



ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR
2020



MISSION

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

Illinois Department of
DCFS
Children & Family Services

SUBMITTED TO:

The Honorable JB Pritzker,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

June 2023

March 22, 2023

Dear Readers,

The death of a child is always heartbreaking. When a death occurs that is preventable, it is beyond tragic. Contained in this 2020 Child Death Review Annual Report is data regarding child deaths that unfortunately occurred in the Illinois during the 2020 calendar year.

This report, composed by the Child Death Review Teams, serves as an encomium for every child that has passed.

The Child Death Review Teams (CDRT) reviewed 247 child deaths that occurred in 2020. Many of these deaths were attributed to natural causes, yet others may have been prevented through alternative actions by parents and caretakers, earlier intervention by public and/or private support systems or increased efforts of public safety campaigns.

The Child Death Review Teams work diligently to better comprehend the nature and causations of child deaths to determine how to prevent future occurrences. The nine Child Death Review Teams throughout the state consist of numerous devoted professionals who volunteer their time and expertise. I am extremely appreciative of the invaluable work and the service they provide.

To ensure the safety of the children of Illinois, DCFS thoughtfully reviewed and often implemented the thoughtful recommendations made by the Child Death Review Teams. Together, we continue to work to prevent child deaths in Illinois.

Sincerely,



Marc D. Smith
Director
Illinois DCFS



Illinois Child Death Review Teams

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Executive Director

March 2023

The Honorable J.B. Pritzker, Governor of the State of Illinois:
The Honorable Members of the 103rd General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2020. 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 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.

The vast majority of deaths that we have reviewed this year, as in previous years, have been sleep related deaths. These deaths are all preventable and for this reason we have partnered with DCFS in developing a Safe Sleep Program to reduce these deaths.

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 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
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, with assistance from Bernadette Emery on Chapter 5 that examines infant deaths during sleep.

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Table of Contents

EXECUTIVE SUMMARY	9
Introduction.....	11
Chapter 1: Child Death Review in Illinois	12
Chapter 2: Child Death Review Recommendations to Prevent Child Deaths	19
Chapter 3: Illinois Child Deaths in 2020.....	43
Child Deaths by Gender	43
Child Deaths by Age	44
Child Deaths by Race/Ethnicity	46
Child Deaths by Category	47
Child Deaths by Manner	48
Child Deaths by Category and Manner	49
Special Analysis: Homicide Deaths	50
Chapter 4: Child Deaths by Category	54
Illness	55
Premature Birth	58
Firearms	62
Suffocation	65
Vehicular Accident	69
Undetermined Deaths	73
Injuries	76
Drowning	79
Fire	82
Poisoning/Overdose	84
Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)	86
Uncommon Death Categories	89
Chapter 5: Infant Deaths During Sleep.....	90
Chapter 6: Trends in Illinois Child Deaths.....	94
Appendix A – Child Death Review Team Regional Map	97
Appendix B – List of CDRT Members by Region.....	98
Appendix C – Illinois Child Deaths by County	100

List of Tables

TABLE 1: 2020 ILLINOIS CHILD DEATHS RECOMMENDATIONS AND RESPONSES.....	20
TABLE 2: CHILD DEATHS BY CATEGORY OF DEATH	48
TABLE 3: MANNER OF DEATH – TOTAL CHILD DEATHS REVIEWED BY CDRTS.....	49
TABLE 4: TOTAL CHILD DEATHS-MANNER OF DEATH BY CATEGORY OF DEATH.....	50
TABLE 5: LOCATION AND ENVIRONMENT OF INFANT DEATHS DURING SLEEP.....	93

List of Figures

FIGURE 1: THE CHILD DEATH REVIEW PROCESS IN ILLINOIS	15
FIGURE 2: CHILD DEATH REVIEWS.....	16
FIGURE 3: ILLINOIS CHILD POPULATION, CHILD DEATHS, CDRT-REVIEWED CHILD DEATHS BY GENDER.....	44
FIGURE 4: 2020 ILLINOIS CHILD POPULATION BY AGE.....	45
FIGURE 5: ILLINOIS CHILD DEATHS BY AGE GROUP.....	46
FIGURE 6: ILLINOIS CHILD DEATHS BY RACE/ETHNICITY.....	47
FIGURE 7: MANNER OF DEATH – TOTAL CHILD DEATHS VERSUS DEATHS REVIEWED BY CDRTS... ..	49
FIGURE 8: CHILD DEATHS DUE TO ILLNESS	55
FIGURE 9: CHILD DEATHS DUE TO ILLNESS BY AGE.....	57
FIGURE 10: CHILD DEATHS DUE TO ILLNESS BY RACE/ETHNICITY.....	58
FIGURE 11: CHILD DEATHS DUE TO PREMATUREITY.....	59
FIGURE 12: CHILD DEATHS DUE TO PREMATUREITY BY RACE/ETHNICITY	60
FIGURE 13: CHILD DEATHS DUE TO FIREARMS	62
FIGURE 14: CHILD DEATHS DUE TO FIREARMS BY AGE.....	64
FIGURE 15: CHILD DEATHS DUE TO FIREARMS BY RACE/ETHNICITY	64
FIGURE 16: CHILD DEATHS DUE TO SUFFOCATION.....	66
FIGURE 17: CHILD DEATHS DUE TO SUFFOCATION BY AGE	67
FIGURE 18: CHILD DEATHS DUE TO SUFFOCATION BY RACE/ETHNICITY	68
FIGURE 19: CHILD DEATHS DUE TO VEHICULAR ACCIDENTS.....	70
FIGURE 20: CHILD DEATHS DUE TO VEHICULAR ACCIDENTS BY AGE.....	71
FIGURE 21: CHILD DEATHS DUE TO VEHICULAR ACCIDENTS BY RACE/ETHNICITY.....	72
FIGURE 22: CHILD DEATHS WITH UNDETERMINED CAUSE OF DEATH.....	73
FIGURE 23: CHILD DEATHS WITH UNDETERMINED CAUSE BY RACE/ETHNICITY.....	74
FIGURE 24: CHILD DEATH DUE TO INJURIES.....	77
FIGURE 25: CHILD DEATHS DUE TO INJURIES BY AGE.....	78
FIGURE 26: CHILD DEATHS DUE TO INJURIES BY RACE/ETHNICITY	78
FIGURE 27: CHILD DEATHS DUE TO DROWNING	79
FIGURE 28: CHILD DEATHS DUE TO DROWNING BY AGE.....	80
FIGURE 29: CHILD DEATHS DUE TO DROWNING BY RACE/ETHNICITY.....	81
FIGURE 30: CHILD DEATHS DUE TO FIRE	82
FIGURE 31: CHILD DEATHS DUE TO POISONING/OVERDOSE.....	84
FIGURE 32: CHILD DEATHS DUE TO SIDS AND SUID.....	87
FIGURE 33: INFANT SLEEP CAUSE OF DEATH.....	91
FIGURE 34: DEATHS BY INFANT AGE.....	92
FIGURE 35: DEATHS BY INFANT SLEEP POSITION.....	93
FIGURE 36: TOTAL CHILD DEATHS REPORTED TO DCFS AND IDPH, 2011–2020	94

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 2020

In 2020, 1,202 children under 18 died in Illinois.¹ This number represents the death information received by DCFS as of April 4, 2022.

Of the total child deaths reported to CDRTs in 2020:

- 59% were boys, 41% were girls, and less than 1% were unknown sex;
- 57% were infants under one year, 10% were young children between 1 and 4 years, 16% were older children between 5 and 14 years, and 17% were youth between 15 and 17 years;
- 44% were White, 37% were Black, 16% were Hispanic, 2% were Asian, and less than 1% were of other or unknown racial/ethnic origin.

When Illinois child deaths in 2020 were examined by the manner of death:

- 63% were attributable to natural causes;
- 15% were accidental;
- 9% were homicides;
- 5% were suicides;
- 7% were undetermined;
- less than 1% were pending.

When deaths occurring in 2020 were examined by the category of death:

- 32% were related to illness;
- 31% were related to premature birth;
- 1% were related to Sudden Unexpected Infant Death (SUID);
- 30% were related to various types of injuries, such as firearms (8%), suffocations (7%), vehicular accidents (7%), drowning (2%), fire (2%), poisoning/overdose (1%), other types of injuries (3%), and less than 1% were pending;
- 5% were due to undetermined causes.

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

2020 Child Deaths Reviewed by the CDRTs

In 2020, 247 child deaths were reviewed by the CDRTs, consisting of 154 mandatory and 93 discretionary reviews. The mandatory reviews occurred for one of several reasons: 92 were indicated death cases, 36 cases had an investigation within the year of the child's death, 19 were indicated investigations, and 5 were DCFS youth in care, and 2 were pending DCFS investigation at the time of death.

Reviewed deaths in 2020 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 186 deaths (17%) were reviewed.
- Champaign – 18 of the 65 deaths (28%) were reviewed.
- Cook – 93 of the 622 deaths (15%) were reviewed.
- East St. Louis – 12 of the 32 deaths 38% were reviewed.
- Marion – 16 of the 41 deaths (39%) were reviewed.
- Peoria – 30 of the 109 deaths (28%) were reviewed.
- Rockford – 22 of the 67 deaths (33%) were reviewed.
- Springfield – 13 of the 68 deaths (19%) were reviewed.
- Out of State – 11 of the 12 deaths (92%) were reviewed.

Of the deaths reviewed by CDRTs in 2020:

- 65% were boys and 35% were girls;
- 48% were infants under 1, 18% were young children between 1 and 4 years, 21% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years.

When reviewed deaths occurring in 2020 were examined by manner of death:

- 39% were attributed to accidents;
- 20% were due to natural causes;
- 15% were homicides;
- 5% were suicides;
- 20% were undetermined.

When reviewed deaths occurring in 2020 were examined by category of death:

- 1% were related to premature birth;
- 19% were related to illness;
- 4% were related to SUID;
- 58% were related to various types of injuries, such as suffocations (21%), firearms (8%), vehicular accidents (7%) drowning (6%), poisoning/overdose (4%), fire (3%), and other types of injuries (8%);
- 18% were due to undetermined causes.

Introduction

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations and safety policies that have led to a decline in infant and child mortality, too many children are still dying. In 2020, there were 1,202 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;
- contribute to initiatives to improve public awareness of issues that affect the safety and well-being of children;

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

- collect data that will inform efforts to reduce child fatalities; and
- keep the governor and legislature apprised of the 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 2021, 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 2020 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.
- Due to COVID-19 there was no Annual Child Death Review Teams Symposium.

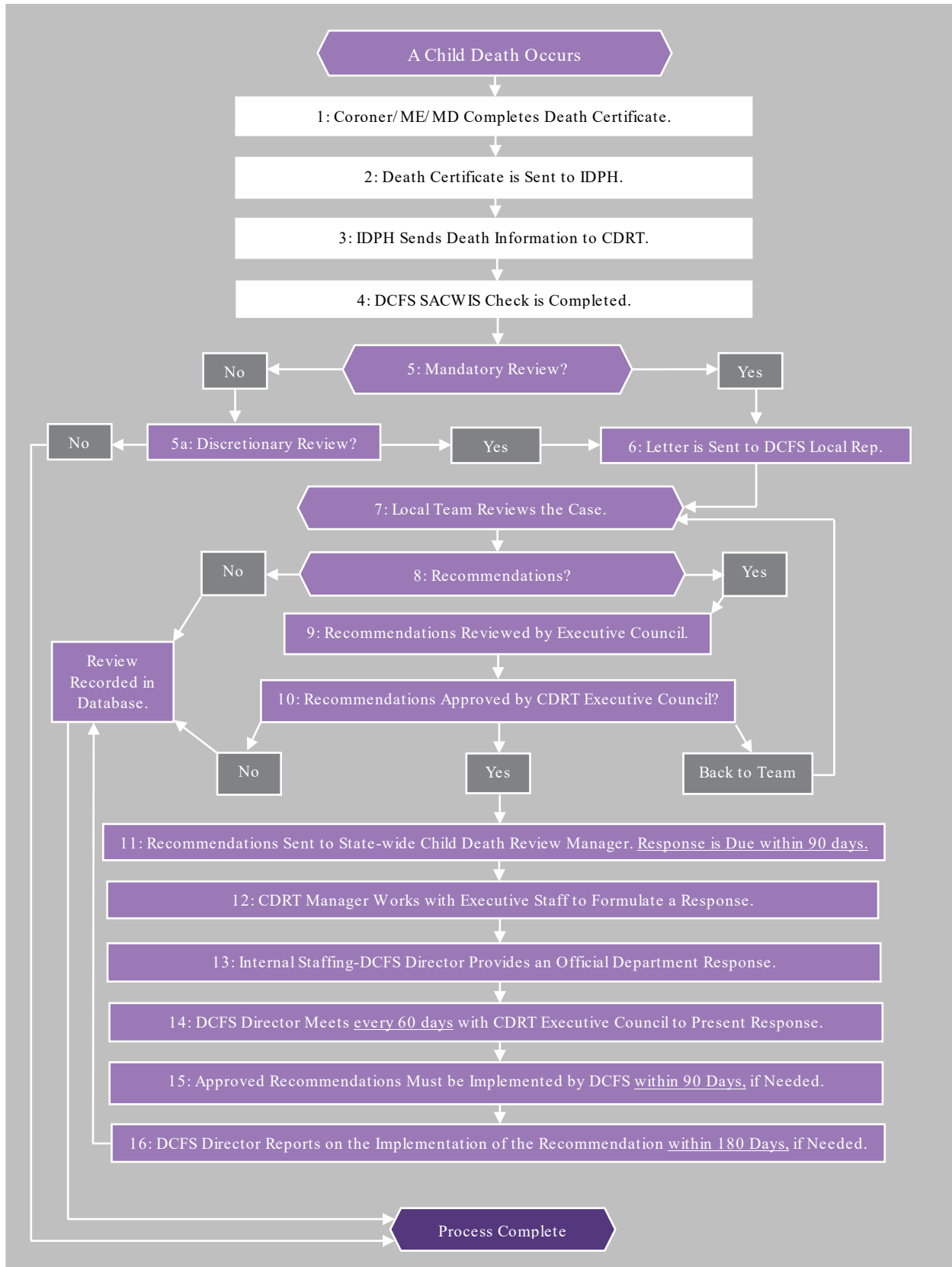
DCFS Roles and Responsibilities

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

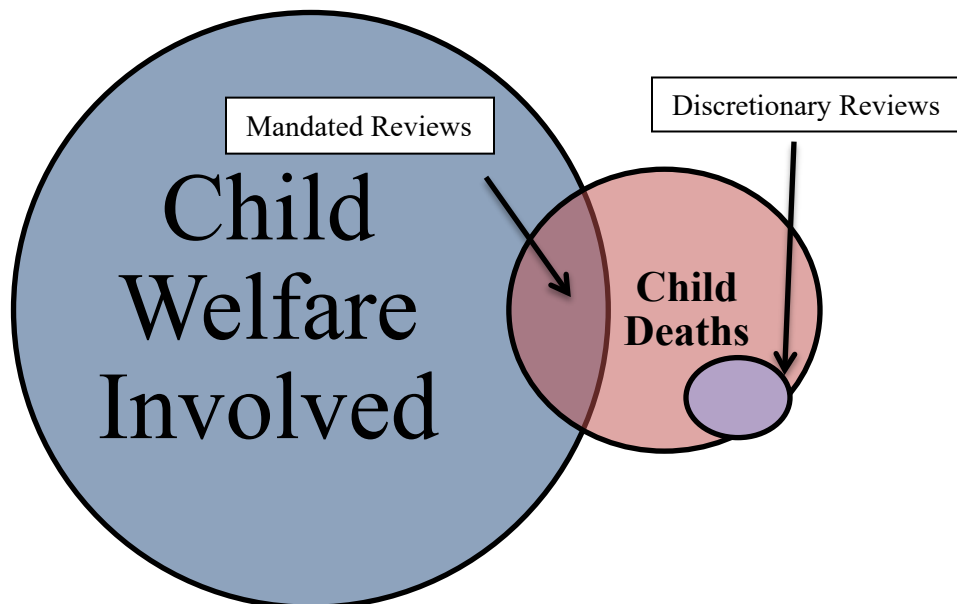


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the information to the Illinois Department of Public Health (IDPH). IDPH provides this information to the Illinois Department of Healthcare and Family Services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

³ In addition to mandated reviews and discretionary reviews, CDRTs can 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 CDRT or other local multidisciplinary team may 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 2019.

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

Confidentiality of CDRT Information

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

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

Chapter 2: Child Death Review

Recommendations to Prevent Child Deaths

The purpose of CDRT recommendations is to prevent or reduce future child fatalities through reasonable means. The importance of CDRT recommendations—and their potential for preventing future child deaths—cannot be overstated. The DCFS director is required by the Child Death Review Act to respond to CDRT recommendations within 90 days.

There are four types of CDRT recommendations, although some recommendations will include elements of more than one type:

- Case-specific – immediate actions which must be taken on a specific child welfare case; usually related to siblings of the deceased or other children still in the home
- Primary prevention – focus on public awareness or public education issues (e.g., drowning prevention, firearm safety, seat belt/car seat campaigns)
- DCFS system – focus on the programs, policies and procedures of DCFS (e.g., safety and risk assessment, foster parent training)
- Other agency/system – focus on agencies or systems outside the parameter of DCFS (e.g., public health, state’s attorney’s office)

In 2020, there were 1,202 Illinois child deaths reported to Child Death Review. Child Death Review Teams reviewed 233 of these 1,202 child deaths. Sixty-eight recommendations were made by CDRT’s on 55 of the 233 child death cases reviewed. Of the 68 recommendations, there were 15 recommendations which focused on DCFS policy and procedures. The DCFS recommendations resulted from four types of reviews including: death indicated (5), investigation within a year of death (1), youth in care (2) and discretionary (7). There were seven recommendations related to other agencies or systems. These recommendations came from three types of reviews including death indicated (4), indicated report at time of death (1) and discretionary (2). There were 46 case specific recommendations from five types of reviews: 21 recommendations resulted from cases where death was indicated, 3 recommendations resulted from cases that had an indicated report at time of death, 14 were from discretionary reviews, 5 were from cases that had an investigation within a year of death and 3 recommendations resulted from youth in care cases. There were no primary prevention recommendations made on 2020 child deaths.

Table Key:

DCFS = DCFS recommendation

PP = Primary Prevention recommendation

CS = Case-specific recommendation

Other = Other System recommendation

Table 1: 2020 Illinois Child Deaths Recommendations and Responses

Type of Recommendation	Recommendation	Response
DCFS	DCFS work to amend ANCRA to include in the list of Mandated Reporters, under Sec. 2 (Social Service Personnel or Sec. 3 (Crisis Shelter Personnel) “staff or volunteer staff of any homeless shelter, Domestic Violence shelter, or other shelter or Halfway House.” This should also be added to Policy Guide 2020.08	<p>The Department agrees with the recommendation to amend ANCRA to include in the list of Mandated Reporters, under Sec. 2 (Social Service Personnel or Sec. 3 category of Crisis Shelter Personnel) “staff or volunteer staff of any homeless shelter, Domestic Violence shelter, or other shelter or Halfway House” and add this to Policy Guide 2020.08. We also acknowledge that domestic violence program personnel are already listed as Mandated Reporters under 325 ILCS Section 4a(3)”.</p> <p>The Department has taken steps to make this legislative change. This has been approved by the Governor’s Office and is scheduled to be addressed in the Spring Legislative Session.</p>
DCFS	DCFS staff should be reminded to do person searches on SACWIS for every adult caregiver in the home.	Pending waiting to be scheduled for review.
DCFS	Placement and Intact workers should have additional training to help identify suspicious bruises or injuries and when to determine that further medical evaluation is needed of the type and quality provided by University of Chicago Hospital MPEEC programming; 2) DCFS to review this case with the involved staff and how it was handled. 3)DCFS should use their existing “undetermined” category in situations when a family or necessary witnesses cannot be located, when needed records are unavailable, when the passage of time would have allowed injuries to heal or witness coaching to occur, or when the investigator otherwise cannot gather enough evidence to truly make an “unfounded” determination. DCFS has previously indicated that they cannot keep an	Waiting to be scheduled with the Director.

	<p>investigation open indefinitely. Therefore, they should utilize the “Undetermined” category in a 2nd manner which would be used in situations like this where there is unverified information. This would be an Undetermined/Closed rather than the current Undetermined category where extensions are granted and the case is kept open to gather additional information.</p>	
DCFS	<p>DCFS to work with the parole board to set up a system by which the parole board checks with DCFS prior to a parolee’s release to make sure that the residence is not a foster home. If the home is foster home, DCFS should flag the case to assess the home situation immediately to determine if it’s safe for the children in the home to be living with the parolee. In situations where the parolee is not permitted to be in the home, foster care workers and licensing workers should be notified so that they can check to see if the parolee frequents the home.</p>	<p>DCFS Disagrees. There are safety assessments built in the licensing process to do background check of all adults and other eligible members in the family composition. The licensee is required by administrative rule to contact their licensing representative when there are changes to the household composition before additions to the household are made. These changes in family compositions are immediately assessed and if there are violations of rules, it can be subjected to sanctions up to and including revocation of license.</p> <p>Also, all convictions are assessed to determine the eligibility for a license per statute and rules. If a process is not covered and supported by the rules and statutes, it is not enforceable and are grounds for appeal. This new proposed recommendation is not covered by statute and or rules.</p> <p>The Illinois Child Care Act and federal law outlines lifetime criminal bars to foster home licensure, as well as other convictions that can be assessed for a waiver once 10 years has passed since the date of conviction. These legal requirements would bar the vast majority of parolees from being approved for being paroled to a licensed foster home.</p> <p>Implementing such a recommendation is a logistical challenge that DCFS cannot commit to. Therefore, DCFS will not be implementing this recommendation.</p>
DCFS	<p>Complex medical issues should require a referral to the DCFS nurse.</p>	<p>Complex cases are currently to be referred to the DCFS Nursing Division</p>

		per Procedure. The Deputy of Child Protection receives a report with allegation 79 (Medical Neglect) and requires that RAs and AAs review these to provide direction on the specific case (i.e., nursing referrals, DSCC involvement).
DCFS	DCFS to consider an entry level case assistant to work with caseworkers to support them in a variety of ways but especially in providing in person visits to ensure relative caregivers are only providing supervised visits to parents as allowed by DCFS or the courts.	DCFS agrees and is in the process of developing a Program Plan for Family Enhancement Workers to provide assistance to staff and families. These workers will not be assigned to every team but will be assigned to help with safety assessments and other case activities. They will be assigned on some higher risk cases, including when a child in the family is in foster care and a child remains in the home of the parent.
DCFS	DCFS to amend any current site safety or scene investigation checklists to include checking for video surveillance cameras or other recording devices, both public and private.	DCFS agrees that primary evidence should be gathered whenever possible. The circumstances of each case will guide the best practice of gathering both public and private video footage. At the in-person DCP meeting, staff will be reminded to check for surveillance systems, limited where the incident occurred, during the course of their investigation.
DCFS	The Department to establish a standardized marijuana intoxication level to use in their assessment of child safety. Executive Council researched whether Illinois has codified the amount of THC that would make a person "under the influence" in civil or criminal court. 625 ILCS 5/11-501.2(a)(6). The limits are 5 nanograms of THC per ml. of blood, or 10 nanograms of THC per ml. of other bodily fluid (urine or saliva).	Child Protection Specialists gather evidence of the alleged perpetrator's ability to care for the child victim during the time that they are in a caregiver role. The presence of THC in the system at the time of testing, while invaluable in our assessment, does not alone speak to the ability to care for the child during the time of the alleged incident. While this is valuable information to obtain, it is challenging to determine the exact levels at the time of the incident unless testing is done at that time. Unless the testing is done immediately, this then falls under Hearsay Evidence and is less useful in making a finding due to THC intoxication. Sometimes exact levels cannot be used but a care takers history of drug/alcohol use or abuse does speak to the risk factors that are present. The Department will continue to support child protection specialists to assess the parenting capacity of alleged

		<p>perpetrators by gathering all evidence (TCH levels included) regarding the environment of the child.</p> <p>There was the question as to whether or not the 5 nanograms of THC per liter of blood should be written into policy. Currently, the .08 blood alcohol level used to determine alcohol intoxication is not written into Procedure. The Department understands the point Executive Council makes but this does not need to be written into procedure. The Department will communicate to staff the point that 5 nanograms of THC per liter of blood is legally considered to be the intoxication level.</p>
DCFS	The Department to explore expanding resources to workers given the pandemic.	DCFS agrees that the pandemic has added additional stressors on staff and will continue to reinforce the need for additional support to address secondary trauma. The Department continues to utilize management staff, clinical staff, and EAP to provide ongoing support to staff.
DCFS	<p>The hotline should take reports for risk of harm when there are mental health concerns (particularly when there is a history of suicide or suicidal ideation) and the parent/caretaker is not taking proper measures to address the risk (i.e., locking up guns, medications, etc.).</p> <p>Given the current climate and added stressors to families and teens, this issue should be stressed with hotline staff.</p>	<p>DCFS agrees. The hotline does take reports for risk of harm when there are mental health concerns, and the parent/caretaker is not taking proper measures to address the risk.</p> <p>The Call Floor staff are required to document the following protocol questions and the response of the caller/online reporter in every intake:</p> <p>Question 1: Is the reporter aware of domestic violence in the home?</p> <p>Question 2: Is the reporter aware of current or prior substance involving the reported participants?</p> <p>Question 3: Is the reporter aware of mental health concerns, diagnoses or mental health treatment for the involved participants?</p> <p>Question 4: Does the reporter have knowledge of prior DCFS involvement for the involved participants?</p> <p>Question 5: Does the reporter have knowledge of any involved participant needing interpreter services?</p>

		<p>Question 6: Does the reporter have knowledge of any involved participant who has a disability?</p> <p>Question 7: Does the reporter have knowledge of any involved participant with Native American ancestry?</p> <p>Question 8: Does the reporter have knowledge of a prior family history of a child death?</p> <p>Question 9: Does the reporter have knowledge of prior contact with law enforcement for any of the involved participants?</p> <p>Question 10: Does the reporter have knowledge of the positive supports who provide assistance to the involved participants?</p> <p>Question 11: Does the reporter have knowledge of any safety concerns (i.e., guns, vicious animals, gang activity, etc.)?</p> <p>The answers provided by the reporter to the protocol questions are a part of the thorough clinical assessment completed by the Call Floor staff. Questions 3 and 6 focus on mental health and disabilities. Question 11 specifically addresses safety concerns and guns, vicious animals are examples used.</p> <p>The Department has stressed with Call Floor Staff, that there are increased mental health stressors on children and parents with the pandemic and other societal tensions.</p>
DCFS	DCFS to discuss the enforceability of administrative subpoenas with the Attorney General to require agencies to comply with such subpoenas.	<p>Administrative subpoenas are only enforceable by seeking a court order in circuit court. In order to seek enforcement of an administrative subpoena DCFS would have to send a request for representation to the Attorney General's office with the legal justification for enforcement of an administrative subpoena. These requests are reviewed by the Attorney General's office on a case-by-case basis to determine if there is an appropriate legal basis to seek court intervention.</p> <p>When staff encounter barriers to gathering information on investigations, they should consult with DCFS legal.</p>

		Further, the Administrative Subpoena process will be shared with all CP staff during upcoming statewide meetings in July and August and documented in meeting minutes.
DCFS	DCFS should seek formal agreements with bordering counties and/or states in order to better coordinate investigations and services.	DCFS agrees to look at this further and will refer this matter to the Workgroup currently working to revise Procedures 300. The Department will seek to add direction to staff when such barriers arise. This will be addressed at the next Statewide DCP leadership meeting.
DCFS	As a policy, DCFS should keep medical neglect cases involving medically complex children open until all recommended medical follow up has occurred or when there is a clear and consistent pattern that the parents are following up on all needed medical care. The primary care physician and any specialists should determine if a clear and consistent pattern has been established.	Waiting to be scheduled with the Director
DCFS	DCFS should conduct a training on the investigation of Medical Neglect cases. CDRT will assist with preparing this training.	Waiting to be scheduled with the Director
Other	Write a letter to Salvation Army shelter to encourage the reporting to the hotline when the shelter has been made aware of children in danger.	Exec Co agrees and letter was written and sent to the shelter. Letter sent 7/20/20
Other	Send a letter to Salvation Army shelter regarding the importance of calling the hotline when the shelter is made aware of danger to children.	Exec Co approves, letter written and sent to the shelter. Letter sent 7/20/20
Other	The team to write a letter to the primary care physician regarding the failure to fully understand and report medical neglect.	Executive Council agreed. CDRT will compose the letter and send to the primary care physician. Letter sent 5/25/21
Other	Team to draft a letter to medical providers to help educate providers on how to access cribs or other safe sleep equipment for parents/infants needing them.	Approved. Letter sent 1/25/21
Other	There are some opportunities for prevention. People on the boat should know how to swim. CPS has made some efforts to promote swimming for all students. This case should be forwarded	Approved. Letter sent 9/20/20

	to CPS to support swimming lessons in schools.	
Other	Team to write a letter to the police and ME about calling in all child deaths.	Approved. Letter sent.
Other	Team to send a letter to the school reminding about the need to call reports in.	Approved. Letter sent.
CS	DCFS to label this case as an egregious acts case based the prior history in Indiana.	The Integrated Assessment did recommend referring this case to legal to consider expedited termination. The Department will consult with the agency to determine next steps.
CS	Team to write a letter to Indiana Child Welfare Services as they should have given notification to Illinois that the family had moved here.	Team will compose a letter. Letter sent 5/25/20
CS	DCFS to send a commendation letter to the worker for their thorough work on this case.	DCFS agrees and has commended the worker for the excellent work on the case.
CS	DCFS to review the handling of the service case from January 2018 to August 2018 as it does not appear that the dad completed all services, and he may have not been fully equipped to care for his kids. These dynamics could be used as a learning experience for the involved staff.	<p>DCFS will work with the private agency to obtain the closed file, Court reports and Court orders regarding services provided to the father. In addition, information related to the Court granting custody of the child to the father, after the death of the mother will be reviewed, to determine what services were completed at the time of closure. Upon review of the prior cases, it will be assessed if there are any learning areas to explore with the agency.</p> <p>The Department continues to recognize the importance of aftercare services when children are returned to their parents' home. Current practice (Policy Transmittal 2020.21) mandates the full 6 months of aftercare be provided when children return home. In this case the monitoring was for a 2-month period before the closure of the Court case. However, currently if the Court case closes, this cooperation of services is voluntary. There were no subsequent investigations, from 2018-2020, after the return home until the death. It is noted that the father was not the perpetrator in the homicide—it was a paramour that became involved with the family after the juvenile court case was closed and the POS agency was no longer involved with the family. Based upon our review</p>

		of the case and the timeline of events we do not feel the agency could have necessarily predicted what eventually occurred or that any change in how the original case was handled at the end by the court and involved parties would have prevented the death. However, completion of services or provision services focused on recognizing red flags/signs of abuse for the primary caretaker may have provided additional skills and protective capacity which may have allowed the father to respond differently to warning signs on prior incidents of injury.
CS	The investigation team should be commended for their work. There was great work and collaboration for all involved.	DCFS agrees and has commended the investigators for their great work.
CS	There should be concerted efforts to conduct a forensic interview on surviving children in the home at the time. Staff should be reminded to pursue these in any death investigation when the children are developmentally available. There should have been attempts to have the forensic interview done out of state once the children moved to Texas.	DCFS agrees. This will be addressed at the 5/27/21 In-Person DCP meeting.
CS	This case should be looked at as to why it was not indicated for medical neglect.	DCFS agrees and will review this case further.
CS	DCFS to commend the worker on this case for their excellent work and documentation.	The Department agrees and will commend the employee for her excellent work and documentation. Drafting a “joint” letter from DCFS (signed by the Director) and CDRT (signed by the Chairperson) may be a good way to address staff commendations moving forward.
CS	DCFS to review this case and how it was handled after the 2018 indicated case and multiple out-of-state cases. Many red flags were noted during both the A and B sequence, but not followed up on and fully assessed. The 2018 case could have been referred to intact or perhaps screened in, maybe for an Order of Protection. This B case should have been indicated and screened in.	DCFS agrees and will review this case as an educational opportunity for the involved staff.

CS	Commend the supervisor for putting the thorough summary of DCFS history in the file and for close oversight on this case.	The Department agrees and will commend the supervisor for the work done on this case.
CS	DCFS to review this case with the involved staff as a learning opportunity. There should be clear documentation that relative caretakers are spoken to about the need to follow the visitation plan, especially when there is to be only supervised contact.	DCFS agrees and has already met with the agency at the time of the incident and reviewed critical factors that were identified in the case.
CS	DCFS to review the A sequence as a learning opportunity as it appears that the case should have been indicated and referred for services.	The Department agrees and will review this matter as a learning opportunity for the involved staff. This matter has been sent to the RA and AA to meet with staff for discussion and review.
CS	DCFS to review the case regarding the worker following through to notify Indiana CP officials to investigate the child of the uncle and his paramour, given the fact that, although it was not determined who shot the gun, it belonged to the uncle's paramour and they were neglectful in not keeping children protected from it.	DCFS agrees and will review the case with the involved staff as a learning opportunity.
CS	DCFS should review the A sequence investigation as an educational opportunity for staff in that: i. The nature of the Hotline call (mom having a black eye caused by her boyfriend, mom citing domestic violence and feeling unsafe with the boyfriend and the need to involve hospital security because of the boyfriend's violent behavior) is such that the case probably should have been taken as an "Action Needed". By the time the case was sent to the field, the mom and baby had been discharged from the hospital, back home with the abusive boyfriend. The report did come in on-line, but it is unclear if the reporter had first attempted to call the hotline and did not get through. ii. CDRT would like detailed information on how the Appeals process is conducted - what statutes or procedures govern? Who makes the decisions, based on what evidence, who presents the evidence, etc.? The Indicated finding on this case was overturned despite what appears to be	DCFS agrees and the SCR Administrator will handle this. Administrative Hearing Process DCFS is mandated by federal regulations to have a process by which individuals who are indicated for child abuse and/or neglect can administratively appeal the indicated finding The law in Illinois mandates that during an investigation, an investigator must gather and consider all evidence, both inculpatory and exculpatory, and make a decision to indicate a case based on the requirements of the specific DCFS allegation that is indicated after a determination that credible evidence exists. At an administrative appeal hearing, Illinois law requires that DCFS prove its case by a preponderance of the evidence.

	<p>clear evidence of ongoing domestic violence between the mom and her boyfriend, as well as between the boyfriend and another woman as well. We would also like to have someone from the Appeals unit present at the next Annual CDRT Symposium so we can understand the process better. This matter should be discussed further with the staff handling the appeal on this case.</p>	<p>The law also recognizes that individuals whose names are placed on the State Central Register as perpetrators of child abuse and/or neglect have certain rights —such as a liberty interest in pursuing the career of their choice and a liberty interest in being with family members.</p> <p>There are specific time frames set forth in the DCFS administrative rules for expungement hearings. The final administrative decision must be issued within 90 calendar days of the receipt of the appeal, not counting any continuances requested by the appellant or agreed to by both parties.</p> <p>The Illinois Supreme Court has held that DCFS must strictly adhere to the 90-day time frame for cases indicated under the credible evidence standard.</p> <p>The Illinois Appellate Court has held that the two purposes to the Abused and Neglected Child Reporting Act, 325 ILCS 5/1 et seq. (ANCRA), are to protect abused children and to protect any person erroneously accused of abuse, noting that many provisions of ANCRA are designed to protect alleged perpetrators of child abuse and/or neglect from the damaging effects of erroneous or false reports.</p> <p>Allegation 60 – Environment Injurious to Health and Welfare</p> <p>Allegation 60, Environment Injurious to Health and Welfare, has been the subject of significant litigation in the past.</p> <p>In 2013, in <i>Julie Q. v. Illinois Department of Children and Family Services</i>, the Illinois Supreme Court found that Allegation 60 was void after the words “environment injurious” were removed from the definition of neglected child in ANCRA. Subsequent litigation alleged that DCFS failed to follow the Administrative Procedures Act and re-promulgate Allegation 60 after the Julie Q. decision. All of this</p>
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		<p>litigation resulted in a revised Allegation 60 with specific evidentiary requirements, including the addition of the statutorily mandated language for blatant disregard.</p> <p>Amendments to ANCRA included a statutory definition of blatant disregard, which is defined as “an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm.” 325 ILCS 5/3.</p> <p>The revised Allegation 60 also contains additional requirements and is now defined as:</p> <p>Environment injurious means that a child’s environment creates a likelihood of harm to the child’s health, physical well-being or welfare and that the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities [325 ILCS 5/3]. This allegation shall be used when the type or extent of harm is undefined but the totality of circumstances, including inculpatory and exculpatory evidence, leads a reasonable person to believe that the child’s environment may likely cause harm to the child’s health, physical well-being or welfare due to the parent’s or caretaker’s blatant disregard. Blatant disregard is defined as an incident where the real, significant and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm [325 ILCS 5/3]. This allegation of harm shall also be used when there are conditions that create a real, significant and imminent likelihood of harm to the child’s health, well-being or welfare (i.e., domestic violence,</p>
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		<p>intimidation, or a child’s participation in a criminal act) and the parent or caretaker blatantly disregarded his/her parental responsibility by failing to exercise reasonable precautionary measures to prevent or mitigate the imminent risk of moderate to severe harm.</p> <p>With respect to allegations involving domestic violence, the revised Allegation 60 provides the following, among other things:</p> <ul style="list-style-type: none"> • An incident of past or current domestic violence may qualify for an Allegation 60 if the domestic violence creates a real, significant and imminent risk of moderate to severe harm to the child’s health, physical well-being or welfare and the parent or caregiver has failed to exercise precautionary measures to prevent or mitigate the risk of harm to the child. • The adult victim of domestic violence, who is the non-offending parent or caregiver, is presumed not to be neglectful or to have created an environment injurious to the child so long as he or she has exercised precautionary measures to prevent or mitigate the real, significant and imminent risk of moderate to severe harm to the child. <p>Other factors to consider include:</p> <ul style="list-style-type: none"> • The child’s age • The child’s medical condition, behavioral, mental or emotional problems, developmental disability or physical handicap, particularly related to his or her ability to protect himself or herself; • The severity of the occurrence; • The frequency of the occurrence; • The alleged perpetrator’s physical, mental and emotional abilities, particularly related to his or her ability to control his or her actions;
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		<ul style="list-style-type: none"> • The dynamics of the relationship between the alleged perpetrator and the child; • The alleged perpetrator’s access to the child; • The previous history of indicated abuse or neglect; • The current stresses or crisis in the home; • The presence of other supporting persons in the home; and • The precautionary measures exercised by a parent or caregiver to protect the child from harm. <p>In order to indicate an investigation for Allegation 60, an investigator should have evidence of a likelihood of harm to a child’s health, physical well-being or welfare; and evidence that the likely harm to the child was a result of a blatant disregard of parent or caregiver. Where the allegation is based on domestic violence, there must be evidence that the incident of domestic violence at issue in the investigation created a real, significant and imminent risk of moderate to severe harm to the child. In addition, there is a presumption that the non-offending parent or caregiver is not neglectful if they exercised precautionary measures to prevent or mitigate the real, significant and imminent risk of moderate to severe harm to the child.</p> <p>Appeal Process and Review of Cases by DCFS Legal and Division of Child Protection</p> <p>Once an appeal is filed, the investigation is assigned to an attorney from the DCFS Office of Legal Services. At the appeal stage, the case must be proven by a preponderance of evidence, which is a legal standard higher than credible evidence. DCFS bears the burden of proof at the administrative hearing.</p> <p>Attorneys review the investigations upon assignment to determine that there is admissible evidence for all of the</p>
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		<p>elements required by the specific allegation that is being indicated and that the case can be proven by a preponderance of the evidence. If the attorney does not believe they can meet the evidentiary burden at the administrative hearing, they may write up the case and request a review by high-level child protection and legal staff. A joint decision (child protection and legal) is made to voluntarily unfound the case based upon this review.</p> <p>For Allegation 60, the Department must prove, at a minimum, by a preponderance of evidence:</p> <ol style="list-style-type: none"> 1. A child’s environment created a likelihood of moderate to severe harm; 2. An incident of suspected neglect; 3. Real, significant and imminent risk obvious to a reasonable parent; and 4. That the parent did not take precautionary measures to mitigate the risk and protect that child from harm. <p>DCFS is open to presenting at the Annual Symposium and requests some specific information on what the Executive Council would like addressed. April Discussion: Executive Council appreciates the detailed response regarding this matter and stressed that there was a significant history of domestic violence regarding this family. The higher burden of proof at the appeal level is different than most states.</p> <p>The Executive Council would like to see additional procedures, Administrative Rule and case law related to this matter. DCFS stated that the Dupuy Consent Decree was one example related to this. The Department will provide additional material for the next meeting.</p> <p>There is some risk in seeking a change regarding this in that the current Credible Evidence burden currently used for indicating cases might then be raised to Preponderance of Evidence level</p>
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		which is the burden at the appeal level. This would lead to fewer indicated cases and leave more children at risk.
CS	Investigators should be commended for their excellent work on these cases.	DCFS agrees and will commend the investigators for their excellent work on these cases.
CS	DCFS to review the case in that: a) the treating physician was not interviewed on the D sequence; b) there should have been a referral to the CAC for a forensic interview on the D sequence. Staff should be reminded of the critical need to conduct forensic interviews; c) the workers seemed to minimize the condition of the home in the sequences prior to the death; and d) many family risk factors were overlooked.	DCFS agrees and will review this case with the involved staff by May 31st. The Department recently implemented a process by which all cases involving Medical Neglect Allegation are reviewed on a weekly basis by Management to provide direction and to seek the involvement of DCFS Nursing staff as needed. The Department is also working closely with DSCC, training staff to reach out to them on all medically complex cases. DSCC leadership has presented to Child Protection, and we plan to make this a routine part of our Child Protection agenda with our child protection supervisors.
CS	DCFS to review the case as a learning opportunity for the involved staff.	DCFS agrees and will review this case with the involved staff.
CS	DCFS to review the case as an educational opportunity as perhaps the case should have been indicated due to the history of domestic violence.	The Department agrees and will review this matter as a learning opportunity for the involved staff. This matter has been sent to the RA and AA to meet with staff for discussion and review.
CS	Team to write a letter to the head of the Southern Illinois Child Death Investigative Task Force asking that he reach out to the Pulaski Co. State's Attorney, sheriff and coroner to discuss utilizing the Task Force in child death investigations. A letter should also go to the coroner to remind that office to call in all child deaths (regardless if abuse or neglect is suspected) into the DCFS hotline.	Approved. Letter sent
CS	ME to have a quick turn around on drug testing and see if there are any "fast track" option for cases when there are surviving children. Team to send a letter to the Cook Co. ME's office.	This was discussed with the ME CDRT members at the July 2021 meeting.
CS	DCFS to review the case with the involved staff for educational/discussion purposes.	Waiting to be scheduled with the Director

CS	DCFS to commend the worker for her good work on this case and her thorough investigation	DCFS agrees and will commend the employee for her good work on this case.
CS	DCFS to commend the investigator for his preparation and work on this case.	DCFS agrees and will commend the investigator for his preparation and work on the case.
CS	<p>DCFS to review the case and how it was handled as an educational opportunity for the involved staff. The following summary describes the concerns of the Team:</p> <p>In a case where the death occurred in July 2020, DCP relied on a previous CAPS consult/opinion from November 2019. There were several additional factors to consider in July that were not present 9 months prior (i.e., significant weight loss, several missed appts, no scheduled g-tube surgery as recommended). Critical medical information regarding the minor's medical condition and the impact of missed appointments during the time period after the November CAPS consult was not obtained or analyzed. The CAPS MD was not called about their prior opinion, despite using that opinion as the main reason to unfound the case. This information would have showed that the minor suffered medical neglect after November 2019. The FTT allegation should have been indicated and a medical neglect allegation added.</p> <p>Additionally, DCP was not able to state what the child's medical condition was which greatly impacted this case. The worker did state that there were concerns of Failure to Thrive but was unaware of the medical diagnoses or condition(s) that led to the Failure to Thrive. Knowing the actual diagnoses is critical (Failure to Thrive is not a diagnosis). This clearly demonstrates a lack of medical knowledge on the part of the worker which should have prompted a referral to the DCFS Nursing Team for a more in-depth assessment of the medical issues."</p>	DCFS agrees and will review this case as an educational opportunity for the involved staff.
CS	Department to review case and how it was handled, in that: 1) The notes about	DCFS agrees and will review this with the involved staff.

	<p>minor’s prior suicidal statements were not followed up on by the mother, or by the Investigator; 2) The cousin’s observations of minor taking her shoelaces out of shoes and saying she was going to tie them around her neck was not followed up on by Investigator (was this unusual? Any other observations, etc.); 3) Mother not speaking to, or even looking in on, or checking on her 13-year-old daughter for 24 hours (6:30 p.m.-6:08 pm the next day) was not considered at all. Per mother, she didn’t see her daughter for that entire period; and 4) Mother gave different explanations of why she finally checked minor’s closet—a feeling; then a smell; then she saw closet light on.</p> <p>Based on re-evaluating these pieces, it is possible that mother should have been indicated.</p>	
CS	The Department should commend the investigator for his work and thorough presentation.	The Department agrees and will commend the investigator for his outstanding work.
CS	Commend the employee for a very good investigation and very professional presentation to the team.	The Department agrees and will commend the investigator for her work.
CS	The worker did a great job on this case and in her presentation. The worker should be commended for her excellent work.	DCFS agrees and will commend the worker for her great work on this case.
CS	<p>DCFS look at this case and how it was handled, in that:</p> <p>a. The B sequence should have been indicated; there were well documented repeated failures by the mother to get her son the needed medical and dental care during 2019 and 2020. The record shows the C sequence came in on 3/13/20. The 4/22/20 contact notes with 2 separate medical professionals state that the child had oral surgery on 2/28/20 but it is unclear whether he got the needed neurological follow-up.</p> <p>b. A DCFS Nursing referral was done on the B Sequence, but there was no real plan to make sure that mom followed up needed medical care, including neurology, orthopedics</p>	Waiting to be scheduled with the Director.

	<p>and dental. This child was in ongoing dental pain for months. A doctor opined that “for sure this was medical neglect.”</p> <p>c. Mom accepted Intact during the B investigation but once it was unfounded, she refused to continue. Cases should not be Unfounded when there is credible evidence to support the allegation. Simply promising to change behavior in the future does not negate the prior Blatant Disregard.</p> <p>d. Medical neglect should not need a doctor’s opinion to Indicate; when the factors in Allegation 79 objectively exist, it doesn’t require a doctor’s opinion. In the B sequence, there was clear evidence of mom's ongoing failure to get this minor the needed medical or dental care. Further, as soon as the case was Unfounded, she stopped Intact services. For example, there is documentation that there was complete noncompliance with needed medical care; that medications were available to help the minor with severe condition, but family "wasn't interested", etc. There can and should be an assessment of the factors laid out in Allegation 79, resulting in either an Indication or Unfounding, without an M.D.s input; at a minimum, there are many other health professionals now involved in the assessment of these cases —Nurses, Nurse Practitioners, Physician's Assistants. Their opinion should also be sought and accepted.</p>	
CS	DCFS to review the case and how it was handled, in that the case wasn’t indicated against the mom due to her inability or unwillingness to protect the child, given that her boyfriend had been abusive to the mom. There were prior injuries in various stages of healing and mom lied about how long she was gone, and where she went, indicating some guilt.	DCFS agrees and has reviewed this matter with the involved staff. The vulnerability of children in domestic violence was highlighted in this case. In some situations, parents are criminally charged with failure to protect their children.
CS	Team to send a letter to the medical providers on the C sequence to do a morbidity and mortality review as there may have been more that could have been done in their assessment.	Executive Council approves. Letter sent by the team. Letter sent 3/19/21
CS	DCFS to review this case further to discuss with the involved staff how the	DCFS agrees and has reviewed this matter with the involved staff.

	case was handled to serve as a learning opportunity for staff.	
CS	DCFS to review the case and how it was handled in that: 1) mom did not follow through on the earlier order of protection or seek criminal charges; 2) mom did not respond in a protective manner; and 3) the case contained several documentation errors.	The Department agrees and will review these matters with the involved staff.
CS	DCFS to review the case and how it was handled in that the older stepbrother was not questioned in detail. Why was it not indicated since the gun was not secured?	This case was reviewed by Child Protection leadership and the Crisis Intervention Team at the time of the death and was discussed with the assigned staff. Child Protection leadership has since discussed specifically the value in having an in-depth interview with the victim's 25-year-old brother.
CS	DCFS to review the case in that: a) there is no Critical Decision documented in SACWIS regarding actions needed following the birth of the infant while his sibling was still in foster care; b) The hotline should have been called when the infant was born since his older sibling was in foster care and the parents only had supervised contact with that sibling; and c) whenever another child is born to a family that has children in foster care, the hotline should be called and the matter should be investigated.	<p>DCFS reviewed this with the involved staff and the issues covered were documenting critical decisions in SACWIS and actions needed following the birth of a child when sibling is in foster care. The treating physician was contacted, and he cited no concerns. The hotline should have been called when the second child was born. The worker will need to follow policy and procedure regarding documentation. The worker will monitor and provide monthly contact when a youth is in the care of their parent(s) when sibling(s) are in foster care.</p> <p>When youth are in the care of parents while sibling(s) are in foster care, the hotline normal protocol should be followed. DCFS shall monitor and provide monthly contact as a minimum requirement in these situations. When a child is born into a family that has an open service case, the supervisor should assess the situation further and make a critical decision as to the next steps. Such critical decisions must be documented in SACWIS. In some of these situations, a hotline call is warranted and should be made by the worker. This process should be incorporated into policy within the next 2 months.</p>

CS	DCFS to commend the investigator for her good work on the case.	DCFS agrees and the employee was commended for her good work on the case.
CS	Team to send a letter to the foster parent commending them.	Approved. Letter sent.
CS	DCFS to review the A and B sequences in that: 1. The child's medical complexities played a factor in these cases, but were not fully investigated; 2. The medical providers should have been contacted and medical records obtained; 3. The Investigators treated the child's medical complexities as a reason that the parents were not at fault, instead of the reason that the parents should have taken extra caution; 4. Medical neglect allegations should have been added to the death investigation and both the A and B sequences should have been indicated.	DCFS agrees and will review this case further. AA's currently review all death cases prior to case closing. Any disagreements or changes to the finding are to be discussed with staff.
CS	Recommendation(s): a. DCFS should look at how this case was handled in that: i. Father was completely uncooperative with services and was repeatedly physically abusive in-front of the children; ii. Children were left in mother's care despite not protecting them by repeatedly reentering into the relationship with a physically abusive partner and not getting an order of protection; iii. Children were repeatedly exposed to domestic violence as an ongoing and frequent issue; iv. Mother repeatedly violated the safety plan exposing herself and the children to potential harm; 1. She violated her OP for herself with abuser; 2. She never got OP for the children; 3. She repeatedly violated safety plan and lied about it; 4. She divulged the address of the domestic violence shelter to the abuser, resulting in her dismissal from the shelter;	The Regional Administrator for Central Region did a paper review of this case on 10/25/2021 regarding recommendation A. A staffing regarding lessons learned and practice issues will be completed with the worker, agency management, APT and intact administrator once the OIG has finished its review. The following is a response to OIG recommendation B by DCFS Agency Performance Team: APT agrees with the recommendation and upon completion of the OIG review and recommendations the Department will have a discussion with the caseworker on assessment of service needs and closure assessment.

	<p>v. Mother has a prior indicated abuse report;</p> <p>vi. Father has a history of domestic violence and prior assault conviction;</p> <p>vii. Ongoing drug abuse by both parents with methamphetamines;</p> <p>viii. Mother was dismissed by contract agency from intact services because of violation of service plans despite serious ongoing issues. (presenters reported she had exhausted their services);</p> <p>ix. Photos show laceration on forehead of child not mentioned in notes Sequence E, F;</p> <p>x. Photo shows what looks like a human bite mark on child not mentioned Sequence E;</p> <p>xi. Photo reveals what looks like a rash on other child Sequence E not mentioned in notes;</p> <p>xii. Case should have been referred for Area Administrator review and possible referral to State’s Attorney</p> <p>b. DCFS should review how the contract agency managed this case.</p> <p>i. Intact services agency simply discontinued services as there were ongoing issues and mother had exhausted their services because of repeated lapses and violations of the service plan;</p> <p>ii. Agency needed to communicate with DCFS about the need to discontinue services and ongoing problems which should have resulted in a review by the Area Administrator.</p>	
CS	<p>In a case involving a specialized foster mother who failed to fill necessary prescriptions related to the deceased’s heart condition post-transplant, was observed to have poor bonding with the deceased prior to death, and who is also adoptive mother to another child with a special medical condition related to organ transplant, DCFS should cease placement of foster children in her home, regardless of the outcome of the appeal to the indicated finding.</p>	<p>Denial of license is subject to due process including an opportunity to correct the violation of licensing standards. If there is a finding of violation of licensing standards and there is a failure to correct such, a denial of license may occur. Even then, the foster parents have appeal rights and can present their case. If the DCP investigation is unfounded or thrown out in appeal, we cannot use it as reasons for denial of license.</p>

		<p>As a result of the GAL complaint, an involuntary hold was placed on the foster home on 10/26/20. This foster parent surrendered her license on 3/10/21.</p> <p>The licensing supervisor confirmed that a licensing investigation was initiated; however, the foster parent was uncooperative and she voluntarily surrendered her license.</p> <p>Due to the foster parent surrendering her licensing while there is a hold on her home, she would need to wait 5 years to reapply as a Quality Care Concerns Applicant. Below is the section of the Child Care Act that addresses this.</p> <p>(225 ILCS 10/6) (from Ch. 23, par. 2216)</p> <p style="text-align: center;">Sec. 6.</p> <p>(d) If a foster family home license (i) is revoked, (ii) is surrendered for cause, or (iii) expires or is surrendered with either certain types of involuntary placement holds in place or while a licensing or child abuse or neglect investigation is pending, or if the Department refuses to renew a foster home license, the foster home may not reapply for a license before the expiration of 5 years following the Department's action or following the expiration or surrender of the license.</p>
CS	The team to write a letter to the local police explaining the gravity of the situation and encourage them to look at this case further and review the law so they can respond differently in the future and ensure the children are safe.	Approved.
CS	The Department should commend the investigator for her devotion and hard work on such a challenging and emotional case.	DCFS agrees and will commend the employee for her hard work and devotion.
CS	DCFS to commend the worker for her good work on the case.	DCFS agrees and will commend the employee for her work on this case.
CS	The team should write a letter to Missouri DCFS asking that they review this case as a learning opportunity.	The Executive Council agrees and a letter will be sent to the Missouri DCFS concerning this case. Letter sent.
CS	The team should refer this case to the Missouri Child Death Review Teams	Agreed.

	asking that they review this case further as one of their discretionary reviews.	
CS	Pair this case with that of a case from the Rockford team as this situation further demonstrates the need for improved collaboration across State lines.	DCFS agrees to look at this further and will refer this matter to the Workgroup currently working to revise Procedures 300. The Department will seek to add direction to staff when such barriers arise. This will be addressed at the next Statewide DCP leadership meeting.

Chapter 3: Illinois Child Deaths in 2020

What do we know about the child deaths that occurred in Illinois during 2020?

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/ethnicity 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 (62% in 2020) 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 Black 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:

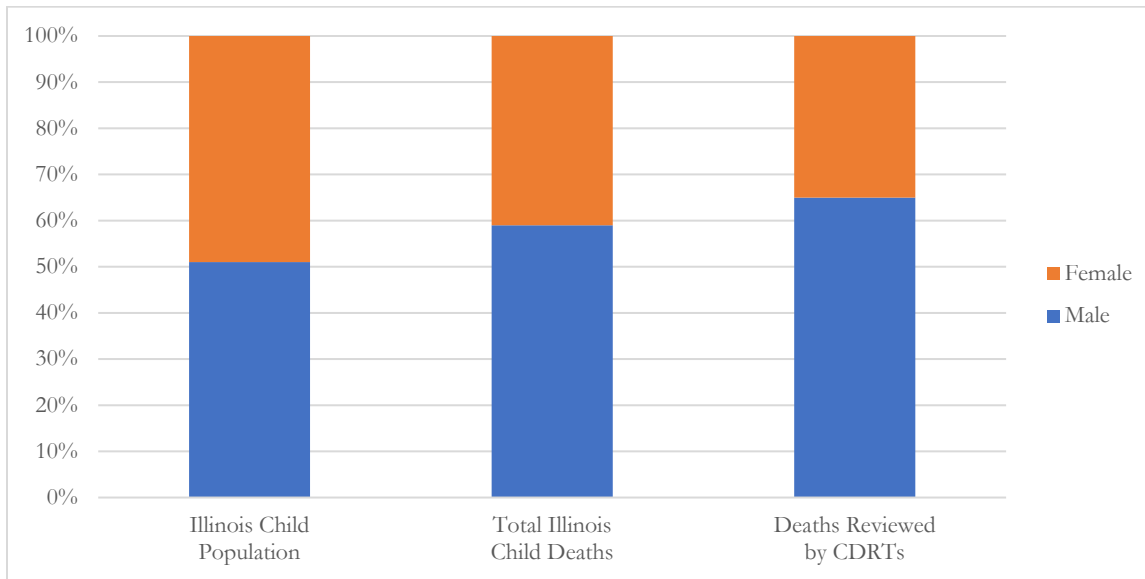
- The population of Illinois children was based on the 2020 Census estimates. According to the Census data, there were approximately 2.85 million children under the age of 18 in Illinois, which constituted about 22.2% of the total Illinois population.⁴
- In 2020, there were 1,202 child deaths reported to the Illinois CDRT database. This included deaths due to all causes, preventable and non-preventable.
- The CDRTs reviewed 247 child deaths that occurred in 2020: 154 of these were mandated for review and 93 were discretionary reviews.

Child Deaths by Gender

According to information from the Census estimates, 51% of the Illinois child population is male and 49% is female. Boys are more likely to die than girls based on CDRTs data: boys made up 59% of total child deaths and 65% of reviewed deaths in 2020 (see Figure 3).

⁴ U.S. Census Bureau. (2022). American Community Survey: Children Characteristics. Retrieved from <https://data.census.gov/cedsci/>

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

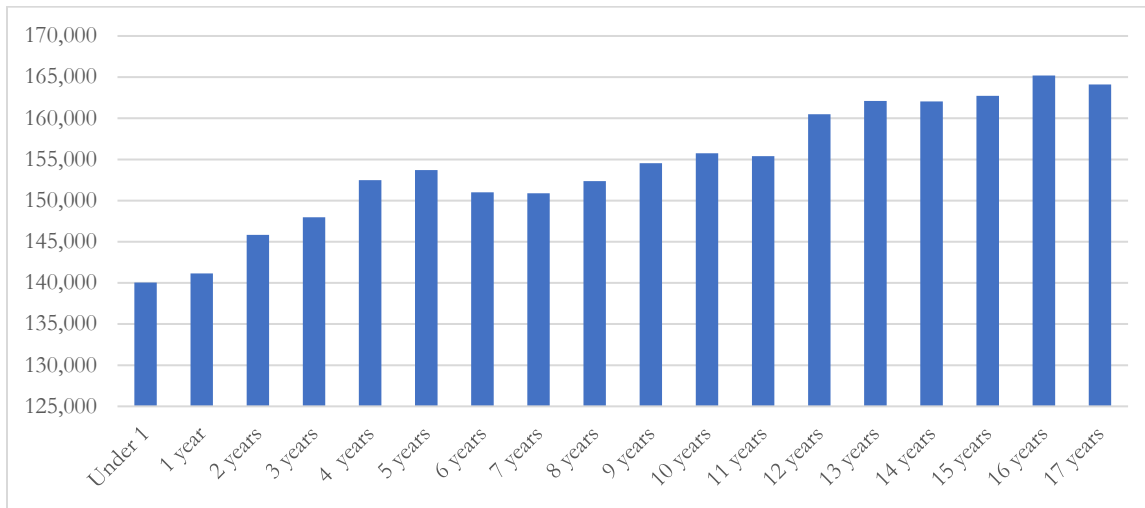


Child Deaths by Age

In 2020, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 2.85 million children in Illinois under 18 years of age, 5% were less than one year, 21% were between 1 and 4 years, 27% were between 5 and 9 years, 29% were between 10 and 14 years and 18% were between 15 and 17 years.⁵

⁵ U.S. Census Bureau. (2022). State population by characteristic: 2010-2020. Retrieved from <https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-state-detail.html>

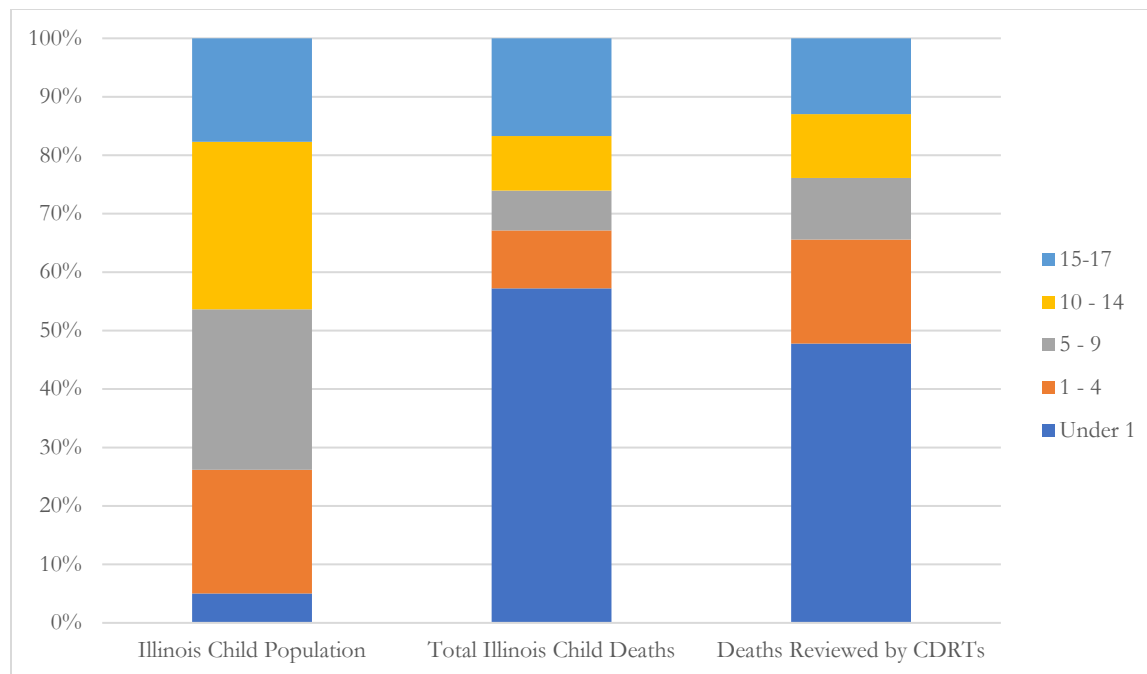
Figure 4: 2020 Illinois Child Population by Age



However, when we examine the total of Illinois child deaths reported to CDRTs by age (see Figure 5), infants less than one-year-old are especially vulnerable—57% of the total deaths in 2020 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). In 2020, 10% of the total deaths were children between 1 and 4 years, 7% were children between 5 and 9 years, 9% were children between 10 and 14 years, and 17% 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 comprised 48% of reviewed deaths in 2020. Children between 1 and 4 years make up 18% of reviewed deaths in 2020. Older children make up a smaller portion of reviewed deaths: 11% were for children aged 5 to 9 years old, 11% were for children aged 10 to 14 and 13% were for children aged 15 to 17. The Disproportionality Index for deaths of youth under age 1 is 11.4 and for reviewed deaths it is 9.6.

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race/Ethnicity

In 2020, 64% of children in Illinois were White, 15% were Black, 5% were Asian and the remaining 16% were of other races/ethnicities (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, Black, Hispanic, Asian, and Other/Unknown.

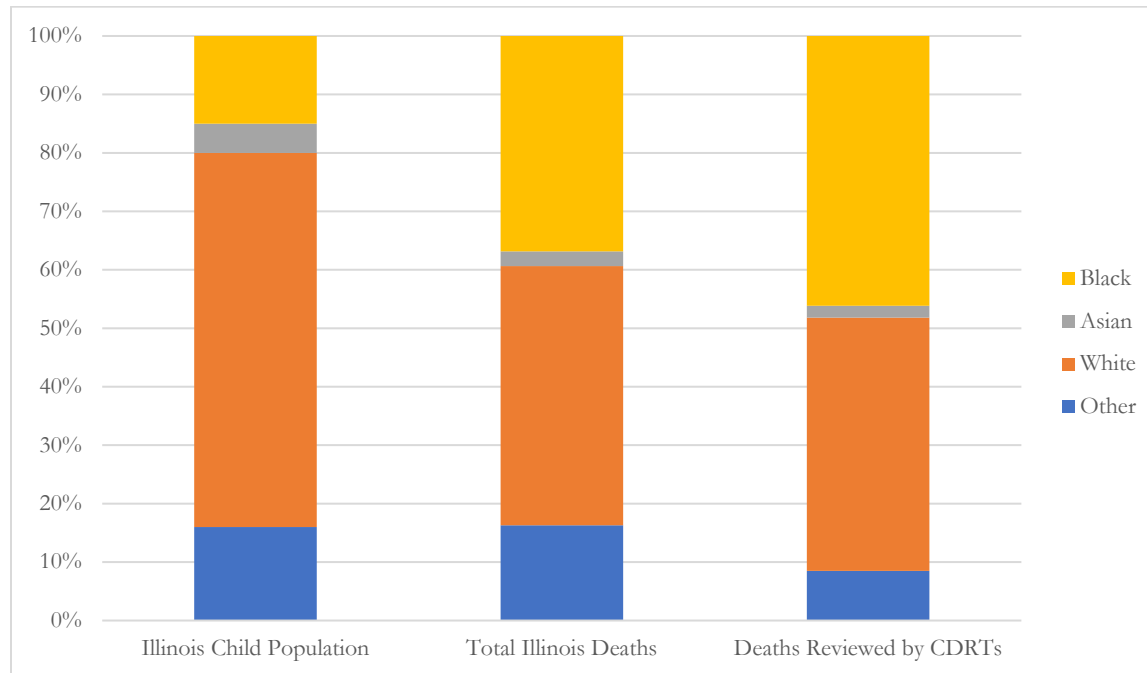
When we examine the total Illinois child deaths by race, it is evident that Black children are at higher risk of death when compared to children in the general population: 37% of the children that died in 2020 were Black, yet they only comprise 15% in the general child population. The proportion of deaths among White children (44%) was lower when compared with their proportion in the general child population (64%). Asian children made up less than 3% of deaths, and children of other race/ethnicity accounted for 16% of child deaths.

Among the 247 child deaths reviewed by the CDRTs in 2020, 46% were Black children, which is larger than their proportion in the overall child population (15%). White children, Asian children,

⁶ U.S. Census Bureau. (2022). 2020: ACS 5-Year Estimates Subject Tables. Retrieved from <https://data.census.gov/cedsci/table?q=children%20under%2018%20illinois&tid=ACSST5Y2020.S0901>

and child of other race/ethnicity made up 43%, 2%, and 9% of reviewed deaths, respectively (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 2020 are shown in Table 2. The majority of total child deaths were related to either illness (32%) or premature birth (31%). The other categories included firearms (8%), suffocation (7%), vehicular (7%), undetermined (5%), injury (3%), drowning (2%), fire (2%), poison/overdose (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 2020, deaths reviewed by CDRTs were most likely to be suffocation (21%), illness (19%) and

undetermined (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	
Illness	382	32%	46	19%
Premature Birth	369	31%	3	1%
Firearms	102	8%	20	8%
Suffocation	82	7%	52	21%
Vehicular	79	7%	18	7%
Undetermined	62	5%	44	18%
Injury	36	3%	20	8%
Drowning	20	2%	15	6%
Fire	20	2%	8	3%
Poison/Overdose	18	1%	9	4%
SUID	15	1%	10	4%
Other	7	<1%	2	<1%
SUCD	1	<1%	0	0%
Pending	9	1%	0	0%
Total	1,202	100%	247	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:

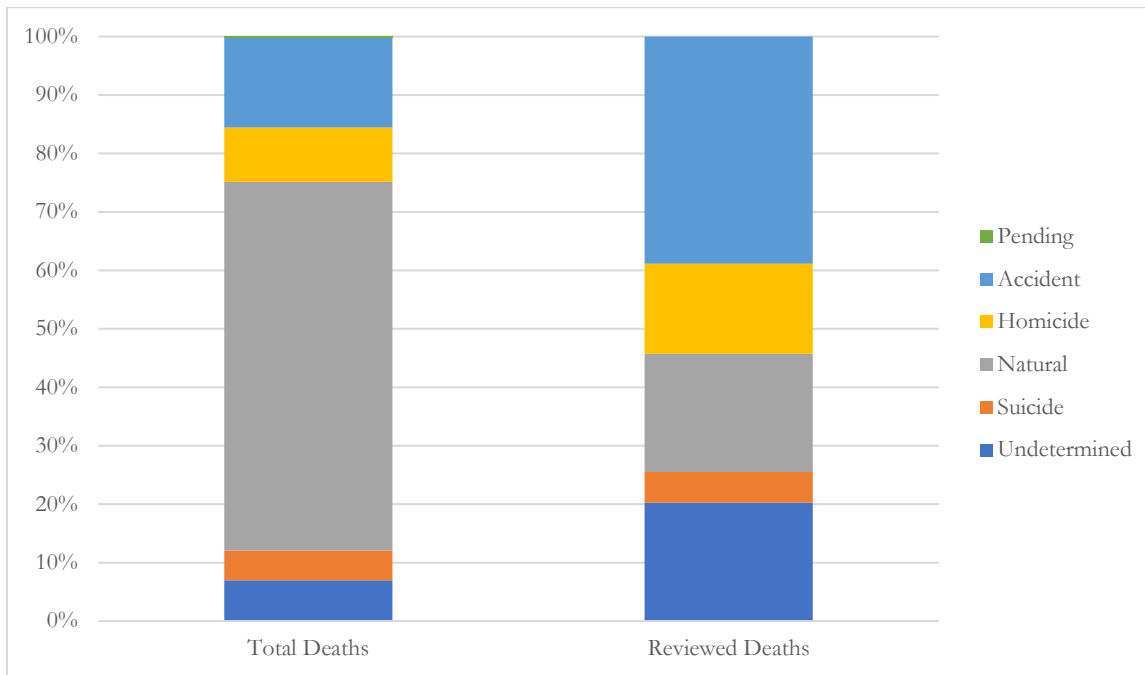
- Natural – the death was a result of natural causes such as illness, disease and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm or death
- Suicide – the death 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 2020 were attributable to natural causes (63%), and accidents accounted for 15% of the total child deaths. In addition, 9% were homicides, 5% were suicides, 7% were undetermined, and less than 1% were still pending. Most deaths reviewed by CDRTs were due to accidents (39%), natural causes (20%), undetermined (20%), and homicides (15%); suicides accounted for 5% of reviewed deaths (see Table 3 and Figure 7).

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

	Total Deaths		Reviewed Deaths	
	Count	Percentage	Count	Percentage
Accident	185	15%	96	39%
Homicide	112	9%	38	15%
Natural	758	63%	50	20%
Suicide	61	5%	13	5%
Undetermined	84	7%	50	20%
Pending	2	<1%	0	0%
Total	1,202	100%	247	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	Manner of Death						Totals
	Accident	Homicide	Natural	Suicide	Undetermined	Pending	
Illness	3	0	377	0	2	0	382
Premature Birth	2	0	367	0	0	0	369
Firearms	2	76	0	22	2	0	102
Suffocation	47	4	1	28	2	0	82
Vehicular	73	2	0	3	1	0	79
Undetermined	1	1	2	0	58	0	62
Injury	8	22	0	4	2	0	36
Drowning	18	0	0	0	2	0	20
Fire	15	2	0	0	3	0	20
Poison or Overdose	9	2	0	4	3	0	18
SUID	7	0	6	0	2	0	15
Other	0	3	4	0	0	0	7
SUCD	0	0	1	0	0	0	1
Pending	0	0	0	0	7	2	9
Total	185	112	758	61	84	2	1202

Special Analysis: Homicide Deaths

There were 112 homicide deaths out of the 1,202 deaths in 2020, and we know from the above tables that many homicides involved either firearms or inflicted injuries of some kind. Additional information on a **selection** of on homicide deaths, presented in Table 5, provides additional information on of the circumstances of these types of child deaths.

Table 5: Homicide Deaths

Category of Death	Age	Race/Ethnicity	Cause of Death
Fire	9	White	Carbon monoxide intoxication apartment fire.
Fire	13	White	Carbon monoxide intoxication apartment fire.
Firearms	2	Black	Gunshot wound of chest.
Firearms	3	Black	Gunshot wound of head.
Firearms	3	Black	Gunshot wound of the back.
Firearms	5	Black	Gunshot wound of the head.
Firearms	7	Black	Gunshot wound of head.
Firearms	8	Black	Gunshot wound of head.
Firearms	9	Black	Gunshot wound of the back.

Firearms	9	Black	Complications of prematurity multiple maternal gunshot wounds.
Firearms	9	Black	Gunshot wound of head.
Firearms	9	Black	Multiple gunshot wounds.
Firearms	14	Black	Gunshot wound of right back.
Firearms	14	Black	Gunshot wound to the chest.
Firearms	14	Black	Gunshot wound to the neck.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Gunshot wound of head.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Multiple gunshot wounds.
Firearms	15	Black	Gunshot wound of the neck.
Firearms	16	Black	Gunshot wound of abdomen.
Firearms	16	Black	Gunshot wound of the head.
Firearms	16	Black	Gunshot wound of the head.
Firearms	16	Black	Gunshot wound of the neck.
Firearms	16	Black	Gunshot wound of left back shot by another person.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Gunshot wound of abdomen.
Firearms	16	Black	Gunshot wound to the back.
Firearms	16	Black	Gunshot wound of chest shot by another person.
Firearms	16	Black	Gunshot wound of head.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	16	Black	Multiple gunshot wounds.
Firearms	17	Black	Gunshot wound of the abdomen.
Firearms	17	Black	Gunshot wound of the chest.
Firearms	17	Black	Gunshot wound to the chest and abdomen.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	17	Black	Multiple gunshot wounds.
Firearms	4	Asian	Gunshot wound to head.
Firearms	12	Hispanic	Gunshot wound of the head.
Firearms	15	Hispanic	Gunshot wound of head.
Firearms	16	Hispanic	Gunshot wound of the head.
Firearms	16	Hispanic	Gunshot wound to head.
Firearms	16	Hispanic	Gunshot wound to the head.
Firearms	16	Hispanic	Multiple gunshot wounds.

Firearms	16	Hispanic	Gunshot wound of head.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	17	Hispanic	Multiple gunshot wounds.
Firearms	11	White	Gunshot wound of head.
Firearms	13	White	Multiple gunshot wounds.
Firearms	15	White	Gunshot wound to the head.
Firearms	16	White	Gunshot of left arm involving chest.
Firearms	16	White	Gunshot wound of the head.
Firearms	16	White	Gunshot wound of head.
Firearms	17	White	Multiple gunshot wounds.
Injury	0	Black	Hypoxic Ischemic Encephalopathy Bronchopneumonia complicating blunt force injuries of the head.
Injury	0	Black	Multiple injuries child abuse.
Injury	1	Black	Closed head injury.
Injury	1	Black	Multiple injuries assault.
Injury	1	Black	Closed head injury child abuse.
Injury	1	Black	Multiple injuries child abuse.
Injury	2	Black	Multiple blunt force injuries fall from height.
Injury	2	Black	Multiple injuries child abuse.
Injury	3	Black	Multiple injuries child abuse.
Injury	4	Black	Multiple fractures and visceral injuries blunt trauma of torso and head.
Injury	5	Black	Multiple incised wounds to neck.
Injury	16	Black	Neck hold by another person.
Injury	16	Black	Multiple stab wounds.
Injury	1	Hispanic	Blunt head trauma child abuse.
Injury	10	Hispanic	Medical and nutritional neglect.
Injury	16	Hispanic	Stab wound of chest.
Injury	16	Hispanic	Stab wound of chest.
Injury	1	White	Blunt force head trauma physical abuse.
Injury	2	White	Blunt trauma of the head.
Injury	2	White	Closed head injury.
Injury	5	White	Blunt force abdominal trauma physical abuse.
Injury	11	White	Penetrating lung injures with Hemopneumothoraxes due to stab and incised wounds of torso, neck and extremities.
Other	0	Black	Hypoxic Ischemic Encephalopathy maternal death multiple gunshot wounds.
Other	0	White	Dehydration and malnutrition neglect.
Other	15	White	Chronic malnutrition and dehydration physical neglect.
Poison Overdose	2	Black	Methadone toxicity.
Poison Overdose	6	White	Olanzapine toxicity.
Suffocation	0	White	Asphyxia intentional overlay.

Suffocation	0	White	Suffocation.
Suffocation	1	White	Asphyxia overlaying co-sleeping/adult bed sharing with an adult.
Suffocation	1	White	Hypoxic ischemic encephalopathy suffocation.
Undetermined	1	Black	Undetermined.
Vehicular	16	Black	Chest injuries motor vehicle crash.
Vehicular	17	White	Multiple blunt force injuries motor vehicle crash.

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 2020 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/ethnicity 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 Black children and young children, the cases reviewed by the CDRT are more likely to be of children who are younger or Black. The CDRTs have also sought to bring increased attention to infant deaths due to unsafe sleep, which accounted for 9% of child deaths of 2020.

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). It is important to note that deaths due to illness and those deemed natural still may be the result of neglect, usually medical neglect.

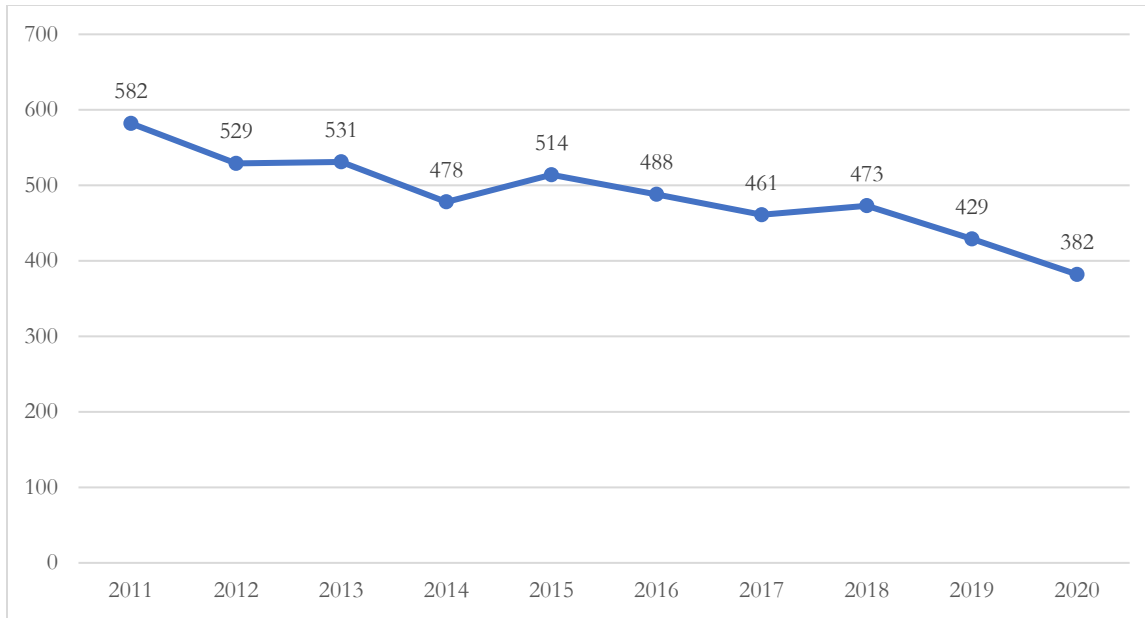
Background

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

Illness has been one of the largest causes of child death in Illinois, but the overall number of deaths has been steadily decreasing over the past decade. In 2020, there were 382 deaths from illness, which is the lowest number of deaths in the observed period (see Figure 8).

Figure 8: Child Deaths Due to Illness



In 2020, 382 of the 1,202 total child deaths (32%) reported to CDRTs were related to illness.

- Boys accounted for a slightly higher proportion of illness deaths (52%) compared to girls (48%).
- Almost half of deaths from illness were among children under the age of 1 (47%), 16% of deaths from illness occurred among children 1 to 4 years old, 12% among children 5 to 9 years old, 16% among children 10 to 14 years old, and 9% among children 15 to 17 years old (see Figure 9).
- The majority (52%) of deaths from illness were White children, followed by Black children (30%), Hispanic children (15%), Asian children (2%), and children of Other/Unknown race/ethnicity (1%) (see Figure 10).
- Nearly all deaths (99%) from illness were attributable to natural causes, and 1% of the remaining deaths were either accidental or undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 46 of the 247 child deaths reviewed by the CDRTs (19%) were related to illness.

- Boys (63%) were more likely to die from illness than girls (37%).
- Illness-related deaths were most common in infants under 1 year old (26%) and children 1 to 4 years old (26%). Children 5 to 9 years, children 10 to 14 years, and children 15 to 17 years old accounted for 15%, 24%, and 9% of deaths, respectively (see Figure 9).

- White (48%) and Black (46%) accounted for most of the deaths reviewed for illness, and 4% were Hispanic children, and one case (2%) was an Asian child (see Figure 10).
- Nearly all (98%) of reviewed deaths that were categorized as illness were attributed to natural causes, and there was one undetermined case (2%).

Figure 9: Child Deaths Due to Illness by Age

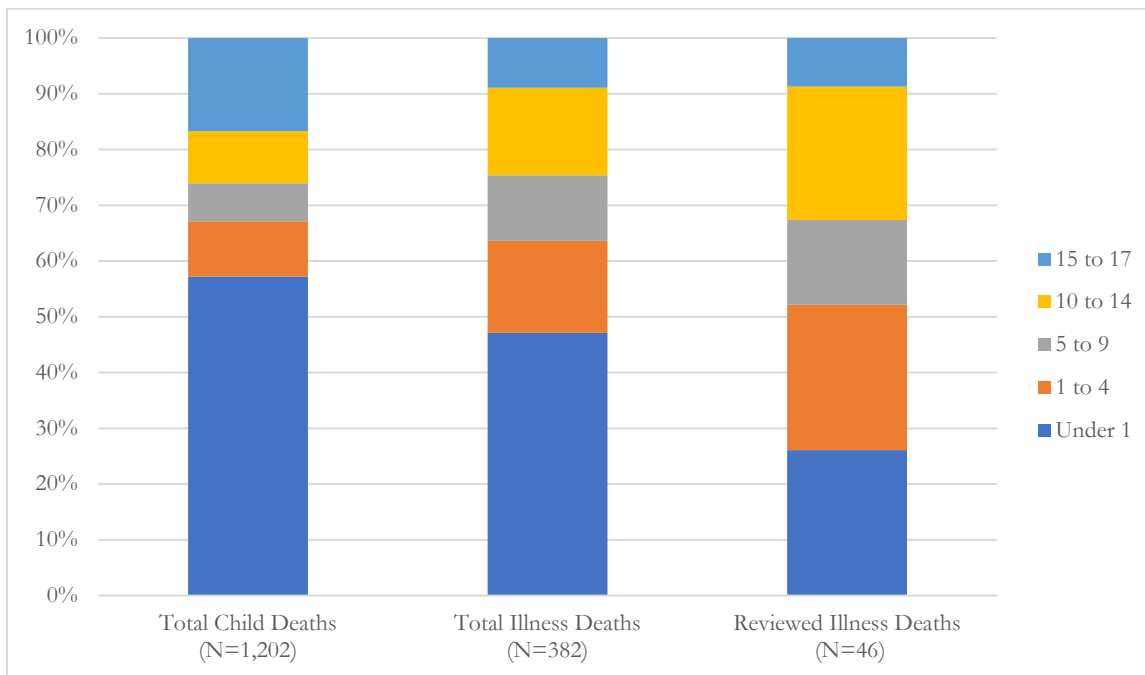
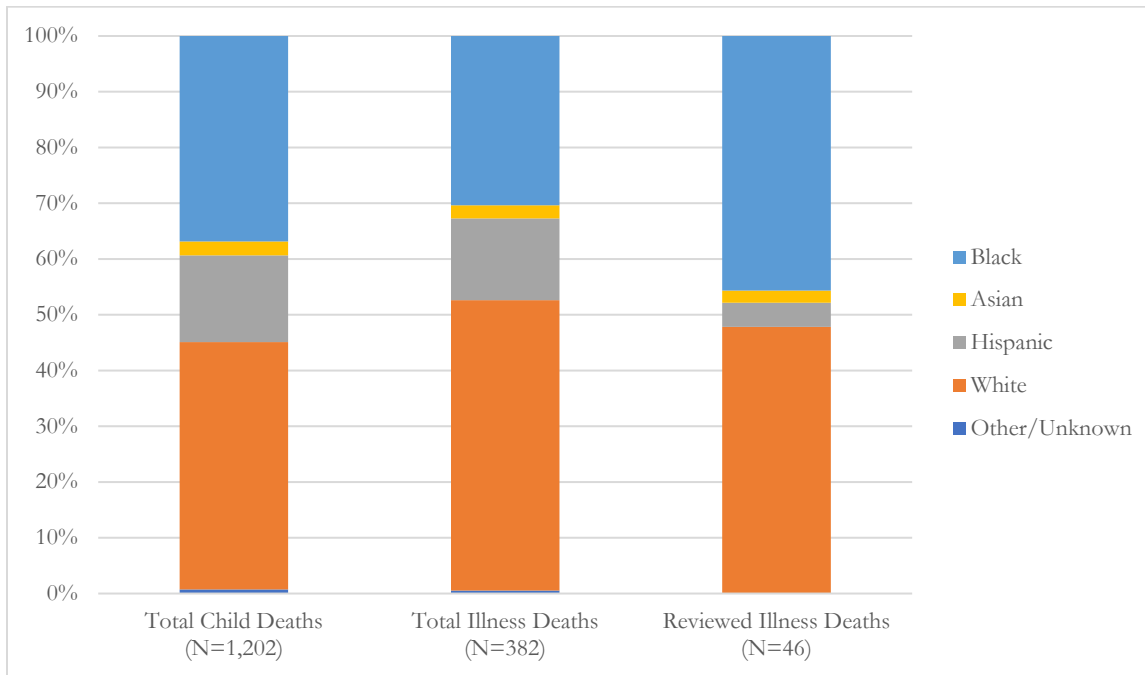


Figure 10: Child Deaths Due to Illness by Race/Ethnicity



Premature Birth

Definition

Although there is no single, agreed-upon definition of preterm birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as “very preterm” (less than 32 weeks of gestation) and “moderately preterm” (32-37 weeks of gestation). In Illinois, deaths in this category include aborted pregnancies where a death certificate was completed, but not fetal deaths. The manner of death associated with prematurity is most often determined to be natural. However, if an infant is born prematurely due to maternal injury, the manner of death may be ruled accidental or homicide.

Background

Premature birth is closely associated with low birth weight. Low birthweight (LBW), one of the five leading causes of infant mortality, is an indicator of child health (current and future) as well as maternal health. LBW babies are more likely 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 10 (10.3%) babies were born preterm in 2020, compared with 10.1% in the nation.⁸ The rate of preterm birth in Illinois between 2018-2020 is highest for Black infants (14.9%), followed by American Indian/Alaska Natives (14.6%), Hispanics (10.4%), Whites (9.4%), and Asian/Pacific Islanders (9.1%).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 decade (ranging between 369 to 572 deaths per year). The number of premature deaths was 369 in 2020, the lowest number of deaths recorded in the past decade.

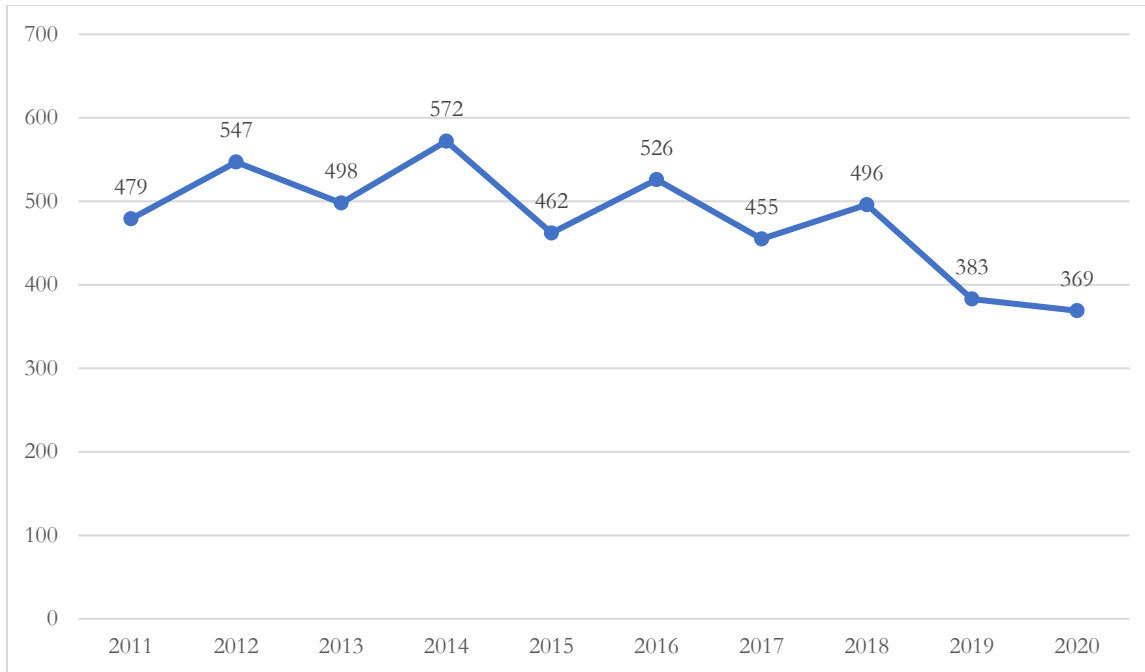
Figure 11: Child Deaths Due to Prematurity

⁷ America's Health Rankings (2020). 2020 Annual Report. United Health Foundation. Retrieved from <https://assets.americashealthrankings.org/app/uploads/annual20-rev-complete.pdf>

⁸ March of Dimes (2021). State summary for Illinois. Retrieved from <https://www.marchofdimes.org/peristats/state-summaries/illinois?lev=1&obj=3®=99&slev=4&sreg=17&stop=55&top=3>

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.



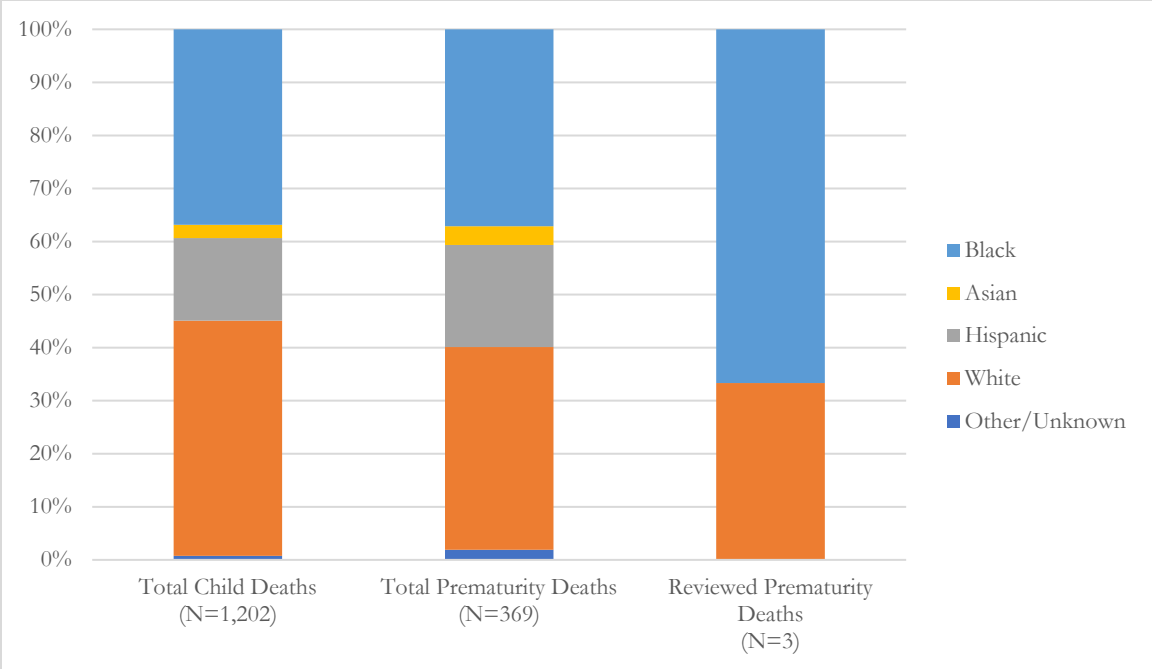
Out of 1,202 child deaths in 2020, 369 (31%) were related to premature birth.

- A larger proportion of children who died prematurely were boys (55%).
- The largest proportion of deaths from prematurity were White children (38%), followed by Black children (37%), Hispanic children (19%), Asian children (4%) and children of other or unknown race/ethnicity (2%) (see Figure 12).
- Nearly all deaths (99%) in this category were the result of natural causes, 2 deaths were from undetermined causes, and 1 death was an accident.

Illinois Data—Deaths Reviewed by the CDRTs

- In 2020, 3 of the 247 child deaths reviewed by CDRTs (1%) were related to premature birth.
- All (100%) of premature deaths reviewed by the CDRTs were boys.
- Two (67%) of the premature reviewed deaths were Black children, and one (33%) was a White child (see Figure 12).
- Two (67%) of premature reviewed deaths were due to natural causes, and one case (33%) was accidental.

Figure 12: Child Deaths Due to Prematurity 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.

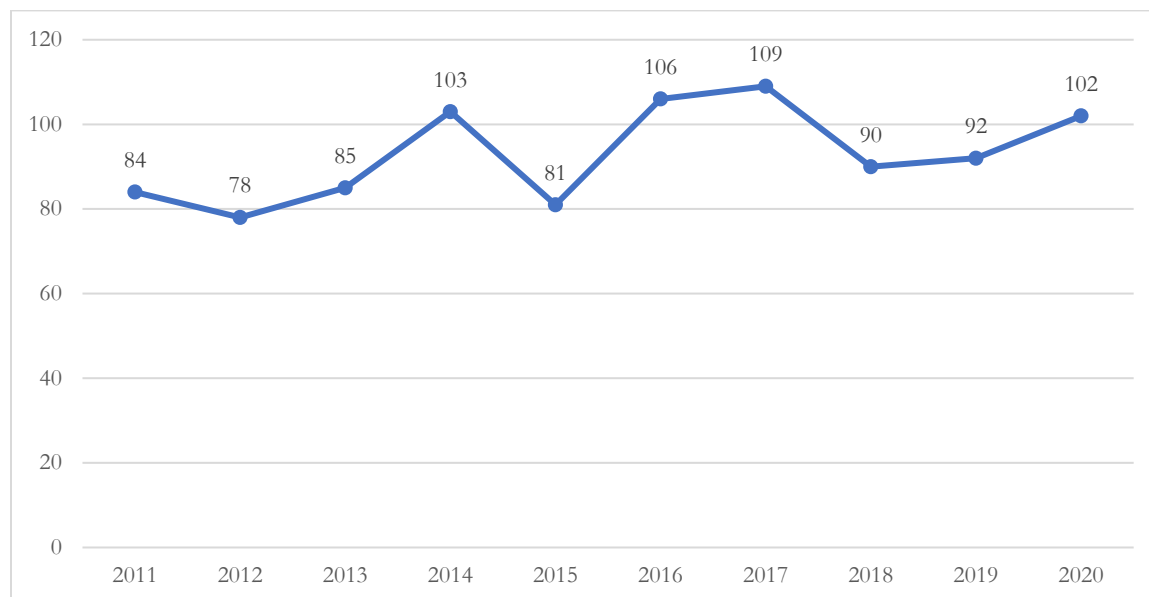
Background

According to data from the Centers for Disease Control and Prevention, 2,281 firearm deaths occurred in 2020 among children under 18 years of age in the United States. The vast majority (67%) of these deaths were youth between the ages of 15 and 17. Race of decedent is also a factor. For example, the crude death rate from firearms for Black males 13 to 17 years old was about four times higher than the rate for White males of the same age group.¹¹

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 2011 through 2013, but there were over 100 child deaths from firearms in 2014, 2016, 2017, and 2020.

Figure 13: Child Deaths Due to Firearms



¹¹ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2022). *Explore Fatal Injury Data Visualization Tool (WISQARS)*. Retrieved from <https://wisqars.cdc.gov/data/explore-data/home>

In 2020, 102 of the 1,202 total deaths (8%) were related to firearms.

- Boys accounted for the vast majority of firearm deaths (90%).
- Three-quarters of firearm deaths occurred in children age 15 to 17 (75%), and children age 10 to 14 were the next largest group (13%) (see Figure 14).
- 61% of the children who died from firearms were Black, 24% were White, 14% were Hispanic, and 2% were Asian (see Figure 15).
- Homicides accounted for 75% of firearm deaths, suicides were 22%, accidents were 2%, and undetermined cases accounted for 2%.

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 20 of the 247 deaths reviewed by the CDRTs (8%) were related to firearms.

- The majority of reviewed firearm deaths were boys (85%).
- Youth 15 to 17 years old accounted for the largest proportion of firearm deaths (45%), followed by children age 10 to 14 (20%) and children age 5 to 9 (15%) (see Figure 14).
- Half (50%) of reviewed firearm deaths were Black children, a quarter (25%) were White children, 15% were Hispanic children, and one child was Asian (10%) (see Figure 15).
- The majority of firearm deaths reviewed by CDRTs were due to homicides (65%), and suicide cases (20%) were the second most common manner of death. Accidental and undetermined cases accounted for 10% and 5%, respectively.

Figure 14: Child Deaths Due to Firearms by Age

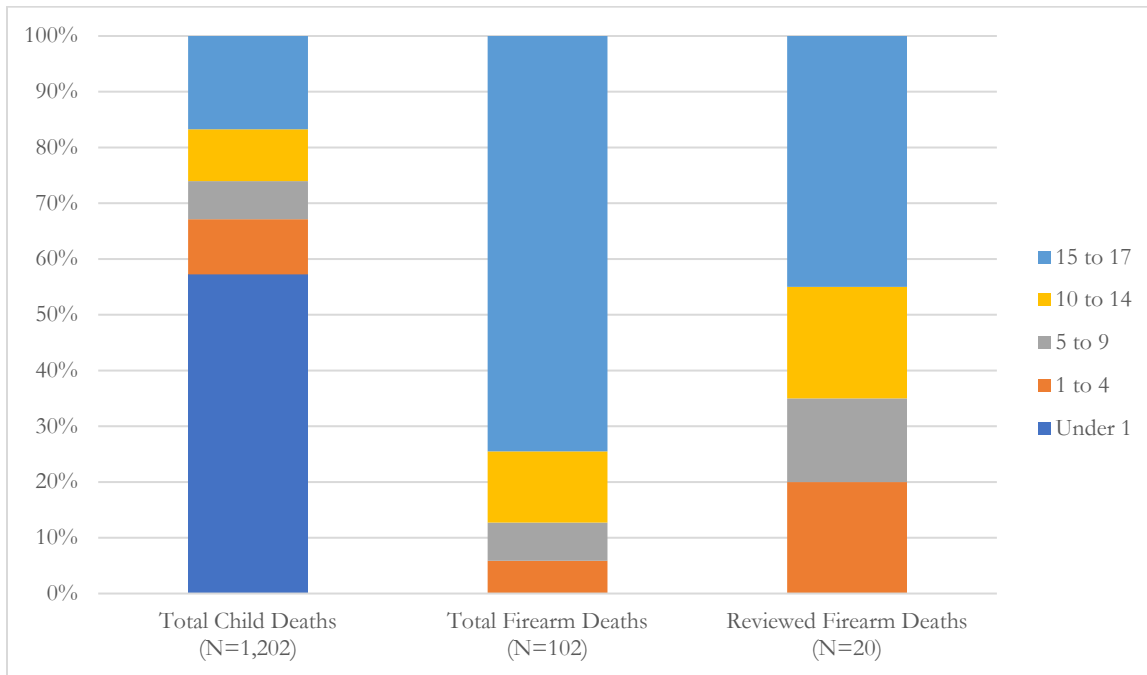
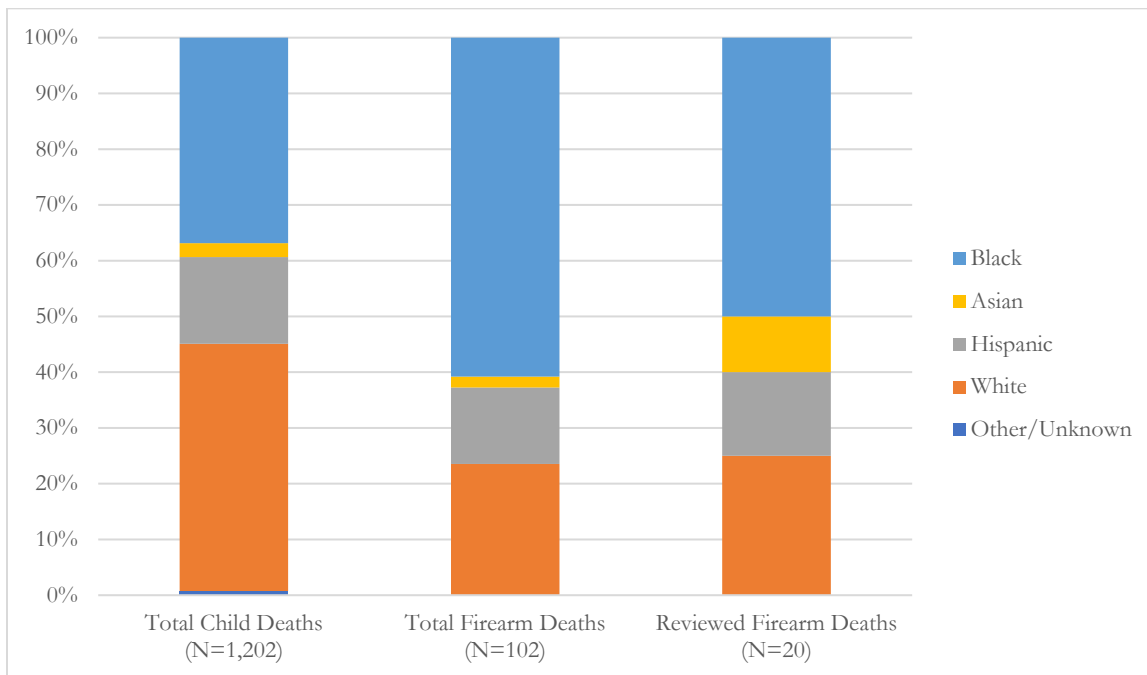


Figure 15: Child Deaths Due to Firearms by Race/Ethnicity



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 2020, 2,110 children under 18 years old in the U.S. died from suffocation.¹² Of these children, 52% were less than one year of age and 58% were ages four and under. Unintentional suffocation is the leading cause of injury-related death among infants less than one year old.¹³

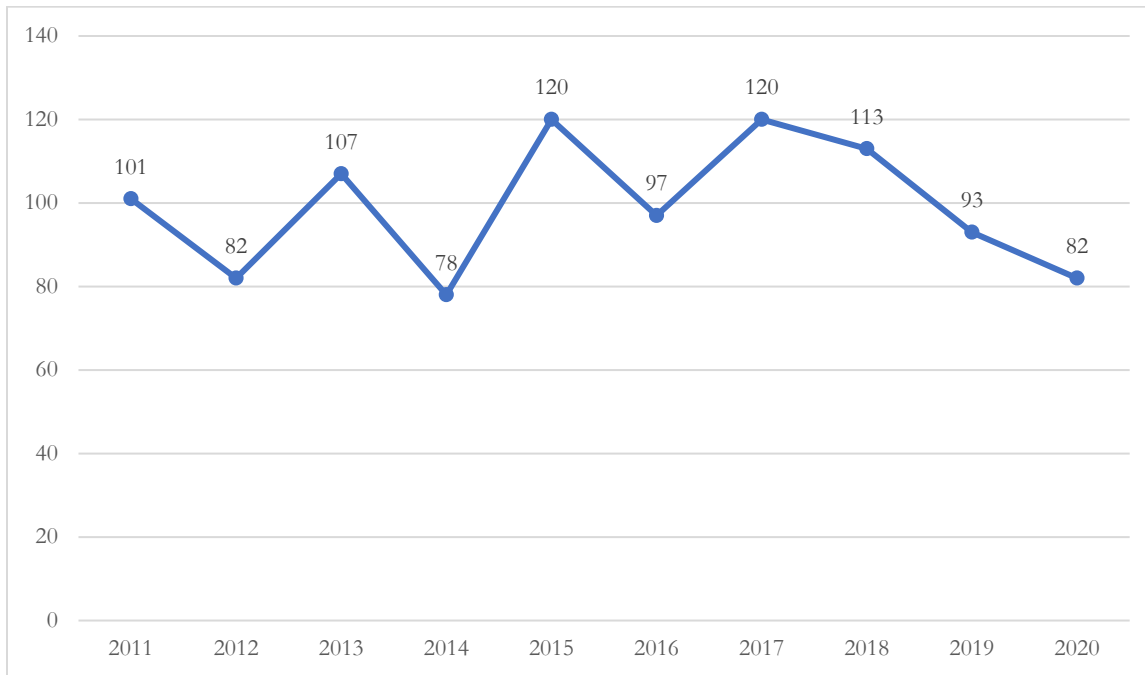
Illinois Data—Total Child Deaths Reported to the CDRTs

Suffocation deaths have fluctuated slightly in the past decade, ranging from a low of 78 to a high of 120. The number of suffocation deaths has dropped for the past several years, and there were 82 suffocation deaths in 2020, close to some of the lowest levels within the past decade (see Figure 16).

¹² Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2022). *Explore Fatal Injury Data Visualization Tool (WISQARS)*. Retrieved from <https://wisqars.cdc.gov/data/explore-data/home>

¹³ Safe Kids Worldwide. (2022). *Suffocation Prevention and Sleep Safety*. Retrieved from <https://www.safekids.org/tip/sleep-safety-and-suffocation-prevention-tips>

Figure 16: Child Deaths Due to Suffocation



In 2020, 82 of the 1,202 total child deaths reported to the CDRTs (7%) were categorized as suffocation.

- The majority of children who died from suffocation were boys (56%).
- Infants under one year made up 56% of deaths in this category. Children ages 1 to 4, 5 to 9, and 10 to 14 accounted for 7%, 4%, and 11% of deaths in this category, respectively. Older children ages 15 to 17 accounted for the second largest proportion of suffocation deaths (22%) (see Figure 17).
- Almost half (46%) of children who died from suffocation were White, 34% were Black, 16% were Hispanic, and 4% were Asian (see Figure 18).
- Most suffocation deaths were accidental (57%) or suicides (34%). The remaining suffocation deaths were homicides (5%), natural causes (1%), or undetermined (2%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 52 of the 247 child deaths reviewed by CDRTs (21%) were related to suffocation.

- The majority of reviewed suffocation deaths were boys (63%).

- Infants under one year made up the majority of reviewed suffocation deaths (77%). Children ages 1 to 4 accounted for 8% of reviewed suffocation deaths, children 5 to 9 for 6%, children 10 to 14 for 6%, and children 15 to 17 were 4% (see Figure 17).
- Almost half (48%) reviewed suffocation deaths were White children. Black children were 38% of reviewed suffocation deaths, 12% were Hispanic children, and one case was an Asian child (2%) (see Figure 18).
- Most reviewed suffocation deaths were accidental (77%). Homicides accounted for 8% of reviewed suffocation deaths, suicides were 13%, and one case (2%) was undetermined.

Figure 17: Child Deaths Due to Suffocation by Age

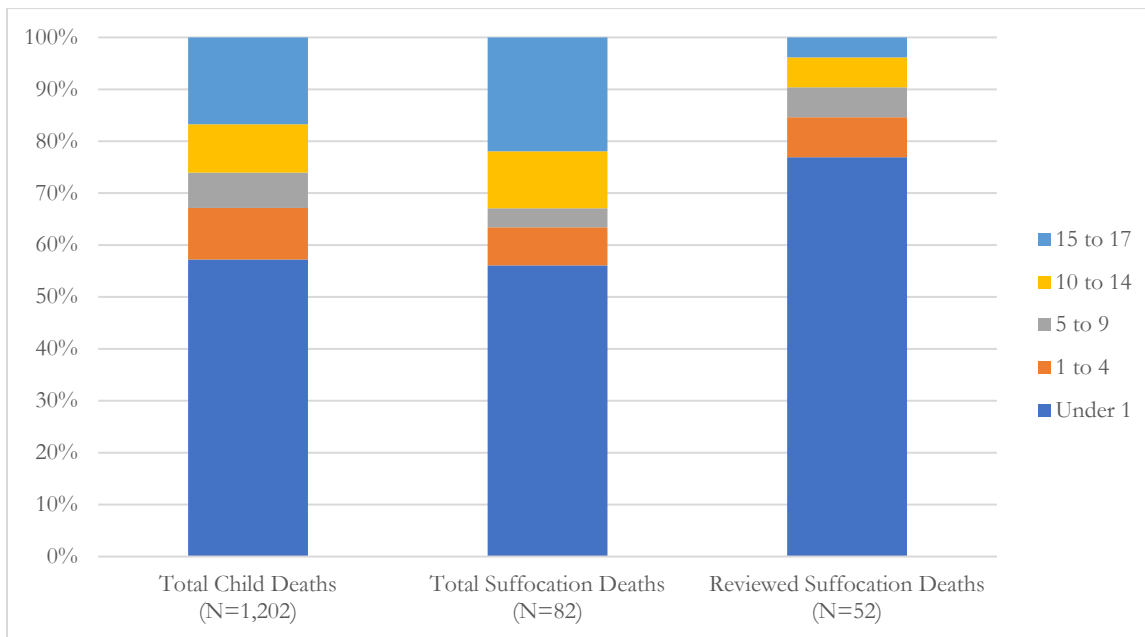
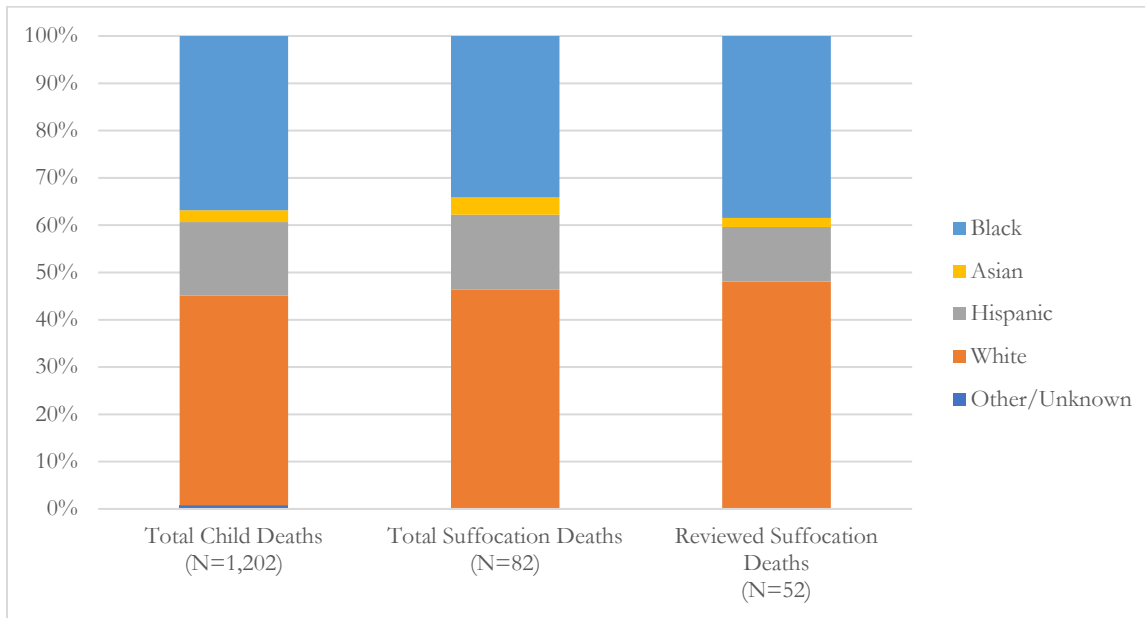


Figure 18: Child Deaths Due to Suffocation by Race/Ethnicity



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 845 children (under the age of 13) died in motor vehicle crashes in 2020.¹⁴ There has been a significant decrease in the rate of motor vehicle crash deaths per million children under 13 since 1975. In 2020, 72% of child motor vehicle crash deaths were passenger vehicle occupants, 17% were pedestrians, 3% were bicyclists, and the remaining 8% were other/unknown. Children 12 and younger are recommended to ride in the rear seats of vehicles. Sixteen percent of passenger vehicle child occupant deaths occurred in front seats, continuing a downward trend that has spanned for several decades. Seventy-five percent were in the rear seat, and 9% were in cargo/unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about a quarter of unintentional injury deaths among children younger than 13. Most 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 75% for children up to age 3, and almost 50% for children ages 4 to 8.¹⁵

In 2020, a total of 2,738 teenagers, ages 13 to 19, died in motor vehicle crashes. This is a decrease of 69% from 1975, but this was an increase of 14% from 2019. Males accounted for about two-thirds of crash deaths, but rates have decreased more for males (71%) than females (61%) since 1975. Teenagers accounted for 7% of motor vehicle crash deaths in 2020 and 9% of passenger vehicle (cars, pickups, SUVs and vans) occupant deaths among all ages, 4% of pedestrian deaths, 3% of motorcycle deaths, 8% of bicyclist deaths and 14% of all-terrain vehicle rider deaths.¹⁶

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 17.¹⁷

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

¹⁴ Insurance Institute for Highway Safety. (2022). *Fatality facts 2020: Children*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/children#age-and-sex>

¹⁵ Ibid.

¹⁶ Insurance Institute for Highway Safety. (2020). *Fatality facts 2019: Teenagers*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/teenagers>.

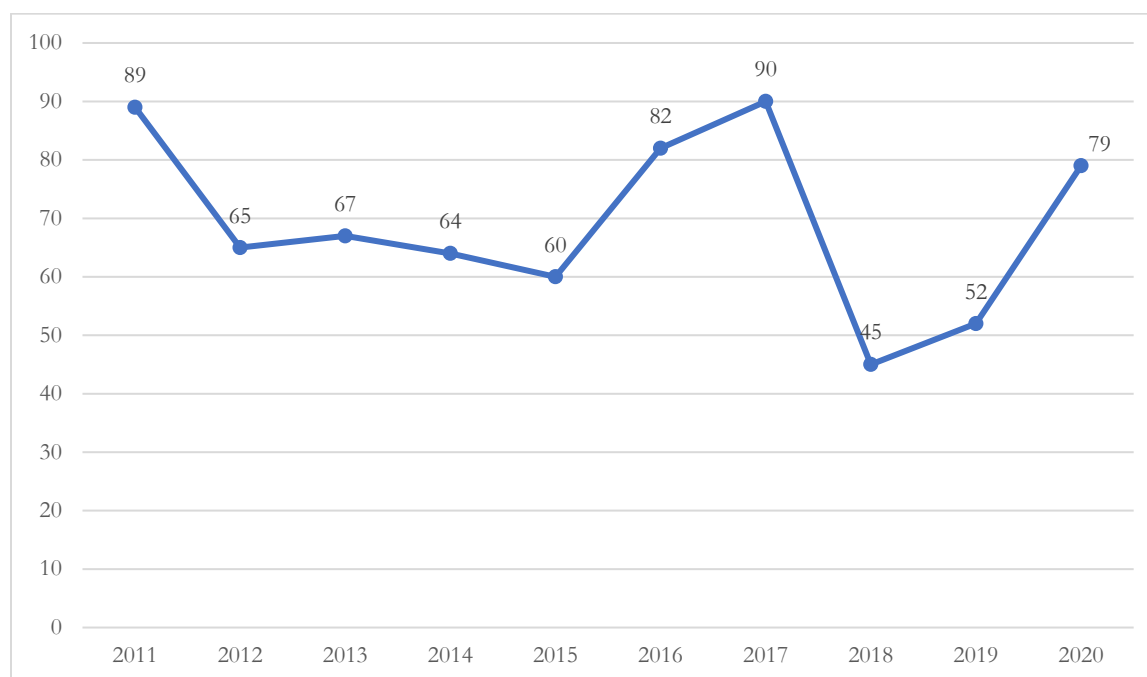
¹⁷ Ibid.

and drowsiness.¹⁸ 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.¹⁹

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of vehicle deaths had previously fluctuated between 60 to 90 in the past decade, and there were 79 vehicle deaths in 2020 (see Figure 19).

Figure 19: Child Deaths Due to Vehicular Accidents



In 2020, 79 out of the 1,202 total child deaths reported to the CDRTs (7%) were related to vehicular accidents.

- Boys accounted for 59% of vehicular accident deaths.
- Older children ages 15 to 17 made up the largest proportion of vehicular deaths (54%). Children in other age groups made up the following proportions of vehicular deaths—

¹⁸ Children’s Hospital of Philadelphia Research Institute (2022). Teen Driving Safety Research. Retrieved from <https://injury.research.chop.edu/teen-driving-safety-research>

¹⁹ Insurance Institute for Highway Safety. (2022). *Fatality facts 2020: Teenagers*. Retrieved from <https://www.iihs.org/topics/fatality-statistics/detail/teenagers>.

children under 1 year were 5%, children 1 to 4 were 9%, 5 to 9 were 14%, and 10 to 14 were 18% (see Figure 20).

- The majority (66%) of vehicular deaths were White children, followed by Black children (24%), and Hispanic children (10%) (see Figure 21).
- The majority of vehicular deaths were accidental (92%). The remaining cases were suicides (4%) and homicides (3%), and 1% were undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 18 of the 247 deaths reviewed by the CDRTs (7%) were related to vehicular deaths.

- Most reviewed vehicular deaths were girls (61%).
- Reviewed vehicular deaths were most common for children between the ages of 15 to 17 (33%), followed by children ages 5 to 9 (28%), and children ages 1 to 4 and ages 10 to 14 each accounted for 17% of deaths. Children under 1 year accounted for the smallest proportion of reviewed deaths (6%) (see Figure 20).
- The majority of reviewed vehicular deaths were White children (61%), a third were Black children (33%), and Hispanic children accounted for 6% (see Figure 21).
- All the reviewed vehicular deaths were accidents (100%).

Figure 20: Child Deaths Due to Vehicular Accidents by Age

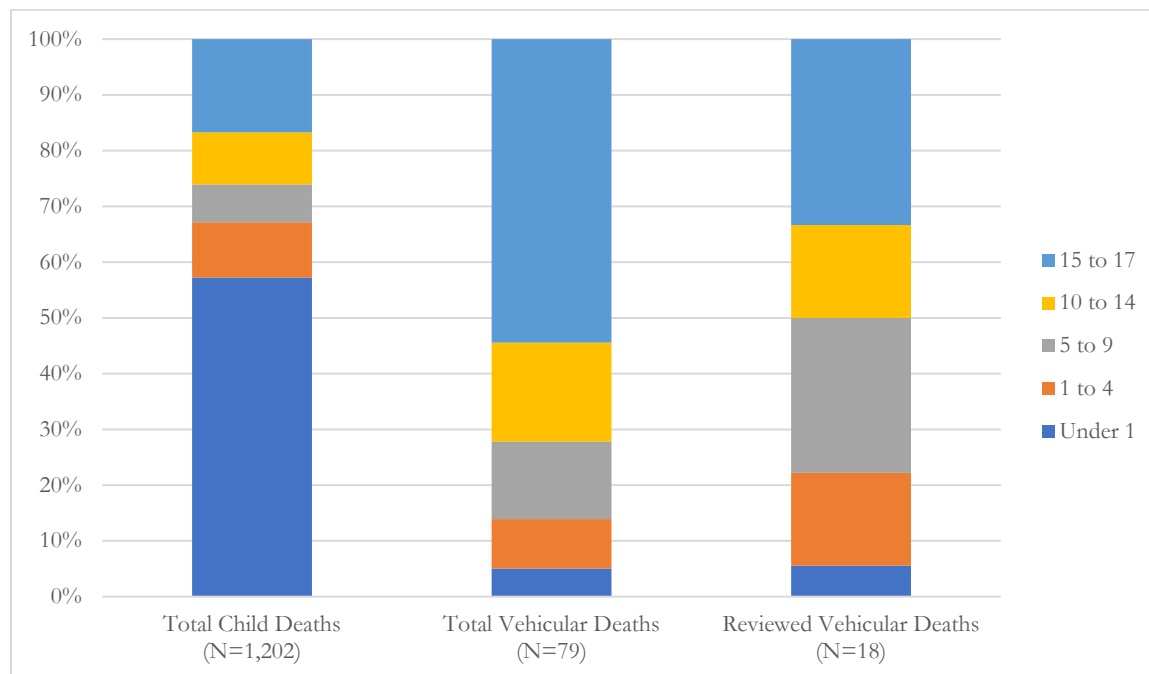
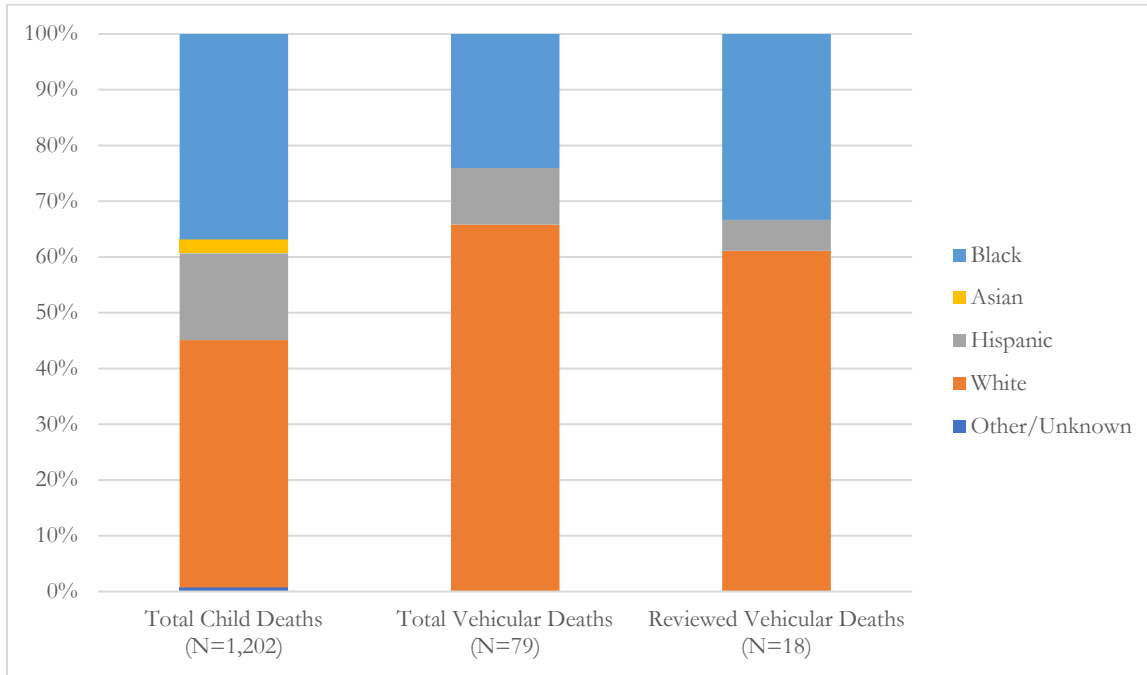


Figure 21: Child Deaths Due to Vehicular Accidents by Race/Ethnicity



Undetermined Deaths

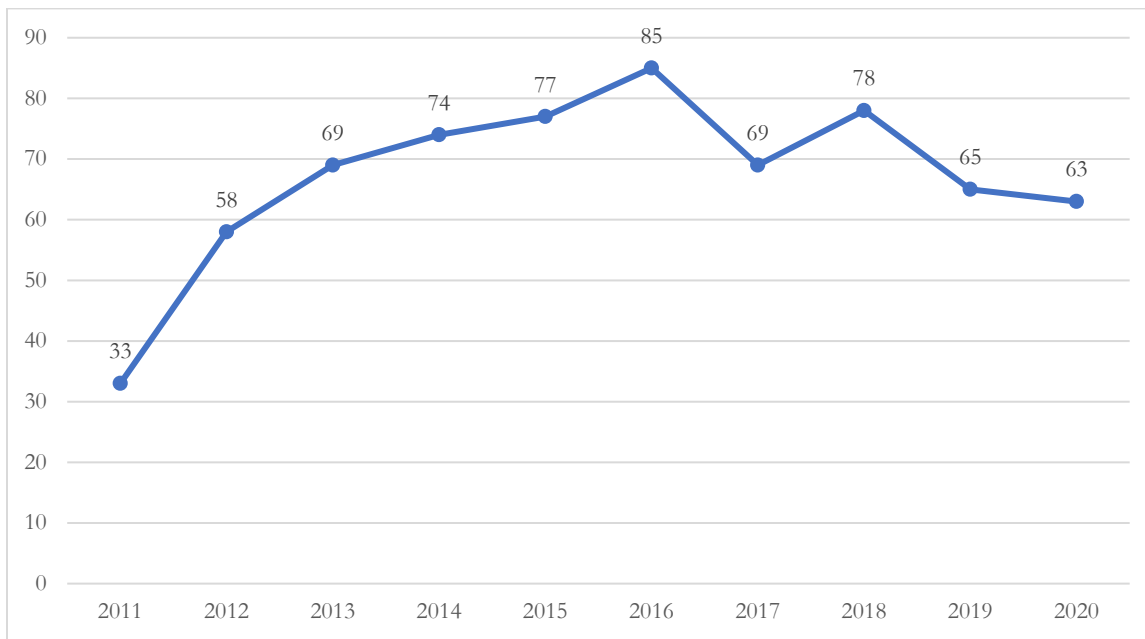
Definition

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 63²⁰ undetermined deaths in 2020 (see Figure 22).

Figure 22: Child Deaths with Undetermined Cause of Death



In 2020, 63 of the 1,202 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

- Deaths due to undetermined causes were more common for boys (67%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (90%), and many cases were sleep-related.

²⁰ Data in this section may show updated counts and percentages not reflected in other tables in report.

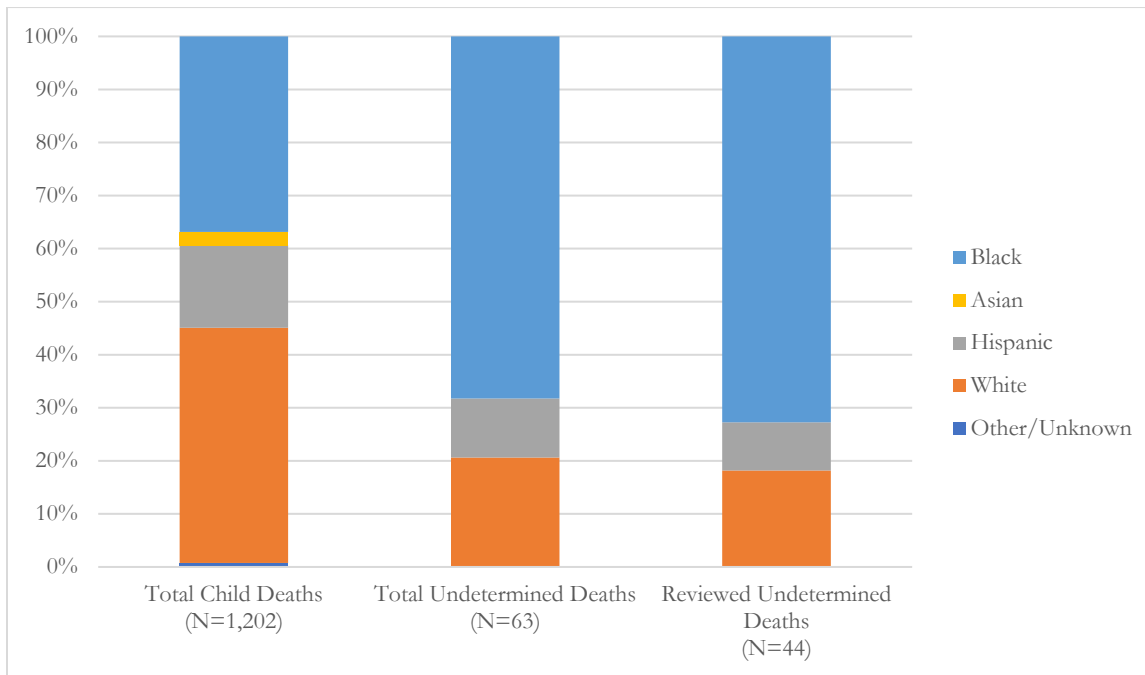
- Black children accounted for the largest proportion of undetermined deaths (68%), followed by White children (21%), and Hispanic children (11%) (see Figure 23).

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 44 of the 247 deaths reviewed by CDRTs (18%) had an undetermined cause of death.

- Reviewed deaths due to undetermined causes were more likely for boys (70%).
- 95% of reviewed undetermined deaths were children under age 1.
- Black children accounted for the largest proportion of undetermined deaths (73%), followed by White children (18%), and Hispanic children (9%) (see Figure 23).

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



Injuries

Definition

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

Background

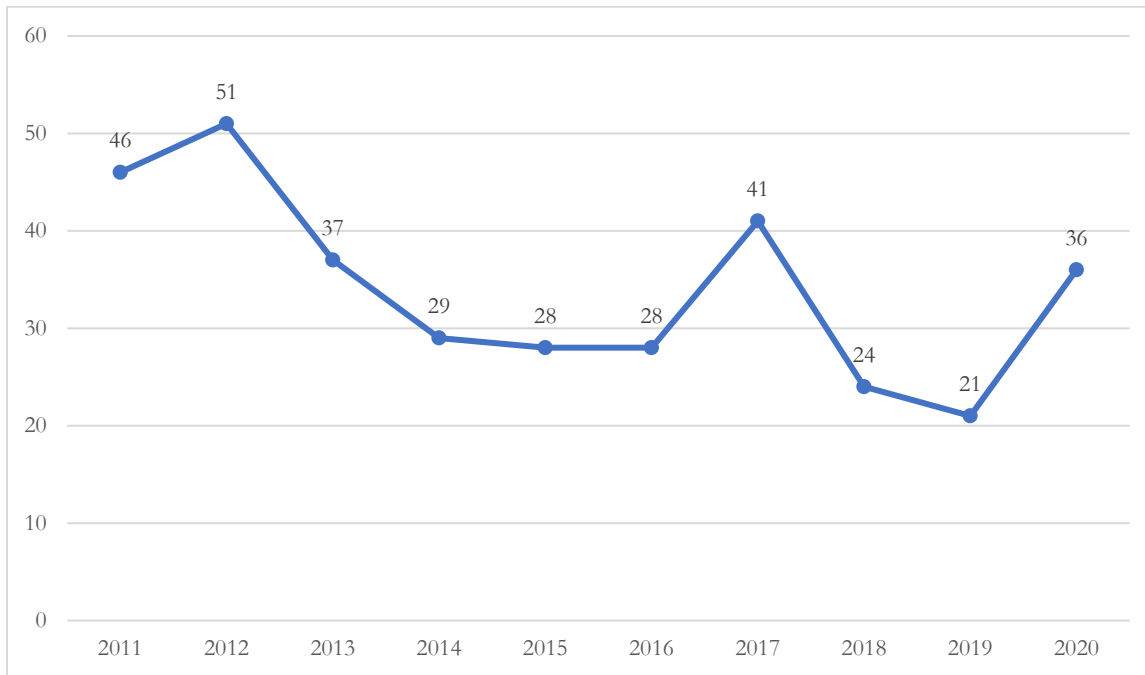
Child maltreatment (including abuse and neglect) is one cause of death from injuries. Based on 2020 data from the National Child Abuse and Neglect Data System (NCANDS), it is estimated that 1,750 children died from abuse and neglect at a rate of 2.38 deaths per 100,000 children. Younger children are the most vulnerable to die as a result of child abuse and neglect. Around 46% of child fatalities were children under one years old. In 2020, girls had higher victimization rates (8.9 per 1,000) than did boys (7.9 per 1,000); however, boys had a higher fatality rate (2.99 per 100,000) compared to girls (2.05 per 100,000). Black children had higher rates of injuries (5.90 per 100,000) compared to White children (1.90 per 100,000) and Hispanic children (1.65 per 100,000).²¹ Of child maltreatment deaths, about three-quarters (73.7%) suffered neglect and 42.6% suffered physical abuse either exclusively or in combination with other maltreatment types (e.g., medical neglect, psychological abuse, sexual abuse).

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries had dropped to a low of 21 in 2019 but increased to 36 in 2020 (see Figure 24).

²¹ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2022). *Child maltreatment, 2020*. Washington, DC: Government Printing Office. Retrieved from <https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf>.

Figure 244: Child Death Due to Injuries



In 2020, 36 of the 1,202 total child deaths reported to the CDRTs (3%) were related to injuries.

- Most injury deaths were boys (72%).
- Children ages 15 to 17 made up the largest proportion of injury deaths (31%), followed by children under 1 (25%), and children 1 to 4 (22%) (see Figure 25).
- Black and White children each accounted for 42% of injury deaths children, Hispanic children were 14%, and 3% were Asian (see Figure 26).
- Most deaths related to injuries were homicides (61%). Accidents accounted for 22% of injury deaths, suicides were 11%, and two cases were undetermined (6%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 20 of the 247 deaths reviewed by the CDRTs (8%) were related to injuries.

- Most injury deaths reviewed by CDRTs were boys (70%).
- Infants and children under 4 years of age made up the majority (75%) of reviewed injury deaths, children 5 to 9 were 5%, and children 15 to 17 were 20% (see Figure 25).
- The majority of reviewed injury deaths were Black children (60%), followed by White children (30%), and Hispanic children (10%) (see Figure 26).

- The majority of reviewed injury deaths were homicides (75%), accidents and suicides were each 10%, and one case was undetermined (5%).

Figure 25: Child Deaths Due to Injuries by Age

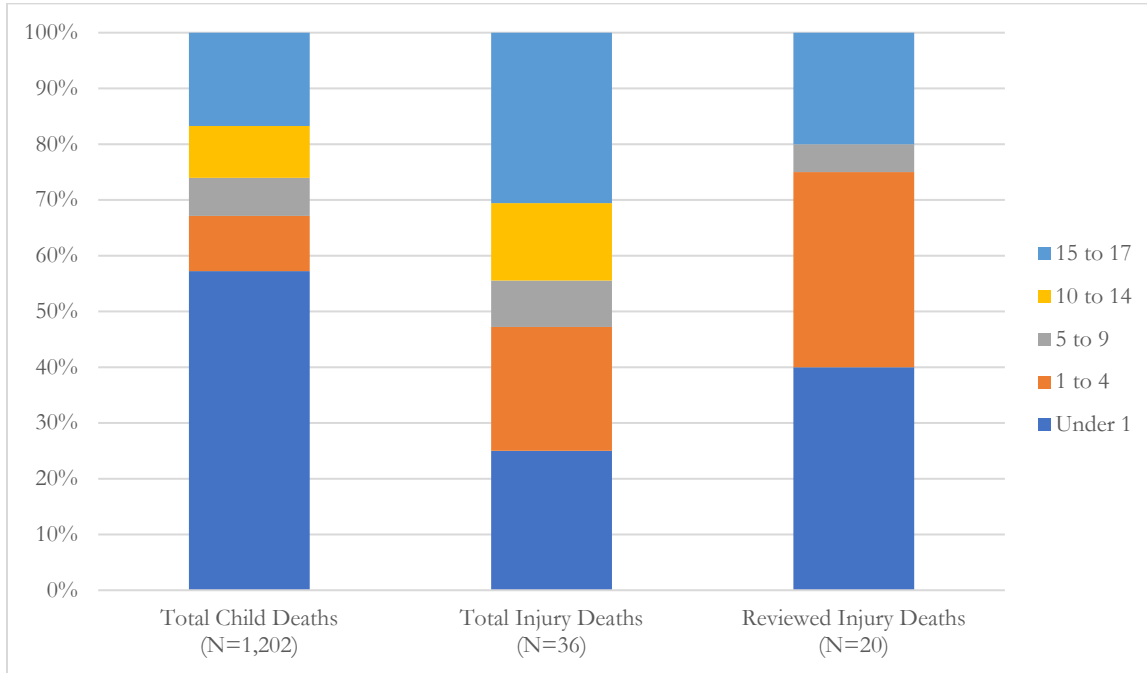
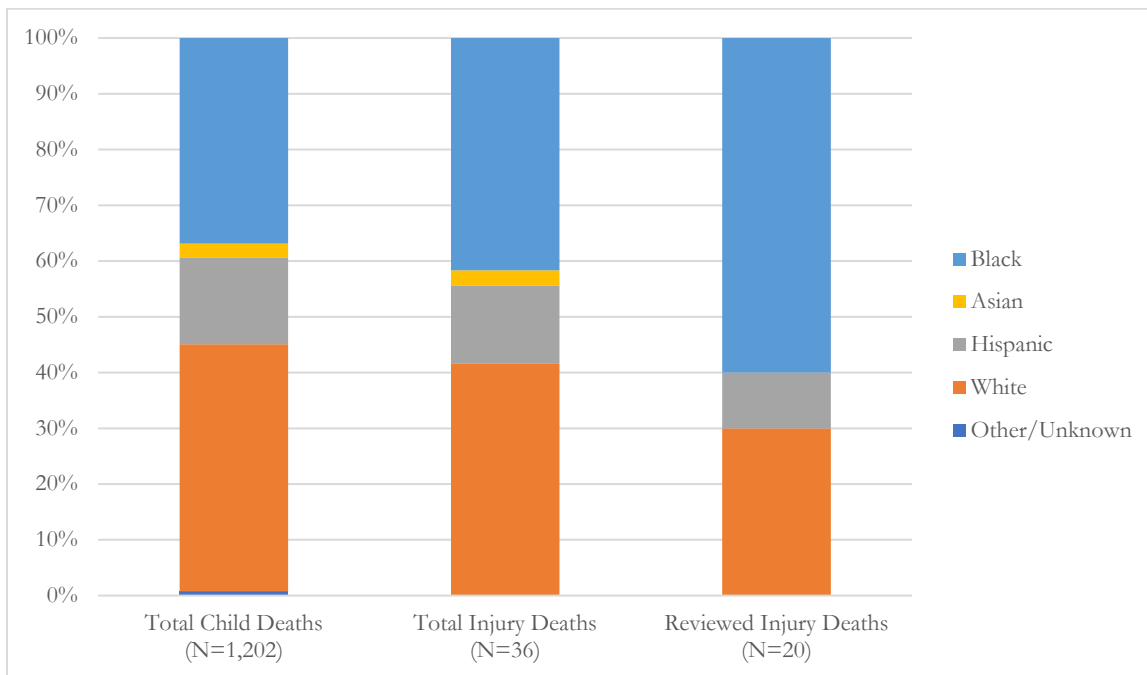


Figure 266: Child Deaths Due to Injuries by Race/Ethnicity



Drowning

Definition

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

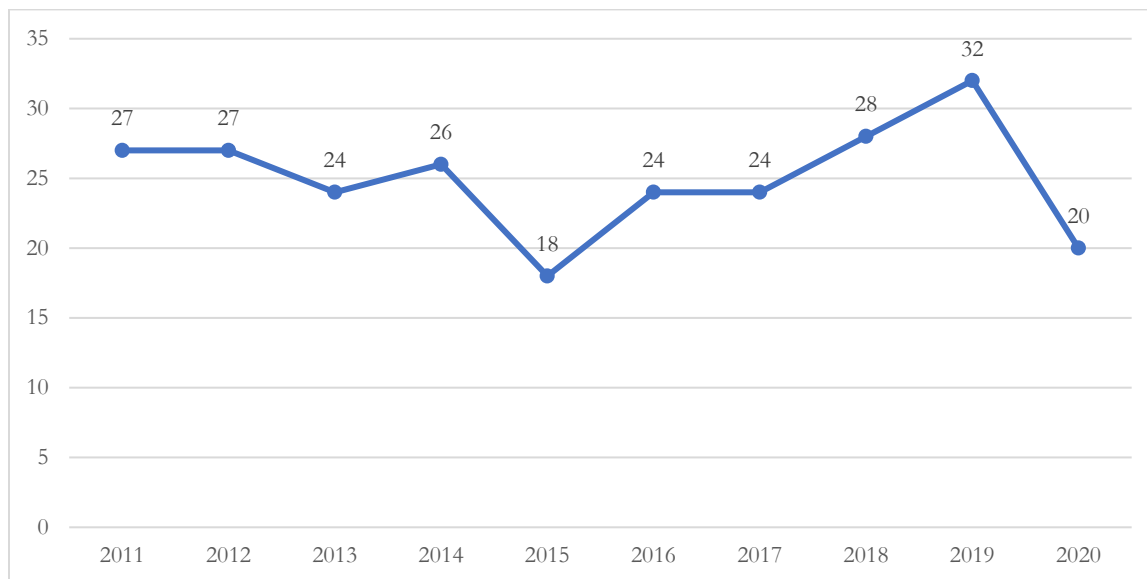
Background

In 2020, 767 children ages 17 and under died as a result of unintentional drowning in the United States. Children 4 and under accounted for 54% of these deaths,²² and drowning is the leading cause of injury-related deaths among children in this age range and the third leading cause of unintentional injury-related death among children 19 and under. Black children ages 5 to 19 years old have a drowning rate 5.5 times higher than that of White children.^{23, 24}

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from drowning have ranged between a low of 18 in 2015 and increased in subsequent years; however, drowning deaths dropped to 20 in 2020 (see Figure 27).

Figure 27: Child Deaths Due to Drowning



In 2020, 20 of the 1,202 total child deaths reported to the CDRTs (2%) were related to drowning.

²² Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2022). *Explore Fatal Injury Data Visualization Tool (WISQARS)*. Retrieved from <https://wisqars.cdc.gov/data/explore-data/home>.

²³ Safe Kids Worldwide. (2021). *Swimming*. Retrieved from <https://www.safekids.org/poolsafety>.

²⁴ Centers for Disease Control and Prevention. (2021). *Unintentional drowning: Get the facts*. Retrieved from <https://www.cdc.gov/homeandrecreationalafety/water-safety/waterinjuries-factsheet.html>

- Boys made up 70% of drowning deaths.
- Children 1 to 4 years of age accounted for nearly half of drowning deaths (45%). Children 5 to 9 years old and children 10 to 14 years old each accounted for 20%, and children 15 to 17 were 15%. There were no drowning deaths of children under 1 (see Figure 28).
- The majority of reviewed drowning deaths were White children (75%), Black children were 19% and Hispanic were each 10%, and Asian children were 5% (see Figure 29).
- The majority of drowning deaths were accidental (90%), and two deaths were undetermined (10%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 15 of the 247 reviewed deaths (6%) were related to drowning.

- Two-thirds (67%) of the reviewed drowning deaths were boys.
- Children 1 to 4 years of age accounted for 40% of reviewed drowning deaths. Children 5 to 9 years old and 10 to 14 years old each accounted for 27%, and children 15 to 17 were 7%. There were no drowning deaths of children under 1 (see Figure 28).
- The majority of reviewed drowning deaths were White children (73%), Black children were 13%, and Hispanic children and Asian children were each 7% (see Figure 29).
- All reviewed drowning deaths were accidents (100%).

Figure 28: Child Deaths Due to Drowning by Age

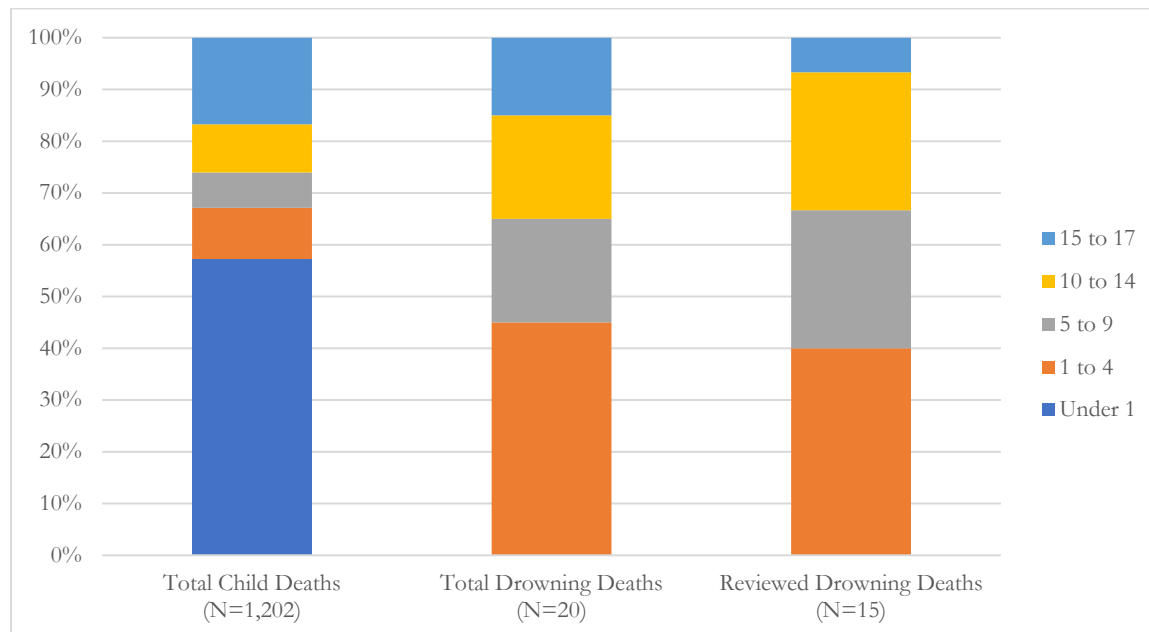
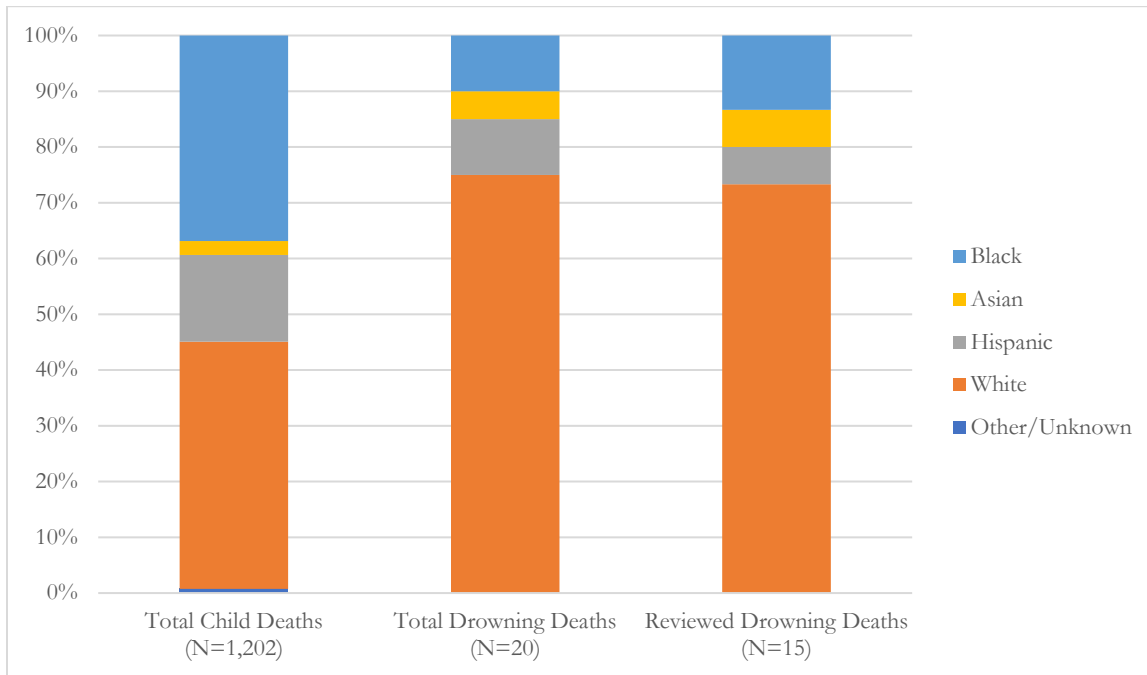


Figure 29: Child Deaths Due to Drowning by Race/Ethnicity



Fire

Definition

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

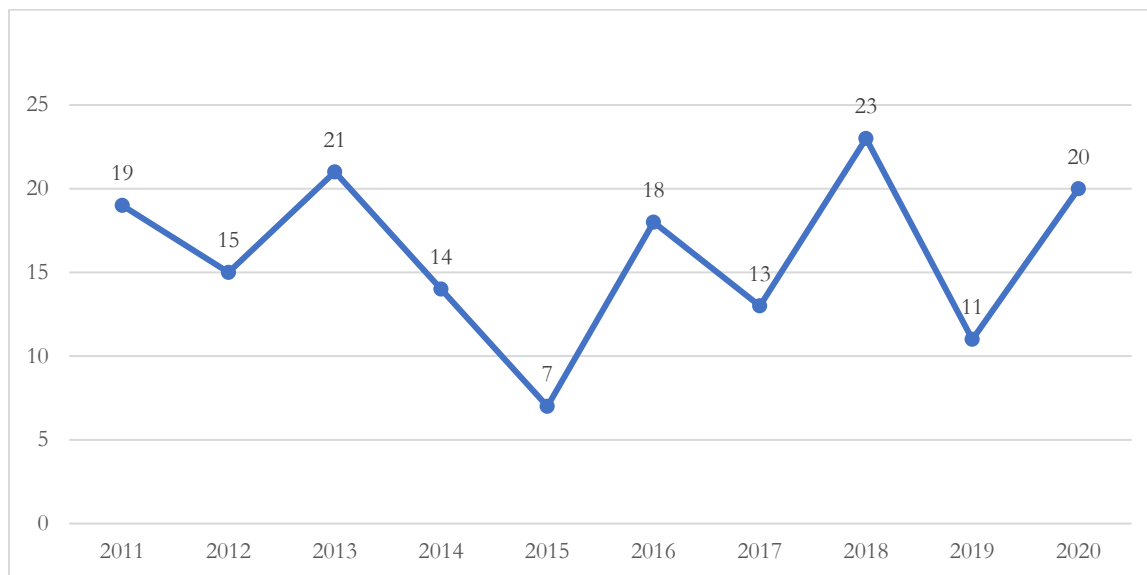
Background

In the United States, fire and burns were the cause of 260 deaths among children between 0 and 17 years in 2020. Forty-two percent of fire deaths occurred in children ages 4 and under.²⁵ A large proportion (about 87%) 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 20 deaths due to fire in 2020 (see Figure 30).

Figure 30: Child Deaths Due to Fire



In 2020, 20 of the 1,202 total child deaths reported to the CDRTs (2%) were related to fires.

- Deaths were an equal amount of fire deaths between boys and girls (50% each).

²⁵ Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2022). *Explore Fatal Injury Data Visualization Tool (WISQARS)*. Retrieved from <https://wisqars.cdc.gov/data/explore-data/home>

²⁶ Safe Kids Worldwide. (2022). *Fire safety*. Retrieved from <https://www.safekids.org/fire>.

- Half of the deaths from fires were children age 1 to 4 (50%). Children 5 to 9 were 35%, and 15% children age 15 to 17. There were no deaths from fire of children under 1 and children age 15 to 17.
- The majority of deaths due to fire were White children (65%), followed by Black children (20%) and Hispanic children (15%).
- The majority of deaths attributable to fire were accidental (75%). The remaining cases were homicides (10%) and undetermined (15%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, eight of the 247 deaths reviewed by the CDRTs were related to fire (3%).

- Boys made up a larger proportion of reviewed fire deaths (63% each).
- Half of the reviewed fire deaths were of children ages 1 to 4 (50%), and children 5 to 9 and children 10 to 14 each accounted for 25% of reviewed fire deaths.
- The majority of deaths due to fire were White children (63%), followed by Black children (25%) and Hispanic children (13%).
- Most reviewed fire deaths were accidental (63%), two cases were undetermined (25%), and the remaining case was a homicide (13%).

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

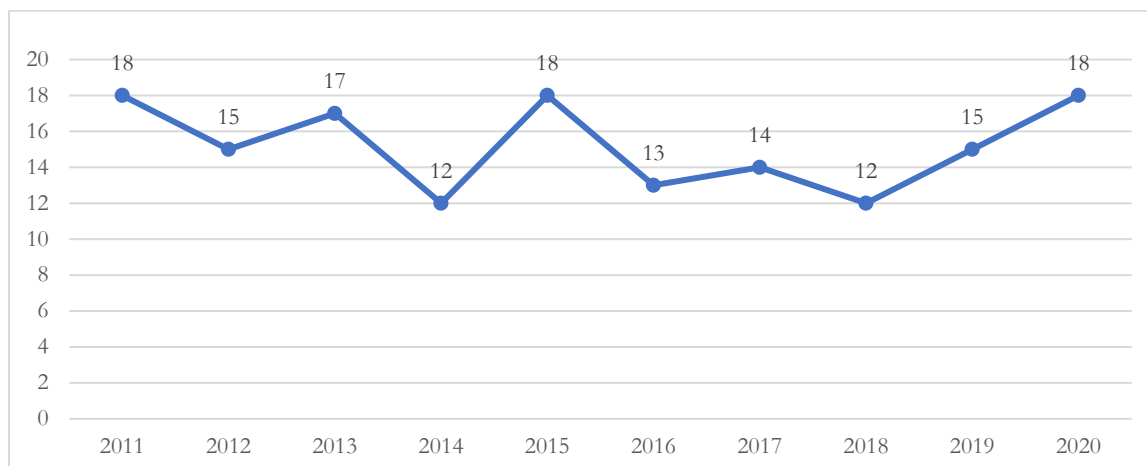
In 2020, 780 children under 18 years died of poisoning in the United States.²⁷ Over six in ten of these deaths occurred in children 15 to 17 years of age. Children 4 and under make up a large proportion of poisoning deaths (19%).

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. (2022). *Explore Fatal Injury Data Visualization Tool (WISQARS)*. Retrieved from <https://wisqars.cdc.gov/data/explore-data/home>

²⁸ Baker J. M., & Mickalide, A.D. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on safe medication*. Washington, DC: Safe Kids Worldwide. Retrieved from <https://www.safekids.org/sites/default/files/documents/ResearchReports/medicine-safety-study-2012.pdf>.

In 2020, eighteen of the 1,202 total child deaths (1%) were related to poisonings or overdoses.

- There were more poisoning or overdose deaths of boys (61%).
- The majority of poisoning or overdose deaths were children ages 15 to 17 (72%), and children under 1 and children 1 to 4 each accounted for 11% each. There was one death of a child between age 5 to 9 (6%), and there were no deaths of children ages 10 to 14.
- The majority of reviewed poison deaths were White children (69%), Black and Hispanic children were each 13%, and 6% were Asian.
- Accidents accounted for half (50%) of poison/overdose deaths, and the remaining cases were suicides (22%) or homicides (11%), and 17% were undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, nine of the 247 deaths reviewed by CDRTs (4%) were related to poisoning/overdose.

- There were slightly more poison deaths reviewed for boys (56%).
- Children ages 15 to 17 made up 56% of reviewed poison deaths. There were two children ages 1 to 4 (22%), and there was a single death of a child under 1 (11%) and another of a child age 5 to 9 (11%).
- The majority of reviewed poison deaths were White children (78%), and two cases were Black children (22%).
- Over half of the reviewed poison/overdose deaths were accidental (56%), and the rest were homicides (22%) or undetermined (22%).

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 3,400 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 2020, 1,389 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

The 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

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. (2022). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Data and Statistics*. Retrieved from <https://www.cdc.gov/sids/data.htm>.

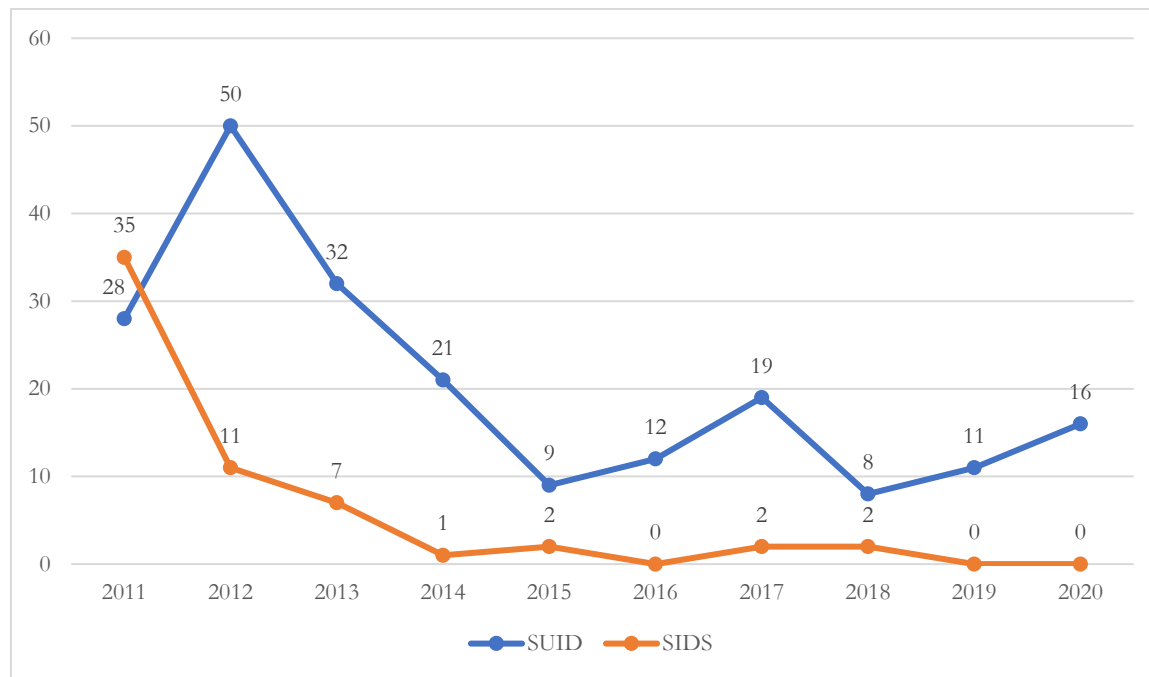
³¹ Shapiro-Mendoza, C.K., Tomaszek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, 163, 762-769.

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 a 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 2020, 16³³ of the 1,202 child deaths were categorized as SUID (1%), and there were no deaths from SIDS (0%).

- The majority of SUID deaths were boys (69%).
- All SUID deaths were infants under 1 year (100%).
- Half of SUID deaths were Black children (50%), White children were 38%, and two children was Hispanic (13%).
- Nearly half of the SUID deaths were accidental (47%), and the remainder were natural (40%) undetermined (13%).

³³ Data in this section may show updated counts and percentages not reflected in other tables in report.

Illinois Data—Deaths Reviewed by the CDRTs

In 2020, 10 of the 247 deaths reviewed by the CDRTs were related to SUID (4%).

- Boys made up the 60% of reviewed SUID deaths.
- All reviewed SUID cases were infants under 1 year of age (100%).
- Half of reviewed SUID deaths were Black children (50%), White children were 40%, and one child was Hispanic (10%).
- Most SUID deaths were accidental (70%), and the rest were natural (30%).

Uncommon Death Categories

There are several less-common categories of deaths. These accounted for less than 1% of child deaths per year.

Sudden Unexplained Child Death (SUCD)

There was one reported SUCD case in 2020, and it was not reviewed by a CDRT.

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 2020, seven deaths fell under this label, and two were reviewed by a CDRT.

Pending

There were 7³⁴ deaths that were currently pending at the time of writing this report.

³⁴ Data in this section may show updated counts and percentages not reflected in other tables in report.

Chapter 5: Infant Deaths During Sleep

Illinois Child Death Review Teams (CDRTs) have been reviewing infant deaths for more than a quarter of a century. The goals of child death reviews include gaining a better understanding of the causes of child deaths and recommending changes in practice to prevent future deaths. Many of the reviews conducted by the CDRTs involve unsafe sleep, and for the past several years they have sought to bring increased attention to infant deaths due to unsafe sleep. This chapter examines the deaths of infants younger than one year of age that occur suddenly and unexpectedly while sleeping.

Definition

Infant deaths during sleep in this chapter are defined as 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 Sudden Infant Death Syndrome (SIDS). Over 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.³⁵ 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.³⁶ Bed sharing, sleeping prone, sleeping in an adult bed, the use of blankets, pillows, secondhand smoke, caretaker inebriated or high all became unsafe sleep conditions. The Safe to Sleep Campaign has had success with educating the public on

³⁵ 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.

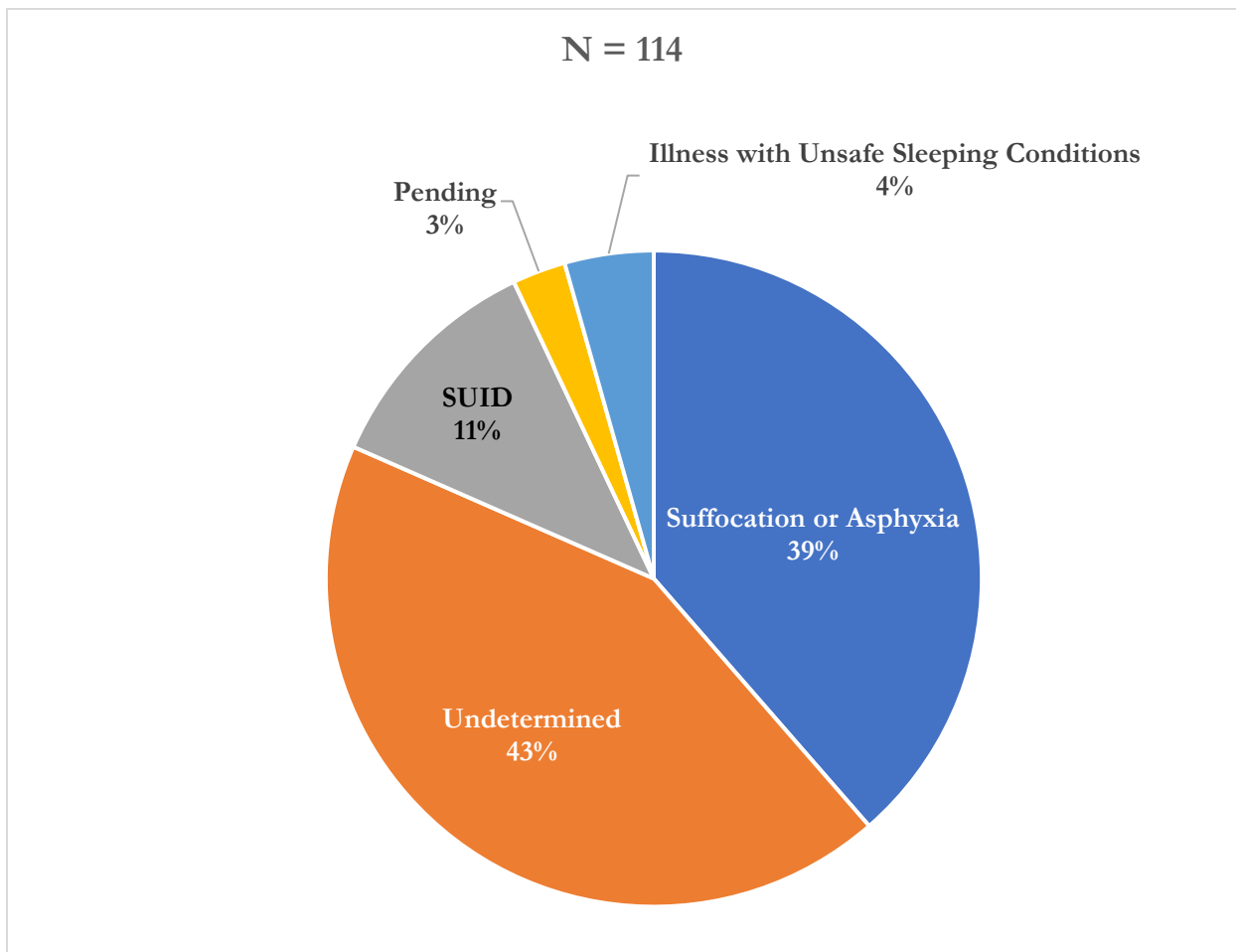
³⁶ U.S. Department of Health and Human Services National Institutes of Health (n.d.). *Safe to sleep public education campaign*. Retrieved from <https://safetosleep.nichd.nih.gov/activities/campaign>.

safe infant sleep. However, traditions and cultural customs are slow to change. There are some professionals that still advocate bed sharing. 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 Infant Deaths During Sleep for 2020

Infant deaths during sleeping was the third leading cause of death of children in Illinois for calendar year 2020. As recorded by Child Death Review Teams, 114 infants died unexpectedly while sleeping in 2020. The sleep related deaths are represented by sections of the Suffocation, Undetermined, SIDS and SUID categories. Suffocation or asphyxia while sleeping caused the death of 44 infants. The undetermined (while sleeping) category accounted for 49 infant deaths. SUID had 13 infant deaths, Illness with Unsafe Sleeping Conditions caused 5 infant deaths, and the cause of 3 deaths is pending.

Figure 33: Infant Sleep Cause of Death



These 114 infant deaths during sleep accounted for 9% of the 1,202 child deaths of 2020, and 109 of the 114 deaths were reviewed by Child Death Review Teams. Each infant sleep death had at least one unsafe sleep condition. Some had multiple unsafe sleep conditions.

- Infant boys made up 65% of infant deaths during sleep.
- Infants four months and under made up over three-quarters of infant deaths during sleep (77%) (see Figure 34).
- The largest proportion of infant deaths during sleep were Black children (57%), followed by White children (32%), Hispanic children (10%), and Asian children (1%).
- Prone (45%) and supine (36%) infant positions were most common in infant sleep deaths (see Figure 35).
- Alcohol or drug use was noted in 27% of deaths.
- Bed-sharing was noted in 73% of deaths.
- Adult beds were the most common location of infant deaths during sleep (68%) (see Table 6).
- The presence of blankets/soft bedding was found in 87% of overall infant deaths during sleep, and pillows were present in 68% of deaths.
- Prior DCFS contact was noted in 44% of deaths.
- The majority of deaths were or will be reviewed by CDRTs (96%).

Figure 34: Deaths by Infant Age

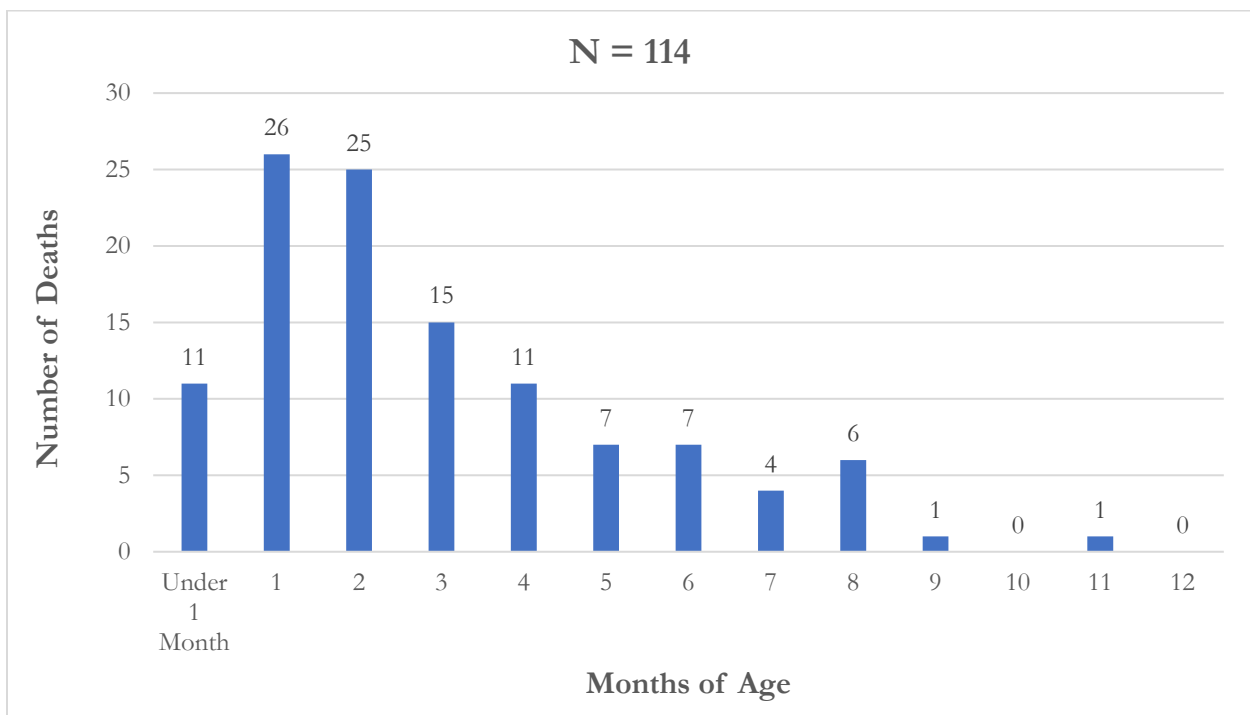


Figure 35: Deaths by Infant Sleep Position

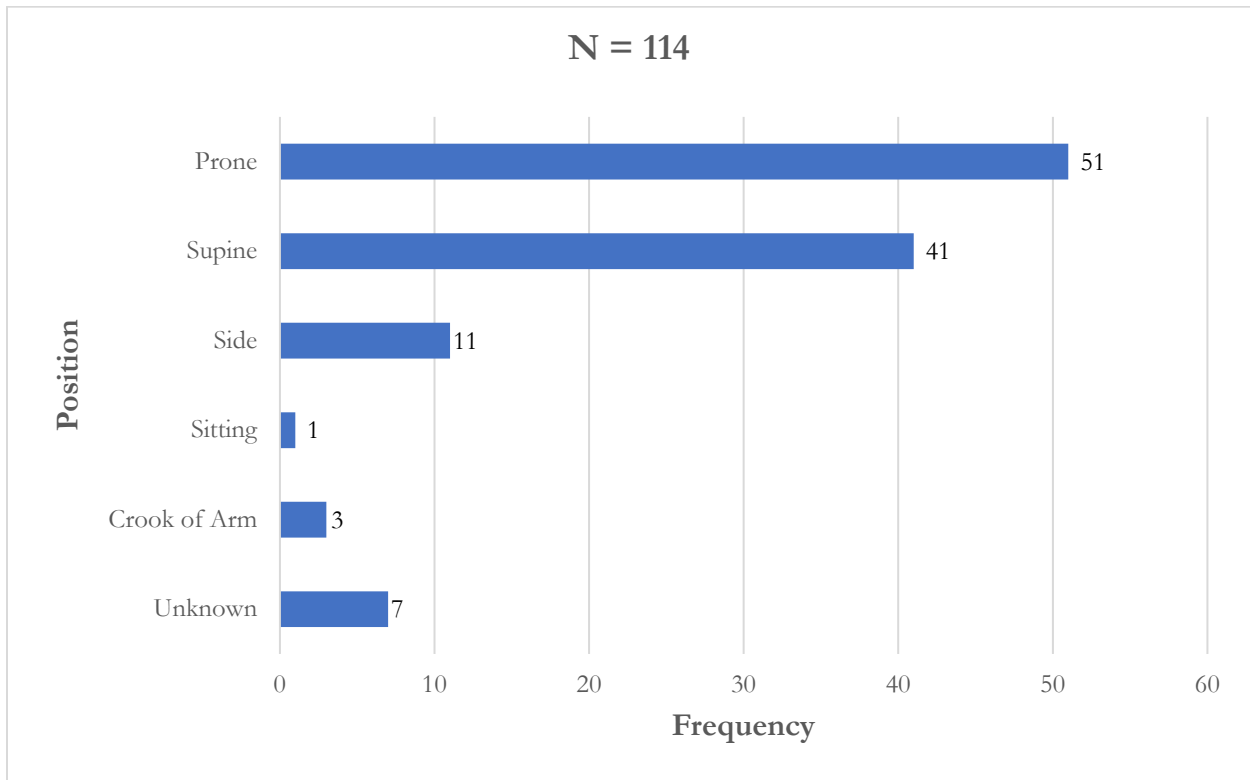


Table 5: Location and Environment of Infant Deaths During Sleep

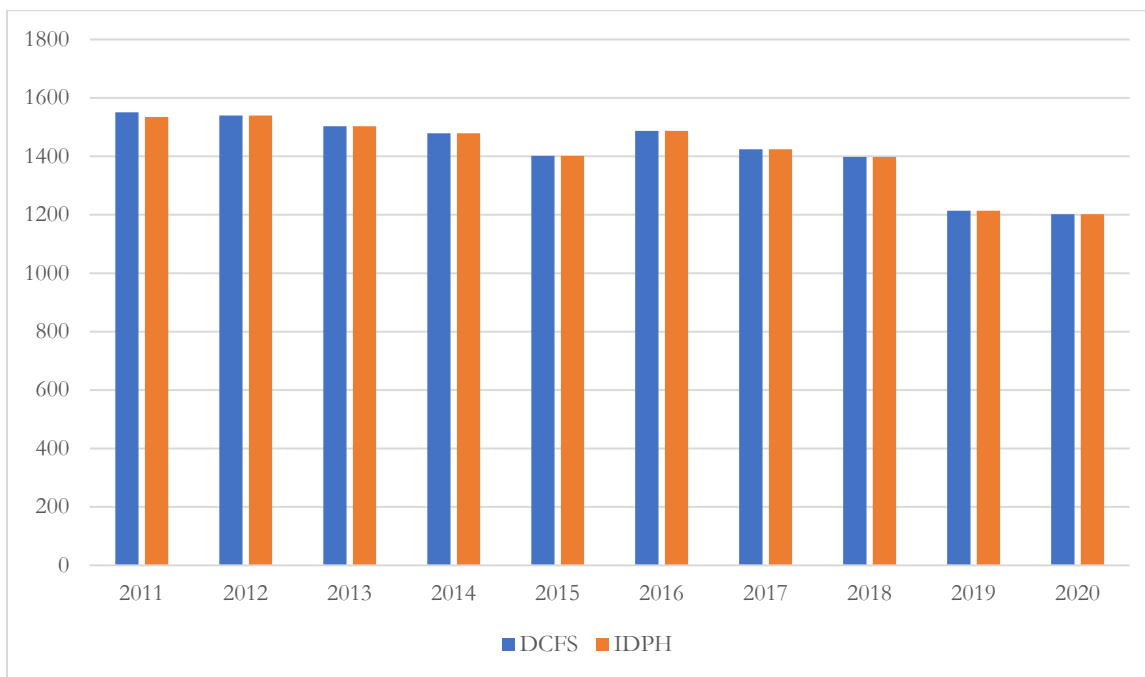
Location of Infant	Counts		
	Number of Deaths	Number with Blanket/Soft Bedding	Number with Pillows
Adult Bed	78	78	78
Couch	7	1	0
Crib	8	6	0
Bassinet	3	3	0
Pack n Play	6	5	0
Car Seat	1	0	0
Floor	1	1	0
Air Mattress	2	2	0
Mattress on Floor	1	1	0
Recliner	2	0	0
Chaise Sofa Bed	1	1	0
Rock n Play	1	1	0
Rocker	1	0	0
Back Seat of Car	1	0	0
Unknown	1	0	0
Total	114	99	78

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 (EDW). The EDW receives the deaths from IDPH. Thus, from 2012 forward, the DCFS deaths and IDPH deaths are consolidated.

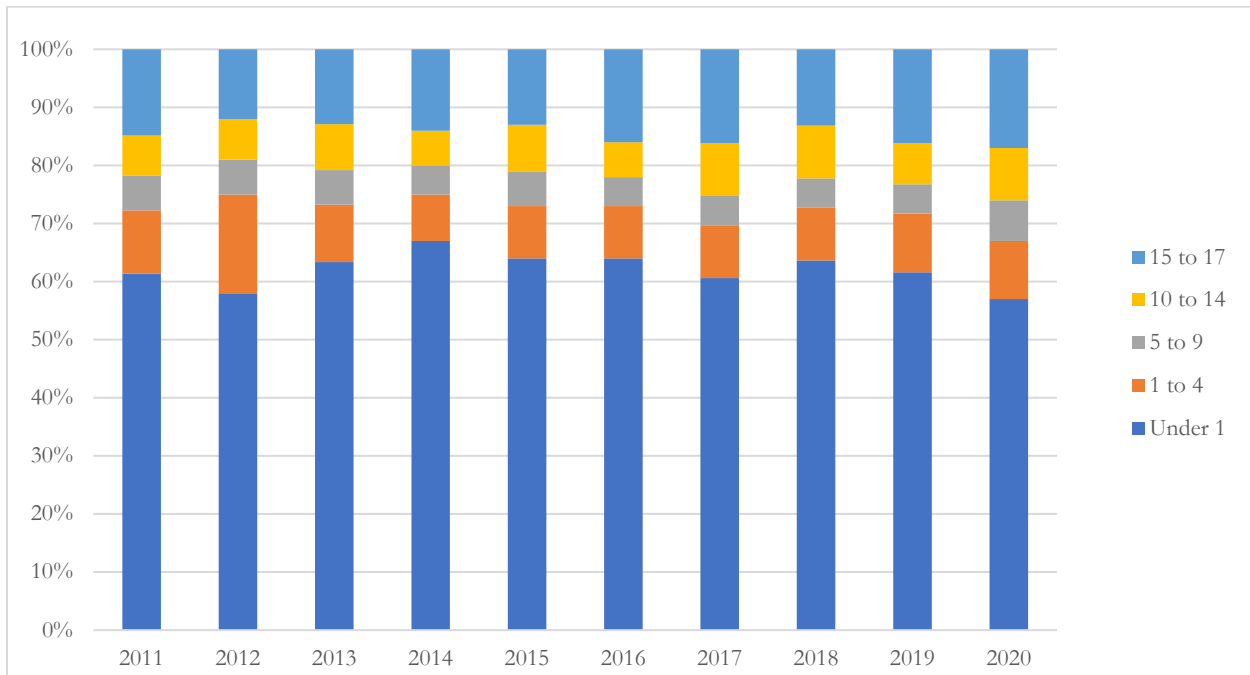
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1,551 (DCFS data) in 2011 to a current low of 1,202 in 2020 (see Figure 36).

Figure 3366: Total Child Deaths Reported to DCFS and IDPH, 2011–2020



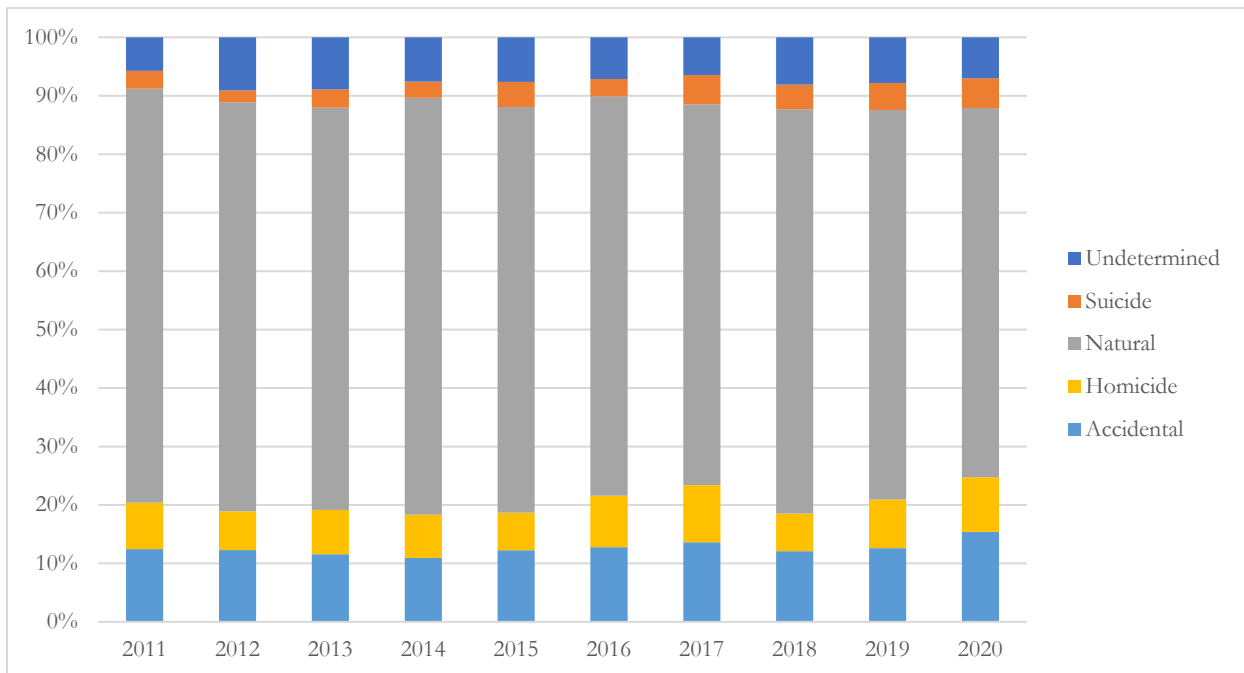
The total child deaths reported to the Child Death Review Team Unit from 2011 to 2020 is broken down by age group in Figure 37. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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 37 shows, the percentage of total deaths in each age group is generally stable over the 10-year period: infants under 1 year comprise 57-67% of all child deaths, children between 1 and 4 years comprise 8-17%, children between 5 and 9 years add another 5-7%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are about 12-17%.

Figure 37: Total Child Deaths (reported to DCFS) by Age Group, 2011-2020



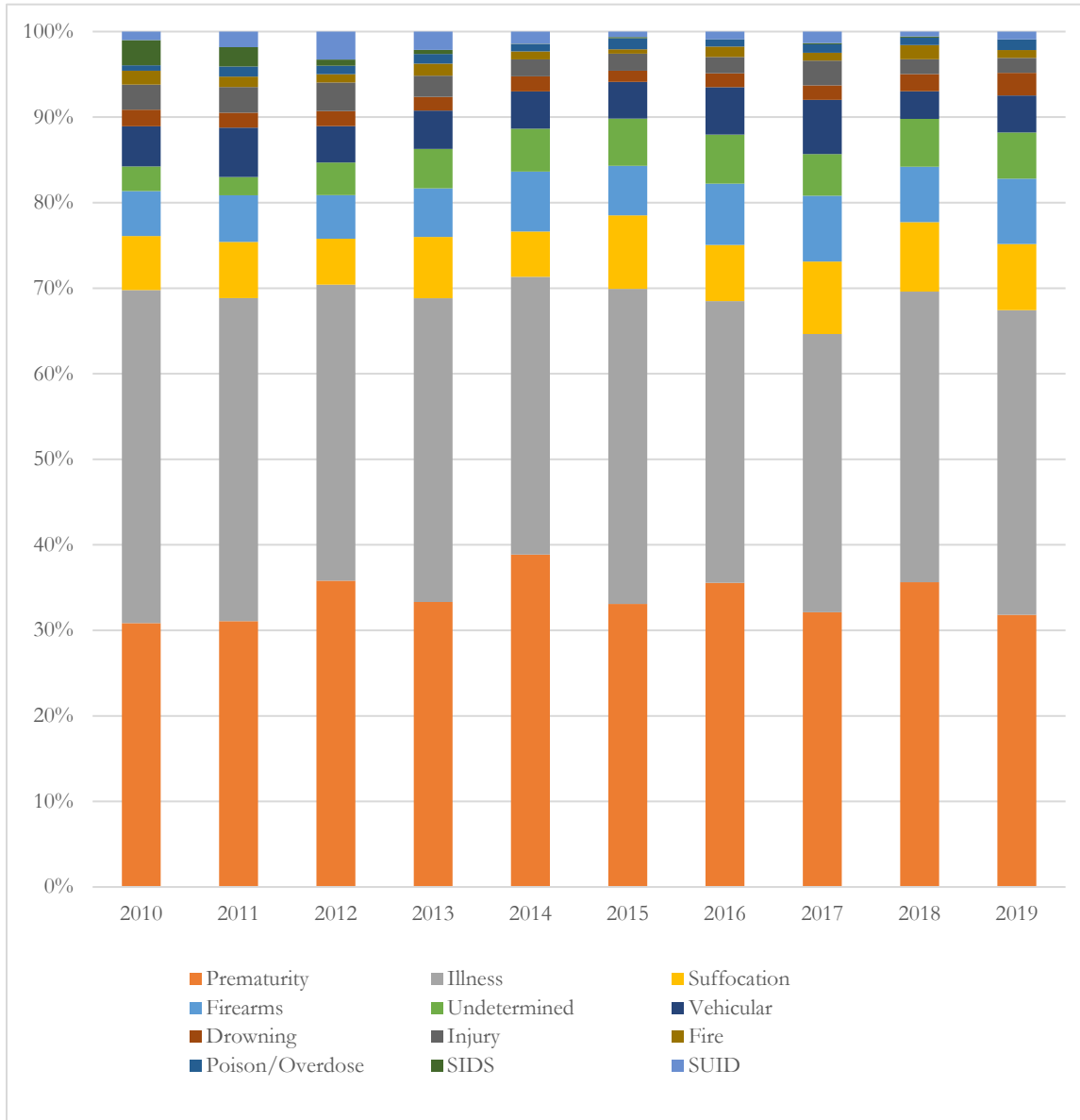
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-14% accidental, 6-10% homicide, 65-72% natural, 2-5% suicide, and 6-9% undetermined (see Figure 38).

Figure 38: Total Deaths (reported to DCFS) by Manner of Death, 2011-2020



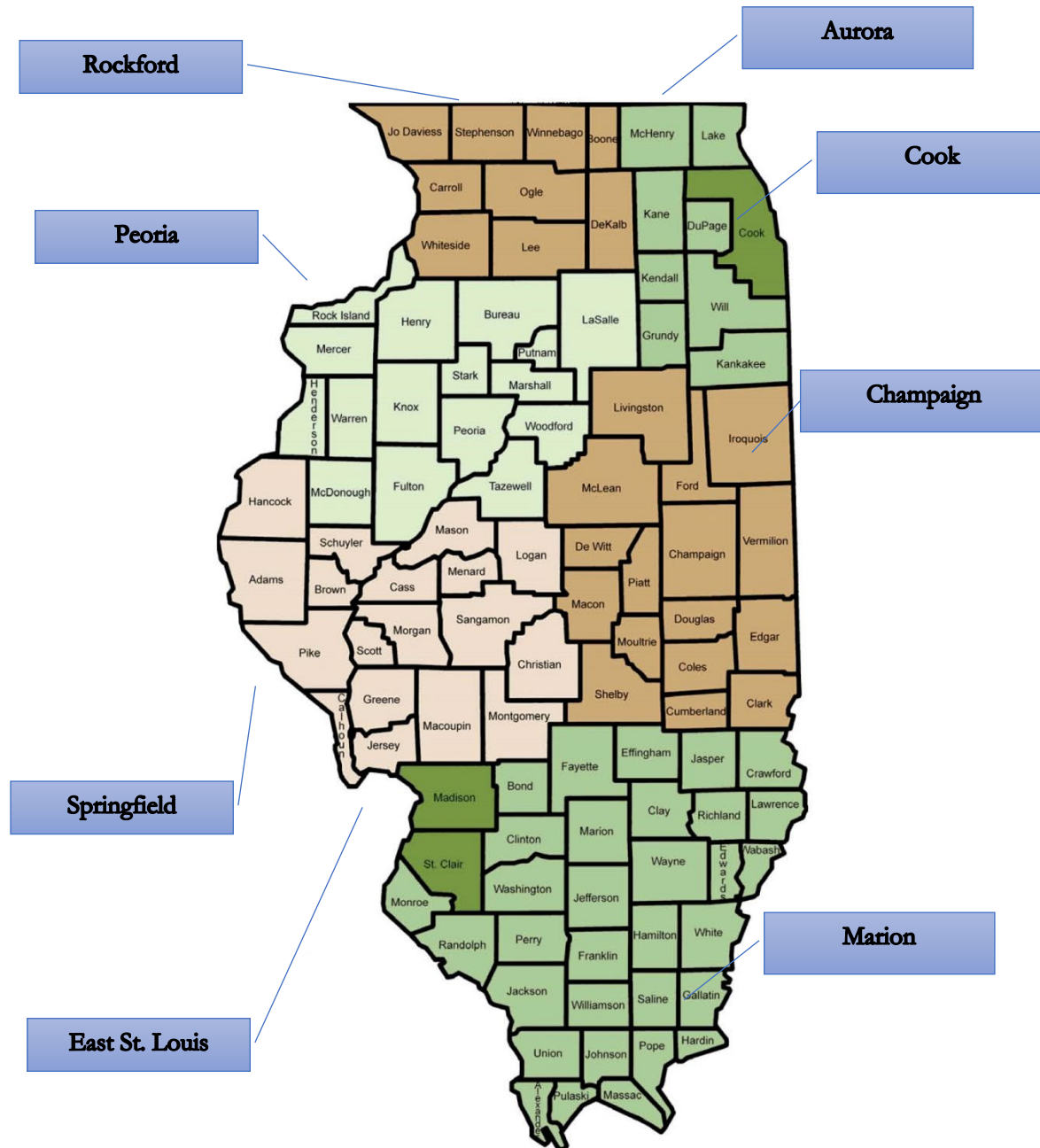
A similar analysis was done for category of death (see Figure 39). The percentage of child deaths related to each category of death across the time period varies. The major categories of deaths from prematurity (31-39%) and illness (32-39%) fluctuated over time. There was an increasing trend for deaths 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 2010 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 39: Total Child Deaths (reported to DCFS) by Category, 2011-2020³⁷



³⁷ Note 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

Jennifer Hess, **Chairperson**
Wendy Payne, **Vice Chairperson**
Donna Bredrup
Patrick Dempsey
Joshua Fourdyce
Jennifer Hillgoth
Mary E. Jones MD, MPH
Nydia Molina
Orson Morrison
Loren Richardson Carrera
Jennifer Samartano
Anne Strickland
Dan Thomas, Special Agent
DCFS Liaison: Tillya Bradford-Hollins

Champaign

Donald F. Davison, Jr. MD, **Chairperson**
Brent Reifsteck, MD, **Vice Chairperson**
Kathleen Carney Buetow, MD
Jackie Dever
Jennifer Doege
Kimberly S. Fitton
Duane Northrup
Judy Osgood, PhD
Cindy Patterson
Daniel Rossiter
Eliza Rudin, RN, BSN, TNS, CEN
DCFS Liaison: Amy Magrini

Cook Team A

Joan M. Pernecke, **Chairperson**
Daniela Silaides, **Vice Chairperson**
Seyedeh Ahadi, MPH
Janet Barnes
Kristen Bilka, MMS, PA-C
Kristine Caraballo
Margaret Conway
Dr. Kristin Escobar-Alvarenga
Brian Finley
Jeana Friday, BSN, RN
Jill Glick, MD

Cook Team A (cont.)

Mary Henderson
Nicole Jackson, MD
Sharon Koc
Eileen Payonk, Special Agent
Kyran Quinlan, MD, MPH
Karen Pitroda
Jennifer Seo, MD, JD
Dion Trotter
Janice Waters
Syed Zaheer
Virginia Zic-Schlomas, Sgt.
DCFS Liaison: Rotates Area Administrators

Cook Team B

Mary Joly Stein, **Chairperson**
Kim King, **Vice Chairperson**
Sweety Agrawal, PsyD
Seyedeh Ahadi, MPH
Shawnte Alexander
Rebecca Chacon, LCSW
Dr. Michael Eckhardt
Craig Engebretson
Lindsay Forrey, LCSW
Kathy Grzelak, MA, LCPC
Nicole Johnson, MD
William Leen, Commander (Retired)
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Veena Ramaiah, MD
Kevin Scott
Dr. Benjamin Soriano
Demetra Soter, MD
Annie Torres, MD
Jason Wynkoop
DCFS Liaison: Rotates Area Administrators

East St. Louis

Daniel Cuneo, PhD, **Chairperson**
David C. Norman, **Vice Chairperson**
Emily Bell
Jamie Brunnworth
Cathy Daesch, ATR-BC, LCPC, ICDVP
Judy Dalan
Carolyn Hubler, Director
Francis Jones, RN
Abeba Lakew
Michael O'Neill
James Piper
Sakina Vernor
DCFS Liaison – Gary Crone

Marion

Mary Louise Cashel, **Chairperson**
Sheryl Woodham, MSW, LCSW, **Vice Chairperson**
Tylor Barber
Lukasz Dabrowski, MD
Connie Edgar
Sarah Fager, RN
Robin Hopper
Lisa Irvin
Jennifer Lindsey
Betti Mucha
Joe Murphy
Brittany Pierce
Kathy Swafford, MD
Tammy Turner
Steve Webb, PhD
DCFS Liaison-Stephanie Grigsby

Peoria

Judy Guenseth, **Chairperson**
Special Agent Timothy Wilkins, **Vice Chairperson**
Dr. Susan Bordenave-Bishop
M/Sgt. Gregg M. Cavanaugh
Jacqueline Diediker
Erik Gibson
Brian Gustafson
Kelsey Haage, BSN
Umair Iqbal, MD, MPH
Ann Lading-Ferguson
Emily McDonnell, MSN
Mark McLaughlin
Marcy O'Brien
Channing Petrak, MD

Peoria (cont.)

Melissa Watkins
DCFS Liaison - Megan Sturtevant

Rockford

Joanna Deuth, **Chairperson**
Holly Peifer, **Vice Chairperson**
Rebecca Anderson
Justin Anderson
Pamela A. Borchardt
Amy Buchenau
Raymond Davis, Jr., MD
David Glessner
Sean Hughes
Allison Huntley
Rebecca Wigget
DCFS Liaison – Aram Perry

Springfield

Betsy Goulet, **Chairperson**
Careyana Brenham, MD, **Vice Chairperson**
Jim Allmon
Ginger Darling, MD
Rachel Deerwester BSN, RN
Heather Hofferkamp
Rebecca Howard, APRN, CPNP-PC
Denise McCaffrey
Susan McCarty BSN, RNC-LRN
Audie Prange, Lieutenant
Eric Weston, Special Agent
Dan Wright
DCFS Liaison – Amie Holzmacher

*** 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	2011*		2012	2013	2014	2015	2016	2017	2018	2019	2020
	DCFS	IDPH									
Adams	4	3	9	5	9	9	8	6	6	2	9
Alexander	0	0	1	0	0	0	1	1	0	2	0
Bond	2	2	4	1	0	2	0	2	0	0	0
Boone	4	2	3	0	1	0	1	2	2	0	0
Brown	0	0	1	1	0	0	0	0	0	0	0
Bureau	1	1	2	1	3	0	2	1	0	0	4
Calhoun	0	0	0	0	0	0	0	0	1	0	0
Carroll	0	0	1	0	1	0	1	1	0	0	0
Cass	0	0	1	0	0	0	0	0	0	2	2
Champaign	43	37	29	49	38	30	45	44	44	39	27
Christian	3	2	2	1	1	4	2	3	1	1	1
Clark	2	2	1	3	0	1	1	1	1	0	0
Clay	0	0	1	1	0	0	3	0	2	1	1
Clinton	2	1	1	3	0	0	1	3	1	2	0
Coles	5	6	4	4	4	2	5	6	3	2	4
Cook	857	824	857	775	815	818	831	766	781	692	622
Crawford	2	1	4	4	0	1	0	4	1	1	1
Cumberland	0	0	1	0	0	0	1	0	0	0	0
DeKalb	5	5	4	9	7	3	6	7	4	8	7
Dewitt	1	1	0	0	3	1	0	1	3	3	1
Douglas	1	1	1	0	1	0	1	2	0	0	0
DuPage	73	68	66	70	80	63	76	56	70	67	64
Edgar	1	1	1	1	1	2	1	0	2	0	0
Edwards	0	0	1	0	1	0	0	0	0	0	0
Effingham	8	7	2	7	5	5	4	3	4	1	1
Fayette	1	1	0	2	3	1	1	1	0	2	0
Ford	0	0	1	2	1	0	0	1	1	2	1
Franklin	2	1	0	2	4	6	3	1	1	0	8
Fulton	0	0	3	0	0	2	2	2	2	1	1
Gallatin	0	0	1	0	0	0	0	0	0	0	0
Greene	0	1	0	0	1	0	0	4	1	1	2
Grundy	3	2	3	2	1	2	1	3	1	0	2
Hamilton	1	1	1	2	0	1	2	0	0	0	1
Hancock	1	1	0	1	3	0	0	1	0	1	2
Hardin	1	2	1	1	1	1	1	1	1	3	0
Henderson	0	0	0	0	0	0	0	0	0	1	0
Henry	4	2	2	3	3	2	5	3	1	1	2
Iroquois	1	1	1	1	0	0	2	2	2	2	1
Jackson	8	6	16	2	5	9	4	9	8	7	5
Jasper	0	0	0	0	0	0	1	0	0	0	0
Jefferson	7	6	2	6	4	2	4	2	6	0	2
Jersey	2	3	4	2	0	4	2	3	0	0	2
Jo Daviess	4	4	0	1	0	0	2	0	0	2	1
Johnson	0	3	2	0	0	0	0	0	0	0	3
Kane	45	42	42	42	44	51	46	39	45	25	22
Kankakee	8	8	12	10	10	6	16	9	13	7	7
Kendall	1	1	2	3	2	0	0	2	1	1	1
Knox	10	10	3	4	6	6	6	4	3	5	3
Lake	35	40	33	37	36	36	34	36	35	31	35

LaSalle	9	8	11	8	7	11	5	4	7	8	8
Lawrence	4	2	1	2	0	1	0	1	1	1	1
Lee	2	2	2	3	3	2	1	6	1	2	0
Livingston	5	2	3	0	4	2	3	2	2	3	2
Logan	2	2	3	3	1	0	3	3	1	2	0
Macon	13	13	7	4	12	11	7	11	7	9	15
Macoupin	0	0	0	5	4	2	0	2	0	1	2
Madison	13	11	8	12	14	18	21	18	23	15	11
Marion	5	9	2	5	5	10	3	4	3	3	3
Marshall	0	0	0	0	0	1	1	0	0	0	0
Mason	0	0	0	3	1	2	1	0	0	1	1
Massac	0	0	2	1	0	1	3	1	1	2	1
McDonough	1	1	1	2	0	1	0	1	3	1	0
McHenry	11	9	12	17	9	9	9	11	9	9	12
McLean	13	12	9	12	13	14	8	11	8	6	9
Menard	0	0	0	0	0	0	0	0	0	0	0
Mercer	1	1	2	6	0	1	0	1	2	0	1
Monroe	1	1	1	1	0	1	0	0	0	1	0
Montgomery	3	2	1	0	4	2	3	0	2	3	0
Morgan	0	1	2	3	3	0	2	4	2	2	3
Moultrie	4	4	1	0	0	0	0	1	0	1	0
Ogle	1	1	0	0	2	3	0	4	0	1	0
Peoria	76	75	109	72	82	63	76	83	68	65	76
Perry	0	0	1	3	2	1	2	0	1	1	0
Piatt	1	1	1	0	0	0	0	2	0	1	0
Pike	0	0	0	0	0	0	1	0	3	2	1
Pope	0	0	1	0	0	0	0	1	0	0	0
Pulaski	0	0	0	0	0	0	0	0	0	0	1
Putnam	0	0	0	0	0	1	0	0	1	0	0
Randolph	1	1	6	7	2	1	3	0	4	1	2
Richland	2	2	1	1	2	1	2	2	1	1	0
Rock Island	12	11	11	9	12	8	9	10	8	10	10
Saline	1	1	3	0	3	3	0	1	5	2	1
Sangamon	38	46	33	46	39	36	45	38	53	33	42
Schuyler	6	0	1	1	1	0	0	2	0	1	1
Scott	0	0	0	2	0	0	1	0	0	0	0
Shelby	0	0	0	2	0	2	1	2	0	0	0
St. Clair	18	15	21	31	26	15	15	31	17	10	21
Stark	0	0	0	0	0	0	0	1	0	1	0
Stephenson	2	2	1	2	4	3	2	5	5	3	3
Tazewell	3	2	3	2	7	5	3	6	7	4	3
Union	1	1	1	2	1	3	0	9	1	0	1
Vermillion	8	6	11	10	7	4	12	5	5	7	5
Wabash	0	0	1	0	1	0	1	0	0	1	2
Warren	1	1	1	1	1	1	1	1	1	4	0
Washington	1	1	0	1	1	0	1	0	1	0	0
Wayne	1	1	2	1	1	3	1	0	0	0	1
White	1	1	1	0	1	0	2	0	0	0	0
Whiteside	4	3	1	4	3	1	6	3	5	1	9
Will	28	26	33	34	38	24	36	34	38	29	43
Williamson	10	9	6	6	13	6	3	5	8	3	6
Winnebago	51	43	40	36	43	46	59	57	47	45	47
Woodford	3	3	1	4	1	2	1	0	0	3	1
Unknown	0	1	0	0	0	0	0	3	0	0	0
Out of State	46	97	47	81	12	11	12	6	0	0	12

Out of Country	–	–	9	0	0	0	0	0	0	0	0
Total	1,551	1,535	1,540	1,503	1,479	1,402	1,487	1,424	1,398	1,214	1,202

***Death numbers for IDPH are for facility of death. Death numbers for DCFS and IDPH have been consolidated since 2012**



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