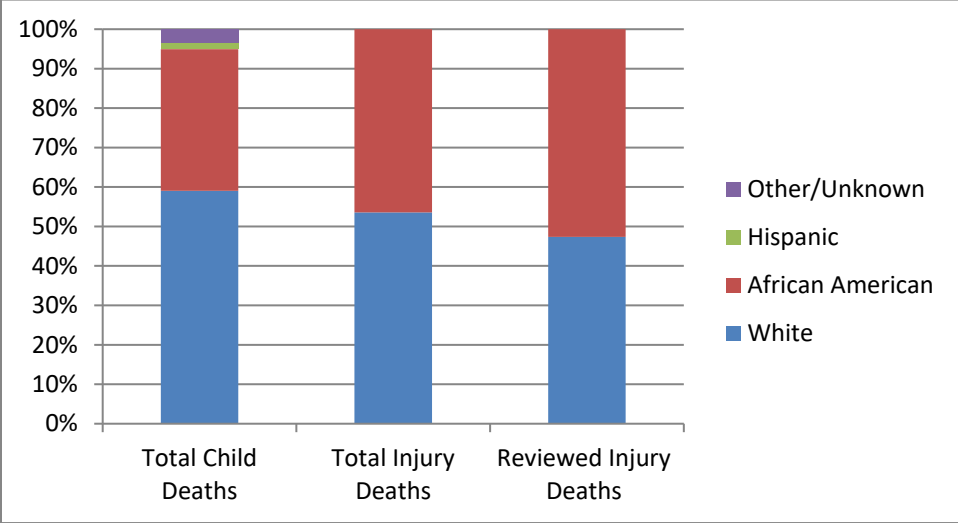


Figure 26: Child Deaths Due to Injury by Race



Drowning

Definition

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

Background

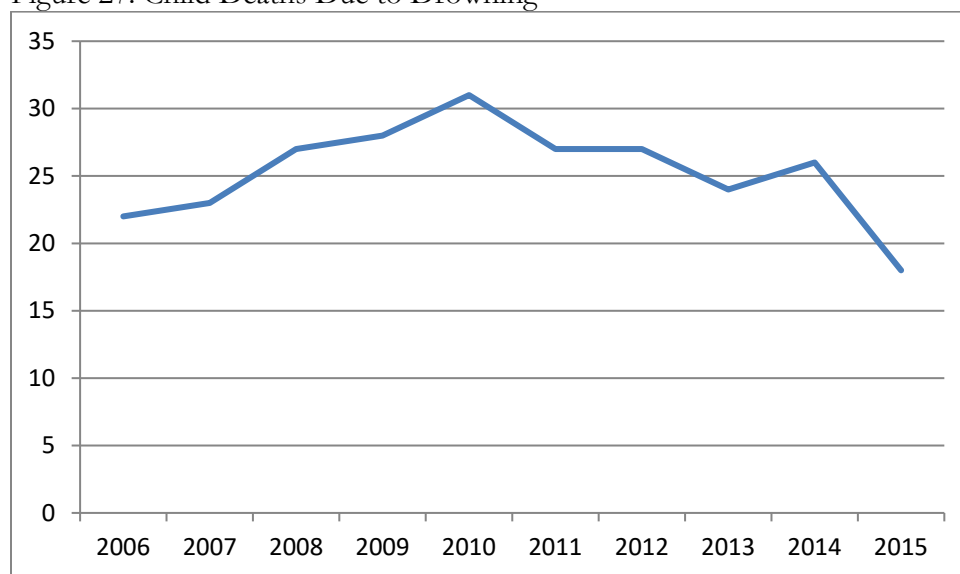
In 2015, 811 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 56% of these deaths.²⁵

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 2.8 times greater than that of white children.²⁶

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of Illinois child deaths due to drowning increased between 2006 and 2010, but then declined since then to its lowest level in 2015 (see Figure 27).

Figure 27: Child Deaths Due to Drowning



²⁵ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

²⁶ Safe Kids Worldwide. (2017). *Swimming and Boating Safety Fact Sheet 2015*. Retrieved from https://www.safekids.org/sites/default/files/documents/skw_swimming_fact_sheet_feb_2015.pdf.

In 2015, 18 of the 1,402 total child deaths reported to the CDRTs (1%) were related to drowning.

- More boys (67%) died from drowning than girls.
- Children 4 years old and under accounted for 72% of the deaths, children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 6%, 17%, and 6% of deaths due to drowning respectively (See Figure 28).
- Most (78%) of the drowning deaths were White children, the remaining were African American children (17%) and children of other races/ethnicities (6%) (see Figure 29).
- Most of the drowning deaths were accidental (89%), and the rest were undetermined (11%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 11 of the 231 reviewed deaths (5%) were related to drowning.

- Slightly more than half (55%) of the reviewed drowning deaths were male.
- All of the reviewed deaths related to drowning occurred among children 4 years old and younger (See Figure 28).
- Most (73%) of the reviewed drowning deaths were White children, the remaining were African American children (18%) and children of other races/ethnicities (9%) (see Figure 29).
- Most (82%) of the reviewed drowning deaths were due to accidental causes.

Figure 28: Child Deaths Due to Drowning by Age

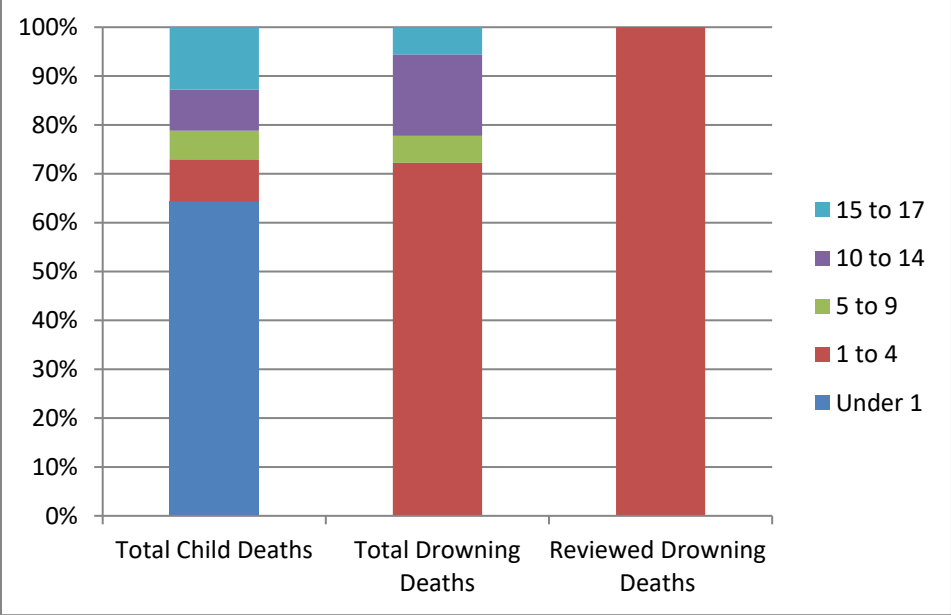
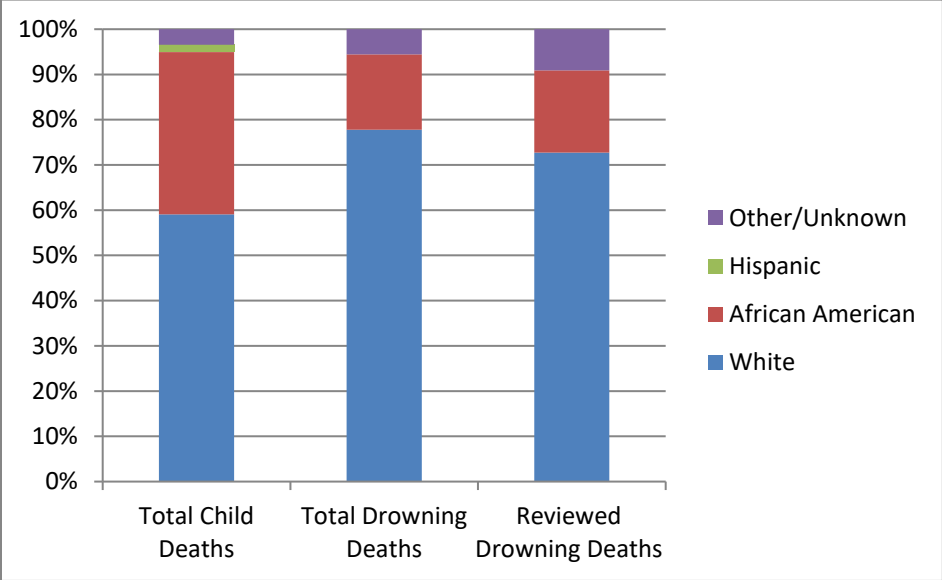


Figure 29: Child Deaths Due to Drowning by Race



Poisoning/Overdose

Definition

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

Background

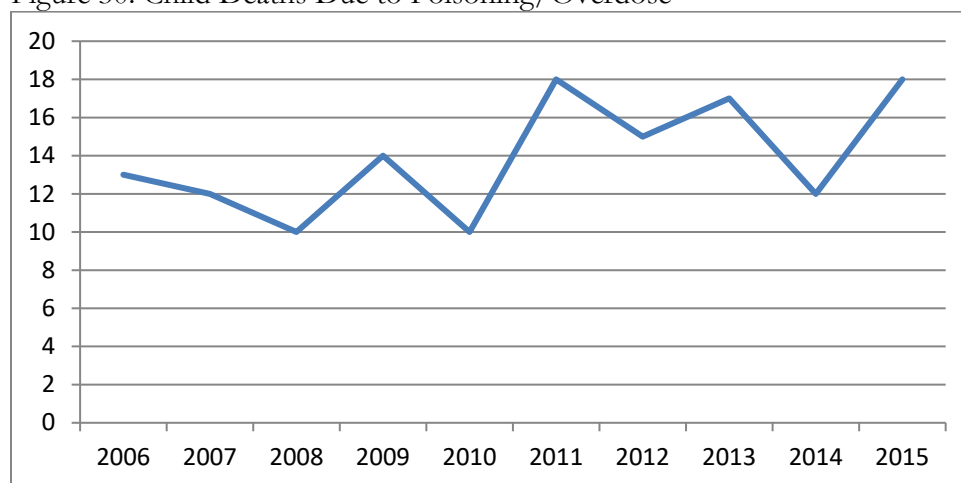
In 2015, 416 children under 18 years died of poisoning in the United States.²⁷ The majority of these deaths occurred in children 15 to 17 years of age (55%). The age group with the second most frequent number of deaths by poisoning was children between 4 and 15 (25%), with children under 4 accounting for 20% 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.²⁸ 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 2006, and there is no clear pattern over time (see Figure 30).

Figure 30: Child Deaths Due to Poisoning/Overdose



²⁷ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

²⁸ 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 2015, 18 of the 1,402 total child deaths reported to the CDRTs (1%) were related to poisonings or overdoses.

- Girls (72%) were more likely to die from poisoning or overdose than boys.
- The majority of the deaths (72%) were children of 15 to 17 years old, 22% of the deaths were children under 4 years old, and the remaining one death (6%) was a child of 10 to 14 years old (see Figure 31).
- Most (89%) of the deaths due to poisoning or overdose were White children, and the remaining were African American children (see Figure 32).
- The majority of the deaths were related to accidents (33%) or suicides (39%), and the remaining deaths were related to homicides (17%) or undetermined causes (11%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 8 of the 231 deaths reviewed by the CDRTs (3%) were related to poisoning/overdose.

- The majority (63%) of the decedents were girls.
- The majority (63%) of the decedents were children of 15 to 17 years old, and the remaining deaths (37%) were children of 1 to 4 years old (see Figure 31).
- Most (88%) of the decedents were White, and the remaining one was an African American child (see Figure 32).
- The deaths were related to accidents (38%), homicides (25%), undetermined causes (25%), and suicide (12%).

Figure 31: Child Deaths Due to Poisoning/Overdose by Age

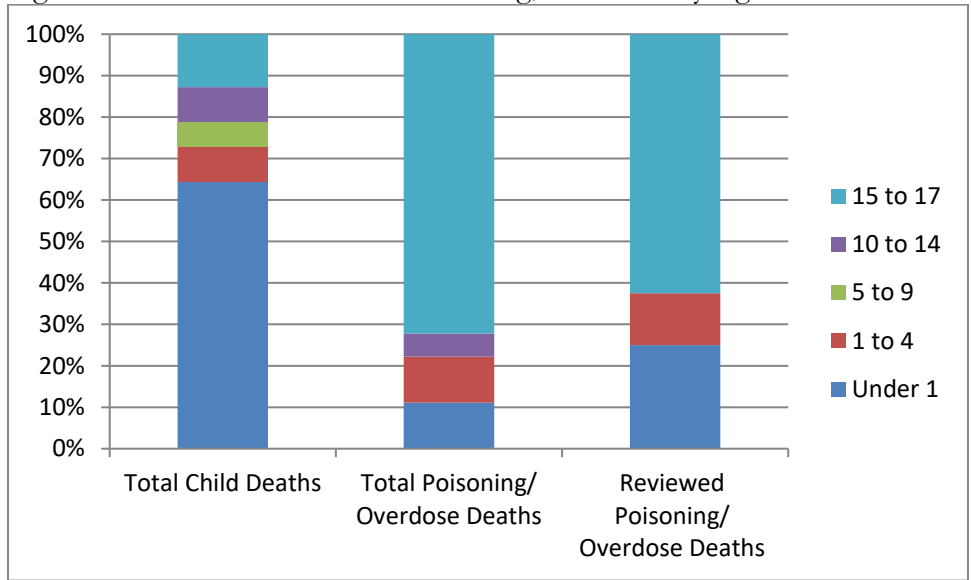
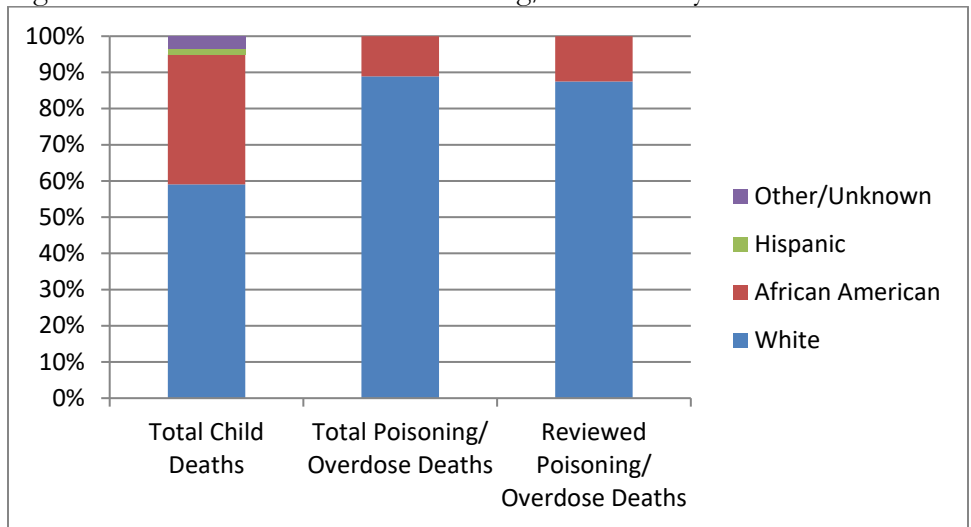


Figure 32: Child Deaths Due to Poisoning/Overdose by Race



Fire

Definition

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

Background

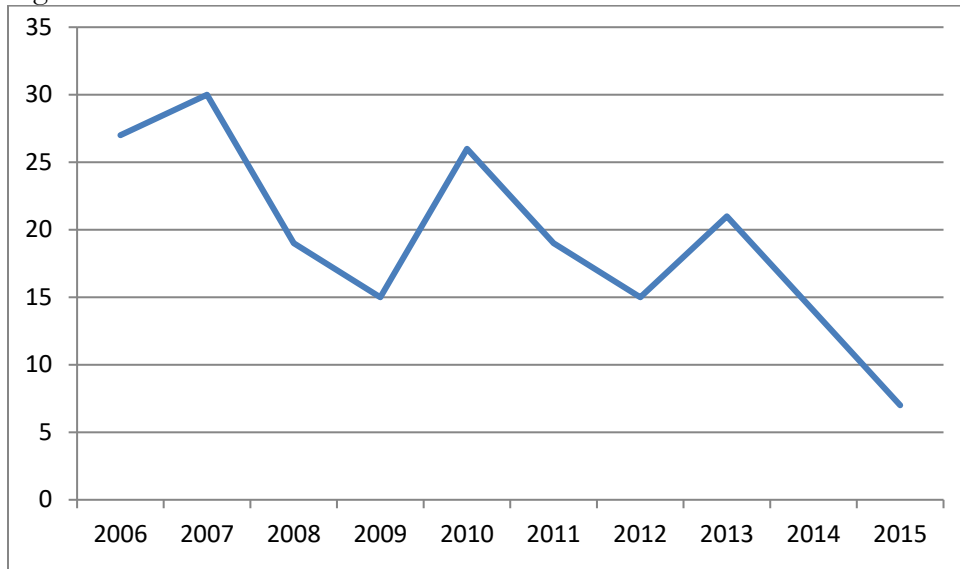
In the United States, fire and burns were the cause of 290 deaths among children between 0 and 17 years in 2015. Forty six percent of fire deaths occurred in children 4 and under.²⁹ Death rates per million among children 14 and under has decreased 24.4% from 2005-2014.³⁰

Home fires account for 87% of all fire-related fatalities in 2013. Working smoke alarms reduce the chances of dying in a fire by nearly 50%.³¹

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from fire have fluctuated typically between 15 and 25 over the decade from 2006 to 2014, but it sharply declined to a single digit in 2015 (see Figure 33).

Figure 33: Child Deaths Due to Fire



²⁹ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

³⁰ U. S. Fire Administration, (2017). Child Fire Death Rates and Relative Risk (2005-2014) Retrieved from http://www.usfa.fema.gov/statistics/estimates/trend_child.shtm.

³¹ Safe Kids Worldwide. (2017). *Fire safety*. Retrieved from <http://www.safekids.org/fire>.

In 2015, 7 of the 1,402 total child deaths reported to the CDRTs (<1%) were related to fires.

- There were slightly more girls (57%) that died from fire.
- Children 5 to 9 (44%) and 10 to 14 (44%) years old accounted for most of the deaths due to fire respectively, and the remaining death was a child of 1 to 4 years old.
- 57% of the deaths were African American children, and 43% were White children.
- The majority of deaths (71%) attributable to fire were accidental, and the remaining deaths (29%) were homicides.

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, 4 of the 231 deaths reviewed by CDRTs were related to fires (2%).

- All of the reviewed decedents were girls.
- Most (75%) of the reviewed deaths were children 5 to 9 years old, and the remaining one (25%) was a child of 10 to 14 years old.
- 50% of the reviewed deaths were African American children and 50% were White children.
- All of the reviewed deaths were due to accidents.

Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)³²

Definition

According to Center for Disease Control (CDC),³³ in 2014, there were about 3,500 sudden unexpected infant deaths (SUID) in the United States. SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation. In 2014, 43% of the SUID deaths are due to Sudden Infant Death Syndrome (SIDS), which is defined as the sudden death of an infant that cannot be explained after a thorough investigation is conducted that includes a complete autopsy, examination of the death scene, and review of the clinical history. Another type of SUID is unknown cause death, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted and cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of “suffocation” in the report.

Background

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

A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.³⁴

Exposure to secondhand smoke is a factor that increases the probability of SIDS. Since 2005, the percentage of children ages 0 to 6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, the percentage of children ages 0 to 6 living in homes where someone smoked regularly was 6%, compared with 27% in 1994.³⁵

³² In previous CDRT reports (2007-2008) SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Center for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained.

³³ Center for Disease Control and Prevention. (2017). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved from <https://www.cdc.gov/sids/aboutsuidandsids.htm>.

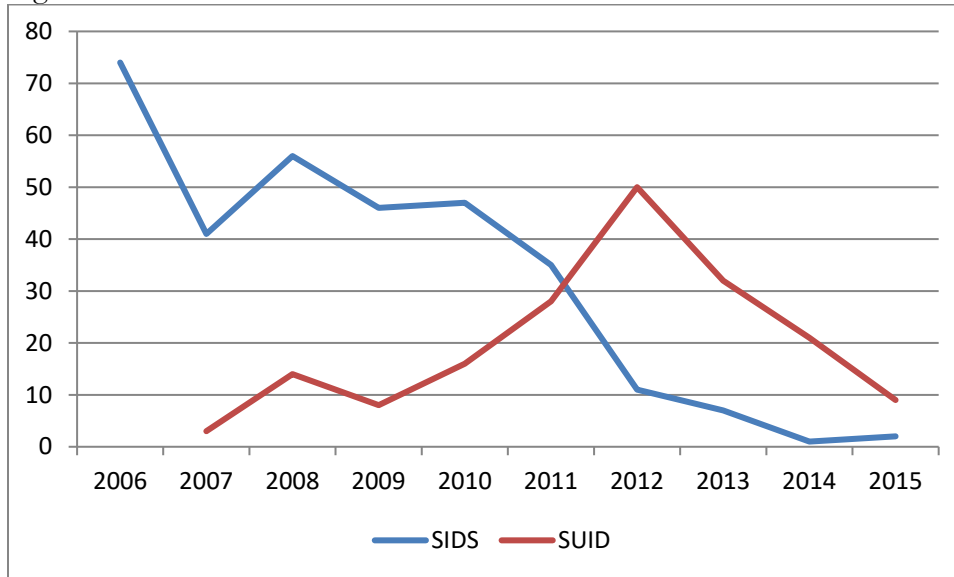
³⁴ Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, 163, 762-769.

³⁵ Federal Interagency Forum on Child and Family Statistics (2017). *America's Children: Key National Indicators of Well-Being, 2015*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://childstats.gov>.

Illinois Data – Total Child Deaths Reported to the CDRTs

Since the peak of 2007, SIDS has generally experienced a sharp decline, with the lowest number of SIDS deaths in 2014 and 2015 (see Figure 34). Infant deaths from SUID were added as a category in 2007, and child deaths due to SUID have increased from 11 in 2007 to 50 in 2012. However, the SUID also continues a sharp decline since 2013.

Figure 34: Child Deaths Due to SIDS and SUID



In 2015, 2 of the 1,402 total child deaths reported to the CDRTs (<1%) were related to SIDS, and 9 deaths (1%) were categorized as SUID.

- The 2 deaths related to SIDS were one boy and one girl, and the majority (78%) deaths related to SUID were boys.

Illinois Data – Deaths Reviewed by the CDRTs

In 2015, none of the 231 deaths reviewed by the CDRTs was related to SIDS and 2 were from SUID.

- One of the reviewed SUID deaths was a boy and another was a girl.

Uncommon Death Categories: Scalding Burn, Sudden Unexplained Child Death (SUCD), and Other

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

Scalding Burn

There were 2 scalding burn deaths in 2015.

Sudden Unexplained Child Death (SUCD)

There was no SUCD in 2015.

Other

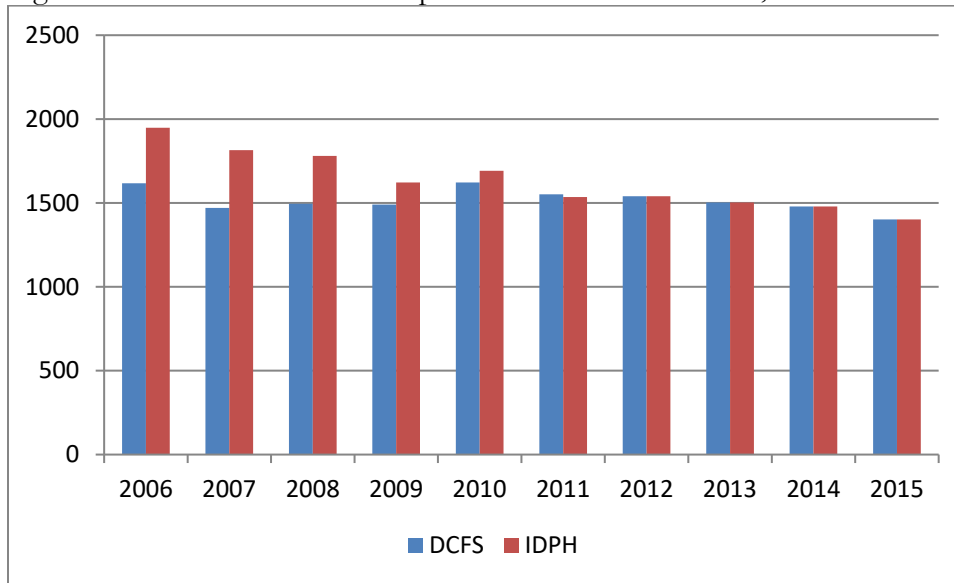
As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2015, 1 death fell in this category and it was reviewed.

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. Since 2012, the deaths reported to IDPH and DCFS have been consolidated and there is only one number for child death reports.

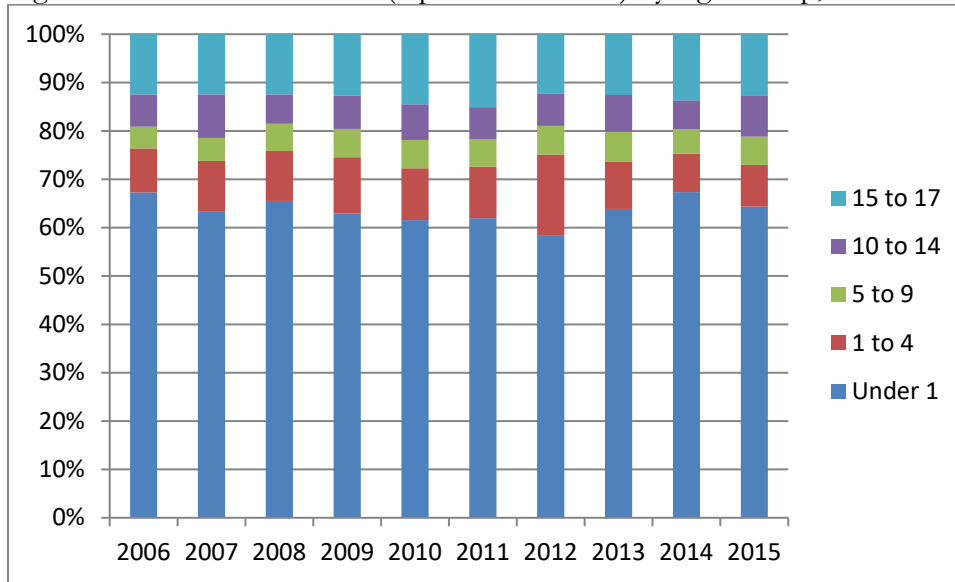
The total number of deaths in Illinois (reported by IDPH before 2012) has declined from 1,948 in 2006 to 1,402 in 2015 (see Figure 35).

Figure 35: Total Child Deaths Reported to DCFS and IDPH, 2006–2015



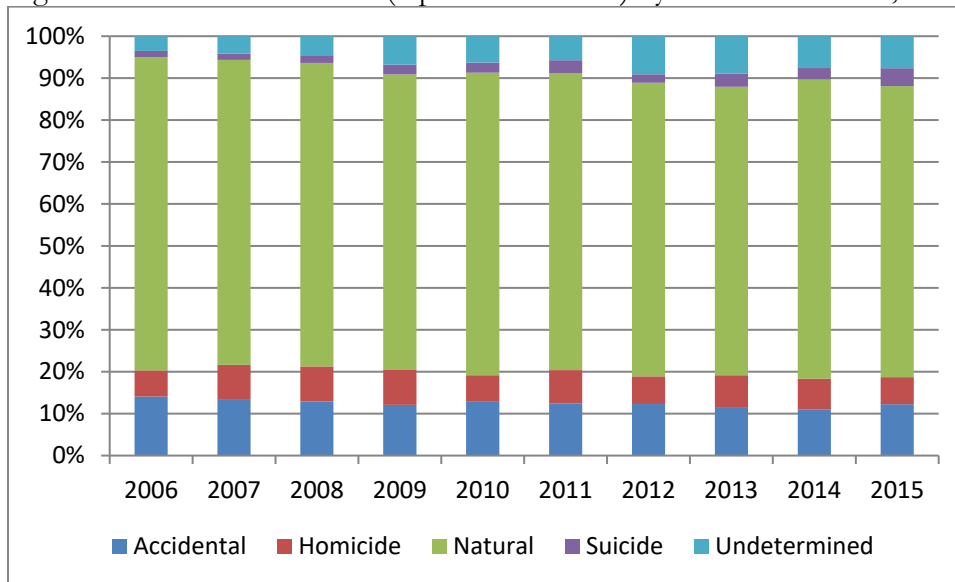
The total child deaths reported to the Child Death Review Team Unit from 2006 to 2015 is broken down by age group in Figure 36. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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 36 shows, except in 2012, the percentage of total deaths in each age group is generally stable over the 10 year period: infants under 1 year comprise 62-67% of all child deaths, children between 1 and 4 years comprise 9-12%, children between 5 and 9 years add another 5-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are the final 12-15%. The percentage of infant deaths (58%) was comparatively lower in 2012 than other years, while the percentage of deaths of 1 to 4 years (17%) was higher in 2012 than other years.

Figure 36: Total Child Deaths (reported to DCFS) by Age Group, 2006–2015



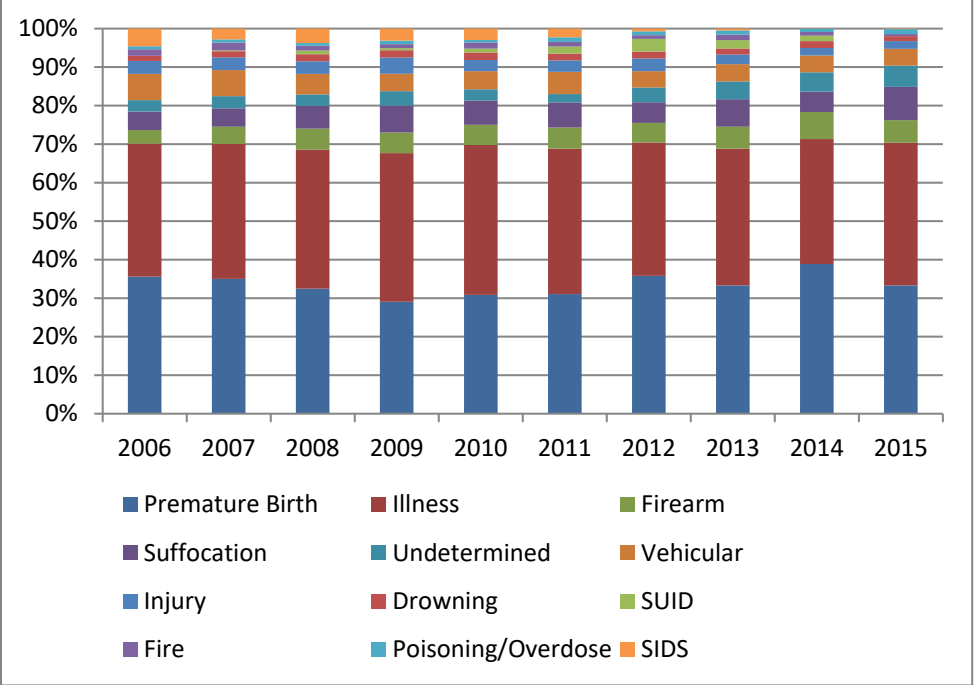
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-13% accidental, 6-8% homicide, 69-73% natural, 1-4% suicide, and 4-9% undetermined (see Figure 37).

Figure 37: Total Child Deaths (reported to DCFS) by Manner of Death, 2006–2015



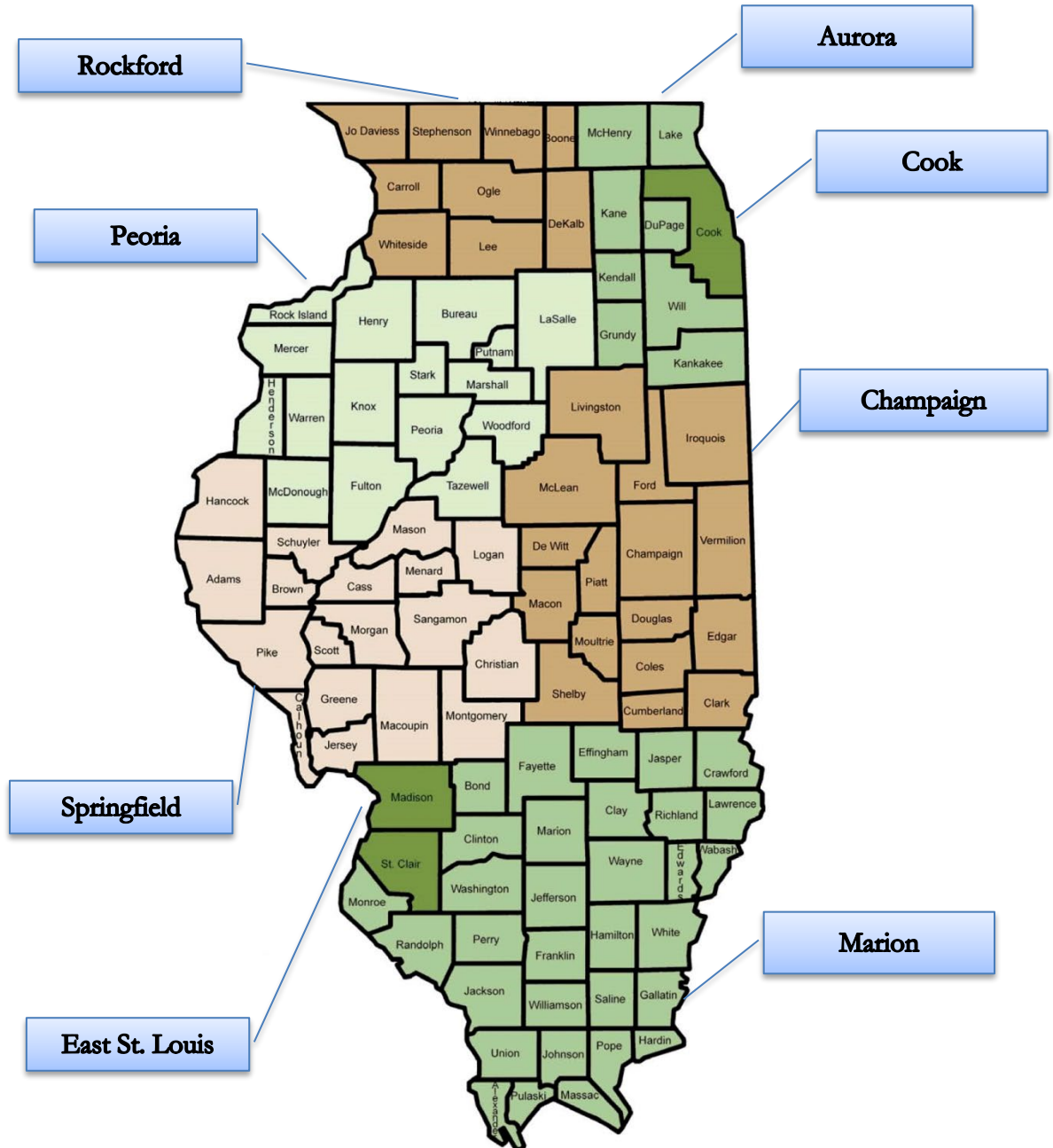
A similar analysis was done for category of death (see Figure 38). The percentage of child deaths related to each category of death across the time period varies: the major categories of deaths from prematurity (31-39%) and illness (32-39%) fluctuated overtime; there was an increasing trend for deaths from firearms (1-5% before 2013 to 6-7% since 2013) and undetermined causes (3-4% before 2013 to 5-6% since 2013); and there was a declining trend for deaths from SIDS (5% in 2006 to 1% or less since 2013), vehicular accidents (5-7% before 2012 and 4% since 2012), and injury (3-4% before 2013 to 2% since 2013). For more detailed changes within category, please refer to charts for specific categories in Chapter 4.

Figure 38: Total Child Deaths (reported to DCFS) by Category, 2006–2015³⁶



³⁶ 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 CDRT Members by Region

Aurora

Myra West, PsyD, **Chairperson**
Mary E. Jones, MD, MPH, **Vice-Chairperson**
Cathleen De La Mar
Patrick Dempsey
Carmel Finnegan
Jody Gleason
Jeff Parsons
Loren Richardson Carrera
Anne Strickland
Dan Thomas
DCFS Staff – Carole Ruzicka

Champaign

Donald F. Davison, Jr., MD, **Chairperson**
Rush Record, **Vice Chairperson**
Kathleen Carney Buetow, MD
Kim Cessna
Jackie Dever
Kimberly S. Fitton
Patricia Metzler, RN, TNS, SANE-A & P
Alex F. Meyer, Sgt.
Susan Elaine Minyard, PhD
Judy Osgood, PhD
Cindy Patterson
Jamie Perry
Brent Reifsteck, MD
Julie Runyon
DCFS Staff – Maria Miller

Cook Team A

Joan M. Pernecke, **Chairperson**
Kristen Bilka, MMS, PA-C, **Vice-Chairperson**
Anne Chambers, Sgt.
Felicia Clark
Margaret Conway
Stephanie Cornette, PC, PsyD
Anne Devaud, PsyD
Kristin Escobar-Alvarenga, MD

Jill Glick, MD
Gabriela Lagos, LCPC
Nicole Johnson, MD
Eileen Payonk
Char Rivette
Norell Rosado, MD
Margaret Scotellaro, MD
Kimberly Souder
Tierney Stutz
Christina Tarazi, MD
Kelley Thornton
Dion Trotter
Kavita Vankineni, MD
Syed Zaheer
Eimad Zakariya, MD
Yvonne M. Zehr
Virginia Zic-Schlomas, Sgt.
DCFS Staff – Jacqui Colyer

Cook Team B

Kathy Grzelak, MA, LCPC, **Chairperson**
Mary Joly Stein, **Vice-Chairperson**
Sweety Agrawal, PsyD
Jennifer Bagby
Larissa Davis
Eric Eason, MD
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Trenton Hubbard, MD
Tracy Kruger, RN, CPNP-PC
Denika Means, MD
Edward Nowak
Alpa Patel
Anna Pesok, MD
Evelyn Polk-Green, M.S.Ed.
Veena Ramaiah, MD
Diane Scruggs
Benjamin Soriano, MD
Annie Torres, MD
Valencia Williams, PsyD
DCFS Staff – Ann Marakis

East St. Louis

Daniel Cuneo, PhD, **Chairperson**
David C. Norman, MD, **Vice-Chairperson**
Jamie Brunnworth
Cathy Daesch, ATR-BC, LCPC, ICDVP
Judy Dalan
Carolyn Hubler
Gilda Johnson
Francis Jones, RN
Carole A. Presson, Lt.
Lynn Shelton, RN
DCFS Staff – Bob Cain

Marion

Chad Brown, Sgt., **Chairperson**
Mary Louise Cashel, **Vice-Chairperson**
Leah Brown
Kathy Clark
Jessica Cullum
Connie Edgar
Jay Goble
Robin Hopper
Lisa Irvin
Shalynn Malone
Jamie Penrod
Kathy Swafford, MD
Dawn Tondini
Steve Webb, PhD
Patrick Windhorst
Sheryl L. Woodham, MSW, LCSW
DCFS Staff – Bob Cain

Peoria

Judy Guenseth, **Chairperson**
Timothy Wilkins, **Vice-Chairperson**
America Bunker, RN
Susan Bordenave-Bishop, MD
Gregg M. Cavanaugh, M/Sgt.
Stefanie Clarke, BSN, RN, CPEN
Donna Cruz
Cindy Fisher
Brian Gustafson
Marcy O'Brien
Channing Petrak, MD
Michele Verda, PhD
DCFS Staff – Jim Marmion

Rockford

Joanna Deuth, **Chairperson**
Holly Peifer, **Vice-Chairperson**
Pamela A. Borchardt
Amy Buchenau, NP
Raymond Davis, Jr., MD
David Glessner
Leah Hantke, RNC, MS, WHNP
Marilyn Hite Ross
Stephanie Klein
Nicole Luster
Angela Mathews
Pam VanderVinne, RN/CMC
Dave Watson
Rebecca Wigget
DCFS Staff – Dawn Moyer

Springfield

John C. Milhiser, **Chairperson**
Cinda Edwards, **Vice-Chairperson**
Careyana Brenham, MD
Roy Harley
John Hayes
Shirley Johnson
Nathaniel Patterson, MD
Leah Raabe
Jim Stone
John Yard, SA
DCFS Staff – Jason Cummins

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

Appendix C – Illinois Child Deaths by County

County	2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths	2014 Deaths	2015 Deaths
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH*	DCFS	CDRTs**	DCFS	IDPH*	CDRTs**	CDRTs**	CDRTs**	CDRTs**
Adams	1	8	8	11	1	10	6	5	6	5	4	3	9	5	9	9
Alexander	0	1	0	1	0	1	1	1	0	2	0	0	1	0	0	0
Bond	0	0	0	0	1	1	0	0	0	1	2	2	4	1	0	2
Boone	0	0	0	0	0	3	3	3	1	1	4	2	3	0	1	0
Brown	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
Bureau	2	4	2	2	1	2	5	5	6	5	1	1	2	1	3	0
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	1	1	0	0	0	1	1	1	2	2	0	0	1	0	1	0
Cass	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Champaign	32	47	3	39	21	36	42	36	36	33	43	37	29	49	38	30
Christian	2	2	0	0	3	4	4	4	4	3	3	2	2	1	1	4
Clark	1	1	0	0	1	1	0	0	0	1	2	2	1	3	0	1
Clay	0	0	0	0	0	1	0	0	1	1	0	0	1	1	0	0
Clinton	0	3	0	3	3	4	1	1	3	3	2	1	1	3	0	0
Coles	0	8	0	3	0	4	3	5	5	2	5	6	4	4	4	2
Cook	1,014	1,141	926	1,066	908	1,010	768	832	887	920	857	824	857	775	815	818
Crawford	0	1	0	1	1	1	0	0	2	1	2	1	4	4	0	1
Cumberland	1	1	0	0	3	2	2	3	2	2	0	0	1	0	0	0
DeKalb	1	14	4	5	3	3	5	3	4	3	5	5	4	9	7	3
Dewitt	0	2	0	1	0	0	2	2	0	0	1	1	0	0	3	1
Douglas	0	0	0	0	0	0	0	0	1	1	1	1	1	0	1	0
Dupage	93	95	97	99	76	81	65	62	89	76	73	68	66	70	80	63
Edgar	2	3	0	1	1	2	0	0	0	0	1	1	1	1	1	2
Edwards	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Effingham	3	4	0	7	5	6	1	1	0	1	8	7	2	7	5	5
Fayette	0	1	0	1	0	0	0	0	1	0	1	1	0	2	3	1
Ford	1	1	1	1	3	3	1	0	1	1	0	0	1	2	1	0
Franklin	1	0	3	3	3	3	4	4	5	3	2	1	0	2	4	6
Fulton	2	2	5	5	0	0	3	4	4	4	0	0	3	0	0	2
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Greene	0	1	0	0	0	1	0	0	0	1	0	1	0	0	1	0
Grundy	2	3	0	5	3	4	3	4	5	5	3	2	3	2	1	2
Hamilton	3	3	1	1	3	3	0	0	1	1	1	1	1	2	0	1
Hancock	0	1	0	0	0	2	2	1	0	0	1	1	0	1	3	0
Hardin	0	0	0	1	0	0	0	0	2	2	1	2	1	1	1	1
Henderson	0	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Henry	1	1	4	4	2	2	2	3	4	4	4	2	2	3	3	2
Iroquois	0	0	0	2	0	1	0	0	3	3	1	1	1	1	0	0
Jackson	0	4	3	4	8	8	9	8	4	5	8	6	16	2	5	9
Jasper	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0
Jefferson	1	2	0	3	1	4	1	1	9	9	7	6	2	6	4	2
Jersey	0	1	1	3	0	2	0	0	1	2	2	3	4	2	0	4

Jo Daviess	3	3	0	1	0	0	0	0	0	0	4	4	0	1	0	0
Johnson	0	1	1	0	0	0	0	2	0	3	0	3	2	0	0	0
Kane	44	61	37	46	59	57	55	53	44	41	45	42	42	42	44	51
Kankakee	14	14	9	9	8	13	5	5	8	8	8	8	12	10	10	6
Kendall	1	1	6	6	6	6	2	2	1	1	1	1	2	3	2	0
Knox	5	5	3	3	4	4	2	2	7	8	10	10	3	4	6	6
Lake	35	58	17	37	26	38	34	47	31	47	35	40	33	37	36	36
LaSalle	0	9	0	8	0	9	7	7	8	9	9	8	11	8	7	11
Lawrence	1	1	0	0	1	3	1	1	6	4	4	2	1	2	0	1
Lee	0	1	0	2	0	1	3	5	1	1	2	2	2	3	3	2
Livingston	0	4	0	5	2	5	2	2	3	3	5	2	3	0	4	2
Logan	0	0	0	0	7	8	6	5	0	0	2	2	3	3	1	0
Macon	18	18	15	16	18	21	15	15	11	10	13	13	7	4	12	11
Macoupin	0	1	0	1	0	0	2	2	2	3	0	0	0	5	4	2
Madison	8	20	14	19	21	25	16	20	15	13	13	11	8	12	14	18
Marion	2	2	4	4	4	3	3	6	3	9	5	9	2	5	5	10
Marshall	0	1	0	0	0	0	3	2	2	1	0	0	0	0	0	1
Mason	0	3	0	0	0	0	0	0	2	1	0	0	0	3	1	2
Massac	1	1	1	1	1	1	4	2	0	0	0	0	2	1	0	1
McDonough	0	2	0	0	0	1	1	2	2	2	1	1	1	2	0	1
McHenry	9	10	23	24	14	19	11	11	7	6	11	9	12	17	9	9
McLean	12	16	11	10	14	14	5	6	9	10	13	12	9	12	13	14
Menard	0	0	0	0	0	1	1	1	1	1	0	0	0	0	0	0
Mercer	0	0	0	0	0	0	0	0	1	1	1	1	2	6	0	1
Monroe	1	1	1	1	0	0	2	2	0	1	1	1	1	1	0	1
Montgomery	2	2	3	3	0	1	1	0	3	3	3	2	1	0	4	2
Morgan	0	1	1	1	0	2	1	1	2	2	0	1	2	3	3	0
Moultrie	1	1	0	0	3	3	0	0	1	1	4	4	1	0	0	0
Ogle	2	2	3	3	4	4	3	3	2	1	1	1	0	0	2	3
Peoria	92	97	51	77	49	86	76	93	81	80	76	75	109	72	82	63
Perry	2	3	1	4	2	3	0	0	4	4	0	0	1	3	2	1
Piatt	0	0	0	1	0	2	0	0	0	0	1	1	1	0	0	0
Pike	0	2	0	0	0	0	0	0	2	2	0	0	0	0	0	0
Pope	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Pulaski	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	1
Randolph	0	0	1	4	0	0	1	1	1	1	1	1	6	7	2	1
Richland	1	3	0	0	1	3	1	1	1	1	2	2	1	1	2	1
Rock Island	4	4	19	19	12	12	18	17	12	9	12	11	11	9	12	8
Saline	3	3	2	2	2	2	4	2	4	3	1	1	3	0	3	3
Sangamon	45	52	48	54	32	46	51	48	46	43	38	46	33	46	39	36
Schuyler	0	3	0	0	0	0	0	0	4	0	6	0	1	1	1	0
Scott	0	0	0	1	0	1	0	2	0	0	0	0	0	2	0	0
Shelby	3	3	1	1	3	3	2	5	1	2	0	0	0	2	0	2
St. Clair	23	35	14	29	7	26	26	28	18	16	18	15	21	31	26	15
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephenson	1	2	3	4	4	5	4	4	5	4	2	2	1	2	4	3
Tazewell	6	9	3	5	4	7	2	2	2	3	3	2	3	2	7	5
Union	0	0	2	2	0	0	2	2	3	3	1	1	1	2	1	3

Vermillion	3	4	9	12	1	6	13	14	7	6	8	6	11	10	7	4
Wabash	0	0	0	1	0	2	3	2	0	0	0	0	1	0	1	0
Warren	0	1	0	0	0	1	0	1	1	1	1	1	1	1	1	1
Washington	0	1	0	1	0	0	0	0	2	2	1	1	0	1	1	0
Wayne	1	1	1	2	0	1	1	1	1	1	1	1	2	1	1	3
White	0	0	0	0	0	0	1	1	1	1	1	1	1	0	1	0
Whiteside	1	4	0	6	0	3	7	6	3	5	4	3	1	4	3	1
Will	40	41	42	43	42	38	44	47	38	35	28	26	33	34	38	24
Williamson	6	2	4	9	8	9	6	5	5	5	10	9	6	6	13	6
Winnebago	61	75	58	65	71	78	59	48	61	49	51	43	40	36	43	46
Woodford	1	2	0	0	1	1	1	2	2	2	3	3	1	4	1	2
Unknown	0	0	0	0	0	0	18	0	1	0	0	1	0	0	0	0
Out of State	1	0	4	0	13	0	27	81	53	117	46	97	47	81	12	11
Out of country	-	-	-	-	-	-	-	-	-	-	-	-	9	0	0	0
Total	1,617	1,948	1,470	1,815	1,495	1,780	1,490	1,622	1,622	1,692	1,551	1,535	1,540	1,503	1,479	1,402

*Death numbers for IDPH are for facility of death

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