ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR 2018

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

July 2020

JB Pritzker
Governor

Illinois Department of
DCFS
Children & Family Services

Marc D. Smith
Acting Director

August 2020

Dear Readers,

It is my honor to present to you the 2020 Illinois Child Death Review Annual Report. The information in the report includes the data for the child deaths that occurred in calendar year 2018.

Every single child death that occurs is tragic. When such deaths are preventable, it is beyond tragic. This report serves as a tribute to every child that died.

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 in order to prevent future child deaths.

This report reflects the diligent efforts of these 9 Child Death Review Teams throughout the State. These teams, in partnership with DCFS Staff, reviewed 285 child deaths and made 80 recommendations for improving and saving the lives of our children. These Teams comprise many professionals who volunteer their time and expertise to painstakingly review and discuss these tragedies, often spending many hours outside their busy schedules. They do this for the sake of our children throughout the State.

I am extremely grateful for the difficult work that they do.

Given our charge to ensure the safety of the children of Illinois, DCFS responded to the recommendations made by these teams and implemented many of them. I am confident that our ongoing partnership with these teams 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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July 2020

The Honorable J.B. Pritzker, Governor of the State of Illinois:
The Honorable Members of the 101st General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2018. 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 (CFRC) at the University of Illinois at Urbana-Champaign.

Illinois Child Death Review Teams staff Tamara Skube, Bernadette Emery, and John Schweitzer 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.

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EXECUTIVE SUMMARY

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

Illinois Child Deaths in 2018

In 2018, 1,398 children under 18 died in Illinois.[1] This number represents the death information received by DCFS as of May 20, 2020.

Of the total child deaths reported to CDRTs in 2018:

- 60% were boys and 40% were girls;
- 63% were infants under one year, 9% were young children between 1 and 4 years, 15% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years;
- 44% were White, 36% were African American, 15% were Hispanic, 4% were Asian, and under 1% were of other or unknown racial/ethnic origin.

When Illinois child deaths in 2018 were examined by the manner of death:

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

When deaths occurring in 2018 were examined by the category of death:

- 35% were related to premature birth;
- 34% were related to illness;
- 10% were sleep related deaths;
- 16% were related to various types of injuries, firearms (6%), vehicular accidents (3%), drowning (2%), fires (2%), poisoning/overdose (<1%) and other types of injuries (2%);
- 6% were due to undetermined causes.

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

2018 Child Deaths Reviewed by the CDRTs

In 2018, 285 child deaths were reviewed by the CDRTs, consisting of 159 mandatory and 126 discretionary reviews. The mandatory reviews occurred for one of several reasons: 81 were indicated death cases, 51 cases had an investigation in the year before the child's death, 14 were indicated investigations, and 8 were DCFS youth in care and 5 were pending DCFS investigation at the time of death.

Reviewed deaths in 2018 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 – 32 of the 212 deaths (15%) were reviewed.
- Champaign – 20 of the 78 deaths (26%) were reviewed.
- Cook – 137 of the 781 deaths (18%) were reviewed.
- East St. Louis – 14 of the 40 deaths (35%) were reviewed.
- Marion – 21 of the 52 deaths (40%) were reviewed.
- Peoria – 22 of the 100 deaths (22%) were reviewed.
- Rockford – 16 of the 64 deaths (25%) were reviewed.
- Springfield – 23 of the 71 deaths (32%) were reviewed.

Of the deaths reviewed by CDRTs in 2018:

- 60% were boys and 40% were girls;
- 59% were infants under 1, 17% were young children between 1 and 4 years, 15% were older children between 5 and 14 years, and 8% were youth between 15 and 17 years.

When reviewed deaths occurring in 2018 were examined by manner of death:

- 35% were attributed to accidents;
- 22% were due to natural causes;
- 8% were homicides;
- 4% were suicides;
- 31% were undetermined.

When reviewed deaths occurring in 2018 were examined by category of death:

- 2% were related to premature birth;
- 18% were related to illness;
- less than 1% were related Sudden Infant Death Syndrome (SIDS), and 2% were related to SUID;
- 53% were related to various types of injuries, such as suffocations (24%), drowning (6%), firearms (6%), vehicular accidents (5%), poisoning/overdose (<1%), fire (6%) and other types of injuries (7%);
- 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 2018, there were 1,398 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 2019, the Illinois Child Death Review Teams (CDRT) accomplished several goals including the following:

- In collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign, the Illinois Child Death Review Teams Annual Report for 2018 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.
- The 23rd Annual Symposium was held at the Crowne Plaza – Springfield, Illinois on March 28th-March 29th, 2019. We had a total of 52 attendees.

Registrations, Speakers, Agenda, Resources and Education Units:

- Registrations were sent out to the Illinois Child Death Review Teams' members in February. The following were speakers at the symposium:
    1) "AMT Children of Hope Baby Safe Haven Foundation" Timothy Jaccard, Foundation President
    2) "SUID Case Registry" Dr. Eric Eason, Cook B Team Member/Cook County Medical Examiner's Office Dr. Michael Eckhardt, Cook B Team Member/Cook County Medical Examiner's Office
    3) "Why Teens Kill" Phil Chalmers true crime writer, law enforcement trainer, youth culture specialist and a television personality.

- Educational units were arranged through DCFS and the Cook County State's Attorneys' Office

DCFS Roles and Responsibilities

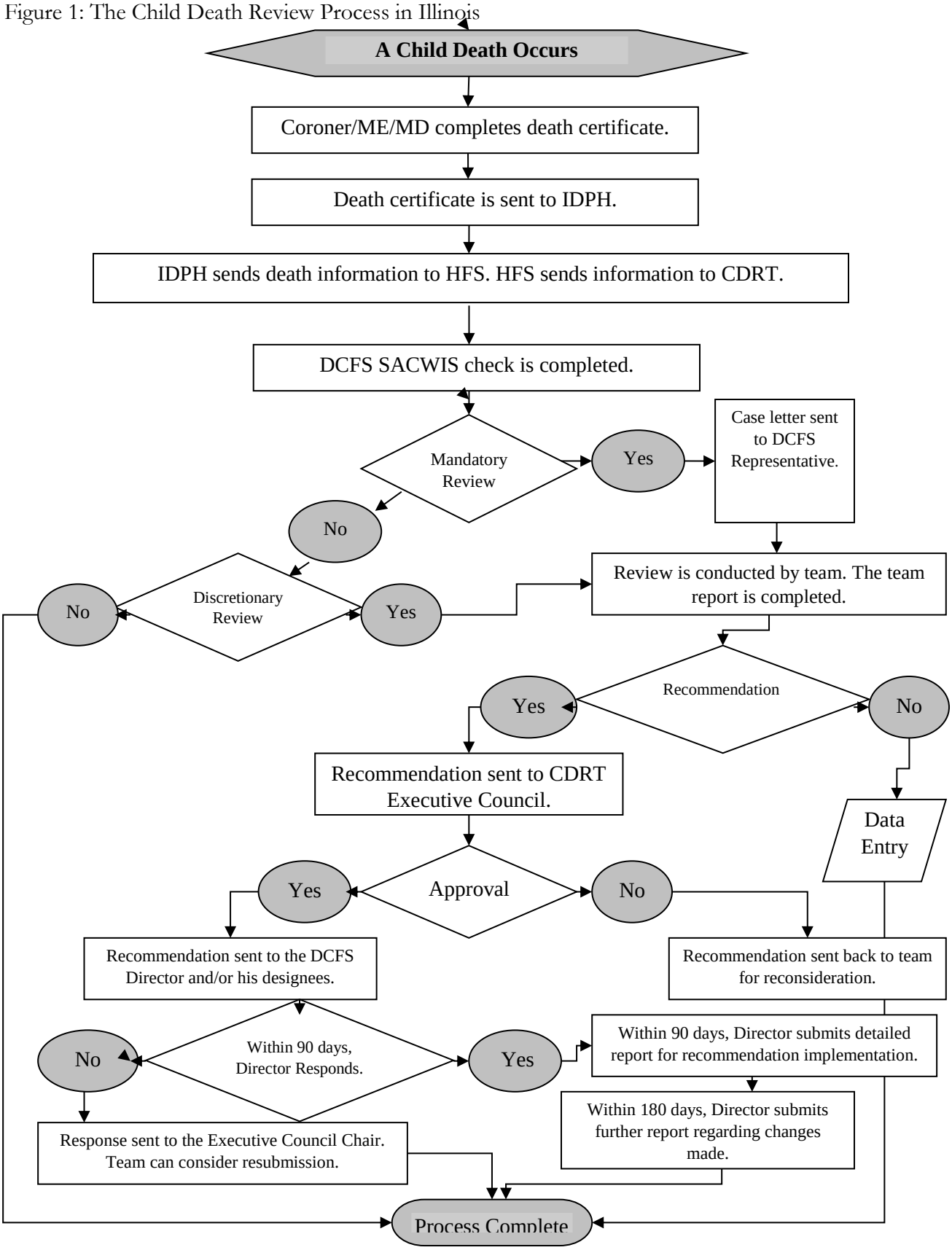
The Illinois DCFS Office of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT manager). In addition, the department serves as a direct link between the review teams and the state's child protection policy makers. The DCFS director must review and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

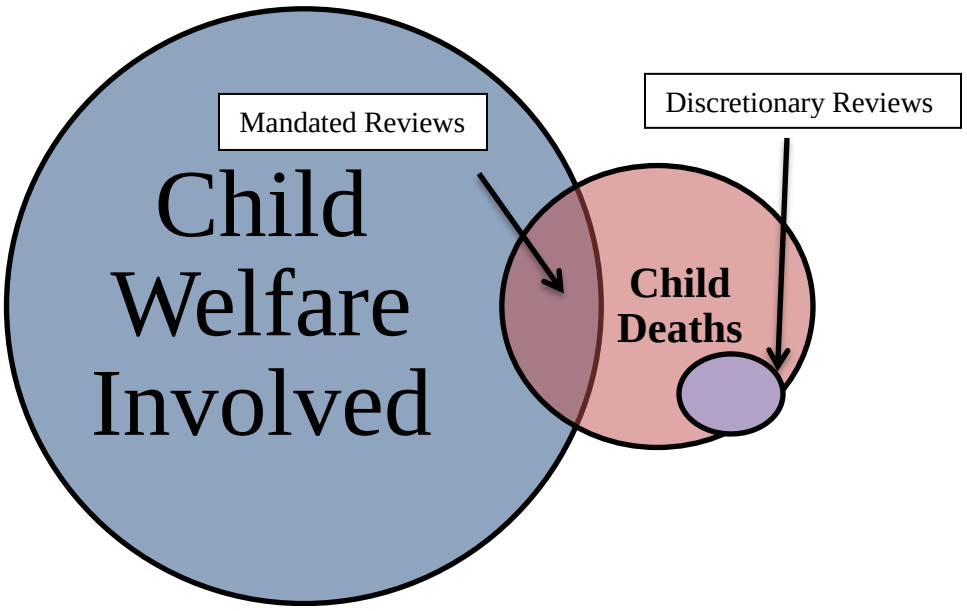


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the information to the Illinois Department of Public Health (IDPH). IDPH provides this information to the Illinois Department of Healthcare and Family Services (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;
- 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
- a 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 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

[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 2018.

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)

In 2018, there were 1,398 Illinois child deaths reported to Child Death Review. Child Death Review Teams reviewed 285 of these 1,398 child deaths. Eighty recommendations were made by CDRTs on 65 of the 285 child death cases reviewed. Of the 80 recommendations, there were 26 recommendations which focused on DCFS policy and procedures. The DCFS recommendations resulted from five types of reviews including: death indicated (4), indicated report at time of death (2), investigation within a year of death (3), youth in care (2) and discretionary (15). There were 11 recommendations related to other agencies or systems. These recommendations came from three types of reviews including death indicated (5), discretionary (5) and youth in care (1). There were 41 case specific recommendations from five types of reviews: four recommendations resulted from cases that had an indicated report at time of death, fourteen recommendations resulted from cases where death was indicated, fifteen were from discretionary reviews, seven were from cases that had an investigation within a year of death and one recommendation resulted from a youth in care case. There were 2 prevention recommendations made, both from discretionary reviews.

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

Table 1: 2018 Illinois Child Deaths Recommendations and Responses

Type of Recommendation	Recommendation	Response
DCFS	"Judici" should be checked on a regular basis by DCFS. Judici.com is the website to obtain information. Not all counties participate in this system, but many do.	Staff already have access to Judici through a link on the Dnet. This has been discussed with union staff and is ongoing at meetings and as a result, staff are aware of the use and access. The department has search procedures in place to assist in locating families.
DCFS	Continue to support the on-going efforts to improve co-sleeping education and the dangers of co-sleeping.	DCFS agrees.
DCFS	In all cases where the caregiver admits knowledge of safe sleep yet doesn't follow safe sleep, the caregiver should be indicated for child neglect in the investigation (especially for someone providing daycare). Potential bias should be discussed and stressed in training.	DCFS considers all circumstances as it relates to each individual unsafe sleep situation. Indicating a case needs to be based on individual case circumstances.
DCFS	DCFS should seek liaisons (one on the DCFS end and one on the police end) to help staff when working with the Chicago Police.	Cook County already has identified liaisons with police departments. The information will be redistributed with staff. Local offices work closely with police and these offices do not have a need for a specific liaison. In offices where police reports cannot be obtained, the area administrators assist as part of their role.
DCFS	DCFS to consider providing training for vicarious trauma. Executive Council states that workers often don't want to acknowledge the trauma they are going through—they appear to be detached from their trauma. CDRT frequently sees the impact of trauma on workers who present. They feel DCFS needs to be more proactive and vigilant in supporting staff and that DCFS needs to be more intentional in this area.	DCFS has been training Trauma 201 since 2009. The course description is: this course builds upon the foundation of Child Trauma 101 and Psychological First Aid by enhancing the ability of child welfare professionals to effectively respond to complex trauma within a systems perspective. The course provides specific strategies that support the well-being of children and their families at each phase of the life of a case. It started with the Learning Collaborative and is now required as part of training for all new direct service staff within 3-6 months of Foundations. It also includes a piece on self-care. DCFS also reinforces the supervisors' role in recognizing and

		responding to VT in the Model of Supervisory Practice (MOSP). DCFS will pursue this further, possibly consulting with the EAP provider to help develop a plan for the Department. Currently, the department is reviewing a proposal designed to increase resiliency for staff. This needs to be a therapeutic response more than a training.
DCFS	Educate the supervisors of DCFS and the intact program regarding the difference between a parent-implemented "care plan" and a DCFS implemented "safety plan" and stress that parents need to be informed of the difference between these two.	Training is being developed regarding the use of safety plans and this will be included.
DCFS	If children are in a parent implemented care plan during an investigation and DCFS has ascertained a risk exists in the home of parents, DCFS should formalize the recommendation that the children remain out of the home in a "safety plan" document.	If an immediate safety issue exists which could result in protective custody, DCFS agrees that care plans should be formalized into safety plans.
DCFS	Subsequent cooperation should not be a factor in assessing the alleged medical neglect that occurred before the investigation. This specific wording should be put in procedures.	Agreed. This is already in procedures 300.50 (g) Assessment of Case Information and Evidence.
DCFS	DCFS provide direction to investigators on shared information with coroners and law enforcement during an open investigation.	DCFS agrees.
DCFS	CDRT to work with the Department to revise the statute on how a parent's drug use is used as evidence in cases. Parental drug use should be considered prima facie evidence of neglect at the time of use of the drug regardless if the children are with them or not.	DCFS does not agree with this recommendation. Neglect per statute requires blatant disregard. Cases should be examined sui generis (of its own kind) to determine the evidence that exist that the child is neglected or abused. A blanket generalization has multiple implications for the Department and the state.
DCFS	DCFS should consider utilizing Intensive Placement Stabilization (IPS) services on HMR/unlicensed homes when children with significant mental health needs are placed in a relative's care. In this case, one of the children had prior psychiatric hospitalizations,	DCFS agrees and will review this with staff. (Note: This was reviewed and a referral for Intensive Placement Stabilization was made on this case) All agree that Intensive Placement Stabilization should be put in place right away, as soon as a need is

	and needed more intensive services than a traditional/unlicensed monitoring can provide. Perhaps if this relative caregiver received a higher level of support and mental health services, she would have made better decisions around the children's care. This child needed assessment and mental health services. Although the worker reported that she thought the child was receiving mental health services post placement to the relative's home, she did not confirm attendance or treatment.	identified. DCFS reiterates that ISP can be put in place at any time. The Department also has Foster Parent Support Specialists that can and do provide additional support to foster parents.
DCFS	DCFS to seek policy and procedure for workers in suicide cases where there were unsecured guns to ensure consistency and provide guidance.	Suicide is already addressed in Policy and Procedure as related to mental health. The Home Safety Checklist addresses gun safety. DCFS will discuss this matter at upcoming staff meetings.
DCFS	Consider a protocol and training for supervisors to recognize secondary trauma and address it.	DCFS provides training for supervisors in vicarious trauma in the Trauma 201 course. DCFS also reinforces the supervisors' role in recognizing and responding to vicarious trauma in the Model of Supervisory Practice (MOSP).
DCFS	The Department should come up with a formal self-care plan and a means by which to address vicarious/secondary trauma.	This recommendation has been made on other cases. DCFS response is: DCFS has been training Trauma 201 since 2009. The course description is: this course builds upon the foundation of Child Trauma 101 and Psychological First Aid by enhancing the ability of child welfare professionals to effectively respond to complex trauma within a systems perspective. The course provides specific strategies that support the well-being of children and their families at each phase of the life of a case. It started with the Learning Collaborative and is now required as part of training for all new direct service staff within 3-6 months of Foundations. It also includes a piece on self-care. DCFS will pursue this further, possibly consulting with the EAP provider to help develop a plan for the Department.

		Currently, the Department is reviewing a proposal designed to increase resiliency for staff. This needs to be a therapeutic response more than a training.
DCFS	When seeking medical records, DCFS investigators should provide more than one identifier to hospital staff.	DCFS agrees.
DCFS	DCFS will work with CDRT to ensure the death investigation training is back on the schedule for training. Based on an investigator's recommendation, we would like a person from Cook County ME office to review and provide input on the training to ensure that there is a greater focus on questioning the parents (at the scene) during such a tragic time. Due to the sensitivity surrounding the death, the investigator thought it would be helpful and supportive to the investigative staff to gain input from someone who is seen as an expert in this area.	DCFS agrees.
DCFS	Revisit the need for a liaison between DCFS and Chicago Police.	This recommendation has been made on another case. Cook County already has identified liaisons with police departments. The information will be redistributed with staff. AAs have been appointed to be liaisons with local law enforcement.
DCFS	Get clarification on DCFS policy of sharing documents with others, i.e. police, fire department.	Several laws and DCFS rules and procedures dictate how DCFS can share documents and which information must be redacted. As an example, the "redaction checklist" is used in responding to subpoenas.
DCFS	DCFS should seek legislation to get police and fire reports.	DCFS disagrees. DCFS intends to focus on collaboration related to the implementation of current laws.
DCFS	Revisit the administrative subpoena issue as this process seems to be a consistent problem. This seems to be ignored consistently.	DCFS agrees that there is great potential for improved collaboration among various stakeholders and has been meeting/will continue to meet with representatives from the Cook County State's Attorney and others to improve this collaboration. DCFS will evaluate the administrative subpoena process and update/improve the process based on its evaluation.

DCFS	Remind staff of the protocol to require forensic interviews on all children.	DCFS agrees and will ensure staff are reminded of this requirement.
DCFS	Add prohibition of boppy pillows specifically in the DCFS Safe Sleep handout/brochure.	DCFS disagrees with naming a specific brand of breast-feeding pillow but will add the language that breast-feeding pillows should not be in a baby's sleep environment. Citing specific name brands in handouts is not something that should be added to handouts. Current safe sleep literature and procedures include the recommendation not to have pillows in an infant's sleep environment. The DCFS website has a safe sleep section that states: "Keep stuffed animals, toys, pillows, blankets, quilts, crib bumpers and sleep positioners out of your baby's crib". Adding "breast-feeding pillows" is more comprehensive than naming a particular brand such as "boppy pillow".
DCFS	There needs to be better cooperation between DCFS and law enforcement.	This matter will be referred to the Regional Administrator to address this further.
DCFS	Staff should be educated on the usage of short-term guardianship forms.	DCFS agrees and will seek to conduct a WebEx training for staff related to short-term guardianship.
DCFS	DCFS to require workers to ask parents to do a drug test in all death and serious harms cases, especially in cases involving children under age three. The team would like data on the effectiveness of field drug testing in immersion sites.	Pending
DCFS	The design of the new CCWIS system should have additional capability to identify prior history on individuals rather than just using a birth date. One possible way would be connecting family members, addresses or other identifying information. IDs that workers check could possibly be scanned or photographed into the system to increase accuracy of information.	Pending
Other	Team should draft a letter to Chicago Police and DCFS to further the idea of MDT's to help increase collaboration and get better answers. A plan needs to	Agreed. Letter pending.

	be in place. The director of the CAC should also be copied in.	
Other	Write a letter to VOA regarding their good work on the case.	DCFS will write a letter to the agency commending them for their good work.
Other	We would like to recommend that CDRT seek to make cribs mandatory in shelters that take infants and young children. There should be some funding connected to this to allow for this to occur.	Agreed. CDRT will pursue this recommendation.
Other	Team to write a letter to the detective at the police department commending him for his thorough investigation and mention in the letter that he could always request a toxicology screen.	Approved. Letter sent.
Other	Team to send a letter to the coroner commending her for the specificity on the report.	Approved. Letter sent.
Other	Ex. Council to send out a reminder letter to all police jurisdictions that all child deaths need to be treated as a crime scene regardless of what the initial impression and that coroners by statute conduct their own investigation and law enforcement should help with the investigation.	Approved. Letter sent.
Other	There should be greater education and awareness on asthma education. Executive Council should perhaps write a letter to DPS to increase awareness.	Approved. Letter sent.
Other	Send notification to Consumer Product Safety Commission about the death being from this product.	Approved. Letter sent.
Other	CDRT to reach out to Consumer Product Safety Commission for potential membership on teams.	Approved.
Other	Team to send a letter to the hospital to conduct an internal review of their care for this child. This letter should also include that the hospital morbidity and mortality should review. The child died the day after being seen at the hospital.	Council approved.
Other	The medical examiner should be informed of all pertinent information on cases when new information is learned.	Agreed.
PP	Share the idea of people (doctors, police, school, other) reminding parents of safe sleep on an ongoing basis. This occurs some but this could be increased.	Approved and this idea has been added to the “think tank”.

	This idea should be provided to the "think tank" that CDRT is pursuing.	
PP	Recommend that safe sleep should be included in high school education in their programs for parenting and health classes.	This is a public health issue and Executive Council should pursue their recommendations with that agency. This is also an Illinois State Board of Education issue. Coordination between agencies is needed and DCFS is willing to work with other agencies but Public Health should take the lead. The director stated that she will mention this item to the Director of Health and Human Services. She asked that Executive Council write a letter to the Director of Health and Human Services as well. DCFS Office of Communications is working on an Interagency Agreement regarding this matter. DCFS also plans on reaching out to other agencies. October is "Safe Sleep" month so there will be efforts highlighted then.
CS	DCFS to review the investigation to determine if allegation #60 should have been added to this investigation. Assess if the attorney made the proper call to unfound the case as it appears the attorney overruled a doctor's finding of medical neglect.	DCFS agrees with the recommendations and will review this with the involved staff.
CS	DCFS to look at this case and how it was handled in respect to the decision-making used to unfound this case versus indicating given that there are significant concerns about mom's capacity to care for the baby alone.	DCFS agrees and will review the case with the involved staff.
CS	DCFS to issue a letter of commendation to those involved in the case.	DCFS agrees. This was communicated to the RA and they agreed to the letter and a presentation at their all PSA meeting.
CS	DCFS to review this case further to determine if the finding on this case is appropriate and to stress that staff need to follow up with the ME or other professionals if they question the wording of any of the reports.	DCFS agrees this report should not have been indicated according to DCFS parameters. This will be unfounded and reviewed with staff.

CS	DCFS to review the case as to why it was indicated as this final disposition appears to conflict with many other cases where unsafe sleep cases are unfounded when no risk factors are present. There were no risk factors present in this case but for co-sleeping. There were 2 supervisory consults on the case documented in the notes. The rationales read the same but for one concluding unfounded and the second concluding indicated. Both cite "DCFS policy" as the basis for the final decision. There appears to be no clear basis for the change in recommendation.	Both cases have been unfounded. The one that was indicated has been overturned on appeal. This will be reviewed with staff for consistency.
CS	Review the case and remind staff that they can and should seek a forensic interview on surviving siblings in some situations, especially if they were in the home or were a witness to the death.	DCFS agrees with the recommendation and will discuss the points outlined with the involved staff.
CS	In a case where, after the death of a sibling, children were in a parent implemented "care plan" which DCFS did not convert to a "safety plan," DCFS did not clarify for mother that she was free to retrieve her children even though an investigation was pending. Look at the case and how it was handled in that the mother was voicing a clear desire to dissolve the care plan she had set up during the hospitalization of the now deceased sibling, but DCFS was not correcting her misunderstanding that she could simply go and get her children without negative repercussions.	DCFS agrees.
CS	DCFS to look at the case and how it was handled. Why wasn't the case screened sooner?	DCFS agrees and will have the regional administrator review the case with the involved worker and supervisor.
CS	Review the A sequence with involved staff as it appears that the case should have been indicated.	Agreed. DCFS will review this with the involved staff.
CS	DCFS to review the case as the intact case should not have been closed while mom was pregnant.	DCFS agrees and will review this matter with the involved staff. DCFS is doing a review of Intact Services and a report should be presented in about 6 weeks. Procedures do not specifically state that a case cannot be closed if the mom in the case is pregnant but DCFS

		will review this matter with the involved staff.
CS	DCFS to review the case in that other kids of the mom and dad were not interviewed and the primary care physician was not contacted. Was there further exploration of the history of domestic violence?	DCFS agrees and while it did not impact the outcome, the investigation was not complete. This will be reviewed with the involved staff.
CS	Worker should be commended for her good work!	DCFS agrees and will commend the employee. DCFS requests that CDRT also send a letter of commendation to her. CDRT agrees.
CS	DCFS to review the case to follow up on seeing/contacting other kids who are not currently living with the parents. The 11yo seemed to just go back to mom and it's unsure if this was a good plan.	DCFS agrees and will review this case with the involved staff.
CS	DCFS to review the case and the unfounded finding as the case possibly should have been indicated.	There is to be a detailed discussion at the time of transition. Staff will be reminded of the importance to communicate and provide accurate information to intact and permanency partners at both the handoff and transitional meetings. Both intact and child protection staff will be educated regarding the various specialty substance abuse programs in place for intact families in Cook. The Intensive Family Recovery program has met with teams in Cook. All intact referrals in Cook are screened through the intact utilization unit. If appropriate and there are openings, they will refer a case directly to the substance abuse specialty program. A quarterly statewide intact provider meeting is in the process of being scheduled for October. A topic for that meeting will be discussion around identifying services, the decision process in place when making a critical decision to close a case and the need for court intervention and screening cases for court. Communication around intact referrals and court screenings will also be a topic at the Operations AA meeting in December. This case will be reviewed with the SCR Administrator to discuss with her staff and to use as a teaching

		moment. A script is utilized at the Hotline to assist in gathering information. They will be reminded of the importance of using this tool and adding all allegations based on information obtained during the call. This will be completed within the next 30 days.
CS	DCFS to review the case regarding: 1) There are concerns that there was no follow up on getting access to the records and contacting the nurse due to the shift change with the nurse who reported. 2) Psychiatric and medical records for mom were obtained by DCFS investigator but never reviewed. Additionally, investigator did not make any attempts to contact reporter due to her working a different shift.	DCFS agrees and will review this with the involved staff.
CS	DCFS to review this case regarding: follow up for services for the 10-year-old and parents, coordination with the police, drug testing follow up, and scene investigation. Overall, this did not appear to be a very thorough investigation. It should be noted that this parent still has continued access to the 10-year-old.	DCFS agrees and will review this case with the involved staff.
CS	DCFS should review the A sequence and findings. Based on DCFS rule, we believe that the A sequence should have been indicated. The worker said that the doctor who saw the child did not tell her it was abuse, so she did not indicate (even though the child disclosed the abuse and the pictures clearly showed marks that were visible). Further, worker on the A sequence was not prepared and knew little information of the case and could not answer basic questions.	DCFS agrees and will review this case with the involved staff. DCFS will discuss with staff the need to be fully prepared for Child Death Review Meetings.
CS	Case should be reviewed regarding the accuracy of the finding. This case should also be reviewed by DCFS Inspector General.	DCFS agrees to review this case. In respect to the IG, this does not appear to be a case that the OIG is mandated to review. DCFS will have its Daycare Licensing Administrator review the case and follow up on the matter from there.

CS	DCFS to review the case and how it was handled. Neither allegations 79 and 82 were addressed in the supervisory note. The initial report showed concerns about facial trauma and it doesn't appear that this was addressed in the investigation.	DCFS agrees and will review this with the involved staff.
CS	DCFS to review the case as some basic protocols were not followed (timeliness of seeing the child, failure to inquire about criminal history of child, not checking on the grandmother's home, no interviews with the dad, probation or the school on behalf of the child). Hospital staff will make a call to the hotline regarding concerns with the younger kids given mom's medical condition.	DCFS agrees and will review this with the involved staff.
CS	DCFS to look at this case and how it was handled. Review the case in that the safety plan should have been monitored on a regular basis. Perhaps the safety plan should have been ended much earlier.	DCFS agrees and has already addressed this issue. Supervisors may approve the use of an in-home or out-of-home safety plan for up to three weeks, if necessary. If the safety of a child is determined unsafe beyond 3 weeks, all subsequent unsafe determinations and safety plan development require Area Administrator approval.
CS	DCFS to recognize the investigator for his outstanding work on this case.	DCFS agrees and will recognize the investigator for his work on this case. (the investigator was given a letter of commendation by the Regional Administrator in Cook)
CS	Case to be reviewed in that the A sequence should have been indicated for risk and opened for intact services or to ensure the child was receiving mental health services. On the B sequence, there should have been further discussion/investigation with the mother of the boy who reported to his therapist. The B sequence involved another incident and there should have been another forensic interview and mental health services. The B sequence should not have been unqualified.	DCFS agrees with the recommendation and will discuss the points outlined with the involved staff.
CS	DCFS to review the case to look at the disconnect between the A and B sequence.	DCFS agrees and will review this matter with the involved staff.
CS	DCFS to review the case to assess if the family should have been referred for	DCFS agrees and will review the case with the involved staff.

	intact services following the A investigation.	
CS	DCFS to look at the case as the mandate worker did not inquire about the position the child was found in.	Pending
CS	DCFS to review the case with the worker and how it was handled as there were indicators that this death could have been caused by inflicted trauma. There were interviews that were not conducted and there was a prior child death involving the stepfather in which the worker did not have any details.	Pending
CS	DCFS training should be more extensive and longer particularly regarding uncooperative parents, home assessments and gaining access to the home.	DCFS agrees. The work on this has been implemented already related to the OIG recommendations that came out as well.
CS	DCFS training should be more extensive and longer particularly regarding uncooperative parents, home assessments and gaining access to the home. (Note: same recommendation made on this case as the previous case. The 2 children were siblings and died on the same day due to a house fire. The team recommended the same recommendation for these 2 cases).	DCFS agrees. The work on this has been implemented already related to the OIG recommendations that came out as well.
CS	DCFS look at the B sequence and how it was handled in that the death was not adequately investigated. Investigator obtained no medical records nor discharge instructions. DCFS follow up on the nursing referral in the A sequence as there is no documentation.	DCFS agrees and will review this investigation with the involved staff. DCFS agrees and the nursing division has followed up on this matter. Per the chief nurse, the nursing referral was completed and an addendum was done about a month prior to the child's death. The assigned nurse was in a staffing with the hospital staff and the child was improving. There was correspondence between the nurse and DCFS.
CS	Review the case in that the case should not have been closed out without a forensic interview being done.	DCFS agrees and will review this with the involved staff.
CS	CDRT team to commend the investigator for their thorough work on this case.	Approved.
CS	Team to send a letter to the police department to review the case and their internal policies to determine if they should have called the hotline.	Approved. Letter sent.

CS	Team recommends that the police contact the State's Attorney's office to discuss the fact that the case was indicated and the police have additional information to see if the SA office will file charges. If this is not effective, then the team will consider writing a letter to the State's Attorney to review the matter and consider criminal charges.	Approved. Letter sent.
CS	DCFS should look at the A sequence and how it was handled. Even though mom began taking the child to the new pediatrician does not mean that medical neglect did not occur due to all the missed appointments with the previous pediatrician who called in the report. DCFS nurse was notified but no apparent consultation occurred.	DCFS agrees and will review this matter with the involved staff. Also, DCFS will review the reason the nursing consult was never received by the worker. The involved staff did complete a consult for the child, however it was not sent prior to the child's death. This systems error will be reviewed with our entire team to guarantee timely and efficient return of consults to all parties concerned. The monthly DCFS Nursing meeting will address the timeliness of documentation and departmental minutes will reflect the same.
CS	The case should be reviewed as to how the A sequence investigation was handled. In a case where serious injuries were documented in the investigation predating the death and the minor made a clear statement describing physical abuse at the hands of his mother's paramour, the investigation was incomplete. The mother's statement that the marks were from "restraining the minor" were taken at face value and given weight over the minor's statement describing physical abuse without detailed questioning and full consideration of all injuries sustained by the minor.	DCFS agrees and will review this matter with the involved staff.
CS	The C sequence should be reviewed with the involved staff as this case probably should have been indicated.	DCFS agrees and will review the case with the involved staff. It should be noted that when mandated reporters fail to call in a report yet cite concerns after someone else calls in a report, their credibility can be questionable.
CS	DCFS to commend the investigator for her good work.	DCFS agrees and will commend the investigator for her excellent work.

CS	DCFS to review the case on how the intact case was handled. In a case where a 9-year-old sibling gave a detailed description of her own homicidal actions toward the decedent, the intact case remained open for a year without the recommended therapeutic services in place for the 9-year-old. Since the death, a subsequent baby was born. There was no investigation into the failed intact services being requested or the case brought to screening.	Pending
CS	DCFS to review the case as to the intact involvement as the case was closed during the investigation. Should there have been further discussion between the intact provider and the investigator? Should there have been a referral to the ASA on this case to keep the other two kids safe? Intact service providers need to be aware that they can refer a case to the ASA.	DCFS agrees and will discuss the matter with the involved agency via email and through APT and quality enhancement. A memo will be provided to all intact agencies and DCFS intact staff by the Deputy Director of Intact Services to remind them of the need to staff thoroughly with DCP prior to case closure and that they should always consider the need to refer a case to ASA for the protection of children, when circumstances warrant it. We will also verbally communicate this information with DCFS Intact Regional Administrators and Statewide Intact Coordinator to inform their staff and again during our POS Leadership meeting. In addition, we will also communicate this to all DCP staff during quarterly CPS meeting. These notifications will all occur throughout March. In addition, DCFS has initiated an unsuccessful case closure protocol to review all unsuccessful case closures prior to closing. The intact utilization unit reviews cases submitted for unsuccessful case closure, initiates recommendations for further steps before closure and makes the determination to staff the case with intact and DCP prior to closure if this has not already occurred. This practice was initiated statewide in July 2019.
CS	The findings on the case should be changed to abuse findings or they should be added.	Based on the information provided in the investigation the rationale states the evidence supported a finding of neglect

		and not abuse. SCR did apply the abuse allegation #1 in the related information on 12/24/2018 based on the information provided by the reporter. The field added the allegation 51 based on the evidence gathered during the course of the investigation.

Chapter 3: Illinois Child Deaths in 2018

What do we know about the child deaths that occurred in Illinois during 2018?

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 (56% in 2018) 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 2018, there were 1,398 child deaths reported to the Illinois CDRT database. This included deaths due to all causes, preventable and non-preventable.

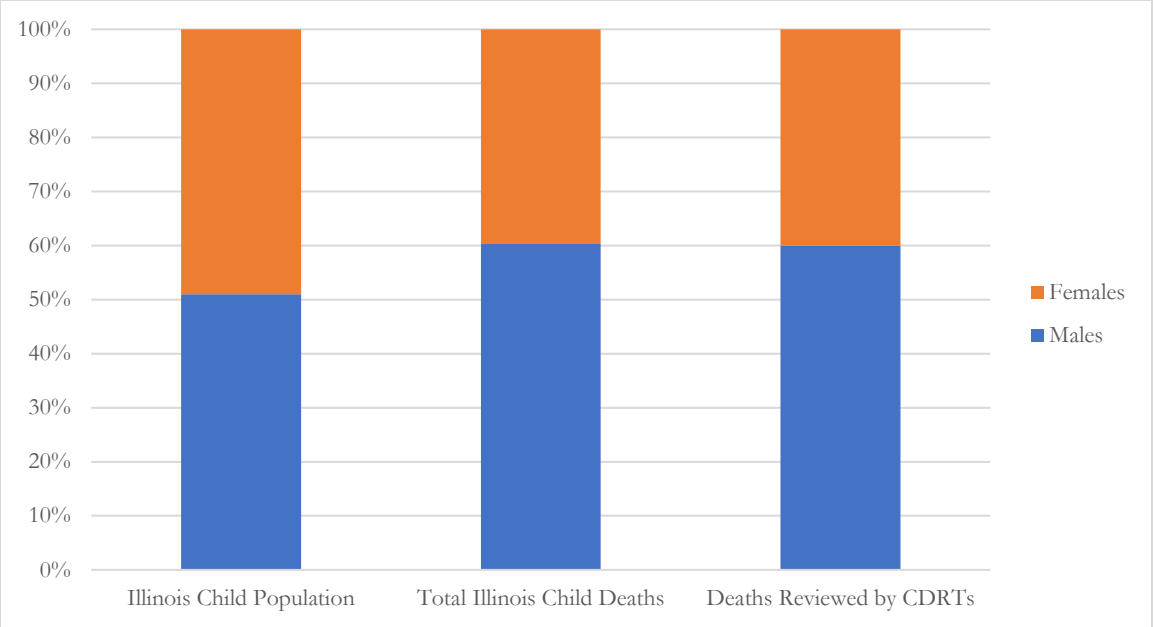
- The CDRTs reviewed 285 child deaths that occurred in 2018: 159 of these were mandated for review and 126 were discretionary reviews.

Child Deaths by Gender

According to information from the 2010 Census, 51% of the Illinois child population is male and 49% is female. However, boys are more likely to die than girls based on CDRTs data: boys made up 60% of both total child deaths and reviewed deaths in 2018. (see Figure 3).

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

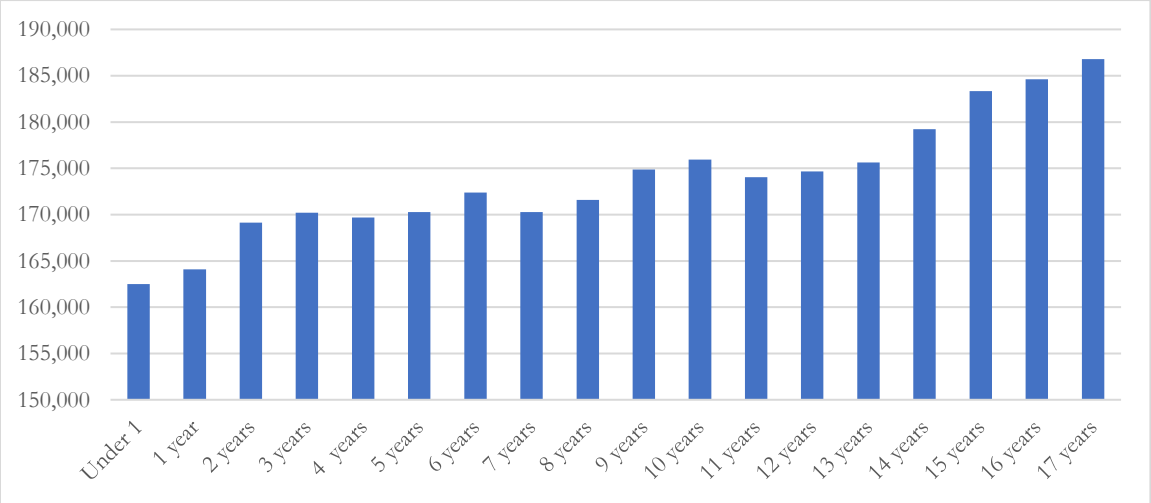
Figure 3: Illinois Child Population, Child Deaths, CDRT-Reviewed Child Deaths by Gender



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

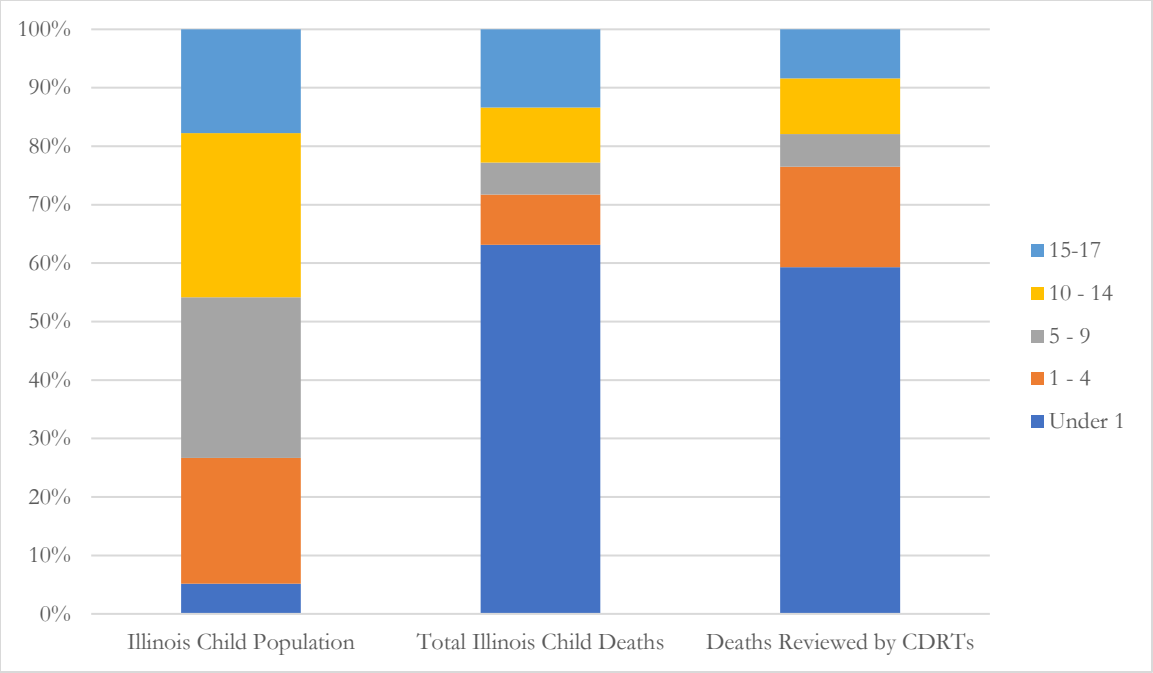


[5] U.S. Census Bureau. (2010). Illinois population by age. Retrieved from http://factfinder.census.gov/.

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—63% of the total deaths in 2018 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). In 2018, 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 13% were between 15 and 17 years.

When we examine the deaths reviewed by the CDRTs by age group (see Figure 5), infants under one year are again over-represented; they comprised 59% of reviewed deaths in 2018. Children between 1 and 4 years make up 17% of reviewed deaths in 2018. Older children make up a smaller portion of reviewed deaths: 6% were for children aged 5 to 9 years old, 9% were for children aged 10 to 14 and 8% were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race/Ethnicity

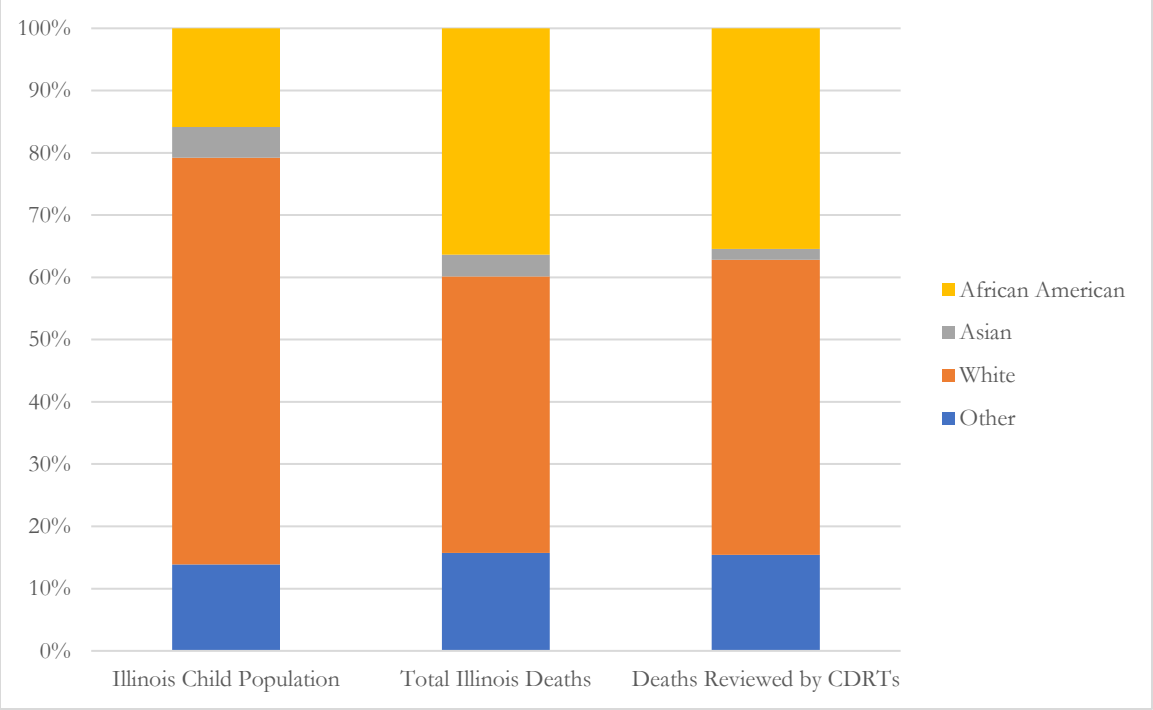
In 2018, 66% of children in Illinois were White, 16% were African American, 5% were Asian and the remaining 14% were of other races (see Figure 6).[6] For reports on ethnicity, 25% self-identified as Hispanic or Latino (of any race) and 51% were White (not Hispanic or Latino). The categories for racial/ethnic origin in the CDRT report are of the following: White, African American, Hispanic, Asian and Other/Unknown.

[6] U.S. Census Bureau. (2020). 2018: ACS 5-Year Estimates Subject Tables. Retrieved from https://data.census.gov/cedsci/table?q=children%20under%2018%20illinois&tid=ACSST5Y2018.S0901&t=Children

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 that died in 2018 were African American, yet they only comprise 16% in the general child population. The proportion of deaths among White children (44%) was 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 16% of child deaths.

Among the 285 child deaths reviewed by the CDRTs in 2018, 35% were African American children, which is larger than their proportion in the overall child population (16%) and about equal to their total child deaths that occurred in 2018 (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 2018 are shown in Table 2. The majority of total child deaths were related to either premature birth (35%) or illness (34%). The other categories

included suffocation (8%), firearms (6%), undetermined (6%), vehicular (3%), drowning (2%), injury (2%), fire (2%), poison (1%), SUID (1%), and other types that accounted for less than 1% of the total deaths.

The CDRTs are far more likely to review certain categories of child deaths than others (see Table 2). In 2018, deaths reviewed by CDRTs were most likely to be suffocation (24%), undetermined (23%) and illness (18%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Prematurity	496	35%	7	2%
Illness	473	34%	51	18%
Suffocation	113	8%	67	24%
Firearms	90	6%	17	6%
Undetermined	78	6%	66	23%
Vehicular	45	3%	13	5%
Drowning	28	2%	18	6%
Injury	24	2%	16	6%
Fire	23	2%	17	6%
Poison	12	1%	1	<1%
SUID	8	1%	7	2%
Other	4	<1%	1	<1%
SIDS	2	<1%	2	1%
Scalding Burn	1	<1%	1	<1%
SUCD	1	<1%	1	<1%
Total	1398	100%	285	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:

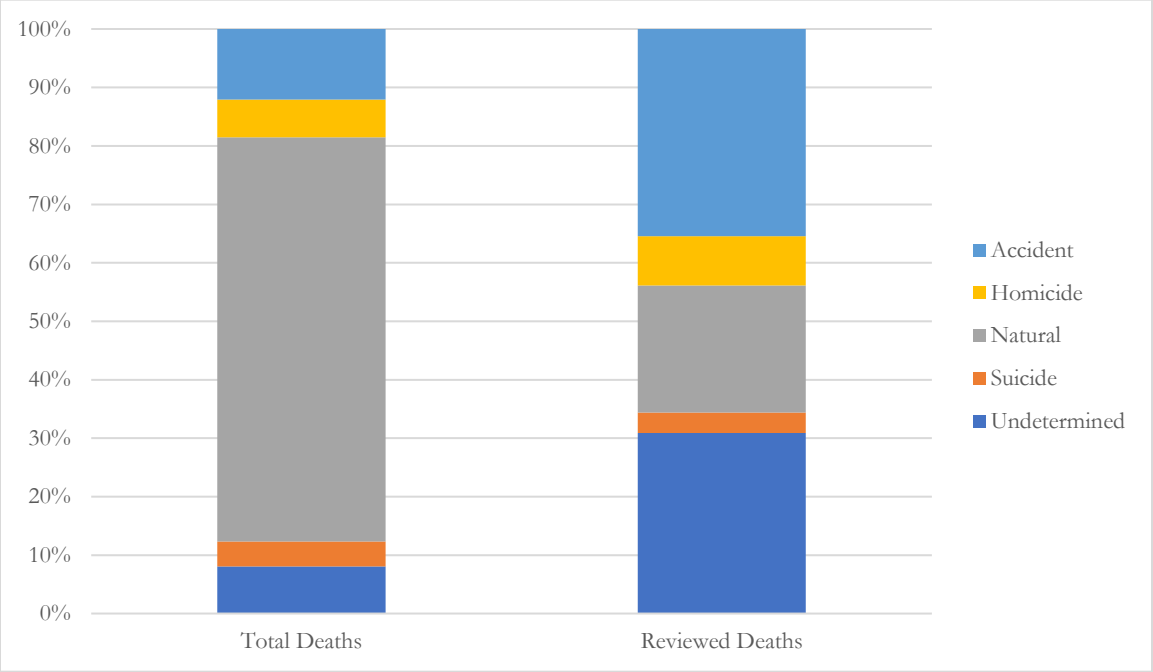
- Natural – the death was a result of natural causes such as illness, disease and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm or death
- Suicide – the death 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 2018 were attributable to natural causes (69%), and accidents accounted for 12% of the total child deaths. In addition, 6% were homicides, 4% were suicides and 8% were undetermined. The majority of deaths reviewed by CDRTs were due to accidents (35%), undetermined (31%) and natural causes (22%). The rates of reviewed deaths for homicides (8%) or suicides (4%) closely matched the proportions from all deaths reported in 2018 (see Table 3 and Figure 7).

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

	Total Deaths		Reviewed Deaths	
Accident	169	12%	101	35%
Homicide	90	6%	24	8%
Natural	967	69%	62	22%
Suicide	59	4%	10	4%
Undetermined	113	8%	88	31%
Total	1398	100%	285	100%

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



Child Deaths by Category and Manner

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

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

Category of Death	Manner of Death					
	Accident	Homicide	Natural	Suicide	Undetermined	Totals
Prematurity	0	1	492	0	3	496
Illness	1	0	468	0	4	473
Suffocation	64	3	0	35	11	113
Firearms	3	67	0	17	3	90
Undetermined	0	0	2	0	76	78
Vehicular	42	1	0	1	1	45
Drowning	24	0	0	0	4	28
Injury	5	16	0	0	3	24
Fire	22	0	0	0	1	23
Poison	5	0	0	5	2	12
SUID	2	0	2	0	4	8
Other	1	1	1	1	0	4
SIDS	0	0	2	0	0	2
Scalding Burn	0	1	0	0	0	1
SUCD	0	0	0	0	1	1
Total	169	90	967	59	113	1398

Special Analysis: Homicide Deaths

There were 90 homicide deaths out of the 1,398 deaths in 2018, and we know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. The majority (66%) of homicides were youth age 15 to 17 years old. 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**	**Race/Ethnicity**	**Cause of Death**
Firearms	3	White	Gunshot wound of neck.
Firearms	7	African American	Gunshot wound of the head.
Firearms	10	African American	Gunshot wound of head.
Firearms	11	White	Multiple shotgun wounds of head.
Firearms	11	White	Shotgun wound of head.
Firearms	12	African American	Gunshot wound of head.
Firearms	13	African American	Gunshot wound of the neck.
Firearms	13	White	Gunshot wound of the head.
Firearms	14	African American	Multiple gunshot wounds.
Firearms	14	African American	Gunshot wound of head.
Firearms	15	African American	Gunshot wound of the chest.

Firearms	15	African American	Gunshot wounds to head, chest, and abdomen.
Firearms	15	African American	Multiple gunshot wounds.
Firearms	15	African American	Multiple gunshot wounds.
Firearms	15	African American	Multiple gunshot wounds.
Firearms	15	White	Gunshot wound of the head.
Firearms	15	White	Gunshot wound of abdomen.
Firearms	16	African American	Gunshot wound to the neck.
Firearms	16	African American	Multiple gunshot wounds.
Firearms	16	African American	Multiple gunshot wounds.
Firearms	16	African American	Gunshot wound of the chest.
Firearms	16	African American	Gunshot wound of chest.
Firearms	16	African American	Gunshot wound of back.
Firearms	16	African American	Gunshot wound of the buttock.
Firearms	16	African American	Multiple gunshot wounds.
Firearms	16	African American	Gunshot wound of chest.
Firearms	16	African American	Gunshot wound of chest.
Firearms	16	African American	Gunshot wound of torso.
Firearms	16	African American	Gunshot wound to the head.
Firearms	16	African American	Multiple gunshot wounds
Firearms	16	African American	Multiple gunshot wounds.
Firearms	16	African American	Multiple gunshot wounds.
Firearms	16	African American	Gunshot wound of chest.
Firearms	16	White	Multiple gunshot wounds.
Firearms	16	White	Multiple gunshot wounds.
Firearms	16	White	Multiple gunshot wounds.
Firearms	16	White	Gunshot wound of torso.
Firearms	17	African American	Gunshot wound of abdomen.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of the head.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of head.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of chest.
Firearms	17	African American	Gunshot wound of abdomen.
Firearms	17	African American	Gunshot wounds of the abdomen.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound to torso.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of head.
Firearms	17	African American	Shotgun wound of chest.
Firearms	17	African American	Multiple gunshot wounds.

Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of the back.
Firearms	17	African American	Gunshot wound of the chest.
Firearms	17	African American	Gunshot wound of torso.
Firearms	17	African American	Gunshot wound of torso.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Gunshot wound of abdomen.
Firearms	17	African American	Gunshot wound of the head.
Firearms	17	African American	Gunshot wound to torso.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	African American	Multiple gunshot wounds.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	17	White	Gunshot wound of head.
Injury	7 mos.	African American	Blunt force injuries of the head.
Injury	3 mos.	White	Closed head injury.
Injury	0	White	Blunt force head trauma.
Injury	0	White	Blunt force injuries of the head and abdomen.
Injury	1	African American	Multiple injuries assault.
Injury	1	African American	Closed head injuries, child abuse.
Injury	1	African American	Multiple injuries, child abuse.
Injury	1	White	Multiple injuries, child abuse.
Injury	2	African American	Multiple injuries, child abuse.
Injury	3	Hispanic	Incised wound of neck.
Injury	4	Hispanic	Multiple injuries, child abuse.
Injury	5	White	Injury inflicted by another person, homicide by unspecified means.
Injury	9	African American	Cardiac arrhythmia, physical abuse, and blood loss from extensive bruising.
Injury	17	African American	Multiple stab wounds.
Injury	17	African American	Complications of remote inflicted head trauma.
Injury	17	White	Multiple stab wounds.
Other	16	African American	Homicide by unspecified means.
Prematurity	0	African American	Was en utero when mother was shot in the head.
Scalding burn	11 mos.	African American	Scalding injuries, immersed in a bathtub of hot water.
Suffocation	5 days	White	Asphyxia.
Suffocation	1	African American	Asphyxia overlaying co-sleeping in an adult bed with an adult.

Suffocation	1	White	Ligature strangulation, said suffered ligature strangulation from car seat unsupervised.
Vehicular	17	African American	Blunt force head trauma, said was the unrestrained passenger in vehicle that was speeding, lost control and struck a tree, said was ejected.

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 2018 so that the most common categories of death are first. For each category section, the following information is presented:

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

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

Premature Birth

Definition

Although there is no single, agreed-upon 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 to have health problems during the newborn period than babies of normal weight. LBW babies may be also at greater risk for serious physical and mental health illness throughout the lifespan.[7]

In Illinois, about 1 in 9 (10.7%) babies were born preterm in 2018, compared with 10.0% in the nation.[8] The rate of preterm birth in Illinois is highest for African American infants (14.5%), followed by American Indian/Alaska Natives (13.1%), Hispanics (9.9%), Whites (9.5%), and Asian/Pacific Islanders (9.4%).[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 between 431 to 572 deaths per year). The number of premature deaths increased from 455 in 2017 to 496 in 2018.

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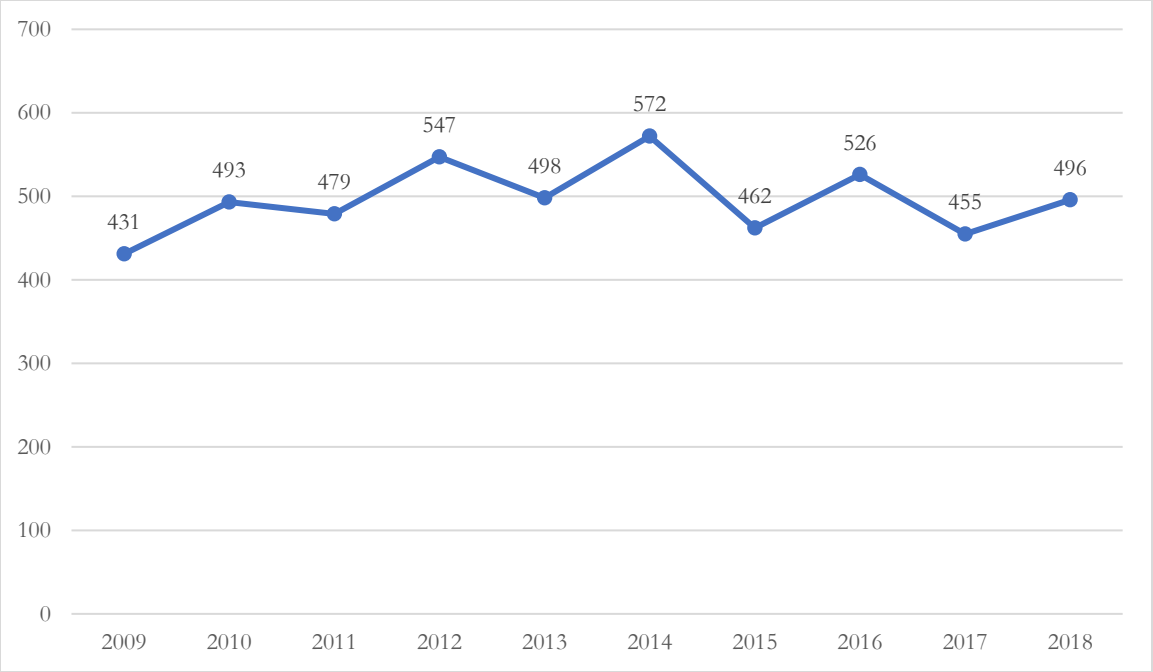
[7] America's Health Rankings (2019). 2019 Annual Report. United Health Foundation. Retrieved from https://assets.americashealthrankings.org/app/uploads/ahr_2019annualreport.pdf.
[8] March of Dimes (2020). Quick facts: *Preterm deaths*. Retrieved from https://www.marchofdimes.org/peristats/viewtopic.aspx?reg=17&top=3&lev=0.
[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 8: Child Deaths Due to Prematurity



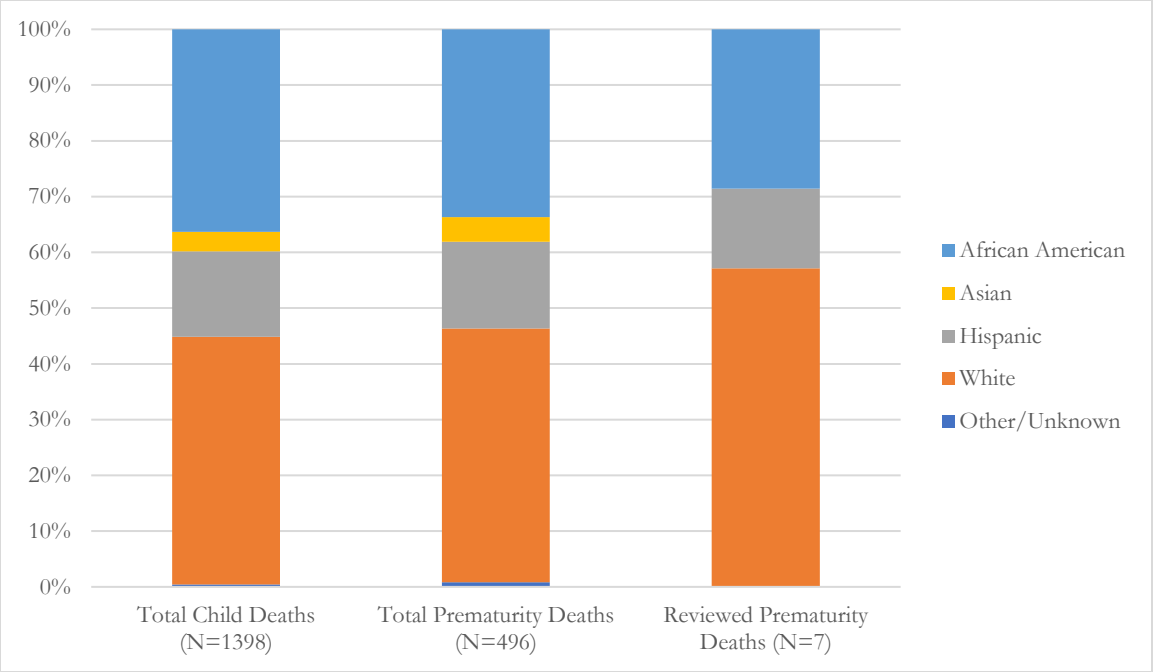
Out of 1,398 child deaths in 2018, 496 (35%) were related to premature birth.

- A majority of children who died prematurely were boys (60%).
- The majority of deaths from prematurity were White children (46%), followed by African American children (34%), Hispanic children (16%), Asian children (4%) and children of other or unknown race/ethnicity (<1%) (see Figure 9).
- Nearly all deaths (99%) in this category were the result of natural causes, 3 deaths were from undetermined causes, and 1 death was a homicide.

Illinois Data – Deaths Reviewed by the CDRTs

- In 2018, 7 of the 285 child deaths reviewed by CDRTs (2%) were related to premature birth.
- Four of the seven (57%) premature deaths reviewed by the CDRTs were boys, and 3 (43%) were girls.
- The majority of premature deaths reviewed by the CDRTs were White children (57%), followed by African American children (29%) and Hispanic children (14%) (see Figure 9).
- All premature deaths reviewed by the CDRTs were the result of natural causes.

Figure 9: Child Deaths Due to Prematurity by Race/Ethnicity



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 deaths were caused by an accident related to their illness, such as malfunctioning medical equipment or surgical error (for example, accidental removal of tracheotomy tubes).

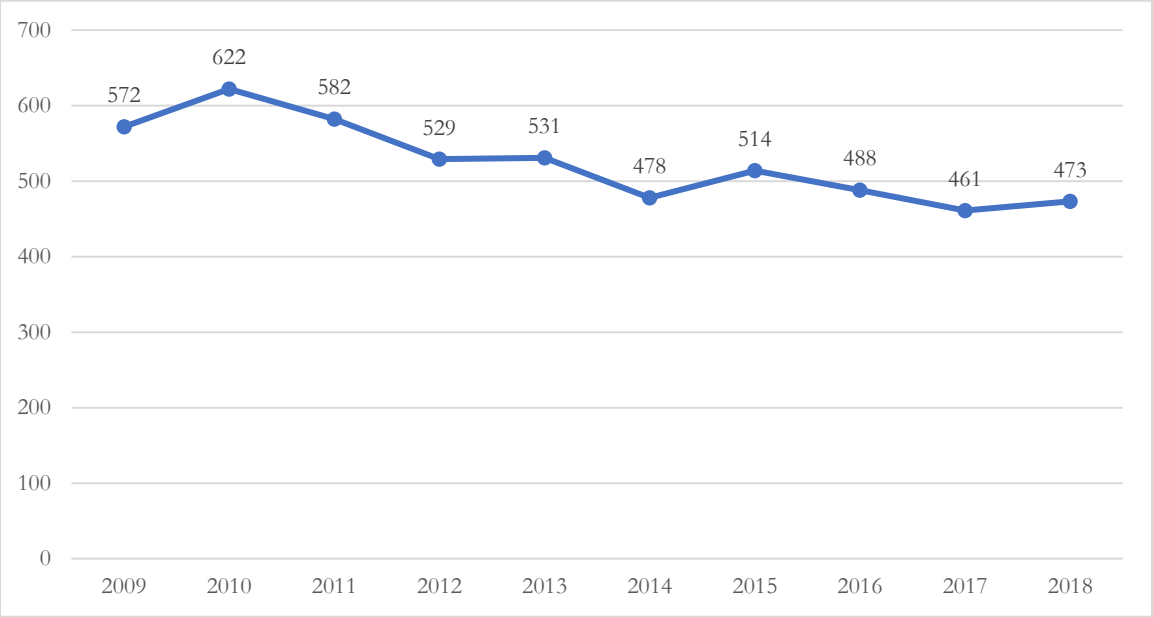
Background

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 as accidents, homicides and suicides are preventable, deaths from certain illnesses, such as birth defects (e.g., neural tube defects), asthma, infectious diseases and some screen-able 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 been under 500 in recent years (see Figure 10).

Figure 10: Child Deaths Due to Illness



In 2018, 473 of the 1,398 total child deaths (34%) reported to CDRTs were related to illness.

- Boys (56%) were more likely to die from illness than girls (44%).
- Almost half of deaths from illness were among children under the age of 1 (48%), 15% of deaths from illness occurred among children 1 to 4 years old, 11% among children 5 to 9 years old, 14% among children 10 to 14 years old and 11% among children 15 to 17 years old (see Figure 11).
- The majority (49%) of deaths from illness were White children, followed by African American children (31%), Hispanic children (16%), and Asian children (4%) (see Figure 12).
- Nearly all deaths (99%) from illness were attributable to natural causes, and less than 1% of the remaining deaths were either accidental or undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 51 of the 285 child deaths reviewed by the CDRTs (18%) were related to illness.

- More than half (61%) of the reviewed deaths related to illness were boys.
- Illness-related deaths were most common in infants under 1 year old (37%) followed by children 1 to 4 (27%). Children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old each made up 12% of reviewed deaths from illness (see Figure 11).
- A little over half (51%) of the reviewed deaths from illness were African American children, 31% were White children, 16% were Hispanic children, and one case (2%) was an Asian child (see Figure 12).
- The majority (96%) of reviewed deaths that were categorized as illness were attributed to natural causes. There was one accidental (2%) and one undetermined (2%) case.

Figure 11: Child Deaths Due to Illness by Age

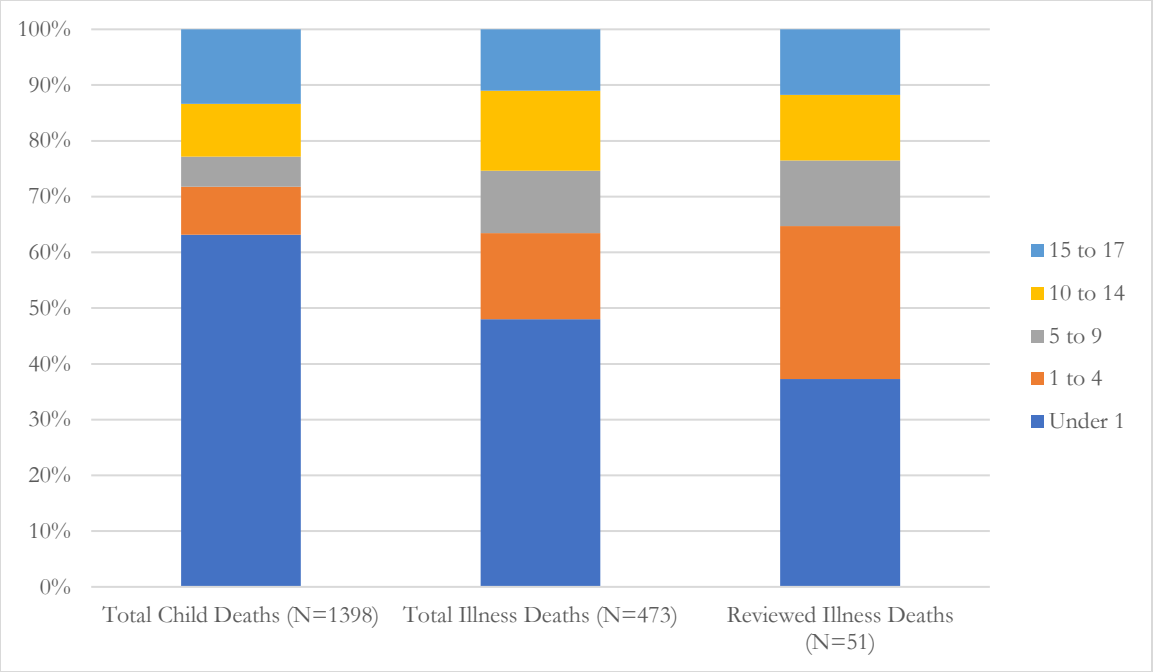
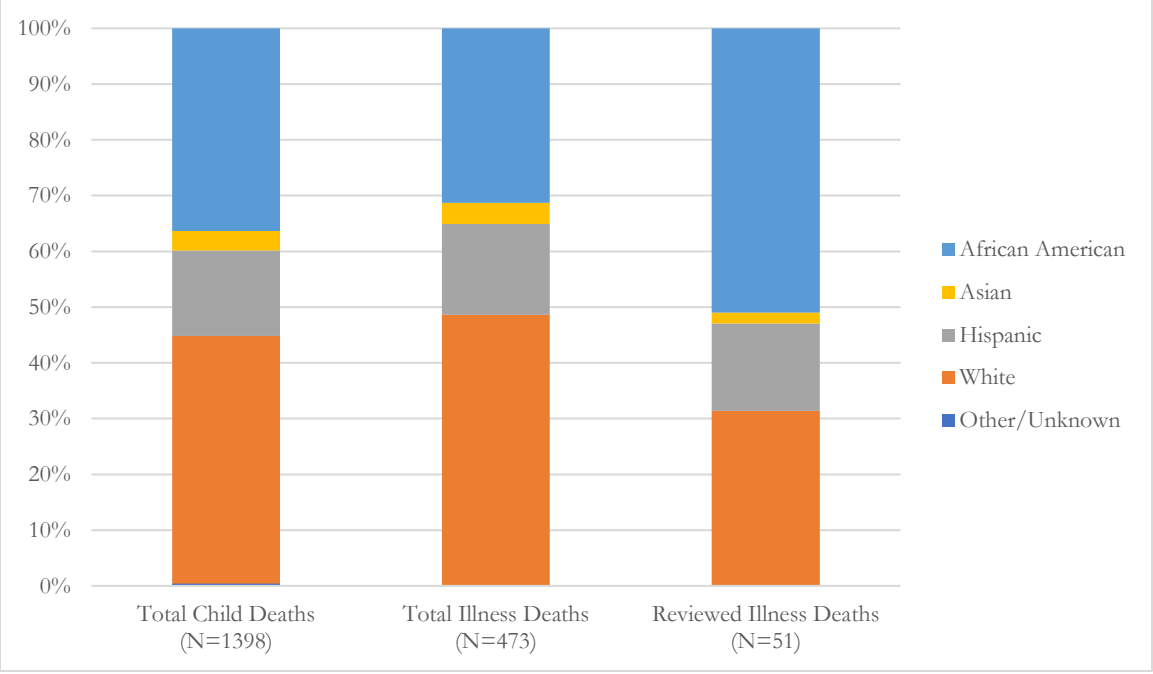


Figure 12: Child Deaths Due to Illness by Race/Ethnicity



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

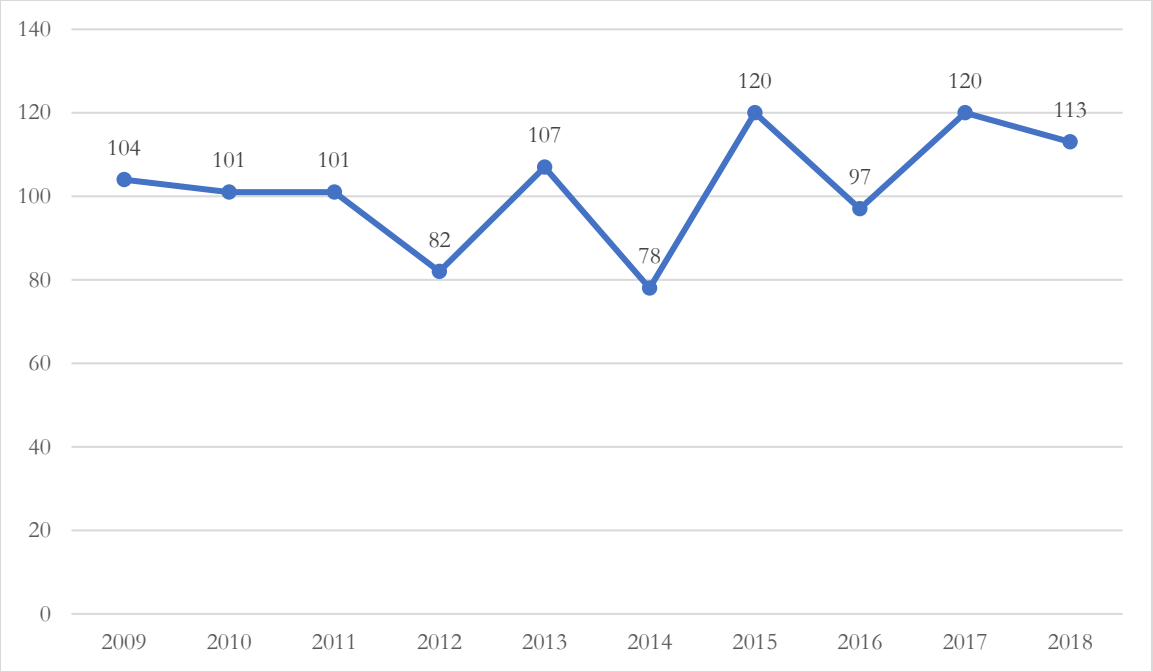
In 2018, 2,251 children ages 17 and under in the U.S. died from suffocation.[11]
Of these children, 47% were less than one year of age and 53% were ages four and under. Unintentional suffocation is the leading cause of injury-related death among infants less than one year old; and 85% of suffocation deaths among infants are from accidental suffocation in bed.[12]

Illinois Data—Total Child Deaths Reported to the CDRTs

Suffocation deaths have fluctuated slightly in the past decade, ranging from a low of 78 to a high of 120. There were 113 suffocation deaths in 2018 (see Figure 13).

[11] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.
[12] Safe Kids Worldwide. (2018). *Suffocation Prevention and Sleep Safety.* Retrieved from https://www.safekids.org/suffocation-prevention-and-sleep-safety.

Figure 13: Child Deaths Due to Suffocation



In 2018, 113 of the 1,398 total child deaths reported to the CDRTs (8%) were categorized as suffocation.

- The majority of children who died from suffocation were boys (58%).
- Infants under one year made up over three-fifths (61%) of deaths in this category. Less than 2% of suffocation deaths were children ages 1 to 4, and there were no deaths of children age 5 to 9. One-fifth (20%) of suffocation deaths were children 10 to 14 years old, and 17% were children 15 to 17 years old.
- Half (50%) of children who died from suffocation were White, 34% were African American, 13% were Hispanic, 3% were Asian, and less than 1% were for other/unknown race/ethnicity.
- Most suffocation deaths were accidental (56%) or suicides (31%); and the remaining suffocation deaths were homicides (3%) or undetermined (10%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 67 of the 285 child deaths reviewed by CDRTs (24%) were related to suffocation.

- The majority of reviewed suffocation deaths were boys (58%).
- Infants under one year made up the majority of reviewed suffocation deaths (90%).

- The majority of reviewed suffocation deaths were White children (48%) and African American children (45%), accounting for 92% of total reviewed suffocation deaths.

Figure 14: Child Deaths Due to Suffocation by Age

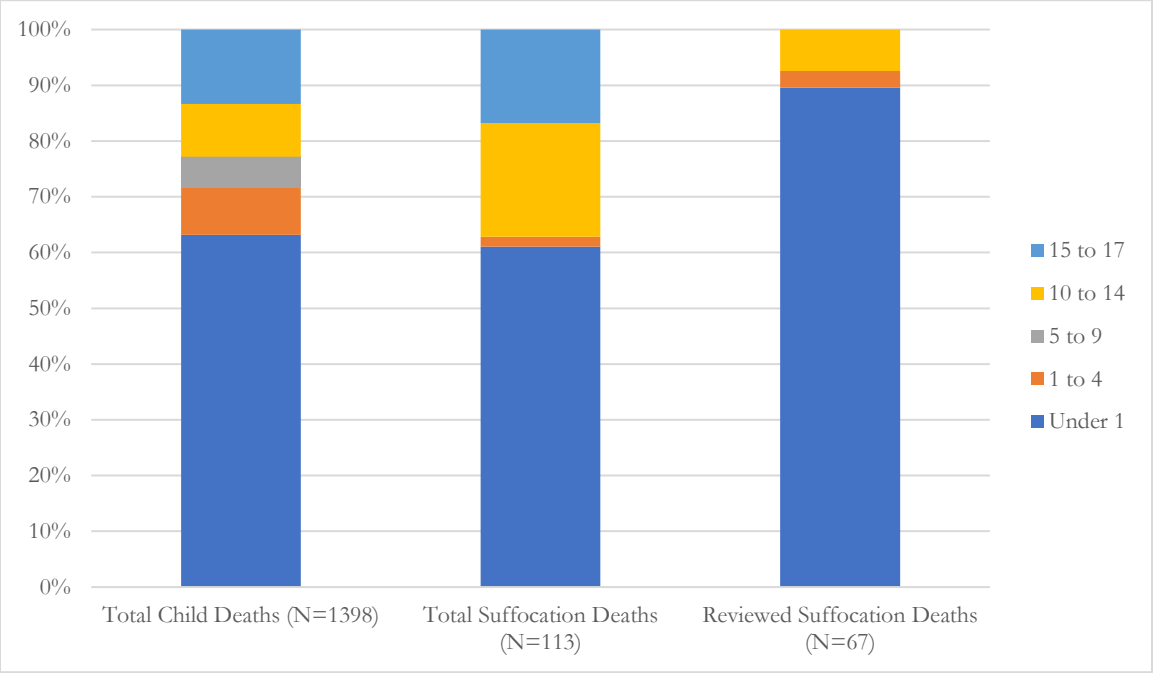
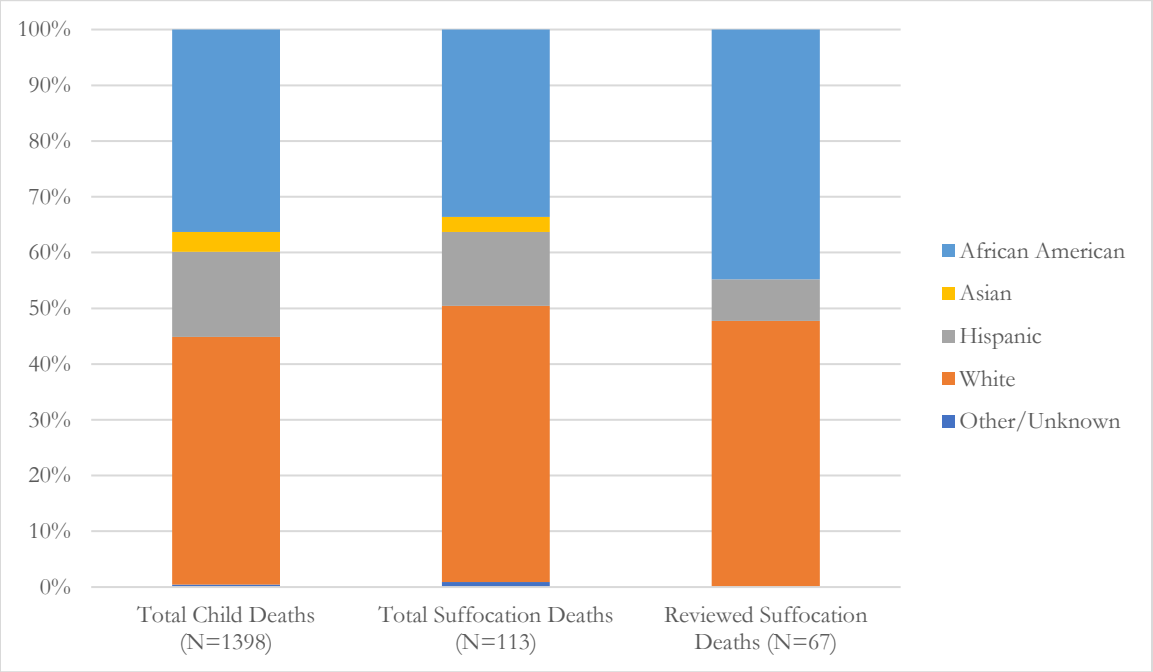


Figure 15: Child Deaths Due to Suffocation by Race/Ethnicity



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, 1,729 firearm deaths occurred in 2018 among children under 18 years of age in the United States. The vast majority (69%) of these deaths were youth between the ages of 15 and 17. Race of decedent is also a factor. In 2018, 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]

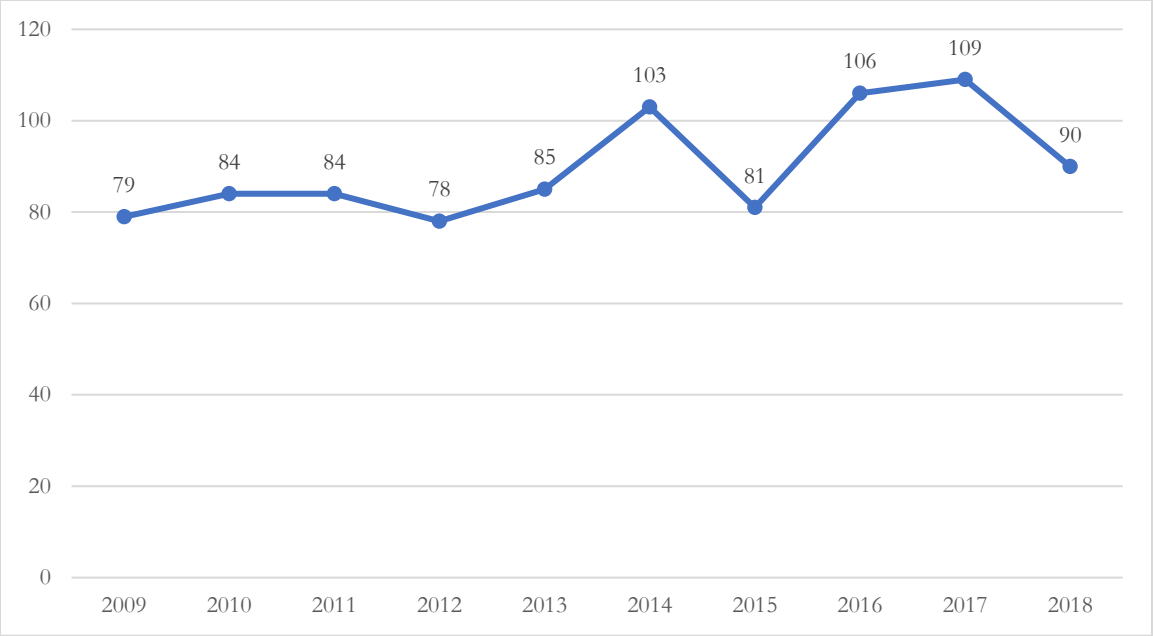
Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from firearms has fluctuated over the past several years. Firearms deaths ranged between 78 to 85 from 2009 through 2013, but there were over 100 child deaths from firearms in 2014, 2016, and 2017. There was a decrease to 90 child deaths from firearms in 2018 (see Figure 16).

[13] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.

[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 2018, 90 of the 1,398 total deaths (6%) were related to firearms.

- Deaths due to firearms overwhelmingly occurred among boys (87%).
- 77% of firearm deaths occurred in children aged 15 to 17 (see Figure 17).
- 71% of the children who died from firearms were African American, 22% were White, and 7% were Hispanic (see Figure 18).
- Homicides accounted for 74% of firearm deaths, suicides were 19%, and accidents and undetermined cases each accounted for 3%.

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 17 of the 285 deaths reviewed by the CDRTs (6%) were related to firearms.

- The majority of reviewed firearm deaths were males (88%).
- Over half (52%) of the firearm deaths reviewed by CDRTs involved youth 15 to 17 years old (see Figure 17).
- Over two-thirds (71%) of reviewed firearm deaths were African American children, slightly less than a quarter (24%) were White children, and 6% were Hispanic children. There were no reviewed firearm deaths of children of other race/ethnicity (see Figure 18).

- Almost half of firearms deaths reviewed by CDRTs were due to homicides (47%), and suicide cases (29%) were the second most common. Accidental and undetermined cases were each 12%.

Figure 17: Child Deaths Due to Firearms by Age

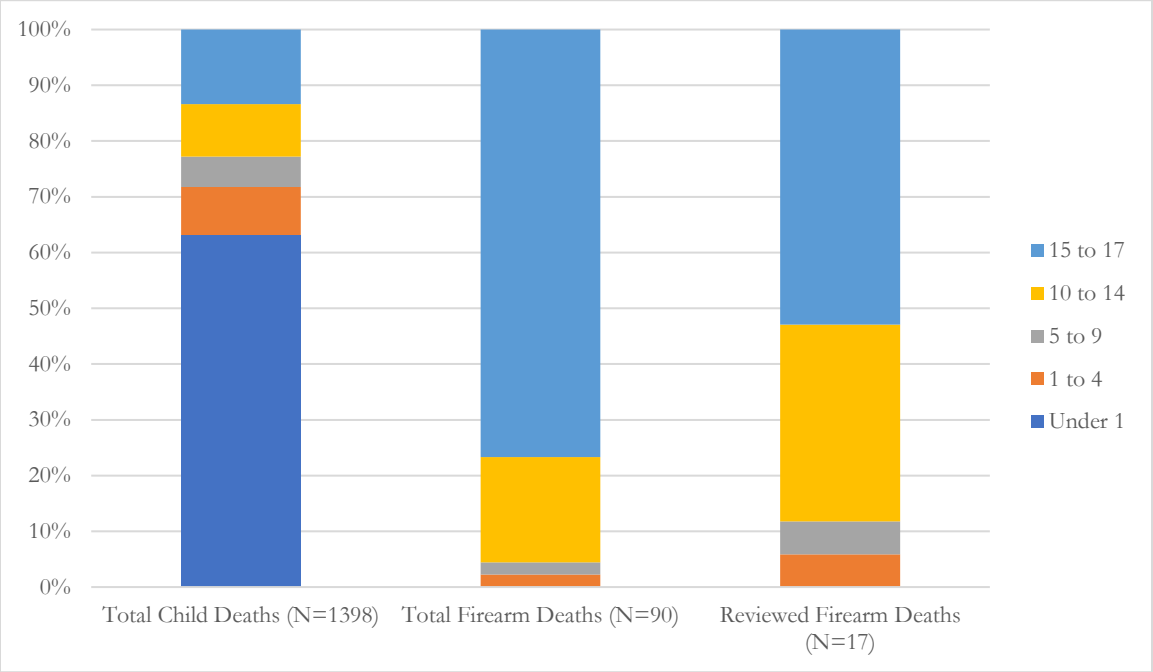
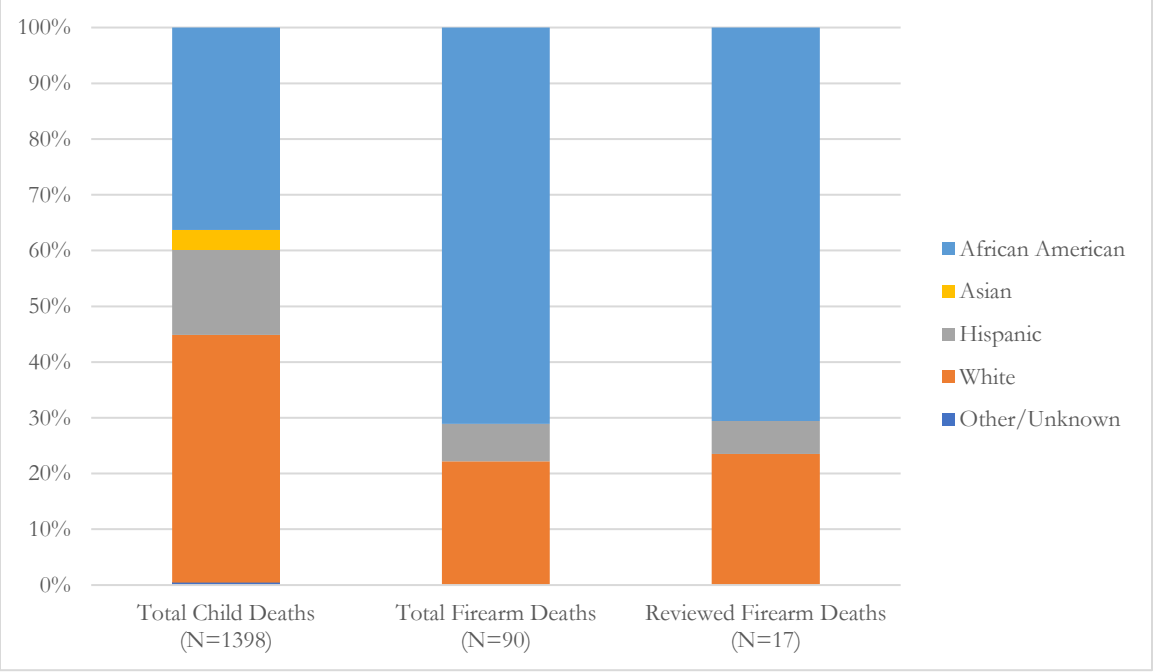


Figure 18: Child Deaths Due to Firearms by Race/Ethnicity



Undetermined Deaths

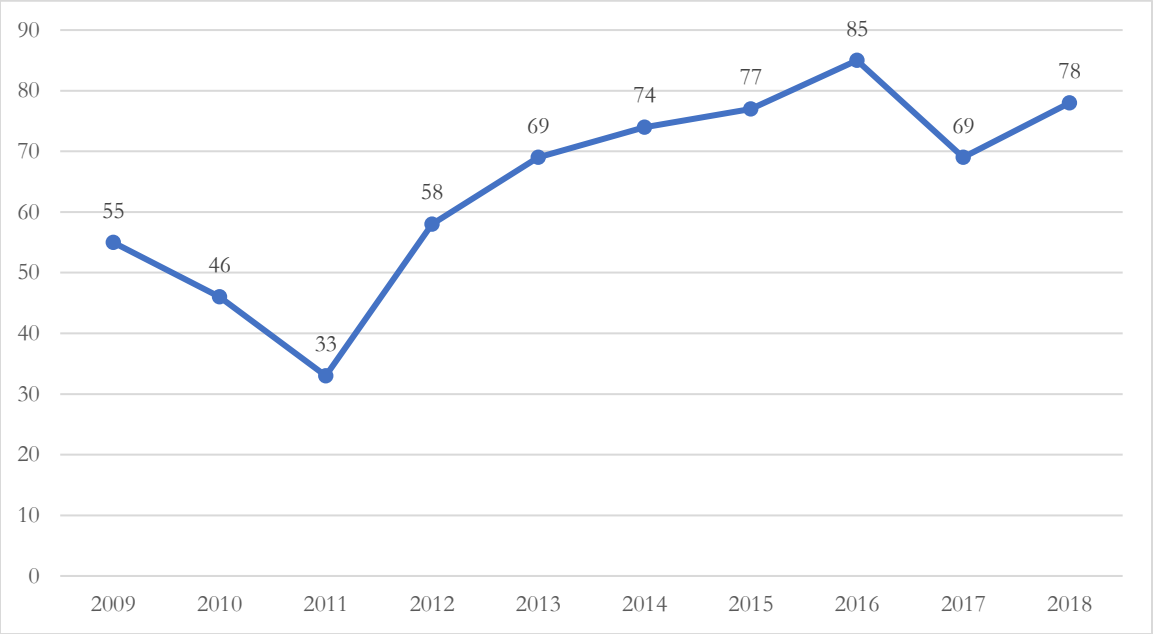
Definition

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 and peaked at 85 in 2016; there were 78 undetermined deaths in 2018 (see Figure 19).

Figure 19: Child Deaths with Undetermined Cause of Death



In 2018, 78 of the 1,398 total child deaths reported to the CDRTs (6%) had an undetermined cause of death.

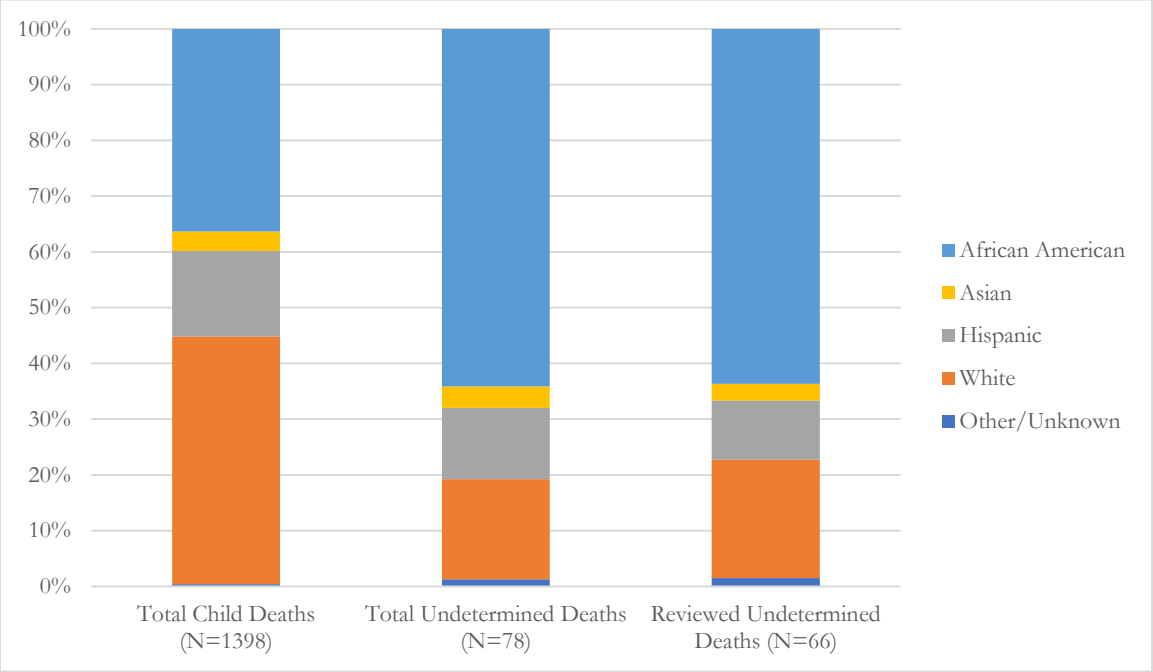
- Deaths due to undetermined causes were slightly more common for girls (51%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (91%).
- The majority of undetermined deaths were African American children (64%), followed by White children (18%), Hispanic children (13%), Asian children (4%), and children of other or unknown race/ethnicity (1%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 66 of the 285 deaths reviewed by CDRTs (23%) had an undetermined cause of death.

- Reviewed deaths due to undetermined causes were slightly more likely for girls (53%).
- 95% 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 20).

Figure 20: Child Deaths with Undetermined Cause 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 880 children (under the age of 13) died in motor vehicle crashes in 2018.[15] There has been a 79% decrease in the rate of motor vehicle crash deaths per million children under 13 since 1975. In 2018, 73% 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 year declined by 90% 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. Thirteen percent of passenger vehicle child occupant deaths occurred in front seats, continuing a downward trend that has spanned for several decades. Eighty percent were in the rear seat and 7% were in cargo/unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about one out of every four unintentional injury deaths among children younger than 13. The 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 2018, a total of 2,476 teenagers, ages 13 to 19, died in motor vehicle crashes. This is a decrease of 72% from 1975 and 10% from 2017. Males accounted for about two out of every three teenagers killed in crashes in 2018. Although males make up a larger number of crash deaths, their rates have decreased more for males (76%) than females (59%) since 1975. Teenagers accounted for 7% of motor vehicle crash deaths in 2018. Teenagers overall account for 8% of passenger vehicle (cars, pickups, SUVs and vans) occupant deaths among all ages, 4% of pedestrian deaths, 3% of motorcycle deaths, 7% of bicyclist deaths and 12% of all-terrain vehicle rider deaths.[17]

In the United States, teenagers drive less than most adults, yet their number 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]

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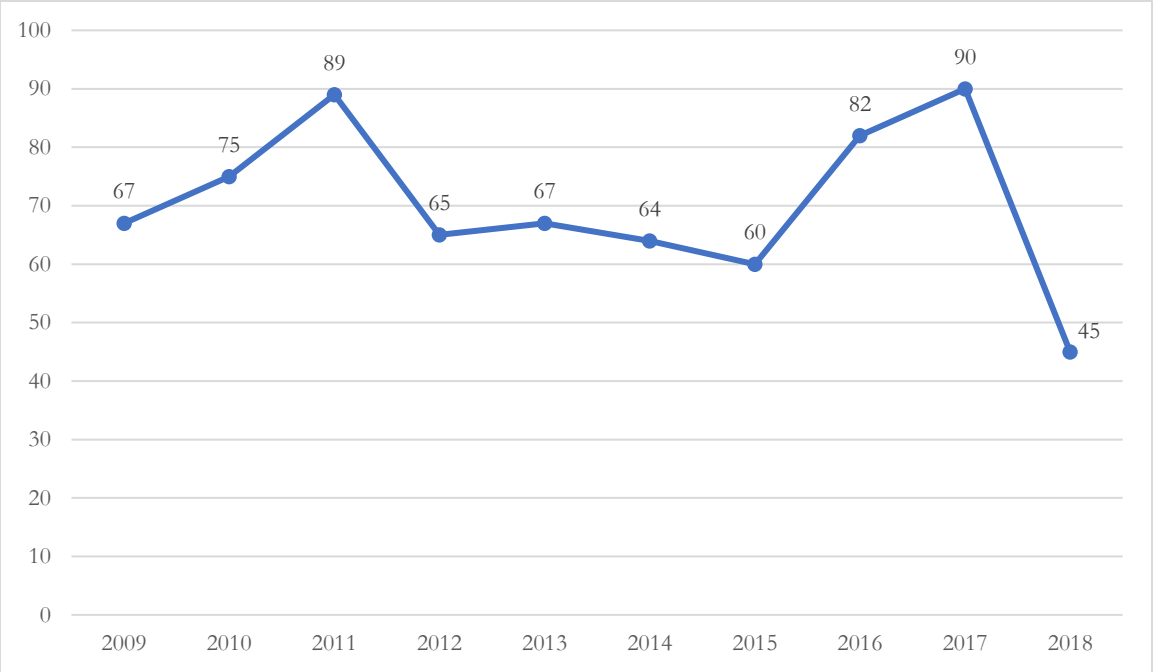
[15] Insurance Institute for Highway Safety. (2019). *Fatality facts 2018: Children.* Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/children#Age-and-gender.
[16] Ibid.
[17] Insurance Institute for Highway Safety. (2019). *Fatality facts 2018: Teenagers.* Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/teenagers.
[18] Ibid.

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 had previously fluctuated between 60 to 90. However, in 2018 there were only 45 vehicle deaths, a 50% decrease from the previous year (see Figure 21).

Figure 21: Child Deaths Due to Vehicular Accidents



In 2018, 45 out of the 1,398 total child deaths reported to the CDRTs (3%) were related to vehicular accidents.

- Boys accounted for two-thirds (67%) of vehicular accident deaths.
- Older children (15 to 17) made up the largest proportion of vehicular deaths (56%). Children in other age groups made up the following proportions of vehicular deaths: there were no

[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.

vehicular deaths of children under 1, children 1 to 4 were 16%, 5 to 9 were 13% and 10 to 14 were 16% (see Figure 22).

- The majority (56%) of vehicular deaths were White children, followed by African American children (24%), Hispanic children (18%) and one child was Asian (2%) (see Figure 22).

- The majority of these deaths were accidental (93%). One homicide, one suicide, and one undetermined case accounted for the remaining 7% of vehicular deaths.

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 13 of the 285 deaths reviewed by the CDRTs (5%) were related to vehicular deaths.

- The majority of reviewed vehicular accident deaths were boys (85%).

- Children 1 to 4 and children 15 to 17 each accounted for 38% of vehicular deaths. Children 5 to 9 accounted for 15%, and children 10 to 14 were 8% (see Figure 22).

- Most of the reviewed deaths related to vehicular accidents were White children (46%), followed by African American children (31%), Hispanic children (15%), and Asian children (8%) (see Figure 23).

- All but one of the reviewed vehicular deaths was an accident (92%); the non-accident was a suicide (8%).

Figure 22: Child Deaths Due to Vehicular Accidents by Age

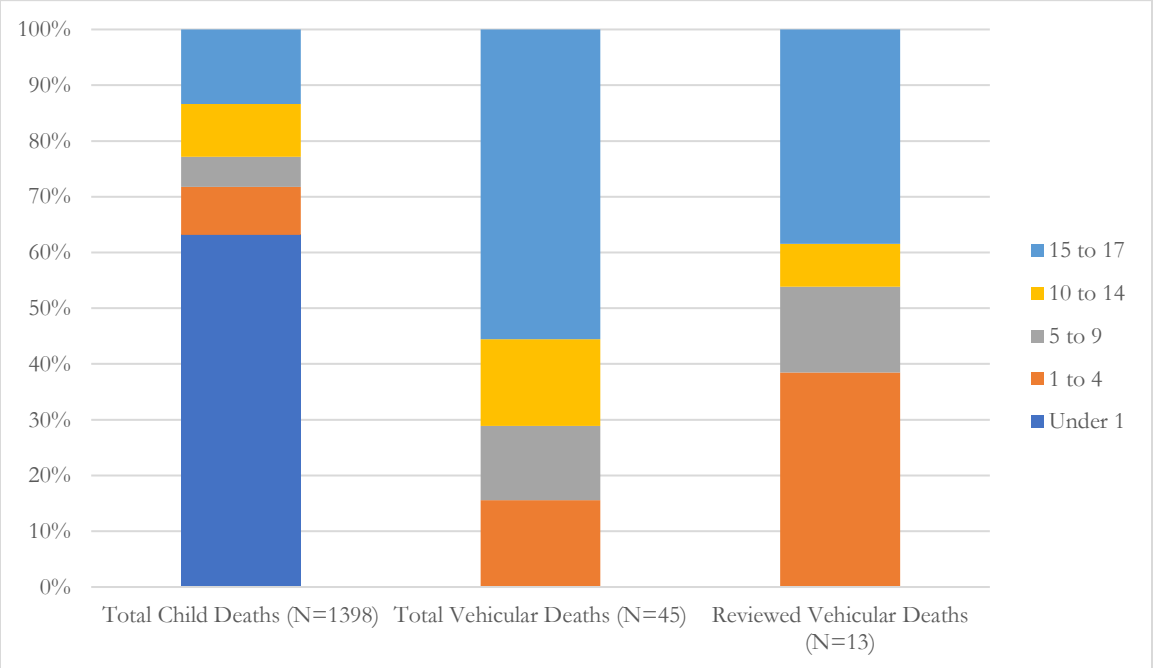
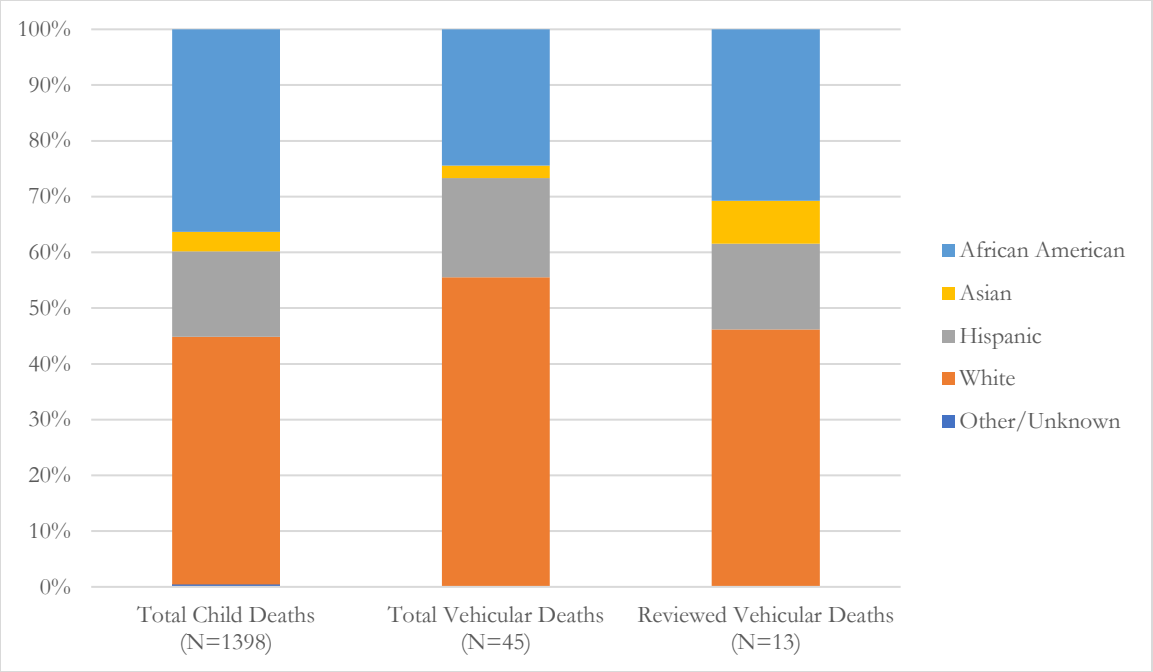


Figure 23: Child Deaths Due to Vehicular Accidents by Race



Drowning

Definition

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

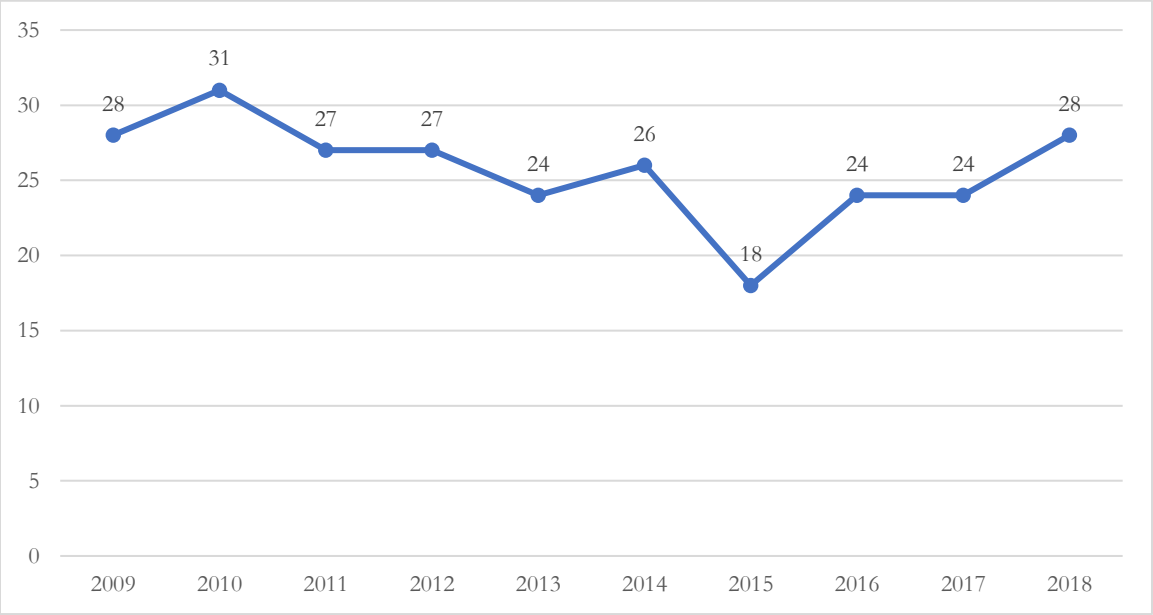
Background

In 2018, 798 children ages 17 and under died as a result of unintentional drowning in the United States. Children 4 and under accounted for 60% of these deaths.[21] 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.[22]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from drowning have ranged between a low of 18 to a high of 31 in the past decade (see Figure 24).

Figure 24: Child Deaths Due to Drowning



[21] 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://wisqars-viz.cdc.gov:8006/explore-data/home.

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

In 2018, 28 of the 1,398 total child deaths reported to the CDRTs (2%) were related to drowning.

- Boys made up two-thirds of reported drowning deaths (68%).
- Children under 4 years of age accounted for 43% of drowning deaths. Children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 18%, 25%, and 14% of deaths due to drowning, respectively (see Figure 25).
- Over half of reported drowning deaths were White children (54%), African American and Hispanic children were each 21% of cases, and one case of an Asian child (4%) (see Figure 26).
- The majority of drowning deaths were accidental (86%), and the remainder were undetermined (14%)

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 18 of the 285 reviewed deaths (6%) were related to drowning.

- Two-thirds (67%) of the reviewed drowning deaths were male.
- Children 4 and under accounted for 61% of reviewed drowning deaths, children 5 to 9 were 17%, children 10 to 14 years were 22%, and there were no cases with children 15 to 17 (see Figure 25).
- Half of reviewed drowning deaths were White children (50%), African American children were 28%, Hispanic children were 17%, and there was one case with an Asian child (6%) (see Figure 26).
- The majority of reviewed drowning deaths were accidents (78%), and the remainder of cases were undetermined (22%).

Figure 25: Child Deaths Due to Drowning by Age

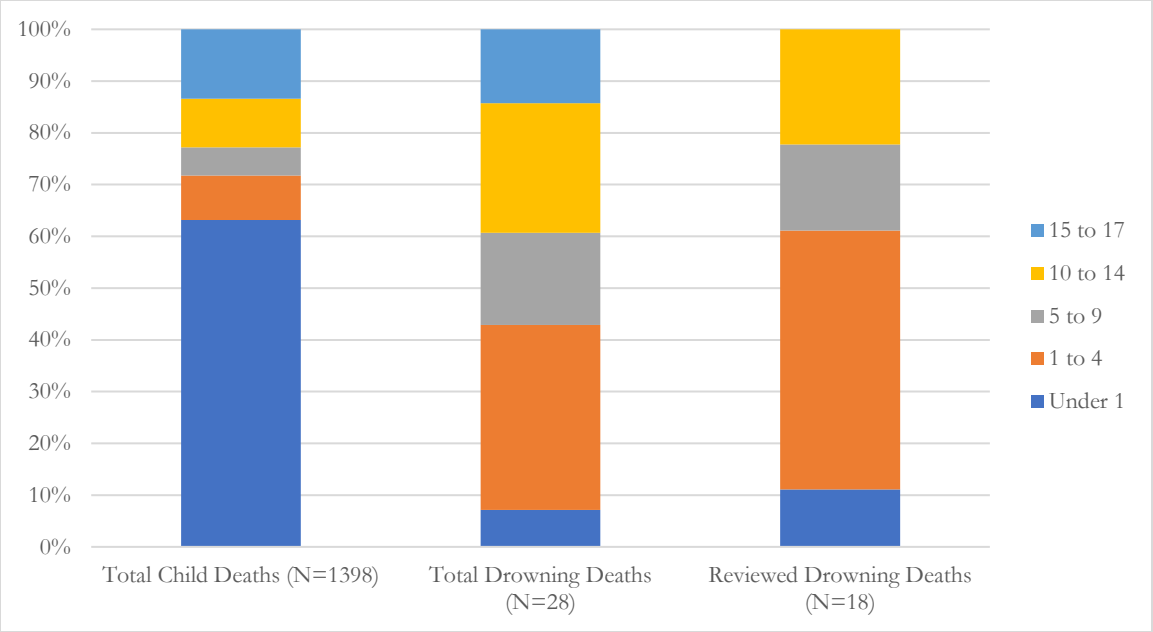
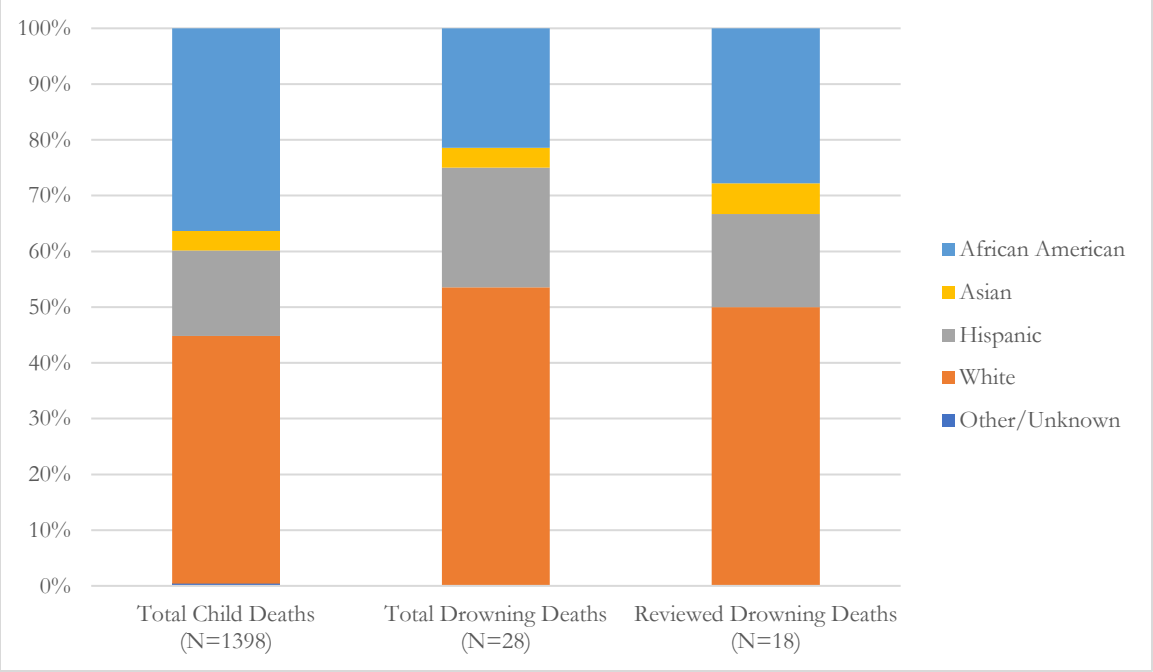


Figure 26: Child Deaths Due to Drowning by Race/Ethnicity



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

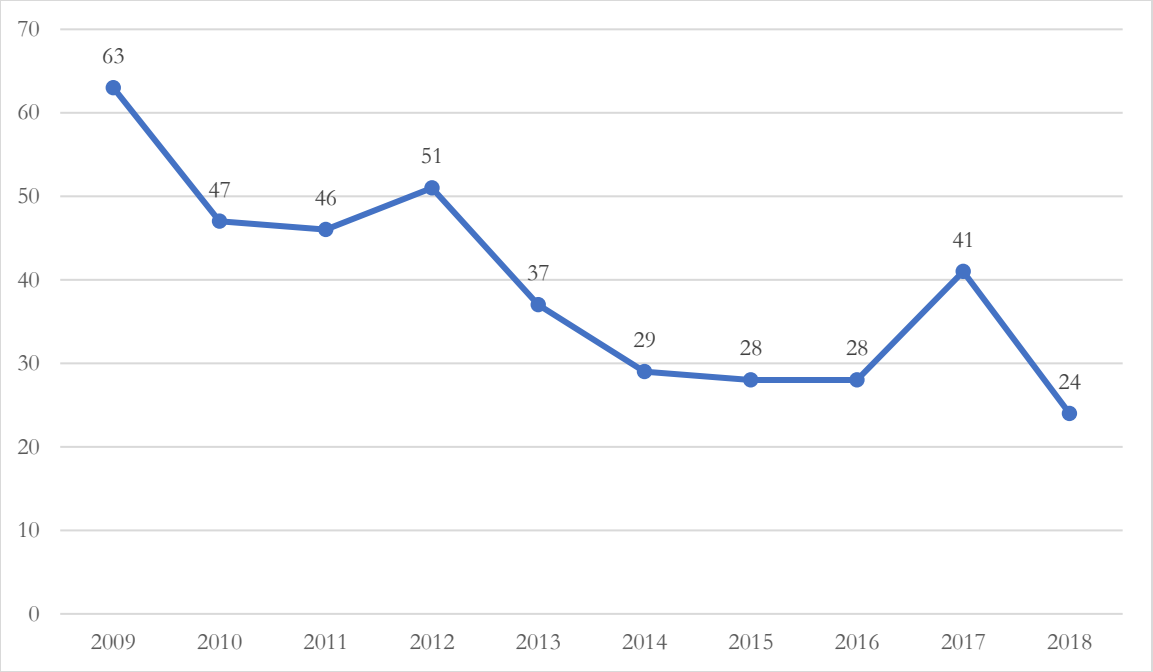
Child maltreatment (including abuse and neglect) is one cause of death from injuries. Based on 2018 data from the National Child Abuse and Neglect Data System (NCANDS), it is estimated that 1,770 children died from abuse and neglect at a rate of 2.39 deaths per 100,000 children. Younger children are the most vulnerable to die as a result of child abuse and neglect. Nearly seventy-one percent (70.6%) of child fatalities were children younger than 3 years old. In 2018, girls had higher victimization rates (9.7 per 1,000) than did boys (8.7 per 1,000); however, boys had a higher fatality rate (2.87 per 100,000) compared to girls (2.19 per 100,000), and African American children had higher rates (5.48 per 100,000) compared to White children (1.94 per 100,000) and Hispanic children (1.63 per 100,000).[23] Of child maltreatment deaths, about three-quarters (72.8%) suffered neglect and 46.1% 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 has mostly declined after 2012. (see Figure 27).

[23] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2020). *Child maltreatment, 2018*. Washington, DC: Government Printing Office. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf.

Figure 27: Child Death Due to Injuries



In 2018, 24 of the 1,398 total child deaths reported to the CDRTs (2%) were related to injuries.

- Two-thirds of injury deaths were boys (67%).
- Infants and children under 4 years of age made up over half (58%) of injury deaths (see Figure 28).
- Half of the injury deaths were White children (50%), followed by African American children (38%) and Hispanic children (13%) (see Figure 29).
- 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 2018, 16 of the 285 deaths reviewed by the CDRTs (8%) were related to injuries.

- The majority of injury deaths reviewed by CDRTs were boys (69%).
- Infants and children under 4 years of age made up the majority (81%) of reviewed injury deaths (see Figure 28).
- African American children and White children were each 44% of reviewed injury deaths, and there was one Hispanic child (13%) (see Figure 29).

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

Figure 28: Child Deaths Due to Injuries by Age

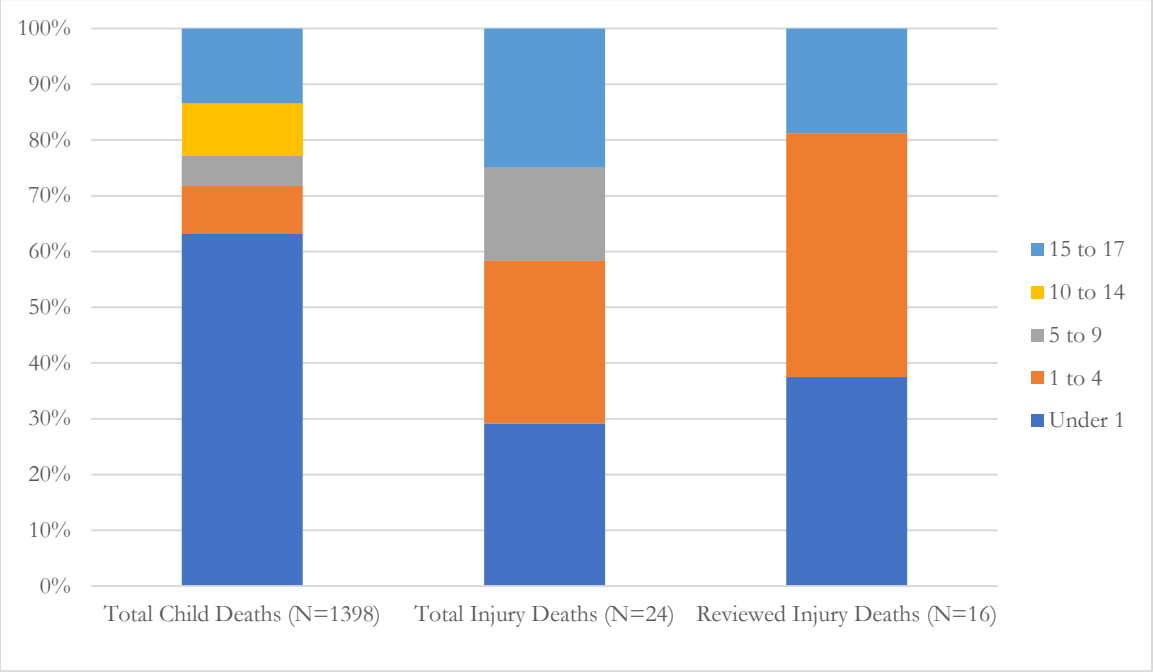
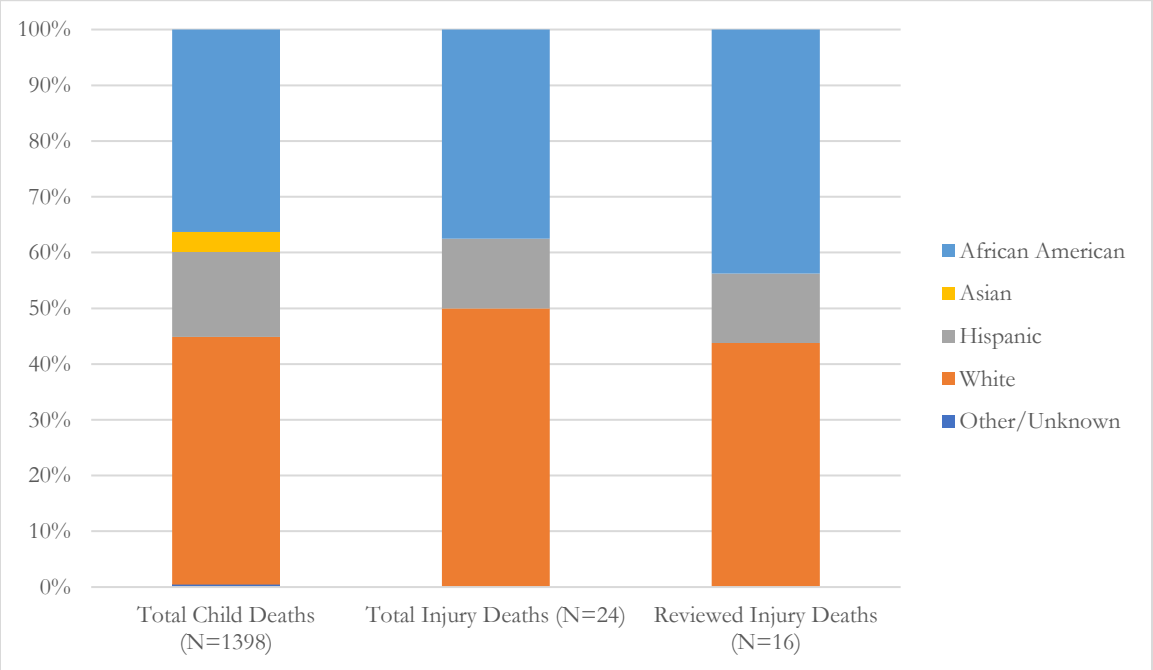


Figure 29: Child Deaths Due to Injuries by Race/Ethnicity



Fire

Definition

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

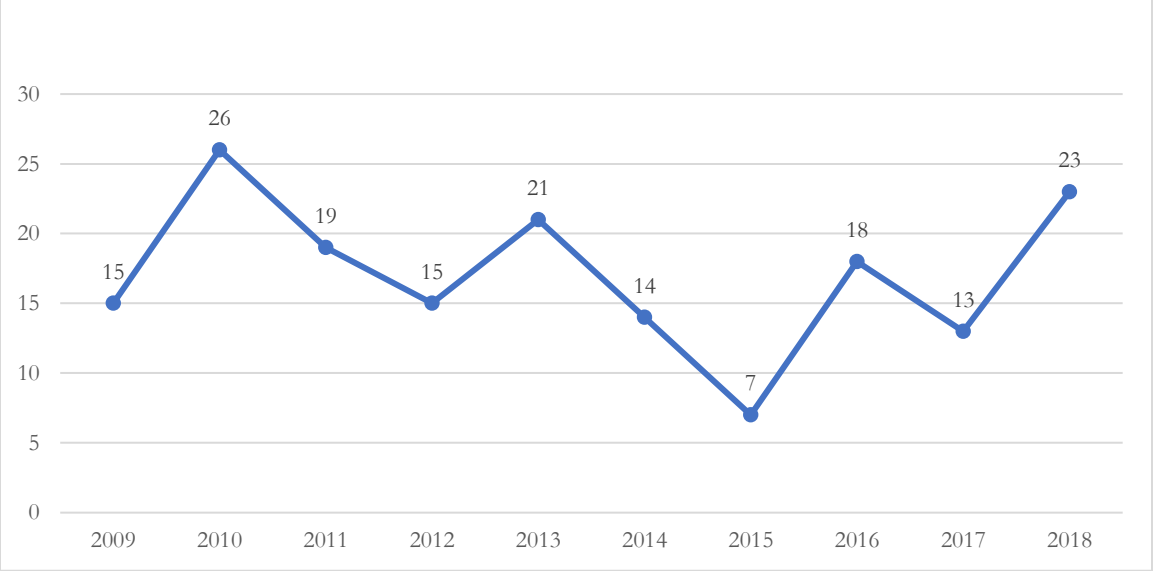
Background

In the United States, fire and burns were the cause of 358 deaths among children between 0 and 17 years in 2018. Forty-six percent of fire deaths occurred in children age 4 and under.[24] Death rates per million among children age 14 and under has decreased 43% from 2007-2016.[25] 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%.[26]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to fire has ranged between a low of 7 to a high of 26 in the past decade. There were 23 deaths due to fire in 2018 (see Figure 30).

Figure 30: Child Deaths Due to Fire



[24] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.
[25] 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.
[26] Safe Kids Worldwide. (2018). *Fire safety*. Retrieved from https://www.safekids.org/fire.

In 2018, 23 of the 1,398 total child deaths reported to the CDRTs (2%) were related to fires.

- The majority of fire related deaths were boys (70%).
- Infants and children 4 and under accounted for 43% of deaths from fires. Children 5 to 9 accounted for 22%, and children 10 to 14 made up 30%. There was one death due to fire of a child age 15 to 17 (4%).
- The largest proportion of deaths due to fire were Hispanic children (43%), followed by White children (35%), and African American children (22%).
- 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 2018, 17 of the 285 deaths reviewed by the CDRTs were related to fire (6%).

- The majority of reviewed deaths related to fire were boys (71%).
- Children under 1 made up 12% of reviewed deaths due to fire, children 1 to 4 were 29%, children 5 to 9 were 24%, children 10 to 14 were 29%, and children 15 to 17 were 6%.
- The majority of reviewed deaths related to fire were Hispanic children (59%), followed by African American children (24%), and White children (18%).
- All but one of the cases were accidents (94%) and the remaining case was undetermined (6%).

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

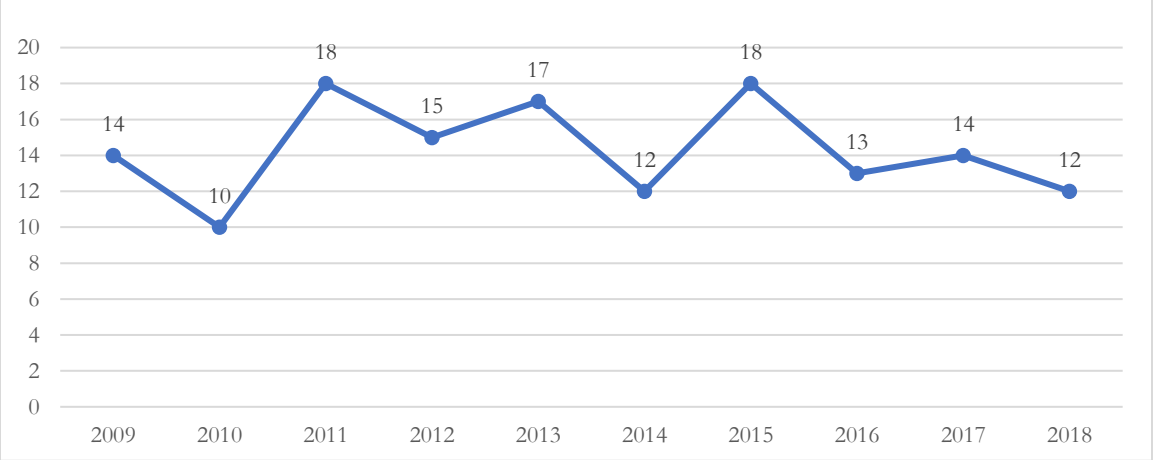
In 2018, 394 children under 18 years died of poisoning in the United States.[27] Nearly six in ten of these deaths occurred in children 15 to 17 years of age. Also, children 4 and under make up a large proportion of poisoning deaths (22%).

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.[28] The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

Illinois Data—Total Child Deaths Reported to the CDRTs

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

Figure 31: Child Deaths Due to Poisoning/Overdose



[27] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from https://wisqars-viz.cdc.gov:8006/explore-data/home.

[28] Baker J. M., & Mickalide, A.D. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on fare 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.

In 2018, 12 of the 1,398 total child deaths (<1%) were related to poisonings or overdoses.

- There was an equal distribution of deaths from poisoning or overdoses between boys and girls (50% each).
- Older children ages 15 to 17 made up 67% of deaths, and children 10 to 14 made up 17%. There was one death of a child between the ages of 1 to 4 (8%) and of another child between the ages of 5 to 9 (8%).
- Half of the poisoning or overdose deaths were White children (50%), Black children were 33%, and there was one Hispanic child (8%) and one Asian child (8%).
- Accidents and suicides each accounted for 42% of poison/overdose deaths, and the remaining cases were undetermined (17%).

Illinois Data—Deaths Reviewed by the CDRTs

- In 2018, 1 of the 285 deaths reviewed by CDRTs (<1%) was related to poisoning/overdose.
- The one reviewed poison/overdose death was a girl (100%).
- The child was 2 years old (1 to 4 age group).
- The manner of death was undetermined.

Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)[29]

Definition

According to Centers for Disease Control and Prevention (CDC),[30] 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.[31]

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.[32]

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[29] 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.

[30] 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.

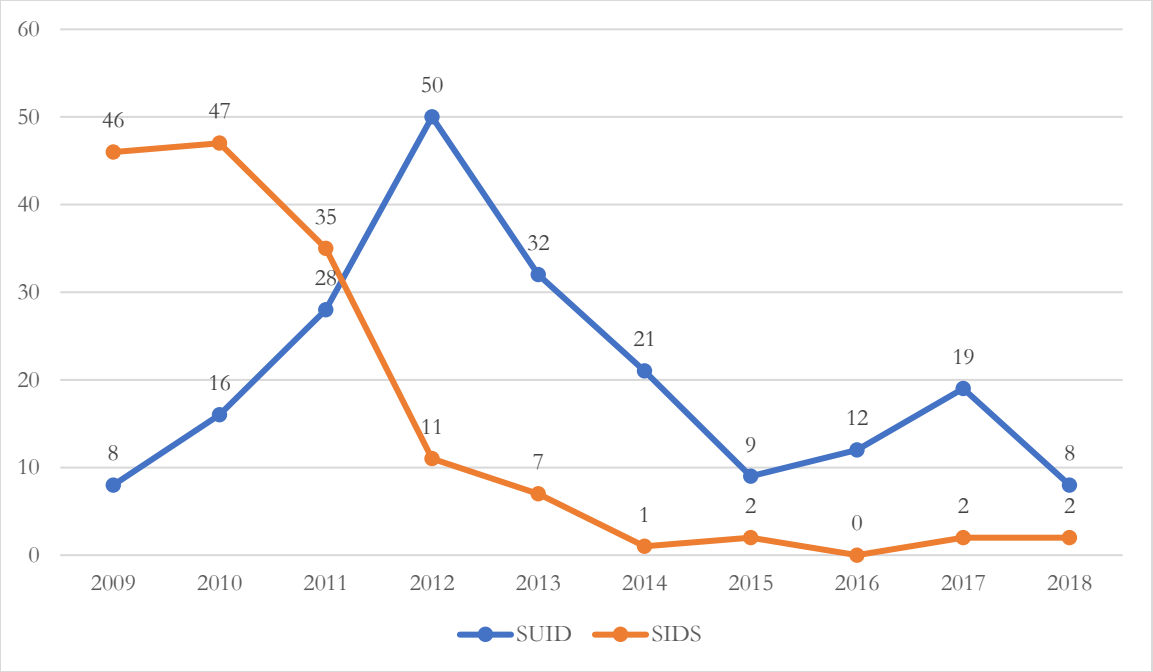
[31] Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology, 163*, 762-769.

[32] United States Environmental Protection Agency (2019). America's Children and Environment. Retrieved from https://www.epa.gov/ace/key-findings-ace3-report.

Illinois Data—Total Child Deaths Reported to the CDRTs

Since the peak of 47 cases in 2010, SIDS has experienced a sharp decline, with very low number of deaths occurring in recent years (see Figure 32). Infant deaths from SUID were added as a category in 2007. Child deaths due to SUID reached a peak of 50 in 2012, but since then also have a large decline.

Figure 32: Child Deaths due to SIDS and SUID



In 2018, 8 of the 1,398 child deaths were categorized as SUID (1%), two were related to SIDS (<1%).

- Both of the SIDS deaths were girls (100%) and the SUID deaths evenly split between boys and girls (50% each).
- All SIDS and SUID deaths were infants under 1 year (100%).
- Both of the SIDS deaths were White children (100%). Half of the SUID deaths were African American children (50%), 38% were White children, and one death was a Hispanic child (13%).
- All SIDS deaths were categorized as natural (100%). Half of the SUID deaths were undetermined (50%) and the remainder were natural (25%) or accidental (25%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2018, 2 of the 285 deaths reviewed by the CDRTs were related to SIDS (<1%), and 7 were related to SUID (2%).

- Both of the SIDS deaths were girls (100%), and there were slightly more SUID deaths of boys (57%).
- All of the SIDS and SUID cases were infants under 1 year of age.
- Both reviewed SIDS deaths were White children (100%). African American children accounted for 57% reviewed SUID deaths, and White children accounted for the remaining 43%.
- All reviewed SIDS deaths were categorized as natural (100%). The largest proportion of SUID deaths were undetermined (43%) and the remainder were either accidental (29%) or natural (29%).

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 was one scalding burn death in 2018, and it was a reviewed by a CDRT. The child was an African American female infant under 1 year of age. The manner of death was deemed a homicide.

Sudden Unexplained Child Death (SUCD)

There was one reported SUCD case in 2018, and it was reviewed by a CDRT. The death was a White female child 1 year of age. The manner of death was undetermined.

Other

As implied by this label, 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 2018, four deaths fell in this label and one was reviewed by a CDRT.

Chapter 5: Sudden Unexpected Infant Deaths During Sleep

Since the inception of Illinois Child Death Review Teams in the mid 1990's, the CDR's have reviewed countless deaths of infants that died during sleep. The question arose, why were babies dying while sleeping?

Definition

Sudden Unexpected Infant Deaths During Sleep is the death of an infant less than one year of age that occurs suddenly and unexpectedly while sleeping. This classification captures all the deaths that are certified as unintentional asphyxia. SUID during sleep also encompasses those deaths certified as Undetermined, SIDS and SUID. For all deaths certified as Asphyxia, the sleep environment was unsafe and the infant died because of the unsafe environment. For infants certified with a cause of death of Undetermined, the Medical Examiner/Coroner has assigned that determination for one of several possible reasons including; there were multiple competing causes of death, or the family refused to allow a thorough investigation of the death perhaps by not allowing a doll re-enactment by an investigator (thus hampering the investigation of the death), or because unsafe sleep conditions may have caused the death. The ME/Coroner is essentially stating "maybe the unsafe sleep environment caused death or maybe it didn't."

Background

For many years, infant sleeping deaths were assigned a classification of Sudden Infant Death Syndrome (SIDS). In time, fewer deaths were classified as SIDS and the classification of SUID (Sudden Unexpected Infant Deaths) came into use. Many studies were initiated to determine what was happening to the babies during sleep. Researchers found that an infant's sleep environment was critically important to the safety of the child.[33] The findings upended prevailing beliefs of where and how a baby should sleep. Unknowingly, caretakers were endangering the lives of their babies by simply following what had been done for decades, how their mothers and grandmothers had put a baby to sleep. For years, parents were told to place the baby on their stomach for sleep and to use blankets to keep the baby warm. Pillows, bumper pads and stuffed animals were welcome additions to the sleep environment. If the baby was fussy, comfort the baby in the caretaker's bed. But the studies found that when babies slept alone, in a crib, on their back without pillows, blankets, toys and bumper pads, fewer babies were dying during sleep. The Safe to Sleep (Back to Sleep) Campaign was started to educate the public on safe sleep practices.[34] Bed sharing, sleeping prone, sleeping in an adult bed, the use of blankets, pillows, secondhand smoke, caretaker inebriated or high all became

[33] Kemp, J.S., Unger, B., Wilkins, D., Psara, R.M., Ledbetter, T.L., Graham, M.A., Case, M., & Thach, B.T. (2000). Unsafe sleep practices and an analysis of bedsharing among infants dying suddenly and unexpectedly: Results of a four-year, population-based, death-scene investigation study of sudden infant death syndrome and related deaths, *Pediatrics*, *106*, e41. Retrieved from https://pediatrics-aappublications-org.proxy2.library.illinois.edu/content/106/3/e41.
[34] U.S. Department of Health and Human Services National Institutes of Health (n.d.). *Safe to sleep public education campaign*. Retrieved from https://safetosleep.nichd.nih.gov/activities/campaign.

unsafe sleep conditions. The Safe to Sleep Campaign has had success with educating the public on safe infant sleep. However, traditions and cultural customs are slow to change. There are some professionals that still advocate bedsharing. Many caretakers still sleep with their infants, place the baby on their stomach for sleep and use blankets and pillows. As a sad consequence of unsafe sleep practices, there still are many infants that die during sleep.

A Review of Sudden Unexpected Infant Deaths During Sleep for 2018

Sudden unexpected infant death while sleeping was the **3rd leading cause of death** of children in Illinois in 2018. As recorded by Child Death Review, 139 infants died unexpectedly while sleeping in 2018. The sleep related deaths are represented by sections of the Suffocation, Undetermined, SIDS and SUID categories. Suffocation while sleeping caused the death of 64 infants. Undetermined (while sleeping) category accounted for 65 infants. SUID had 8 infant deaths. SIDS caused 2 infant deaths. A total count of 139 infants results from 64 suffocation + 65 undetermined + 8 SUID + 2 SIDS. This represents 9.94% of the 1398 child deaths of 2018. Each infant sleep death had at least one unsafe sleep condition. Some had multiple unsafe sleep conditions.

Table 6. Summary Statistics and Sleeping Conditions of the 139 Sleep Related Deaths

CAUSE OF DEATH	Number
# of Deaths specified as Suffocation or Asphyxia by Coroner or ME	64
# of Deaths specified as Undetermined by Coroner or ME	65
# of Deaths specified as SUID by Coroner	8
# of Deaths specified as SIDS by Coroner	2
INFANTS DIED WHILE SLEEPING IN 2018 (as reported to Child Death Review Database)	**139**
RACE / ETHNICITY	Number
Black	71
White	51
Hispanic	14
Asian/Oriental	2
Native American	1
GENDER	Number
Male	80
Female	59
LOCATION OF INFANT	Number
Adult Bed	82 (all beds had pillows and blankets)
Couch	14 (5 had a blanket/bedding items)
Crib	11 (9 had a blanket)
Bassinet	8 (3 had a blanket, 4 had a pillow)
Pack n Play	4 (4 had a blanket, 2 had a pillow)
Car Seat	4 (3 with a blanket)
Floor	3 (3 with a blanket)

Air Mattress	2 (2 with bedding)
Bouncer	2
Futon	2 (2 with blanket)
Unknown location	2 (2 with bedding)
Toddler Bed	1 (bedding)
Love Seat	1 (nursing pillow)
Twin Mattress	1 (bedding)
Child Bed	1 (pillow)
Recliner	1
INFANT POSITIONS	
Prone	64
Supine	43
Side	19
Sitting	5
Unknown position	4
Cradled in Arm	2
Crook of Arm	1
Slumped forward – head on chest	1
ALCOHOL OR DRUG USE INVOLVEMENT	
Alcohol or drugs YES	32
Alcohol or drugs NO	103
Alcohol or drugs Unknown if used	4
INFANT SLEEPING ALONE OR WITH OTHERS	
Bed-sharing YES	98
Infant sleeping ALONE	40
Unknown	1
AGE OF INFANT AT DEATH	
Under 1 month	20
1 month	27
2 months	24
3 months	24
4 months	11
5 months	9
6 months	7
7 months	5
8 months	5
9 months	3
10 months	2
11 months	2

Infant Sleep Deaths Reviewed by Child Death Review

In 2018, 131 of the 139 sudden unexpected infant deaths during sleep (94%) were reviewed by Child Death Review Teams. When looking at the total number of reviews of 2018 deaths, 131 of the 285 deaths reviewed by the CDRTs were infant sleep deaths.

- 77 of the 131 reviews were boys (59%); 54 were girls (41%).

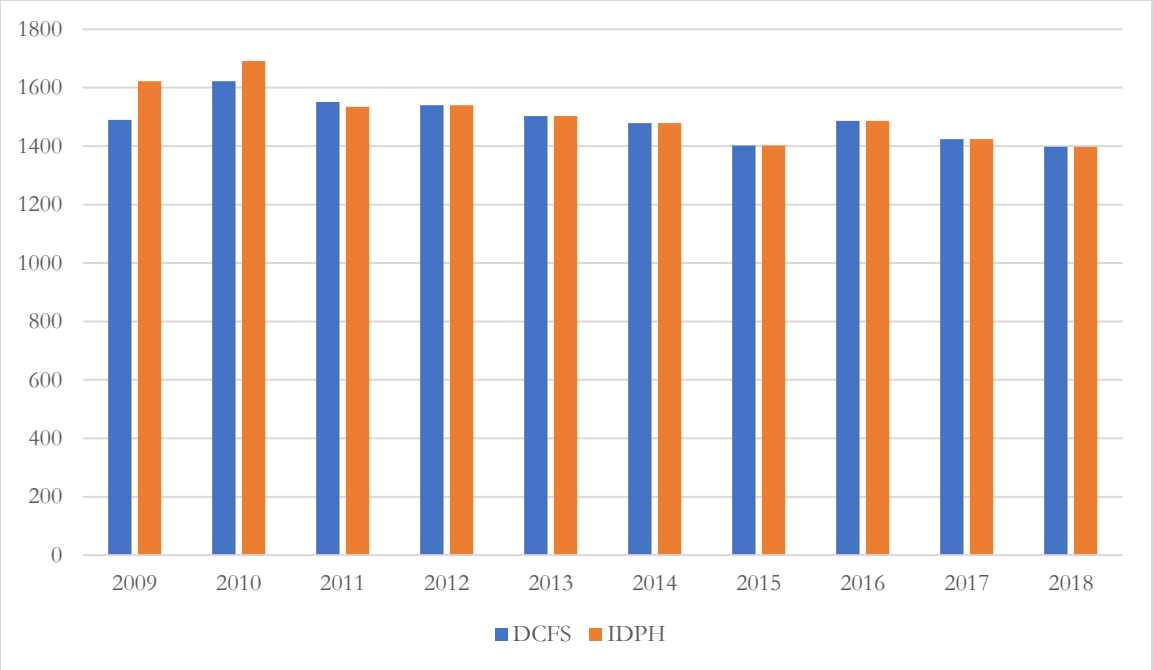
- 47 of the 131 reviews were White children (36%), 70 were African American children (53%), 12 were Hispanic (9%), 1 was Asian (<1%), and 1 was other or unknown race/ethnicity (<1%).

Chapter 6: 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.

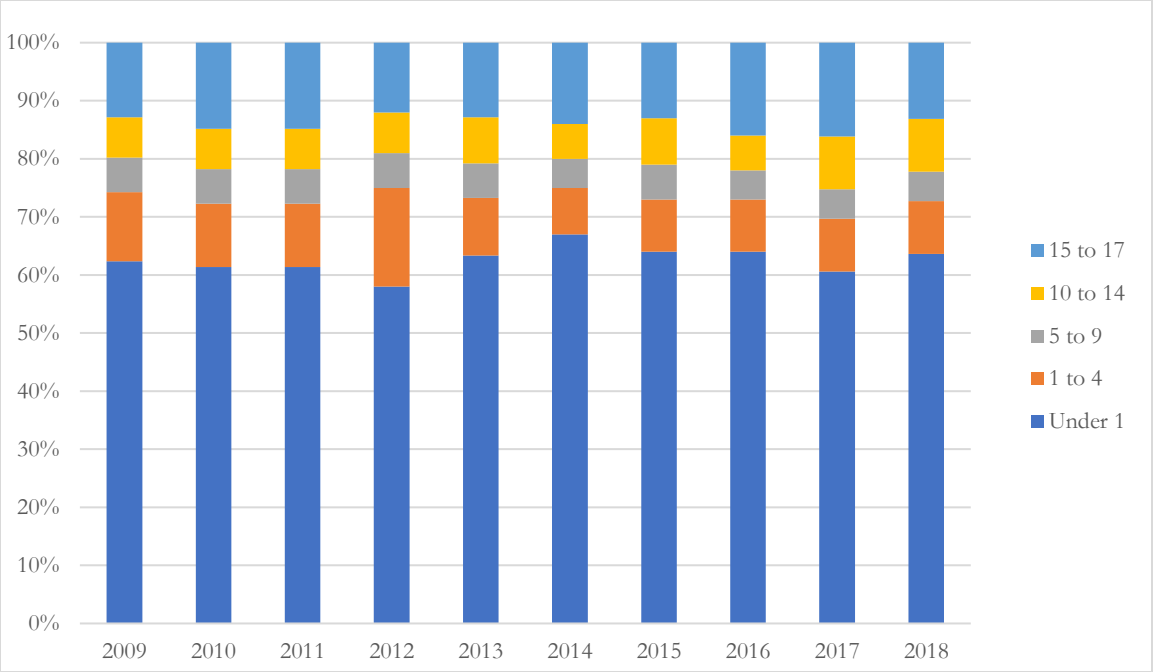
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1,622 (DCFS data) in 2010 to a current low of 1,398 in 2018 (see Figure 33).

Figure 33: Total Child Deaths Reported to DCFS and IDPH, 2009–2018



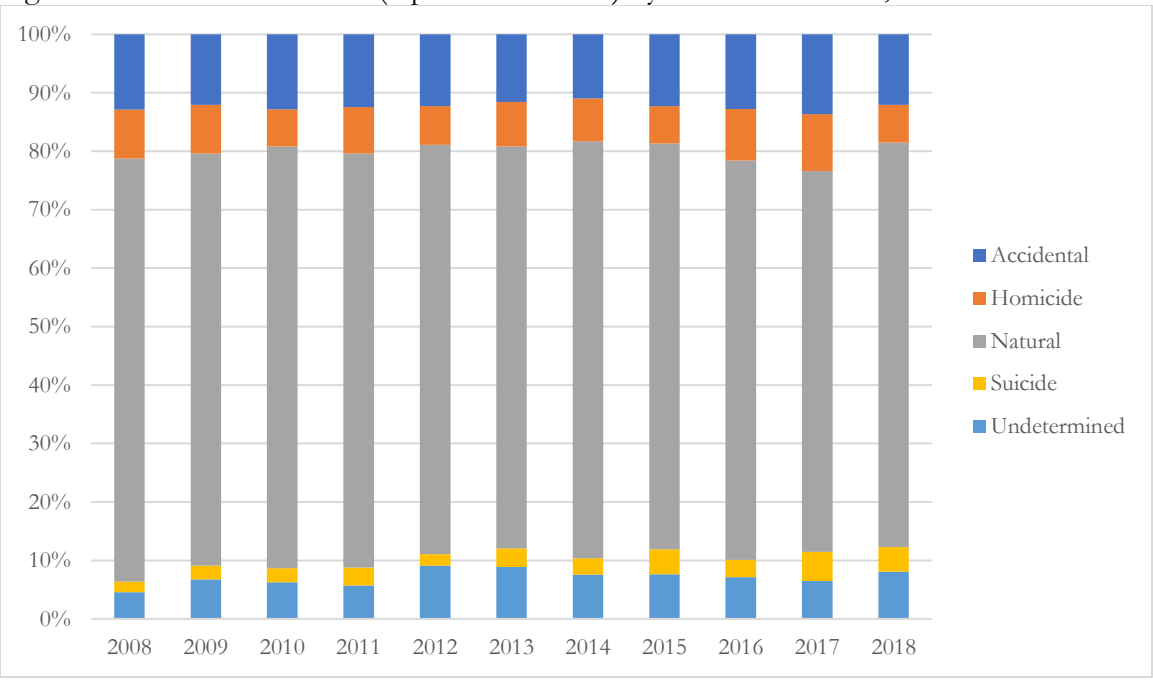
The total child deaths reported to the Child Death Review Team Unit from 2009 to 2018 is broken down by age group in Figure 34. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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, 2009-2018



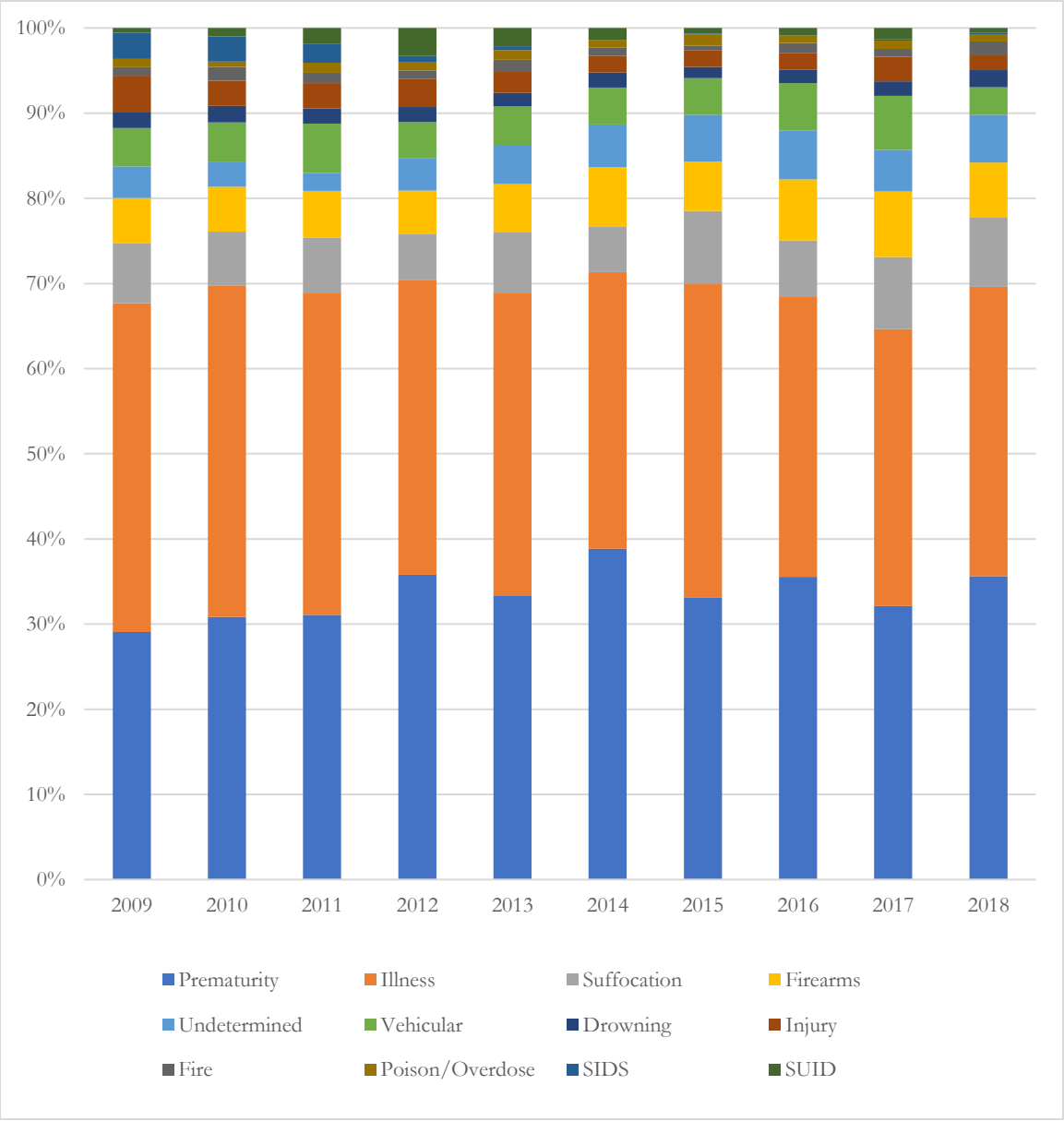
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-14% accidental, 6-10% homicide, 65-72% natural, 2-5% suicide, and 5-9% undetermined (see Figure 35).

Figure 35: Total Child Deaths (reported to DCFS) by Manner of Death, 2009-2018



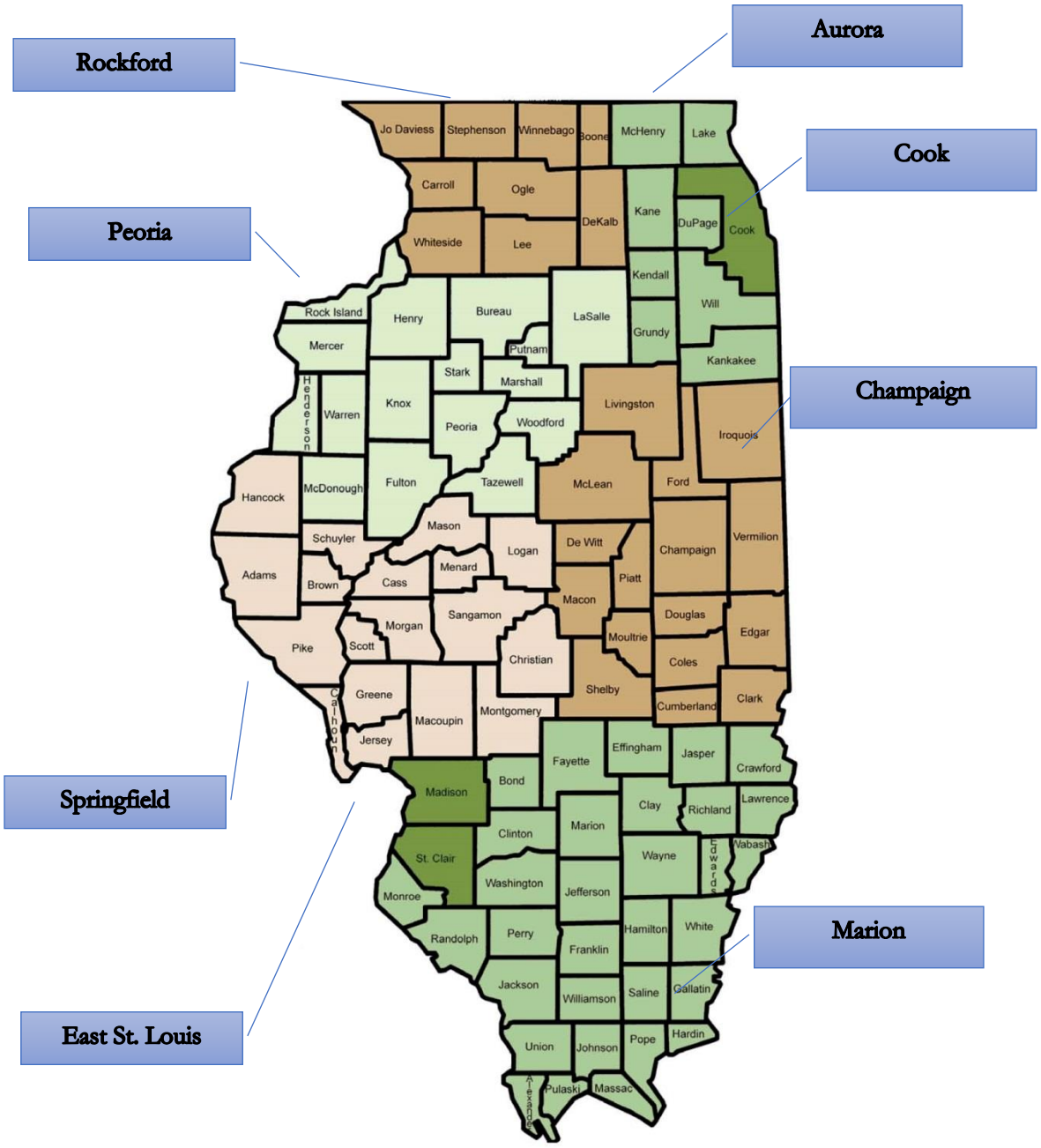
A similar analysis was done for category of death (see Figure 36). The percentage of child deaths related to each category of death across the time period varies. The major categories of deaths from prematurity (29-39%) and illness (32-39%) fluctuated over time. There was an increasing trend for deaths 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 (2-3% from 2009 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, 2009-2018[35]



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

Appendix A – Child Death Review Team Regional Map



Appendix B – List of CDRT Members by Region

Aurora
Mary E. Jones MD, MPH, **Chairperson**
Dan Thomas, **Vice Chairperson**
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

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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
Julie Runyon
Windy Westfall

Cook Team A
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Joan M. Pernecke, **Vice Chairperson**
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Kristen Bilka, MMS, PA-C
Kristine Caraballo
Felicia Clark
Margaret Conway
Anne Devaud
Dr. Kristin Escobar-Alvarenga
Kenneth Fox, MD
Jeana Friday, BSN, RN
Jill Glick, MD

Cook Team A (cont.)
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Mary Henderson
Eileen Payonk, Special Agent
Abbey Mastroianni
Kyran Quinlan, MD, MPH
Karen Pitroda
Char Rivette
Jennifer Seo, MD, JD
Kimberly Souder
Kelley Thornton
Dion Trotter
Syed Zaheer
Virginia Zic-Schlomas, Sgt.
DCFS Staff – Tanya Carriere

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Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Kathy Grzelak, MA, LCPC
Nicole Johnson, MD
Kim King
William Leen, Commander
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Veena Ramaiah, MD
Kevin Scott
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Francis Jones, RN
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James Piper
Sakina Vernor
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Robin Hopper
Lisa Irvin
Jennifer Lindsey
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Joe Murphy
Brittany Pierce
Kathy Swafford, MD
Tammy Turner
Steve Webb, PhD
Sheryl Woodham, MSW, LCSW
DCFS Staff – Bob Cain

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Special Agent Timothy Wilkins, **Vice Chairperson**
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M/Sgt. Gregg M. Cavanaugh
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Brian Gustafson
Umair Iqbal, MD, MPH
Ann Lading-Ferguson
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Mark McLaughlin
Marcy O'Brien
Channing Petrak, MD
Michele Verda, PhD
Melissa Watkins
DCFS Staff – Jim Marmion

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Holly Peifer, **Vice Chairperson**
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Raymond Davis, Jr., MD
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Rebecca Wigget
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Heather Hofferkamp
Rebecca Howard, APRN, CPNP-PC
Denise McCaffrey
Eric Weston, Special Agent
DCFS Staff – Angie Kramp

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

Appendix C – Illinois Child Deaths by County

County	2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths	2014 Deaths	2015 Deaths	2016 Deaths	2017 Deaths	2018 Deaths
	DCFS	IDPH *	DCFS	IDPH *	DCFS	IDPH *	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **	DCFS **
Adams	6	5	6	5	4	3	9	5	9	9	8	6	6
Alexander	1	1	0	2	0	0	1	0	0	0	1	1	0
Bond	0	0	0	1	2	2	4	1	0	2	0	2	0
Boone	3	3	1	1	4	2	3	0	1	0	1	2	2
Brown	0	0	0	0	0	0	1	1	0	0	0	0	0
Bureau	5	5	6	5	1	1	2	1	3	0	2	1	0
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	1
Carroll	1	1	2	2	0	0	1	0	1	0	1	1	0
Cass	0	0	0	0	0	0	1	0	0	0	0	0	0
Champaign	42	36	36	33	43	37	29	49	38	30	45	44	44
Christian	4	4	4	3	3	2	2	1	1	4	2	3	1
Clark	0	0	0	1	2	2	1	3	0	1	1	1	1
Clay	0	0	1	1	0	0	1	1	0	0	3	0	2
Clinton	1	1	3	3	2	1	1	3	0	0	1	3	1
Coles	3	5	5	2	5	6	4	4	4	2	5	6	3
Cook	768	832	887	920	857	824	857	775	815	818	831	766	781
Crawford	0	0	2	1	2	1	4	4	0	1	0	4	1
Cumberland	2	3	2	2	0	0	1	0	0	0	1	0	0
DeKalb	5	3	4	3	5	5	4	9	7	3	6	7	4
Dewitt	2	2	0	0	1	1	0	0	3	1	0	1	3
Douglas	0	0	1	1	1	1	1	0	1	0	1	2	0
DuPage	65	62	89	76	73	68	66	70	80	63	76	56	70
Edgar	0	0	0	0	1	1	1	1	1	2	1	0	2
Edwards	0	0	0	0	0	0	1	0	1	0	0	0	0
Effingham	1	1	0	1	8	7	2	7	5	5	4	3	4
Fayette	0	0	1	0	1	1	0	2	3	1	1	1	0
Ford	1	0	1	1	0	0	1	2	1	0	0	1	1
Franklin	4	4	5	3	2	1	0	2	4	6	3	1	1
Fulton	3	4	4	4	0	0	3	0	0	2	2	2	2
Gallatin	0	0	0	0	0	0	1	0	0	0	0	0	0
Greene	0	0	0	1	0	1	0	0	1	0	0	4	1
Grundy	3	4	5	5	3	2	3	2	1	2	1	3	1
Hamilton	0	0	1	1	1	1	1	2	0	1	2	0	0
Hancock	2	1	0	0	1	1	0	1	3	0	0	1	0
Hardin	0	0	2	2	1	2	1	1	1	1	1	1	1
Henderson	0	1	0	0	0	0	0	0	0	0	0	0	0
Henry	2	3	4	4	4	2	2	3	3	2	5	3	1
Iroquois	0	0	3	3	1	1	1	1	0	0	2	2	2
Jackson	9	8	4	5	8	6	16	2	5	9	4	9	8
Jasper	0	0	2	1	0	0	0	0	0	0	1	0	0
Jefferson	1	1	9	9	7	6	2	6	4	2	4	2	6
Jersey	0	0	1	2	2	3	4	2	0	4	2	3	0
Jo Daviess	0	0	0	0	4	4	0	1	0	0	2	0	0
Johnson	0	2	0	3	0	3	2	0	0	0	0	0	0
Kane	55	53	44	41	45	42	42	42	44	51	46	39	45
Kankakee	5	5	8	8	8	8	12	10	10	6	16	9	13
Kendall	2	2	1	1	1	1	2	3	2	0	0	2	1
Knox	2	2	7	8	10	10	3	4	6	6	6	4	3
Lake	34	47	31	47	35	40	33	37	36	36	34	36	35
LaSalle	7	7	8	9	9	8	11	8	7	11	5	4	7
Lawrence	1	1	6	4	4	2	1	2	0	1	0	1	1
Lee	3	5	1	1	2	2	2	3	3	2	1	6	1
Livingston	2	2	3	3	5	2	3	0	4	2	3	2	2
Logan	6	5	0	0	2	2	3	3	1	0	3	3	1

Macon	15	15	11	10	13	13	7	4	12	11	7	11	7
Macoupin	2	2	2	3	0	0	0	5	4	2	0	2	0
Madison	16	20	15	13	13	11	8	12	14	18	21	18	23
Marion	3	6	3	9	5	9	2	5	5	10	3	4	3
Marshall	3	2	2	1	0	0	0	0	0	1	1	0	0
Mason	0	0	2	1	0	0	0	3	1	2	1	0	0
Massac	4	2	0	0	0	0	2	1	0	1	3	1	1
McDonough	1	2	2	2	1	1	1	2	0	1	0	1	3
McHenry	11	11	7	6	11	9	12	17	9	9	9	11	9
McLean	5	6	9	10	13	12	9	12	13	14	8	11	8
Menard	1	1	1	1	0	0	0	0	0	0	0	0	0
Mercer	0	0	1	1	1	1	2	6	0	1	0	1	2
Monroe	2	2	0	1	1	1	1	1	0	1	0	0	0
Montgomery	1	0	3	3	3	2	1	0	4	2	3	0	2
Morgan	1	1	2	2	0	1	2	3	3	0	2	4	2
Moultrie	0	0	1	1	4	4	1	0	0	0	0	1	0
Ogle	3	3	2	1	1	1	0	0	2	3	0	4	0
Peoria	76	93	81	80	76	75	109	72	82	63	76	83	68
Perry	0	0	4	4	0	0	1	3	2	1	2	0	1
Piatt	0	0	0	0	1	1	1	0	0	0	0	2	0
Pike	0	0	2	2	0	0	0	0	0	0	1	0	3
Pope	0	0	0	0	0	0	1	0	0	0	0	1	0
Pulaski	2	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	2	2	0	0	0	0	0	0	0	1	0	0	1
Randolph	1	1	1	1	1	1	6	7	2	1	3	0	4
Richland	1	1	1	1	2	2	1	1	2	1	2	2	1
Rock Island	18	17	12	9	12	11	11	9	12	8	9	10	8
Saline	4	2	4	3	1	1	3	0	3	3	0	1	5
Sangamon	51	48	46	43	38	46	33	46	39	36	45	38	53
Schuyler	0	0	4	0	6	0	1	1	1	0	0	2	0
Scott	0	2	0	0	0	0	0	2	0	0	1	0	0
Shelby	2	5	1	2	0	0	0	2	0	2	1	2	0
St. Clair	26	28	18	16	18	15	21	31	26	15	15	31	17
Stark	0	0	0	0	0	0	0	0	0	0	0	1	0
Stephenson	4	4	5	4	2	2	1	2	4	3	2	5	5
Tazewell	2	2	2	3	3	2	3	2	7	5	3	6	7
Union	2	2	3	3	1	1	1	2	1	3	0	9	1
Vermillion	13	14	7	6	8	6	11	10	7	4	12	5	5
Wabash	3	2	0	0	0	0	1	0	1	0	1	0	0
Warren	0	1	1	1	1	1	1	1	1	1	1	1	1
Washington	0	0	2	2	1	1	0	1	1	0	1	0	1
Wayne	1	1	1	1	1	1	2	1	1	3	1	0	0
White	1	1	1	1	1	1	1	0	1	0	2	0	0
Whiteside	7	6	3	5	4	3	1	4	3	1	6	3	5
Will	44	47	38	35	28	26	33	34	38	24	36	34	38
Williamson	6	5	5	5	10	9	6	6	13	6	3	5	8
Winnebago	59	48	61	49	51	43	40	36	43	46	59	57	47
Woodford	1	2	2	2	3	3	1	4	1	2	1	0	0
Unknown	18	0	1	0	0	1	0	0	0	0	0	3	0
Out of State	27	81	53	117	46	97	47	81	12	11	12	6	0
Out of country	–	–	–	–	–	–	9	0	0	0	0	0	0
Total	1,490	1,622	1,622	1,692	1,551	1,535	1,540	1,503	1,479	1,402	1487	1424	1398

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

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

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