



ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR
2017



MISSION

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

Illinois Department of
DCFS
Children & Family Services

SUBMITTED TO:

The Honorable JB Pritzker,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

June 2019

June 2019

Dear Readers,

Every single child death that occurs is tragic. When such deaths are preventable, it is beyond tragic.

The 2019 Illinois Child Death Review Annual Report includes the data for the child deaths that occurred in calendar year 2017. This report serves as a tribute to every child that died and reflects our deep commitment to providing the care that our vulnerable children and families truly deserve.

While many of the deaths were due to natural causes, others may have been prevented through alternative actions by parents and other caretakers, earlier intervention by public and/or private support systems, or increased efforts of public safety campaigns.

The goal of the Child Death Review Teams is to gain greater understanding of the incidence and causes of child deaths to prevent future child deaths.

This report reflects the efforts of nine Child Death Review Teams throughout the State. In partnership with DCFS, these teams have reviewed over 250 child deaths and made 90 recommendations for improving and saving the lives of our children. The department responded to the recommendations made by these teams and implemented many of them.

We share a deep commitment to protecting vulnerable children. It has been an incredible privilege to work with such dedicated people who volunteer their time and expertise to painstakingly review and discuss these tragedies.

I am confident that our ongoing partnership will serve to prevent more child deaths in the future.

Sincerely,



Marc D. Smith
Acting Director
Illinois Department of Children and Family Services

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June 2019

The Honorable J.B. Pritzker, 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 2017. 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.

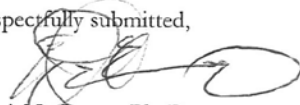
The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department 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 Marc D. Smith 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 Pritzker and the members of the General Assembly for the opportunity to protect and serve the welfare of the children of Illinois.

Respectfully submitted,



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

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 (DCFS) 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 Teams database and suggestions to Dr. Steve Tran. Children and Family Research Center staff, Drs. Steve Tran and Tamara Fuller, wrote the report.

Illinois Child Death Review Team

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CDRT Executive Director

Tamara Skube

Table of Contents

Executive Summary.....	8
Introduction	10
Chapter 1: Child Death Review in Illinois.....	11
Chapter 2: Child Death Review Recommendations to Prevent Child Deaths	19
Chapter 3: Illinois Child Deaths in 2017.....	42
Chapter 4: Child Deaths by Category.....	54
Illness.....	55
Premature Birth	58
Suffocation	61
Firearms	65
Vehicular Accident.....	68
Undetermined Deaths.....	73
Injuries.....	75
Drowning.....	78
Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)	81
Poisoning/Overdose.....	84
Fire.....	86
Uncommon Death Categories: Scalding Burn, Sudden Unexplained Child Death (SUCD), and Other	88
Chapter 5: Trends in Illinois Child Deaths.....	89
Appendix A – Child Death Review Team Regional Map	92
Appendix B – List of CDRT Members by Region	93
Appendix C – Illinois Child Deaths by County.....	95

List of Tables

Table 1: 2017 Illinois Child Deaths Recommendations and Responses.....	20
Table 2: Child Deaths by Category of Death.....	46
Table 3: Manner of Death – Total Child Deaths Reviewed by CDRTs.....	47
Table 4: Total Child Deaths – Manner of Death by Category of Death.....	48
Table 5: Homicide Deaths	48

List of Figures

Figure 1: The Child Death Review Process in Illinois.....	15
Figure 2: Child Death Reviews.....	16
Figure 3: Illinois Child Population, Child Deaths, CDRT-Reviewed Child Deaths by Gender.....	43
Figure 4: 2010 Illinois Child Population by Age.....	43
Figure 5: Illinois Child Deaths by Age Group.....	44
Figure 6: Illinois Child Deaths by Race/Ethnicity	45
Figure 7: Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs	47
Figure 8: Child Deaths Due to Illness	55
Figure 9: Child Deaths Due to Illness by Age	57
Figure 10: Child Deaths Due to Illness by Race/Ethnicity	57
Figure 11: Child Deaths Due to Prematurity	59
Figure 12: Child Deaths Due to Prematurity by Race/Ethnicity.....	60
Figure 13: Child Deaths Due to Suffocation.....	62
Figure 14: Child Deaths Due to Suffocation by Age.....	63
Figure 15: Child Deaths Due to Suffocation by Race/Ethnicity	64
Figure 16: Child Deaths Due to Firearms	66
Figure 17: Child Deaths Due to Firearms by Age.....	67
Figure 18: Child Deaths Due to Firearms by Race/Ethnicity.....	68
Figure 19: Child Deaths Due to Vehicular Accidents	70
Figure 20: Child Deaths Due to Vehicular Accidents by Age.....	71
Figure 21: Child Deaths Due to Vehicular Accidents by Race	72
Figure 22: Child Deaths with Undetermined Cause of Death	73
Figure 23: Child Deaths with Undetermined Cause by Race/Ethnicity.....	74
Figure 24: Child Death Due to Injuries	76
Figure 25: Child Deaths Due to Injuries by Age.....	77
Figure 26: Child Deaths Due to Injuries by Race/Ethnicity	77
Figure 27: Child Deaths Due to Drowning.....	79
Figure 28: Child Deaths Due to Drowning by Age	80
Figure 29: Child Deaths Due to Drowning by Race/Ethnicity	80
Figure 30: Child Deaths due to SIDS and SUID	82
Figure 31: Child Deaths Due to Poisoning/Overdose.....	85
Figure 32: Child Deaths Due to Fire.....	86
Figure 33: Total Child Deaths Reported to DCFS and IDPH, 2008–2017.....	89
Figure 34: Total Child Deaths (reported to DCFS) by Age Group, 2008-2017.....	90
Figure 35: Total Child Deaths (reported to DCFS) by Manner of Death, 2008-2017	90
Figure 36: Total Child Deaths (reported to DCFS) by Category, 2008-2017	91

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 2017

In 2017, 1,424 children under 18 died in Illinois.¹ This number represents the death information received by DCFS as of March 27, 2019.

Of the total child deaths reported to CDRTs in 2017:

- 60% were boys and 40% 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;
- 58% were white, 36% were African American, 4% were Asian, nearly 2% were Hispanic and under 1% were of unknown racial origin.

When Illinois child deaths in 2017 were examined by the manner of death:

- 65% were attributable to natural causes;
- 14% were accidental;
- 10% were homicides;
- 5% were suicides;
- 6% were undetermined.

When deaths occurring in 2017 were examined by the category of death:

- 32% were related to illness;
- 32% were related to premature birth;
- 1% were related to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID);
- 29% were related to various types of injuries, such as suffocations (8%), firearms (8%), vehicular accidents (6%), drowning (2%), fires (<1%), poisoning/overdose (<1%) and other types of injuries (11%);
- 5% were due to undetermined causes.

¹ The Illinois Department of Public Health reports all death data to the Enterprise Data Warehouse that is managed by Healthcare and Family Services (HFS).

2017 Child Deaths Reviewed by the CDRTs

In 2017, 266 child deaths were reviewed by the CDRTs, including 155 mandatory and 111 discretionary reviews. The mandatory reviews occurred for one of several reasons: 80 were indicated death cases, 47 cases had an investigation in the year before the child's death, 21 were indicated investigations, five were DCFS youth in care and two 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 – 26 of the 190 deaths (14%) were reviewed.
- Champaign – 23 of the 91 deaths (25%) were reviewed.
- Cook – 111 of the 766 deaths (13%) were reviewed.
- East St. Louis – 17 of the 49 deaths (35%) were reviewed.
- Marion – 14 of the 51 deaths (27%) were reviewed.
- Peoria – 28 of the 117 deaths (24%) were reviewed.
- Rockford – 23 of the 85 deaths (27%) were reviewed.
- Springfield – 18 of the 66 deaths (27%) were reviewed.
- In addition, six of the six deaths (100%) that were out of state were reviewed.

Of the deaths reviewed by CDRTs in 2017:

- 62% were boys and 38% were girls;
- 58% were infants under 1, 20% were young children between 1 and 4 years, 8% were children between 5 and 9 years, 8% were children 10 and 14 years and 6% were youth between 15 and 17 years.

When reviewed deaths occurring in 2017 were examined by manner of death:

- 34% were attributed to accidents;
- 22% were due to natural causes;
- 15% were homicides;
- 3% were suicides;
- 27% were undetermined.

When reviewed deaths occurring in 2017 were examined by category of death:

- 2% were related to premature birth;
- 19% were related to illness;
- 5% were related to SUID;
- 52% were related to various types of injuries, such as suffocations (24%), drowning (6%), firearms (3%), vehicular accidents (8%), poisoning/overdose (1%), fire (2%) and other types of injuries (8%);
- 23% were due to undetermined 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 2017, there were 1,424 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 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, P.A. 92-468 on August 22, 2001, P.A. 95-405 and P.A. 95-527 on June 1, 2008, P.A. 95-876 on August 21, 2008, P.A. 96-328 on August 11, 2009, P.A. 96-955 on June 30, 2010, P.A. 96-1000 on July 2, 2010, P.A. 98-558 on January 1, 2014, P.A. 100-159 on August 18, 2017, P.A. 100-397 on January 1, 2018, P.A. 100-1122 on November 27, 2018, and most recently P.A. 100-733 on January 1, 2019.² 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 how 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 DCFS director and inspector general 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;

² The complete Act is available online at www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=244&ChapterID=5.

- contribute to initiatives to improve public awareness of issues that affect the safety and well-being of children;
- collect data that will inform efforts to reduce child fatalities; and
- keep the governor and legislature apprised of CDRTs 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 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;
- Representative of the Illinois State Police;
- Representative of the Department of Public Health.

Teams may make recommendations to the DCFS inspector general 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 inspector general 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 in person quarterly and teleconferences monthly to review the procedures and recommendations made by the teams in the examination of child deaths. The Executive Council operates pursuant to Section 40 of the Illinois Child Death Review Team Act. 20 ILCS 515/40. 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 to protect children;
- collaborating with the Illinois General Assembly, DCFS and others 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 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 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 2018-2019, the Illinois CDRTs accomplished several goals, including:

- 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 2017 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the DCFS director 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 22nd annual symposium was held at the Crowne Plaza Springfield, Illinois on March 8-9, 2018. A total of 63 team members attended.
 - Registrations were sent out to the Illinois CDRTs’ members in February.
 - The following were speakers at the symposium: 1) “Updates on the DCFS Hotline” Deanna Large, DCFS and Nora Harms-Pavelski, DCFS; 2) “IDPH Efforts to Decrease Child Deaths” Jennifer L. Martin, MSW, IDPH injury and violence prevention project manager; 3) “Manner of Death Training” Joan Perneck, Executive Council chairperson/Cook A chairperson and Dr. Eric Eason, Cook B team member/Cook County Medical Examiner’s Office; 4) “Legislative Updates” Meryl Paniak, DCFS inspector general. An agenda, presenters’ biographies and additional handouts were printed and placed in participant folders.
 - Educational units were arranged through DCFS and the Cook County State’s Attorneys’ Office.

DCFS Roles and Responsibilities

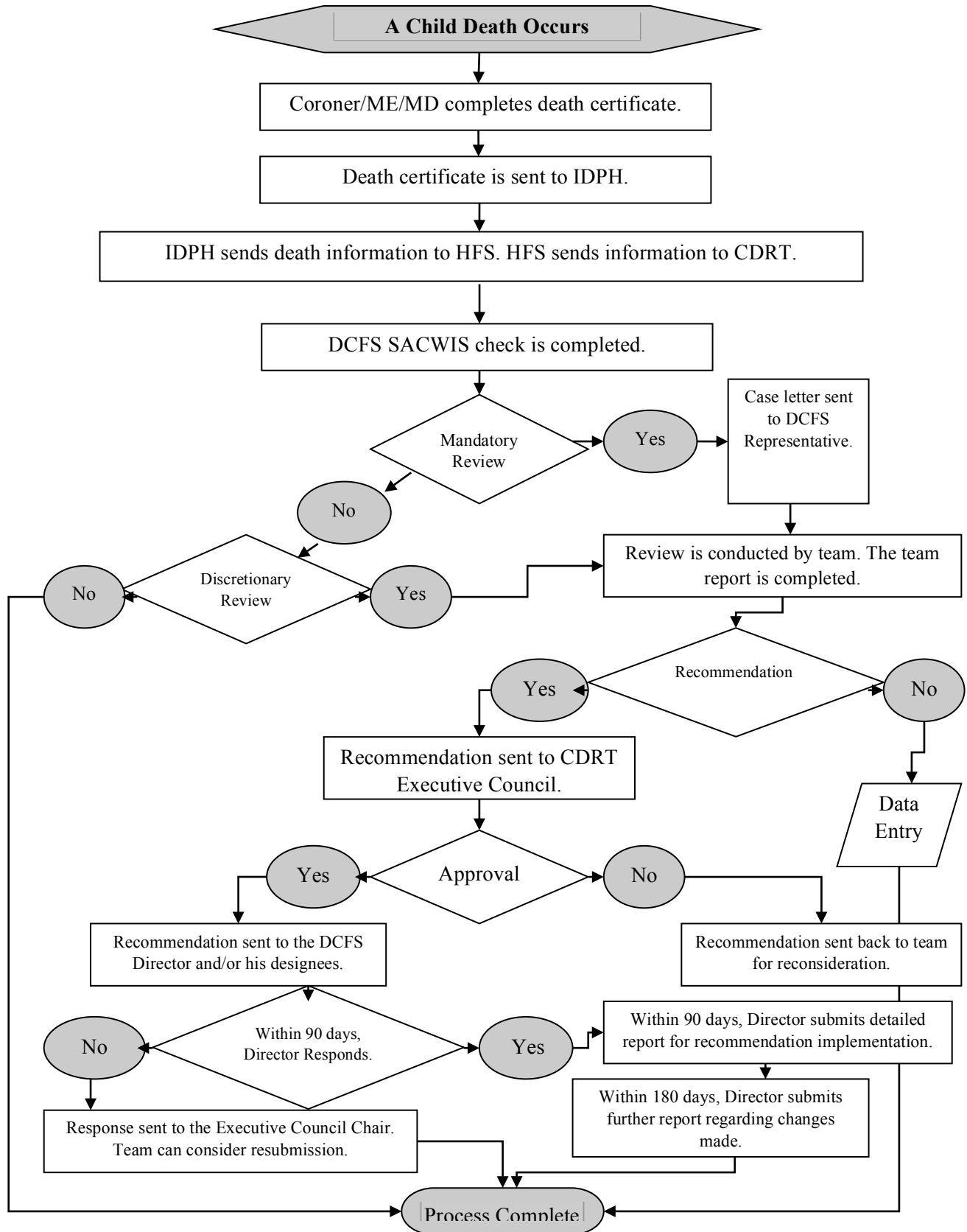
The Illinois DCFS Office of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT manager). In addition, the department serves as a direct link between the review teams and the state's child protection policy makers. The DCFS director must review and 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 CDRT process is outlined in a flow chart in Figure 1.

Figure 1: The Child Death Review Process in Illinois

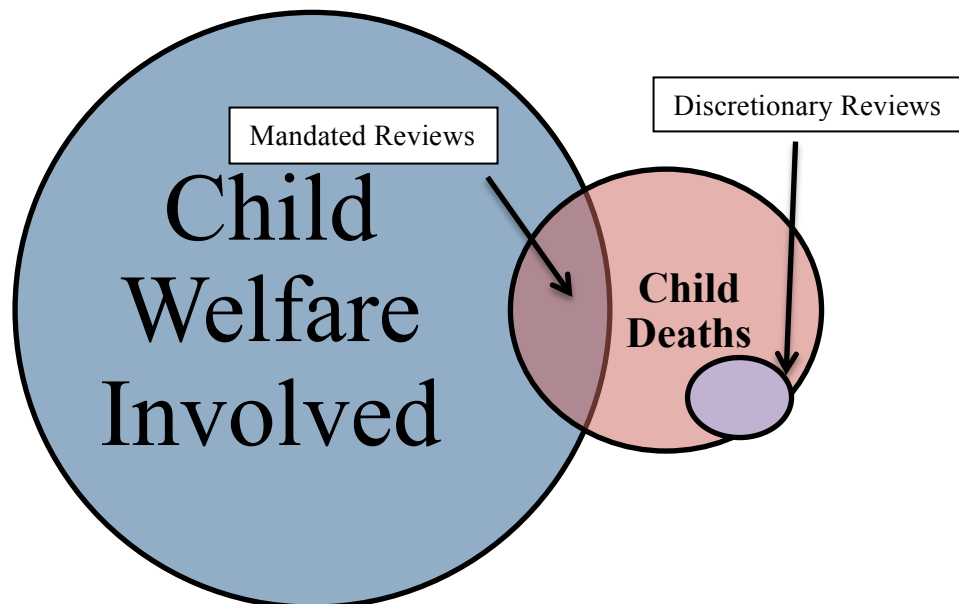


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the information to the Illinois Department of Public Health (IDPH). IDPH provides this information to the Illinois Department of Healthcare and Family Services (HFS) Enterprise Data Warehouse which then sends the death certificate information to the Child Death Review Office. 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 child 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 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.³ 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 DCFS director 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 he or she intends 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

³ In addition to mandated reviews and discretionary reviews, CDRTs are required to review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the mandated reporter may ask for a CDRT or other local multidisciplinary team to review the report. The team will review all pertinent information and make a recommendation to DCFS. There were no reviews of this nature requested in 2017.

gained through the Child Advocacy Center protocol for cases of serious or fatal injuries. In addition, a CDRT has access to all records and information in the possession of a state or local agency that are relevant to the team's review of a child's death. This includes, but is not limited to, birth certificates, relevant medical and mental health records, law enforcement agency records, Department of Correction parole records, probation and court services records and social service agency records regarding services to the child or family.

Confidentiality of CDRT Information

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

Illinois child deaths of 2017 reported to Child Death Review numbered 1,424. CDRTs reviewed 266 of these 1,424 child deaths. Ninety recommendations were made by CDRTs on 53 of the 266 child death cases reviewed. Of the 90 recommendations, there were 45 recommendations which focused on DCFS policy and procedures. The DCFS recommendations resulted from five types of reviews including: death indicated (19), investigation within a year of death (3), indicated report at time of death (6), discretionary (15) and youth in care (2). There were 20 recommendations related to other agencies or systems. These recommendations came from four types of reviews including: death indicated (10), discretionary (5), investigation within a year of death (3), and indicated report at time of death (2). There were 25 case specific recommendations from five types of reviews: seven recommendations resulted from cases where death was indicated, six were from discretionary reviews, six were from cases that had an indicated report at time of death, four were from cases that had an investigation within a year of death and two recommendations resulted from youth in care cases.

Table Key:

DCFS = DCFS recommendation

OS = Other System recommendation

PP = Primary Prevention recommendation

CS = Case-specific recommendation

Table 1: 2017 Illinois Child Deaths Recommendations and Responses

Type	Recommendation	Response
DCFS-1	There should be policy in Procedure 300 specifically regarding juvenile diabetes.	There is a medical section within procedure 300 and a section regarding consulting for specialty services which would include consultation regarding juvenile diabetes.
DCFS-2	There should be clear written policy about when a nursing referral must or should be made, and what to do thereafter (how to use the information, how to consult with the nurse in real time in order to conduct a better investigation).	<p>Reports of medical neglect of disabled newborns and infants under one year of age must be referred by the child protection specialist to the regional nurse. If the situation is an emergency, the regional nurse shall be notified of the report via telephone. The child protection specialist shall provide the nurse with copies of any medical records, reports or recommendations about the involved newborn or infant. The child protection specialist and/or supervisor shall consult with the regional nurse regarding the protective custody decision of the disabled newborn or infant if the imminent danger to life and health is related to the child’s disability or medical condition. When the department has assumed legal responsibility for the disabled newborn or infant, the nurse is responsible for securing treatments and evaluations, if needed, and shall refer the child to a perinatal center, when necessary, to obtain specialized care or an independent evaluation. The nurse shall provide professional judgment whether there is evidence of medical neglect for each report involving a disabled newborn or infant less than one year of age. However, the child protection specialist is responsible for recommending a final finding based</p>

		<p>upon the nurse’s judgment and other evidence gathered during the course of the investigation.</p> <p>Children with special health care needs: When an alleged child victim of a report of medical neglect is identified by the child protection specialist as having or possibly having special health care needs or a child with special health care needs is living in the home of an alleged perpetrator, the child protection specialist must refer the child for nursing consultation services no later than 48 hours after case assignment. To refer a child for nursing consultation services, complete the DCFS Regional Nurse Referral Form and email the completed form via Outlook to “nurseref” or fax the form with any supporting documentation to the attention of child welfare associate specialist.</p> <p>Note: A child with special health care needs living in the home of an alleged perpetrator, but not named as a victim in the pending investigation, must be added to the pending investigation as a newly identified alleged victim under Allegation #10, Substantial Risk of Physical Injury; #60, Environment Injurious to Health and Welfare; #79 Medical Neglect or any other allegation supported by investigation information. Considering the above, DCFS is not proposing that we write any procedures regarding juvenile diabetes as this disease would be covered in the above procedures.</p>
DCFS-3	The team recommends that the department commend the DCFS investigator for her great work.	DCFS agrees and will commend her for her work.
DCFS-4	The team recommends DCFS review the contract language that pushes agencies to close cases in six months.	There are provisions within the intact policy that allow cases to remain open as long as the services are needed.

	<p>There should be an evaluation for closure at six months rather than closure at six months. DCFS should check to see if mom is living with the grandmother and kids.</p>	<p>Intact cases are not pushed to close in six months and can be identified at opening to be open at least 12 months based on service needs and case dynamics. Case length and the determination to close is individual and should be based on the individual needs of the family to ensure the child can be maintained safely within his/her home. Staff have been sent to assess the current situation regarding the placement with the grandmother and check if mom is residing with the grandmother and the kids.</p> <p>DCFS did go out an assess the children's situation further. The kids are in two different homes. Most of the kids were spoken to and talked about visitation with their mom. There was no evidence to suggest that the mom is currently living with any of the kids. All of the kids were in good shape and the homes they are staying in were in good shape.</p> <p>In this situation, there were community people that were in the home and should have known about this problem before the home got in such bad shape. DCFS will be meeting with staff and will use this case as a training example.</p>
DCFS-5	<p>DCFS should reconsider expungement of unfounded cases. There was a prior burn investigation from January of 2016 on the 3 y/o sibling of this deceased child (sibling child burned over 80% of his body, allegedly from dad carrying boiling water and the minor either running in to him or dad accidentally spilling it on him) that was no longer in SACWIS during the death investigations of either child. During the death investigation in October 2016, the family reported that DCFS</p>	<p>This has been previously discussed and resolved as Senate Bill 293 amends ANCRA and provides that the department maintain in the central register all unfounded reports for five years. Extends the period the department is required to maintain all prior unfounded reports pertaining to an individual who is the subject of a pending investigation to five years (rather than 12 months) or until the pending investigation has been completed. Removes language requiring the department to maintain</p>

	<p>had investigated the burn but didn't indicate.</p> <p>DCP also learned during the death investigation of both this minor and her brother (who was murdered in October 2016) that the deceased sibling had been subject to and exposed to abuse for his whole life, including an ongoing DV relationship by dad on mom and grandparents saying that the sibling minor was always appearing with injuries for which the parents had multiple excuses. Had the expunged or missing information been available, it could have led to a better assessment or DCFS intervention that may have prevented these tragic deaths.</p>	<p>in the central register for three years a listing of unfounded reports involving the death of a child, the sexual abuse of a child, or serious physical injury to a child as defined by the department in Rules. Removes language requiring the department to maintain all other unfounded reports for 12 months following the date of the final finding. Effective 1/1/19.</p>
DCFS-6	<p>Team requests that DCFS use this case as part of the Cause of Death/Manner of Death training.</p>	<p>DCFS agrees with the recommendation. Child Death Review will add a slide to the Manner/Cause of Death Training that CDRT revised. This will be sent for distribution to DCFS child protection executive staff.</p>
DCFS-7	<p>After a death investigation, if the family moves to another state, if they have been uncooperative or if there are other circumstances that cause concern, a Protective Services Alert should be made. After a death investigation, whether it was indicated, unfounded or undetermined, in situations where:</p> <ul style="list-style-type: none"> a) the family is or has moved out of state; and b) the family was uncooperative or there are other risk factors or concerns, DCFS should staff the case to determine whether to call the receiving state to make a protective services report. 	<p>Current practice is to consider an out-of-state Protective Services Alert when a family moves and there are concerns about the safety and/or well-being of children. If the location of the family is known, investigators can also call the other state and request a child welfare check if there are concerns regarding the children.</p>
DCFS-8	<p>DCFS should not unfound cases simply because a family is uncooperative or has moved. DCFS should utilize the existing category of "undetermined."</p>	<p>The recommendation regarding the issue of expanding the current use of "undetermined" status is currently pending on another case. When situations arise and a family cannot be</p>

		located, the basic information in any unfounded report is still available and should be reviewed when any new investigation comes in. There was further discussion on what information is available on an expunged or purged case. DCFS stated that the subjects, allegations and basic narrative information is available. DCFS is to complete investigations within 60 days but they can be extended 30 days for “good cause.” These extended cases are considered “undetermined.” DCFS cited 7.10 and 7.12 of ANCRA which discusses some of this. DCFS is not able to keep cases in an undetermined status indefinitely.
DCFS-9	DCFS protocol should be expanded such that in a serious harms investigation, if a decision to open to intact is met with a refusal for services by caregivers, cases should automatically be screened with the States Attorney's office since the risk of future harm has not yet been mitigated. This protocol should be explained to caregivers at the time that intact is offered.	DCFS will consider this as we move forward in assessing and revising our Intact Program. There is pending legislation related to this that will mandate intact services.
DCFS-10	DCFS Licensing should prohibit crib bumper pads from licensed foster homes.	Crib bumper pads are already prohibited from foster homes. The foster parent was in violation of the standard.
DCFS-11	DCFS should update and follow all current AAP safety requirements for safe sleep.	DCFS follows all current AAP safety requirements for safe sleep.
DCFS-12	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 if drug use is a contributing factor in these deaths. We recommend that DCFS explore	Police can conduct drug/alcohol testing if they feel it is warranted. Additionally, DCFS can send individuals for such testing if a situation warrants it.

	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).	
DCFS-13	DCFS should have an in-house medical expert to review cases of medical neglect.	DCFS has in-house medical experts to review cases of medical neglect. Staff will be reminded to utilize this source in their investigations.
DCFS-14	The team recommends DCFS seek more aggressive drug testing when a baby dies, especially when the baby was born positive for marijuana. DCFS should explore other states that use “automatic” drug testing in child death cases to determine the efficacy of it and if it’s a contributing factor.	Police can conduct drug/alcohol testing if it is warranted. Additionally, DCFS can send individuals for such testing if a situation warrants it.
DCFS-15	Procedure 300 should include paramours as eligible perpetrators for neglect allegations, not just abuse allegations.	Paramours should be, and are, added as a perpetrator when it is confirmed that they were in a caretaker role at the time of the incident. If the mom and paramour are together and a NEGLECT situation occurs, the mom is responsible for ensuring the needs of the child(ren) are met, not the paramour.
DCFS-16	DCFS should look at developing a specialized intact unit focusing specifically on domestic violence, separate from the statewide DV consultants.	DCFS will consider this moving forward. Domestic violence needs further attention and should be looked at in the totality of the case. DCFS has a grant and is working on a “DV co-location” Unit. We have pilot sites (Waukegan and Rockford) for this. Because DV is so prevalent in the families we work with (much like substance abuse) we can’t have a specialized unit in every area. Practice related to DV needs to be embedded into our Intact Service Program. The goal of this pilot is to learn and understand the dynamics further and then implement the effective aspects in other offices.
DCFS-17	Safety plans should be utilized as short-term tools to protect at risk children during open investigations.	DCFS agrees.

DCFS-18	On DCFS investigations that close and go to intact services with an unsafe CERAP/out-of-home safety plan, DCFS should look critically at the feasibility of intact providers being charged with the duty of continually monitoring the safety plan given the fact that intact workers are not trained investigators.	Intact workers are CERAP-certified and therefore qualified to assess a child’s safety throughout the life of the case. Intact workers are encouraged to consult with the referring investigator if they have questions about the investigator’s involvement.
DCFS-19	DCFS should provide more resources/funding within intact agency contracts when an intact agency is simultaneously providing services to parent/clients and monitoring out-of-home safety plans and ensure that all information that factored into choosing specific safety plan providers be provided to the intact agency.	DCFS will consider this issue. At the handoff between the investigator and intact worker, procedures outline the need to discuss safety plan providers.
DCFS-20	Investigators should be trained that on unsafe sleep cases, DCFS policy requires them to provide education to caregivers regarding safe sleep.	DCFS agrees.
DCFS-21	Team recommends that DCFS have specialized investigators handle Priority 1 cases. For investigators to handle Priority 1 cases, they must have specialized training. DCFS should consider “regionally-based Priority 1 teams” for areas outside of Cook County.	It is a current expectation that death and serious injury cases be handled by Priority 1/serious harms teams where available. However, given the specific dynamics of: a) cases; b) workers; c) teams; d) offices and e) workload, there are some occasions when it is necessary to deviate from this goal. In areas where those teams are not available, it is always best practice to ensure an experienced, skilled investigator is assigned those most serious cases including death and serious harms.
DCFS-22	Establish a dedicated hotline number for medical personnel and law enforcement (attorneys, police, etc.)	DCFS will continue to consider the need for a separate hotline number specifically for medical personnel and law enforcement. There were some questions regarding a timeframe for this. DCFS is currently working with SCR to research the possibility of another line. Finances, manpower and other factors are at play in coming up with a final determination. While

		there is no set deadline, there is progress being made on this issue. Hotline calls have increased by 9% so that is a factor as well.
DCFS-23	When there is a related information report on an existing investigation called in, the caller should not have to go over all the other information.	Normally, the original reporter does not have to go through all the original information they first called in. This issue will be addressed with the hotline to discuss at their next all staff meeting. Mandated reporters receive an intake number when they call the hotline as a reference number should they call back. With that intake number, all information previously reported can be located so there is not a need to repeat information.
DCFS-24	DCFS to develop a separate unsafe sleep allegation that has a shorter retention period (perhaps 7-10 years), and that possibly results in a family "flag" instead of an indication for the first instance. It is very difficult to gather the data on how frequently these avoidable deaths happen unless they are tracked. We often see second or subsequent deaths due to unsafe sleep, and for a second such death, this should result in an indicated finding.	DCFS will not be adding an "Unsafe Sleep" allegation at this time. DCFS is working to expand the current computer system to capture data on the different types/causes of death. Most unsafe sleeping deaths are accidents. Parents often feel bed sharing is nurturing. The director stated that DCFS is looking at universal home visits for children birth to three and are partnering with other agencies. The key is to educate prior to the death of a child and we need to identify "high risk" parents. There definitely is a need for a "culture shift" related to this issue.
DCFS-25	DCFS medical director to research/survey with Priority 1/serious harms staff to determine if the lack of cooperation amongst doctors and hospitals (not returning calls, not providing records, etc.) is widespread; We on CDRT hear this frequently. In addition, the team recommends that based on which hospitals or facilities are putting up barriers, plan specific interventions to improve the relationship between DCFS and medical providers and ensure timely communication and receipt of records from medical	CDRT should collectively put a letter together to the medical community asking for greater responsiveness to DCFS. The risk management divisions of medical providers should be seeking to remove such barriers.

	providers.	
DCFS-26	The team recommends that DCFS move forward with the proposed legislation changes to ANCRA that have been submitted twice but not acted on by DCFS. This legislation would require medical providers to provide requested medical records to DCFS DCP within three business days of the request with consequences of fines or otherwise for failure to comply. Currently, the statute requires that the records be given to DCFS but with no timeframe or deadline or consequences for failure to do so.	CDRT should collectively put a letter together to the medical community asking for greater responsiveness to DCFS. The risk management divisions of medical providers should be seeking to remove such barriers.
DCFS-27	DCFS to develop some criteria for adding an unknown perpetrator when there is some question in pinpointing the actual perpetrator (especially when both parents are suspected).	The department currently is in discussion regarding the use of unknown perpetrator.
DCFS-28	DCFS to consider establishing "Priority 1" workers in some areas.	It is a current expectation that death and serious injury cases be handled by Priority 1/serious harms teams where available. However, given the specific dynamics of: a) cases; b) workers; c) teams; d) offices; and e) workload, there are some occasions when it is necessary to deviate from this goal. In areas where those teams are not available, it is always best practice to ensure an experienced, skilled, investigator is assigned those most serious cases including death and serious harms. DCFS will reassess the use of Priority 1 teams.
DCFS-29	Procedure 300 requires notification to the FBI for child trafficking cases. Procedure 300 should also require DCFS to notify the local state's attorney's office when a child abuse or neglect investigation regarding human trafficking has been initiated or is indicated.	Procedure 300 Appendix B requires notification to the State's Attorney unless waived by the supervisor. Staff will be reminded this should be treated like a sex abuse allegation and the required notifications made in accordance with procedures and local CAC protocols.
DCFS-30	Team recommends DCFS maintain unfounded reports according to the law, which sets NO date for	Pending

	expungement if the report is made by a mandated reporter, or is a priority one or two report.	
DCFS-31	DCFS to clarify whether shelter employees are mandated reporters under ANCRA.	Pending
DCFS-32	DCFS seek to gain access to the IClear system to assist in the assessment processes and in ensuring DCFS worker safety where there is violence or weapons or drug use in the home. This is important for the investigator to know before going in, to consider asking for police to accompany the investigator and to further the investigation.	The director supports looking into this item further but there is some question about ongoing LEADS access. Recently, we've had correspondence with the State Police and they indicated that any agency that has access to LEADS can also be given access to IClear. The state police contact stated that the IClear system will not only provide LEADS information but it also contains mug shots and data interface with the Chicago Police Department. This additional information can be very useful to staff in assessing the safety of kids and assessing their own safety as they are out in the community.
DCFS-33	DCFS to consider developing a new allegation specific to safe sleep for babies 12 months and younger.	At this time, DCFS will not add a separate "unsafe sleep" allegation but we are seeking to add "drop down" categories in SACWIS to further specify the type of death. Unsafe sleep would be one of these categories.
DCFS-34	DCFS to create a separate unsafe sleep allegation.	At this time, DCFS will not add a separate "unsafe sleep" allegation but we are seeking to add "drop down" categories in SACWIS to further specify the type of death. Unsafe sleep would be one of these categories.
DCFS-35	DCFS to provide clarification of a decision tree for sleep-related cases.	DCFS would welcome an effective decision tree.
DCFS-36	Intact family services should be mandatory for families when there is a finding of medical neglect.	DCFS agrees and will review this matter with the involved staff.
DCFS-37	DCFS should consider ways to better access law enforcement information so that elements of risk can be more fully understood.	DCFS agrees and will review this with staff.
DCFS-38	Update the mandated reporter	Accidental bruising can also be a

	training to discuss the difference between accidental and inflicted bruising (again, pictures are helpful).	form of neglect. The Hotline is there to guide mandated reporters and the field is there to investigate to determine the difference between inflicted and accidental bruising. This concept may be difficult to explain via a manual and the Hotline is always available along with the local office if a mandated reporter has a question or needs direction.
DCFS-39	If a parent/guardian is directed to take a child to the doctor by DCFS, the child must be accompanied by the 65A form and the form must have contact information including after-hours information. The form should also clearly state if a safety plan is in place and whether the child can be discharged after medical evaluation. Improved training among DCFS investigators regarding the 65A is needed as it is not used consistently. Revisions to the 65A would make the form more useful for investigators and medical personnel.	Procedures currently provide direction for the use of a 65A form. Regional administrators can provide a review of the procedures to staff. Changes to the 65A form will be made.
DCFS-40	In this case, a medical professional called the Hotline twice in 2004 to raise the alarm about mother doing the same thing to this child that she did to her others. This report by a mandated reporter should have been maintained. The child was not screened into court until 2016 after yet another hotline call was made for medical neglect and severe malnourishment. These unfounded reports made by mandated reporters should be maintained in perpetuity.	There is now legislation to retain unfounded reports for five years and staff have the ability to review basic information from expunged reports.
DCFS-41	Look at either expanding allegation 85 (Medical Neglect of a Disabled Infant) to include all medically complex children, or create a separate allegation of Medical Neglect of Chronic Disease. These children have special needs for maintaining ongoing care that rise above the needs of an otherwise healthy child.	DCFS would like to discuss this further with the Executive Council.

DCFS-42	DCFS to consider developing a system by which someone (perhaps a private agency) follow up on families that have experienced a death. This could be an annual check-in with the family. Consider group treatment or a support group for parents who have lost a child.	When parents have a child die and the department investigates, we have the ability to refer parents to support services for grief and loss issues such as the local hospital, mental health clinic or family advocacy center. We also provide information related to unsafe sleep to help educate parents along with physicians and hospitals should the family become pregnant again. By statute, there are only certain conditions by which DCFS can intervene within a family. A yearly “check-in” would not fall within those parameters.
DCFS-43	This case is another example of a case that would support SB3112. This case is also another example of why cases should not be expunged due to the case being unfounded.	DCFS will notify hospitals/providers if there are specific concerns on a case. It is suggested that CDRT Executive Council and medical providers reach out to the medical community regarding this issue.
DCFS-44	DCFS bring up the drug testing issue to the task force to have them push for drug testing in cases like this. Suggest legislation for mandatory drug screening in child death cases. If a family refuses to do a test when requested, the issue should be referred to the State’s Attorney to seek a warrant.	DCFS will handle this internally with the task force. Mandatory drug testing in all child death cases is rather harsh and DCFS does not support this. If the presenting evidence suggests that there may be drug usage, DCFS will use drug testing. The key on this item is to do the drug testing timely. DCFS is piloting “on the spot” drug testing and continues to seek to expand resources throughout the state to assist in getting more sites to do drug testing.
DCFS-45	DCFS consider a preliminary verbal report from a coroner or ME about a child’s death when determining length of safety plan for other involved children.	The area administrator currently is able to waive the requirement of obtaining the autopsy report and can accept the ME or coroner’s verbal report to close out a case and lift a safety plan. DCFS agrees that safety plans should not be in place longer than needed.
OS-1	Chairperson to write a letter to the ASA concerning this death and the maternal use of meth which caused the premature birth and death of the infant.	Approved. Letter sent to the ASA.

OS-2	CDRT to write a letter to the doctor on the case regarding staff contacting DCFS.	Approved. Letter sent to doctor.
OS-3	CDRT to send a letter to the nursing agency to examine how they handled the case and some of the shortcomings of the agency.	Agreed.
OS-4	CDRT to send a letter to the Cook County MEO commending the handling of this case, for their thoughtful evaluation and determination that this drowning death was indeed a homicide (death at the hands of another) where a parent placed an infant and 3-year-old in a tub with running water and left the area to go check Facebook.	Approved. Letter sent.
OS-5	It may benefit to change the districts and get more involvement from other agencies to help in investigating death cases. This issue will be addressed at the next task force meeting.	Approved.
OS-6	CDRT should write a letter to the hospital regarding this case and ask the hospital if they document asking the parent if they have a crib, bassinet or pack n play and are aware of safe sleep practices.	Executive Council approves. The chairperson of the team will contact the hospital.
OS-7	Child death review team send a letter to the coroner and police to remind them to report all deaths of children to the DCFS Hotline.	Approved. Letter sent.
OS-8	The team recommends that a letter of commendation be sent by CDRT to the supervisor on how well he handled this case.	Approved. Letter sent.
OS-9	Team to send a letter to the doctor/hospital to review the case further in regard to the child's visit the night before.	Council approved.
OS-10	CDRT team to send a letter to the park police and request they call the hotline.	Council approved.
OS-11	CDRT to follow up with the City of Chicago on their procedures for looking beyond lead testing and what they do if they see other	Council approved.

	problems/violations.	
OS-12	Reach out to the police to do some mandated reporter training for the local police.	The regional administrator will reach out to the local police and State's Attorney on this matter. Specific concerns on this case will be noted and any needed follow up training will be offered.
OS-13	CDRT send a letter to the shelter involved reminding them to call the Hotline with any concerns about parents and their care of kids.	Approved.
OS-14	There should be legislation that should seek to regulate and license the practice of doulas in the state of Illinois. This recommendation is more for DPH than DCFS as this issue is within their purview.	Approved.
OS-15	All day care centers should have in-person mandated reporter training. (This could be done in a video and should have pictures. Licensing staff could monitor to make sure all staff take part in the in-person training. Possibly use this case as an example when training daycare staff).	At this time, DCFS cannot agree with the recommendation to amend rule to require that mandated reporter training be provided in person for day care center staff. There are presently 3,052 licensed day care centers with staffing ranging from one to 100 or more, depending upon the capacity of each center. All staff, including the director, must have on-file documentation that they have completed the online mandated reporter training (407.100.c.6). This must be completed within 30 days of hire for new staff. Because of the nature of staff turn-over in centers, it would be a tremendous burden on the department, especially to the Child Protection and Training divisions for making this training available. With constant turn-over in staff, the demand would be high and geographically challenging, at best. The additional information suggested in the CDRT's response would be well-served to be included in an updated version of the training, which would continue to be available online to our day care applicants and licensees and their staff, and would

		reach over 100,000 child care and early education professionals every year. According to the Office of Professional Development's (Training) statistics for the 2018 Annual Report to the General Assembly, 128,701 individuals completed the mandated reporter training in FY 2018. Additionally, an important factor to consider with this particular daycare is that since mom worked there, they had a relationship with the mom. This relationship may have been why they failed to report. This incident does not warrant revamping mandated reporter training for all day care centers.
OS-16	A letter will be sent by CDRT to the women's center to show appreciation that they have cribs and staff that check to see the cribs are being used.	Approved.
OS-17	Team write a letter to the hospital to do an internal morbidity and mortality review on this case. All local hospitals that have access to a child abuse pediatrician should consult with that doctor in situations like this (death of a child under 2).	Approved.
OS-18	DCFS to recommend that the Board of Education have some type of monitoring for child safety when children are home-schooled. This likely would require some legislation.	Pending
OS-19	Send an educational letter to the Wood River Police Department listing new possible procedures in handling cases such as this one.	Approved.
OS-20	The hospital should be reminded of their duties as mandated reporters, that they are to immediately notify police and DCFS when child presents with serious injuries at their hospital even if they are transporting the child to another hospital at the time.	Approved. The chairperson will write the letter.
CS-1	DCFS look at this case and how it was handled in regard to: a. the multiple previous SCR numbers	DCFS will review this case with the investigator and team. We are now linking cases but can only "start" the

	<p>and none of them were linked;</p> <p>b. multiple unfounded investigations regarding failure to thrive, medical neglect and inadequate supervision of this minor and sibling with cerebral palsy;</p> <p>c. not following through with getting medical records or seeking an administrative subpoena;</p> <p>d. lack of understanding or clear procedure for what to do once a nursing referral is made.</p>	<p>sequence with the most current. Basic information regarding the priors is available even if not linked.</p>
CS-2	<p>DCFS to review the case as to why the maternal grandmother was not investigated and indicated on this case. She knew dad was violent toward her daughter repeatedly and yet allowed him to remain in the home and be the primary caretaker for the baby.</p>	<p>Agree. This case will be reviewed with staff.</p>
CS-3	<p>DCFS to review the case with the foster care agency, regarding ensuring that safe sleep practices are followed in all foster homes and providing any necessary assistance with furnishings given that this foster home did not have a functioning crib from the time the minor moved to this residence until the time of death.</p>	<p>DCFS agrees and will review the case and safe sleep policy with the assigned agency.</p>
CS-4	<p>DCFS to review the case. It's uncertain if there was any attempt to get medical records. On the previous deaths, there should be corroboration from an independent source (ME or other medical providers).</p>	<p>DCFS Response: Agreed. DCFS will review the case with the worker and supervisor stressing the importance of obtaining all medical records and corroborating such information.</p>
CS-5	<p>DCFS to look at this case and how it was handled as the Hotline worker probably should have included allegation #11 (cuts/bruises/welts)</p>	<p>DCFS will review this case with the involved staff. It should also be noted that investigative staff can, and should, add additional allegations to a case.</p>
CS-6	<p>In a case where an unexplained fracture was found at autopsy on a 6-month-old infant and another infant remained in the home, DCFS should look at the case and how it was handled given that non accidental trauma was the likely cause of the</p>	<p>DCFS agrees and will review this case with the involved worker and supervisor, stressing the need to utilize the courts when warranted. This was reviewed with staff on 6/4.</p>

	fracture. After offered intact services were refused, the case should have been screened with the State's Attorney's office.	
CS-7	DCFS review this case in regards to the licensing worker not visiting the home for over a month after the foster family moved.	<p>DCFS agrees. Agencies and Institutions Licensing is responsible for insuring the agency conducts a foster family home monitoring to address the following concerns in the foster home:</p> <ul style="list-style-type: none"> a. Assess safety of environment for youth in care, 0-3 years; b. Ensure appropriate crib/bed in the home for any youth in care; c. Ensure no unsafe child products are present in the foster home; d. Ensure appropriate supervision of any other caretakers within the foster home; e. The acting associate director of licensing will assess the agency training for the foster parents regarding appropriate care for 0-3 year youth in care. <p>Actions/assessment is as follows: Several documents/forms were reviewed with the agency (these include information on: safe sleep, infant care, cribs, never shake a child, water supervision, cigarette use around newborns, SIDS and toddlers). The agency has identified that they have a specific training for foster families who accept children in the 0-3 age group. Any family caring for a child 0-3 will now receive an information packet and training from their licensing worker on the specific safety needs of this age group. The family also signs the Infant Care Checklist to document their training. The agency has forwarded DCFS the training materials. It appears to be an appropriate training for foster parents who have children of this age group placed in their home. The acting</p>

		<p>associate deputy for licensing reviewed the CFS 597 FFH dated 11/1/17 which outlines a thorough monitoring visit by the licensing representative. The agency worked with this family to ensure compliance of 402 and specifically the care of children 0-3 in their home. They found the family to be very cooperative and their home has been assessed to be appropriate for the 0-3 age group.</p>
CS-8	<p>DCFS to review the case as the CWS referral should have been taken as an investigation.</p>	<p>DCFS disagrees. The CWS does not meet the criteria for an investigation. However, DCFS certainly needs to assess situations like this further to help in prevention efforts. CWS referrals like this need close attention to provide support to families in situations like this. Team chair added that at some point the mom disclosed that a child was removed from her care previously and this is noted in the narrative. The director stated that we need to look at “the front door” a bit differently and do more. There is a difference between a “handoff” (which involves a face-to-face meeting with the family, DCFS and provider) and a “referral” (providing a resource or phone number for the family to follow through on their own). Executive Council would like to have input when DCFS looks at revising this process. It was agreed that DCFS will involve Executive Council when this occurs.</p>
CS-9	<p>DCFS to look at the case and how it was handled. Why wasn't the case screened sooner, back in 2016?</p>	<p>DCFS agrees and will have the regional administration review the case with the involved worker and supervisor.</p>
CS-10	<p>DCFS should look at the case and how it was handled. In this case DCFS set up an out-of-home safety plan, transitioned the case to intact services and closed out the investigation. The minor was</p>	<p>DCFS agrees and will have the RA/AA review this case with the supervisor and worker. DCFS is currently reviewing its intact services and will make any needed changes after careful consideration.</p>

	thereafter murdered by the safety plan provider who had a past history of domestic violence with his current partner. The intact worker was not made aware of the history as it related to the safety plan providers.	
CS-11	DCP should be advised to come to death review prepared and be educated on presenting to CDRT as well as her role to provide education on unsafe sleep deaths. DCP presented unprepared and unable to answer multiple questions.	DCFS agrees and will have DCP administration remind staff of the guidelines for CDRT and send a reminder of the need to provide safe sleep education.
CS-12	Monitor the intact case carefully and screen if there is continued drug use, no follow up on mental health treatment and continuing to be with dad given the risk he poses.	Agree with the recommendation.
CS-13	DCFS to review the case: 1. with regard to the condition of the apartment on the first investigation (where the pictures were taken showing a very dirty kitchen including exposed wiring in the home. It is difficult to believe that an apartment can go from "fine" to uninhabitable in less than two months. Relying on the evaluation of the lead inspector is not sufficient as they are only concerned with the lead, not other cleanliness or safety hazards. 2. With regard to unbounding the first case despite the family not following through with medical follow-up until the investigation began, simply because the caregivers change their behavior does not mean the original behavior did not occur.	DCFS agrees. The case is to be reviewed by April 30, 2018.
CS-14	DCFS to review the case to monitor the cooperation with intact services and to screen the case to court if there is limited cooperation.	DCFS will review this case with staff. If parents are not culpable for death, they cannot be held accountable for a lack of supervision associated with death. Case will be reviewed by intact to ensure it's on track.
CS-15	DCFS to look at the case and how it was handled: 1. Why the case was not followed up by intact services or the	This case will be reviewed with staff.

	B sequence worker; 2. Why the case was not referred for intact services after the A sequence, as that was mother's second documented incident in not supervising her autistic son, placing him in harm's way.	
CS-16	DCFS to review the A and D sequence regarding if the case should have been screened due to the prior child dying in 2009, the significant burn not being treated for months and parents lying about how the burn occurred.	Pending
CS-17	The team requests that DCFS look at the case and how it was handled in that they did not assess the lengthy history of recent and serious DV incidents (mother being punched, kicked, pushed down stairs, another incident where pepper spray was used) between mother and one of the fathers and did not refer it to intact because of this risk factor.	DCFS agrees and will review this with the involved staff.
CS-18	DCFS to review the A sequence as there were conflicting notes in the case as to if the children were supervised or not, and upon that review the question as if this case should have been indicated or not.	Case will be reviewed by regional administrator and shared with staff as determined necessary.
CS-19	DCFS to look at the case to review the timing of the notes (re-interviewing the kids right after their mom/brother's murder when the immediacy of the interview was not necessary), inconsistency in the notes/documentation of what occurred. The conclusion of the case did not match the content of the case (especially the supervisor's documentation that the child was not hit). There were eyewitnesses and the perpetrator admitted to beating the child.	DCFS agrees. This case will be given to the RA to review with staff by April 30.
CS-20	DCFS to review the case to see how it was handled. It appears that the case was unfounded because the	This will be reviewed with staff.

	mom was not the driver. However, mom is still responsible for the safety of her children.	
CS-21	DCFS to look at this case regarding how the B sequence was handled. Given the extensive history of DV (including stabbing and choking) in the home with both parents as aggressors, the case should have been brought to the State's Attorney for screening at the B sequence if not sooner. Additionally, DCP was not aware of two additional incidents when law enforcement investigated the parents for serious DV.	DCFS agrees and will review this case with the involved staff.
CS-22	DCFS to review the case regarding the decision making for not indicating the case or opening to intact services.	This case will be reviewed with involved staff.
CS-23	Team requests DCFS review the case. This child was left in mom's care from birth. Twelve other kids were in DCFS care, four with the same medical condition as this child left with the mom. Mom has a longstanding pattern of medically neglecting her children yet this child was left in mom's care from birth on 3/16/2000. He should have been screened into court as an additional sibling.	Agreed. DCFS will review the case and consider the points made. It should be noted however, that some of the case specific issues were several years ago and involved staff may no longer be in their role or with the department. There is now legislation to retain unfounded reports for five years and staff can review basic information from expunged reports. This 17yo was not getting proper medical care. Many chronic medical conditions carry over from infancy to childhood (and even adulthood). One thought is to carry or lengthen the age on this allegation to go beyond infancy. Most medical neglect is linked to a lack of access to care or medication. Many times, these conditions require multiple doctors' visits-rarely can such issues be addressed in a onetime visit or routine visits.
CS-24	DCFS to review the case in that: a) the worker didn't call Haymarket; b) the surviving children were not interviewed; c) not indicated the case regarding the other minors; d) didn't corroborate mom's drug usage; e) not	Agree-this case will be reviewed with involved staff. IFRP falls under clinical division-they have been notified regarding concerns with the family.

	confronting mom on knowing she was pregnant; f) didn't contact the school that the older children attend. Workload issues may be a factor in the performance here.	
CS-25	DCFS review this case and how it was handled as to why the AA or supervisor decided to carry out this safety plan.	This will be reviewed with the involved staff. DCFS agrees that safety plans should not be in place longer than needed.

Chapter 3: Illinois Child Deaths in 2017

What do we know about the child deaths that occurred in Illinois during 2017?

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 general 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 (58% in 2017) 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:

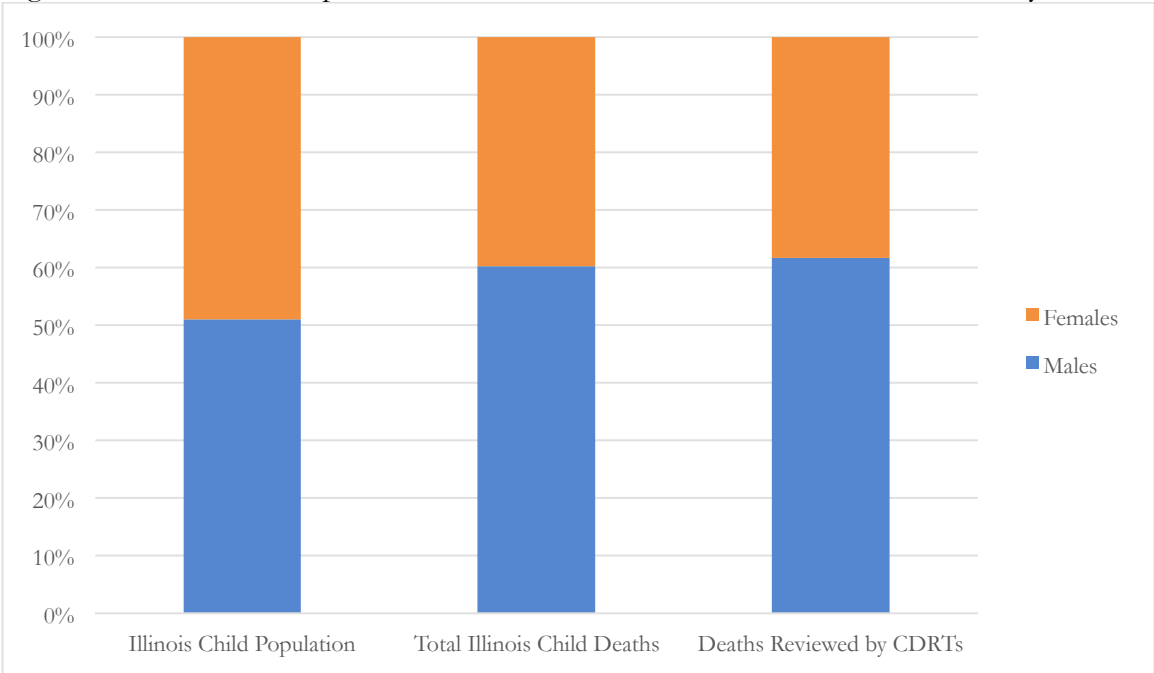
- The population of Illinois children was based on the 2010 Census. According to 2010 Census data, there were approximately 3.13 million children under the age of 18 in Illinois, which constituted about 24.4% of the total Illinois population.⁴
- In 2017, there were 1,424 child deaths reported to the Illinois CDRT database. This included deaths due to all causes, preventable and non-preventable.
- The CDRTs reviewed 266 child deaths that occurred in 2017: 155 of these were mandated for review and 111 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 based on CDRTs data: boys made up 60% of total child deaths in 2017. Deaths of boys were also more likely to be reviewed: 62% of reviewed deaths were boys in 2017 (see Figure 3).

⁴ U.S. Census Bureau. (2010). Illinois population by age. Retrieved from <https://www.factfinder2.census.gov>.

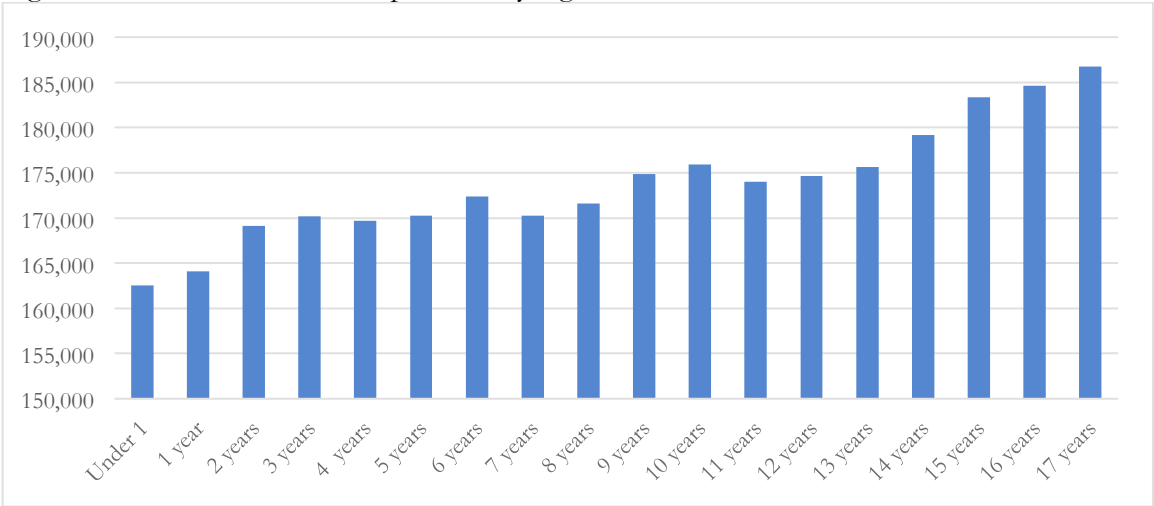
Figure 3: Illinois Child Population, Child Deaths, CDRT-Reviewed Child Deaths by Gender



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 of age, 5% were less than one year, 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.⁵

Figure 4: 2010 Illinois Child Population by Age

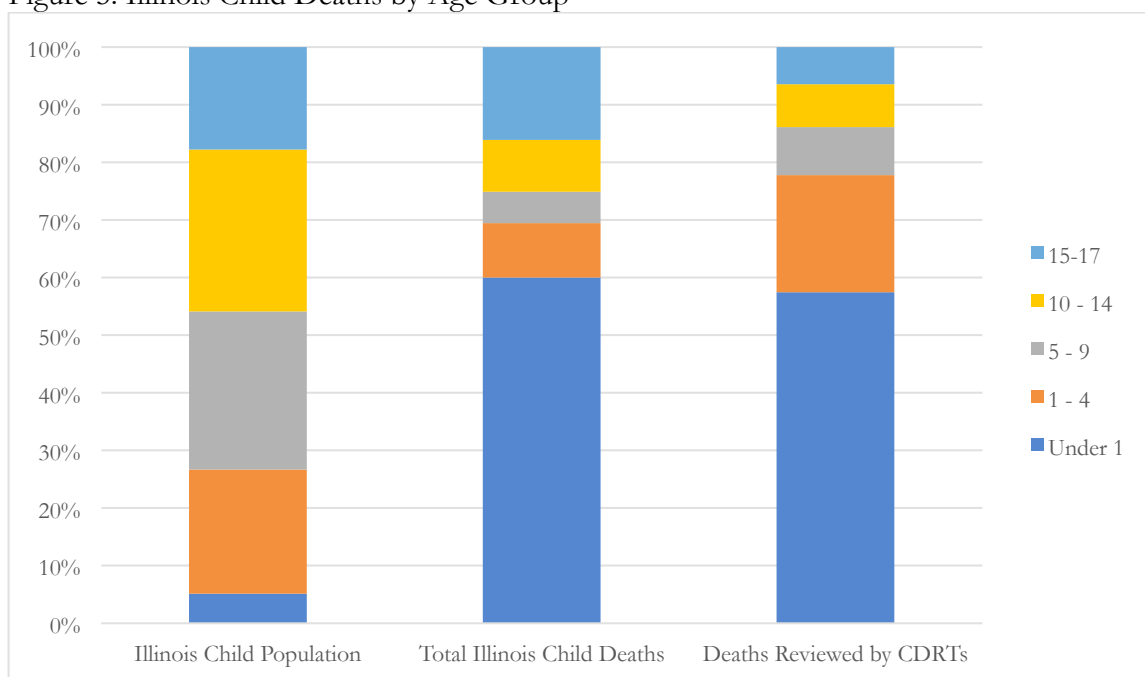


⁵ U.S. Census Bureau. (2010). Illinois population by age. Retrieved from <http://factfinder.census.gov/>.

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 – 60% of the total deaths in 2017 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). In 2017, 9% of the total deaths were children between 1 and 4 years, 5% were children between 5 and 9 years, 9% 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 58% of reviewed deaths in 2017. Children between 1 and 4 years make up 20% of reviewed deaths in 2017. Older children make up a smaller portion of reviewed deaths: 8% were for children aged 5 to 9 years old, 8% were for children aged 10 to 14 and 6% were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race/Ethnicity

In 2017, 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).⁶ For reports on ethnicity, 24% self-identified as Hispanic or Latino (of any race) and 52% were white (not Hispanic or Latino). The categories for racial/ethnic origin in the CDRT are of the following: White, African American, Hispanic, Asian and Unknown.

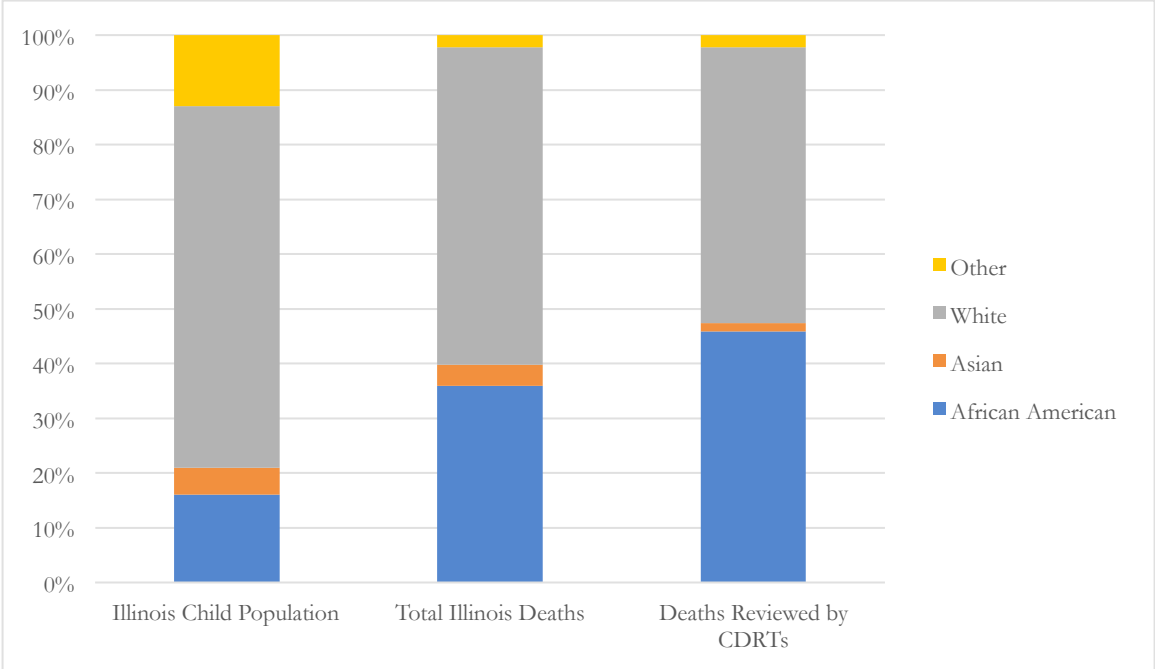
When we examine the total Illinois child deaths by race, it is evident that African American children are at higher risk of death when compared to children in the general population: 36% of the children

⁶ U.S. Census Bureau. (2018). Children characteristics 2013 – 2017 American Community Survey 5-year estimates. Retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

that died in 2017 were African American, yet they only comprise 16% in the general child population. The proportion of deaths among Caucasian children (58%) was slightly lower when compared with their proportion in the general child population (66%). Asian children made up less than 4% of deaths and children of other race/ethnicity accounted for under 2% of child deaths.

Among the 266 child deaths reviewed by the CDRTs in 2017, 46% were African American children, which is larger than their proportion in the overall child population (16%) and the total child deaths that occurred in 2017 (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 2017 are shown in Table 2. The majority of total child deaths were related to either illness (32%) or premature birth (32%). The other categories included suffocation (8%), firearms (8%), vehicular accidents (6%) undetermined (5%), injury (3%), drowning (2%), SUID (1%), poisoning/overdose (<1%), fire (<1%) 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 2017, deaths reviewed by CDRTs were most likely to be suffocation (24%), undetermined (21%) and illness (19%). 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	
	Count	Percentage	Count	Percentage
Illness	461	32%	50	19%
Prematurity	455	32%	4	2%
Suffocation	120	8%	63	24%
Firearms	109	8%	9	3%
Vehicular	90	6%	22	8%
Undetermined	69	5%	56	21%
Injury	41	3%	22	8%
Drowning	24	2%	15	6%
SUID	19	1%	14	5%
Poison/Overdose	14	<1%	3	1%
Fire	13	<1%	4	2%
Other	4	<1%	2	<1%
Pending	2	<1%	0	0%
SIDS	2	<1%	1	<1%
SUCD	1	<1%	1	<1%
Total	1424	100%	266	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

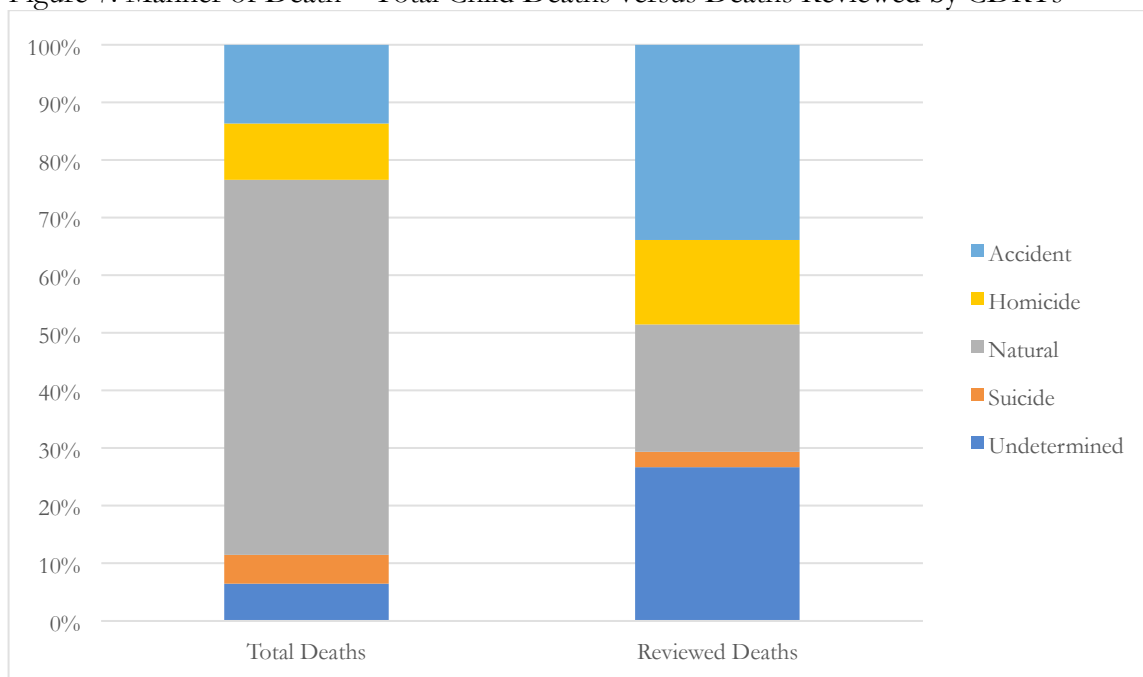
The majority of total child deaths in 2017 were attributable to natural causes (65%) and accidents accounted for 14% of the total child deaths. In addition, 10% were homicides, 5% were suicides and 6% were undetermined. The majority of deaths reviewed by CDRTs were due to accidents (34%), undetermined (27%) and natural causes (22%). The rates of reviewed deaths for homicides (10%) or

suicides (5%) closely matched the proportions from all deaths reported in 2017 (see Table 3 and Figure 7).

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

	Total Deaths		Reviewed Deaths	
Accident	194	14%	90	34%
Homicide	139	10%	39	15%
Natural	928	65%	59	22%
Suicide	71	5%	7	3%
Undetermined	92	6%	71	27%
Total	1424	100%	266	100%

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



Child Deaths by Category and Manner

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

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

Category of Death	Manner of Death					Totals
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	1	1	456	0	3	461
Prematurity	0	0	454	0	1	455
Suffocation	62	6	4	42	6	120
Firearms	2	92	0	15	0	109
Vehicular	81	6	0	3	0	90
Undetermined	0	0	3	0	66	69
Injury	5	30	0	5	1	41
Drowning	20	1	0	0	3	24
SUID	4	0	7	0	8	19
Poison/Overdose	8	0	0	6	0	14
Fire	11	1	0	0	1	13
Other	0	2	2	0	0	4
Pending	0	0	0	0	2	2
SIDS	0	0	2	0	0	2
SUCD	0	0	0	0	1	1
Total	194	139	928	71	92	1424

Special Analysis: Homicide Deaths

There were 139 homicide deaths out of the 1,424 deaths in 2017, and we know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. The majority (58%) of homicides were youth age 15 to 17 years old, and an overwhelming majority (74%) 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	Cause of Death	Perpetrator	Race/Ethnicity
Firearms	0	Gunshot wound of torso. Maternal gunshot wound of abdomen.	Unknown	African American
Firearms	1	Complications of prematurity. Maternal death due to gunshot wound of head.	Unknown	African American
Firearms	2	Gunshot wound of the back. Shot by an adult.	Unknown	African American
Firearms	2	Gunshot wound of head.	Unknown	African American
Firearms	5	Gunshot wound of the head.	Unknown	White
Firearms	6	Multiple gunshot wounds of the head.	Unknown	White
Firearms	6	Multiple gunshot wounds of the head.	Unknown	White
Firearms	10	Gunshot wound of the back.	Unknown	White
Firearms	12	Gunshot wound of head.	Unknown	African

				American
Firearms	13	Gunshot wound to the face.	Unknown	African American
Firearms	13	Gunshot wound of the neck.	Unknown	White
Firearms	14	Shotgun wound of the abdomen.	Unknown	White
Firearms	14	Gunshot wound of the head.	Unknown	White
Firearms	14	Gunshot wound of chest.	Unknown	White
Firearms	14	Multiple gunshot wounds.	Unknown	White
Firearms	14	Multiple gunshot wounds.	Unknown	African American
Firearms	15	Multiple gunshot wounds.	Unknown	African American
Firearms	15	Multiple gunshot wounds.	Unknown	White
Firearms	15	Gunshot wound of torso.	Unknown	African American
Firearms	15	Gunshot wound of chest.	Unknown	African American
Firearms	15	Gunshot wound of the chest.	Unknown	African American
Firearms	15	Multiple gunshot wounds to the head.	Unknown	White
Firearms	15	Cause of death: multiple gunshot wounds.	Unknown	Hispanic
Firearms	15	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Gunshot wound to mouth.	Unknown	White
Firearms	16	Gunshot wound of back.	Unknown	White
Firearms	16	Multiple gunshot wounds.	Unknown	White
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	White
Firearms	16	Gunshot wound of back.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Gunshot wound to head.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Gunshot wound of neck.	Unknown	African American
Firearms	16	Gunshot wound of head.	Unknown	African American

Firearms	16	Gunshot wound of the back.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Multiple gunshot wounds.	Unknown	African American
Firearms	16	Gunshot wound of head.	Unknown	African American
Firearms	16	Gunshot wounds of the chest and abdomen.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Complications of multiple gunshot wounds.	Unknown	African American
Firearms	17	Gunshot wound of torso.	Unknown	White
Firearms	17	Gunshot wound of the head.	Unknown	White
Firearms	17	Gunshot wound of the head.	Unknown	White
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Gunshot wound of back.	Unknown	African American
Firearms	17	Gunshot wound of chest.	Unknown	African American
Firearms	17	Gunshot wound of head.	Unknown	White
Firearms	17	Gunshot wound of head.	Unknown	African American
Firearms	17	Gunshot wounds of the chest.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Gunshot wound of torso.	Unknown	African American
Firearms	17	Gunshot wound of head.	Unknown	White
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds. Gunshot wound of the head. Traumatic encephalopathy.	Unknown	African American
Firearms	17	Gunshot wound to the back.	Unknown	Hispanic
Firearms	17	Gunshot wound of head.	Unknown	African American
Firearms	17	Complications of gunshot wound of the chest.	Unknown	African American
Firearms	17	Gunshot wound to the head.	Unknown	White
Firearms	17	Multiple gunshot wounds.	Unknown	African

				American
Firearms	17	Gunshot wound of the back.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	White
Firearms	17	Gunshot wound of the back.	Unknown	African American
Firearms	17	Gunshot wound of abdomen.	Unknown	White
Firearms	17	Gunshot wound of chest.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	White
Firearms	17	Gunshot wound of chest.	Unknown	African American
Firearms	17	Gunshot wound of head.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Gunshot wound of the back.	Unknown	White
Firearms	17	Gunshot wound of head.	Unknown	African American
Firearms	17	Complications of gunshot wound of head.	Unknown	White
Firearms	17	Gunshot wound of head.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	White
Firearms	17	Gunshot wound of abdomen.	Unknown	White
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Gunshot wound of torso.	Unknown	White
Firearms	17	Gunshot wound of chest.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American
Firearms	17	Multiple gunshot wounds.	Unknown	African American

Firearms	17	Multiple gunshot wounds.	Unknown	White
Firearms	17	Gunshot wound of the chest.	Unknown	African American
Injury	0	Blunt force injuries of the head, trunk and extremities.	Unknown	African American
Injury	0	Blunt force head trauma.	Unknown	White
Injury	0	Multiple injuries from child abuse.	Unknown	African American
Injury	0	Blunt force injuries of head assault.	Unknown	African American
Injury	0	Multiple injuries from abusive trauma.	Unknown	White
Injury	0	Craniocerebral trauma.	Unknown	White
Injury	0	Blunt force injuries from assault.	Unknown	African American
Injury	0	Complications of prematurity maternal assault.	Unknown	African American
Injury	1	Multiple injuries from child abuse.	Unknown	Hispanic
Injury	1	Complications of hypoxic ischemic encephalopathy maternal uterine rupture and placental abruption. Blunt force injuries to mother due to assault.	Unknown	African American
Injury	1	Blunt force injuries of the head due to assault.	Unknown	African American
Injury	1	Multiple injuries from child abuse.	Unknown	African American
Injury	1	Complications of blunt force head injury.	Unknown	White
Injury	1	Multiple injuries from child abuse. Significant conditions: none	Unknown	White
Injury	1	Homicide by unspecified means.	Unknown	Unknown
Injury	2	Multiple blunt force injuries of the head and neck from assault.	Unknown	White
Injury	2	Blunt force head trauma from child abuse.	Unknown	African American
Injury	2	Multiple injuries child abuse.	Unknown	African American
Injury	3	Blunt abdominal trauma from assault.	Unknown	White
Injury	3	Subdural hematoma from child abuse.	Unknown	White
Injury	4	Multiple injuries from assault.	Unknown	White
Injury	4	Multiple stab wounds to the chest.	Unknown	White
Injury	7	Multiple injuries from child abuse.	Unknown	African American
Injury	11	Homicidal violence.	Unknown	White
Injury	12	Influenza B and bacterial pneumonia. Traumatic brain injury. Blunt head trauma.	Unknown	African American
Injury	13	Multiple sharp force and blunt force	Unknown	African

		injuries from assault.		American
Injury	15	Stab wound of the chest.	Unknown	African American
Injury	17	Hemoperitoneum and bilateral pneumothorax blunt impact trauma to chest, abdomen and pelvis laceration. Disruption of the right lobe of liver.	Unknown	White
Injury	17	Multiple injuries from assault.	Unknown	White
Injury	17	Stab wound of the chest.	Unknown	African American
Suffocation	0	Ligature strangulation.	Unknown	White
Suffocation	1	Anoxic brain injury and cardiac arrest from smothering.	Unknown	White
Suffocation	2	Ligature strangulation.	Unknown	White
Suffocation	9	Asphyxia from ligature strangulation.	Unknown	Hispanic
Suffocation	12	Asphyxia from ligature strangulation.	Unknown	Hispanic
Suffocation	14	Homicidal violence from probable asphyxia.	Unknown	White
Vehicular	2	Cranio-cerebral injuries as a pedestrian struck by a sport utility vehicle.	Unknown	African American
Vehicular	2	Acute cardiopulmonary arrest. Traumatic brain injury with internal torso injuries. Trauma suffered in a passenger car versus pickup truck head on crash.	Unknown	African American
Vehicular	7	Multiple blunt force injuries motor vehicle collision.	Unknown	White
Vehicular	14	Blunt trauma of the head from motor vehicle crash.	Unknown	White
Vehicular	16	Complications of multiple blunt force injuries motor vehicle striking bicyclist.	Unknown	White
Vehicular	17	Multiple blunt force injuries pedestrian struck by motor vehicle.	Unknown	African American
Drowning	1	Drowning.	Unknown	White
Fire	1	Carbon monoxide intoxication inhalation of smoke and soot house fire.	Unknown	African American
Illness	0	Meconium aspiration syndrome.	Unknown	White
Other	2	Severe dehydration.	Unknown	African American
Other	6	Failure to thrive and extreme malnutrition.	Unknown	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 2017 so that the most common categories of death are first. For each category section, the following information is presented:

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

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

Illness

Definition

This category includes any death that was the result of a medical condition. The manner of death for this category is most often determined to be natural. On occasion, however, the manner of death may be determined to be accidental. An accidental determination would include children whose death was caused by an accident related to their illness, such as malfunctioning medical equipment or surgical error (for example, accidental removal of tracheotomy tubes).

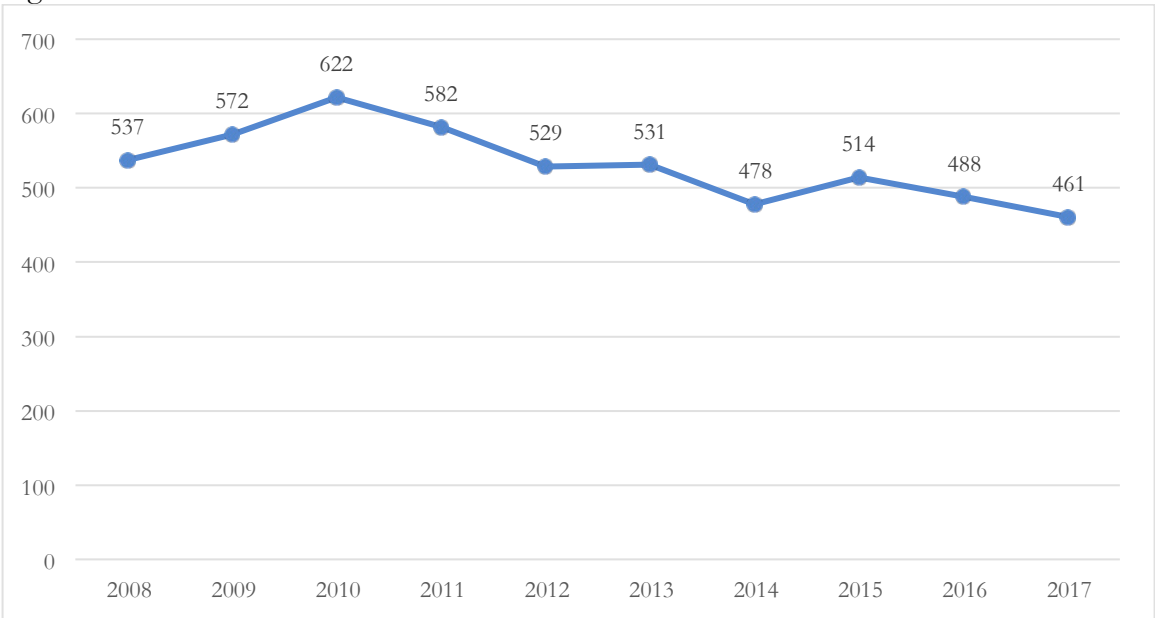
Background

A death due to illness can result from one of many serious health conditions, such as congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart or respiratory disorders and infections. Although many of these conditions are not believed to be preventable in the same way that accidents, homicides and suicides are preventable, deaths from certain illnesses, such as birth defects (e.g., 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 (see Figure 8).

Figure 8: Child Deaths Due to Illness



In 2017, 461 of the 1,424 total child deaths (32%) reported to CDRTs were related to illness.

- A slight majority of children who died from illness were male (52%).
- Half of deaths from illness were among children under the age of 1 (50%), 16% of deaths from illness occurred among children 1 to 4 years old, 11% occurred among children 5 to 9 years old, 13% occurred among children 10 to 14 years old and 10% occurred among children 15 to 17 years old (see Figure 9).
- The majority (64%) of deaths from illness were white children, followed by African American children (28%) and Asian children (7%). Hispanic children accounted for the smallest proportion of deaths related to illness (2%) (see Figure 10).
- Nearly all deaths (99%) from illness were attributable to natural causes, and less than 1% of the remaining deaths were attributable either to accidents, homicides or were undetermined.

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, 50 of the 266 child deaths reviewed by the CDRTs (19%) were related to illness.

- More than half (58%) of the reviewed deaths related to illness were boys.
- Illness-related deaths were most common in infants under 1 year old (40%); children 1 to 4 (28%) and children 5 to 9 years old (18%). Children 10 through 14 years old (6%) and children 15 to 17 years old (8%) made up a smaller proportion of reviewed illness-related deaths (see Figure 9).
- Half (50%) of the reviewed deaths from illness were white children, 48% were African American children and one (2%) was an Asian child (see Figure 10).
- The majority (94%) reviewed deaths that were categorized as illness were attributed to natural causes. One case (2%) was a homicide and two cases (4%) were undetermined.

Figure 9: Child Deaths Due to Illness by Age

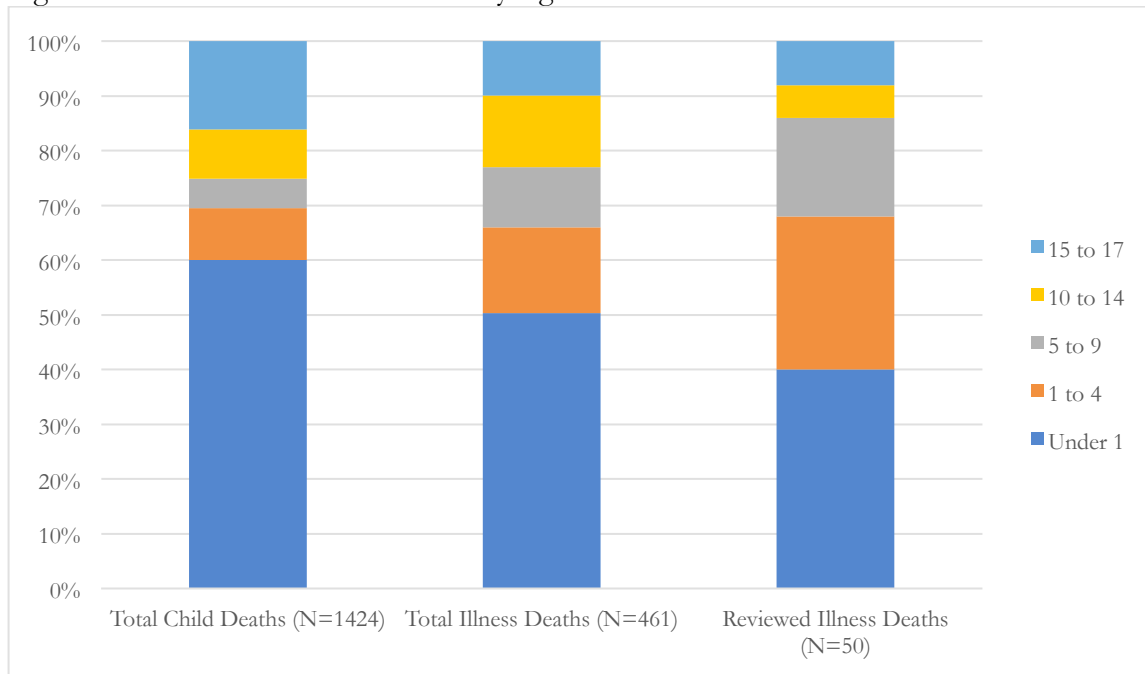
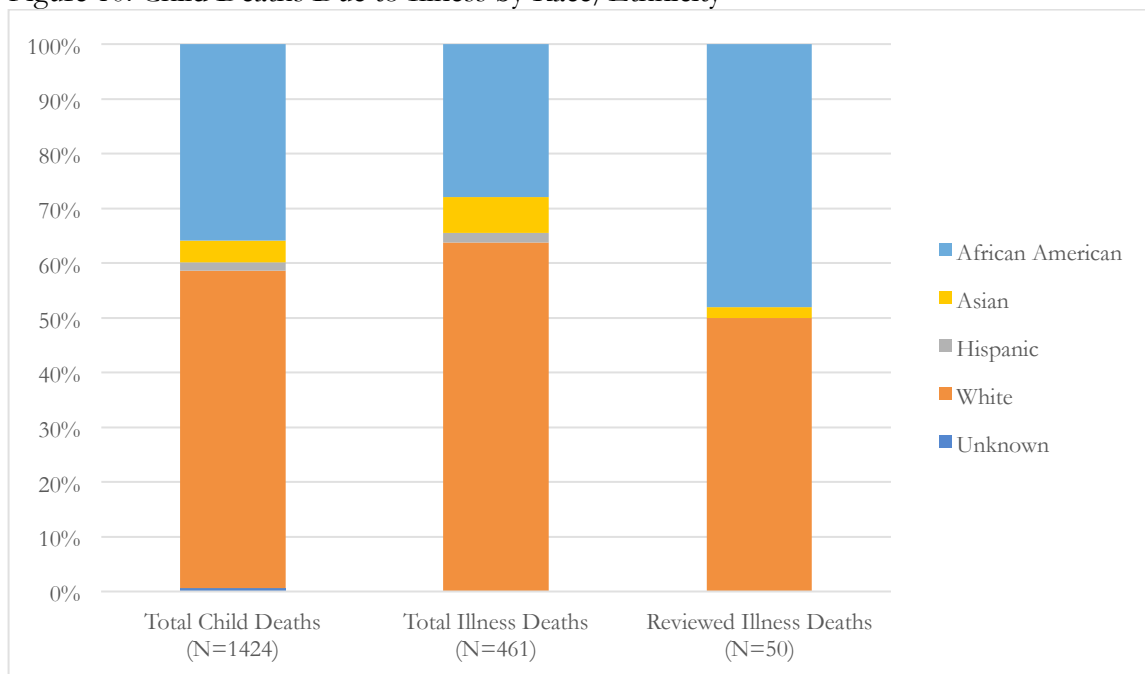


Figure 10: Child Deaths Due to Illness by Race/Ethnicity



Premature Birth

Definition

Although there is no single, agreed-upon definition of 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 of gestation) and “moderately preterm” (32-37 weeks of 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.⁷

In Illinois, about 1 in 10 (10.4%) babies were born preterm in 2017, compared with 9.9% in the nation.⁸ The rate of preterm birth in Illinois is highest for African American infants (14.2%), followed by Native Americans (11.9%), Hispanics (9.4%), whites (9.3%), and Asian/Pacific Islanders (9.3%).⁹ 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.¹⁰ Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

Illinois Data – Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death 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 from 526 in 2016 to 455 in 2017.

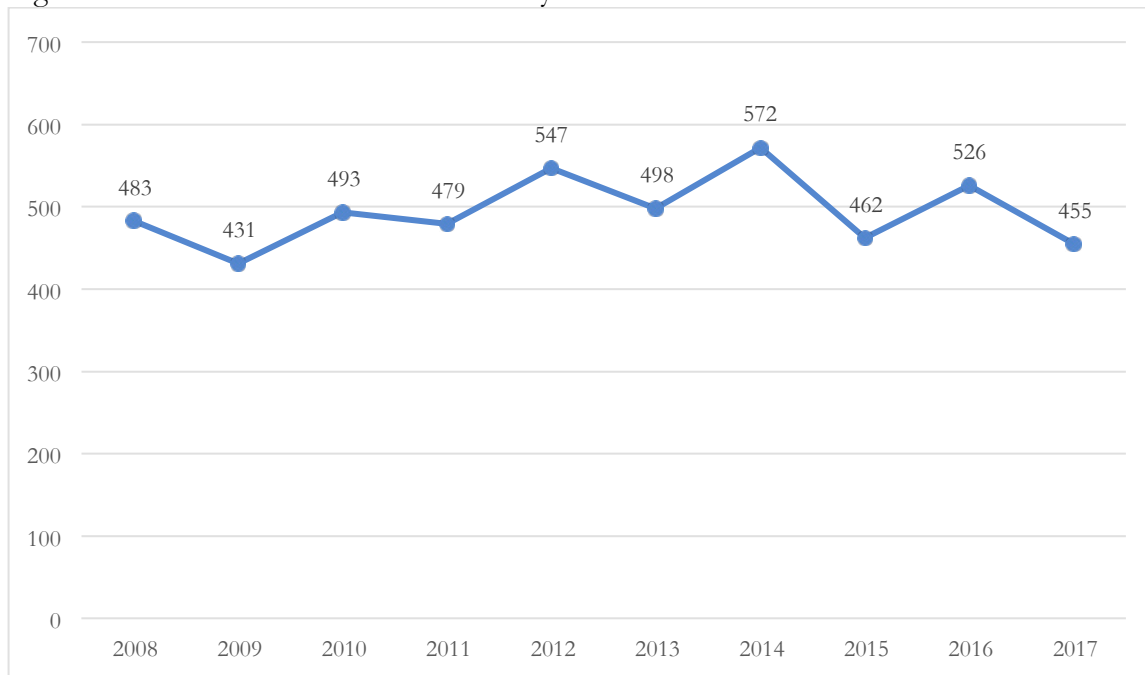
⁷ America’s Health Rankings (2017). A call to action for individuals and their communities. United Health Foundation (2015 Edition). Retrieved from <http://www.americashealthrankings.org/learn/reports/2016-annual-report>.

⁸ March of Dimes (2019). Quick facts: *Preterm deaths*. Retrieved from <https://www.marchofdimes.org/peristats/viewtopic.aspx?reg=17&top=3&lev=0>.

⁹ 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>.

¹⁰ Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America’s health: State rankings, 2004 Edition*. United Health Foundation.

Figure 11: Child Deaths Due to Prematurity



Out of 1,424 child deaths in 2017, 455 (32%) were related to premature birth.

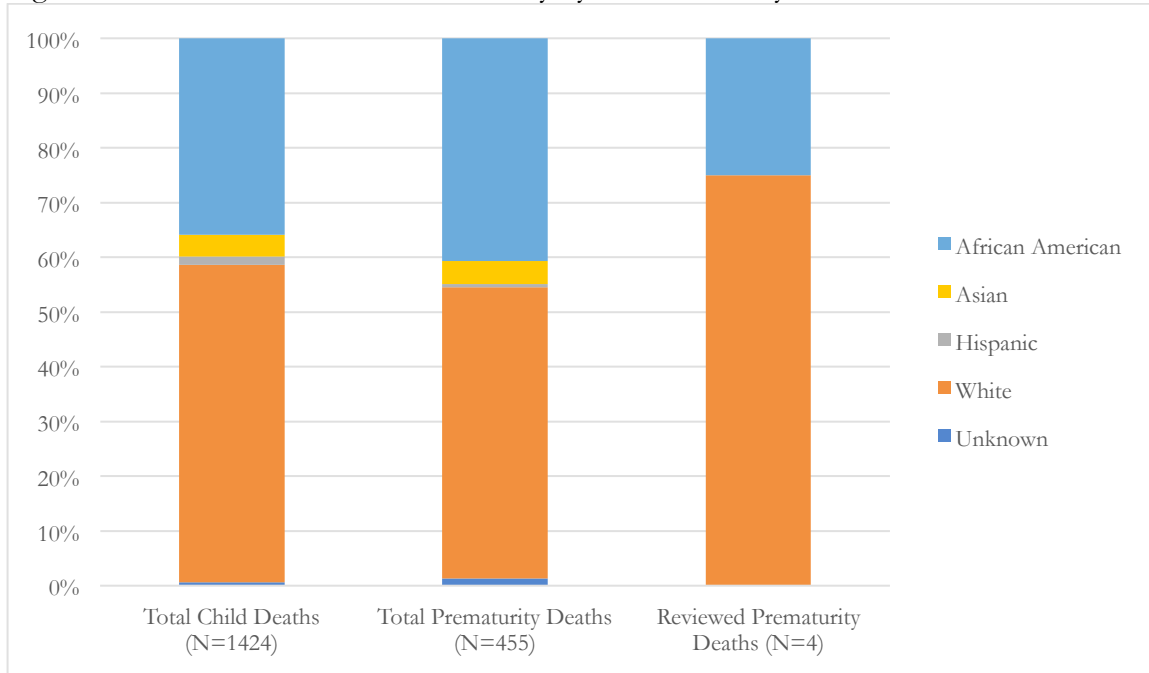
- A majority of children who died prematurely were boys (62%).
- The majority of deaths from prematurity were white children (53%), followed by African American children (41%), Asian children (4%) and Hispanic and children unknown race/ethnicity (2%).
- Nearly all deaths (99%) in this category were the result of natural causes, and one death was undetermined.

Illinois Data – Deaths Reviewed by the CDRTs

- In 2017, four of the 266 child deaths reviewed by CDRTs (2%) were related to premature birth.
- Premature deaths reviewed by CDRTs were evenly split (50%) between male and female children (two each).
- Three of the four (75%) premature deaths reviewed by the CDRTs were white children and one (25%) was an African American child.

- Three of the four (75%) premature deaths reviewed by the CDRTs were the result of natural causes and one (25%) was undetermined.

Figure 12: Child Deaths Due to Prematurity by Race/Ethnicity



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 2017, 2,327 children ages 17 and under in the U.S. died from suffocation.¹¹ Of these children, 51% were less than one year of age and 57% 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.¹²

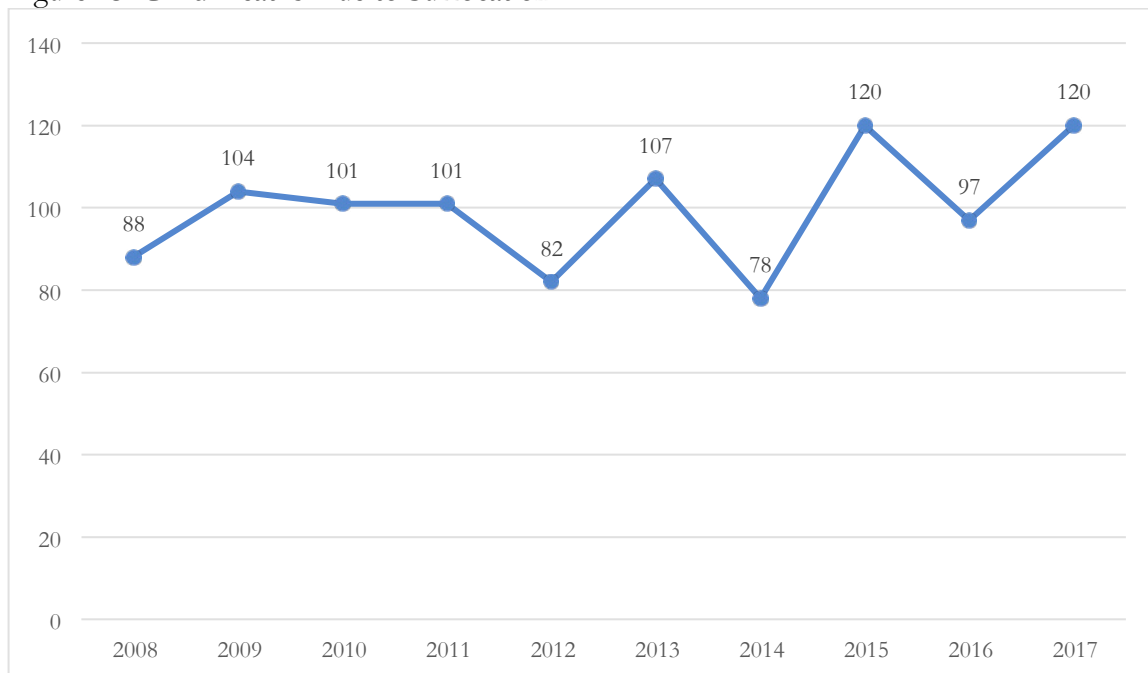
¹¹ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2018). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

¹² Safe Kids Worldwide. (2018). *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

There has been no clear trend when observing the data on the number of child deaths from suffocation over the past decade. Suffocation deaths were relatively stable from 2009 to 2011 (between 101 and 104), but they have fluctuated ever since. Suffocation deaths increased from 97 in 2016 to 120 in 2017, tied with 2015 as the year with the most suffocation deaths in the past decade (see Figure 13).

Figure 13: Child Deaths Due to Suffocation



In 2017, 120 of the 1,424 total child deaths reported to the CDRTs (8%) were categorized as suffocation.

- The majority of children who died from suffocation were boys (70%).
- Infants under one year made up over half (52%) of deaths in this category.
- The majority (62%) of children who died from suffocation were white, 32% were African American, 4% were Hispanic and 3% were Asian.
- Most suffocation death were accidental (52%) or suicides (35%); and the remaining suffocation deaths were homicides (5%), undetermined (5%) or from natural causes (3%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, 63 of the 266 child deaths reviewed by CDRTs (24%) were related to suffocation.

- Two-thirds (67%) of reviewed suffocation deaths were boys.
- Infants under one made up the majority of reviewed suffocation death (78%).
- African American and white children each accounted for 46% of reviewed suffocation deaths (92% total).

Figure 14: Child Deaths Due to Suffocation by Age

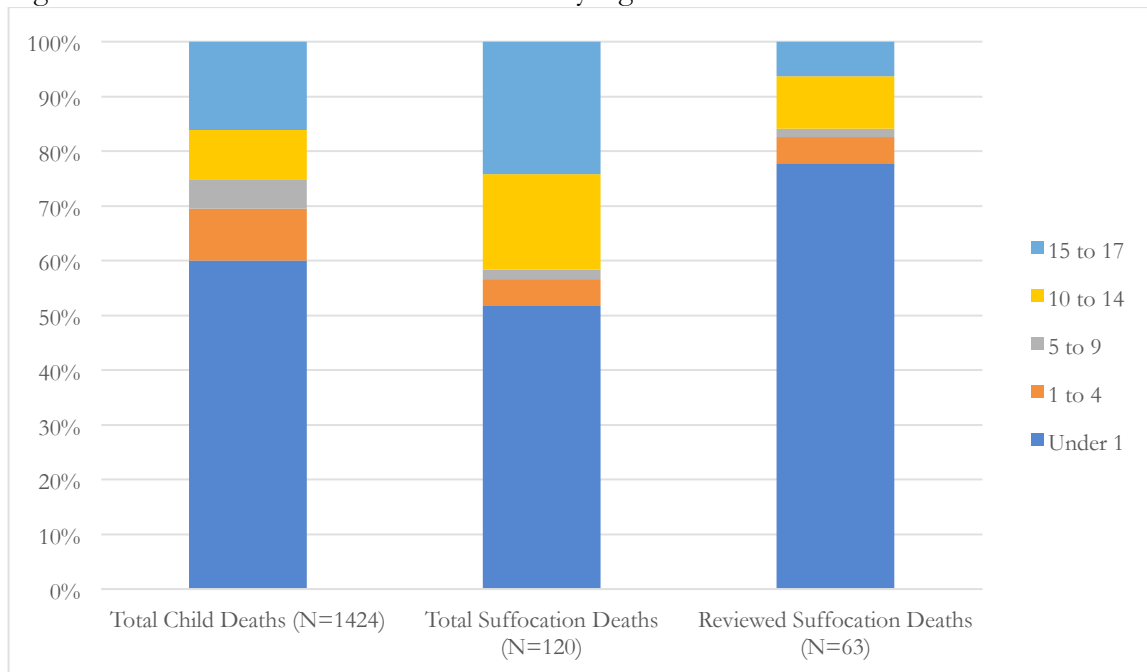
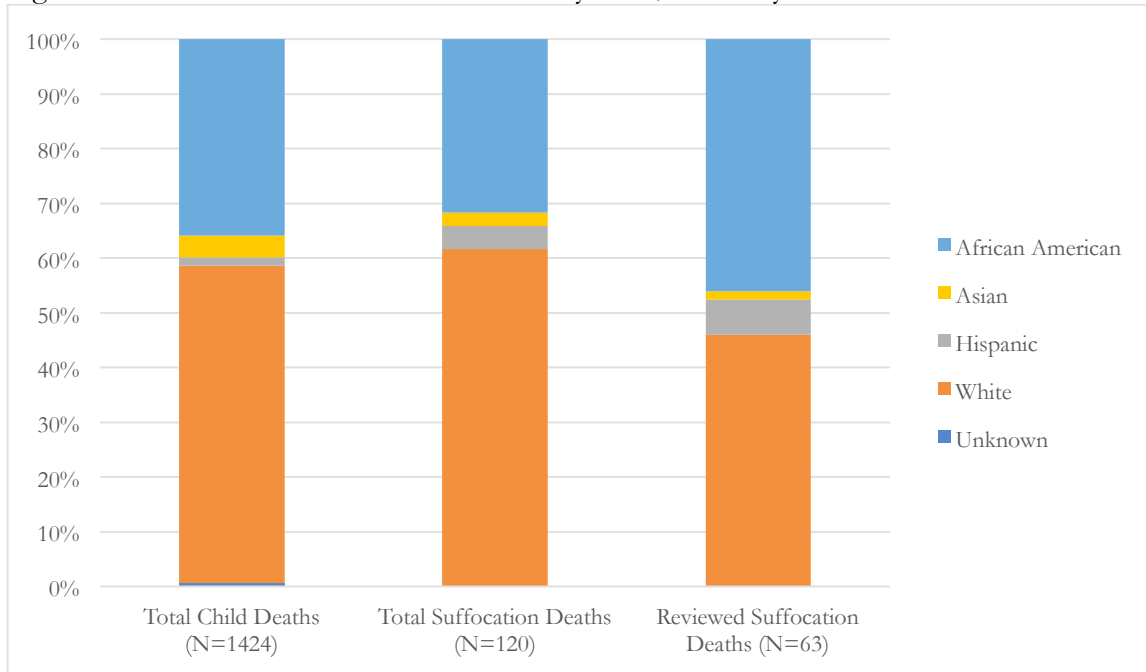


Figure 15: Child Deaths Due to Suffocation by Race/Ethnicity



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 Centers for Disease Control and Prevention, 1,814 firearm deaths occurred in 2017 among children under 18 years of age in the United States. The vast majority (71%) of these deaths were youth between the ages of 15 and 17. Race of decedent is also a factor. In 2017, the homicide rate with firearms for African American males 13 to 17 years old was over nine times higher than the rate for white males of the same age group.¹³ The proportion of teenage deaths due to firearms decreased dramatically over the span of nearly two decades. The rates were 27.8 per 100,000 in 1994 and fell down to 9.7 in 2013; however, rates have increased by nearly 30% to 13.8 per 100,000 in 2017.¹⁴

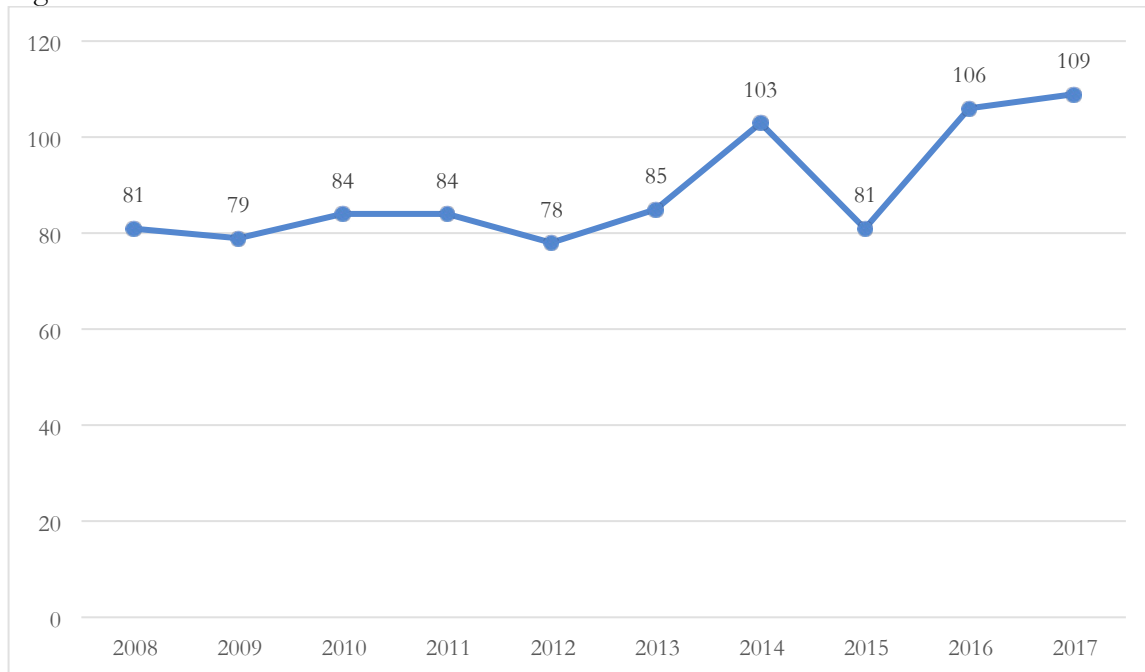
Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths from firearms has fluctuated over the past several years. Firearm deaths ranged from between 79 to 85 for the majority of years in the past decade. However, there was a spike to 103 firearm deaths in 2014 and 106 firearm deaths in 2016. The 109 firearm deaths in 2017 was the highest observed in the past decade (see Figure 16).

¹³ 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>.

¹⁴ Child Trends. (2017). *Teen homicide, suicide, and firearm deaths*. Retrieved from <https://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths>.

Figure 16: Child Deaths Due to Firearms



In 2017, 109 of the 1,424 total deaths (8%) were related to firearms.

- Deaths due to firearms overwhelmingly occurred among boys (83%).
- 81% of firearm deaths occurred in children aged 15 to 17 (see Figure 17).
- 57% of the children who died from firearms were African American, 40% were white and 3% were Hispanic (see Figure 18).
- Homicides accounted for 84% of firearm deaths, suicides were 14% and accidents accounted for the remaining 2%.

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, 9 of the 266 deaths reviewed by the CDRTs (3%) were related to firearms.

- Over three-quarters of reviewed firearm deaths were males (78%).
- Over half (56%) of the firearm deaths reviewed by CDRTs involved youth 15 to 17 years old (see Figure 17).

- Two-thirds (67%) of reviewed firearm deaths were white children and one-third (33%) were African American children. There were no reviewed firearm deaths of children of other race/ethnicity (see Figure 18).
- Nearly all of the firearm deaths reviewed by CDRTs were due to homicides (89%); and there was a single death (11%) that was categorized as a suicide.

Figure 17: Child Deaths Due to Firearms by Age

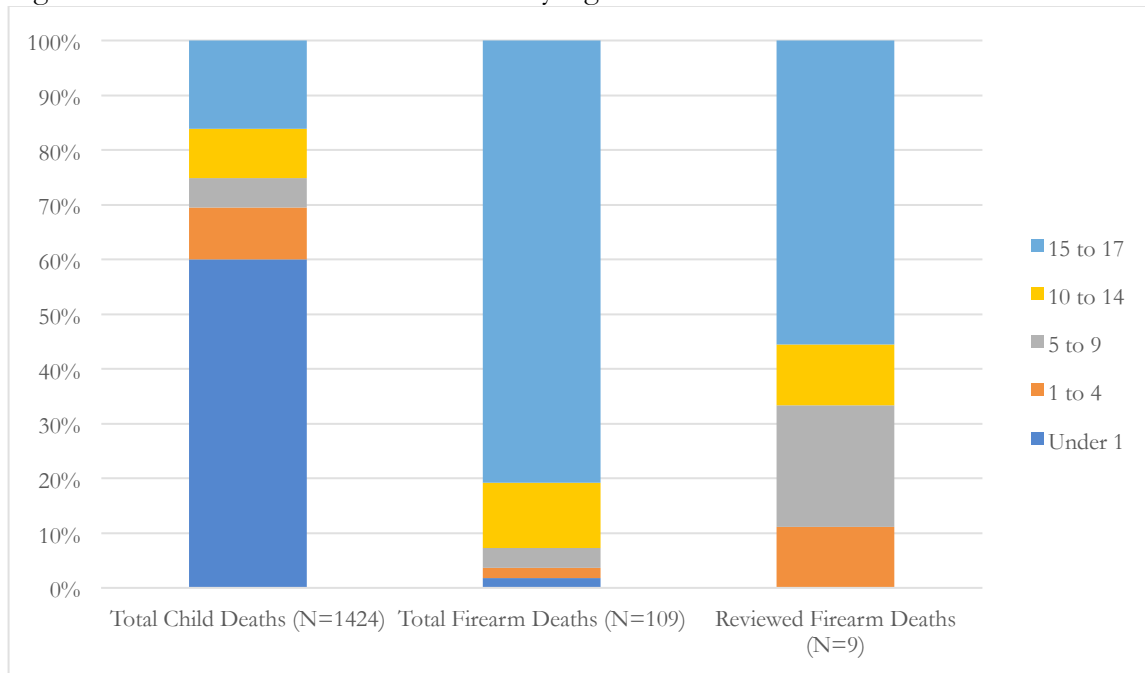
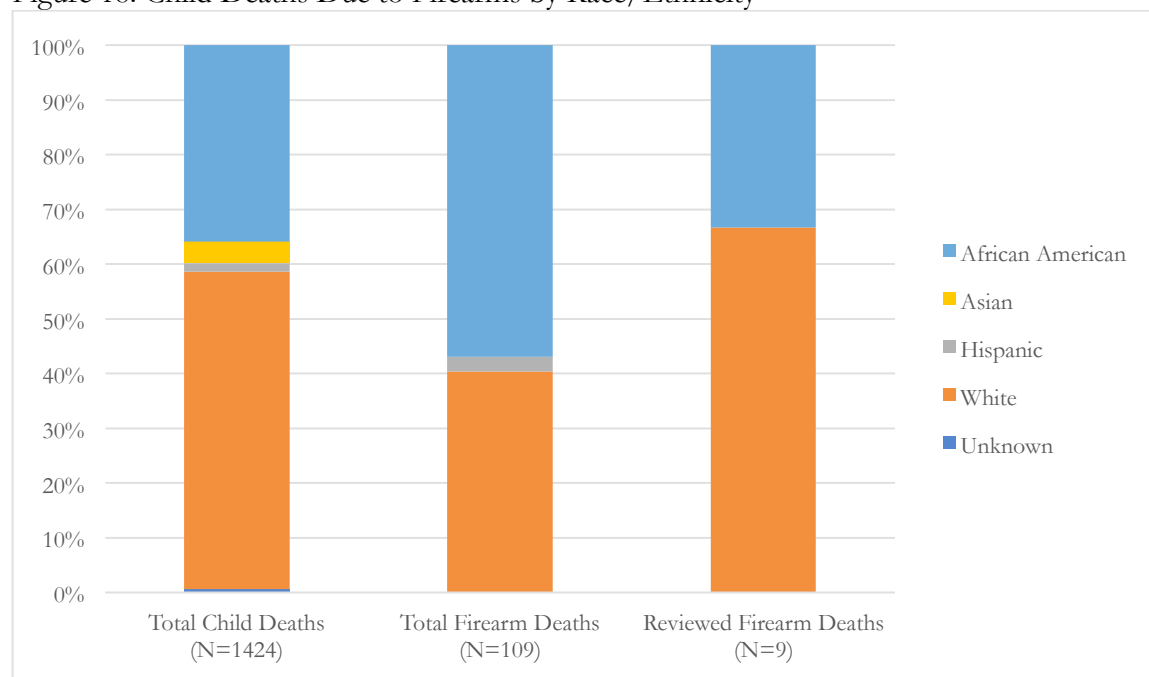


Figure 18: Child Deaths Due to Firearms by Race/Ethnicity



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 939 children (under the age of 13) died in motor vehicle crashes in 2017.¹⁵ There has been a 78% decrease in the rate of motor vehicle crash deaths per million children under 13 since 1975. In 2017, 72% of child motor vehicle crash deaths were passenger vehicle occupants, 18% were pedestrians and 3% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 91% and 94%, respectively, and passenger child occupant deaths decreased by 58%. Children 12 and younger are recommended to ride in the rear seats of vehicles. Twelve percent of passenger vehicle child occupant deaths occurred in front seats, continuing a downward trend that has spanned for several decades. Eighty-one percent were in the rear seat and 8% were in cargo/unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about one of every four unintentional injury deaths among children younger than 13. The

¹⁵ Insurance Institute for Highway Safety. (2018). *Fatality facts 2017: Children*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/children#Age-and-gender>

majority of deaths from crashes are among children traveling as passenger vehicle occupants, which could potentially be reduced through proper restraint use. 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 8.¹⁶

In 2017, a total of 2,734 teenagers ages 13 to 19 died in motor vehicle crashes. This is a decrease of 69% from 1975 and 4% from 2016. Males accounted for about two out of every three teenagers killed in crashes in 2017. Although males make up a larger number of crash deaths, their rates have decreased more (72%) than females (58%) since 1975. Teenagers accounted for 7% of motor vehicle crash deaths in 2017. Teenagers overall account for 9% of passenger vehicle (cars, pickups, SUVs and vans) occupant deaths among all ages, 5% of pedestrian deaths, 4% of motorcycle deaths, 9% of bicyclist deaths and 17% of all-terrain vehicle rider deaths.¹⁷

In the United States, teenagers drive less than most adults, yet their numbers of crashes and deaths from crashes are disproportionately high. The fatal crash rate per mile driven for 16- to 19-year-olds is about three times the rate of older drivers 20 and over, with the highest risk among teenagers ages 16 to 17.¹⁸

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 riding with peers and drowsiness.¹⁹ 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.²⁰

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of vehicle deaths declined from 2011 to 2015, but rates have increased since then and are currently at the highest point for this decade (see Figure 19).

¹⁶ Ibid.

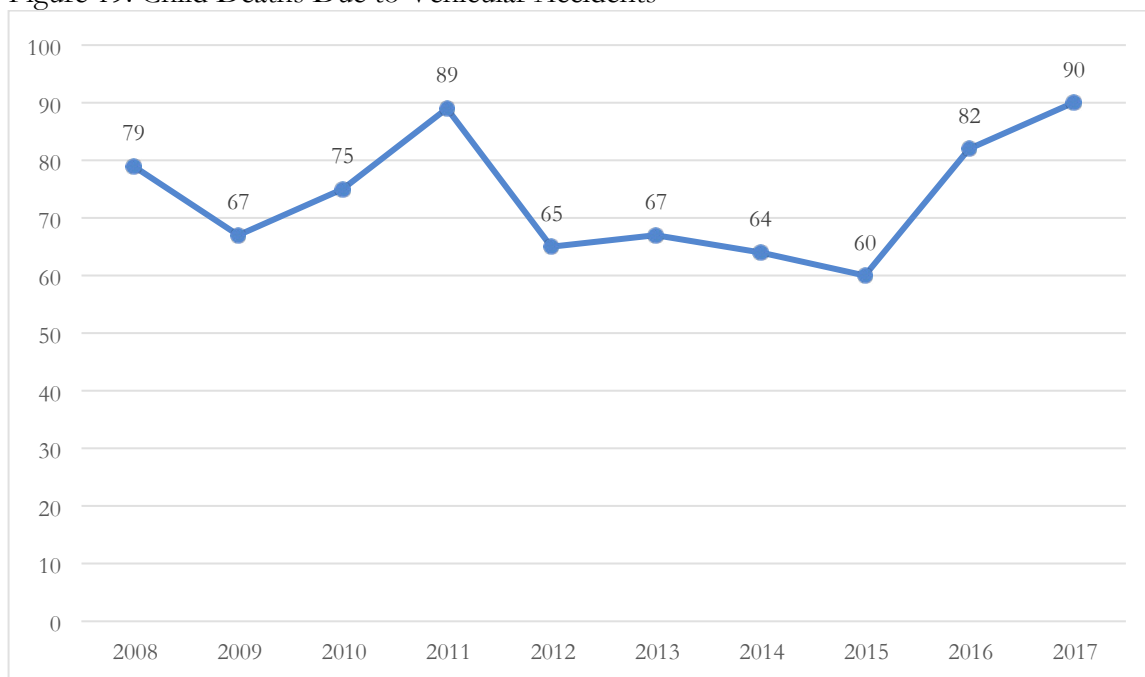
¹⁷ Insurance Institute for Highway Safety. (2018). *Fatality facts 2016: Teenagers*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/teenagers>

¹⁸ Ibid.

¹⁹ Children's Hospital of Philadelphia Research Institute (2019). Teen Driving Safety: Distracted Driving Research. Retrieved from <https://injury.research.chop.edu/teen-driving-safety/distracted-driving-research>.

²⁰ Insurance Institute for Highway Safety. (2018). *Fatality facts 2017: Teenagers*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/teenagers>.

Figure 19: Child Deaths Due to Vehicular Accidents



In 2017, 90 out of the 1,424 total child deaths reported to the CDRT's (6%) were related to vehicular accidents.

- The majority of vehicular accident deaths were boys (62%).
- Older children (15 to 17) made up the largest proportion of vehicular accident deaths. Children in other age groups made up the following proportions of vehicular deaths: children under 1 accounted for 4%, children 1 to 4 were 16%, 5 to 9 were 13% and 10 to 14 were 21% (see Figure 20).
- The majority (72%) of deaths due to vehicular accidents were white children, followed by African American children (24%), Hispanic children (2%) and one child was of unknown race/ethnicity (1%) (see Figure 21).
- The majority of these deaths were accidental (90%). Seven percent were homicides and 3% were suicides.

Illinois Data – Deaths Reviewed by the CDRT's

In 2017, 22 of the 266 deaths reviewed by the CDRT's (8%) were related to vehicular accidents.

- The majority of reviewed vehicular accident deaths were boys (59%).
- Children under 10 made up the majority of reviewed vehicular accident deaths (64%) and children 10 to 17 made up the remaining 36% (see Figure 20).

- Most of the reviewed deaths related to vehicular accidents were white children (64%), followed by African American children (32%). One death was a Hispanic child (5%) (see Figure 21).
- The majority of reviewed vehicular accident deaths were accidental (86%) and 14% were homicides.

Figure 20: Child Deaths Due to Vehicular Accidents by Age

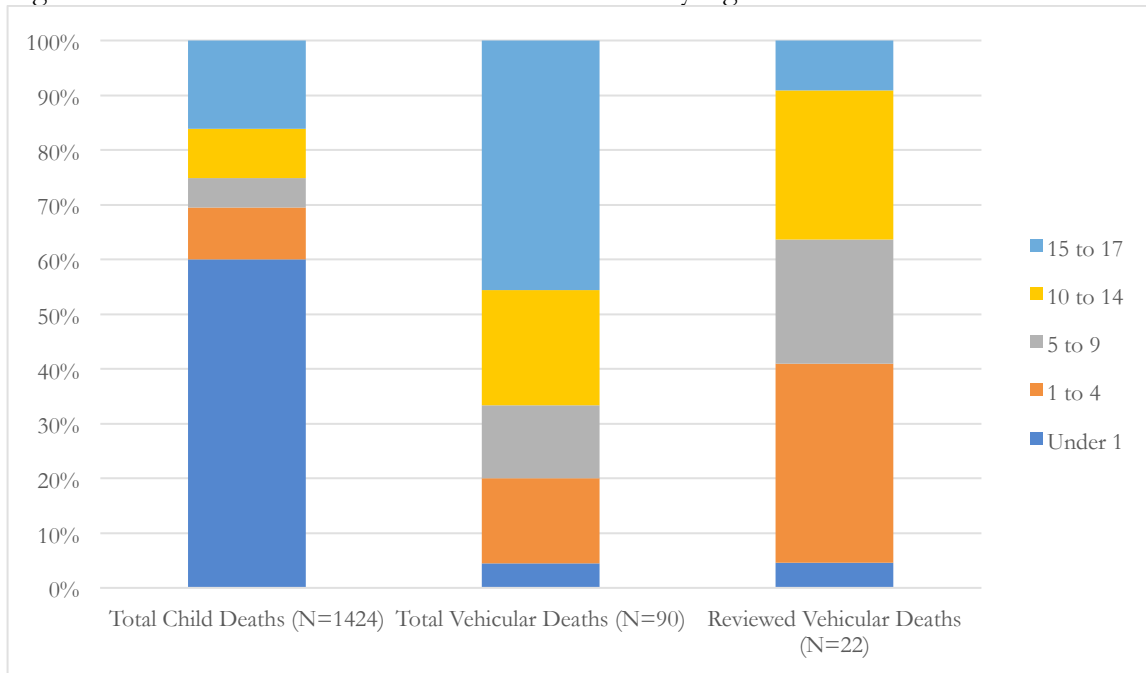
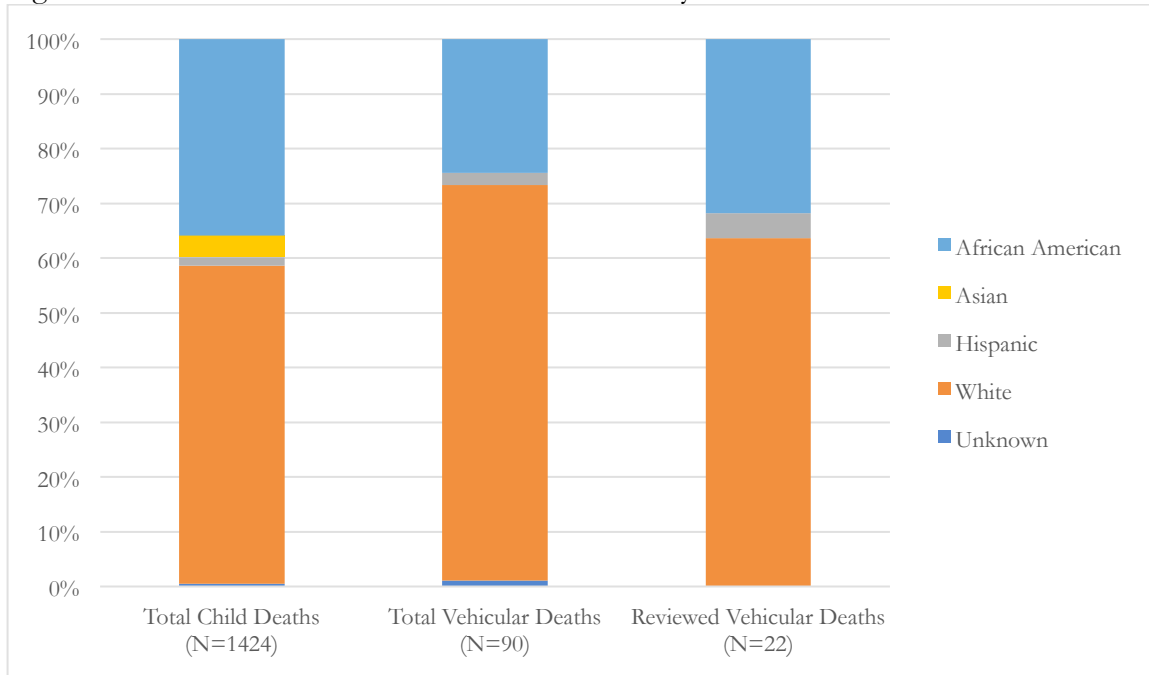


Figure 21: Child Deaths Due to Vehicular Accidents by Race



Undetermined Deaths

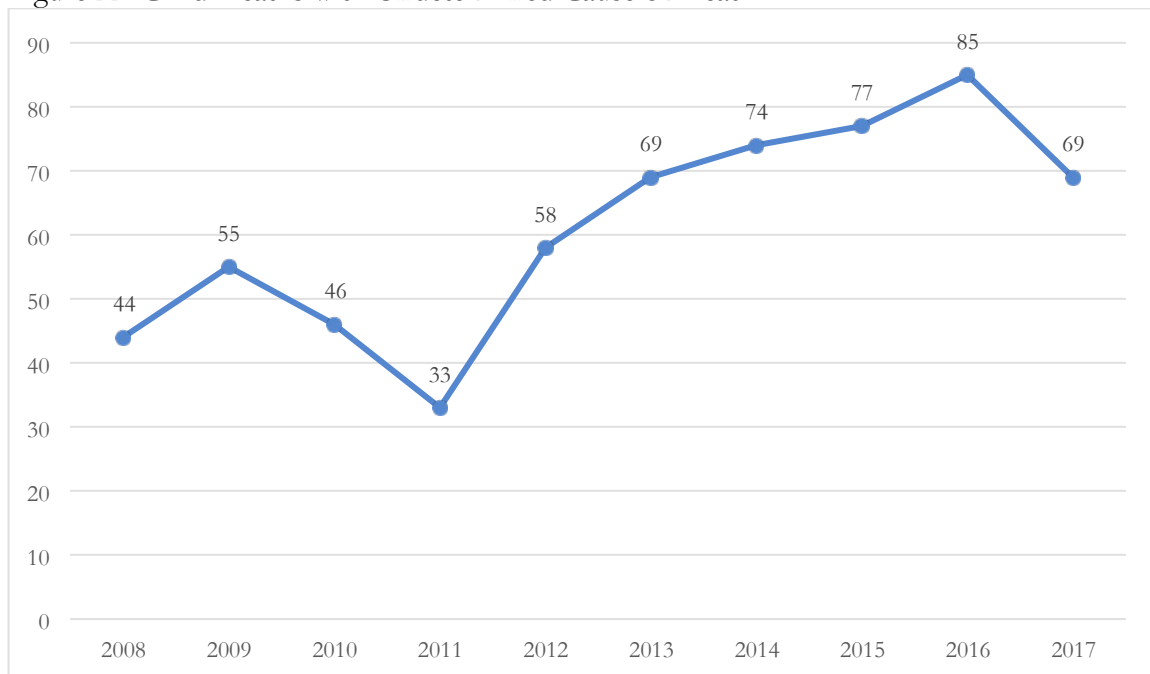
Definition

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 since the low of 33 in 2011. The number peaked at 85 in 2016 and dropped to 69 in 2017 (see Figure 22).

Figure 22: Child Deaths with Undetermined Cause of Death



In 2017, 69 of the 1,424 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

- Deaths due to undetermined causes were slightly more common for boys (61%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (88%).
- The majority of undetermined deaths were African American children (62%), followed by white children (35%) and Asian children (3%).

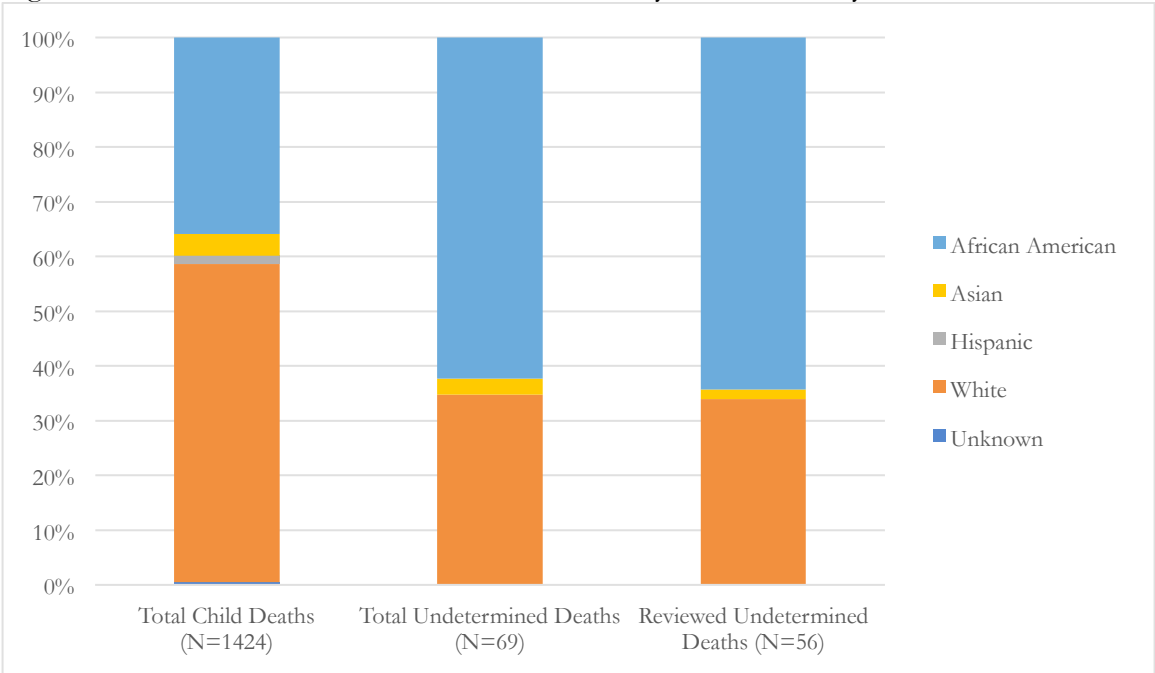
Illinois Data – Deaths Reviewed by the CDRTs

In 2017, 56 of the 266 deaths reviewed by CDRTs (21%) had an undetermined cause of death.

- The majority of reviewed deaths due to undetermined causes were boys (64%).
- 89% of reviewed undetermined deaths were children under age 1.

The majority of undetermined deaths were African American children (64%), followed by white children (34%) and Asian children (2%) (see Figure 23).

Figure 23: Child Deaths with Undetermined Cause by Race/Ethnicity



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

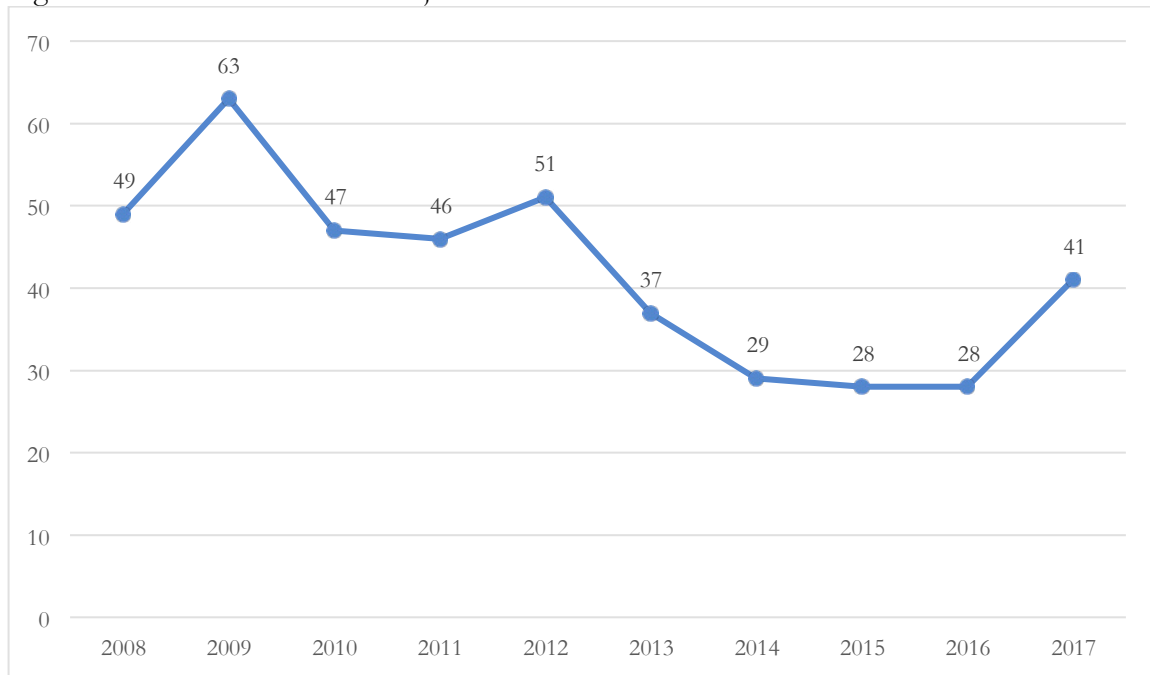
Child maltreatment (including abuse and neglect) is one cause of death from injuries. In Federal Fiscal Year 2017 (FFY 2017), the National Child Abuse and Neglect Data System (NCANDS) reported 1,688 injury-related child fatalities in the United States. Based on the NCANDS data, it is estimated that 1,720 children died from abuse and neglect at a rate of 2.32 deaths per 100,000 children. Younger children are the most vulnerable to death as a result of child abuse and neglect. Seventy-two percent (71.8%) of child fatalities were children younger than 3 years old. Boys had a higher fatality rate (2.68 per 100,000) compared to girls (2.02 per 100,000), and African American children had higher rates (4.86 per 100,000) compared to white children (1.84 per 100,000) and Hispanic children (1.59 per 100,000).²¹ Of child maltreatment deaths, about three quarters (75.4%) suffered neglect and 41.6% suffered physical abuse either exclusively or in combination with other maltreatment types (e.g., medical neglect, psychological abuse, sexual abuse).

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries had declined after 2012, but there was an increase in 2017 (see Figure 24).

²¹ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2019). *Child maltreatment, 2017*. Washington, DC: Government Printing Office. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf>

Figure 24: Child Death Due to Injuries



In 2017, 41 of the 1,424 total child deaths reported to the CDRTs (3%) were related to injuries.

- There were slightly more injury deaths for females (51%) than boys (49%).
- Infants and children under 4 years of age made up over half (59%) of injury deaths (see Figure 25)
- The majority of injury deaths were white children (56%), followed by African American children (37%). Hispanic and children of unknown race/ethnicity made up the remaining 7% of injury deaths (see Figure 26).
- The majority of injury deaths were homicides (73%). Accidents and suicides each accounted for 12% and one death was undetermined (2%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, 22 of the 266 deaths reviewed by the CDRTs (8%) were related to injuries.

- Child deaths reviewed by CDRTs were evenly split between males and females.
- Infants and children under 4 years of age made up the majority (82%) of reviewed injury deaths.
- African American children made up half of reviewed injury deaths (50%), white children were 45% and there was one Hispanic child (5%).

- Nearly all of the reviewed injury deaths were homicides (95%), and one was accidental (5%).

Figure 25: Child Deaths Due to Injuries by Age

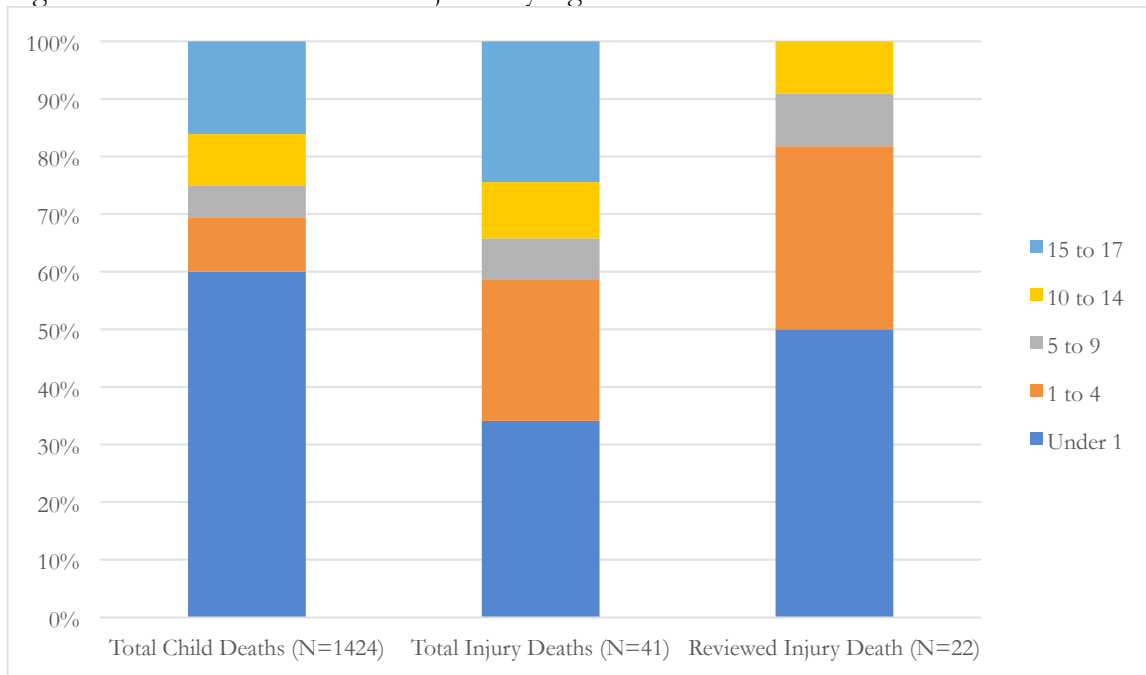
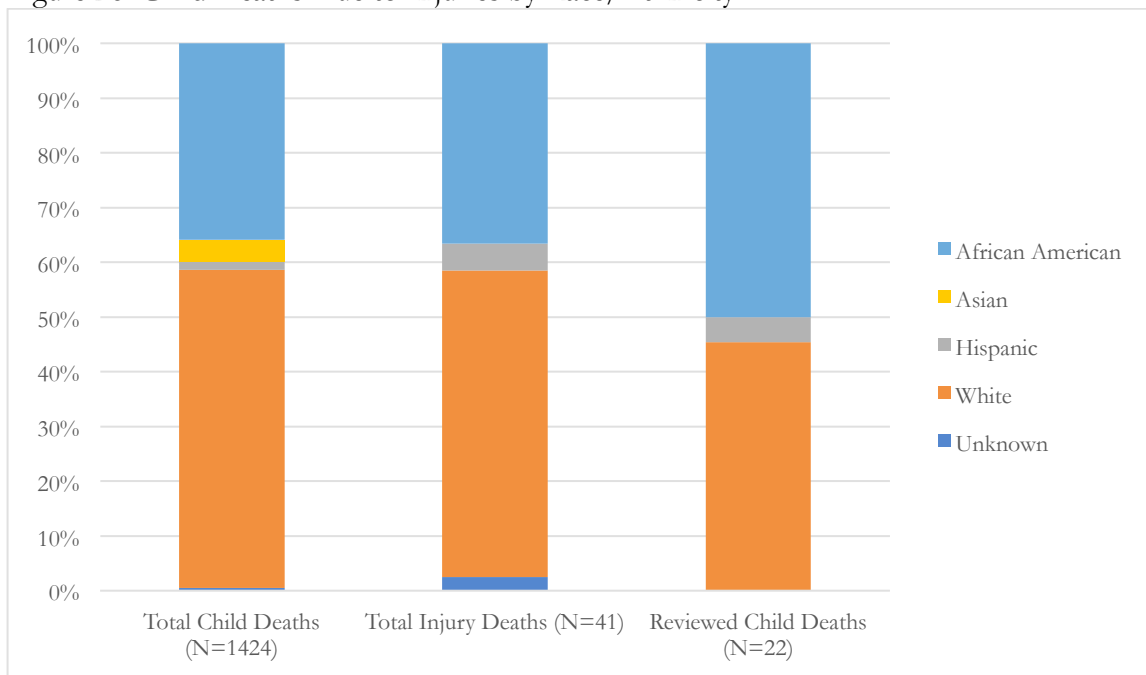


Figure 26: Child Deaths Due to Injuries by Race/Ethnicity



Drowning

Definition

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

Background

In 2017, 808 children ages 17 and under died as a result of unintentional drowning in the United States. Children 4 and under accounted for 58% of these deaths.²² The majority of infant drowning deaths happens 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 three quarters of pool submersion deaths occur at home. African American children ages 5 to 14 years old have a drowning rate 2.8 times greater than that of white children.²³

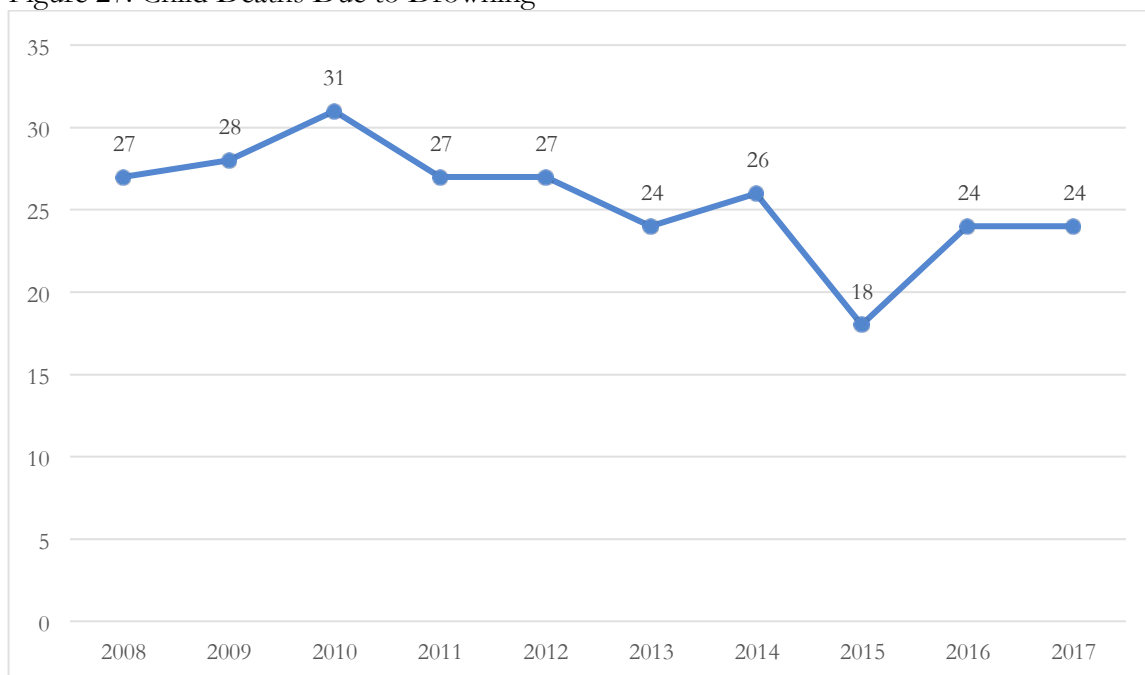
Illinois Data – Total Child Deaths Reported to the CDRTs

The number of Illinois child deaths due to drowning was highest in 2010 (31 deaths). There had been small decreases to a low of 18 drowning deaths in 2015 (see Figure 27). There was a small increase up to 24 drowning deaths in 2016, and there were the same number of drowning deaths in 2017.

²² 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/fatal.html>.

²³ 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.

Figure 27: Child Deaths Due to Drowning



In 2017, 24 of the 1,424 total child deaths reported to the CDRT's (2%) were related to drowning.

- Boys made up two-thirds of reported drowning deaths (67%).
- Children under 4 years of age accounted for half of the deaths (50%). Children 5 to 9 years old, 10 to 14 years old and 15 to 17 years old accounted for 17%, 21%, and 13% of deaths due to drowning, respectively (see Figure 28).
- Two-thirds of reported drowning deaths were white children (67%), 29% were African American and one was Asian (4%) (see Figure 29).
- The majority of drowning death were accidental (83%). Three cases were undetermined (13%) and one case was a homicide (4%).

Illinois Data – Deaths Reviewed by the CDRT's

In 2017, 15 of the 266 reviewed deaths (6%) were related to drowning.

- Two-thirds (67%) of the reviewed drowning deaths were male.

Children 4 and under accounted for 73% of the deaths, children 5 to 9 years old were 20% and there was a single death of a child 10 to 14 years old (7%) (see Figure 28).

- The majority of reviewed drowning deaths were white children (60%), followed by African American children (33%) and there was one case with an Asian child (7%) (see Figure 29).

- The majority of reviewed drowning deaths were accidents (73%), 20% were undermined and one case was a homicide (7%).

Figure 28: Child Deaths Due to Drowning by Age

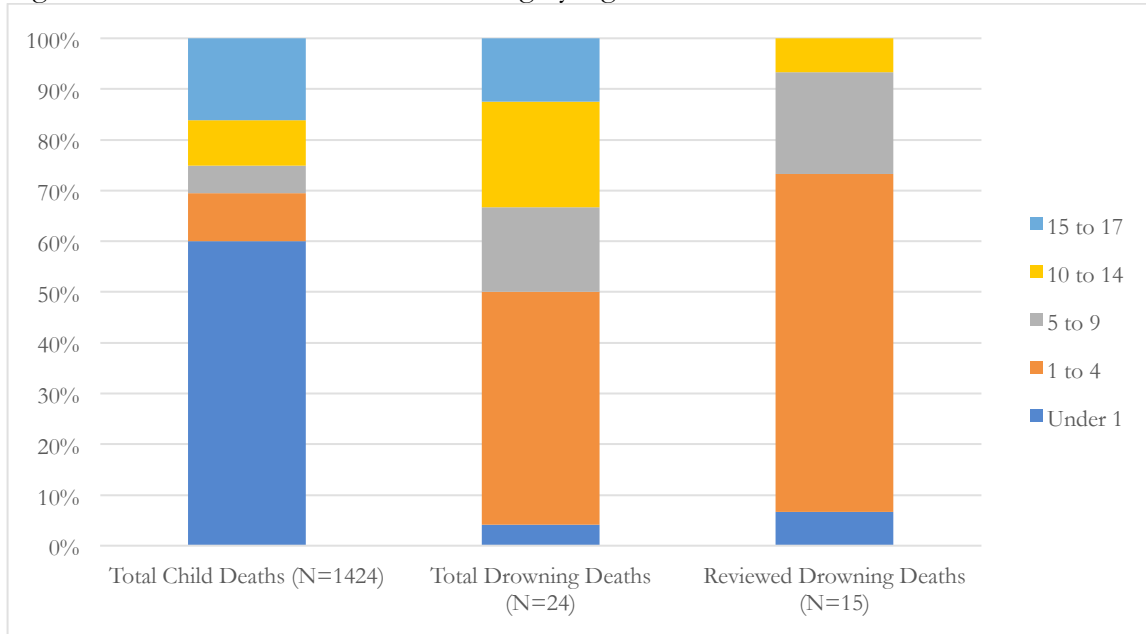
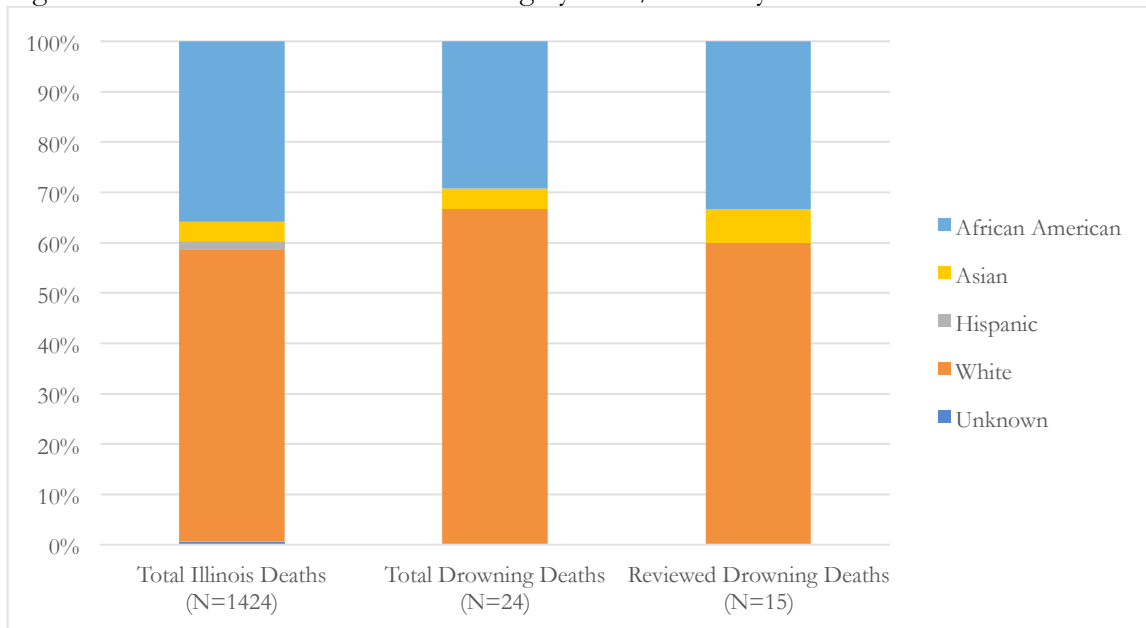


Figure 29: Child Deaths Due to Drowning by Race/Ethnicity



Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)²⁴

Definition

According to Centers for Disease Control and Prevention (CDC),²⁵ 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 were 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.²⁶

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 1994.²⁷

²⁴ 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.

²⁵ Center for Disease Control and Prevention. (2018). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved from <https://www.cdc.gov/sids/aboutsuidandsids.htm>.

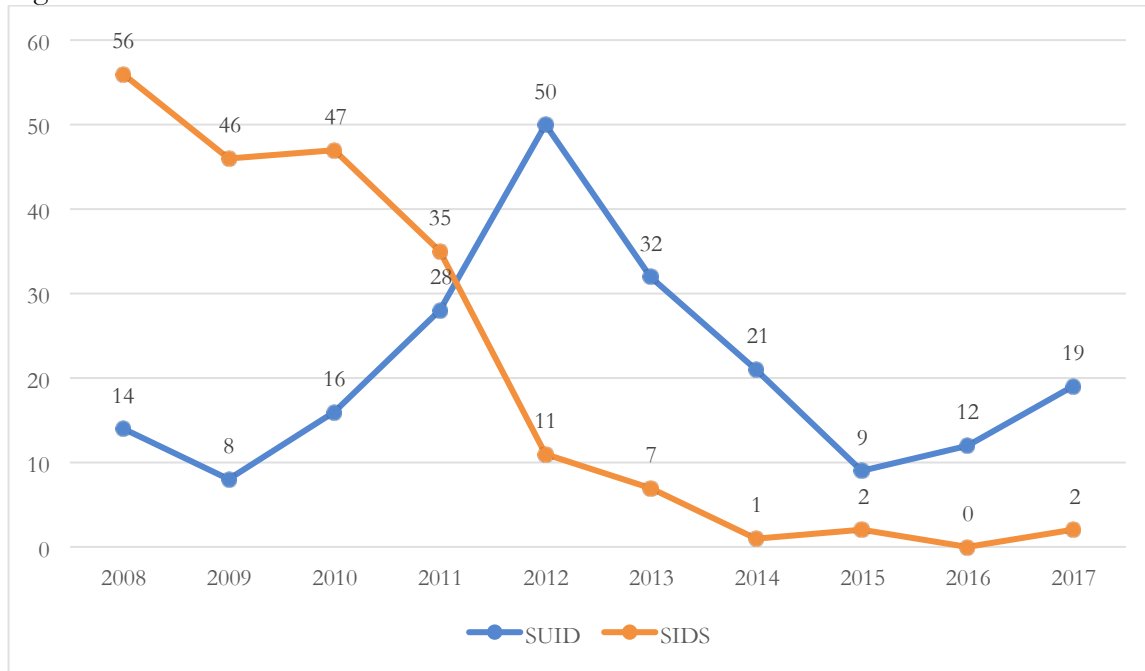
²⁶ Shapiro-Mendoza, C.K., Tomaszek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, 163, 762-769.

²⁷ 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 CDRT's

Since the peak of 56 deaths in 2008, SIDS has experienced a sharp decline, with very low number of deaths occurring in recent years (see Figure 30). Infant deaths from SUID were added as a category in 2007. Child deaths due to SUID reached a peak of 50 in 2012 but has since experienced a general decline.

Figure 30: Child Deaths due to SIDS and SUID



In 2017, two of the 1,424 child deaths reported to the CDRT's were related to SIDS (<1%) and 19 were categorized as SUID (1%).

- Both of the SIDS deaths were male children (100%) and the majority of SUID deaths were males (68%).
- All but one of the SUID deaths were infants under 1 year (95%) and one was an infant 1 year of age (5%).
- Both of the SIDS deaths were white children (100%). The majority of SUID deaths were also white children (74%) and the remaining deaths were African American children (26%).
- All SIDS deaths were categorized as natural. The largest proportion of SUID deaths were undetermined (42%) and the remainder were either natural (37%) or accidental (21%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, one of the 266 deaths reviewed by the CDRTs were related to SIDS (<1%) and 14 were related to SUID (5%).

- The one SIDS death was a male infant (100%) and the majority of SUID deaths were males (64%).
- All of the SIDS and SUID cases were infants under 1 year of age.
- The SIDS death was a white child (100%). White children accounted for 79% of SUID deaths and African American children accounted for 21%.
- The SIDS death was categorized as natural (100%). The largest proportion of SUID deaths were undermined (43%) and the remainder were either natural (36%) or accidental (21%).

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 2017, 402 children under 18 years died of poisoning in the United States.²⁸ Over half of these deaths occurred in children 15 to 17 years of age (54%). Children 4 and under also make up a large proportion of poisoning deaths (23%).

Each year, 60,000 children in the United States 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.²⁹ 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.

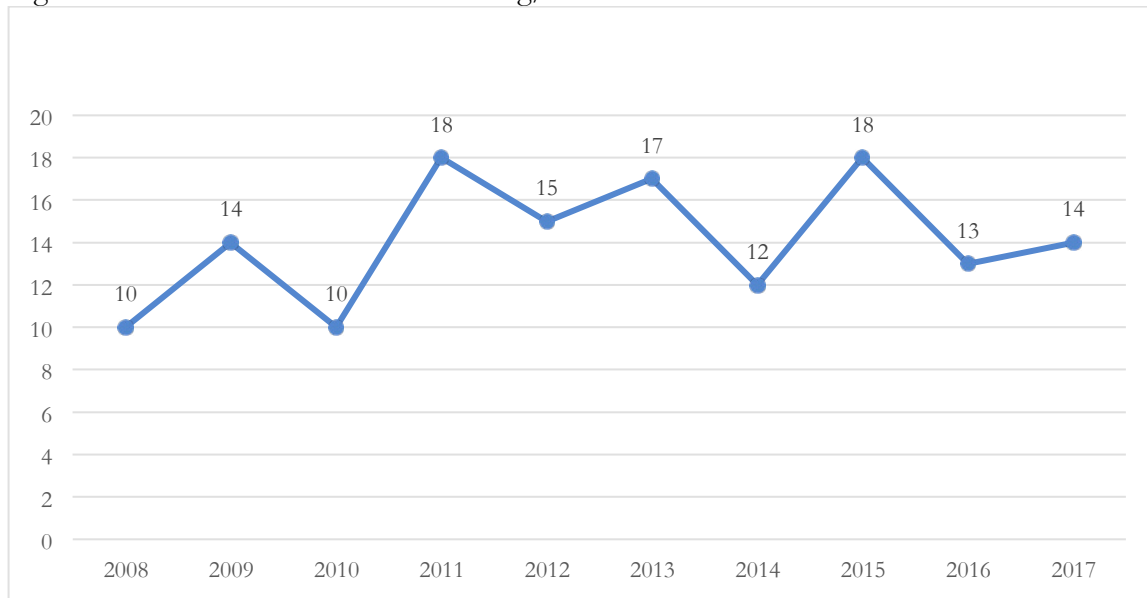
Illinois Data – Total Child Deaths Reported to the CDRTs

Between 10 and 18 children died from poisoning per year in the past decade (see Figure 31).

²⁸ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2019). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <https://www.cdc.gov/injury/wisqars/index.html>.

²⁹ Baker J. M., & Mickalide, A.D. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on safe medication*. Washington, DC: Safe Kids Worldwide. Retrieved from <https://www.safekids.org/research-report/safe-storage-safe-dosing-safe-kids-report-nation-safe-medication-march-2012>.

Figure 31: Child Deaths Due to Poisoning/Overdose



In 2017, 14 of the 1,424 total child deaths (<1%) were related to poisonings or overdoses.

- Males made up over half (57%) of the deaths related to poisoning or overdoses.
- Older children ages 15 to 17 made up 64% of deaths; and children 10 to 14 made up 36%. There were no children younger than age 10 that died from poisoning or overdose deaths in 2017.
- Almost of the poisoning or overdose deaths were white children (93%), with the exception of a single case of an Asian child (7%).
- Over half of the deaths were accidental (57%) and the remaining cases were suicides (43%).

Illinois Data – Deaths Reviewed by the CDRTs

- In 2017, three of the 266 deaths reviewed by CDRTs (1%) were related to poisoning/overdose.
- Two of the poison/overdose deaths were females (67%) and one was a male (33%).
- Two of the deaths were children age 15 to 17 (67%) and one was a child age 10-14 (33%).
- Two deaths were accidental (67%) and one was a suicide (33%).

Fire

Definition

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

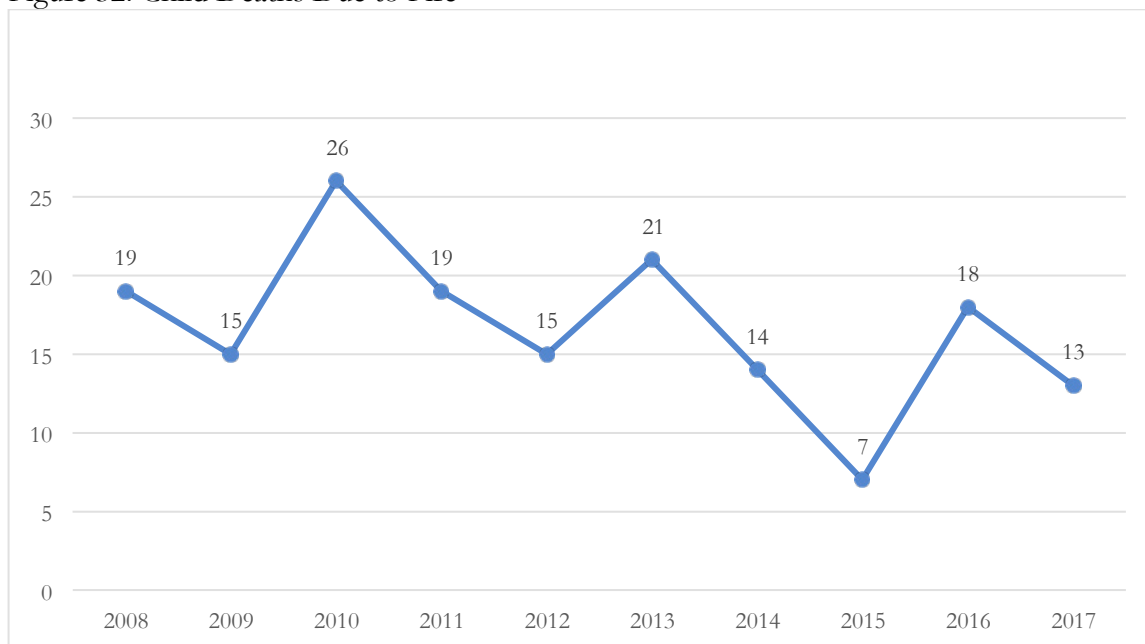
Background

In the United States, fire and burns were the cause of 341 deaths among children between 0 and 17 years in 2017. Forty percent of fire deaths occurred in children age 4 and under.³⁰ Death rates per million among children age 14 and under has decreased 43% from 2007-2016.³¹ A large proportion of fire-related fatalities are due to home fires, but functioning smoke alarms can reduce the chances of dying by almost 50%.³²

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to fire has ranged between a high of 26 to a low of seven in the past decade. There were 13 deaths due to fire in 2017 (see Figure 32).

Figure 32: Child Deaths Due to Fire



³⁰ 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>.

³¹ U. S. Fire Administration. (2018). *Child fire deaths, fire death rates and relative risk (2007-2016)* Retrieved from https://www.usfa.fema.gov/data/statistics/fire_death_rates.html.

³² Safe Kids Worldwide. (2018). *Fire safety*. Retrieved from <https://www.safekids.org/fire>.

In 2017, 13 of the 1,424 total child deaths reported to the CDRTs (<1%) were related to fires.

- The majority of deaths related to fire were females (69%).
- Children 4 and under accounted for 69% of deaths and children 10 to 14 years and children 15 to 17 both accounted for 15% each. There were no deaths of children 5 to 9 years.
- The majority of deaths due to fire were white children (77%) and 23% were African American children. There were no deaths of children of other race/ethnicity.
- The majority of deaths attributable to fire were accidental (85%). There was one suicide (8%) and one undetermined (8%) case.

Illinois Data – Deaths Reviewed by the CDRTs

In 2017, four of the 266 deaths reviewed by the CDRTs were related to fire.

- All four (100%) decedents were female.
- All of the decedents (100%) were 4 years or younger.
- African American and white children each accounted for 50% of reviewed fire deaths.
- Three of the four deaths were accidents (75%) and one case was undetermined (25%).

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 no scalding deaths reported to CDRTs in 2017.

Sudden Unexplained Child Death (SUCD)

There was one reported SUCD case in 2017, and it was reviewed by the CDRTs. The death was a white male child 1 year of age.

Other

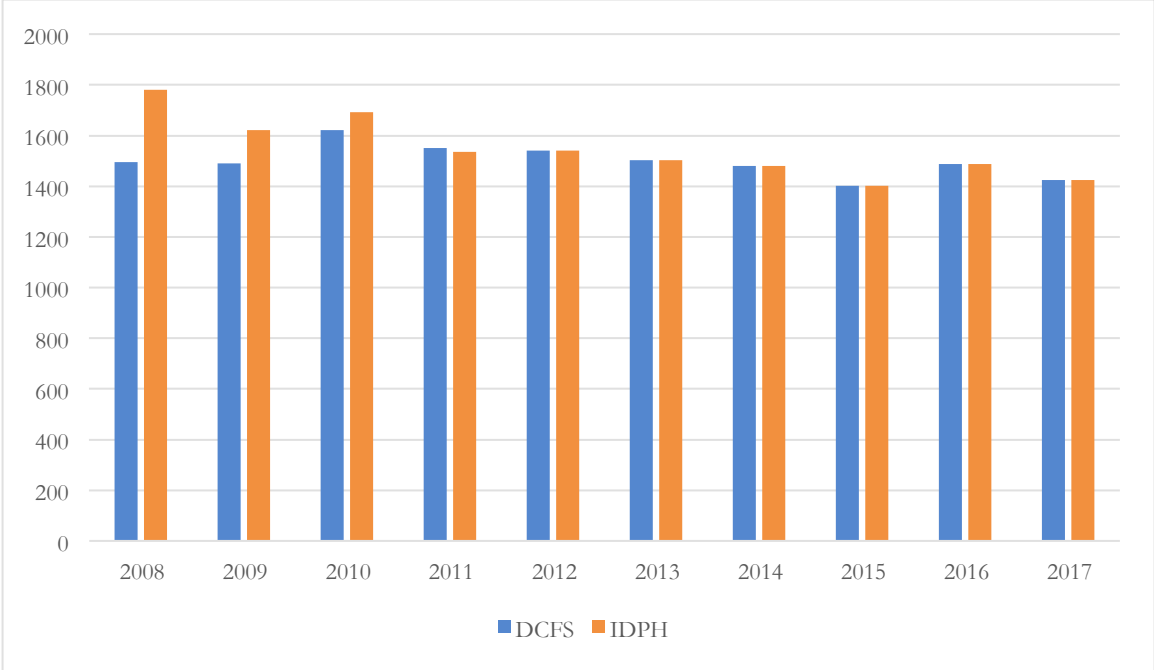
As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism and malnourishment). In 2017, four deaths fell in this category and two were reviewed by the CDRTs.

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 DCFS come from the HFS Enterprise Data Warehouse. The EDW receives the deaths from IDPH. Thus, from 2012 forward, the DCFS deaths and IDPH deaths are consolidated.

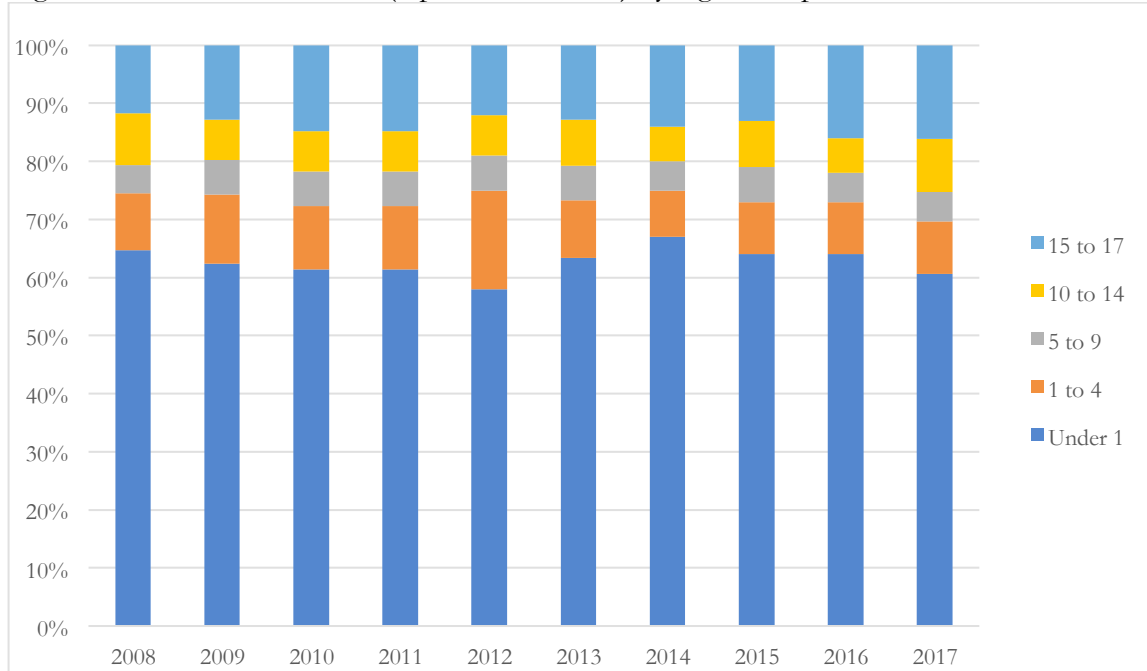
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1,948 in 2007 and a low of 1,402 in 2015, and have stayed around the same level. There were 1,424 total child deaths in 2017 (see Figure 33).

Figure 33: Total Child Deaths Reported to DCFS and IDPH, 2008–2017



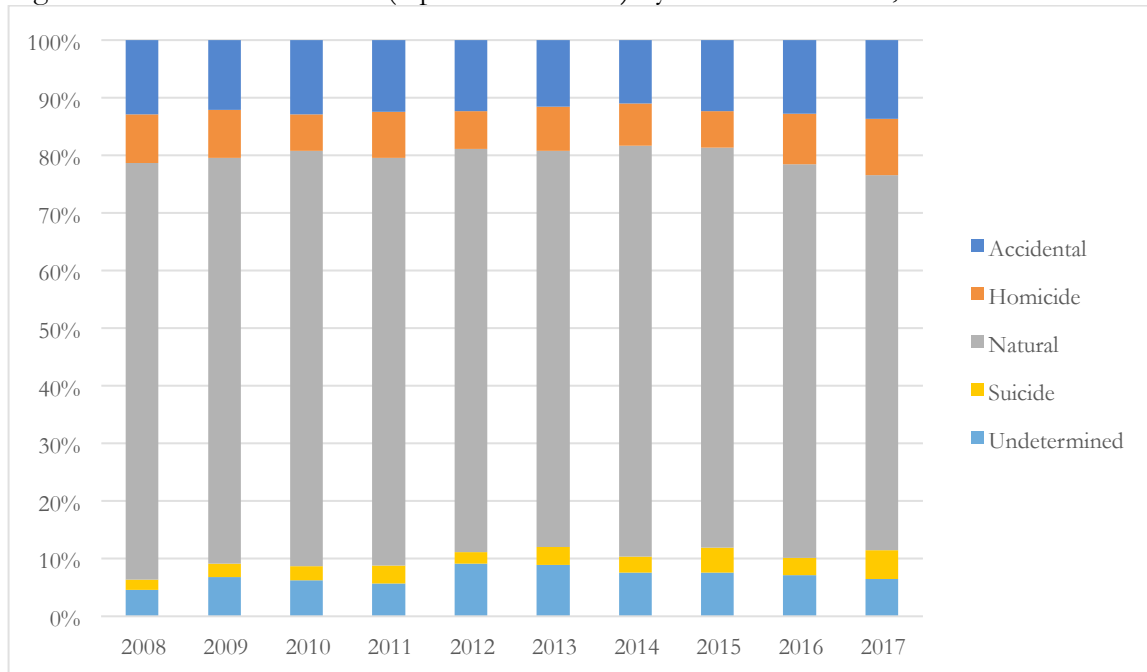
The total child deaths reported to the Child Death Review Team Unit from 2008 to 2017 is broken down by age group in Figure 34. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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 34 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 58-67% 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 34: Total Child Deaths (reported to DCFS) by Age Group, 2008-2017



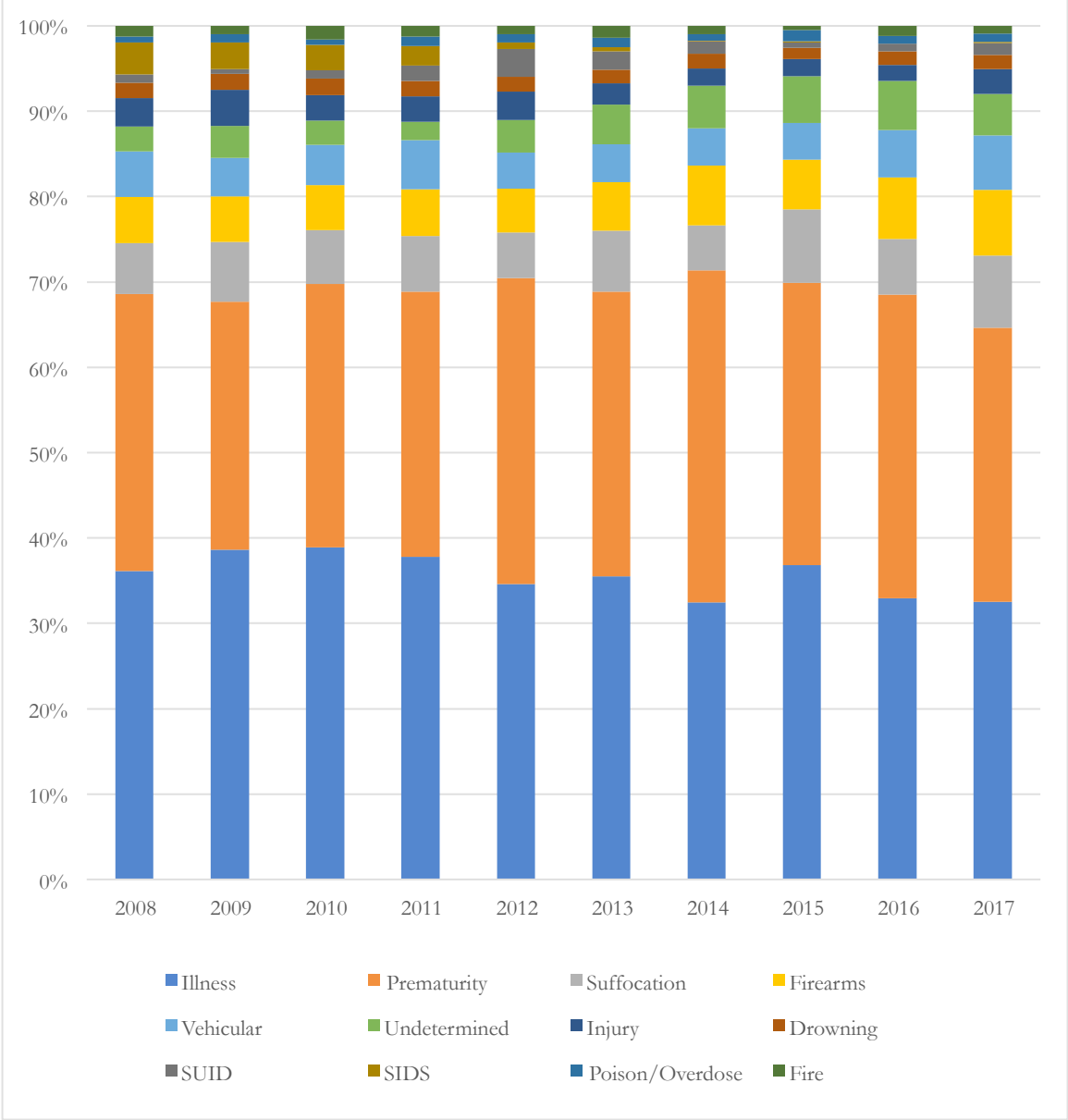
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-14% accidental, 6-10% homicide, 65-72% natural, 2-5% suicide and 5-9% undetermined (see Figure 35).

Figure 35: Total Child Deaths (reported to DCFS) by Manner of Death, 2008-2017



A similar analysis was done for category of death (see Figure 36). The percentage of child deaths related to each category of death across the time period varies. The major categories of deaths from illness (32-39%) and prematurity (29-39%) fluctuated over time. There was an increasing trend for deaths from firearms (5% before 2013 to 6-8% 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 less than 1% since 2013). For more detailed changes within each category, please refer to the charts for specific categories in Chapter 4.

Figure 36: Total Child Deaths (reported to DCFS) by Category, 2008-2017³³



³³ Notice that four rare categories are not included in this chart: pending, other, scalding burn and SUCD.

Appendix B – List of CDRT Members by Region

Aurora

Mary E. Jones, MD, MPH, **Chairperson**
Dan Thomas, **Vice Chairperson**
Donna Bredrup
Patrick Dempsey
Joshua Fourdyce
Jennifer Hess
Nydia Molina
Orson Morrison
Wendy Payne
Loren Richardson Carrera
Jennifer Samartano
Anne Strickland
DCFS Staff – Rhonda Laye

Champaign

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

Cook Team A

Kristen Bilka, MMS, PA-C, **Chairperson**
Daniela Silaides, **Vice Chairperson**
Janet Barnes
Felicia Clark
Margaret Conway
Stephanie Cornette, PC, PsyD
Dr. Kristin Escobar-Alvarenga
Kenneth Fox, MD
Jena Friday, BSN, RN
Jill Glick, MD

Cook Team A (cont.)

Sharon Koc
Mary Henderson
Nicole Johnson, MD
Abbey Mastroianni
Eileen Payonk, Special Agent
Kyran Quinlan, MD, MPH
Joan M. Pernecke
Char Rivette
Danielle Rynczak
Kimberly Souder
Kelley Thornton
Dion Trotter
Kavita Vankineni, MD
Syed Zaheer
Dr. Eimad Zakariya
Virginia Zic-Schlomas, Sgt.
DCFS Staff – Tanya Carriere

Cook Team B

Kathy Grzelak, MA, LCPC, **Chairperson**
Mary Joly Stein, **Vice Chairperson**
Sweety Agrawal, PsyD
Natosha Cuyler-Toller
Dr. Eric Eason
Dr. Michael Eckhardt
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Shawnte Jenkins
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Veena Ramaiah, MD
Kevin Scott
Diane Scruggs
Dr. Benjamin Soriano
Annie Torres, MD
Valencia Williams, PsyD
DCFS Staff – Tierney Stutz

East St. Louis

Daniel Cuneo, PhD, **Chairperson**
David C. Norman, **Vice Chair**
Jamie Brunnworth
Cathy Daesch, ATR-BC, LCPC, ICDVP
Judy Dalan
Carolyn Hubler, Director
Francis Jones, RN
Michael O'Neill
James Piper
Lynn Shelton, RN
DCFS Staff – Stacy Short

Marion

Mary Louise Cashel, **Chairperson**
Shalynn Malone, **Vice Chairperson**
Connie Edgar
Robin Hopper
Lisa Irvin
Betti Mucha
Kathy Swafford, MD
Tammy Turner
Steve Webb, PhD
Sheryl Woodham, MSW, LCSW
DCFS Staff – Bob Cain

Peoria

Judy Guenseth, **Chairperson**
Special Agent Timothy Wilkins, **Vice Chairperson**
America Bunker, RN
Dr. Susan Bordenave-Bishop
M/Sgt. Gregg M. Cavanaugh
Stefanie Clarke, BSN, RN, CPEN
Jacqueline Diediker
Brian Gustafson
Umair Iqbal, MD, MPH
Ann Lading-Ferguson
Emily McDonnell, MSN
Mark McLaughlin
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**
Rebecca Anderson
Pamela A. Borchardt
Amy Buchenau
Raymond Davis, Jr., MD
David Glessner
Rebecca Wigget
DCFS Staff – Patrice Thomas

Springfield

Careyana Brenham MD, **Chairperson**
Cinda Edwards, **Vice Chairperson**
Betsy Goulet
Heather Hofferkamp
Rebecca Howard, APRN, CPNP-PC
Denise McCaffrey
Nathaniel Patterson, MD
Eric Weston, Special Agent
Dan Wright
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	2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths DCFS **	2013 Deaths DCFS **	2014 Deaths DCFS **	2015 Deaths DCFS **	2016 Deaths DCFS **	2017 Deaths DCFS **
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPHs	DCFS	IDPH						
Adams	1	10	6	5	6	5	4	3	9	5	9	9	8	6
Alexander	0	1	1	1	0	2	0	0	1	0	0	0	1	1
Bond	1	1	0	0	0	1	2	2	4	1	0	2	0	2
Boone	0	3	3	3	1	1	4	2	3	0	1	0	1	2
Brown	0	0	0	0	0	0	0	0	1	1	0	0	0	0
Bureau	1	2	5	5	6	5	1	1	2	1	3	0	2	1
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	1	1	1	2	2	0	0	1	0	1	0	1	1
Cass	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Champaign	21	36	42	36	36	33	43	37	29	49	38	30	45	44
Christian	3	4	4	4	4	3	3	2	2	1	1	4	2	3
Clark	1	1	0	0	0	1	2	2	1	3	0	1	1	1
Clay	0	1	0	0	1	1	0	0	1	1	0	0	3	0
Clinton	3	4	1	1	3	3	2	1	1	3	0	0	1	3
Coles	0	4	3	5	5	2	5	6	4	4	4	2	5	6
Cook	908	1,010	768	832	887	920	857	824	857	775	815	818	831	766
Crawford	1	1	0	0	2	1	2	1	4	4	0	1	0	4
Cumberland	3	2	2	3	2	2	0	0	1	0	0	0	1	0
DeKalb	3	3	5	3	4	3	5	5	4	9	7	3	6	7
Dewitt	0	0	2	2	0	0	1	1	0	0	3	1	0	1
Douglas	0	0	0	0	1	1	1	1	1	0	1	0	1	2
DuPage	76	81	65	62	89	76	73	68	66	70	80	63	76	56
Edgar	1	2	0	0	0	0	1	1	1	1	1	2	1	0
Edwards	0	0	0	0	0	0	0	0	1	0	1	0	0	0
Effingham	5	6	1	1	0	1	8	7	2	7	5	5	4	3
Fayette	0	0	0	0	1	0	1	1	0	2	3	1	1	1
Ford	3	3	1	0	1	1	0	0	1	2	1	0	0	1
Franklin	3	3	4	4	5	3	2	1	0	2	4	6	3	1
Fulton	0	0	3	4	4	4	0	0	3	0	0	2	2	2
Gallatin	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Greene	0	1	0	0	0	1	0	1	0	0	1	0	0	4
Grundy	3	4	3	4	5	5	3	2	3	2	1	2	1	3
Hamilton	3	3	0	0	1	1	1	1	1	2	0	1	2	0
Hancock	0	2	2	1	0	0	1	1	0	1	3	0	0	1
Hardin	0	0	0	0	2	2	1	2	1	1	1	1	1	1
Henderson	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Henry	2	2	2	3	4	4	4	2	2	3	3	2	5	3
Iroquois	0	1	0	0	3	3	1	1	1	1	0	0	2	2

Jackson	8	8	9	8	4	5	8	6	16	2	5	9	4	9
Jasper	0	0	0	0	2	1	0	0	0	0	0	0	1	0
Jefferson	1	4	1	1	9	9	7	6	2	6	4	2	4	2
Jersey	0	2	0	0	1	2	2	3	4	2	0	4	2	3
Jo Daviess	0	0	0	0	0	0	4	4	0	1	0	0	2	0
Johnson	0	0	0	2	0	3	0	3	2	0	0	0	0	0
Kane	59	57	55	53	44	41	45	42	42	42	44	51	46	39
Kankakee	8	13	5	5	8	8	8	8	12	10	10	6	16	9
Kendall	6	6	2	2	1	1	1	1	2	3	2	0	0	2
Knox	4	4	2	2	7	8	10	10	3	4	6	6	6	4
Lake	26	38	34	47	31	47	35	40	33	37	36	36	34	36
LaSalle	0	9	7	7	8	9	9	8	11	8	7	11	5	4
Lawrence	1	3	1	1	6	4	4	2	1	2	0	1	0	1
Lee	0	1	3	5	1	1	2	2	2	3	3	2	1	6
Livingston	2	5	2	2	3	3	5	2	3	0	4	2	3	2
Logan	7	8	6	5	0	0	2	2	3	3	1	0	3	3
Macon	18	21	15	15	11	10	13	13	7	4	12	11	7	11
Macoupin	0	0	2	2	2	3	0	0	0	5	4	2	0	2
Madison	21	25	16	20	15	13	13	11	8	12	14	18	21	18
Marion	4	3	3	6	3	9	5	9	2	5	5	10	3	4
Marshall	0	0	3	2	2	1	0	0	0	0	0	1	1	0
Mason	0	0	0	0	2	1	0	0	0	3	1	2	1	0
Massac	1	1	4	2	0	0	0	0	2	1	0	1	3	1
McDonough	0	1	1	2	2	2	1	1	1	2	0	1	0	1
McHenry	14	19	11	11	7	6	11	9	12	17	9	9	9	11
McLean	14	14	5	6	9	10	13	12	9	12	13	14	8	11
Menard	0	1	1	1	1	1	0	0	0	0	0	0	0	0
Mercer	0	0	0	0	1	1	1	1	2	6	0	1	0	1
Monroe	0	0	2	2	0	1	1	1	1	1	0	1	0	0
Montgomery	0	1	1	0	3	3	3	2	1	0	4	2	3	0
Morgan	0	2	1	1	2	2	0	1	2	3	3	0	2	4
Moultrie	3	3	0	0	1	1	4	4	1	0	0	0	0	1
Ogle	4	4	3	3	2	1	1	1	0	0	2	3	0	4
Peoria	49	86	76	93	81	80	76	75	109	72	82	63	76	83
Perry	2	3	0	0	4	4	0	0	1	3	2	1	2	0
Piatt	0	2	0	0	0	0	1	1	1	0	0	0	0	2
Pike	0	0	0	0	2	2	0	0	0	0	0	0	1	0
Pope	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Pulaski	0	0	2	2	0	0	0	0	0	0	0	0	0	0
Putnam	0	0	2	2	0	0	0	0	0	0	0	1	0	0
Randolph	0	0	1	1	1	1	1	1	6	7	2	1	3	0
Richland	1	3	1	1	1	1	2	2	1	1	2	1	2	2
Rock Island	12	12	18	17	12	9	12	11	11	9	12	8	9	10
Saline	2	2	4	2	4	3	1	1	3	0	3	3	0	1

Sangamon	32	46	51	48	46	43	38	46	33	46	39	36	45	38
Schuyler	0	0	0	0	4	0	6	0	1	1	1	0	0	2
Scott	0	1	0	2	0	0	0	0	0	2	0	0	1	0
Shelby	3	3	2	5	1	2	0	0	0	2	0	2	1	2
St. Clair	7	26	26	28	18	16	18	15	21	31	26	15	15	31
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Stephenson	4	5	4	4	5	4	2	2	1	2	4	3	2	5
Tazewell	4	7	2	2	2	3	3	2	3	2	7	5	3	6
Union	0	0	2	2	3	3	1	1	1	2	1	3	0	9
Vermillion	1	6	13	14	7	6	8	6	11	10	7	4	12	5
Wabash	0	2	3	2	0	0	0	0	1	0	1	0	1	0
Warren	0	1	0	1	1	1	1	1	1	1	1	1	1	1
Washington	0	0	0	0	2	2	1	1	0	1	1	0	1	0
Wayne	0	1	1	1	1	1	1	1	2	1	1	3	1	0
White	0	0	1	1	1	1	1	1	1	0	1	0	2	0
Whiteside	0	3	7	6	3	5	4	3	1	4	3	1	6	3
Will	42	38	44	47	38	35	28	26	33	34	38	24	36	34
Williamson	8	9	6	5	5	5	10	9	6	6	13	6	3	5
Winneshago	71	78	59	48	61	49	51	43	40	36	43	46	59	57
Woodford	1	1	1	2	2	2	3	3	1	4	1	2	1	0
Unknown	0	0	18	0	1	0	0	1	0	0	0	0	0	3
Out of State	13	0	27	81	53	117	46	97	47	81	12	11	12	6
Out of country	—	—	—	—	—	—	—	—	9	0	0	0	0	0
Total	1,495	1,780	1,490	1,622	1,622	1,692	1,551	1,535	1,540	1,503	1,479	1,402	1,487	1,424

*Death numbers for IDPH are for facility of death

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

