Illinois Child Death Review Teams: A Partnership for Protecting Children

Annual Report on Child Deaths That Occurred in Calendar Year 2016

MISSION

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

SUBMITTED TO:

The Honorable Bruce Rauner, Governor, State of Illinois
Illinois State Senate
Illinois House of Representatives

MAY 2018

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April 2018

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 2016. 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,

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

Bruce Rauner
Governor

Beverly J. Walker
Acting Director

May 15, 2018

To the Citizens of Illinois:

The members of the nine regional Child Death Review Teams spend countless hours each year studying the causes of child deaths and helping us identify steps we can take to make kids safer. At the end of each calendar year, the teams complete their assessments and summarize their work in an annual report like this one.

So many child deaths continue to be from suffocation as a result unsafe sleep practices. We all understand the temptation of parents to sleep with children as they are crying or nursing, but it is dangerous. So is putting soft blankets, pillows, and bumpers into a crib with a baby. 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 public awareness and education about safe-sleep practices and the dangers of unsafe practices.

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.

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,

BJ Walker

Acting Director

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ACKNOWLEDGEMENTS

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

The production of this report represents the ongoing collaboration between the Illinois CDRT Executive Council, the Illinois Department of Children and Family Services, 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. Steve Tran. Children and Family Research Center staff Dr. Steve Tran 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 2016

In 2016, 1,487 children under 18 died in Illinois.[1] This number represents the death information received by DCFS as of January 30, 2018.

Of the total child deaths reported to CDRTs in 2016:

- 59% were boys and 41% were girls;
- 64% were infants under one year, 9% were young children between 1 and 4 years, 12% were older children between 5 and 14 years, and 16% were youth between 15 and 17 years.[2]
- 62% were White, 36% were African American, and nearly 3% were Asian.

When Illinois child deaths in 2016 were examined by the manner of death:

- 68% were attributable to natural causes;
- 13% were accidental;
- 9% were homicides;
- 3% were suicides;
- 7% were undetermined.

When deaths occurring in 2016 were examined by the category of death:

- 33% were related to illness;
- 35% were related to premature birth;
- Less than 1% were related to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID);
- 25% were related to various types of injuries, such as suffocations (7%), firearms (7%), vehicular accidents (5%), drowning (2%), fires (1%), poisoning/overdose (<1%), and other types of injuries (2%);
- 6% 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 1/30/2018.

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

2016 Child Deaths Reviewed by the CDRTs

In 2016, 256 child deaths were reviewed by the CDRTs, including 130 mandatory and 126 discretionary reviews. The mandatory reviews occurred for one of several reasons: 56 were indicated death cases, 56 cases had an investigation in the year before the child's death, 13 were indicated investigations, 2 were DCFS youth in care, and 3 involved an open DCFS investigation at the time of death.

Reviewed deaths in 2016 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 – 31 of the 218 deaths (14%) were reviewed.
- Champaign – 20 of the 87 deaths (23%) were reviewed.
- Cook – 110 of the 831 deaths (13%) were reviewed.
- East St. Louis – 20 of the 36 deaths (56%) were reviewed.
- Marion – 19 of the 46 deaths (41%) were reviewed.
- Peoria – 22 of the 111 deaths (20%) were reviewed.
- Rockford – 12 of the 78 deaths (15%) were reviewed.
- Springfield – 10 of the 68 deaths (15%) were reviewed.
- In addition, 12 of 12 deaths (100%) that were out of state were reviewed.

Of the deaths reviewed by CDRTs in 2016:

- 57% were boys and 43% were girls;
- 60% were infants under one, 17% were young children between 1 and 4 years, 12% were older children between 5 and 14 years, and 11% were youth between 15 and 17 years.
- 52% were White, 48% were African American, and under 1% were Asian.

When reviewed deaths occurring in 2016 were examined by manner of death:

- 35% were attributed to accidents;
- 21% were due to natural causes;
- 11% were homicides;
- 2% were suicides;
- 30% were undetermined.

When reviewed deaths occurring in 2016 were examined by category of death:

- 2% were related to premature birth;
- 18% were related to illness;
- 3% were related to SUID; 52% were related to various types of injuries, such as suffocations (24%), drowning (7%), firearms (6%), vehicular accidents (4%), poisoning/overdose (2%), fire (1%) and other types of injuries (6%);
- 25% 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 2016, there were 1,487 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.

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

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

- keep the governor and legislature apprised of CDRT findings and recommendations and of legislation needed to reduce child fatalities and protect the lives of children.

Child Death Review 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.

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 2017-2018 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 2016 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.
- The 21st Annual Symposium was held at the Crowne Plaza – Springfield, Illinois on May 4-5th 2017. There was a total of 68 attendees. The following presentations included: 1) The State of Child Maltreatment Fatalities in the United States by Emily M. Douglas, Ph.D. Associate Professor of Social Work/Bridgewater State University. 2) Case Specific Presentation by Donald Davison, M.D., Carle Clinic Association/Champaign Team Chairperson, 3) and Vicarious Trauma by Patricia Metzler, RN, TNS, SANE-A, SANE-P/Carle Foundation Hospital/Champaign Team Member.

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.

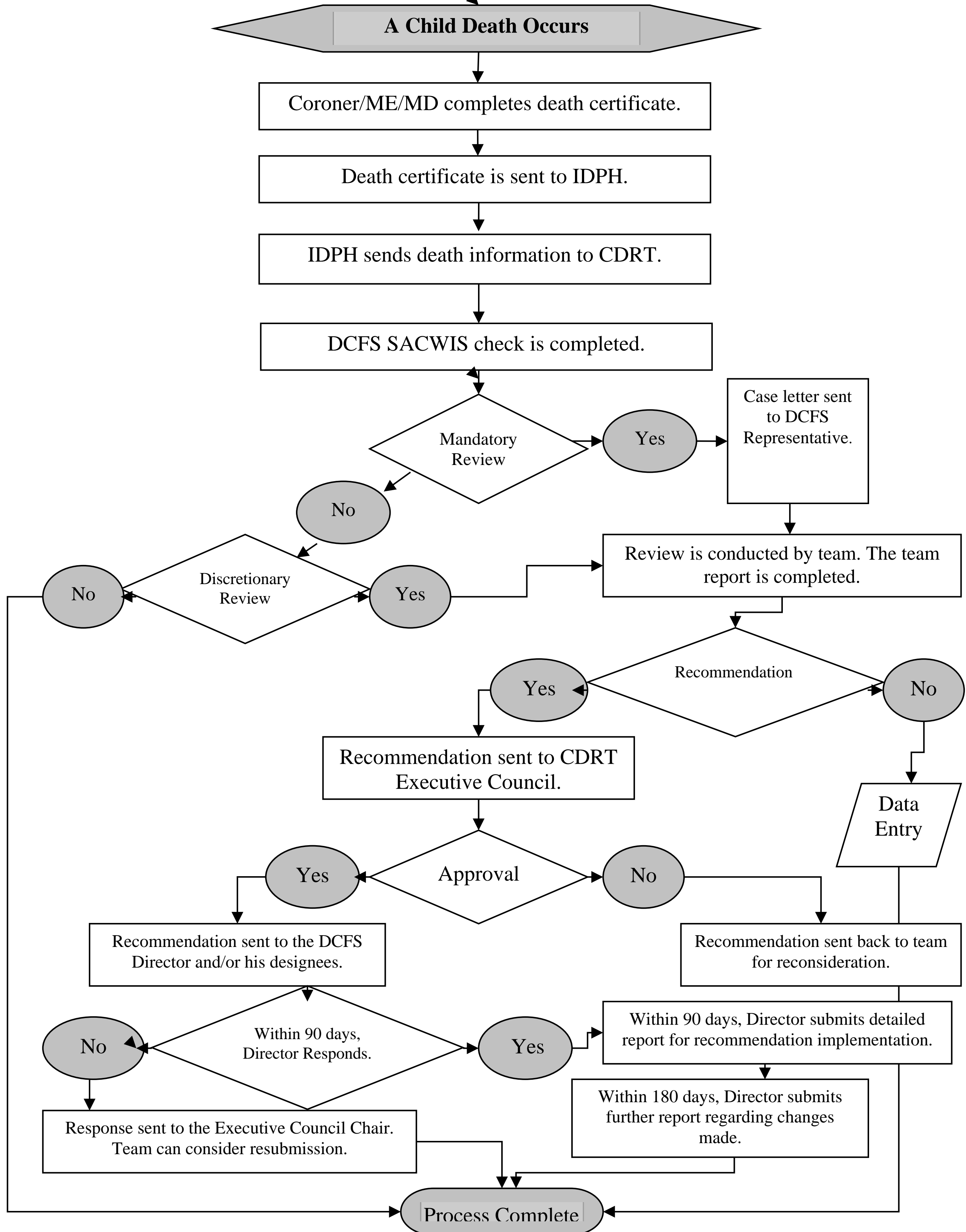
Illinois Child Death Review Process

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.

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

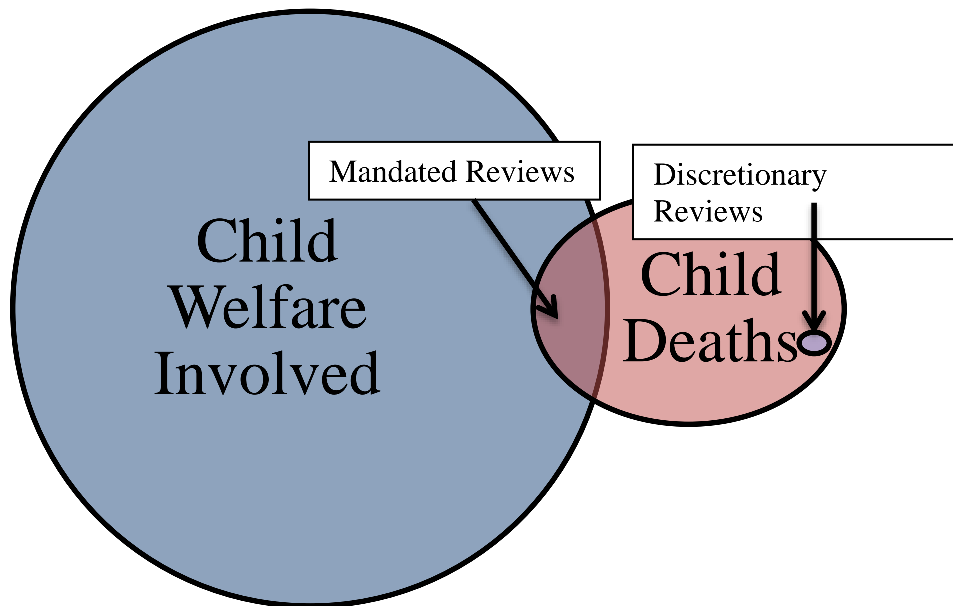


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the death certificate to the Illinois Department of Public Health (IDPH). IDPH electronically provides the Child Death Review Office with the information.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

[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 2016.

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

Confidentiality of CDRT Information

To ensure the confidentiality of the CDRT process, the Child Death Review Team Act mandates that information provided to and maintained by a CDRT 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)

Child Death Review Teams conducted reviews on 256 child deaths in 2016 and made 123 recommendations related to 68 child death cases. Of the 123 recommendations, there were 68 recommendations focused on DCFS policy and procedures (see Table 1). The DCFS recommendations resulted from four types of reviews including: death indicated (28), discretionary (24), investigation within a year of death (13), and indicated report at time of death (3). There were 21 recommendations related to other agencies or systems. These recommendations came from four types of reviews, including death indicated (7), discretionary (11), investigation within a year of death (2), and pending investigation at time of death (1). There were four primary prevention recommendations from two types of reviews, death indicated (2), and discretionary (2). There were 30 case-specific recommendations from four types of reviews: 11 recommendations resulted from cases where death was indicated, 10 were from cases that had an investigation within a year of death, 6 were discretionary reviews, and 3 were from cases that had an indicated report at time of death.

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

Table 1: 2016 Recommendations and Responses

Type	Recommendation	Response
DCFS-1	DCFS should have an in house medical expert to review cases of medical neglect.	Several similar recommendations have been made and this issue is pending still. DCFS does have medical staff available.
DCFS-2	Given that the SACWIS system is being revised, DCFS should include within the new system the ability to merge cases and "AKAs" after an investigation is complete when it is later learned that to do so would be appropriate. In a case where the natural mother who used an AKA was investigated three times, her investigations were recorded under two different SCR numbers resulting in multiple "A" sequence investigations in her history instead of a single SCR number with the proper progression of lettered sequences. In the event of a future indicated investigation, her history will thus incorrectly prompt a "B" sequence instead of a "C." Despite the fact that DCFS is now aware of the inaccuracy, SACWIS currently does not allow for correcting this error for more accurate record keeping.	Staff is required by procedure 300 to perform a person search and update screens or request assistance from Placement Clearance Desk once they see inaccuracies. There is even a special form and mailbox to request assistance. Names/sequences can be merged after the fact but it can be a more difficult process and require additional assistance from OITS. Regarding this particular report, the names/sequencing is being updated now.
DCFS-3	In cases where there is a pending investigation, the agency should continue to service the family.	Agreed. Cases should remain open based on the individual dynamics of the case and while an investigation is pending.
DCFS-4	Medical providers and law enforcement should get immediate access to the hotline or be given a separate hotline number.	Calls are handled immediately as they come into the Hotline. The average response time to answer a call is 1 minute 25 seconds for FY16. If there is a need to take a message, the calls are triaged and questions are asked specifically-including if this is an emergency, are you holding a child in

		your care, do you have a child with injuries-if the answer is yes, the call will be transferred immediately or the person will be called back within 15 minutes. That is standard Hotline policy. If this is not happening, law enforcement officers and medical providers need to contact the SCR Administrator. The Hotline is always looking at ways/opportunities to be more responsive to professionals-currently we are researching the possibility and feasibility of on line reporting for professionals. This will be discussed with the SCR Administrator and a reminder sent to Hotline staff regarding emergency situations. This will be completed within the next 30 days: by 10/15/16.
DCFS-5	The Team recommends that DCFS create and utilize a checklist of what questions to ask during the investigation of an unexpected death of an infant involving unsafe sleep. We see that even experienced workers with the best of intentions do not always ask the necessary questions or follow up on missing pieces of information. A checklist that is used routinely will elicit all necessary information and result in consistent and thorough unsafe sleep investigations. Such checklists are available from the national Infant Fatality Review and other sources.	We will take this under consideration- checklists can result in workers not utilizing critical thinking, just asking closed questions without getting to the root of the issue, which is most important. Appendix K is being revised to provide more guidance to staff regarding unsafe sleep. The Executive Council has a work group looking at Appendix K. A newer draft of Appendix K was sent out to the Executive Council. At the July Executive Council meeting this will be discussed further and input will be provided to DCFS. DCFS plans to put more focus on 0-3 population and do an in-depth analysis of unsafe sleep. Some public health information was distributed at the symposium that would be helpful in addressing the unsafe sleep problem. October Meeting: Executive Council did complete their review of Appendix K on Safe Sleep and made comments. Additionally, Executive

		Council completed its review of the "DCFS Cause/Manner of Death" Training/PowerPoint. Executive Council would like to know about the next steps for these 2 revisions as they would like to provide some assistance in doing the "Cause/Manner of Death" Training. Legal, Operations, Policy and Professional Development Divisions will need to look at these revisions further and consider incorporating them in upcoming revisions. In regards to the Checklist Idea, many coroners currently complete these forms and DCFS can request the forms from them. Completing another checklist is not viable for DCFS especially if they are already being completed by coroners. There is consensus that when the coroner completes the checklist, there is no need to duplicate the work and redo the checklist. Executive Council would like DCFS to do the checklist when the coroner doesn't do it. At this time, DCFS is not in a position to complete the checklist in these situations. Use of checklists can reduce critical thinking and there are currently several checklists DCFS staff must complete. DCFS suggested that CDRT encourage coroners to complete the form. DCFS discussed this matter with the Division of Professional Development and it was determined that a work group will be formed to officially incorporate this into training. Medical examiners will be asked for input. There is no target date for this as of yet.

		December Discussion: The Ex. Council would also like to have some role in the actual training as well.
DCFS-6	Team requests DCFS create an unsafe sleep allegation with a shorter retention period. This case certainly indicated that dad had a blatant disregard for child's safety, no baby bed, etc.	The previous DCFS Director was considering this but then left. This is now a pending recommendation with the current Director.
DCFS-7	DCFS create an additional possible finding called SUSPENDED or INCOMPLETE that could be assigned if parents/caregivers are non-cooperative or DCFS is unable to find caregivers. Suspended/Incomplete finding would be an additional option that joins the options of Indicated and Unfounded.	This is being considered and will be discussed with the new Director.
DCFS-8	Team requests that DCFS create an unsafe sleep allegation with a shorter retention period. This allows for accurate statistics and appropriate services. In this case, there was a previous investigation where mother had no beds, she was given a bed but still chose not to use the bed, which led to the death of the baby. (Note: This recommendation was made on another case this year.)	The previous DCFS Director was considering this but then left. This is now a pending recommendation with the new Director.
DCFS-9	The team recommends that DCFS bring cases to screening at the State Attorney's Office, at least after a second indicated case or an indicated and more than two unfounded.	Staff is required to notify the State's Attorney after 2 indicated abuse cases. Other cases are brought to the State's Attorney's attention based on the dynamics of the case in review with the Supervisor and discussion as needed with legal. This case will be reviewed with staff and they will be reminded that screening with the State's Attorney should be considered a resource to assist with families at risk or in non-compliance. Discussion at Director meeting of 6-29-17: Executive Council would like to add the notification requirement to include 2nd Indicated reports for "Neglect" in addition to the current requirement for "Abuse" cases given

		that they see many serious neglect cases. DCFS will need to review this request further. To add the requirement that DCFS notify the ASA on cases where there is 1 indicated case and 2 or more unfounded cases will increase the volume of notifications significantly (probably thousands) but the Cook ASA indicates they would still like to see this added as a requirement. DCFS will need to review this request further. There was no uniform process in Cook County for notifying the ASA of a 2nd Indicated abuse report. DCFS is working on a form that will be completed on this and the notification to the Cook Co. ASA will be given. October Meeting: Update from DCFS needed on the other types of notifications as cited above. The current notification requirement for sending 2 Indicated Abuse reports will remain. For the other types of notifications mentioned above, DCFS will have a higher level of assessment (the Area Administrator) when families come in with multiple indicated or unfounded reports. The Area Administrator will make the final decision on whether to refer these situations to the State's Attorney. CDRT Manager will do some inquiry as to how other States handle this situation. New Mexico responded that they do not have written policies. October discussion: No further discussion regarding the other types of notifications recommended. For 2nd Indicated Abuse reports, DCFS

		has not yet finalized the form letter to be used in Cook Co. A draft letter was done but it needs additional information/revision. Once this draft letter is completed, DCFS Child Protection Division will send the form letter along with a memo to all staff. Executive Council would like to see a copy of the memo and form letter as well as any feedback that other States provide. December discussion: DCFS will send a memo to Area Administrators reminding them that they need to assess cases where there have been multiple indicated or unfounded reports. DCFS plans to create a form to be used Statewide when referring cases to the ASA.
DCFS-10	The team recommends that DCFS follow up on “Ongoings” and return to screening in a timely manner. Do not incorrectly refer to or code an "Ongoing" case as a "rejection" or failed screening.	When the case is discussed, staff will be reminded of the difference between ongoing and failed and the need to follow up with ongoing status cases.
DCFS-11	Maintain unfounded investigation files in perpetuity for use in subsequent investigations.	This is currently under discussion.
DCFS-12	AA's and RA's should not instruct POS agencies to not call the Hotline, and should allow the taking of Protective Custody when the Investigator and/or the Supervisor feel that children are at risk.	This will be addressed with DCFS Personnel. No one should tell a mandated reporter when to call/not call in a case.
DCFS-13	The Team recommends reassignment of DCFS Liaisons for some teams.	Liaisons are always from the sub region or local office as they have the subject matter knowledge regarding DCFS and the area. Liaisons will be reminded of their role within CDRT. CDRT Manager will draft something to send out after review and approval.
DCFS-14	The team recommendation is that DCFS should not base their finding in an investigation on what an appeal may bring. Define “Blatant Disregard” consistently between parents and other caretakers. The	Further discussion with DCFS Legal is needed. DCFS requests further clarity on this recommendation. Further clarification: The Team is advocating for notification to the State's Attorney's office when there

	team recommends an amendment to ANCRA 325 ILCS 5/7.8. When a case is pending, there is a GAL appointed. Pending cases require notification of the GAL. The current statute is really focused on Cook Co because they have a Public Guardian. In other counties, GALs are on contract and their level of investment varies from GAL to GAL (their priority is their private practice and not cases where they are GAL on that case). In addition to the GAL, the reports should be released to the ASA.	is a pending case of abuse involving a parent who is already involved in an open abuse or neglect case with the court system. Currently, ANCRA is written to only notify the GAL when a new case of suspected abuse occurs. Downstate contracted GAL's may often overlook this type of notification due to a busy private practice. The State's Attorney is kept in the dark about the new, suspected case of abuse, which could affect outcomes in the open court case. In this particular case, the lack of notification lead to the homicide death of the child. If the SA had been notified of the pending investigation, the SA could have filed a petition to remove the newborn infant from the home. As the ASA member put it in the meeting is that foster parents and other caretakers are held to a higher standard than actual parents. Both can have behavior labeled as blatant disregard but that definition is not consistent between actual parents and foster parents. When we discussed this, the DCFS AA concurred that was in fact the case. Whether there is an actual definition difference in the book, how it is applied in the field is inconsistent. Our recommendation is that in real case application, that investigators hold foster parents to the same standard they apply to parents. What is deemed wrong or inappropriate for a parent should apply to foster parents. October discussion: The "further clarification" cited above has not been fully reviewed by DCFS including legal staff. December Meeting: Update from DCFS: Foster parents should be held

		to a higher standard than birth parents. December Discussion: There is agreement that Foster Parents should be held to a higher standard so this portion of the discussion is resolved. The issue surrounding Recommendation 3 still needs to be discussed further. GAL requirements vary between jurisdictions. ANCRA is clear on being cautious on releasing information. ANCRA contains a section on who should be notified. DCFS procedures say to release information to the ASA but ANCRA does not. DCFS will send the section of the Statute to forward to Ex. Council for further discussion.
DCFS-15	Caseworkers need a resource to help them tie all the medical information together on such medically complex cases. They need "real time" help.	Staff has the ability to utilize our Medical Director and/or the medical resource network for that area to assist in receiving "real time" support and direction for medically complex cases. In many instances there is also a local provider who can be a resource to assist and staff should be encouraged to reach out. It is an expectation that our nurses also assist in this realm. There are certain allegations that require consultation. P300.100 talks about medical issues and utilizing the DCFS Medical Director. Foundations training may need to emphasize this issue more. The nursing referral form is also in the process of being revised. Nurses have the ability to enter their notes into a SACWIS case file and are to do so. With the new proposed CCWIS system (SACWIS replacement), DCFS is looking to include the referral form right in the case.
DCFS-16	The team recommends that DCFS review how follow up is done in complex medical issues.	Staff has the ability to utilize our Medical Director and/or the medical resource network for that area to

		assist in receiving "real time" support and direction for medically complex cases. In many instances there is also a local provider who can be a resource to assist and staff should be encouraged to reach out. It is an expectation that our nurses also assist in this realm.
DCFS-17	Nonverbal children involved in a child death should be consulted or evaluated by a child abuse specialist.	DCFS has procedures in place that all children should receive medical exams. This should always be performed by a child abuse physician when available. Staff will be reminded.
DCFS-18	DCFS should have an identified medical resource that is experienced in abuse, neglect and medically complex children. This resource should be contacted immediately to help educate DCP in the medical issues, as well as serve as a resource when there are conflicting medical opinions.	DCFS does have four medical resource networks statewide that staff can reach out to and consult. DCFS Administration is currently working with the Medical Director for MPEEC to enhance these networks and access to them along with creating a clear second referral process to MPEEC. Procedures 300 outlines actions the investigator should take when there are conflicting medical opinions including a discussion with the Medical Director. Nursing referrals are also required whenever there is a medically complex child for consultation and guidance. Child Protection Administration will reinforce via written communication to the field the use of medical experts, resource networks, nursing referrals and utilizing the expertise of the Medical Director when there are conflicting opinions.
DCFS-19	DCFS should provide education to DCFS nurses, DCP, and Supervisors about how to investigate a medically complex child, and allegations of medical neglect.	DCFS Administration is currently working with the Medical Director of MPEEC to enhance the education, consultation, and documentation process for staff and supervisors regarding children who are medically complex or have been seriously physically abused.
DCFS-20	The DCFS Medical Director should be more involved in cases like this.	There are procedures in place regarding consultation with the DCFS Medical Director. This will be

		addressed via a written communication with the field.
DCFS-21	DCFS should not start over and over again with A sequences. With any investigation, whether it is indicated or unfounded, it should remain in the letter sequence.	Unfounded reports are considered to "not exist" within the State Central Register. As such, a sequence cannot build on that. Cases are kept on file according to ANCRA guidelines. State's Attorneys and others have access to those according to ANCRA. Recommendation 1 is determined by statute. Even if there are several unfounded reports, it likely is an indicator that there are some problems within the family. One member likened the issue to a police investigation or arrest. Even though there may not be enough to charge a person, the background information can be very helpful. Director-Can the Executive Council take a formal position on this and send something to DCFS? Once this occurs, the Director can take the issue to the legislature. We may need to do some research and see what other states are doing in this regard. DCFS will have further internal discussion on this matter. DCFS will look further for statutory clarification. Procedures 431 will also be part of the discussion. DCFS will not start over with "A" sequences on families/alleged perpetrators. August 5th is the planned implementation date for this change.
DCFS-22	DCFS should not unfound solely on an undetermined cause of death and a judge's decision. Specific training on these issues should be planned, and invite CDRT team members and Medical Examiner/Coroner staff.	DCFS will conduct Manners of Death training.
DCFS-23	DCFS should not expunge unfounded cases. They should be kept in perpetuity, but only available to DCFS and other POS agency personnel, to the State's Attorney	Cases are held and released in accordance with ANCRA guidelines for reference. State's Attorneys and others have access to those

	when a later case is screened in, and to CDRT for our review.	according to ANCRA. This is determined by statute.
DCFS-24	The team would like more information on the appeal process which is more of a "pre-appeal" process by having the case overturned by the field. Who is involved in this type of discussion or decision (supervisor, AA, RA)?	The general process for Requests for Voluntary Unfounds occurs when an attorney is assigned an appeal and reviews the un-redacted file for the Investigation that is being appealed. If the attorney does not feel that there is sufficient evidence to sustain the Department's burden of proof by a preponderance of the evidence, the assigned attorney will request a recommendation from the Area Administrator as to whether he/she feels the Investigation should remain Indicated or Voluntarily Unfounded. In either case, the attorney fills out an attached form, stating the reason(s) the case should be Unfounded, along with a recitation of relevant facts. The Request is then sent to the Associate Deputy Director DCP, and the Assistant Deputy General Counsel for review. They then review the file. The Assistant Deputy General Counsel considers the recommendation of the Associate Deputy Director DCP as well as that of the Area Administrator before making a final decision as to whether the case should be Voluntarily Unfounded (insufficient evidence to sustain our burden of proof) or Proceed to Hearing. If it is decided that a case should be Voluntarily Unfounded, an email is sent to the Administrative Hearings Unit-Springfield (AHU), the assigned Administrative Law Judge, and the assigned attorney noting the case name and Administrative Hearing Unit Number and that it is being Voluntarily Unfounded. A letter is then generated informing the Appellant that his/her appeal is being voluntarily unfounded. The

		case is then amended at SCR from Indicated to Unfounded.
DCFS-25	CDRT applauds the Department for getting iPhones which will allow Investigators to enter their notes in a timely fashion and aid in making correct decisions and follow up as needed.	No response required.
DCFS-26	DCFS to explain its process in determining how guardianship is established in cases when a parent transfers guardianship. How does DCFS decide if parent/family handles this process via notarized document vs probate court vs juvenile court?	We inform the family of their options, benefits and disadvantages, and they may choose the route to take. We do encourage guardianship be formalized in some cases and do refer families to Extended Family Support as needed. Child victims are assessed ongoing for safety issues and decisions guided by the Department's CERAP policy and dynamics of the case. DCFS should be giving families as much information as possible as to their options, but it is their choice.
DCFS-27	Please describe the process by which a determination is made that an indicated case will not be screened into court. Is this written in procedures or policy anywhere?	Decisions to file a petition/screen into court are based on the dynamics of the case and the safety concerns for the child. The decision requires discussion with the supervisor. Legal can always be consulted. This case would not have been screened by requirement as these were neglect allegations until the sex abuse and the children were not found in this state, so we would not file.
DCFS-28	When an Investigator or worker tells a parent to see a pediatrician, there needs to be follow up to determine if this was done. Further, the Investigator should walk the parent through making the appointment with the doctor or hospital, advise the doctor or hospital that the parent/child are coming and why, and then follow up with the doctor so that the doctor knows that DCFS is involved with an agreement to call back after the visit or if they don't make the visit. An investigation should not be closed until this is	The need to gather medical records, consult with doctors, follow up on any recommendations/directions given is outlined in procedure 300. Investigations should never be closed until all information is gathered and reviewed. There are guidelines in procedure 300 related to observing and viewing children. Staff will be reminded it is not sufficient to simply view a child under blankets in a crib.

	done. Get extensions on cases when the Investigator feels that the child should be seen by the doctor or the doctor has asked to see a child. We have made similar recommendations that were accepted in the past.	
DCFS-29	DCFS should provide greater training for staff on premature babies and growth charts, and how much children should grow if getting proper nutrition. Have Investigators and workers physically examine children who are at risk, like this infant was and document their appearance by photo. Have the growth charts on DCFS phones for reference.	Staff has been previously reminded to utilize internal resources such as the DCFS Medical Director and nurses when there are any medical questions related to a child involved with DCFS. Regional and Area Administrators were reminded of this at the Ops meeting held 12/7/16. In addition the DNET contains information regarding medical issues and failure to thrive that staff can reference at any time.
DCFS-30	Workers and Investigators need counseling services to deal with their trauma. This secondary trauma counseling should be promoted by management. The caseloads of workers and investigators are still too high for them to be able to access this counseling. DCFS should look at and work further to reduce the case loads of Investigators.	Staff has the ability to access services through our employee assistance program or through the union assistance program. In addition, the Department has a debriefing team through our clinical division that can respond immediately for staff suffering from a traumatic event related to work. Administration does not hesitate to dispatch them to assist staff and just offered that assistance regarding a death case. Administration constantly reviews intake, headcount and vacancies to ensure positions are filled at a ratio of 10:1.
DCFS-31	The Team recommends that Investigators get documentation from Primary Care Physicians as to what appointments were made, missed, cancelled, rescheduled, etc. These records should be made part of the investigation to determine whether or not there was neglect or medical neglect.	This case will be reviewed with staff. (Reviewed with staff on 1/13/17)
DCFS-32	When evidence of medical neglect is learned during an investigation, that allegation should be added to the investigation. The situation where a parent never sought medical care or checkups on a child comes within	Investigators have the ability to add allegations during the course of an investigation if evidence is found to support it. With allegations of death, the parent is deemed "culpable" or not for the death-if they are not held

	the definition of medical neglect. In this instance, it most likely contributed to her death. The person mom identified as the pediatrician did not see the child. Should this have been indicated for medical neglect?	liable for the death, it is difficult to indicate them for other allegations related to the deceased child related to the death incident. This will also be discussed with the team investigating this case.
DCFS-33	DCFS Director to reach out to other officials to help improve cooperation with outside entities to get the information that is required per procedures. DCFS should use their administrative subpoena ability to obtain such information.	As stated in the review of the case, DCFS does utilize Administrative Subpoenas on cases within their jurisdiction. If DCFS does not have an ongoing investigation or open case, we have no authority to request records without changes in the law. Local CDRTs can seek the assistance from their States Attorney to follow up on getting information when DCFS did not investigate the death or there is no open case.
DCFS-34	DCFS should make sure that any HIV related case is referred to the DCFS HIV liaison and that there is documented follow up from the liaison.	DCFS will remind investigative staff regarding the HIV liaison and their role and the need to make referrals and document timely within the file.
DCFS-35	Team requests that DCFS Investigators use the CDC tool on the CDC website when doing unsafe sleep investigations. It is uniform and very thorough.	Regarding the use of the CDC form, this was previously recommended by CDRT and it is under consideration.
DCFS-36	Team requests that DCFS send the CDC form to all other coroners throughout the state with a request to coordinate the interviews/investigations done by the coroner with those done by DCFS.	In regards to DCFS sending the CDC form to all coroners, DCFS could possibly do that. DCFS thinks it would be helpful to have a letter formulated by the Exec Council as to why this is so important and to reinforce the DCFS request.
DCFS-37	Team recommends in the event you have a perpetrator that is a minor, there should be a supervisory review of the forensic interview.	The supervisor should review all investigations before final approval, which would include information regarding the Forensic Interview. The ARA will send out a reminder to all supervisors and AA's that they are required to read all documents associated with a case before final approval.
DCFS-38	Team requests DCFS ensure that a Children's Advocacy Center post forensic interview conference takes	The CAC and DCFS will discuss setting up these staffing's. The ARA will remind staff of the importance

	place and that all parties are in agreement.	and need to attend all CAC staffing's.
DCFS-39	Workers and Investigators need counseling services to deal with their trauma. This secondary trauma counseling should be promoted by management. The caseloads of workers and investigators are still too high for them to be able to access this counseling. DCFS should look at and work further to reduce the case loads of Investigators. (Note: This recommendation was made on another case this year.)	Staff has the ability to access services through our employee assistance program or through the union assistance program. In addition, the Department has a debriefing team through our clinical division that can respond immediately for staff suffering from a traumatic event related to work. Administration does not hesitate to dispatch them to assist staff and just offered that assistance regarding a death case. Administration constantly reviews intake, headcount and vacancies to ensure positions are filled at a ratio of 10:1.
DCFS-40	Work with the CACI and other victim advocacy groups to seek a possible legislative fix to amend the Illinois Eavesdropping Statute to allow for child victims and witnesses to have their interviews recorded and for it to not be considered as eavesdropping. Also, DCFS should look at and modify its position that they cannot consent to recording unless they have court ordered Temporary Custody.	This recommendation/discussion needs to be addressed by our Director, legal, and Guardian. Per DCFS Legal, taping conversations is not our decision. Obtaining consent for over hears are very difficult to get. ASA's should push this issue legislatively. Practice on this varies as some ASA's get permission and others just give notification and then conduct the interview. On Protective Custody cases, there can be a lag in getting permission but the Guardian's Office is doing well in responding. There should be ongoing discussion at CACI on this matter. The DCFS Guardianship Administrator cannot exceed the legal authority granted under the various relevant statutes. The Guardianship Administrator cannot legally consent to the taping of the interviews until there is a legal relationship with the child. The legal relationship is established at/after the Temporary Custody hearing.

		DCFS is not legally authorized to consent on behalf of a child who is not in our custody. Nor are we in the best position to evaluate the likelihood the SA can get such an interview into evidence. The ASA position is that they or police or CACs can interview a child without permission but cannot record the child without permission because it violates the eavesdropping statute. The ASA was suggesting they may draft legislation to allow taping of child victims without consent of the parent or guardian. The DCFS position was that we would not give permission until after Temporary Custody.
DCFS-41	When an Investigator or worker tells a parent to see a pediatrician, there needs to be follow up to determine if this was done. Further, the Investigator should walk the parent through making the appointment with the doctor or hospital, advise the doctor or hospital that the parent/child are coming and why, and then follow up with the doctor so that the doctor knows that DCFS is involved with an agreement to call back after the visit or if they don't make the visit. An investigation should not be closed until this is done. Get extensions on cases when the Investigator feels that the child should be seen by the doctor or the doctor has asked to see a child. We have made similar recommendations that were accepted in the past. (Note: This recommendation was made on another case this year.)	The need to gather medical records, consult with doctors, follow up on any recommendations/directions given is outlined in procedure 300. Investigations should never be closed until all information is gathered and reviewed. There are guidelines in procedure 300 related to observing and viewing children.
DCFS-42	Team recommends that DCFS get expedited medical follow up with a board certified Child Abuse Pediatrician for kids in situations like this, when possible. (ER visits to hospitals without a Child Protection team are insufficient as the doctors really don't know what they are	Staff has been previously reminded to utilize internal resources such as the DCFS Medical Director and nurses when there are any medical questions related to a child involved with DCFS. Regional and Area Administrators were reminded of this at the Ops meeting held

	looking for). DCFS should partner with Child Abuse team hospitals to develop a means by which to get these expedited follow up visits. It is already part of Procedures 300 to have siblings of a dead child brought to a hospital that has a Child Protection team when possible. Here, it was possible, as these surviving siblings are in Chicago.	12/7/16. In addition, the dnet contains information regarding medical issues and failure to thrive that staff can reference at any time.
DCFS-43	Send a reminder memo to staff to have a sense of urgency in conducting a scene investigation, preferably with the police but if they delay, DCFS should proceed with the scene investigation on their own.	DCFS has the ability to perform scene investigations and it is within procedures. Staff must be careful not to interfere with any criminal investigation at the same time. DCFS will be conducting an in-depth analysis of unsafe sleep.
DCFS-44	DCFS should tell families that intact family workers are not going to be DCFS workers but private agency workers.	Investigators will be reminded that once known who the intact provider will be, to notify all involved parties including medical providers. In addition the investigator will identify if the services are provided by DCFS staff or a private agency partner. Private Agency partners are required to follow all DCFS rule and procedure.
DCFS-45	On cases like this, the investigator needs to tell medical providers that DCFS, while indicating the case, will no longer follow the case and the medical providers must be the ones that follow up and call it back in if there are issues.	Investigators will be reminded to ensure they explain their role to all providers.
DCFS-46	DCFS should clarify with medical personnel or reporters that PC doesn't have to be taken on every case and that an order of protection can be sought with the children remaining in the home. This would be monitored by DCFS or a POS agency.	When considering protective custody or protective orders, the investigator will ensure the difference is explained to all parties.
DCFS-47	DCFS should have an in-house medical expert in addition to nursing, to handle medical neglect cases in general, to determine risk to the child if NOT removed from the parent's care, and DCFS should	DCFS has a Medical Director who can be consulted on all cases involving medical neglect and/or medical issues to assist the investigator in determining and making safety assessments regarding a child. Staff have previously been

	review this case in terms of what nursing did or didn't do.	reminded of the ability of the medical director to consult on cases. This case will be given to the clinical division to review and address with nursing staff.
DCFS-48	DCFS should develop specific supervision policies as well as appropriate safety devices for foster homes and daycare homes regarding pool safety.	Pending
DCFS-49	DCFS should look at the use of safety plans in unsafe sleep cases to make sure procedure is followed and the trauma of children removed is considered when assessing the decision.	The use of safety plans will be discussed along with evidence to support an indicated finding.
DCFS-50	If one of the parents has a documented history of drug or alcohol abuse, DCFS should request a drug drop immediately.	DCFS has the ability to request a drug test based on the dynamics of the case. This case will be reviewed with the team along with the importance of requesting toxicology screens when the specific dynamics identify the need.
DCFS-51	Although there was a nursing assessment by DCFS, when you have a kid with medical needs, there needs to be access for the agency to have comprehensive medical case management or they need to be referred to an agency that has medical resources, or consider specialty intact contract for medical. Further, there should be a medical presence at the transitional visit to highlight the medical needs and follow up agency. The medical specialty could have assisted in assessment of failure to thrive of the siblings and whether or not mom's care was a contributing factor.	Pending
DCFS-52	DCFS should keep death case investigations with a Priority One/Serious Harms Team. The investigator in the C sequence was inexperienced.	Pending
DCFS-53	DCFS should not allow criminal case services or supervision to substitute for DCFS/child protection court supervision and services. In this case,	Pending

	mother was court ordered for services in a DUI criminal case and DCFS did nothing further. If she had been receiving child protection services and supervision, this child may not have died.	
DCFS-54	DCFS should use their existing "undetermined" category in situations when a family or necessary witnesses cannot be located or are uncooperative, when needed records are unavailable, when the passage of time would have allowed injuries to heal or witness coaching to occur, or when the investigator otherwise cannot gather enough evidence to truly make an "unfounded" determination.	When such situations arise and a family cannot be located, the basic information in any unfounded report is still available and should be reviewed when any new investigation comes in. DCFS currently has procedures for diligent searches. If, after a diligent search provides no useful information, DCFS staff can contact their Regional Counsel and seek access to the County Clerk's Database. Keeping unverified information beyond any legal requirement is a violation of a person's civil rights.
DCFS-55	DCFS work to increase the number of staff that has access to the County Court Clerk's database.	DCFS staff can contact their Regional Counsel and seek access to the County Clerk's Database.
DCFS-56	Consider adding an item in the home safety checklist that specifically asks if window blind cords are safe for kids.	DCFS will look and see where it can possibly be added in as a factor. DCFS did find a place to put this in the current Home Safety Checklist along with fastening heavy furniture to the wall to prevent "tip over". Once this is done, it will go to the Policy Unit to put into procedure and modify the forms. The bigger question is whether or not families are really getting educated on items on the Home Safety Checklist. Over the years, many tasks have been added to front line staff and are they really able to do it all? Perhaps a time study should be done on this matter and caseload sizes should be adjusted so staff can do all they are required to do. Are staff and families being set up to fail given all the requirements for workers and the question if they have time to do it all? This item was in the Intact and Placement Home

		Safety Checklists but not the DCP one. This item will be put in the DCP Home Safety Checklist.
DCFS-57	Daycares should allow random, unannounced visits as a condition of their licensure. DCFS Licensing should make random, unannounced visits.	Pending
DCFS-58	DCFS should not rely exclusively on ME/Coroner manner of death to determine the indicating or unfounding of cases.	DCFS will be conducting Manner of Death Trainings for staff. These trainings will remind staff to not rely exclusively on ME/Coroner manner of death to determine the indicating or unfounding of cases.
DCFS-59	CDRT has previously made the recommendation to explore automatic voluntary drug testing with an instant test performed in the field for all death cases. Since unsafe sleep death cases continue to make up a large portion of our CDRT cases, we believe that this testing would help us further understand whether or not drug use is a contributing factor in these deaths. We recommend that DCFS explore other states that use automatic drug testing to determine the efficacy of it and how it may help us understand unsafe sleep dynamics (to better educate the community).	Police have the ability to do drug/alcohol testing if it is warranted. Additionally, DCFS has the ability to send individuals for such testing if a situation warrants it.
DCFS-60	DCFS to clarify the ability of staff and the procedures by which they should access Facebook and other social media systems for investigative purposes.	Policy Transmittal 2015.19 was issued on 7/2/15. The purpose of this Policy Transmittal is to issue revisions to Administrative Procedure 20, Electronic Communication and Distribution, and form CFS 123-1, Facebook Site Contact Agreement, which are needed to ensure that staff responsibly uses social media in a way that does not compromise confidentiality. The Department's Office of Information Technology Service (OITS) is setting up Department Facebook (FB) accounts for staff to use in the furtherance of their duties.

		Each office will have a unique FB account, which will be maintained by site contact individuals designated by OITS. Each office's FB account will be activated after OITS has received the CFS 123-1, Facebook Site Contact Agreement, from the designated contact person. Department social media accounts may only be used by authorized staff. Each Department social media account will be monitored by an individual site contact person, who will be designated as such by OITS. Each site contact person for a Department Facebook account must sign as CFS 123-1, Facebook Site Contact Agreement. DCFS will send a reminder to staff reminding them of the process for obtaining Facebook Access. The CDRT Manager will check with OITS to see if every office has access. Per OITS, there still needs to be some discussion regarding social media policy as it's not fully in place. December Discussion: This is still not resolved as DCFS does not have clear instructions for workers on how to best use social media to help in their investigation and casework practice. Many police officers who utilize social media have an alternate account they use (not their personal one). Worker safety is important so this needs to be factored in when coming up with a resolution.
DCFS-61	DCFS to pass the issue on to consumer product safety to seek to have additional safeguards on hot water heaters so they can't be turned up easily (a "retro-fit" would need to be developed for existing water heaters). The high limit on water safety should be at a safer level.	DCFS currently gives out a handbook that discusses safe water temperature for children. Safe water temperature is also on a home safety checklist that workers complete with a family.
DCFS-62	DCFS to pursue legislation that will require landlords to monitor and regulate water heater temperature at	DCFS responds that this area does not fall under DCFS area of expertise.

	a safe level. This could be done at an annual inspection by landlords.	
DCFS-63	DCFS to test hot water temperature when they go out to a home (it should be tested at the faucet nearest the water heater).	DCFS monitors temperature of hot water in foster homes and day care homes and centers. DCFS currently gives out a handbook that discusses safe water temperature for children. Safe water temperature is also on a home safety checklist that workers complete with a family.
DCFS-64	Team recommends as a matter of rules, if there are 2 or more indicated reports as matter of procedure, medical and psychiatric releases are to be signed. If there is a known psychiatric disorder, a release is mandatory in any investigation.	Current procedures need to be followed regarding Administrative Subpoenas. If there is difficulty in getting compliance, staff can contact their Regional Counsel and/or the Inspector General's Office.
DCFS-65	Team recommends that the Attorney General's Office validate the Department's Administrative Subpoena Process.	DCFS stated that the AG will enforce non-compliance with Administrative Subpoenas but they should only be used as a last resort. Investigators have various "tools" (including the attached CFS 600-5) that they should be using to get information related to their investigation.
DCFS-66	DCFS to require intact workers to have regular (monthly?) contact with local police to get updates on any new police contacts with the family. Release forms should be obtained from the family to allow this.	Investigators need to be diligent on following up on Administrative subpoenas.
DCFS-67	DCFS support a universal reporting system that all child deaths be called into the hotline (except kids who have been on hospice). This may require a change to the mandated reporter act.	DCFS does not support this recommendation. If any professional involved in investigating a child death suspects abuse or neglect, the Mandated Reporter Act requires that they call the Hotline to report such abuse.
DCFS-68	Educate DCFS staff on screening procedures (particularly in regards to rescreening cases and that a new investigation does not need to occur for rescreening).	DCFS staff will be reminded on screening procedures.
OS-1	Chairperson to write a letter to the hospital asking that they conduct a quality assurance review of this case.	Approved. Letter sent to the hospital on 9/2016 with the request.

OS-2	Team requests that a letter be sent to the States Attorney and Law Enforcement to remind them to contact DCFS right away by calling the hotline in all death cases.	Approved. Letter sent to the States Attorney and Law Enforcement.
OS-3	Team requests the case be reviewed by the board of the Southern Illinois Child Death Review Task Force.	Agreed.
OS-4	Have another coroner look at the report to review the findings (redacted report). Team Chair will ask Executive Council for another coroner to review the redacted report. CDRT Manager will then forward the redacted report to that coroner for review. Then possibly have the CDR Team request that the coroner's office conduct a review of the cause of death in relation to the documented injuries. The injuries suggest compression injuries as opposed to suffocation.	Approved. A coroner reviewed the report and the Team Chair sent the letter with the request to review the cause of death. Completed 11/2016.
OS-5	Team requests that letters be sent to the first responders, hospital and the police department reminding them to call the hotline.	Approved. All three letters sent 8/2016.
OS-6	CDRT should write a letter to the hospital regarding this case.	This case will be reviewed with the investigative team and remind them that perpetrators and allegations can be added to a report in the field. Review will be completed by 2/15/17.
OS-7	Team recommends a letter be sent to the hospital to look at this case internally for review and possible further training.	Approved. Chairperson sent the letter to the hospital. Completed 11/2016.
OS-8	Team will write letters to the Coroner and physician in reference to the Cause and manner of death.	Coroner called in for meeting of 11/18/16. The coroner explained the coroner process and his justification for the decision of cause and manner of death. The team decided that the purpose of the letter to the coroner was to inform and understand the coroner process and this was accomplished by the discussion. Thus the letter to the Coroner does not need to be sent

		out. The letter to the Physician will be sent.
OS-9	CDRT send a letter to Medical Examiner/Coroners in Illinois asking them to document on Death Certificate and in the Autopsy if there was "Unsafe Sleep Circumstances Involved". This will help with data and make it easier to plan further preventative efforts.	Approved 10/2016.
OS-10	Public Health should partner with DCFS to target young parents in the high risk areas (by zip code) and focus education and prevention efforts there.	In addressing SR1941, which is to consider moving CDRT Administration to the Department of Public Health, the relationship with DPH has been greatly enhanced. The formal response to the Senate will further solidify this relationship.
OS-11	The team wishes to speak to the ME to discuss consistency in cases on determining accidental or undetermined.	Council approved 2/2017.
OS-12	The task force is reaching out to some local departments seeking staff to join the task force. The Team Chair will contact the task force to follow through on reaching out more to get greater task force involvement.	Council approved 5/2017.
OS-13	Team members will have a conversation with medical personnel about how this could have been handled better.	Approved 11/2016.
OS-14	A letter should be written to the Department of Pediatrics to review how the case was handled and if there should have been greater follow-up when mother missed so many appointments.	Approved 5/2017.
OS-15	Team Chair and Vice Chair to write letter to physician.	Approved 7/2017.
OS-16	CDRT to send a letter to the hospital to review how this case was handled and do an internal review, particularly in regards to contacting DCFS timely.	Approved 9/2017.
OS-17	Team recommends that when the police are called out to a home and an investigation is conducted, a call should be made to DCFS.	CDRT Executive Council can write to organizations that do not comply to reiterate the need for this information.

OS-18	Have the Team send a letter of commendation to the Child Death Task Force Leader.	Approved 9/2017.
OS-19	CDRT will write a letter to the Coroner's Association, even accidental deaths should be called in to check on the need for services for the family.	Approved 10/2017. Letter written 11/2017. Complete.
OS-20	CDRT team will send a letter to the Police Department and the local hospital due to the case not being called in.	Approved 10/2017. Letter written 11/2017. Complete.
OS-21	Look at expanding the Southern Region Child Death Task Force concept to Central Region and/or other parts of the State.	Pending
PP-1	Consider more aggressive campaign to target unsafe sleep issues such as doing a "radio road block" to address safe sleep practices. Also look at trying to get out notices or alerts on cell phones. Partner with Public Health to get this out.	DCFS is actually very aggressive and called TV and radios stations asking them to play the recorded audio and video PSAs. Here is what we are up against: 1. Broadcasters are no longer required to run PSAs to fulfill an obligation to operate in the public interest. Tough economic times have reduced the size and budgets of newspapers and magazines. Competition for PSA space is fierce, so you can't be certain your PSA will be used. Newspapers and magazines often use PSAs to fill in only when advertising is cancelled which is not often. 2. Here is what we are up against in TV: Television is the most in-demand PSA medium so therefore it's the most competitive and often TV stations already have charity partners like Special Olympics, Fire Departments and Wounded Warriors. They often dedicate PSA time to their charity partners and consider it part of their marketing budget. Both

		television and radio PSAs are unlikely to be broadcast during prime time. Many PSAs are shown in the very early morning hours when viewership is at its lowest. Last year, DCFS called the top radio stations downstate and asked them to play our Safe Sleep message. Only one of them agreed. We called the Community Relations Directors for each TV and top radio station in Chicago. The only one who got back to DCFS was ABC 7 Chicago and they said no as they already have charity partners. Radio told us to buy airtime but said sometimes they will play it if they need to fill air.
PP-2	Consider more aggressive campaign to target unsafe sleep issues such as doing a "radio road block" to address safe sleep practices. Also look at trying to get out notices or alerts on cell phones. Partner with public health to get this out. (Note: This recommendation has been made on another case review this year.)	The previous recommendation and this recommendation are the same. The DCFS response given for the previous recommendation also applies to this recommendation.
PP-3	Propose partnership with Safe Haven. More public service announcements concerning safe haven given to state universities, colleges and high schools.	DCFS has not typically done these PSAs. Save Abandoned Babies Foundation has done some things in the past. They have put some posters in bus stops in Cook County. This organization has brochures and pamphlets. DCFS also has brochures available for the public. The Executive Council should contact the Save Abandoned Babies Foundation to pursue PSAs for this. DCFS can order brochures for distribution by the CDRTs.
PP-4	Ask DCFS and IDPH to draft a letter to educate hospitals, nursery and nurse managers to specifically ask if families have a safe sleep bed when leaving the hospital. The hospital needs to know that DCFS is	There should be local resources that families can go to for this as well. DCFS will check with local hospitals to see what resources they are able to provide and work further on this, perhaps creating a list. We will seek written protocols from hospitals on

	able to provide pack and plays if the need arises.	their resources and see if they ask new parents about having a safe sleep bed. Once more information is gained as to resources available, DCFS will determine its role in providing pack and plays to persons not involved with the Department.
CS-1	Team request DCFS review this case. DCFS should have obtained the medical records from the ER/hospital that mother repeatedly took the child to. Mother should have been investigated for medical neglect. Child started having seizures 3 years prior to death, seized 3-4 times a month, moms only response was taking her to the ER.	This case will be reviewed with staff.
CS-2	DCFS look at this case and how it was handled. DCFS should review the case to determine why there wasn't supervision on the case to ensure that the safety plan was being monitored. Record shows there were only 2 safety assessments in the 5 month period.	Agree. This case will be reviewed with staff.
CS-3	DCFS should look at this case and how it was handled.	This case will be sent to the RA for review. This case will be reviewed also by the intact Utilization Unit.
CS-4	DCFS should look at this case and how it was handled. There were many risk factors that created an Environment Injurious and Substantial Risk of Injury not only for the deceased child, but for the surviving siblings. For example, mother allegedly was developmentally delayed, but this was not corroborated. Mother didn't know what medications she was on, had major health issues, "anxiety" and deferred most questions to her mother (MGM). MGM had a history of domestic violence and other criminal behavior. MGM was primary decision maker/caretaker for her three grandchildren. However, there was no PCP for the decedent or other children aged 2 and 4. MGM said alternately that the	This case will be reviewed with staff. Review to be completed by 2/15/17.

	baby was "diagnosed" with bronchitis, or asthma, even though this is an unlikely diagnosis for a small infant, the baby hadn't been to the doctor (even to get immunizations) and there was no evidence of asthma at autopsy. Further, MGM allowed the mother and her boyfriend to co-sleep with the baby in their bed. The boyfriend is a self-admitted marijuana smoker and mother said that he smoked regularly. More importantly, the doctor at the hospital where the baby was brought was "adamant" that father reeked of marijuana and appeared under the influence. The boyfriend disappeared during the investigation. He is currently charged with felony weapons and cannabis offenses. There is every reason to believe that boyfriend will come back as he recently purchased a home for mother and MGM with a "settlement" that he won. Finally, mother was only 20 but had three children, the oldest being 4. These children are currently in an Injurious Environment. Mother, father and MGM should have all been indicated for Death by Neglect, and for Allegation 60.	
CS-5	Team requests DCFS look at this case. Why was this case not indicated for torture? DCFS investigators should consider the allegation of torture. Just because an allegation of 1 or 51 is indicated does not or should not exclude other allegations.	The factors and evidence is assessed independently for all investigations. Allegations can be added by the field when they are supported by the information and warranted. Staff will be reminded of their ability to add/change an allegation in the field.
CS-6	DCFS should look at the case and how it was handled, in that the live-in paramour, who was caretaker for the child, was not investigated or indicated even though he is the one who took the child off his seizure medication.	This case will be reviewed with the investigative team and remind them that perpetrators and allegations can be added to a report in the field. Review will be completed by 2/15/17.
CS-7	DCFS to look at how the case was handled and why a DCFS nursing	Case will be reviewed with the team within the next 30 days. Investigators

	referral was not made. Also why did DCFS not indicate for medical neglect on this case?	have the ability to add an allegation when the evidence supports. For death cases, the parent is "culpable" for the death or is not. If medical neglect was associated or cause for the death, then the death allegation should be indicated for 1/51 rather than a medical neglect allegation.
CS-8	DCFS should look at this case and how it was handled. DCP did not speak to surgeon, did not get medical records, did not have a clear understanding from the DCFS nurse as to why it was stated that mother was not neglectful.	This case has been discussed with the involved staff.
CS-9	DCFS should look at this case and how it was handled, in that the case was not screened in earlier.	This case will be reviewed with staff.
CS-10	Team requests DCFS review the case and how it was handled. Team concerned that a 13 month old, even if developmentally delayed, would have been capable of some independent movement, and would not have just fallen out of bed and died.	The case will be reviewed with staff by 4/15/17.
CS-11	DCFS should look at this case and how it was handled. In an otherwise well-handled investigation, there was an opportunity to track down the mother of the perpetrator/father's other child, in accordance with DCFS policy, to apprise her of the abuse he was indicated on.	Agreed. DCFS will remind staff to include notification to non-involved parent. SCR will be reminded to ask about other children that may be involved. Update: This was discussed at the Operations meeting on 12/7/16.
CS-12	Team requests that DCFS reach out and educate the school staff. Notify the state board of education to say they cannot obstruct calling into the hotline. Also need to ask the hospital to do a review of the situation.	The Director will discuss with ISBE, when meeting with them, that they can always utilize the Hotline as a resource for guidance and direction if they are not sure an incident rises to the level of abuse/neglect. DCFS is asking that the Executive Council notify or send a letter to the State Board of Education in regards to this recommendation. Executive Council will send the letter.
CS-13	DCFS to look at this case and how it was handled. Why was this not screened in to court after 3 indicated findings in short order? In this	Pending

	specific case, children have now spent years in the care of maternal cousin and her husband in Louisiana, but it is unclear if those caregivers have any true legal rights or responsibilities. There is a concern that Mom could travel to Louisiana, pick up the kids, and assert her parental rights.	
CS-14	Team requests DCFS look at this case and how it was handled - when the mother stated that the minor saw a certain Primary Care Physician, but that PCP denied having her as a patient, no follow up was done.	This case will be reviewed with the Area Administrator, Supervisor and team.
CS-15	In a case where a newborn exposed to a blood borne illness in utero was immediately upon birth the subject of a DCFS investigation, neither DCP nor the intact family services agency followed up to determine whether the baby was receiving the necessary anti retro viral treatment required for the first weeks of life. DCFS to review the case regarding the lack of addressing these medical concerns because it is unclear whether or not the case should have been indicated/investigated for medical neglect. The Intact Agency should review the case to address the same lack of follow up on the blood borne illness treatment concerns and the required blood borne illness treatment.	Case was reviewed –at the time of this investigation; the child was not born with any illness and released from the hospital. Intact services were put into place. The child died later of natural causes. Medical neglect does not appear to be an appropriate allegation for the A sequence investigation. While the mother engaged in unprotected sex and had different medical conditions, according to the file, the child was not born with any condition, and medicine was acting as a prophylactic. It would be difficult to say this was medical neglect. The Intact Utilization Manager will review this case with the intact agency and review procedures regarding the need for follow-through with the HIV coordinator and nursing referral.
CS-16	Team requests DCFS review the case and how it was handled.	Case will be reviewed with staff within 30 days.
CS-17	DCFS to look at the case and how it was handled, in that the investigator was unaware of mother's Child Endangerment conviction, or that the children under age two (a one year old and a 9 month old) needed to be seen by a doctor more than once in the first 2 years; or not checking a photo ID for dad to confirm birthdates, and not seeming	We continually work to strengthen our relationship with pediatricians and other stakeholders. Education specifically on child abuse/neglect aspects is a known issue and we continue to address it. CDRT Teams could support this also-possibly create a "joint letter"? The Executive Council will draft a letter and provide it to DCFS. It would be

	to be concerned that there was no running water despite 7 people and 5 minors residing in the home, which had been condemned.	good if doctors and other professionals had to take mandated reporter training-this could possibly be an area where Ethics Training Credit is given as Ethics is an area where little training is available. DCFS cannot take on the responsibility for educating every public entity. It is suggested that CDRT go through the American Medical Association or American Pediatric association to help train and require Mandated Reporter training for doctors. (Side note: DCFS has made Mandated Reporter training available on-line).
CS-18	DCFS to review the case and supervisory oversight to look at the criteria by which they unfounded the case. Identified risk factors include that the parents were drinking and that the 6YO could not wake the mom. Was the prior history considered? Further explore the opinion of the ME in determining the finding on the case.	This case is being reviewed with all parties and chain of command that "touched" this case. Decision making based on ME findings will be discussed. Case review to be completed with all parties within the next 30 days. This was reviewed with staff on 8/1/17.
CS-19	DCFS should review this case and how it was handled, in that the Investigator had not reviewed the earlier medical neglect investigation, had not considered screening the case for an order of protection, and relied on one medical professional who opined that there was medical neglect, but "the child shouldn't be removed" from mother.	This case will be reviewed with involved staff. Review to be completed by 4/15/17.
CS-20	Team requests that DCFS review how this case was handled.	Agreed. This case was reviewed with the Regional Administrator and is being addressed. The Director would like to make drug testing a requirement in many situations like this. There is a current OIG investigation on this case.
CS-21	DCFS should look at this case; in an otherwise very well handled investigation, DCFS should be indicating the case for risk of harm to the sibling during visits with mother. If a parent has a child on a	Pending

	visit and there is a situation where there is risk to a child, this should be indicated.	
CS-22	DCFS to look at this case and how it was handled. In this case there was no follow thru in assessing mom's mental health and her capability to care for her 4 children. Because there was not a true assessment of her mental capacity, how could the mother develop an implementable care plan? A parenting assessment could have been recommended.	Pending
CS-23	Team requests DCFS look at the case and how it was handled. The B sequence could have been screened in, as mother had only unofficially let dad have custody of the other children, which could be changed at any time. Further, the C sequence should have been indicated and screened in. Mom saw a bruise on the baby's cheek after the baby was in boyfriend's care two days before baby was murdered, the kids told her that he was hurting them and she admitted knowing that the boyfriend "played rough" with the kids.	Pending
CS-24	If there are 2 investigations within the same home, they should be assigned the same investigator. This case needs to be looked at how it was handled. This child should have seen a specialist. These 2 cases should have been assigned to the same investigator.	This case will be reviewed with staff.
CS-25	DCFS to review this case in regards to the 2nd investigator's review of the first investigation and examining all medical aspects.	Agreed. DCFS will review the case.
CS-26	DCFS to look at this case and how it was handled. In a case where a minor (now murdered as a result of having been likely sex trafficked) made a positive disclosure of sexual abuse in a VSI and then another subsequent positive disclosure of sexual abuse to a therapist, she was not provided a second VSI. DCFS	Agreed. DCFS will review the case. The CAC Protocol was recently updated. DCFS will seek the best interest of each individual child first and will seek to have a VSI done in all cases like this.

	should review with involved staff why protocol to conduct a VSI on any outcry of sexual abuse was not followed and the biases at play in this case as to the minor's credibility.	
CS-27	The case be reviewed to make sure staff are aware that a scene investigation needs to be done (using a "bean bag" baby may be helpful as they are easier to position and are not very "lifelike" as it doesn't evoke an emotional response-possibly ask the Simulation Lab to look at this). DCFS should use the SUDI form in their investigations.	DCFS agrees that the case should be reviewed with the involved staff and supervisor. DCFS will explore the possibility of using "bean bag" dolls. DCFS will not use the SUDI form on cases as they should be done by the local coroner (this was a prior recommendation addressed by DCFS).
CS-28	DCFS to review the intact case to see how it was handled.	DCFS agrees and has reviewed this case. There clearly were some missteps on this case which were addressed over a year ago when this case was reviewed internally.
CS-29	DCFS to review the case in regards to the repeated unfounded investigations.	Agreed. DCFS will review the case.
CS-30	DCFS to look at how the case was handled in that: 1) why the case was not opened to intact initially; 2) why the case was not returned to screening; 3) why the case was not screened for several months since the case came in; 4) why the case was not screened in after mom refused intact services and had a newborn child who may be at risk (child may have a congenital condition that the mom and the deceased child had).	DCFS agrees to look at how the case was handled in that: 1) why the case was not opened to intact initially; 2) why the case was not returned to screening; 3) why the case was not screened for several months since the case came in; 4) why the case was not screened in after mom refused intact services and had a newborn child who may be at risk (child may have a congenital condition that the mom and the deceased child had).

Chapter 3: Illinois Child Deaths in 2016

What do we know about the child deaths that occurred in Illinois during 2016?

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 (51% in 2016) 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 2016, there were 1,487 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.

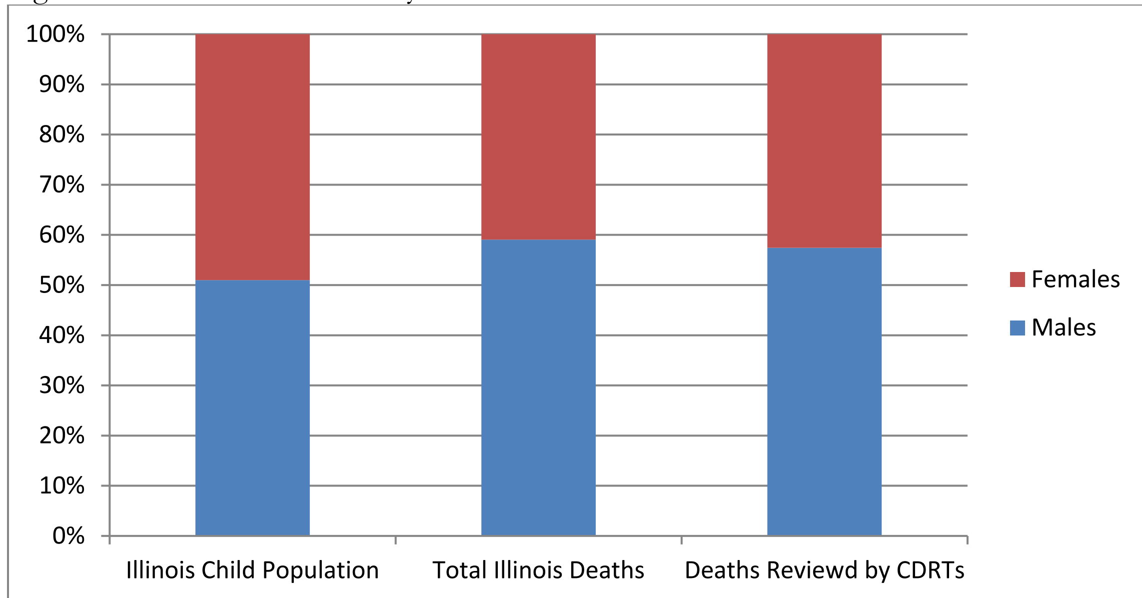
- The CDRTs reviewed 256 child deaths that occurred in 2016: 130 of these were mandated for review and 126 were discretionary reviews.

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 59% of total child deaths in 2016. Deaths of boys were also more likely to be reviewed: 57% of reviewed deaths were boys in 2016 (see Figure 3).

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

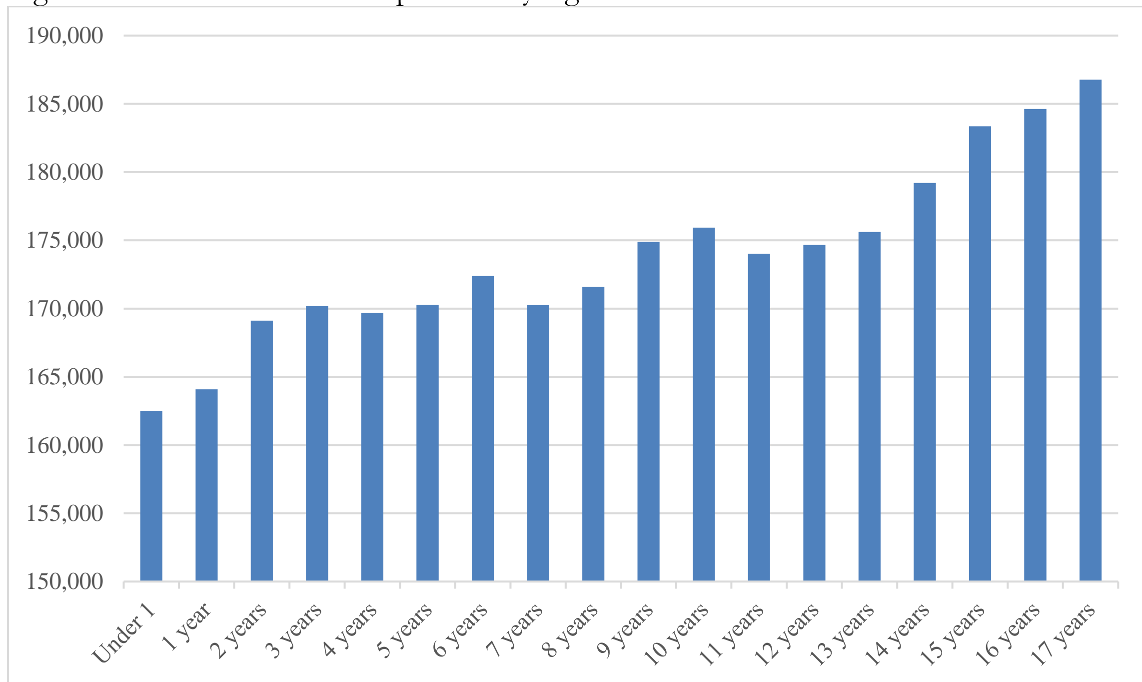
Figure 3: Illinois Child Deaths by Gender



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

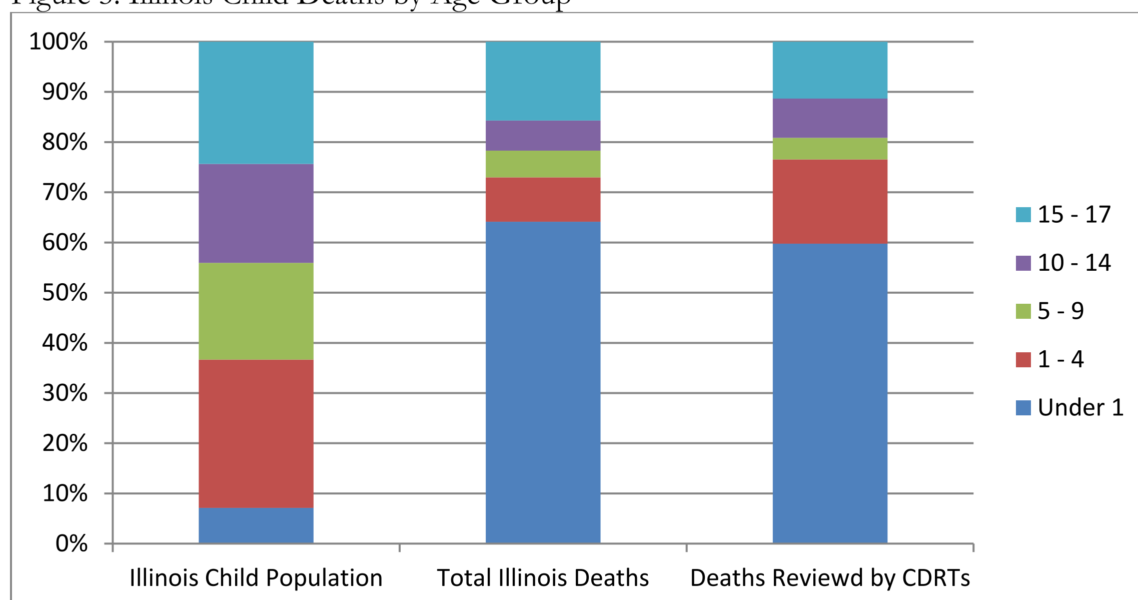


[6] U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from http://factfinder.census.gov/

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 2016 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 2016, 9% of the total deaths were children between 1 and 4 years, 5% were children between 5 and 9 years, 6% were children between 10 and 14 years, and 16% were between 15 and 17 years.

When we examine the deaths reviewed by the CDRTs by age group (see Figure 5), infants under one year are again over-represented; they comprised 60% of reviewed deaths in 2016. Children between 1 and 4 years make up 17% of reviewed deaths in 2016. Older children make up a smaller portion of reviewed deaths: 4% were for children aged 5 to 9 years old, 8% were for children aged 10 to 14, and 11% were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race

In 2016, 66% of children in Illinois were White, 16% were African American, 5% were Asian, and the remaining 13% were of other races (see Figure 6).[7] Although the CDRT has information on race, it does not have information on ethnicity. Therefore, the report is only able to provide data for race with the following categories: White, Black, Asian, and Other.

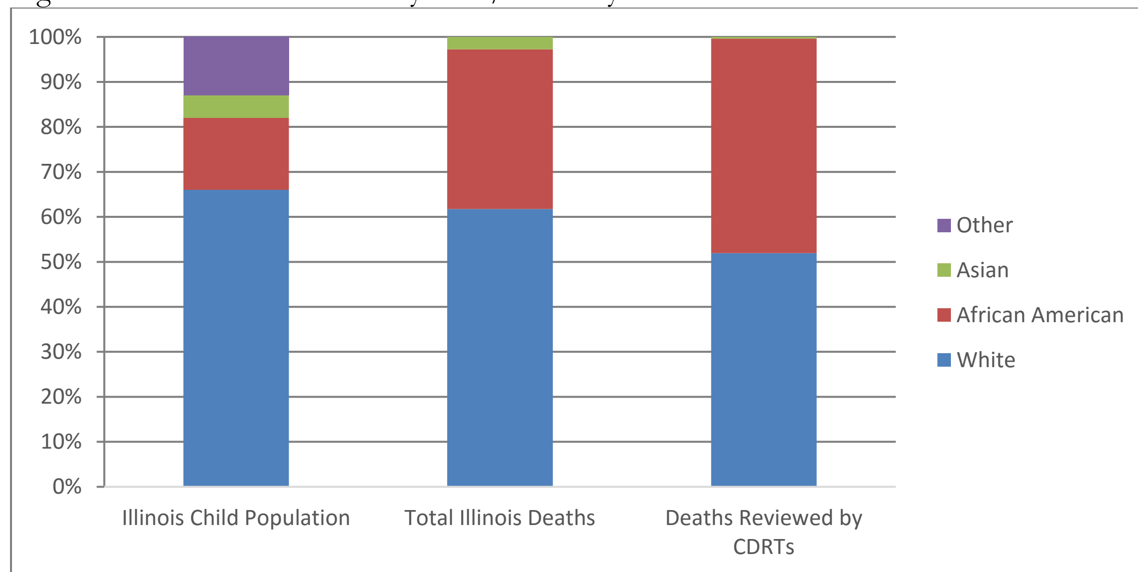
When we examine the total Illinois child deaths by race, it is evident that African-American children are at higher risk of death when compared to their numbers in the general population: 36% of the children that died in 2016 were African-American, yet they only comprise 16% in the general child population. The proportion of deaths among Caucasian children (62%) was slightly lower when compared with their proportion in the general child

[7] U.S. Census Bureau. (2017). Children characteristics 2012 – 2016 American Community Survey 5-year estimates. Retrieved from https://factfinder.census.gov/bkmk/table/1.0/en/ACS/16_5YR/S0901/0400000US17

population (66%). Asian children made up less than 3% of deaths, and they comprise nearly 5% of the general child population in Illinois.

Among the 256 child deaths reviewed by the CDRTs in 2016, 48% were African American children, which is larger than their proportion in the overall child population (16%) and the total child deaths that occurred in 2016 (36%) (see Figure 6).

Figure 6: Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

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

Categories for child deaths that occurred in Illinois in 2016 are shown in Table 2. The majority of total child deaths were related to either premature birth (35%) or illness (33%). The other categories included firearms (7%), suffocation (7%), undetermined (6%), vehicular accidents (6%), injury (2%), drowning (2%), fire (1%), poisoning/overdose (<1%), SUID (<1%), 2 cases of scalding burn, 1 case of SUCD, and other types that accounted for less than 1% of the total deaths respectively.

The CDRTs are far more likely to review certain categories of child deaths than others (see Table 2). In 2016, deaths reviewed by CDRTs were most likely to be undetermined (25%), suffocation (24%), and illness (18%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Prematurity	526	35%	5	2%
Illness	488	33%	47	18%
Firearms	106	7%	15	6%
Suffocation	97	7%	62	24%
Undetermined	85	6%	65	25%
Vehicular	82	6%	11	4%
Injury	28	2%	14	5%
Drowning	24	2%	18	7%
Fire	18	1%	3	1%
Poison/Overdose	13	<1%	5	2%
SUID	12	<1%	7	3%
Other	4	<1%	2	<1%
Scalding burn	2	<1%	2	<1%
SUCD	1	<1%	0	0%
Pending	1	<1%	0	0%
Total	1487	100%	256	100%

Child Deaths by Manner

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

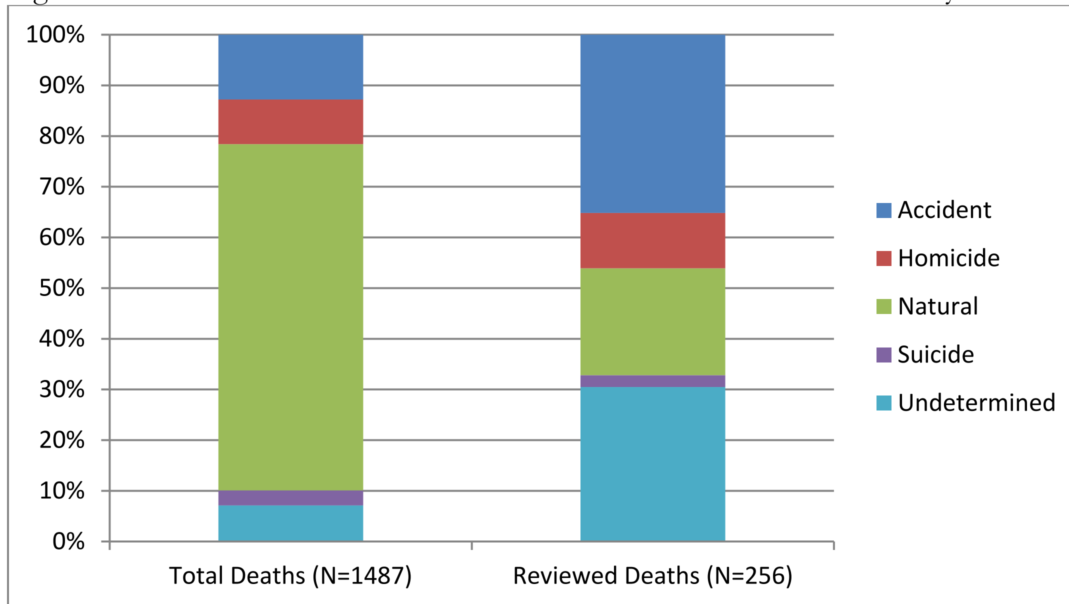
- Natural – the death was a result of natural causes such as illness, disease, and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death
- Suicide – the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

The majority of total child deaths in 2016 were attributable to natural causes (68%), and accidents accounted for 13% of the total child deaths. In addition, 9% were homicides, 3% were suicides, and 7% were undetermined. The majority of deaths reviewed by CDRTS were due to accidents (35%), undetermined (30%), and natural causes (21%). The rates of reviewed deaths from homicides (11%) or suicides (2%) closely matched the proportions from all deaths reported in 2016 (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	190	13%	90	35%
Homicide	131	9%	28	11%
Natural	1016	68%	54	21%
Suicide	44	3%	6	2%
Undetermined	106	7%	78	30%
Total	1487	100%	256	100%

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



Child Deaths by Category and Manner

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

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

Category of Death	Manner of Death					
	Accident	Homicide	Natural	Suicide	Undetermined	Totals
Prematurity	0	0	524	0	2	526
Illness	0	1	486	0	1	488
Firearms	2	87	0	14	3	106
Suffocation	60	6	0	27	4	97
Undetermined	0	0	0	0	85	85
Vehicular	78	2	0	2	0	82
Injury	4	22	0	0	2	28
Drowning	23	0	0	0	1	24
Fire	9	9	0	0	0	18
Poison/Overdose	11	1	0	1	0	13
SUID	0	0	5	0	7	12
Other	2	2	0	0	0	4
Scalding Burn	1	1	0	0	0	2
SUCD	0	0	1	0	0	1
Pending	0	0	0	0	1	1
Total	190	131	1016	44	106	1487

Special Analysis: Homicide Deaths

There were 131 homicide deaths out of the 1,487 deaths in 2016, and we know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. The majority (64%) of homicides were youth age 15 to 17 years old, and an overwhelming majority (79%) 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 of Death	Age	Circumstance	Perpetrator	Race
Firearm	0	Complications of extreme prematurity emergency cesarean section delivery gunshot wound(s) to mother.	Unknown	African American
Firearm	3	Multiple gunshot wounds	Unknown	African American
Firearm	3	Shotgun wound of the head	Unknown	White
Firearm	10	Multiple gunshot wounds	Unknown	African American
Firearm	11	Gunshot wound to the chest	Unknown	African American
Firearm	13	Gunshot wound to the back	Unknown	White
Firearm	14	Gunshot wound of the chest	Unknown	African American
Firearm	14	Gunshot wound of head	Unknown	African American
Firearm	14	Gunshot wound to the chest	Unknown	African American
Firearm	15	Multiple gunshot wounds	Unknown	African American
Firearm	15	Gunshot wound to head	Unknown	African American
Firearm	15	Gunshot wound to the back	Unknown	African American
Firearm	15	Gunshot wound of the head	Unknown	White
Firearm	15	Gunshot wound to head	Unknown	African American
Firearm	15	Complications of multiple gunshot wounds	Unknown	African American
Firearm	15	Gunshot wound of chest	Unknown	African American
Firearm	15	Multiple gunshot wounds	Unknown	White
Firearm	15	Multiple gunshot wounds	Unknown	African American
Firearm	15	Multiple gunshot wounds	Unknown	African American
Firearm	15	Multiple gunshot wounds	Unknown	African American
Firearm	15	Gunshot wound of the head	Unknown	White
Firearm	15	Gunshot wound to the neck	Unknown	African American
Firearm	16	Shotgun wound to the chest	Cousin	White
Firearm	16	Gunshot wound of the head	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	White

Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Gunshot wound to the face	Unknown	African American
Firearm	16	Gunshot wound of the head	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Gunshot wound of head	Unknown	African American
Firearm	16	Gunshot wound of head	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	White
Firearm	16	Gunshot wound to back and chest	Unknown	White
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Gunshot wound of back	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Shot by police: gunshot wound to chest	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Gunshot wound of head	Unknown	African American
Firearm	16	Gunshot wound of chest	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	16	Blunt force injuries of torso motor vehicle striking fixed object after receiving multiple gunshot wounds	Unknown	White
Firearm	16	Gunshot wound of back	Unknown	African American
Firearm	16	Gunshot wound of head	Unknown	White
Firearm	16	Gunshot wound of neck	Unknown	African American
Firearm	16	Gunshot wound of head	Unknown	African American
Firearm	16	Gunshot wound of chest	Unknown	African American
Firearm	16	Gunshot wounds of the chest	Unknown	African American

Firearm	16	Gunshot wound of head	Unknown	African American
Firearm	16	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	White
Firearm	17	Gunshot wound of torso	Unknown	African American
Firearm	17	Gunshot wound of the head	Unknown	African American
Firearm	17	Gunshot wound of torso	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	White
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of back	Unknown	African American
Firearm	17	Gunshot wound of head	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	White
Firearm	17	Gunshot wound of the head	Unknown	African American
Firearm	17	Gunshot wound of back	Unknown	African American
Firearm	17	Gunshot wound of chest	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of the chest	Unknown	African American
Firearm	17	Gunshot wound to the chest	Unknown	White
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of head	Unknown	African American
Firearm	17	Gunshot wound of chest and abdomen	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of head	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American

Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of back	Unknown	African American
Firearm	17	Gunshot wound to the abdomen	Unknown	White
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of the abdomen	Unknown	African American
Firearm	17	Gunshot wound to chest	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	White
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Multiple gunshot wounds	Unknown	African American
Firearm	17	Gunshot wound of head	Unknown	White
Injury	0	Blunt force injuries to the head; abuse	Unknown	White
Injury	0	Traumatic brain injury: multi system organ failure (from Shaken Baby Syndrome)	Father	White
Injury	0	Blunt force trauma of head; child abuse	Grandfather	African American
Injury	0	Multiple injuries due to child abuse	Babysitter	African American
Injury	0	Multiple injuries; abuse	Father	African American
Injury	0	Closed Head Injury; abuse (father violently shook the infant)	Father	White
Injury	0	Blunt force head trauma	Mother and Father	African American
Injury	0	Blunt force injuries of head	Mother	African American
Injury	0	Her pregnant mother was stabbed by another person causing massive blood loss. Bronchopneumonia hypoxic ischemic encephalopathy maternal stab wound of the chest	Unknown	African American

Injury	0	Closed head injuries; child abuse	Unknown	White
Injury	0	Multiple blunt force injuries	Mother and Roommate	White
Injury	0	Multiple blunt force injuries	Mother and Father	African American
Injury	1	Multiple injuries; child abuse	Unknown	White
Injury	1	Multiple injuries due to blunt force trauma	Father	African American
Injury	2	Complications of blunt force injuries to head	Unknown	White
Injury	3	Abusive head trauma	Mother and Paramour	African American
Injury	3	Multiple injuries; child abuse	Father	African American
Injury	4	Acute subdural hemorrhages on the brain and multiple contusions consistent with blunt force head trauma. The extensive injuries of various ages on the body are consistent with non-accidental, inflicted trauma	Father	African American
Injury	10	Multiple sharp force injuries assault	Unknown	White
Injury	13	Multiple sharp force injuries assault	Unknown	White
Injury	15	Stab wound of chest	Unknown	African American
Injury	16	Multiple injuries; assault	Unknown	African American
Fire	0	Asphyxia acute carbon monoxide poisoning from residential house fire.	Unknown	White
Fire	0	Multiple injuries; fall from height during attempted escape from apartment fire. Significant conditions: carbon monoxide toxicity due to apartment fire	Unknown	African American
Fire	2	Inhalation injuries from apartment fire	Unknown	African American
Fire	3	Asphyxia acute carbon monoxide poisoning from residential house fire	Unknown	White
Fire	4	Inhalation injuries from apartment fire	Unknown	African American

Fire	4	Thermal injuries and carbon monoxide toxicity from apartment fire	Unknown	African American
Fire	6	Asphyxia acute carbon monoxide poisoning; residential house fire	Unknown	White
Fire	7	Thermal injuries and carbon monoxide toxicity from apartment fire	Unknown	African American
Fire	15	Thermal injuries; incendiary fire in garbage can	Unknown	African American
Scalding burn	1	Burns (placed in scalding hot bath)	Stepfather	African American
Suffocation	0	Smothering by another person	Mother	White
Suffocation	0	Complications of anoxia from mother hanging self (while pregnant)	Mother	White
Suffocation	4	Asphyxia by compression	Mother	White
Suffocation	8	Asphyxiation suffocation and manual strangulation with sexual assault	Family Acquaintance	White
Suffocation	9	Asphyxia; acute carbon monoxide poisoning; residential house fire.	Unknown	White
Suffocation	16	Asphyxia; restraint by staff	Group Home Staff	African American
Poison overdose	8	Asphyxia; acute carbon monoxide poisoning (father made him ingest a lethal amount of carbon monoxide)	Father	White
Vehicular	9	Multiple injuries from automobile striking a mini-van	Unknown	White
Vehicular	17	Blunt trauma of the head from motor vehicle-pedestrian crash	Unknown	White
Illness	16	Bronchial asthma (stress associated with gunshots fired into crowd)	Unknown	African American
Other	0	Starvation and dehydration; neglect	Mother and Father	African American
Other	4	Homicide by unspecified means (probable neglect)	Mother	White

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 2016 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.

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, about 1 in 10 (10.3%) babies were born preterm in 2016, compared with 9.8% in the nation.[9] The rate of preterm birth in Illinois is highest for African American infants (13.8%), followed by Native Americans (11.8%), whites (9.3%), Hispanics (9.3%), and Asian/Pacific Islanders (9.2%).[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.

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[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

[9] March of Dimes (2018). Quick facts: *Preterm deaths.* Retrieved from https://www.marchofdimes.org/peristats/viewtopic.aspx?reg=17&top=3&lev=0

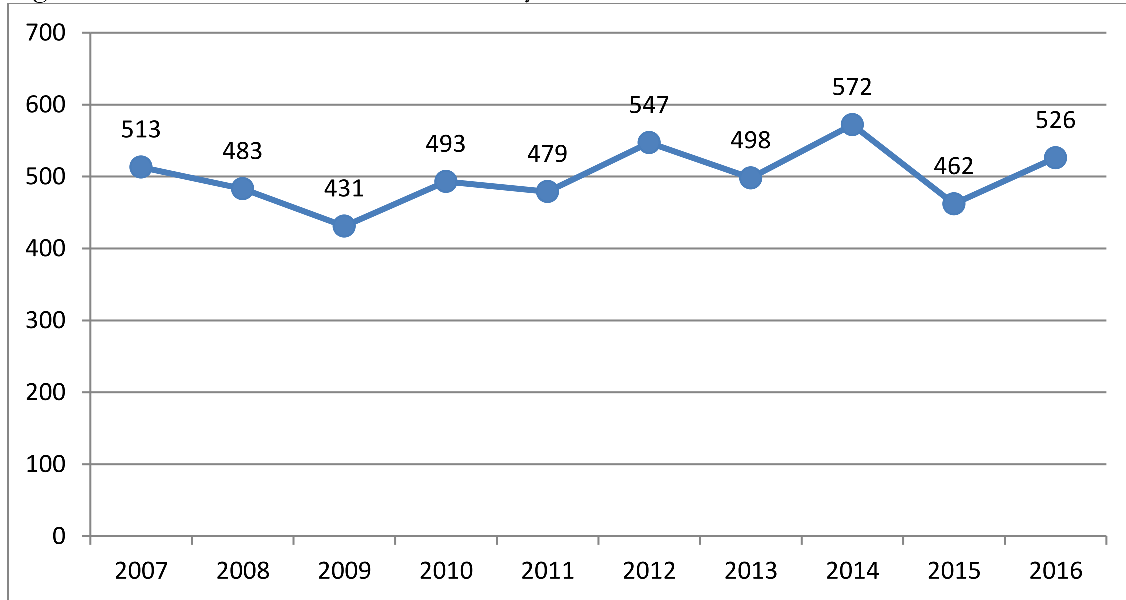
[10] National Center for Health Statistics. *Illinois prematurity data*. Retrieved from http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4.

[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 been either the largest or second largest category in the past 10 years (ranging from 431 to 572 deaths per year). The number of prematurity deaths declined to as low 431 in 2009 but has had an overall upwards trend since 2009 (see Figure 8).

Figure 8: Child Deaths Due to Prematurity



Of the 1,487 total child deaths in 2016, 526 (35%) were related to premature birth.

- A majority of children who died from prematurity were boys (60%).
- The majority of deaths from prematurity were White children (58%), followed by African American children (38%) and Asian children (4%) (see Figure 9).
- Nearly all deaths (99%) in this category were the result of natural causes, and two deaths were undetermined.

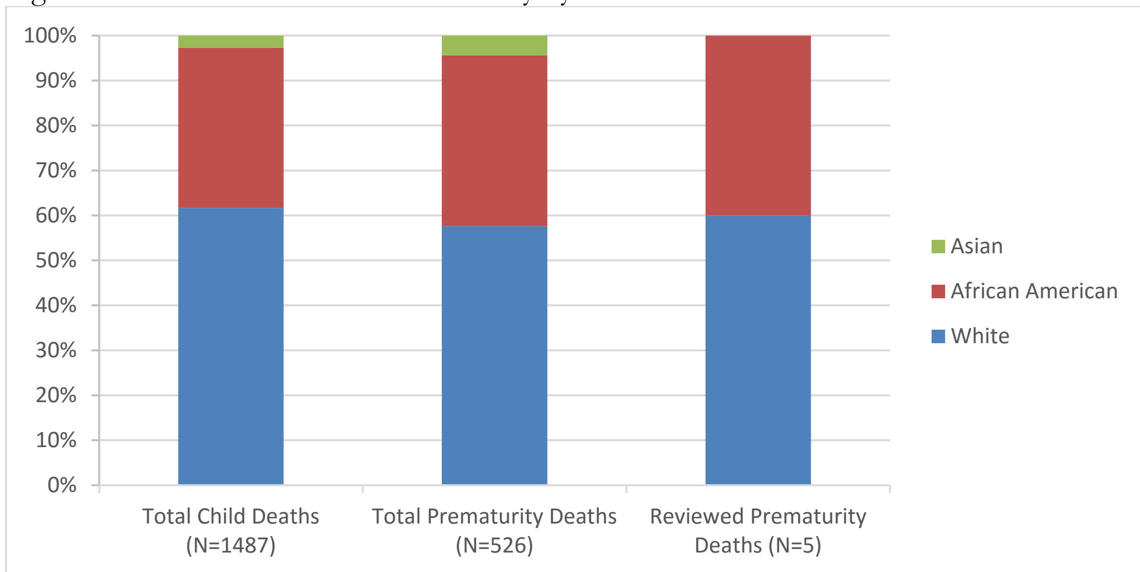
Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 5 of the 256 child deaths reviewed by CDRTs (2%) were related to premature birth.

- Three of the five (60%) premature deaths reviewed by the CDRTs were of males, and the other two (40%) were of females.
- Three of the five (60%) of the premature deaths reviewed by the CDRTs were of White children, and the other two (40%) were for African American children (see Figure 9).

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

Figure 9: Child Deaths Due to Prematurity by Race



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).

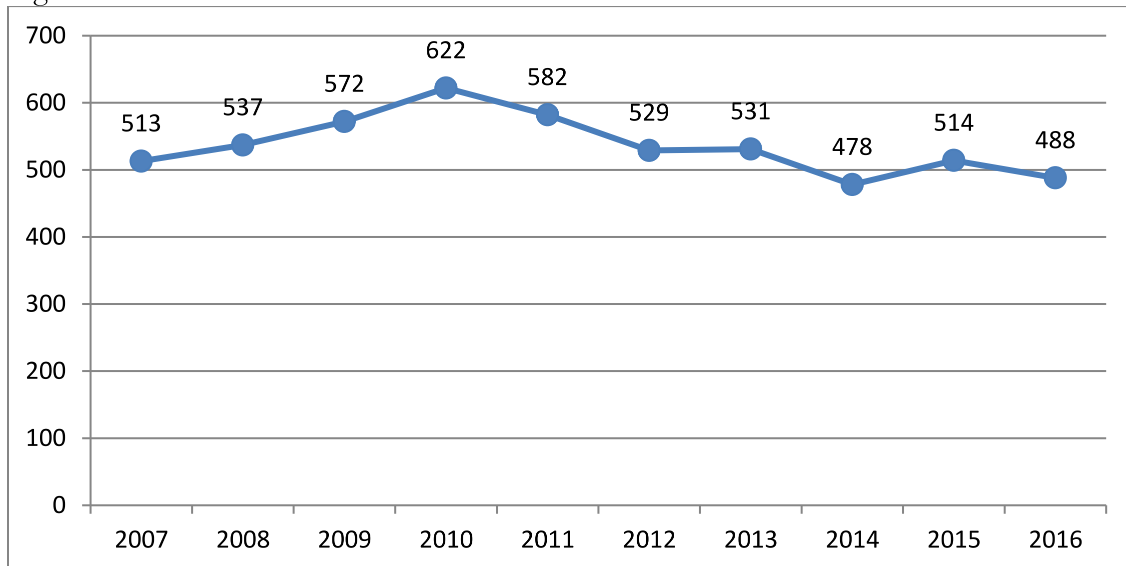
Background

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 in 2010 at 622 and has since generally declined since then (see Figure 10).

Figure 10: Child Deaths Due to Illness



In 2016, 488 of the 1,487 total child deaths (37%) reported to CDRTs were related to illness.

- A slight majority of children who died from illness were male (52%).
- A little more than half of deaths from illness were among children under the age of one (53%); 14% of deaths from illness occurred among children 1 to 4 years old, 11% occurred among children 5 to 9 years old, 11% occurred among children 10 to 14 years old, and 10% occurred among children 15 to 17 years old (see Figure 11).
- The majority (70%) of deaths from illness were White children, followed by African American children (27%), and Asian children accounted for the smallest proportion of deaths related to illness (3%) (see Figure 12).
- All but two (486) of the deaths were attributable to natural causes, with the exceptions of one homicide and one undetermined death.

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 47 of the 256 child deaths reviewed by the CDRTs (18%) were related to illness.

- More than half (60%) of the reviewed deaths related to illness were boys.
- Illness deaths were most common in infants under 1 year old (34%), children 1 to 4 (28%) and children 10 to 14 years old (23%); children 5 to 9 years old (6%) and children 15 to 17 years old (9%) made up a smaller proportion of reviewed illness-related deaths (see Figure 11).
- Over half (55%) of the reviewed deaths from illness were African American children, 43% were White children, and one case (2%) was of an Asian child (see Figure 12).
- All 47 reviewed deaths that were categorized as illness were attributed to natural causes.

Figure 11: Child Deaths Due to Illness by Age

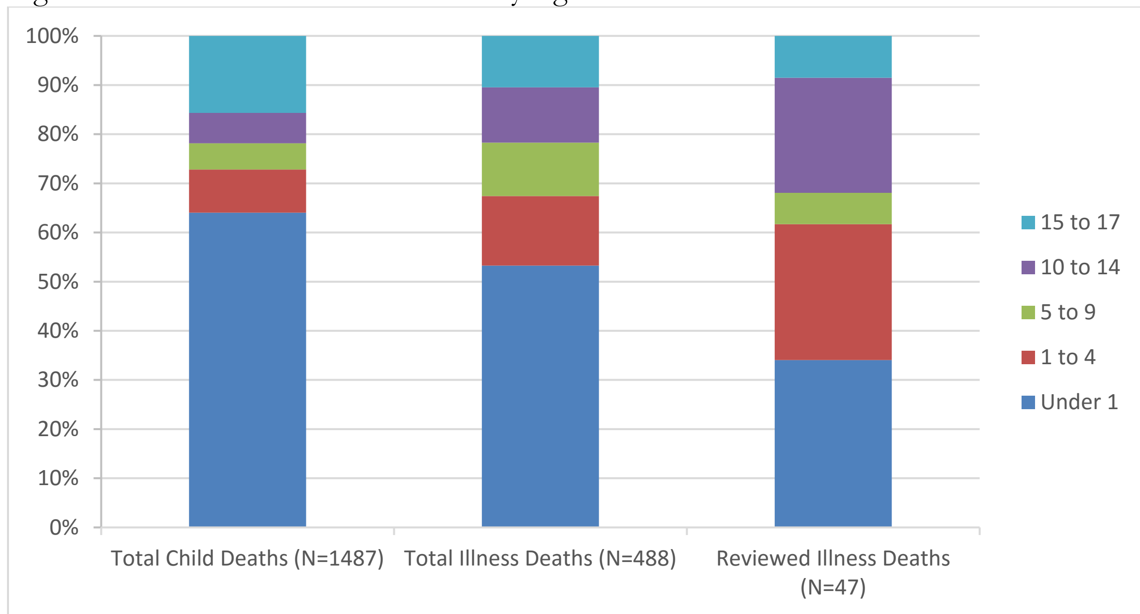
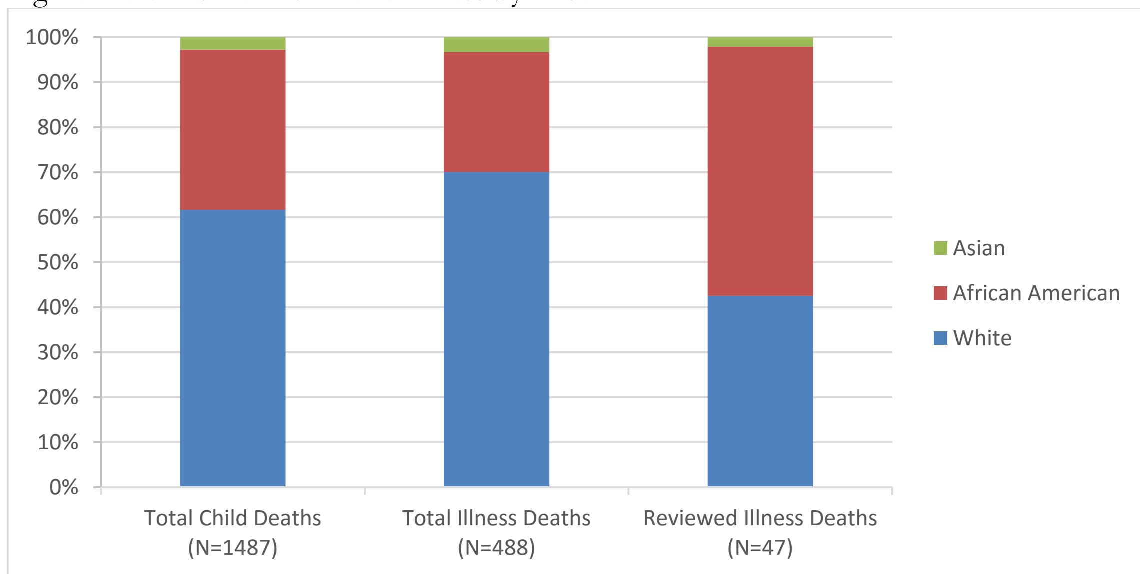


Figure 12: Child Deaths Due to Illness by Race



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, 1,637 firearm deaths occurred in 2016 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 2016, the homicide rate with firearms for African American males 13 to 17 years old was over 10 times higher than the rate for Whites.[12]

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.[13] 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.[14]

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from firearms steadily increased from 66 in 2007 to 83 in 2008 and have remained fairly level until 2013. There were noticeable increases in 2014 and 2016 (see Figure 13).

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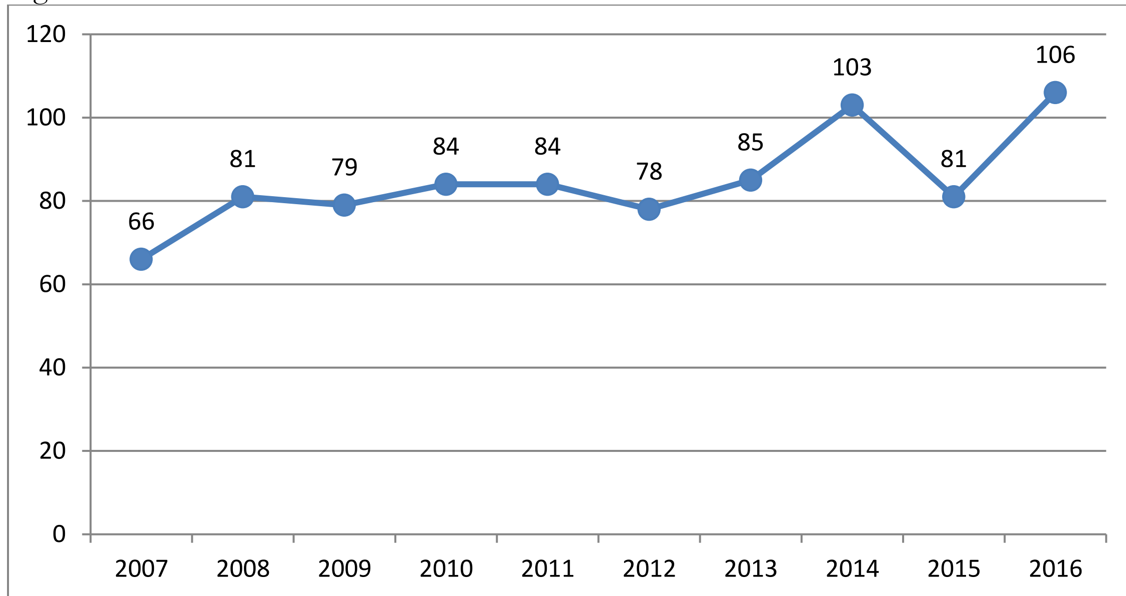
[12] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

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

[14] 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 13: Child Deaths Due to Firearms



In 2016, 106 of the 1,487 total deaths (7%) were related to firearms.

- Deaths due to firearms overwhelmingly occurred among boys (90%).
- 88% of firearm deaths occurred in children aged 15 to 17 (see Figure 14).
- 70% of the children who died from firearms were African American and 30% were White (see Figure 15).
- Homicides accounted for 82% of the firearm deaths, suicides accounted for 13%, and accidents and undetermined causes accounted for the remaining 5%.

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 15 of the 256 deaths reviewed by the CDRTs (6%) were related to firearms.

- Almost three-quarters (73%) of reviewed firearm deaths were of males.
- Most of the firearm deaths reviewed by CDRTs involved youth 15 to 17 years old (60%) (see Figure 14).
- Two-thirds (67%) of reviewed firearm deaths were of African American children, and one-third (33%) were of White Children. There were no reviewed firearm deaths of children of other race/ethnicity (see Figure 15).
- The majority of firearm deaths reviewed by CDRTs were due to homicides (60%), and the remaining deaths were categorized as suicide (13%), accidental (13%), and undetermined (13%).

Figure 14: Child Deaths Due to Firearms by Age

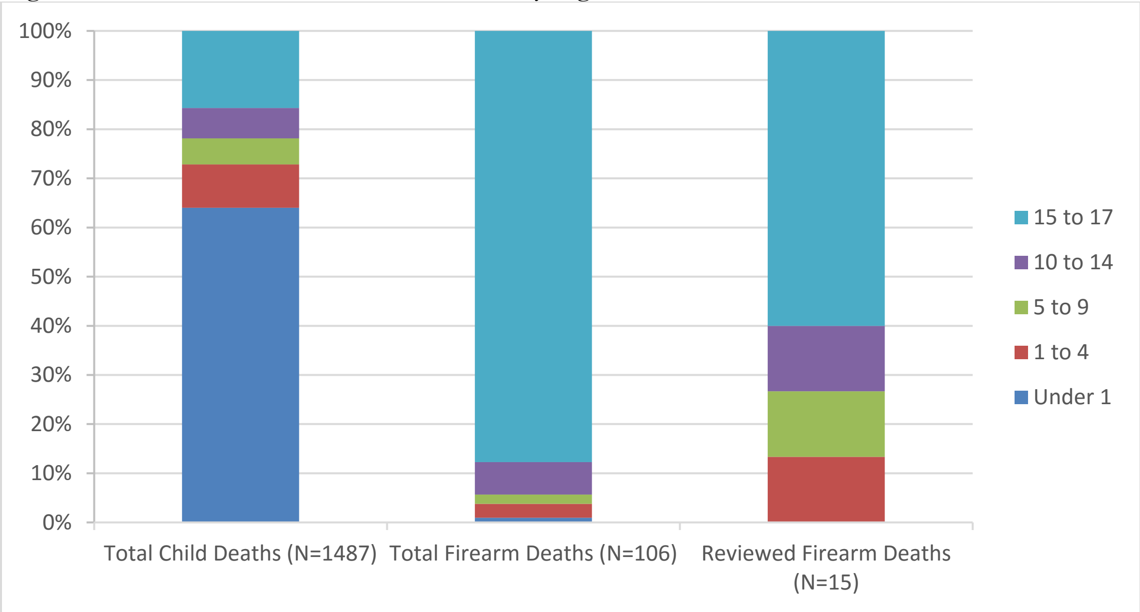
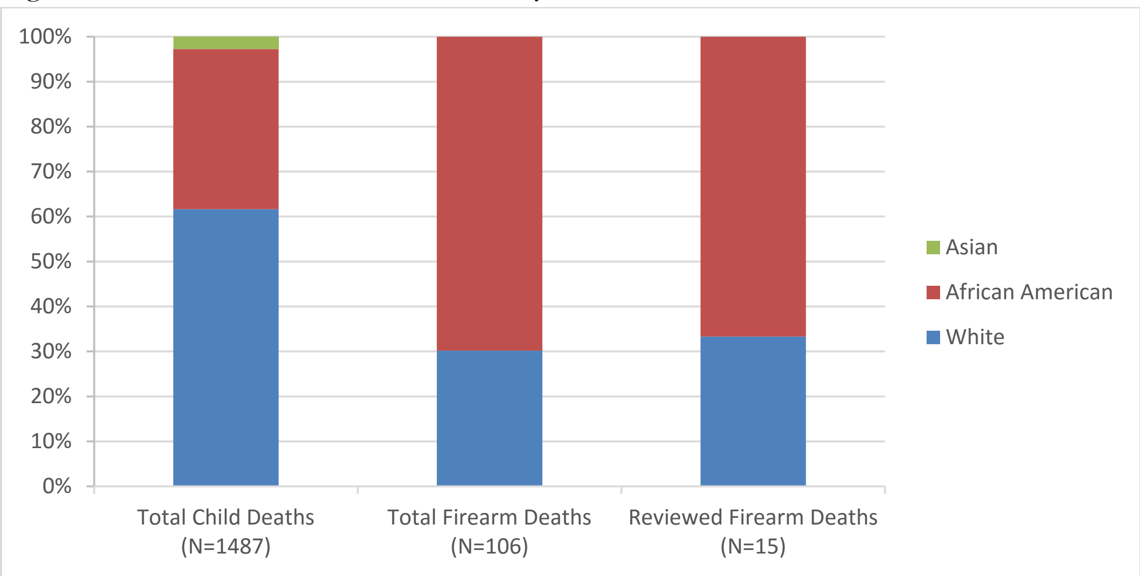


Figure 15: Child Deaths Due to Firearms by Race



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 2016, 2,110 children ages 17 and under in the U.S. died from suffocation.[15] Of these children, 52% were less than one year of age and 59% were ages four and under. Accidental suffocation is the leading cause of injury-related death among infants less than one year old, and 82% of suffocation deaths among infants are from accidental suffocation in bed.[16]

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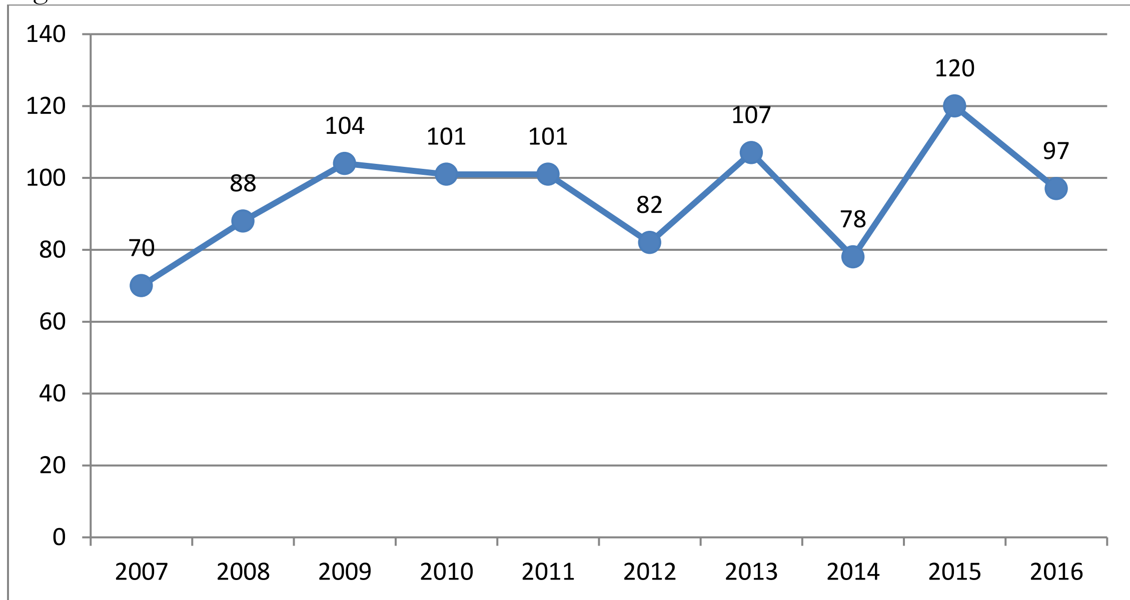
[15] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2017). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

[16] Safe Kids Worldwide. (2017). *Suffocation Prevention and Sleep Safety*. Retrieved from https://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 peak number in 2015; however, the number of suffocation deaths dropped below 100 in 2016 (see Figure 16).

Figure 16: Child Deaths Due to Suffocation



In 2016, 97 of the 1,487 total child deaths reported to the CDRTs (7%) were categorized as suffocation.

- The majority of children who died from suffocation were boys (60%).
- Infants under one year were the largest group in this category, accounting for 59% of the deaths (see Figure 17).
- The majority (65%) of children who died from suffocation were White, and 35% were African American; there were no suffocation deaths for other races/ethnicities (see Figure 18).
- The manner of the suffocation deaths primarily included accidents (62%) and suicides (28%), with the remaining suffocation deaths due to homicides (6%) or undetermined causes (4%)

Illinois Data – Deaths Reviewed by CDRTs

In 2016, 62 of the 256 deaths reviewed by CDRTs (24%) were categorized as suffocation.

- A little over half (53%) of the reviewed suffocation deaths were boys.

- Infants under one year accounted for the majority of the reviewed suffocation deaths (82%) (see Figure 17).

- Over half (52%) of children who died from suffocation were White, and 48% were African American children; there were no suffocation deaths from for other race/ethnicities (see Figure 18).

- Most (81%) of the reviewed deaths due to suffocation were accidental.

Figure 17: Child Deaths Due to Suffocation by Age

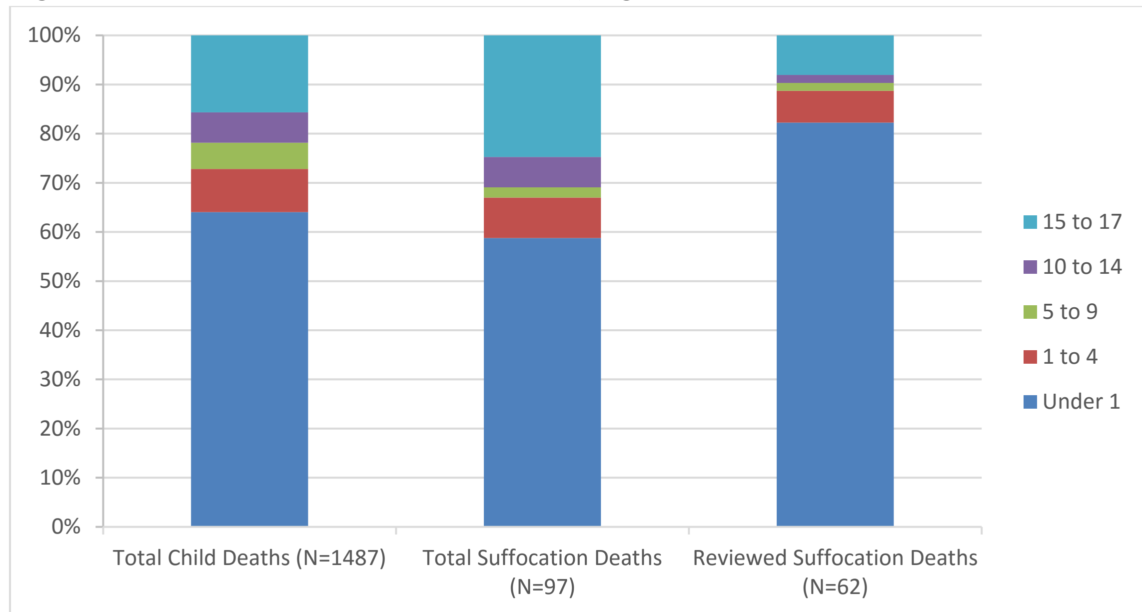
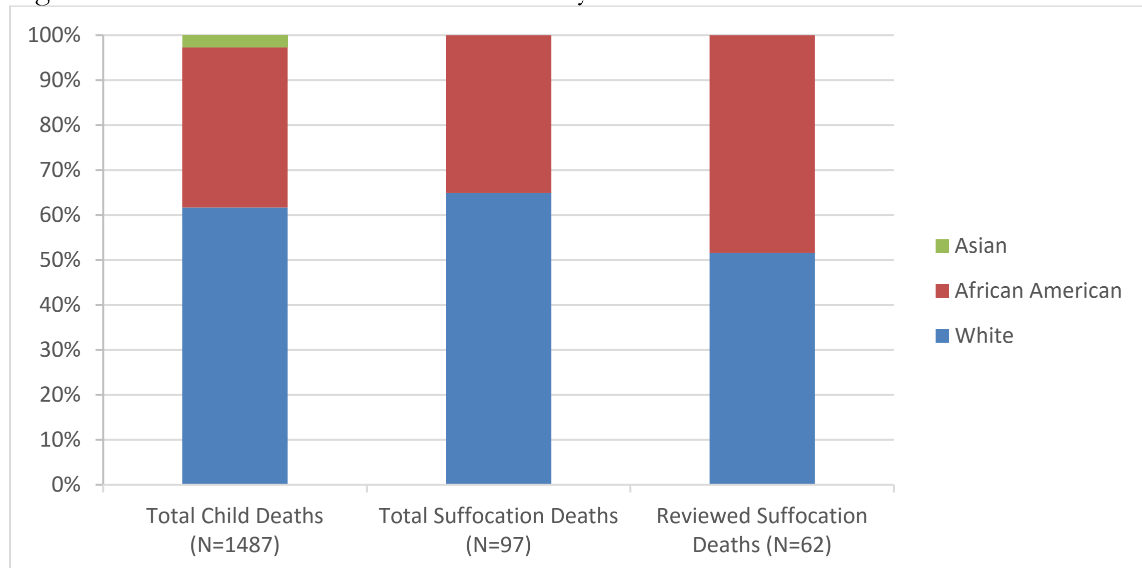


Figure 18: Child Deaths Due to Suffocation by Race



Undetermined Deaths

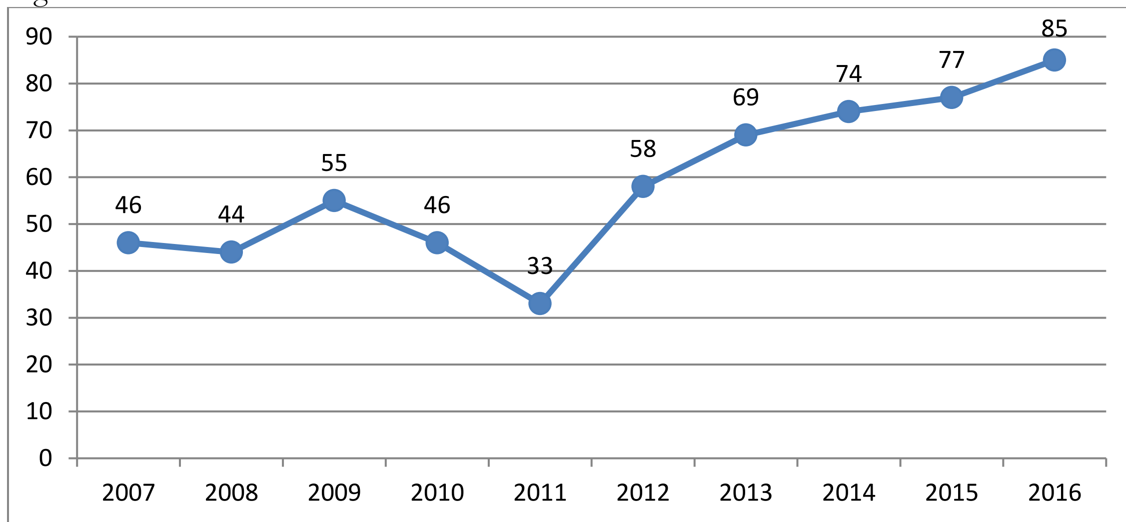
Definition

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

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of undetermined deaths in Illinois has been steadily increasing over the past 5 years, from a low of 33 in 2011 to a high of 85 in 2016 (see Figure 19).

Figure 19: Child Deaths with Undetermined Cause of Death



In 2016, 85 of the 1,487 total child deaths reported to the CDRTs (6%) had an undetermined cause of death.

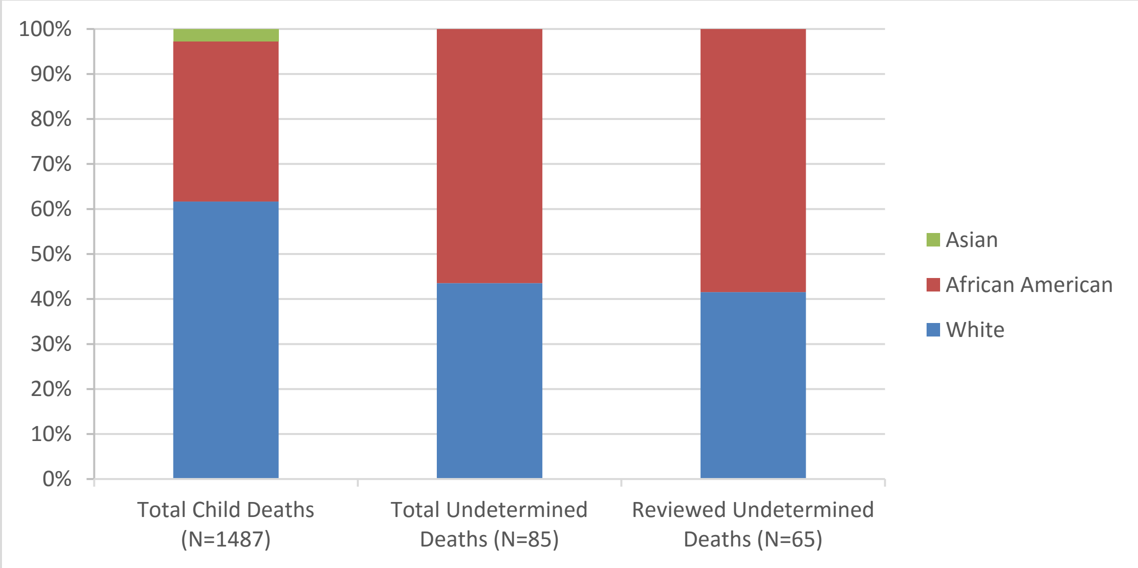
- Deaths due to undetermined causes were slightly more common for boys (55%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (93%), with the remaining being children 1 to 4 years (6%) and 5 to 9 years old (1%).
- Slightly over half (56%) of children who died due to undetermined causes were African American, and 44% were White (see Figure 20).

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 65 of the 256 deaths reviewed by CDRTs (25%) had an undetermined cause of death.

- The majority of reviewed deaths due to undetermined causes were boys (58%).
- 97% of reviewed undetermined deaths were of children under the age of 1.
- 58% of reviewed children who died due to undetermined causes were African American and 42% were White (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 1,023 children (under the age of 13) died in motor vehicle crashes in 2016.[17] The rate of motor vehicle crash deaths per million children under 13 has decreased 76% since 1975. In 2016, 71% of child motor vehicle crash deaths were passenger vehicle occupants, 19% were pedestrians, and 3% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 88% and 92%, respectively. Passenger vehicle child occupant deaths in 2016 were 48% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Fourteen percent of the passenger vehicle child occupant deaths in 2016 occurred in front seats, down from 46% in 1975. Seventy-six 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. The majority of deaths from crashes are 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 2,820 teenagers ages 13 to 19 died in motor vehicle crashes in 2016. About 2 out of every 3 teenagers killed in crashes in 2016 were males. In 2016, teenagers accounted for 8% of motor vehicle crash deaths. They comprised 9% 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 15% of all-terrain vehicle rider deaths.[19]

In the United States, teenagers drive less than most adults, but their numbers of crashes and deaths from crashes 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, with teenagers ages 16 to 17 with the highest levels of risk. The fatal crash rate per mile driven for 16 to 17-year-olds is nearly twice as high as the rate for 18- to 19-year-olds.[20]

Distracted driving is often the cause of fatal accidents. The most common distraction for teen drivers is cell phone use. Other common sources of distraction for teen drivers are

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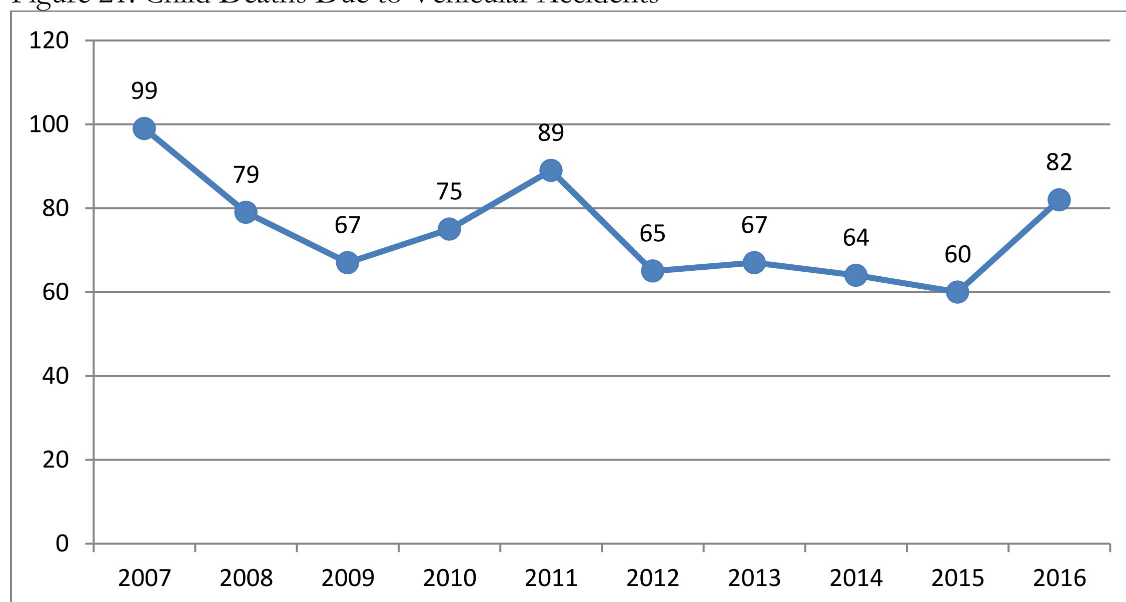
[17] Insurance Institute for Highway Safety. (2018). *Fatality facts 2016: Children.* Retrieved from http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety#Age-and-gender
[18] Ibid.
[19] Insurance Institute for Highway Safety. (2017). *Fatality facts 2016: Teenagers.* Retrieved from http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers/2016
[20] Ibid.

riding with peers and drowsiness.[21] Another factor that affects teenage vehicular fatalities is inexperience. To address this, all states have adopted graduated licensing systems, which phase in full driving privileges. National studies of graduated licensing found that strong laws were associated with substantially lower fatal crash rates and substantially lower insurance claim rates among young teen drivers covered by the laws.[22]

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of vehicular deaths declined from 2011 to 2015 but increased in 2016 (see Figure 21).

Figure 21: Child Deaths Due to Vehicular Accidents



In 2016, 82 of the 1,487 total child deaths reported to the CDRTs (6%) were related to vehicular accidents.

- More boys (65%) had deaths related to vehicular accidents.

Older children (15 to 17) made up the largest proportion of vehicular accident deaths (60%). Children in other age groups made up the following proportions of vehicular deaths; children under 4 years old accounted for 15%, 5- to 9-year-olds were 12%, and children 10 to 14 accounted for the remaining 13% (see
Figure 22).

- The majority (84%) of deaths due to vehicular accidents were White children, followed by African American children (15%), and one child was Asian (1%) (see Figure 23).

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[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.

- The majority (95%) of these deaths were accidental, and the remaining deaths (5%) were either homicides or suicide (2 deaths each).

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 11 of the 256 deaths reviewed by the CDRTs (4%) were related to vehicular accidents.

- A little over half (55%) of the reviewed deaths in this category were females.
- Infants and children up to 10 years old made up 64% of reviewed vehicular deaths, and children 10 to 17 years old comprised the remaining 36% (see Figure 22).
- Most of the reviewed deaths related to vehicular accidents were White (73%), and 27% were African American (see Figure 23).
- All the reviewed deaths in this category were accidental.

Figure 22: Child Deaths Due to Vehicular Accidents by Age

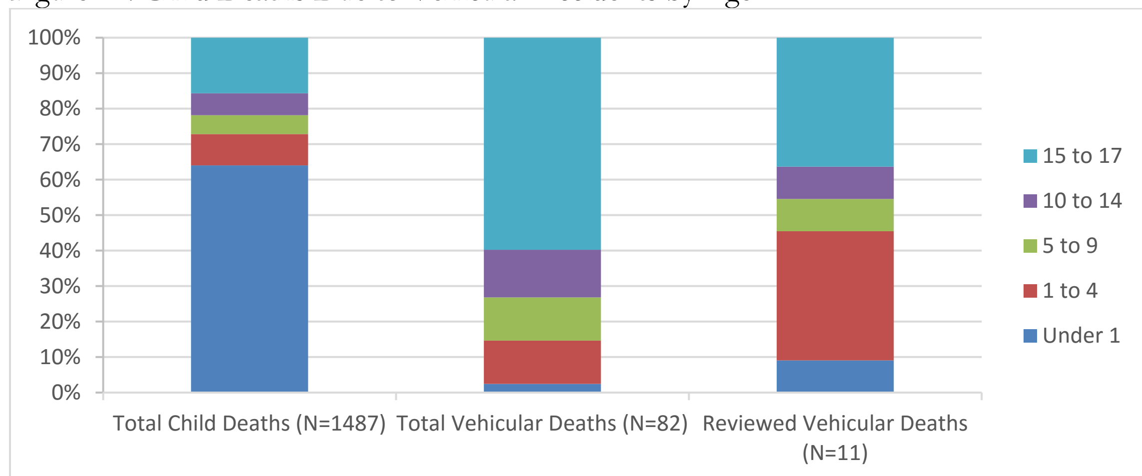
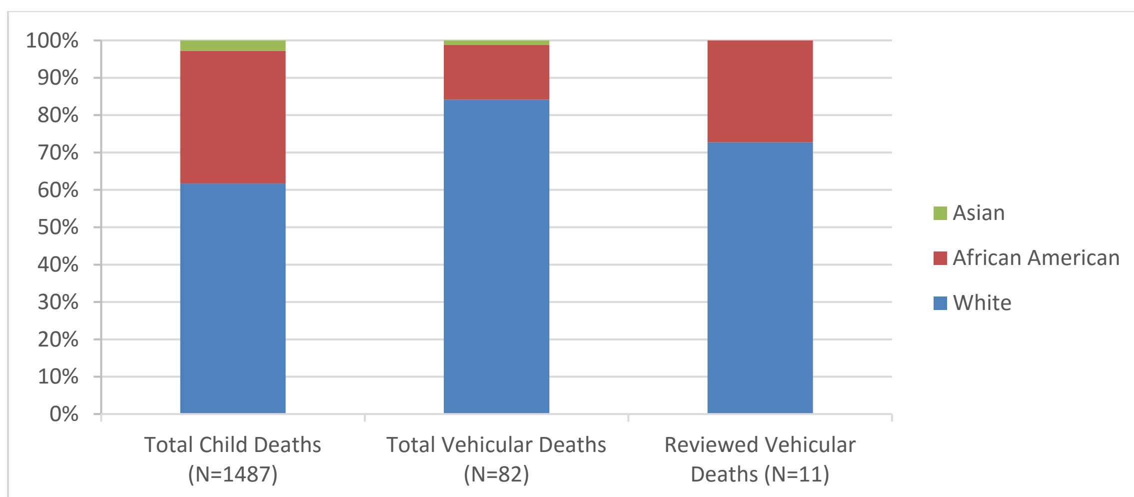


Figure 23: Child Deaths Due to Vehicular Accidents by Race



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

Background

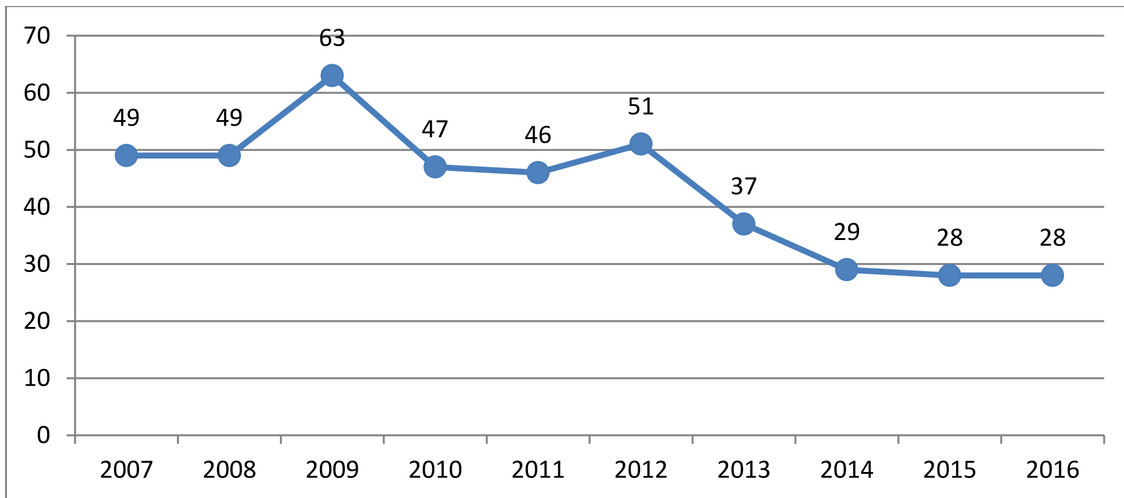
Child maltreatment (including abuse and neglect) is one cause of death from injuries. In 2016, the National Child Abuse and Neglect Data System (NCANDS) reported 1,700 fatalities from child maltreatment based on data from 49 states. For FY 2016, an estimated 1,750 children died from abuse and neglect at a rate of 2.36 per 100,000 children in the population. Younger children are the most vulnerable to death as the result of child abuse and neglect. Seventy 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, 74.6% suffered neglect and 44.2% suffered physical abuse either exclusively or in combination with maltreatment type.

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. (2018). *Child maltreatment, 2016*. Washington, DC: Government Printing Office. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf



In 2016, 28 of the 1,487 total child deaths reported to the CDRTs (2%) were related to injuries.

- Children deaths from injuries were evenly split between males and females.
- Younger children were more vulnerable to death from injuries: 75% 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 46% were African American children (see
-
-
- Figure 26).
- The majority (79%) of the injury deaths were due to homicides, with the remaining due to accidents (14%) or undetermined causes (7%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 14 of the 256 deaths reviewed by the CDRTs (5%) were related to injuries.

- 57% of the reviewed injury deaths were male.
- The vast majority (93%) of the reviewed cases involved young children 4 years and under (see Figure 25).
- The majority (64%) of the reviewed deaths due to injuries were African American children, and the remaining 36% were White children (see Figure 26).
- Most (86%) of the reviewed injury deaths were due to homicides, with the remaining 14% due to accidents or undetermined causes (1 case each).

Figure 25: Child Deaths Due to Injuries by Age

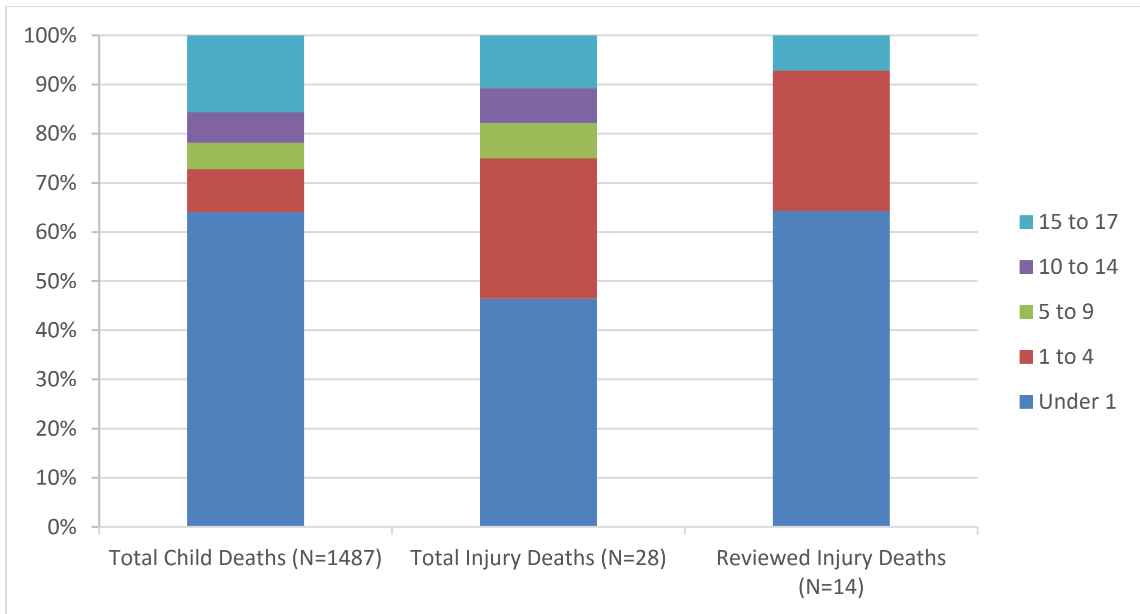
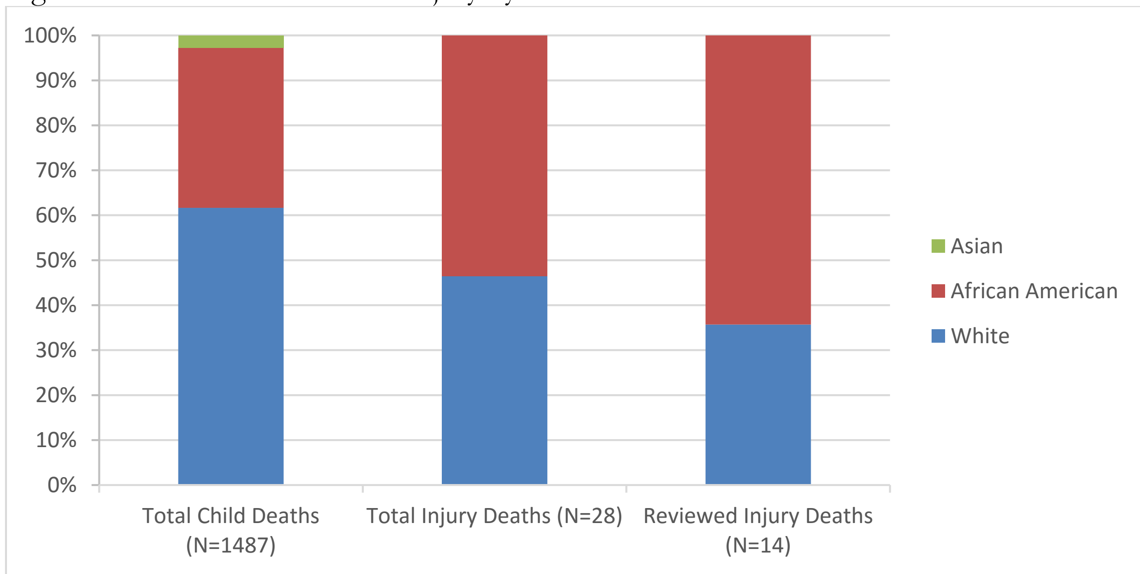


Figure 26: Child Deaths Due to Injury by Race



Drowning

Definition

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

Background

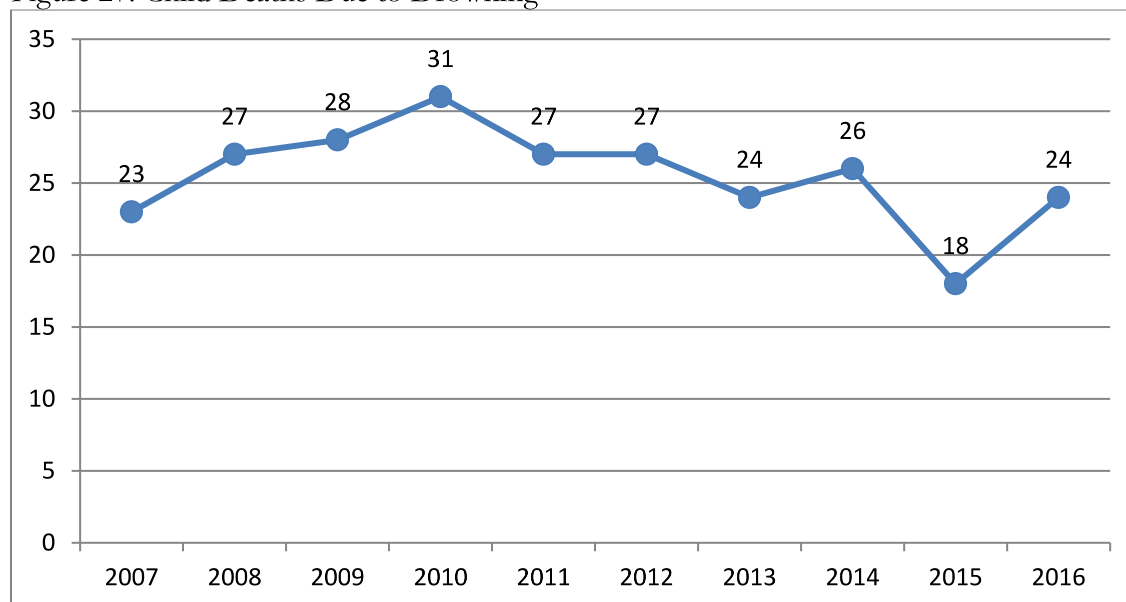
In 2016, 848 children ages 17 and under died as a result of unintentional drowning in the United States. Children ages 4 and under accounted for 55% of these deaths.[24]

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.[25]

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of Illinois child deaths due to drowning increased between 2007 and 2010 but declined between 2011 through 2015; however, there was an increase in 2016 (see Figure 27).

Figure 27: Child Deaths Due to Drowning



[24] 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.

[25] 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 2016, 24 of the 1,487 total child deaths reported to the CDRTs (2%) were related to drowning.

- The majority of drowning deaths were boys (63%).
- Children under 4 years of age accounted for 54% of the deaths; children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 17%, 21%, and 8% of deaths due to drowning, respectively (see Figure 28).
- Nearly all of the drowning deaths were White children (96%), and one was African American (Figure 29).
- All but one of the drowning deaths were accidental (96%), and one case was undetermined.

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 18 of the 256 reviewed deaths (7%) were related to drowning.

- Two-thirds (67%) of the reviewed drowning deaths were male.
- Children 4 years old and under accounted for 61% of the deaths; children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 11%, 22%, and 6% of deaths due to drowning, respectively (see Figure 28).
- All but one (94%) of the reviewed drowning deaths were White children, and one was an African American child (6%) (see Figure 29).
- All but one (94%) of the reviewed drowning deaths were due to accidental causes, with the remaining case being from undetermined causes.

Figure 28: Child Deaths Due to Drowning by Age

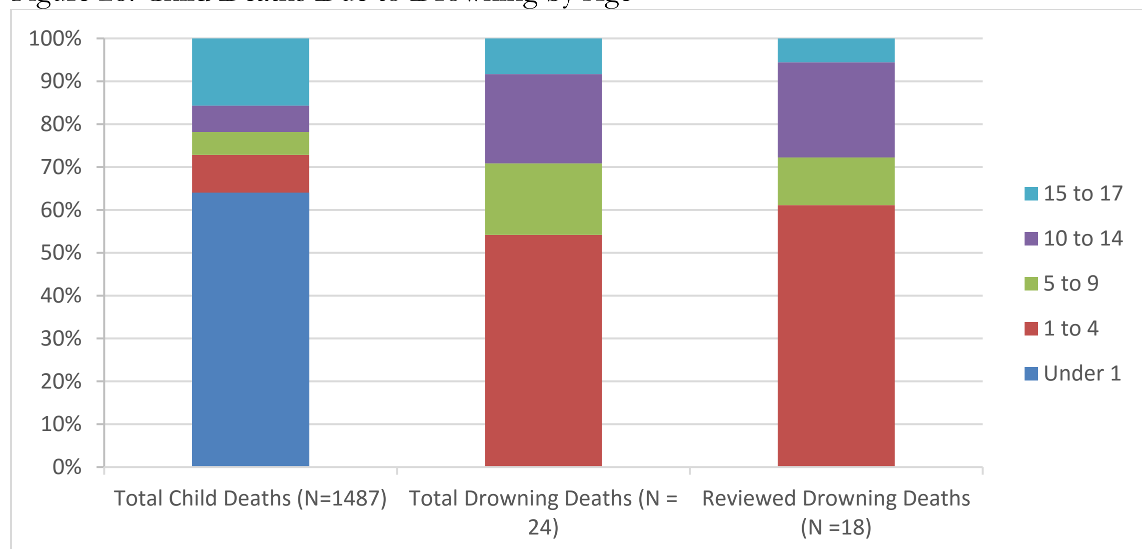
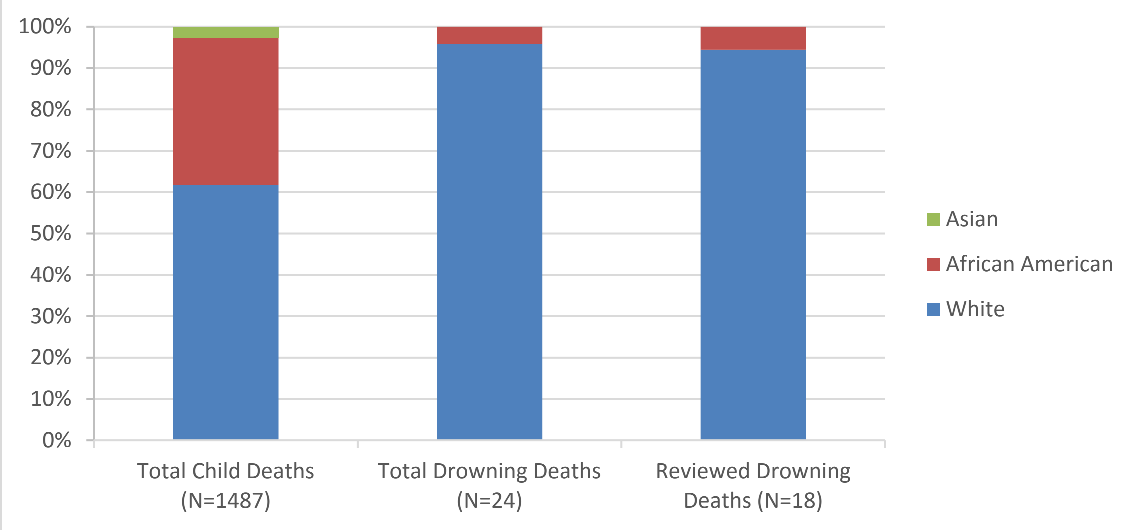


Figure 29: Child Deaths Due to Drowning by Race



Fire

Definition

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

Background

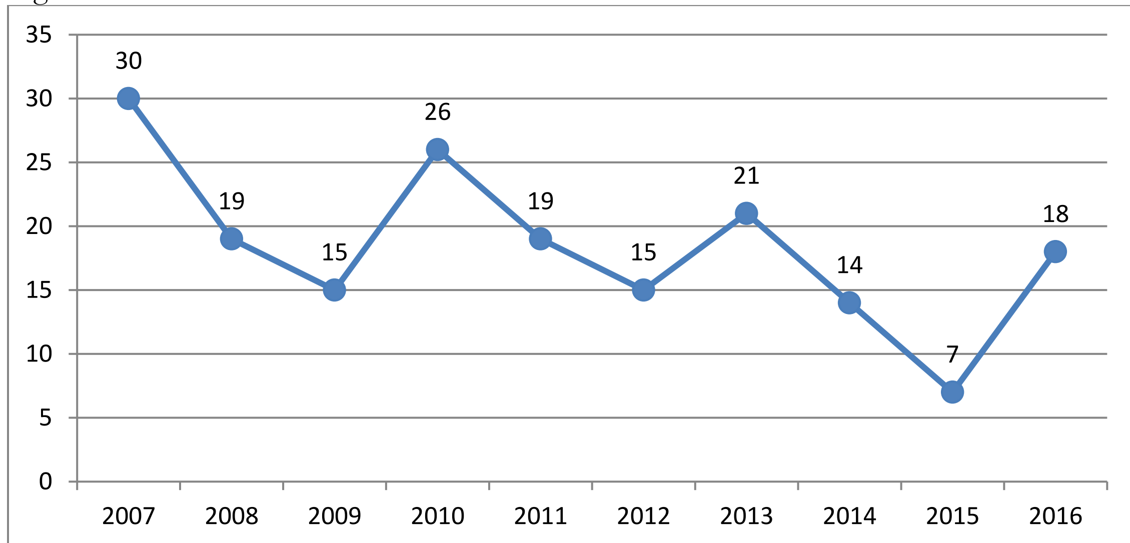
In the United States, fire and burns were the cause of 336 deaths among children between 0 and 17 years in 2016. Forty-five percent of fire deaths occurred in children 4 and under.[26] Death rates per million among children 14 and under has decreased 47.6% from 2006-2015.[27]

Residential fires account for 75% of all fire-related fatalities in 2015.[28] Working smoke alarms reduce the chances of dying in a fire by nearly 50%.[29]

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to fire has ranged between 7 and 30 over the past decade (see Figure 30).

Figure 30: Child Deaths Due to Fire



[26] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2018). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://www.cdc.gov/injury/wisqars/index.html
[27] U. S. Fire Administration. (2018). Child fire deaths, fire death rates and relative risk (2006-2015) Retrieved from https://www.usfa.fema.gov/data/statistics/fire_death_rates.html
[28] U.S. Fire Administration (2017). Fire in the United States 2016-2015. Retrieved from https://www.usfa.fema.gov/downloads/pdf/publications/fius19th.pdf
[29] Safe Kids Worldwide. (2018). *Fire safety*. Retrieved from https://www.safekids.org/fire

In 2016, 18 of the 1,487 total child deaths reported to the CDRTs (1%) were related to fires.

- Two-thirds of deaths related to fire were males (67%).
- Children under the age of 4 years accounted for over half of deaths (56%), and children 5 to 9 years, children 10 to 14 years, and children 15 to 17 years accounted for 17%, 11%, and 17% of deaths, respectively.
- Deaths due to fire were equally likely among African American (50%) and White (50%) children.
- Half of the deaths (50%) attributable to fire were accidental, and the remaining half of deaths (50%) were homicides.

Illinois Data – Deaths Reviewed by the CDRTs

- In 2016, 3 of the 256 deaths reviewed by CDRTs were related to fires (1%).
- Two of the three (67%) of reviewed decedents were male.
- There was a death of a single child in the following ranges (each accounting for 33% of deaths): 5 to 9 years, 10 to 14 years, and 15 to 17 years.
- All the decedents were White children.
- All the reviewed deaths were due to accidents.

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

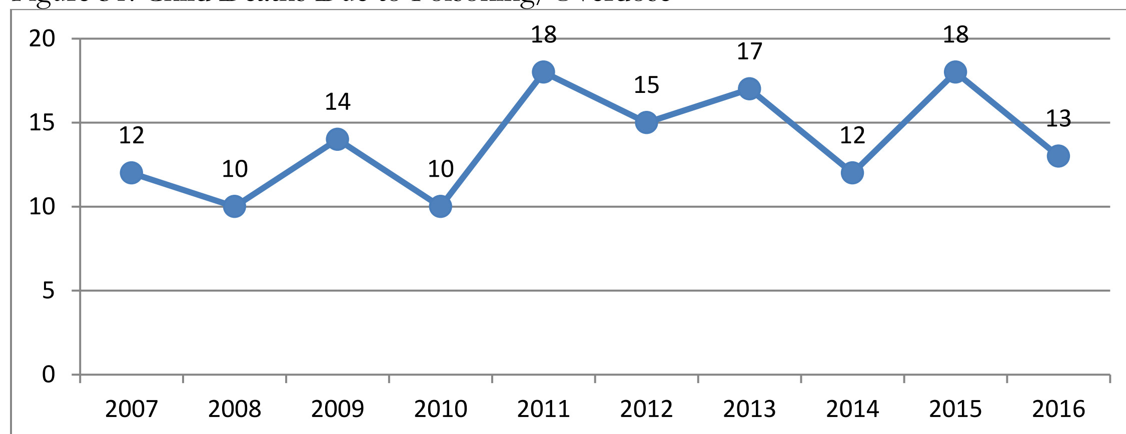
In 2016, 439 children under 18 years died of poisoning in the United States.[30] The majority of these deaths occurred in children 15 to 17 years of age (58%). The age group with the second most frequent number of deaths by poisoning was children 4 years and younger (24%).

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.[31] 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 31).

Figure 31: Child Deaths Due to Poisoning/Overdose



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[30] 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.

[31] 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 2016, 13 of the 1,487 total child deaths reported to the CDRTs (<1%) were related to poisonings or overdoses.

- Girls (62%) were more likely to die from poisoning or overdose than boys.
- A little over half of the deaths (54%) were children 15 to 17 years old, one death (8%) was a child under 4 years old, one death (8%) was a child 5 to 9 years old, and the remaining 31% of deaths were children 10 to 14 years old (see Figure 32).
- All (100%) of the deaths due to poisoning or overdose were White children.
- The majority of the deaths were related to accidents (84%), and the two remaining deaths were from a homicide and a suicide (8% each).

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, 5 of the 256 deaths reviewed by the CDRTs (2%) were related to poisoning/overdose.

- All the decedents were girls.
- The majority (80%) of the decedents were children 15 to 17 years old, and the remaining death was a child between 10 and 14 years old (see Figure 32).
- Most (88%) of the decedents were White, and the remaining decedent (12%) was African American (see
- Figure **33**).
- All deaths were related to accidents (100%).

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

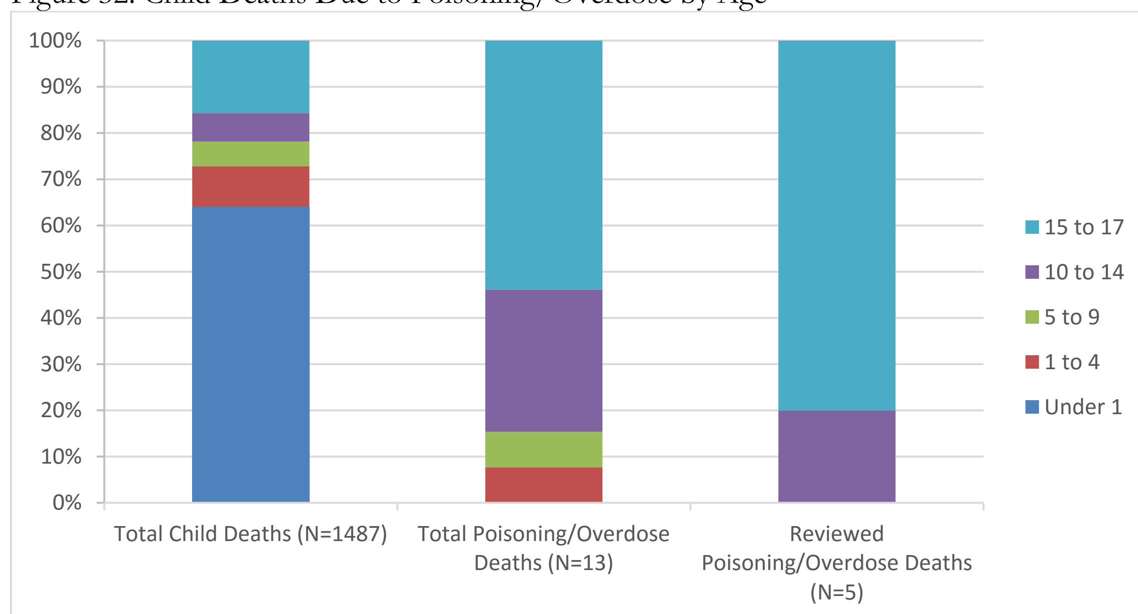
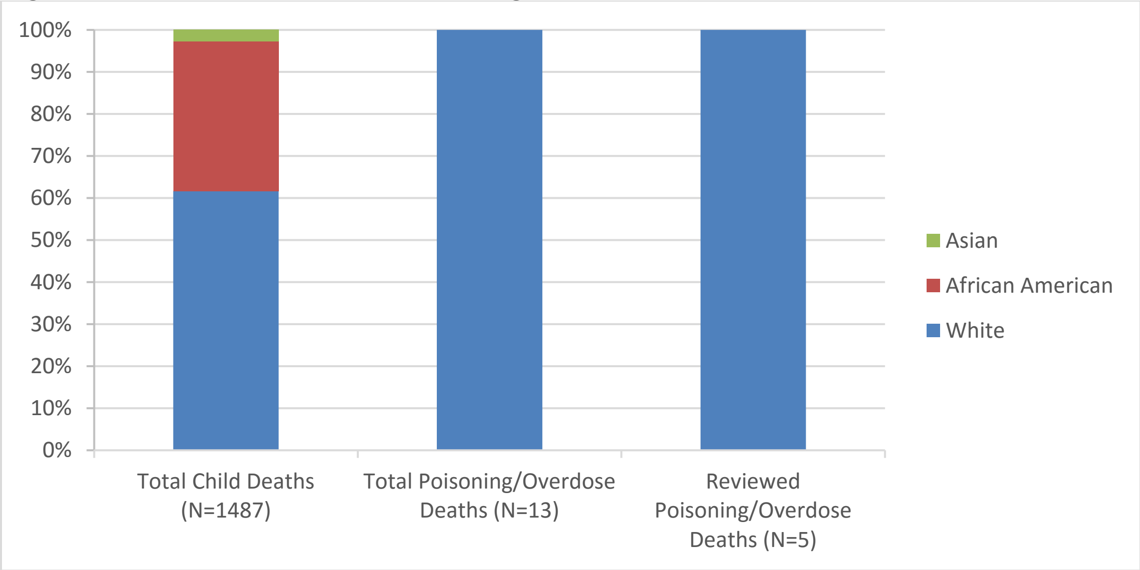


Figure 33: Child Deaths Due to Poisoning/Overdose by Race



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

Definition

According to Center for Disease Control (CDC),[33] there are about 3,500 sudden unexpected infant deaths (SUID) each year in the United States. SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation. In 2015, 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 of unknown cause, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted, and the cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of "suffocation" in the report.

Background

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

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

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[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

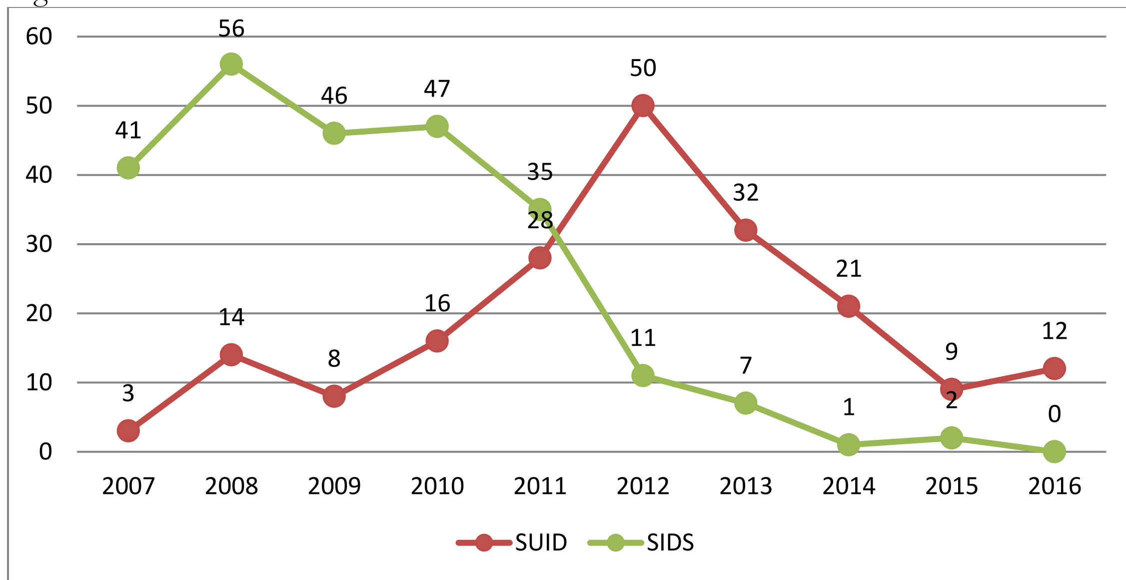
[34] Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, *163,* 762-769.

[35] United States Environmental Protection Agency (2018). *America's Children and Environment.* Retrieved from https://www.epa.gov/ace/key-findings-ace3-report

Illinois Data – Total Child Deaths Reported to the CDRTs

Since the peak of 2008, SIDS has experienced a sharp decline, with very low numbers of deaths occurring in 2014-2016 (see Figure 34). Infant deaths from SUID were added as a category in 2007, and child deaths due to SUID have increased from 3 in 2007 to 50 in 2012 but has since experienced a decline.

Figure 34: Child Deaths Due to SIDS and SUID



In 2016, none of the 1,487 total child deaths reported to the CDRTs were related to SIDS, and 12 deaths (<1%) were categorized as SUID.

- The majority of SUID deaths were boys (58%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2016, none of the 256 deaths reviewed by the CDRTs was related to SIDS, and 7 were from SUID.

- The majority of reviewed SUID deaths were boys (71%).

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

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

Scalding Burn

There were two scalding burn deaths in 2016, and both were reviewed.

Sudden Unexplained Child Death (SUCD)

There was one SUCD in 2016, and it was not reviewed.

Other

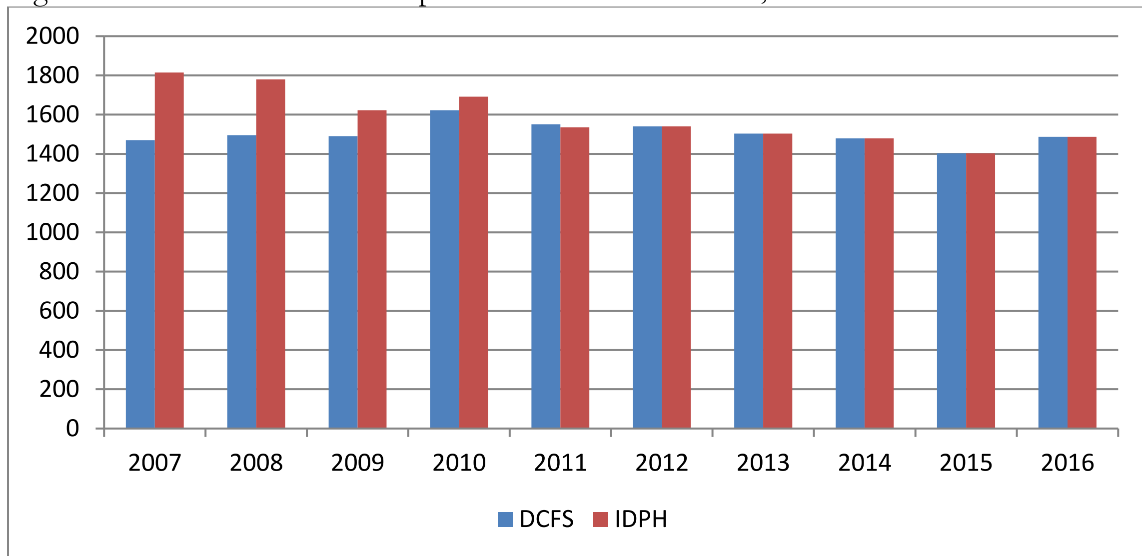
As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2016, four deaths fell in this category, and two were reviewed.

Chapter 5: Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths since 2000, which allows for an analysis of the trends in Illinois child deaths over time. Since 2012, the deaths reported to IDPH and DCFS have been consolidated and there is only one number for child death reports.

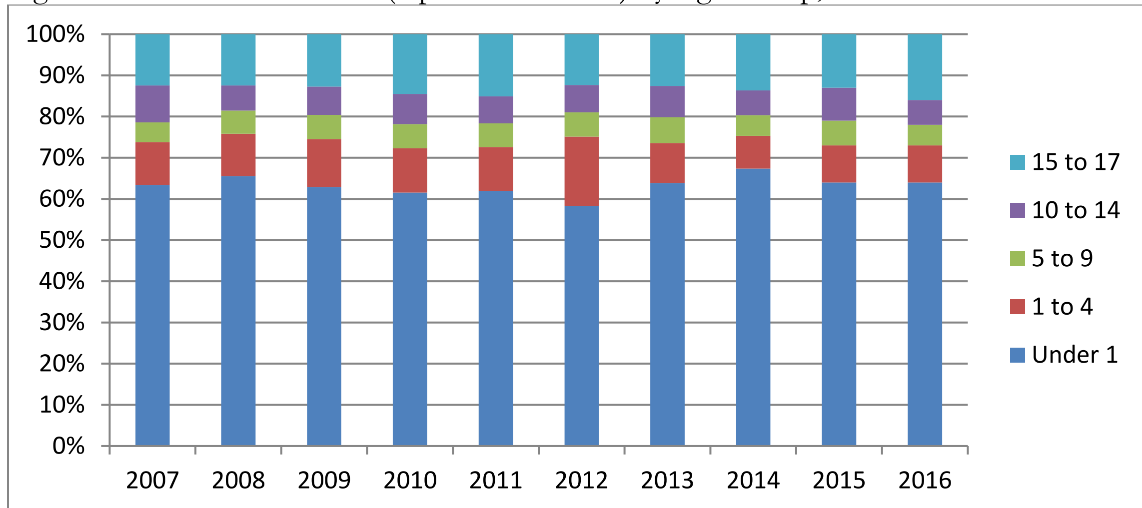
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1948 in 2007 and a low of 1402 in 2015. There was a slight increase in the number of child deaths in 2016 (see Figure 35).

Figure 35: Total Child Deaths Reported to DCFS and IDPH, 2007–2016



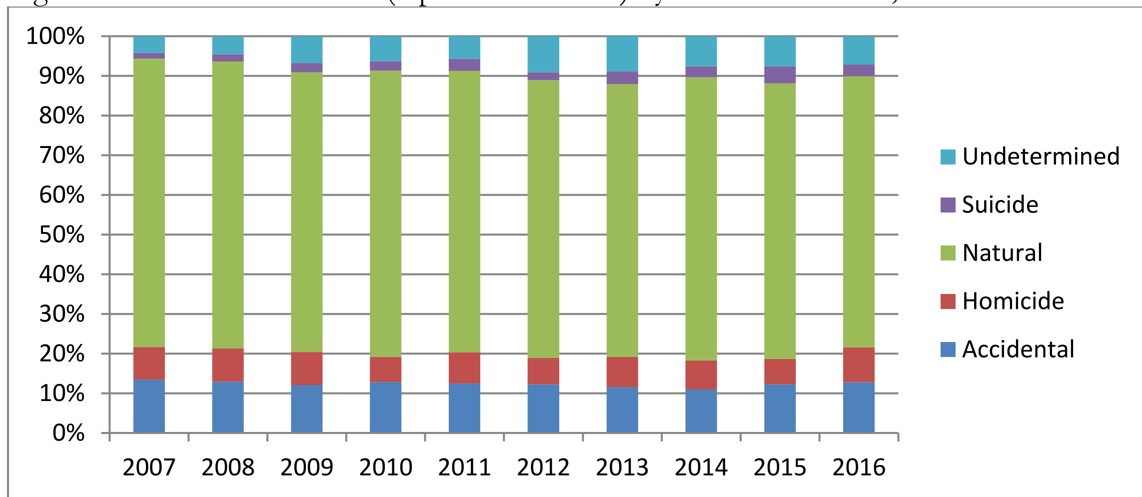
The total child deaths reported to the Child Death Review Team Unit from 2007 to 2016 is broken down by age group in Figure 36. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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 8-12%, 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 12-16%. 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, 2007–2016



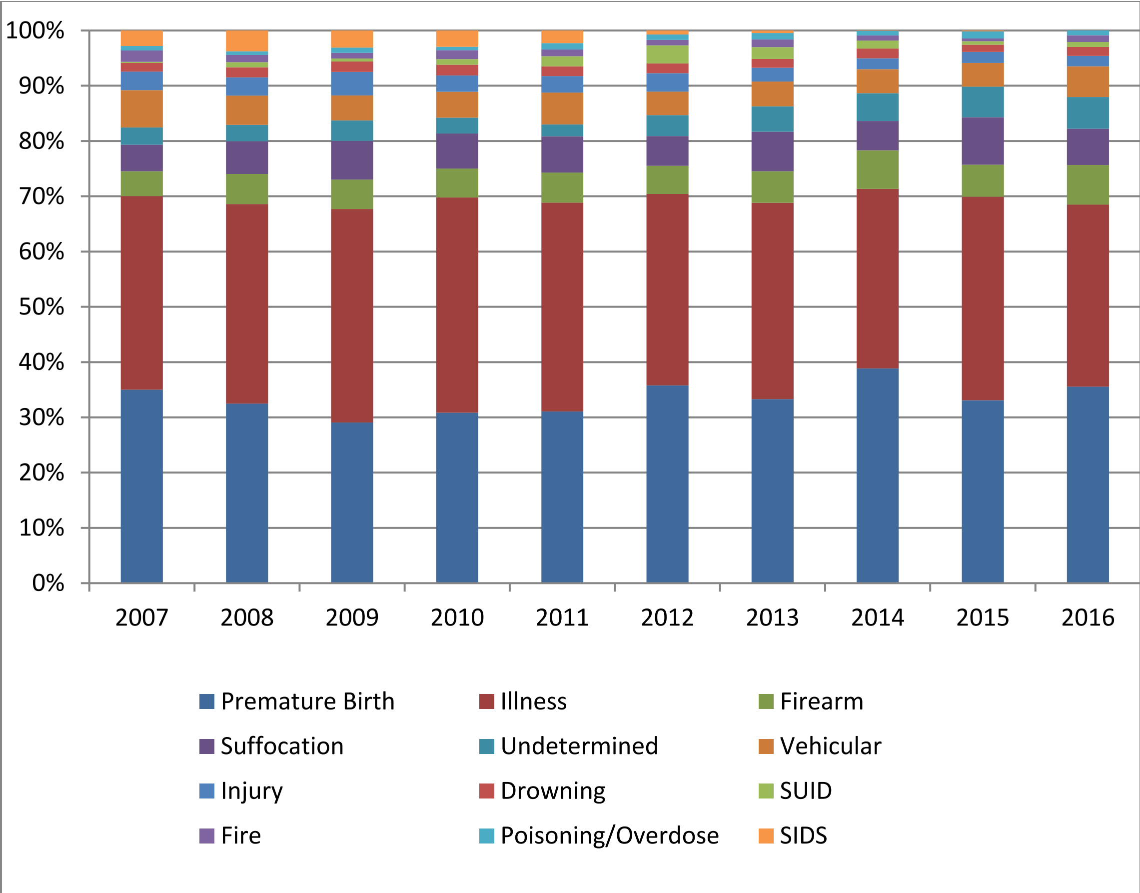
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-13% accidental, 6-9% homicide, 68-73% natural, 2-4% suicide, and 5-9% undetermined (see Figure 37).

Figure 37: Total Child Deaths (reported to DCFS) by Manner of Death, 2007–2016



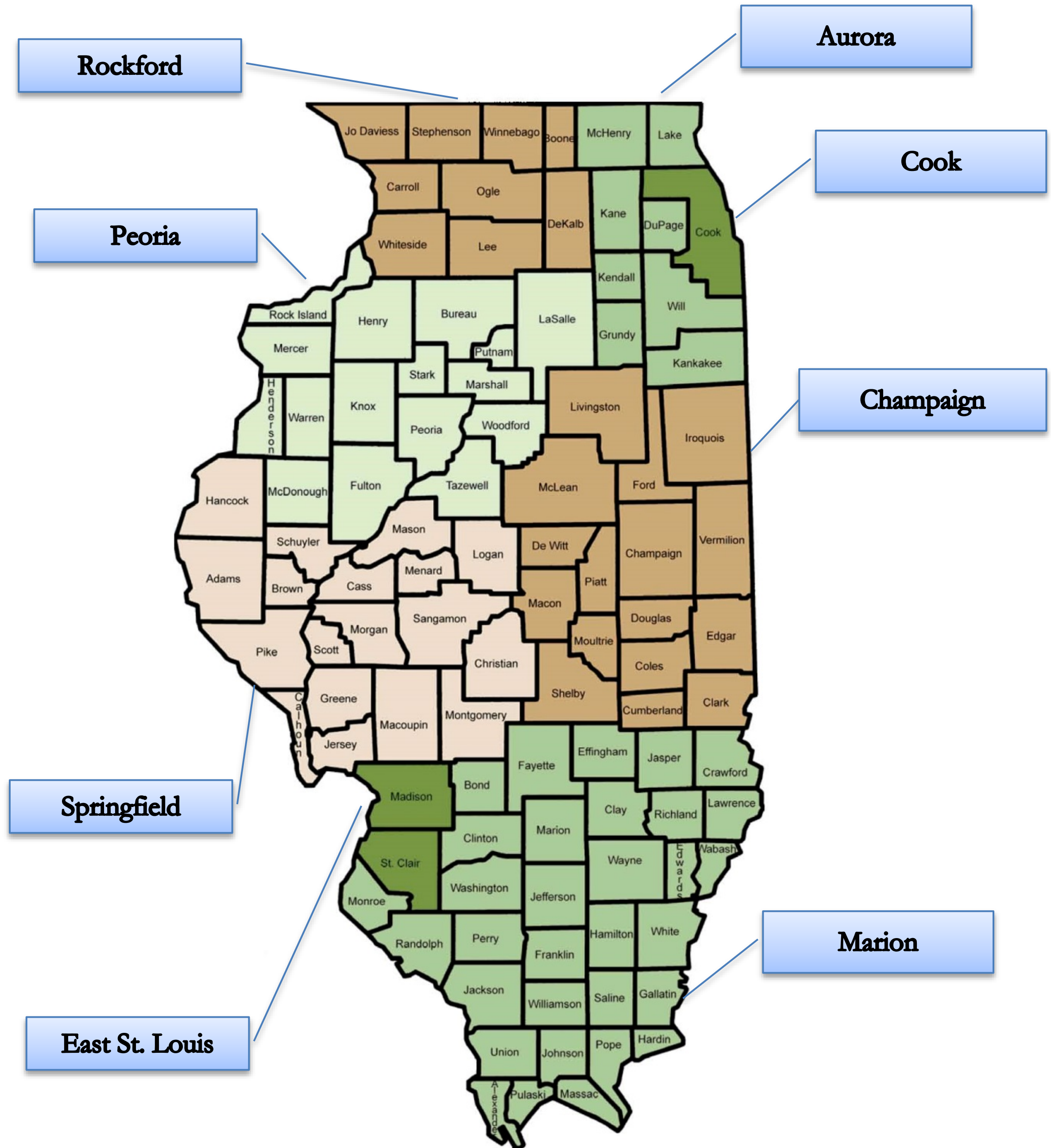
A similar analysis was done for category of death (see Figure 38). The percentage of child deaths related to each category of death across the time period varies: the major categories of deaths from prematurity (29-39%) and illness (32-39%) fluctuated over time; there was an increasing trend for deaths from firearms (1-5% before 2013 to 6-7% since 2013) and undetermined causes (2-4% before 2013 to 5-6% since 2013); and there was a declining trend for deaths from SIDS (1-3% from 2007 to 2012 to 0% since 2013), vehicular accidents (5-7% before 2012 and then stayed at 4% until a rise back up to 6% in 2016), 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, 2007–2016[36]



[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
Mary E. Jones MD, MPH, **Chairperson**
Dan Thomas, **Vice Chairperson**
Patrick Dempsey
Joshua Fourdyce
Jennifer Hess
Helen Kapas
Nydia Molina
Orson Morrison
Wendy Payne
Loren Richardson Carrera
Jennifer Samartano
Anne Strickland
DCFS Staff – Carole Ruzicka

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

Cook Team A
Vacant, **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
Nicole Johnson, MD
Eileen Payonk, Special Agent
Char Rivette
Norell Rosado, MD
Margaret Scotellaro, MD
Daniela Silaides
Kimberly Souder
Tierney Stutz
Christina Tarazi, MD
Kelley Thornton
Dion Trotter
Kavita Vankineni, MD
Syed Zaheer
Eimad Zakariya, MD
Yvonne M. Zehr, Chief Deputy
Virginia Zic-Schlomas, Sgt.
DCFS Staff – Tanya Carriere

Cook Team B
Kathy Grzelak, MA, LCPC, **Chairperson**
Mary Joly Stein, **Vice Chairperson**
Sweety Agrawal, PsyD
Eric Eason, DO
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Trenton Hubbard, MD
Shawnte Jenkins
Tracy Kruger, RN, CPNP-PC
Denika Means, DO
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Evelyn Polk-Green, MSEd.
Veena Ramaiah, MD
Diane Scruggs
Benjamin Soriano, MD
Annie Torres, MD
Valencia Williams, PsyD
DCFS Staff – Tierney Stutz

East St. Louis

Daniel Cuneo, PhD, **Chairperson**
David C. Norman, **Vice Chairperson**
Jamie Brunnworth
Cathy Daesch, ATR-BC, LCPC, ICDVP
Judy Dalan
Desarie Holmes, PhD
Carolyn Hubler, Director
Francis Jones, RN
Carole A. Presson, Lt.
Lynn Shelton, RN
DCFS Staff – Stacy Short

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
Betti Mucha
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, Special Agent, **Vice Chairperson**
America Bunker, RN
Susan Bordenave-Bishop, DMD
Gregg M. Cavanaugh, M/Sgt.
Stefanie Clarke, BSN, RN, CPEN
Donna Cruz
Brian Gustafson
Emily McDonnell, MSN
Marcy O'Brien
Channing Petrak, MD
Mark Thomas
Michele Verda, PhD
Melissa Watkins
DCFS Staff – Jim Marmion

Rockford

Joanna Deuth, **Chairperson**
Holly Peifer, **Vice Chairperson**
Pamela A. Borchardt
Amy Buchenau
Raymond Davis, Jr., MD
David Glessner
Leah Hantke, RNC, MS, WHNP
Marilyn Hite Ross
Stephanie Klein
Janice Leamon
Angela Mathews
Dave Watson
Rebecca Wigget
DCFS Staff – Dawn Moyer

Springfield

Careyana Brenham, MD, **Chairperson**
Shirley Johnson, **Vice Chairperson**
Cinda Edwards
John Hayes, Detective
Heather Hofferkamp
Nathaniel Patterson, MD
Dan Wright
John Yard, Special Agent
DCFS Staff – Jason Cummins

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

Appendix C – Illinois Child Deaths by County

County	2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths	2014 Deaths	2015 Deaths	2016 Deaths
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH *	DCFS	IDPHs *	DCFS	IDPH *	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **
Adams	8	11	1	10	6	5	6	5	4	3	9	5	9	9	8
Alexander	0	1	0	1	1	1	0	2	0	0	1	0	0	0	1
Bond	0	0	1	1	0	0	0	1	2	2	4	1	0	2	0
Boone	0	0	0	3	3	3	1	1	4	2	3	0	1	0	1
Brown	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0
Bureau	2	2	1	2	5	5	6	5	1	1	2	1	3	0	2
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	0	1	1	1	2	2	0	0	1	0	1	0	1
Cass	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Champaign	3	39	21	36	42	36	36	33	43	37	29	49	38	30	45
Christian	0	0	3	4	4	4	4	3	3	2	2	1	1	4	2
Clark	0	0	1	1	0	0	0	1	2	2	1	3	0	1	1
Clay	0	0	0	1	0	0	1	1	0	0	1	1	0	0	3
Clinton	0	3	3	4	1	1	3	3	2	1	1	3	0	0	1
Coles	0	3	0	4	3	5	5	2	5	6	4	4	4	2	5
Cook	926	1,066	908	1,010	768	832	887	920	857	824	857	775	815	818	831
Crawford	0	1	1	1	0	0	2	1	2	1	4	4	0	1	0
Cumberland	0	0	3	2	2	3	2	2	0	0	1	0	0	0	1
DeKalb	4	5	3	3	5	3	4	3	5	5	4	9	7	3	6
Dewitt	0	1	0	0	2	2	0	0	1	1	0	0	3	1	0
Douglas	0	0	0	0	0	0	1	1	1	1	1	0	1	0	1
DuPage	97	99	76	81	65	62	89	76	73	68	66	70	80	63	76
Edgar	0	1	1	2	0	0	0	0	1	1	1	1	1	2	1
Edwards	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
Effingham	0	7	5	6	1	1	0	1	8	7	2	7	5	5	4
Fayette	0	1	0	0	0	0	1	0	1	1	0	2	3	1	1
Ford	1	1	3	3	1	0	1	1	0	0	1	2	1	0	0
Franklin	3	3	3	3	4	4	5	3	2	1	0	2	4	6	3
Fulton	5	5	0	0	3	4	4	4	0	0	3	0	0	2	2
Gallatin	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Greene	0	0	0	1	0	0	0	1	0	1	0	0	1	0	0
Grundy	0	5	3	4	3	4	5	5	3	2	3	2	1	2	1
Hamilton	1	1	3	3	0	0	1	1	1	1	1	2	0	1	2
Hancock	0	0	0	2	2	1	0	0	1	1	0	1	3	0	0
Hardin	0	1	0	0	0	0	2	2	1	2	1	1	1	1	1
Henderson	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Henry	4	4	2	2	2	3	4	4	4	2	2	3	3	2	5
Iroquois	0	2	0	1	0	0	3	3	1	1	1	1	0	0	2

Jackson	3	4	8	8	9	8	4	5	8	6	16	2	5	9	4
Jasper	0	0	0	0	0	0	2	1	0	0	0	0	0	0	1
Jefferson	0	3	1	4	1	1	9	9	7	6	2	6	4	2	4
Jersey	1	3	0	2	0	0	1	2	2	3	4	2	0	4	2
Jo Daviess	0	1	0	0	0	0	0	0	4	4	0	1	0	0	2
Johnson	1	0	0	0	0	2	0	3	0	3	2	0	0	0	0
Kane	37	46	59	57	55	53	44	41	45	42	42	42	44	51	46
Kankakee	9	9	8	13	5	5	8	8	8	8	12	10	10	6	16
Kendall	6	6	6	6	2	2	1	1	1	1	2	3	2	0	0
Knox	3	3	4	4	2	2	7	8	10	10	3	4	6	6	6
Lake	17	37	26	38	34	47	31	47	35	40	33	37	36	36	34
LaSalle	0	8	0	9	7	7	8	9	9	8	11	8	7	11	5
Lawrence	0	0	1	3	1	1	6	4	4	2	1	2	0	1	0
Lee	0	2	0	1	3	5	1	1	2	2	2	3	3	2	1
Livingston	0	5	2	5	2	2	3	3	5	2	3	0	4	2	3
Logan	0	0	7	8	6	5	0	0	2	2	3	3	1	0	3
Macon	15	16	18	21	15	15	11	10	13	13	7	4	12	11	7
Macoupin	0	1	0	0	2	2	2	3	0	0	0	5	4	2	0
Madison	14	19	21	25	16	20	15	13	13	11	8	12	14	18	21
Marion	4	4	4	3	3	6	3	9	5	9	2	5	5	10	3
Marshall	0	0	0	0	3	2	2	1	0	0	0	0	0	1	1
Mason	0	0	0	0	0	0	2	1	0	0	0	3	1	2	1
Massac	1	1	1	1	4	2	0	0	0	0	2	1	0	1	3
McDonough	0	0	0	1	1	2	2	2	1	1	1	2	0	1	0
McHenry	23	24	14	19	11	11	7	6	11	9	12	17	9	9	9
McLean	11	10	14	14	5	6	9	10	13	12	9	12	13	14	8
Menard	0	0	0	1	1	1	1	1	0	0	0	0	0	0	0
Mercer	0	0	0	0	0	0	1	1	1	1	2	6	0	1	0
Monroe	1	1	0	0	2	2	0	1	1	1	1	1	0	1	0
Montgomery	3	3	0	1	1	0	3	3	3	2	1	0	4	2	3
Morgan	1	1	0	2	1	1	2	2	0	1	2	3	3	0	2
Moultrie	0	0	3	3	0	0	1	1	4	4	1	0	0	0	0
Ogle	3	3	4	4	3	3	2	1	1	1	0	0	2	3	0
Peoria	51	77	49	86	76	93	81	80	76	75	109	72	82	63	76
Perry	1	4	2	3	0	0	4	4	0	0	1	3	2	1	2
Piatt	0	1	0	2	0	0	0	0	1	1	1	0	0	0	0
Pike	0	0	0	0	0	0	2	2	0	0	0	0	0	0	1
Pope	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Pulaski	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0
Putnam	0	0	0	0	2	2	0	0	0	0	0	0	0	1	0
Randolph	1	4	0	0	1	1	1	1	1	1	6	7	2	1	3
Richland	0	0	1	3	1	1	1	1	2	2	1	1	2	1	2
Rock Island	19	19	12	12	18	17	12	9	12	11	11	9	12	8	9
Saline	2	2	2	2	4	2	4	3	1	1	3	0	3	3	0

Sangamon	48	54	32	46	51	48	46	43	38	46	33	46	39	36	45
Schuyler	0	0	0	0	0	0	4	0	6	0	1	1	1	0	0
Scott	0	1	0	1	0	2	0	0	0	0	0	2	0	0	1
Shelby	1	1	3	3	2	5	1	2	0	0	0	2	0	2	1
St. Clair	14	29	7	26	26	28	18	16	18	15	21	31	26	15	15
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephenson	3	4	4	5	4	4	5	4	2	2	1	2	4	3	2
Tazewell	3	5	4	7	2	2	2	3	3	2	3	2	7	5	3
Union	2	2	0	0	2	2	3	3	1	1	1	2	1	3	0
Vermillion	9	12	1	6	13	14	7	6	8	6	11	10	7	4	12
Wabash	0	1	0	2	3	2	0	0	0	0	1	0	1	0	1
Warren	0	0	0	1	0	1	1	1	1	1	1	1	1	1	1
Washington	0	1	0	0	0	0	2	2	1	1	0	1	1	0	1
Wayne	1	2	0	1	1	1	1	1	1	1	2	1	1	3	1
White	0	0	0	0	1	1	1	1	1	1	1	0	1	0	2
Whiteside	0	6	0	3	7	6	3	5	4	3	1	4	3	1	6
Will	42	43	42	38	44	47	38	35	28	26	33	34	38	24	36
Williamson	4	9	8	9	6	5	5	5	10	9	6	6	13	6	3
Winnebago	58	65	71	78	59	48	61	49	51	43	40	36	43	46	59
Woodford	0	0	1	1	1	2	2	2	3	3	1	4	1	2	1
Unknown	0	0	0	0	18	0	1	0	0	1	0	0	0	0	0
Out of State	4	0	13	0	27	81	53	117	46	97	47	81	12	11	12
Out of country	–	–	–	–	–	–	–	–	–	–	9	0	0	0	0
Total	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	1487

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

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