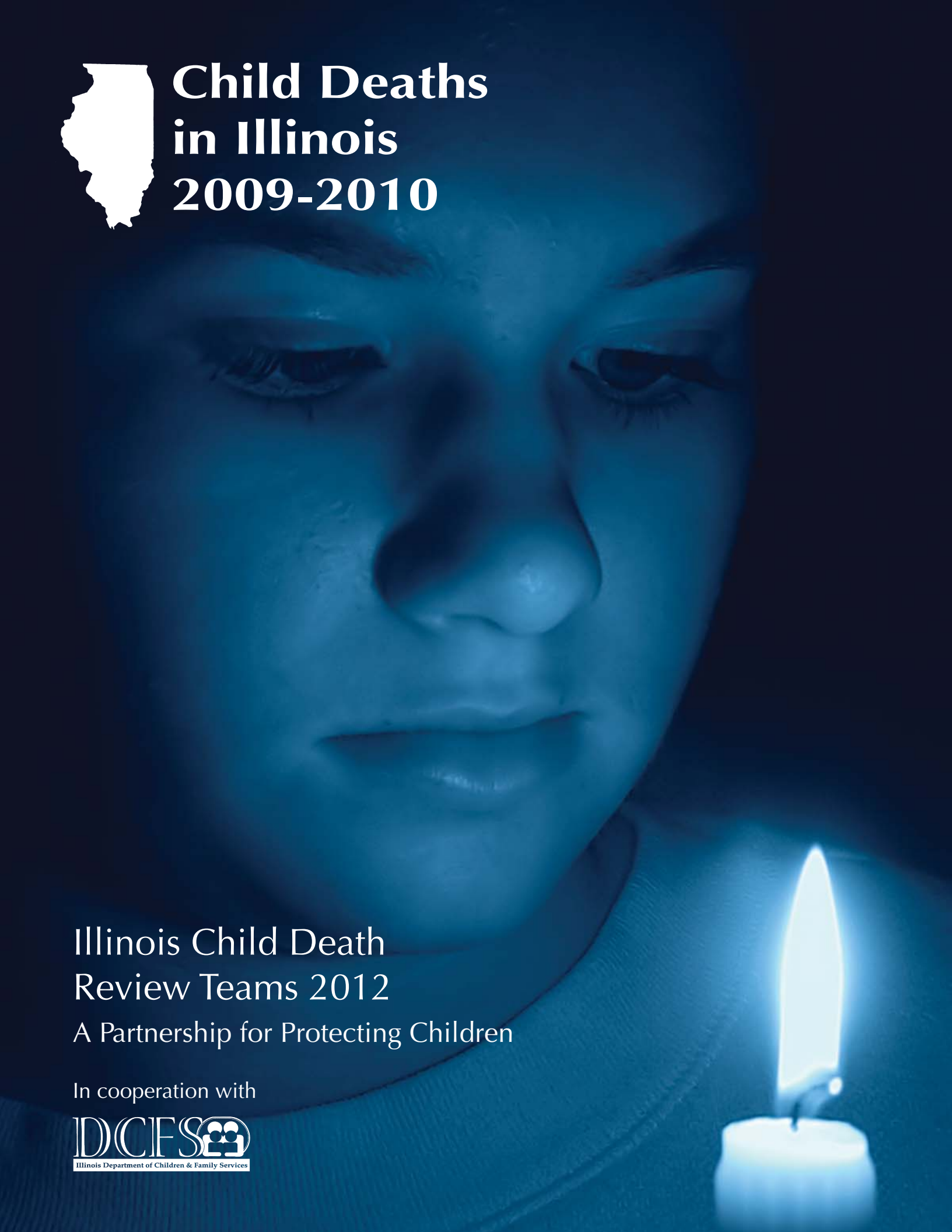

Child Deaths in Illinois 2009-2010

Illinois Child Death Review Teams 2012

A Partnership for Protecting Children

In cooperation with

DCFS
Illinois Department of Children & Family Services

ILLINOIS CHILD DEATH REVIEW TEAMS: A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT ON CHILD DEATHS IN 2009 AND 2010

MISSION

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

SUBMITTED TO:

The Honorable Pat Quinn, Governor, State of Illinois
Illinois State Senate
Illinois House of Representatives

JUNE 2012

Illinois Child Death Review Teams

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May 2012

The Honorable Pat Quinn, Governor of the State of Illinois:
The Honorable Members of the 97th General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2009-2010. In accordance with the Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All of the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department of Children and Family Services (DCFS). The CDRT Executive Council reviews all recommendations made by the nine Illinois Child Death Review Teams and submits them to DCFS. The CDRT Executive Council continues to value the time the Director of DCFS dedicates to meet with the Executive Council, in-person, to discuss the recommendations made by the child death review teams, the responses given by DCFS to these recommendations, and the implementation of these recommendations.

The Southern Illinois Child Death Investigation Task Force continues to be a successful program for the Southern Region of Illinois. The Regional Task Force Teams continue to be activated and have assisted on 25 cases to date. Assistance to local agencies by the task force has resulted in charges being filed on 12 of these cases. These charges have ranged from felony child endangerment to first degree murder.

We want to thank DCFS Director Richard H. Calica for agreeing to meet with the CDRT Executive Council in person and continuing to work with child death review. We truly appreciate all of your extra time and efforts. We would also like to thank all of the DCFS staff that is currently working with child death review. Thank you for your cooperation and for providing the necessary resources for the nine Child Death Review Teams and the Executive Council.

We would also like to express our sincere appreciation to the almost two hundred professionals of multiple disciplines who are the members of the nine CDRTs. Thank you for volunteering your time, your expertise, and your experiences to this very important effort. A special thanks goes to our fellow members of the Executive Council who not only serve as the Chairpersons and Vice Chairpersons of their individual teams, but who also attend additional meetings to finalize teams' recommendations and discuss general child death review issues. All of you are invaluable to this process of protecting Illinois' children.

Lastly, we thank Governor Quinn and the members of the General Assembly for the opportunity to protect and serve the welfare of the children of Illinois.

Respectfully submitted,

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

Duane Northrup, Champaign County Coroner
Vice Chairperson, Executive Council
Illinois Child Death Review Teams

Pat Quinn
Governor

Richard H. Calica
Director

Illinois Department of Children & Family Services

Dear Readers,

I am pleased to present the *2012 Illinois Child Death Review Teams Annual Report, A Partnership for Protecting Children*. The information in the report includes the data for the child deaths that occurred during the 2009 and 2010 calendar years. During that time, 3,106 children under the age of 18 died in Illinois. While many of these deaths were due to natural causes, others may have been prevented through alternative actions by parents and other caregivers, earlier intervention by public support systems, or increased efforts of public safety education campaigns.

In Illinois, the Child Death Review Teams (CDRT) play an important role in the effort to reduce preventable child deaths. Since 1994, CDRT and the CDRT Executive Council have made hundreds of recommendations to the Department of Children and Family Services. As the newly-appointed Director, I take these recommendations very seriously. I have met with the Child Death Review Teams Executive Council to discuss these recommendations and how we can work together to more effectively serve and protect children in Illinois.

The child death review process is an example of all of us sharing the responsibility of advocating for children and working together to keep them safe. This process would not be possible without the commitment and support of hundreds of caring professionals across the state who volunteer their time and expertise to case review and discussions of prevention strategies to reduce child injury and death. I thank the CDRT for their efforts and look forward to working with these dedicated individuals in the future.

Sincerely,

Richard H. Calica
Director
Illinois Department of Children and Family Services

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ACKNOWLEDGEMENTS

This report would not be possible without the dedication and unwavering support of almost 200 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams.

Members of the Child Death Review Team Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

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

Illinois Child Death Review Teams Staff, Sherry Barr, Kate Watson, and Bernadette Emery provided the data analyses from the Child Death Review Team database to Jill Comerford Schreiber. Jill Comerford Schreiber, Research Specialist for the Children and Family Research Center wrote the report. The report was designed by Kate Watson and Sherry Barr.

Illinois Child Death Review Team
Executive Council

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Vice-Chairperson, Champaign, Illinois

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Lori Chassee, Chairperson
Executive Director
Kane County Child Advocacy Center

Susan Fackler, LCSW, CADC, Vice Chairperson
Clinical Director
Ela Township Social Work Program

Champaign
Duane Northrup, Chairperson
Champaign County Coroner

Mark Wichman, MS, Vice Chairperson
Licensed Clinical Professional Counselor
Institute for Human Resources

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Susan Storcel, Chairperson
Director of Child Protection Mediation and Facilitation
Circuit Court of Cook County

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Child Abuse Pediatrician
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Cook B
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Executive Director
Healthy Families

Sgt. Holly Robinson, Vice Chairperson
Chicago Police Department
Juvenile Intervention and Support Center

East St. Louis
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Marion
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Executive Director
The Guardian Center, Inc.

Leigh Hammer, RN, Vice Chairperson
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Joanna Deuth, Chairperson
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Rebecca Hooks, Vice Chairperson
ISP - Crime Scene Investigator
Rockford Forensics Science Lab

Springfield
Tracy Lower, MD, Chairperson
SIU School of Medicine - Pediatrics

Roy Harley, Vice Chairperson
Executive Director
Prevent Child Abuse Illinois

Ex-Officio Member
Denise Kane, PhD
Inspector General – DCFS

CDRT Staff
Kate Ashmore-Watson
Executive Director

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EXECUTIVE SUMMARY

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

Illinois Child Deaths in 2009 and 2010

2009

In 2009, 1,490 children under 18 died in Illinois. These numbers represent the death certificates received by the Department of Children and Family Services (DCFS) State Central Register (SCR) and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the SCR; therefore, this number is a low estimate of the actual number of child deaths that occurred in Illinois.

Of the total child deaths reported to DCFS in 2009:[1]

- 59% were boys and 41% were girls;
- 63% were infants under one year, 12% were young children between 1 and 4 years, 13% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years.

When Illinois child deaths in 2009 were examined by the manner of death:

- 70% were attributable to natural causes;
- 12% were accidental;
- 8% were homicides;
- 2% were suicides;
- 7% were undetermined.

When deaths occurring in 2009 were examined by the category of death:

- 38% were related to illness;
- 29% were related to premature birth;
- 3% were related to Sudden Infant Death Syndrome (SIDS);
- 24% were related to various types of injuries, such as vehicular accidents (4%), firearms (5%), drowning (2%), fires (1%), suffocations (7%), and other types of injuries (4%);
- 4% were due to undetermined causes.

[1] Note that data on the race of the decedents was missing in a large portion of the cases and was unable to be analyzed for 2009 and 2010.

2010

In 2010, 1,622 children under 18 died in Illinois. Of the total child deaths reported to DCFS in 2010:[2]

- 58% were boys and 42% were girls;
- 62% were infants under one year, 11% were young children between 1 and 4 years, 15% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years.

When Illinois child deaths in 2010 were examined by the manner of death:

- 72% were attributable to natural causes;
- 13% were accidental;
- 6% were homicides;
- 2% were suicides;
- 6% were undetermined.

.

When deaths occurring in 2010 were examined by the category of death:

- 38% were related to illness;
- 30% were related to premature birth;
- 3% were related to Sudden Infant Death Syndrome (SIDS);
- 22% were related to various types of injuries, such as vehicular accidents (5%), firearms (5%), drowning (2%), fires (1%), suffocations (6%), and other types of injuries (3%);
- 3% were due to undetermined causes.

Child Deaths Reviewed by the CDRTs

2009

There were 245 child deaths that occurred during 2009 that were reviewed by the CDRTs (171 mandatory and 74 discretionary reviews). Of the deaths reviewed by CDRTs in 2009:

- 58% were boys and 42% were girls;
- 63% were infants under one, 22% were young children between one and four years, 11% were older children between 5 and 14 years, and 4% were youth between 15 and 17 years.

When reviewed deaths occurring in 2009 were examined by manner of death:

- 30% were attributed to natural causes;
- 28% were due to accidents;

[2] Note that data on the race of the decedents was missing in a large portion of the cases and was unable to be analyzed for 2010.

- 18% were homicides;
- 2% were suicides;
- 22% were undetermined.

When reviewed deaths occurring in 2009 were examined by category of death:

- 16% were related to illness;
- 4% were related to premature birth;
- 9% were related to Sudden Infant Death Syndrome (SIDS);
- 54% were related to various types of injuries, such as vehicular accidents (3%), firearms (4%), drowning (4%), fires (3%), suffocations (27%), and other types of injuries (14%);
- 13% were due to undetermined causes.

2010

There were 208 child deaths that occurred during 2010 that were reviewed by the CDRTs (182 mandatory and 26 discretionary reviews). Of the deaths that occurred in 2010 reviewed by CDRTs:

- 63% were boys and 37% were girls;

- 52% were infants under one, 26% were young children between one and four years, 16% were older children between 5 and 14 years, and 7% were youth between 15 and 17 years.

When reviewed deaths occurring in 2010 were examined by manner of death:

- 35% were attributed to natural causes;
- 29% were due to accidents;
- 16% were homicides;
- 2% were suicides;
- 17% were undetermined.

When reviewed deaths occurring in 2010 were examined by category of death:

- 22% were related to illness;
- 6% were related to premature birth;
- 5% were related to Sudden Infant Death Syndrome (SIDS);
- 5% Unexplained/Unknown Infant Death;
- 49% were related to various types of injuries, such as vehicular accidents (4%), firearms (4%), drowning (6%), fires (5%), suffocations (20%), and other types of injuries (10%);
- 7% were due to undetermined causes.

CDRT Recommendations to Prevent Child Deaths

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

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

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

There were 38 system recommendations made by the CDRTs on deaths occurring in 2009 (many of these had several components). The majority of the recommendations (28) focused on DCFS policy and procedures, followed by recommendations for other systems (10). There were no primary prevention recommendations on deaths occurring in 2009. There were 3 case specific recommendations in 2009, which are not included in this report in order to protect confidentiality.

There were 33 system recommendations made by the CDRTs on deaths occurring in 2010 (many of these also had several components). Twenty-seven focused on DCFS policy and procedures, and six were for other systems. There were no primary prevention recommendations on deaths occurring in 2010. There were 5 case specific recommendations in 2010, but the case specific details are not included in this report.

A complete list of CDRT system recommendations and the corresponding DCFS responses is provided in Appendix E.

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 Illinois children are still dying. In 2009 there were 1,490 child deaths and 1,622 children died in 2010.[3] 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 CDRT produced its first annual report summarizing team findings and presenting recommendations for reducing preventable child deaths. The CDRT annual report is presented to the Governor, the Illinois Legislature, and other interested parties in a continued effort to understand and reduce preventable child deaths in Illinois.

Since the implementation of the child death review process, individuals and agencies responding to child deaths have come to understand the importance of a coordinated, multi-agency response. Recommendations from the CDRTs have helped to develop, streamline, and implement better practices regarding child safety.

This report honors the memory of all children who have died in Illinois. The Child Death Review Teams present this report in the hope of furthering understanding of how we can make Illinois a safer and healthier state for children.

[3] This represents the number of death certificates received by DCFS and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the CDRTs; therefore, this number does NOT represent the total number of child deaths that occurred in Illinois during 2009 and 2010.

Chapter 1 Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998 and more recently by P.A. 95-0405 on August 24, 2007 and P.A. 95-0527 on August 28, 2007 (see Appendix A for copy of the amended Act). 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 Department of Children and Family Service (DCFS) Division of Child Protection.

Child Death Review Team Composition

The composition of CDRTs and the process for selecting members is outlined in the Child Death Review Team Act. There are nine child death review teams in Illinois, one in each of the seven DCFS administrative sub-regions outside Cook County and two within Cook County. A map of the CDRT sub-regions is located in Appendix B.

The Child Death Review Team Act requires that each CDRT include at least one member from each of the following disciplines:

- Pediatrician or other physician knowledgeable about child abuse and neglect,
- Representative of the department,
- State's attorney or state's attorney's representative,
- Representative of a local law enforcement agency,
- Psychologist or psychiatrist,
- Representative of a local health department,
- Representative of a school district or other education or child care interests,
- Coroner or forensic pathologist,
- Representative of a child welfare agency or child advocacy organization,
- Representative of a local hospital, trauma center, or provider of emergency medical services, and
- Representative of the Department of State Police.

Teams may make recommendations to the DCFS Director concerning additional professionals to serve on their team as needed. Team members, who are volunteers, are appointed to the team for two years and are eligible for reappointment upon expiration of their term. The Director must fill any vacancy in a team within 60 days after the vacancy occurs. Each team elects a Chairperson and Vice-chairperson from their members.

Child Death Review Team Executive Council

The CDRT Executive Council is the coordinating and oversight body for child death review activities in Illinois. It consists of the chairpersons and vice-chairpersons of each of the nine CDRTs. The Executive Council meets quarterly to review the procedures common to the examination of child deaths throughout the state. According to P.A. 92-0468 (effective August 2002), Executive Council responsibilities include, but are not limited to:

- serving as the voice of child death review in Illinois;
- providing oversight of regional CDRTs to ensure that their work is coordinated and in compliance with legislation and the operating protocol;
- ensuring that the data, results, findings, and recommendations of the teams are adequately used to make necessary changes in the policies, procedures, and statutes in order to protect children;
- collaborating with the Illinois General Assembly, DCFS, and others in order to develop legislation needed to prevent child fatalities and protect children;
- assisting in the development of quarterly and annual reports based on the work and the findings of the CDRTs;
- ensuring that the review processes of regional teams are standardized in order to convey data, findings, and recommendations in a usable format;
- serving as a link with CDRTs throughout the country and participate in national child death review team activities;
- developing an annual statewide symposium to update the knowledge and skills of CDRT members and to promote the exchange of information between teams;
- serving as a sub-committee of the DCFS Citizen's Review Panel;
- providing the CDRTs with the most current information and practices concerning child death review and related topics; and
- performing any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

During FY2011, 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 2009 and 2010 was written and printed.

- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.

- The Southern Illinois Child Death Investigation Task Force (CDITF) was developed and is in operation and available to the southernmost 34 counties including Madison, St. Clair, Bond, Fayette, Effingham, Jasper, Crawford, Clinton, Marion, Clay, Richland, Lawrence, Monroe, Washington, Jefferson, Wayne, Edwards, Wabash, Randolph, Perry, Franklin, Hamilton, White, Jackson, Williamson, Saline, Gallatin, Union, Johnson, Pope, Hardin, Alexander, Pulaski, and Massac. The task force became available and effective on January 15, 2011.

  The Southern Illinois Child Death Investigation Task Force (CDITF) is available to assist on investigations involving all unexplained, unexpected, unusual, suspicious, and/or inflicted serious life-threatening injuries and deaths of children under the age of 18 at the request of any Southern Illinois Lead Law Enforcement Investigating Agency or Coroner. The mission of CDITF is to enhance the investigation especially when child abuse and/or neglect may have played a role in the injury or death. The task force can also provide invaluable resources to assist smaller communities in the investigation and successful prosecution of these types of crimes.

- The Illinois Child Death Review Teams Executive Council agreed to work with DCFS on developing a protocol to establish uniform procedures for investigating a death that may be attributed to unsafe sleeping conditions. The goal of the Executive Council's participation in this process was to ensure that Child Protection Investigation Specialists, Intact Family Specialists, Permanency Specialists, and Purchase of Services Staff who are servicing families understand safe sleeping practices for infants, understand how to investigate a death that may have been caused by an unsafe sleeping practice, and understand the different ways deaths can be classified on a death certificate when an unsafe sleeping practice has contributed to the death. DCFS developed the protocol and the Executive Council revised the protocol multiple times with input from DCFS. The Executive Council will continue to work with DCFS on how to implement this protocol with DCFS staff.

- The 15th Annual Child Death Review Teams Symposium was held April 7-8, 2011 at the Crowne Plaza in Springfield. The presentations included: 1) To Prosecute or Not to Prosecute by A State's Attorney's Panel, including Johnson County State's Attorney Tricia Shelton, Madison County Assistant State's Attorney Ali Summers, Kane County Assistant State's Attorney Jody Gleason, Peoria County Assistant State's Attorney Donna Cruz, and Cook County Chief of Criminal Prosecutions

Bureau Fabio Valentini; 2) Serial Torture by Dr. Barbara Knox, Medical Director of the University of Wisconsin Child Protection Program at the American Family Children's Hospital in Madison, Wisconsin; 3) Illinois Child Death Review Teams Best Practice and Protocol Review by the Illinois Child Death Review Teams Executive Council Members, Dr. Daniel Cuneo, Lori Chassee, Diane Scruggs, and Susan Storcel; 4) Error Reduction in Child Welfare by Denise Kane, Inspector General of the Illinois Department of Children and Family Services, Lisa Coconato, Director of Child Death Investigations with the Office of Inspector General, and Diane Moncher, Director of Error Reduction with the office of Inspector General; 5) The Impact of Current Illinois Prevention Programs by Patricia Metzler, RN, TNS, SANE-A, SANE-P, Emergency Department at Carle Hospital, Jessica Blackford, Office of the State Fire Marshall, Dena Schumacher, Champaign Fire Department, and Daniel Leonard, MS, Illinois Emergency Medical Services for Children. The symposium was well attended with over 100 members present.

- The Child Death Review Teams Executive Council promoted two major campaigns aimed at reducing child fatalities. The first campaign, *Safe Sleep for Baby*, is aimed at reducing infant deaths. The nine child death review teams continue to see many infant deaths related to the caregiver and infant bed sharing. DCFS workers currently distribute a safe sleeping brochure to families with infants receiving services. The brochure, *Safe Sleep for Your Baby*, from the National Institute of Child Health and Human Development, following the recommendations set forth by the American Academy of Pediatrics (AAP), urges caregivers to room share and not bed share with infants.

Rock a Bye Baby ALONE in your CRIB,

Lying on your BACK, NO Pillows, No Quilts,

Sleep SAFELY Baby ALL the time.

Questions? Call 1.800.432.7437 (SIDS of Illinois, Inc. number).

A total of 26 billboards were placed in locations across the state including Peoria, Pekin, Champaign, Bloomington, Springfield, Carbondale, Marion, Effingham, Mt. Vernon, Cairo, Joliet, Kankakee, Aurora, Rockford, Galena, East St. Louis, Granite City, Quincy, LaSalle, Harvey, Dolton, Oak Park, Cicero, Streamwood, Des Plaines, and Danville.

The second campaign, *Get Water Wise – Supervise*, is aimed at reducing deaths of children of all ages. The promotion of the statewide public awareness campaign on child drowning, *Get Water Wise – Supervise* continues to be widely circulated throughout the state of Illinois. A drowning prevention committee has been developed that includes representatives from the Child Death Review Teams Executive Council, DCFS, Department of Human Services, Prevent Child Abuse Illinois, the Red Cross, and the Illinois Department of Public Health. The posters and brochures are available in both English and Spanish. The campaign carries a powerful message to parents and caregivers about the importance of adult

supervision at all times when children are in and around water. Billboards and bus cards were developed and displayed for 6 weeks starting in May 2011. Billboards were placed in Quincy, Springfield, Decatur, and Effingham. Bus cards were placed in Springfield (100), Peoria (50), Danville (15), Urbana (75), Granite City (50), Arlington Heights (600), Carbondale (20), Rock Island (50), and Decatur (50). The billboard included a picture of a toddler in a bath tub with the following message:

"I left her in the bath for just a minute." A minute is all it takes for a child to slip silently underwater while her caregiver leaves the room to answer the phone.*

*Drowning is the leading cause of accidental death for young children. The good news is that these tragedies can be prevented. Watch kids near water, and save a life.

Representatives from the committee also attend caregiver and kid friendly events to hand out these materials and educate the general public.

DCFS Roles and Responsibilities

The Illinois DCFS Division of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT Coordinator). In addition, the Department serves as a direct link between the review teams and the State's child protection policy makers. The Director of DCFS must review and reply to recommendations made by the CDRTs within 90 days of receipt.

Illinois Child Death Review Process

The Illinois child death review process is outlined in the CDRT *Protocol for the Multi-disciplinary Review of Child Deaths*. This protocol provides a practical manual for CDRT members and ensures comparability of CDRT reviews and findings among the teams by defining: 1) the types of cases to be reviewed, 2) the procedures used to review cases, and 3) the confidentiality parameters of review findings and recommendations.

Purpose of Child Death Review

The overarching mission of child death review is to reduce the number of preventable child deaths in Illinois. CDRTs achieve this goal by fulfilling the objectives stated below:

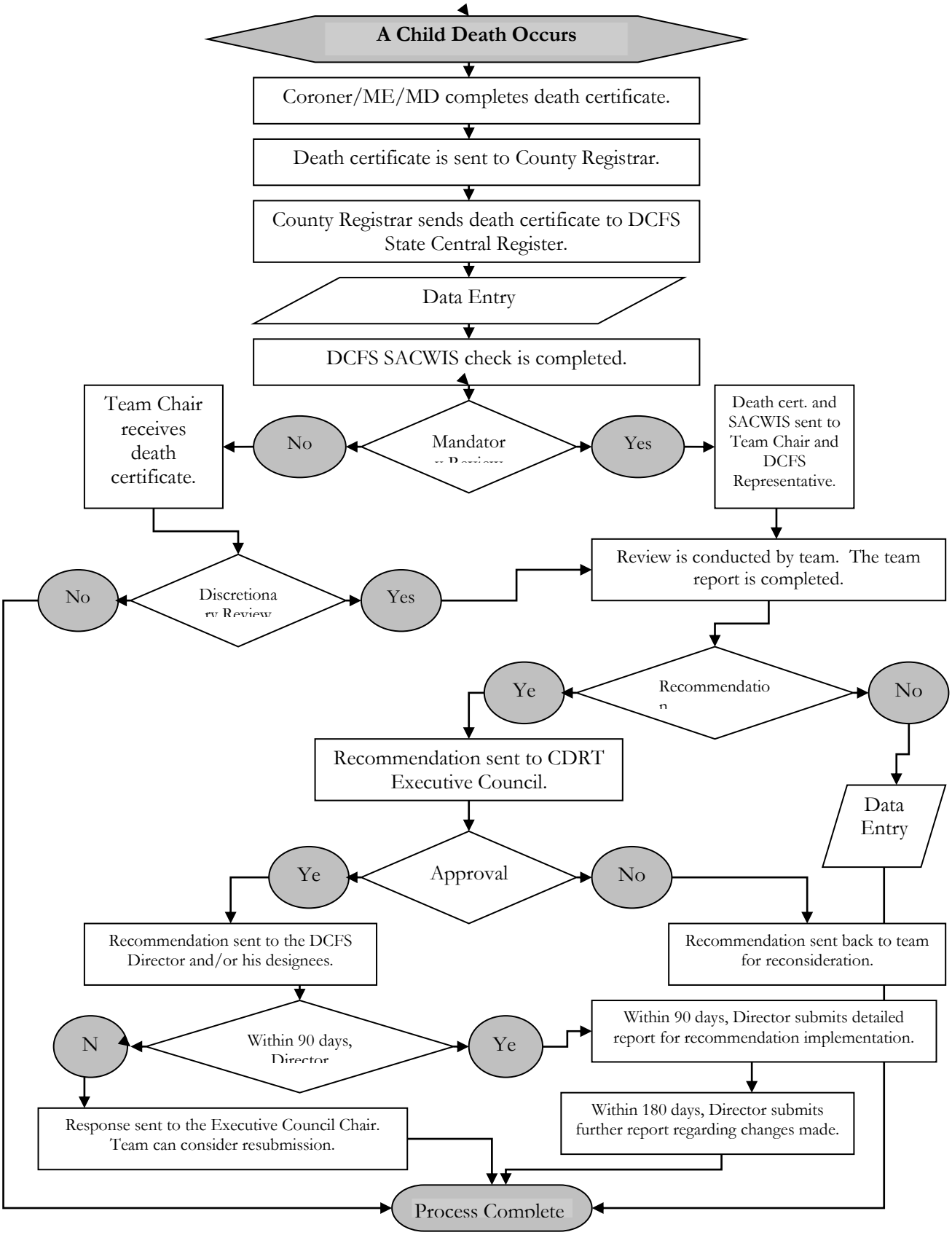
- Evaluate the means by which the death might have been prevented.
- Report findings and recommendations to appropriate agencies.
- Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect.
- Make specific recommendations to the Director and Inspector General of DCFS concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

Other responsibilities of the CDRT are to:

- assist in identifying systemic barriers that reduce the effectiveness of child welfare and child protective services;
- assist in increasing the effectiveness of public health services, prevention efforts, intervention services, and investigative and legal processes aimed at reducing child mortality;
- enhance and support cooperation and communication among agencies;
- share information about advances in the field of investigation, prevention, intervention, and prosecution regarding child maltreatment and child fatalities;
- contribute to initiatives to improve public awareness of issues that affect the safety and well-being of children;
- collect data that will inform efforts to reduce child fatalities; and
- keep the governor and legislature apprised of CDRT findings and recommendations and of legislation needed to reduce child fatalities and protect the lives of children.

Child Death Review Procedures

Figure 1 delineates the child death review process in Illinois.


A Child Death Occurs
Coroner/ME/MD completes death certificate.
Death certificate is sent to County Registrar.
County Registrar sends death certificate to DCFS State Central Register.
Data Entry
DCFS SACWIS check is completed.
Team Chair receives death certificate.
No
Mandator
Yes
Death cert. and SACWIS sent to Team Chair and DCFS Representative.
No
Discretiona
Yes
Review is conducted by team. The team report is completed.
Ye
Recommendatio
No
Recommendation sent to CDRT Executive Council.
Data Entry
Ye
Approval
No
Recommendation sent to the DCFS Director and/or his designees.
Recommendation sent back to team for reconsideration.
N
Within 90 days,
Ye
Within 90 days, Director submits detailed report for recommendation implementation.
Response sent to the Executive Council Chair. Team can consider resubmission.
Within 180 days, Director submits further report regarding changes made.
Process Complete

After a child's (age 17 or younger) death occurs, a coroner, medical examiner, or other physician/pathologist completes the death certificate. At this point, the county registrars are required by the Illinois Vital Records Act (see Appendix C) to send a copy of the death certificate to the DCFS State Central Register (SCR). Unfortunately, although county registrars are required to submit copies of all child death certificates to the SCR, many do not. The importance of this requirement cannot be overstated, as only those child death certificates sent to the SCR are entered into the CDRT database and analyzed for this report. If significant numbers of child deaths are not included, it diminishes the ability of the CDRTs to analyze and understand child death in Illinois and to make sound recommendations for preventing future deaths.

Once the death certificate is received by the SCR, a search of the Statewide Automated Child Welfare Information System (SACWIS) for the child/family name is performed to identify those cases in which the child had prior involvement with DCFS. Child death review is required, or mandated, for all child deaths in which there was prior family involvement with DCFS within the prior year. Specifically, CDRTs are required to review the deaths of all children aged 17 or younger if the deceased child was:

- a ward of DCFS,
- a non-ward, when death occurs in a licensed foster home,
- the subject of an open DCFS service case,
- the subject of a pending child abuse or neglect investigation,
- the subject of an abuse or neglect investigation during the preceding 12 months, and/or
- any other child whose death is reported to DCFS's State Central Register as the result of indicated child abuse or neglect.

CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18 at their discretion, as well as cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.[4]

Information from the death certificates received by the SCR is 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 sent to the appropriate CDRT for review and completion.

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

[4] In addition to mandated reviews and discretionary reviews, CDRTs are required to review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the mandated reporter may ask for a CDRT or other local multidisciplinary team to review the report. The team will review all pertinent information and make a recommendation to DCFS. There were no reviews of this nature requested in 2009 or 2010.

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 CDRT report form is completed, it is sent back to DCFS for entry into the CDRT database. All recommendations are sent to the Executive Council for approval and then approved recommendations are sent to the Office of Inspector General and the Director of DCFS, who must review and reply to recommendations (except case-specific), within 90 days of receipt. Pursuant to the new legislation, the Director shall submit his or her reply both to the chairperson of that team and to the chairperson of the Executive Council. The Director's reply to each recommendation must include a statement as to whether the Director intended to implement the recommendation.

In addition, the Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or non-implementation of the recommendations. Specifically, within 90 days after the Director submits a reply to the CDRT teams and Executive Council, he or she must submit an additional report that sets forth the way, if any, in which the recommendation will be implemented and the schedule for implementing the recommendation. The Director shall submit this report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. Within 180 days after the Director submits this report concerning the implementation of a recommendation, he or she shall submit a further report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to the recommendation.

CDRT Access to Information

According to the Child Death Review Team Act, DCFS personnel are required to provide the CDRTs with all records and information in their possession that are relevant to the team's review of a child's death, including information concerning previous DCFS investigations and information gained through the Child Advocacy Center protocol for cases of serious or fatal injuries. In addition, a CDRT has access to all records and information in the possession of a State or local agency that are relevant to the team's review of a child's death. This includes, but is not limited to, birth 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 are 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
Illinois Child Deaths in 2009 and 2010

What do we know about the child deaths that occurred in Illinois during 2009 and 2010?

To answer this question, there are three important sets of numbers that need to be compared: 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.

Comparing the children who died to the total child population in Illinois can add to our understanding of how characteristics such as gender, age, and race are associated with child deaths and how children that die differ from those in the general child population in Illinois. However, it is important to note that **this report bases its analysis on the total child deaths reported to DCFS** by county registrars and coroners. Although all deaths certificates are required by law to be submitted to DCFS, not all counties comply with this requirement, so the number of child deaths reported to DCFS is typically a low estimate of the total number of deaths that occur in Illinois. Previous comparisons between the number of child deaths reported to DCFS and those reported to the Illinois Department of Public Health suggest that the child deaths reported to DCFS range from 73% to 92% of all child deaths that occur in Illinois in a given year.[5]

The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths are mandated because the decedent's family was involved in the child welfare system in Illinois. In 2009, 70% of reviewed cases were mandated and in 2010, 88% of reviewed cases were mandated. 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 in child welfare in Illinois differs from the total child population in Illinois on a number of characteristics.

According to recent analysis of children indicated for abuse and neglect in Illinois, almost half of the children indicated for abuse or neglect were five years of age or younger. This is much higher than the number of children in that age range in the total child population in Illinois. In addition, the "indication rate" (i.e., the number of children indicated for abuse or neglect per 1,000 children) among African-American children (13.5) was considerably higher than that of either White (6.1) or Hispanic children (2.7).[6] Thus, the Illinois child welfare population is over-represented by young children and African-American children when compared to the total child population in Illinois. It is, therefore, likely that deaths reviewed by the CDRTs, which primarily come from this population, will also be over-represented on these two characteristics.

[5] The number of total child deaths reported to the Illinois Department of Public Health in 2009 and 2010 was not available at the time of publication of this report.

[6] Rolock, N., & Testa, M. (2008). *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, stability, continuity, permanence, and well-being.* Retrieved from http://www.cfrc.illinois.edu/publications.php#O.

With this information in mind, the following provides a brief look at the three groups:

- The population of Illinois children was based on the 2010 Census. According to Census 2010 data, there were approximately 3.13 million children under the age of 18 in Illinois, which constitutes about 24.4% of the total Illinois child population.

- In 2009, there were 1,490 child deaths reported to the Illinois CDRT database, and in 2010 there were 1,622 child deaths reported. This includes deaths due to all causes, preventable and non-preventable.

- There were 245 child deaths that occurred in 2009 that were reviewed by the CDRTs – 171 of these were mandated for review and 74 were discretionary reviews. There were 208 child deaths that occurred in 2010 that were reviewed by CDRTs – 182 were mandated for review and 26 were discretionary reviews. The majority of discretionary reviews were in three categories, SIDS, unknown/unexplained infant deaths, and suffocation.

Child Deaths by Gender

According to information from the 2010 Census, 51% of the Illinois child population is male and 49% is female. However boys are more likely to die than girls: boys made up 59% of child deaths and 58% of reviewed deaths in 2009 (Figure 2), and 58% of child deaths and 63% of reviewed deaths in 2010 (Figure 3).

Figure 2. Illinois Child Deaths by Gender (2009)

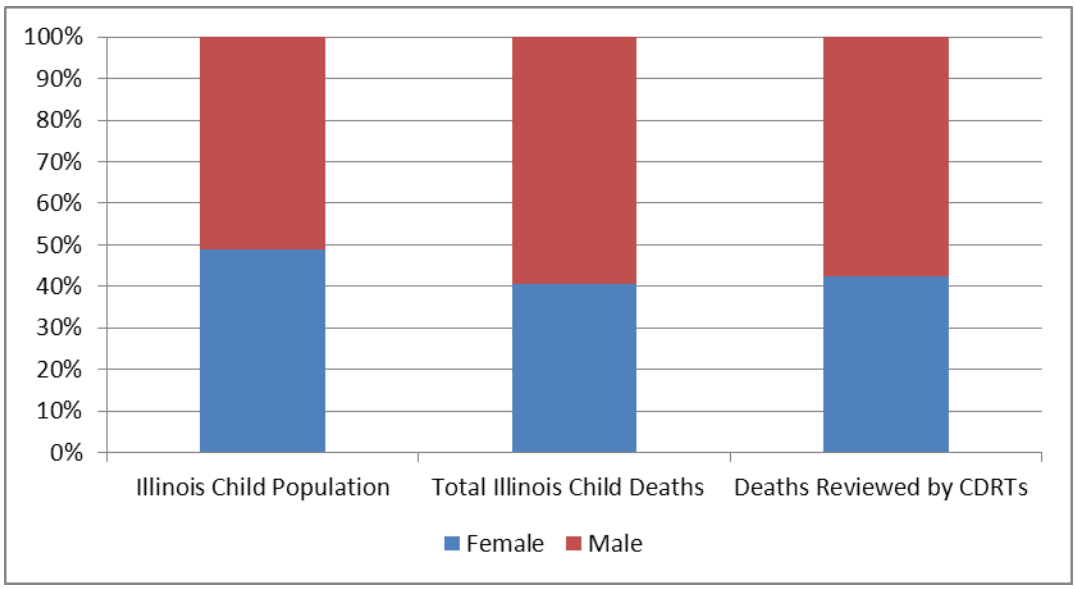
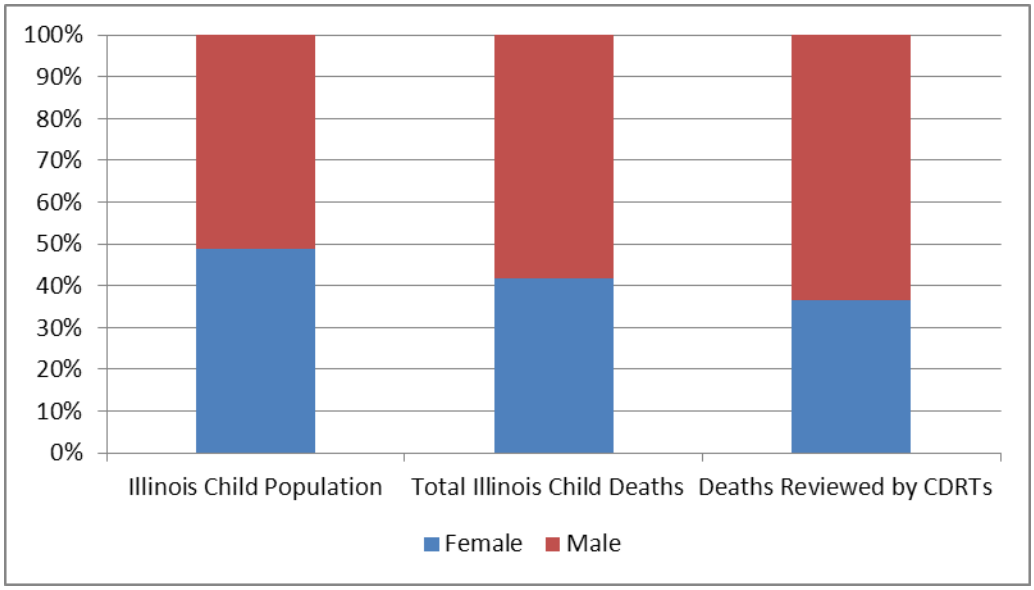


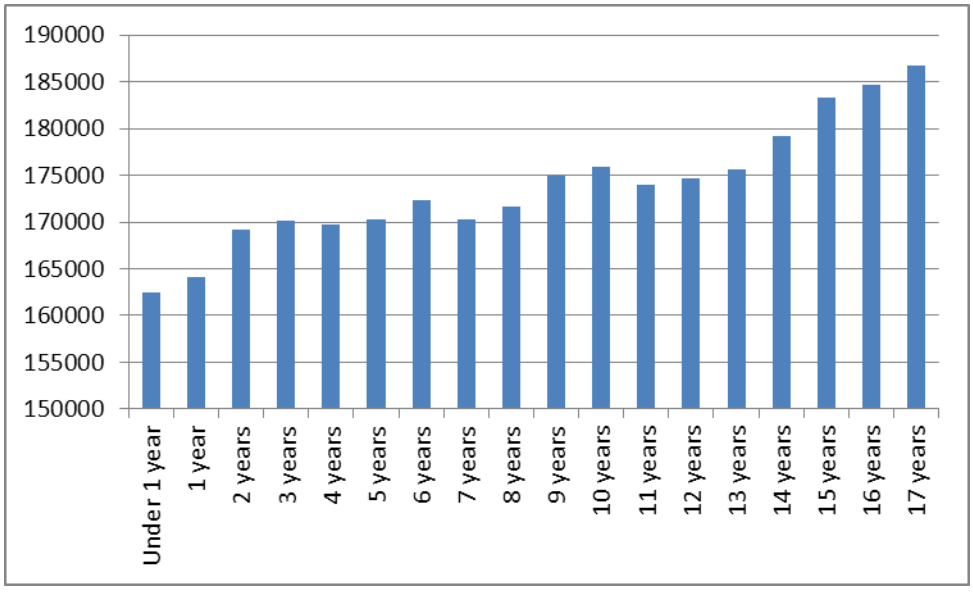
Figure 3. Illinois Child Deaths by Gender (2010)



Child Deaths by Age

In 2010, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 3.13 million children in Illinois under 18 years, 5% are less than one year of age, 22% are between 1 and 4 years, 27% are between 5 and 9 years, 28% are between 10 and 14 years, and 18% are between 15 and 17 years.[7]

Figure 4. Illinois 2010 Child Population by Age



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

However, when the total Illinois child deaths reported to DCFS are examined by age (Figures 5 and 6), it becomes clear that infants less than one year old are especially vulnerable – 63% of the total deaths in 2009 and 62% of the total deaths in 2010 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Older children are less likely to die; in 2009 and 2010: 11-12% of the total deaths were children between 1 and 4 years, 6% were children between 5 and 9 years, 7% were children between 10 and 14 years, and 13-15% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group, infants under one year are again over-represented; they comprised 63% of reviewed deaths in 2009 and 52% of reviewed deaths in 2010. Children between 1 and 4 years made up 22% of reviewed deaths in 2009 and 26% in 2010. Older children make up a smaller portion of reviewed deaths, 6-9% of reviewed deaths were 5 to 9 years old, 5-7% of reviewed deaths were aged 10 to 14, and 4-7% of reviewed deaths were for children aged 15 to 17 (Figures 5 and 6).

Figure 5. Illinois Child Deaths by Age Group (2009)

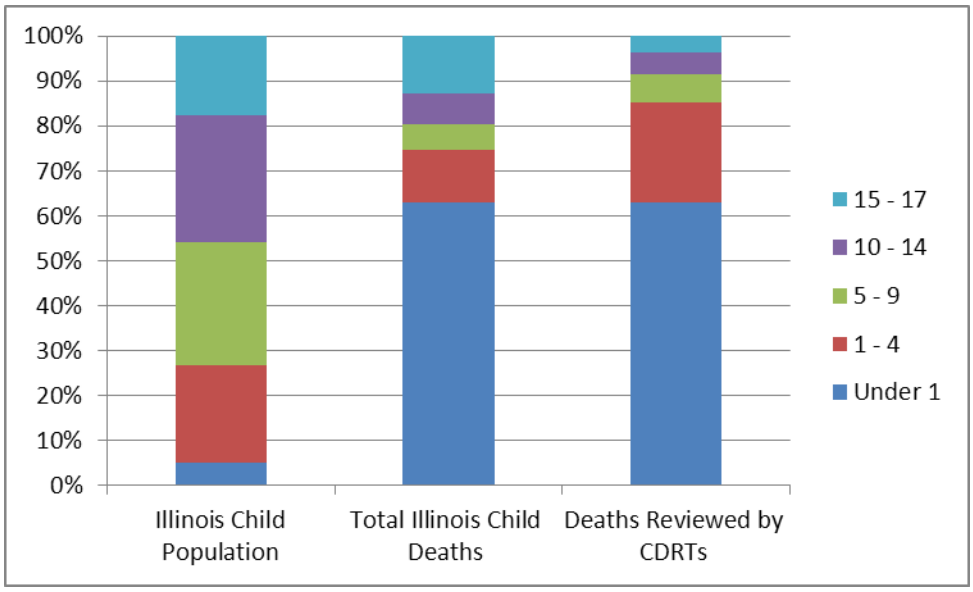
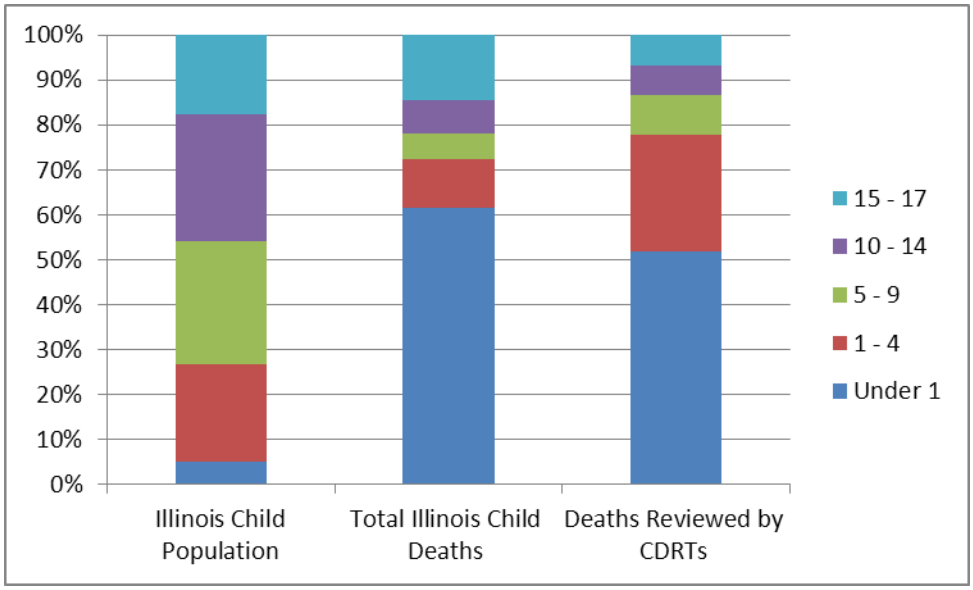


Figure 6. Illinois Child Deaths by Age Group (2010)



Child Deaths by Race

Previous reports have included analysis of child deaths by child race. However, due to a new online reporting system, race was not recorded for a large portion of the deaths that occurred in 2009 and 2010. This oversight is being corrected and information on child race will be included in future reports.

In previous reports, African-American children were at increased risk of death when compared to their numbers in the general population. Conversely, deaths among Hispanic were infrequent compared to their numbers in the general population. The portion of deaths among Caucasian children was roughly equivalent to their proportion in the general child population.

Child Deaths by Category and Manner

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and "other" deaths. Three new categories were added in 2007: scalding burn, sudden unexplained infant death which is now called unknown/unexplained infant death and sudden unexplained child death (SUCD). 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 of death for child deaths that occurred in Illinois in 2009 and 2010 are shown in Table 1.[8] The majority of total child deaths were related to either illness (38%) or premature birth (29-30%). The other categories accounted for the remaining 30% of the total child deaths, ranging from suffocation (6-7%), firearms (5%), vehicular accidents (4%), injuries (3-4%), SIDS (3%), drowning (2%), fire (1-2%), and poisoning/overdose (1%).

Table 1. Child Deaths by Category of Death 2009 – 2010

	TOTAL CHILD DEATHS				DEATHS REVIEWED BY CDRTS			
	2009*		2010*		2009		2010**	
	N	%	N	%	N	%	N	%
Illness	572	38	622	38	39	16	46	22
Premature Birth	431	29	493	30	10	4	13	6
Suffocation	104	7	101	6	66	27	41	20
Firearm	79	5	84	5	2	1	9	4
Vehicular Accident	67	4	75	5	8	3	9	4
Injury	63	4	47	3	34	14	21	10
Undetermined	55	4	46	3	31	13	14	7
Sudden Infant Death Syndrome	46	3	47	3	21	9	10	5
Drowning	28	2	31	2	10	4	13	6
Fire	15	1	26	2	8	3	11	5
Poisoning/Overdose	14	1	10	1	5	2	2	1
Sudden Unexplained Infant Death	8	1	16	1	7	3	10	5
Other	4	<1	11	1	3	1	7	3
Scalding Burn	1	<1	2	<1	0	0	2	1
Sudden Unexplained Child Death	1	<1	0	0	1	<1	0	0
Total	1,488		1,622		245		208	

*There were 2 "pending" deaths in 2009 and 11 pending for 2010 at the time of this report.
** There was a "pending" death in 2010 at the time of this report.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 1). In 2009, deaths reviewed by CDRTs were most likely to be related to suffocation (27%), illness (16%), and injury (14%). In 2010, deaths reviewed by CDRTs were most likely to be related to illness (22%), suffocation (20%), and injury (10%).

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

- Natural – the death was a result of natural causes such as illness, disease, and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death

[8] These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths.

- 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

Child deaths that occurred in 2009 and 2010 are examined by manner of death in Table 2 and Figures 7 and 8. The majority of total child deaths were attributable to natural causes (70-72%). Accidents accounted for 12-13% of the total child deaths, 6-8% were homicides, 2% were suicides, and 6-7% were undetermined. When compared to total child deaths, deaths reviewed by CDRTs are much more likely to be homicides, accidents, and undetermined, and much less likely to be due to natural causes.

Table 2. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs

	Total Deaths*				**Reviewed Deaths**			
	2009		**2010**		**2009**		**2010**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Accident	180	12	208	13	68	28	61	29
Homicide	124	8	103	6	45	18	34	16
Natural	1050	70	1170	72	73	30	73	35
Suicide	35	2	39	2	5	2	4	2
Undetermined	101	7	102	6	54	22	36	17
Total	1,490		1,622		245		208	

*These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths.

Figure 7. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs (2009)

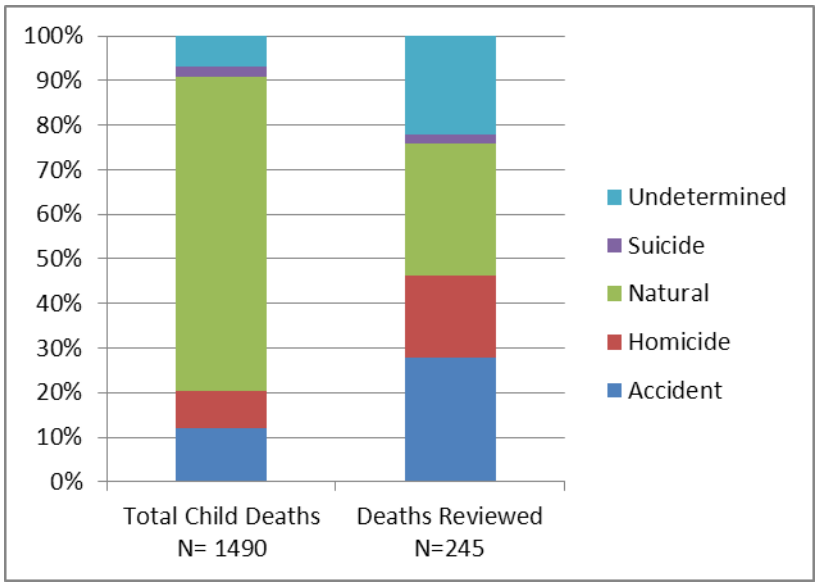
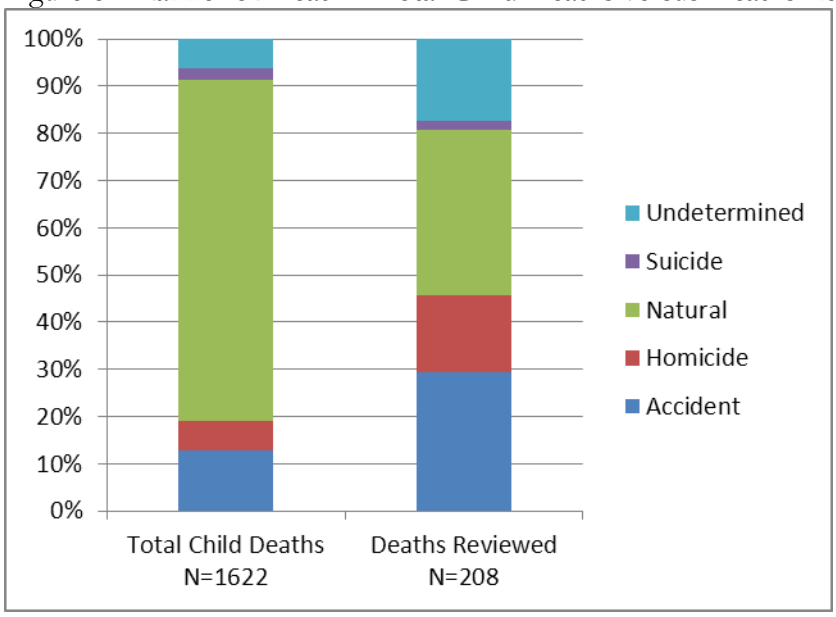


Figure 8. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs (2010)



Finally, it is interesting to examine the manner of child death juxtaposed with the categories of death (Tables 3 and 4). For instance, the majority of accidental child deaths are due to vehicular accidents and suffocations followed by drowning, injury, and fire related causes. Most homicides involve either firearms or other inflicted injuries. Hanging (suffocation) is the most frequent method of child/youth suicide. Almost all child deaths due to natural causes are the result of illness, premature birth, or sudden infant death syndrome (SIDS).

Table 3. 2009 Total Child Deaths – Manner of Death by Category of Death

Category of Death	Manner of Death					
	Accident	Homicide	Natural	Suicide	Undetermined	Total
Illness	3[1]	0	568	0	1	572
Premature Birth	1[2]	0	425	0	5	431
Suffocation	55	6	1	23	19	104
Firearm	1	66	0	10	2	79
Vehicular Accident	54	5	0	1	7	67
Injury	19	41	0	0	3	63
Undetermined	0	0	7[3]	0	48	55
Sudden Infant Death Syndrome	0	0	44	0	2	46
Drowning	24	1	0	0	3	28
Fire	10	3	0	0	2	15
Poisoning /Overdose	10	1	0	1	2	14
Sudden Unexplained Infant Death	0	0	3	0	5	8
Other	2[4]	1[5]	1[6]	0	0	4
Scalding Burn	1	0	0	0	0	1
Sudden Unexplained Child Death	0	0	1	0	0	1
Total	180	124	1,050	35	99	1,488

Note: 2 cases are still pending - manner is undetermined.

[1] perforation of hemiazygous vein; insufflation of air into vagina, intrauterine pregnancy; fractured pacemaker lead to left ventricle congenital heart disease.

[2] maternal demise.

[3] death category ruled undetermined after autopsies for these 7 children - could not find a cause of death.

[4] hypothermia, heat stroke due to environmental heat.

[5] hyperthermia.

[6] dehydration.

Table 4. 2010 Total Child Deaths – Manner of Death by Category of Death

	Manner of Death					
Category of Death	Accident	Homicide	Natural	Suicide	Undetermined	Total
Illness	3[1]		616		3	622
Premature Birth	1[2]		492			493
Suffocation	61	2	3[3]	23	12	101
Firearm	2	64		11	7	84
Vehicular Accident	69	3		1	2	75
Injury	19	26		1	1	47
Undetermined	2[4]		2[5]		42	46
Sudden Infant Death Syndrome			47			47
Drowning	24				7	31
Fire	21	1			4	26
Poisoning/Overdose	3	1	1[6]	3	2	10
Sudden Unexplained Infant Death			7		9	16
Other	2[7]	5[8]	2[9]		2[10]	11
Scalding Burn	1	1				2
Sudden Unexplained Child Death						
Total	208	103	1170	39	91	1,611

Note: 11 cases are still pending- manner is undetermined.

[1] 1) under developed lungs, anoxia, hypoxic; 2) commotio cordis, congenital heart disease; 3) anaphylaxis, food allergy.

[2] maternal cocaine abuse and inflammation of the uterus, prematurity.

[3] 1) cerebral palsy, aspiration pneumonia, 2) positional asphyxia probably natural underlying, 3) neonatal asphyxia.

[4] 1) co sleeping and baby fell out of bed and onto heater, 2) cannot exclude overlay or suffocation.

[5] no cause of death could be determined after complete autopsy.

[6] maternal cocaine abuse.

[7] 1) hypothermia, 2) air embolism, diving accident.

[8] 1) hyperthermia, 2) dehydration, 3) malnourishment, 4) neglect, 5) dehydration.

[9] 1) cardiac arrest, hypoxic brain injury, 2) hypoxic ischemic encephalopathy.

[10] 1) hypoxic ischemic encephalopathy, 2) dehydration.

Special Analysis: Homicide Deaths in 2009 and 2010

There were 124 homicide deaths in 2009 and 103 in 2010. We know from the above tables that the majority of homicides involve either firearms or inflicted injuries of some kind. Additional information on homicide deaths allows for a more complete understanding of the circumstances of these types of child deaths.

Table 5. 2009 Homicide Deaths

2009 Homicide Deaths			
Category of Death	**Child Age**	**Circumstances**	**Perpetrator or Alleged Perpetrator**
Injury	5 mo	Multiple Injuries, Blunt Trauma	Father
	1 yr	Thrown to the Floor	Female Daycare Worker
	7 yr	Stab Wound of Back	Father
	3 mo	Squeezed and Thrown	Father
	4 yr	Multiple Incised Wounds to Neck	Brother (Minor)
	3 yr	Head Trauma	Uncle
	10 mo	Abusive Head Trauma	Father
	2 yr	Subdural Hematoma	Male Paramour
	1 yr	Head Injuries	Mother and/or Male Paramour
	1 yr 11 mo	Blunt Force Trauma	Stepmother
	4 yr	Head Injury; Assault	Male Paramour
	1 yr	Blunt Force Trauma	Male Paramour (Lived out of State)
	17 yr	Assault	21-Year-Old Male
	7 mo	Blunt Head Trauma	Father
	2 mo	Blunt Head Trauma	Father
	5 mo	Multiple Injuries; Blunt Force	Brother (Minor)
	2 mo	Cerebral Injury; Blunt Head Trauma	Father
	1 yr	Head Injuries – Blunt Force Trauma	Male Paramour
	2 yr	Multiple Blunt Trauma	Aunt
	3 yr	Blunt Head Trauma	Unknown
	3 yr	Blunt Head Trauma	Male Paramour
	2 yr	Cerebral Injuries, Blunt Head Trauma	Unknown (Out of State)
	1 mo	3-Story-Fall	Stepfather
	1 yr	Multiple Injuries	Male Paramour
	5 mo	Subdural Hematoma, Blunt Head Trauma	Father
	6 mo	Cerebral Injuries, Head Trauma	Unknown

	11 yr	Craniocerebral Injuries; Assault	Ex-Brother-In-Law
	16 yr	Craniocerebral Injuries; Assault	Ex-Brother-In-Law
	14 yr	Craniocerebral Injuries; Assault	Ex-Brother-In-Law
	5 yr	Abusive Head Trauma	Father
	2 yr	Multiple Injuries	Male Paramour
	1 yr	Craniocerebral Injuries; Blunt Head Trauma	Male Paramour
	3 yr 11 mo	Multiple Injuries, Blunt Force Trauma	Male Paramour
	16 yr	Blunt Trauma of Abdomen	22-Year-Old Male Paramour
	2 mo	Subdural Hematoma; Blunt Force Trauma	Father
	8 mo	Blunt Head Trauma	Mother
	16 yr old	Blunt Force Trauma to Head; Assault	4 Teenagers (19, 16, 18, and 18)
	1 yr	Craniocerebral Injuries, Blunt Head Trauma	Female Babysitter's Husband
	8 mo	Abusive Head Trauma	Female Babysitter
	1 yr	Craniocerebral Injuries	Father
Fire	12 yr	Carbon Monoxide Intoxication of Smoke and Soot	17-year-old Male and 20-year-old Male
	7 yr	Inhalation Injuries	18-year-old Male; Gang-related
	11 yr	Carbon Monoxide Intoxication, Inhalation of Smoke and Soot	Father
Suffocation	11 yr	Ligature Strangulation	Father
	9 yr	Ligature Strangulation	Father
	4 mo	Suffocation	Father
	3 mo	Asphyxiation, Suffocation	Father and Mother
	1 yr	Suffocation	Male Babysitter
	1 yr	Asphyxia from an Undetermined Means	
Firearm	16 yr	Gunshot Wound to Head	6 Males (18, 19, 18, 18, 18, and 16)
	15 yr	Gunshot Wound to Chest	Brother Playing with Gun
	9 mo	Multiple Gunshot Wounds	36-yr-old Male Paramour

	14 yr	Gunshot Wound to Chest	16-year-old Male
	17 yr	Gunshot Wound to Back	Gang-related
	16 yr	Multiple Gunshot Wounds	
	15 yr	Gunshot Wound to Neck	
	16 yr	Multiple Gunshot Wounds	15-Year-Old Male
	16 yr	Gunshot Wound to Head	
	17 yr	Gunshot Wound to Face	Stepfather
	15 yr	Gunshot Wound to Back	22-Year-Old Male; Gang-related
	17 yr	Gunshot Wound to Back	Drive-by Shooter
	16 yr	Gunshot Wound to Back	Police Officer
	16 yr	Gunshot to the Face	17-Year-Old Male
	15 yr	Gunshot Wound to the Head	
	15 yr	Gunshot Wound to the Neck	
	17 yr	Gunshot Wound to Chest	
	17 yr	Multiple Gunshot Wounds	
	17 yr	Gunshot Wound to Head	16-Year-Old Male and 17-Year-Old Male
	16 yr	Gunshot Wound to Back	
	17 yr	Gunshot Wound to Head	
	16 yr	Gunshot Wound to Head	
	17 yr	Gunshot Wound to Head	
	16 yr	Multiple Gunshot Wounds	25-Year-Old Male and 22-Year-Old Male
	17 yr	Gunshot Wound to Head	Gang-related
	17 yr	Multiple Gunshot Wounds	
	16 yr	Gunshot Wound to Head	36-Year-Old Male
	17 yr	Gunshot Wound to Chest	
	14 yr	Gunshot Wound to Head	(Out-of-State)
	17 yr	Multiple Gunshot Wounds	
	17 yr	Multiple Gunshot Wounds	
	16 yr	Gunshot Wound to Chest	
	3 yr	Gunshot Wound to Chest	
	16 yr	Multiple Gunshot Wounds	
	16 yr	Gunshot Wound to Buttocks	
	17 yr	Gunshot Wound to Back	
	17 yr	Multiple Gunshot Wounds	
	15 yr	Multiple Gunshot Wounds	
	17 yr	Multiple Gunshot Wounds	2 – 20-Year-Old Males; Gang-related
	16 yr	Multiple Gunshot Wounds	20-Year-Old Male and 17-Year-Old Male; Gang-related
	15 yr	Multiple Gunshot Wounds	2 – 20-Year-Old Males; Gang-related
	14 yr	Gunshot Wound to the Back	

	17 yr	Gunshot Wound to Head	Gang-related
	17 yr	Gunshot Wound to Head	
	17 yr	Multiple Gunshot Wounds	
	17 yr	Multiple Gunshot Wounds	
	17 yr	Gunshot Wound to Head	
	13 yr	Gunshot Wound to Back	2 – 20-Year-Old Males; Gang-related
	16 yr	Gunshot Wound to Face	
	15 yr	Gunshot Wound to Chest	17-Year-Old Male
	14 yr	Gunshot Wound to Back	Gang-related
	17 yr	Gunshot Wound to Face	
	15 yr	Gunshot Wound to Head	15-Year-Old Male and 18-Year-Old Male; Gang-related
	17 yr	Multiple Gunshot Wounds	
	16 yr	Gunshot Wound to Head	Gang-related
	16 yr	Gunshot wound to Back	
	15 yr	Multiple Gunshot Wounds	
	17 yr	Gunshot Wounds to Abdomen	
	17 yr	Gunshot Wound to Chest	25-Year-Old Male
	15 yr	Thoracocervical Gunshot Wound	
	17 yr	Gunshot Wound to Chest	21-Year-Old Male; Gang-related
	16 yr	Gunshot Wound to Head	Drive-by Shooting
	15 yr	Gunshot Wound to Head	15-Year-Old Male
	16 yr	Gunshot Wound to Chest	21-Year-Old Male and 15-Year-Old Male
	17 yr	Gunshot Wound Fleeing from Police	Police Officer
	17 yr	Gunshot	Robbing Home – Shot by Homeowner
Poisoning/ Overdose	9 yr	Quetiapine and Alprazolem Intoxication	Father
Other	8 mo	Hyperthermia	Babysitter
Vehicular	9 yr	Craniothoracic and Abdominal Blunt Trauma	Drunk Driver
	4 yr	Blunt Force Injuries of Head	17 –Year-Old Under the Influence: Drugs
	5 yr	Multiple Injuries, Impalement by Fence Post	Father
	16 yr	Multiple Injuries, Ejection from Car	
	17 yr	Multiple Blunt Force Trauma, SUV vs. Fixed Object	Male Friend Driving Drunk
Drowning	1 yr 10 mo	Drowning	Father

Table 6. 2010 Homicide Deaths

2010 Homicide Deaths			
Category of Death	**Child Age**	**Circumstances**	**Perpetrator/ Alleged Perpetrator**
Injury	2 yr	Multiple Injuries; Blunt Trauma	Male Paramour
	3 yr	Subdural Hematoma; Blunt Head Trauma	Male Paramour (out of state)
	17 yr	Blunt Head Trauma	17-Year-Old Male and 15-Year-Old Male
	8 yr	Infantile Cerebral Injuries	Unknown
	5 yr	Blunt Force Traumatic Injuries	Stepmother
	3 mo	Blunt Trauma of Head; Child Abuse; Subdural Hemorrhages	Father
	1 mo	Blunt Head Trauma; Child Abuse	Father
	5 mo	Multiple Blunt Force Trauma; Child Abuse	Mother
	3 mo	Blunt Trauma of the Head	Father
	1 yr	Multiple Blunt Force Trauma; Child Abuse	Male Paramour
	1 yr	Craniocerebral Injuries; Blunt Head Trauma; Child Abuse	Mother
	9 days	Multiple Injuries; Blunt Trauma; Child Abuse	Mother and Father
	2 yr	Anoxicencephalopathy; Multiple Injuries; Child Abuse	Father
	4 yr	Incised Wound of Neck	Mother
	11 mo	Multiple Injuries; Child Abuse	Male Paramour
	2 yrs	Multiple Injuries; Blunt Trauma; Child Abuse	Mother
	4 mo	Craniocerebral Injuries; Blunt Trauma of Head	Father
	1 yr	Closed Head Blunt Trauma	Father
	17 yr	Stab Wound to Chest	Unknown
	17 yr	Stab Wound to Neck	17-Year-Old Female
	2 yr	Multiple Blunt Force Trauma; Child Abuse	Mother or Male Paramour
	5 mo	Subdural Hematoma; Child Abuse	Father (Out-of-State)
	4 yr	Blunt Trauma to Abdomen and Head	Male Paramour
	11 yr	Multiple Stab Wounds	Sisters' 18-Year-Old

			Boyfriend
	17 yr	Multiple Injuries; Assault	18-Year-Old Boyfriend
	16 yr	Stab Wound to Chest; Hemorrhagic Shock; Sharp Force Injury to Heart	19-Year-Old Male
Fire	12 yr	Smoke Inhalation	33-Year-Old Male
Suffocation	1 yr	Suffocation	Mother
	1 yr	Strangulation	Father
Firearm	17 yr	Multiple Gunshot Wounds	Gang-related
	15 yr	Gunshot Wound to Head	Multiple shots fired at Group of Teens
	16 yr	Gunshot Wound to Abdomen	18-Year Old and 17-Year-Old Brothers; On-going Dispute
	15 yr	Multiple Gunshot Wounds to Chest	Drive-by shooting
	15 yr	Gunshot Wound to Back	Shooting into party
	16 yr	Gunshot Wound to Back	
	16 yr	Gunshot Wound to Head	
	8 yr	Gunshot Wound	11 yr old Brother
	17 yr	Multiple Gunshot Wounds	18 yr old Male
	12 yr	Shotgun Wound to Face	15 yr old Male
	2 yr	Gunshot Wound to Head	21 yr old Male – Target Gang Member Father, Child sitting in Car
	15 yr	Gunshot Wound to Head	Gang-related
	6 yr	Multiple Gunshot Wounds	Step Grandfather
	10 yr	Gunshot Wound to Face	Drug Related
	16 yr	Gunshot Wound to Abdomen	
	16 yr	Gunshot Wound to Head	Altercation between 2 Teen Groups
	16 yr	Gunshot Wound	
	16 yr	Gunshot Wound to Head	Gang-related; Drive-by shooting
	12 yr	Gunshot Wound to Face	Friend playing with gun
	13 yr	Gunshot Wound to Temple	Friend playing with gun
	17 yr	Multiple Gunshot Wounds	
	17 yr	Multiple Gunshot Wounds	Gang-related
	16 yr	Multiple Gunshot Wounds	
	17 yr	Gunshot Wound to Head	
	15 yr	Gunshot Wound to Back	18 year old Male Robbery
	17 yr	Gunshot Wound to Face	
	7 mo	Gunshot Wound to Face	Father

	3 yr	Gunshot Wound to Head	Uncle
	15 yr	Gunshot Wound to Head	
	17 yr	Gunshot Wound to Back	Gang-related – 38 year old male
	16 yr	Multiple Gunshot Wounds	Gang-related
	17 yr	Multiple Gunshot Wounds	
	16 yr	Gunshot Wound to Chest	Drive-by shooting
	15 yr	Gunshot Wound to the Head	18-Year-Old Male
	15 yr	Multiple Gunshot Wounds	
	15 yr	Gunshot Wound of Neck	20-Year-Old Male; Gang-related
	16 yr	Gunshot Wound of Flank	
	16 yr	Multiple Gunshot Wounds	Drive-By Shooting
	16 yr	Multiple Gunshot Wounds	Gang-related
	17 yr	Multiple Gunshot Wounds	Male
	17 yr	Gunshot Wound to Head	
	17 yr	Gunshot Wound to the Chest	
	15 yr	Gunshot Wound to Head	22-Year-Old Male; Drive-by Shooting
	16 yr	Multiple Gunshot Wounds	Gang Violence
	15 yr	Homicidal Violence; Gunshot Wounds	18-Year-Old Male and 17-Year-Old Male
	13 yr	Multiple Gunshots	
	5 yr	Gunshot Wound to Abdomen	5-Year-Old Brother
	8 yr	Gunshot to Head	17-Year-Old Male
	16 yr	Gunshot Wound to Back	
	15 yr	Gunshot Wound to Chest	Gang-related
	17 yr	Gunshot Wound to Chest	Gang-related
	15 yr	Gunshot Wound to the Back	
	14 yr	Gunshot Wound of Chest	
	16 yr	Gunshot Wound of Arm	16-Year-Old Male
	17 yr	Multiple Gunshot Wounds	Gang-related
	15 yr	Gunshot Wound of Head	
	17 yr	Gunshot Wounds of Back	
	17 yr	Gunshot Wound of Head	Playing with Gun with Other
	17 yr	Gunshot Wound of Chest	
	15 yr	Multiple Gunshot Wounds	Gang-related
	16 yr	Gunshot Wound to Back	Gang-related
	14 yr	Gunshot Wound of Head	19-Year-Old Male
	17 yr	Multiple Gunshot Wounds	
Other	1 yr	Hypertension due to Parental Neglect	Mother
	1 yr	Hyperthermia due to Environmental Exposure due to Maternal Neglect	Mother

	4 mo	Dehydration due Gastroenteritis Stomach Flu due to Parental Neglect	Parents
	2 mo	Dehydration and Malnourishment	Mother
	Minutes	Neglect; Prematurity	Mother
Scalding Burn	2 yr	Thermal Injuries from Scalding Bathtub Water	Mother
Vehicular	4 yr	Craniothoracic Blunt Trauma; Unrestrained Passenger in Auto	
	16 yr	Carniocerebral Injuries; Pick-up Truck Striking Objects	
	16 yr	Multiple Injuries; Auto Striking Pedestrian	
Poisoning/ Overdose	14 yr	Anoxic Brain Injury; Adverse Effects of Drugs of Abuse	Friend's Mother

Chapter 3 Child Deaths Reviewed 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 a specific cause 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 2009 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 State Central Register (SCR/DCFS).
- Numbers of deaths from categories over the past 11 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender and age of three groups: 1) the total child deaths,[9] 2) deaths from a specific category, and 3) reviewed deaths from that category. Previous reports have included comparisons by child race, but due to a lack of data, race is not included in the analysis this year.

Once again, there are two important facts to remember about these analyses. The first is that not all child deaths in Illinois are reported to DCFS as required by statute. Thus, the number of total child deaths, and any analyses using this number, will be an estimate of the true number of child deaths in Illinois. Second, it is important to remember that 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 must be reviewed. Since the child welfare system in Illinois over-represents African-American children and young children, the cases reviewed by the CDRT are more likely to be younger or African-American.

[9] Previous reports had used the population of Illinois as the comparison group in the charts, rather than total child deaths. The advantage of using the total child deaths as a comparison is that it allows for a finer distinction to be made based on category influence. For example, males are overrepresented in total child deaths, but the gender distribution in specific category of death (like suffocation) may or may not contribute to the gender disparity in total child deaths.

Illness

Definition

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

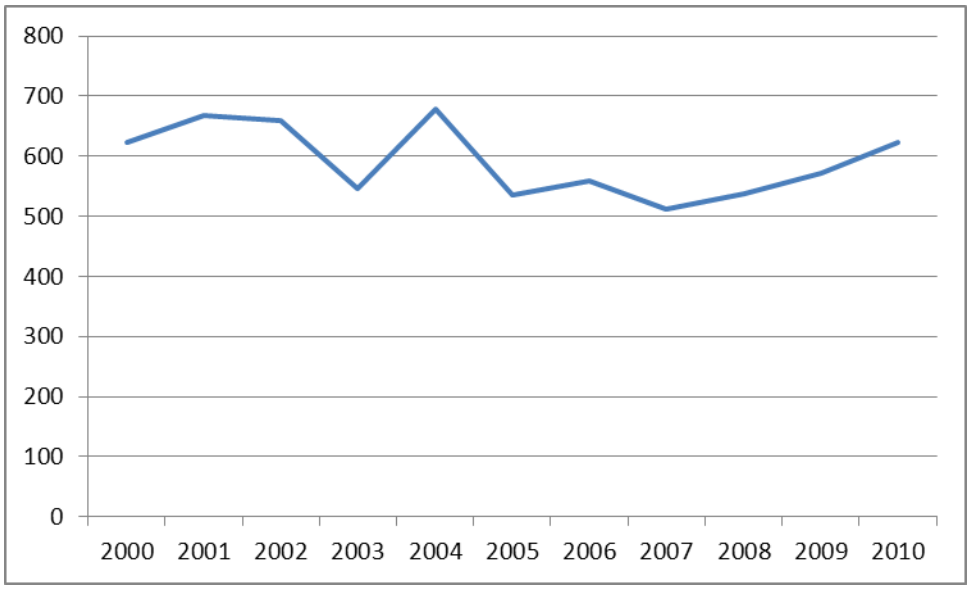
Background

The majority of all child deaths are due to natural causes, and the majority of all illness deaths occur during the first year of life.[10] A death due to illness can result from one of many serious health conditions, such as congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart or respiratory disorders, and infections. Although many of these conditions are not believed to be preventable in the same way that accidents, homicides, and suicides are preventable, deaths from certain illnesses, such as neural tube defects, asthma, infectious diseases, and some screenable genetic disorders are now believed to have a preventable component.

Illinois Data – Total Child Deaths Reported to the SCR

For the past decade, illness has been the largest or nearly the largest cause of child death (in 2005 and 2006 prematurity was slightly larger). The number of deaths from illness has ranged from 513 in 2007 to 668 in 2001 (See Figure 9).

Figure 9. Child Deaths Due to Illness



[10] Missouri Department of Social Services. (2004). *Preventing child deaths in Missouri: The Missouri Child Fatality Review Program annual report for 2003*. Jefferson City, MO: Author.

In 2009, 572 of the 1,490 total child deaths (38%) reported to the SCR were related to illness; in 2010, 622 of the 1,622 total child deaths (38%) were related to illness.

- The vast majority of these deaths (over 99%) were attributable to natural causes.
- A majority of children who die from illness are male (57% in 2009 and 56% in 2010).
- A majority of deaths from illnesses were among children under the age of one (51-53%); 15-16% of the illness deaths occurred among children between 1 and 4 years, 10-11% occurred among the 5 to 9 year olds, 11-12% among those 10 to 14 years old, and 9-11% occurred among 15 to 17 year olds.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 39 of the 245 child deaths reviewed by CDRTs (16%) were related to illness; in 2010, 46 of the 208 child deaths reviewed by CDRTs (22%) were related to illness.

- More boys (56-57%) than girls who had deaths related to illness were reviewed.
- Children under the age of one represent the largest percentage of the illness deaths reviewed by CDRTs (37-49%). Reviewed illness deaths also included 26-28% of 1 to 4 year olds, 13-20% of children aged 5-9, 8-9% of children aged 10 to 14 and 3-9% of children aged 15 to 17.
- Nearly all deaths that are categorized as illness are natural (a few are accidental or undetermined).

The age distributions of the total child deaths, deaths resulting from illness, and deaths resulting from illness that were reviewed by the CDRTs are presented in Figures 10 for 2009 and 11 for 2010. Although deaths from illness are most likely to occur for infants under the age of one, it is clear when comparing deaths from illness to the total deaths, that children aged 1-14 have a higher proportion of death from illness than from other causes and that these aged children are likely to have their deaths reviewed.

Figure 10. Child Deaths Due to Illness by Age (2009)

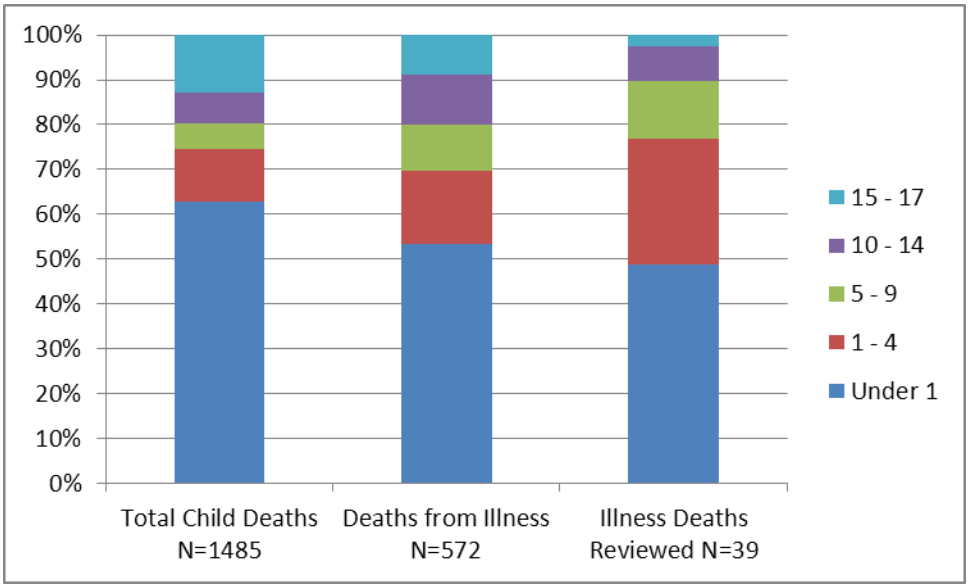
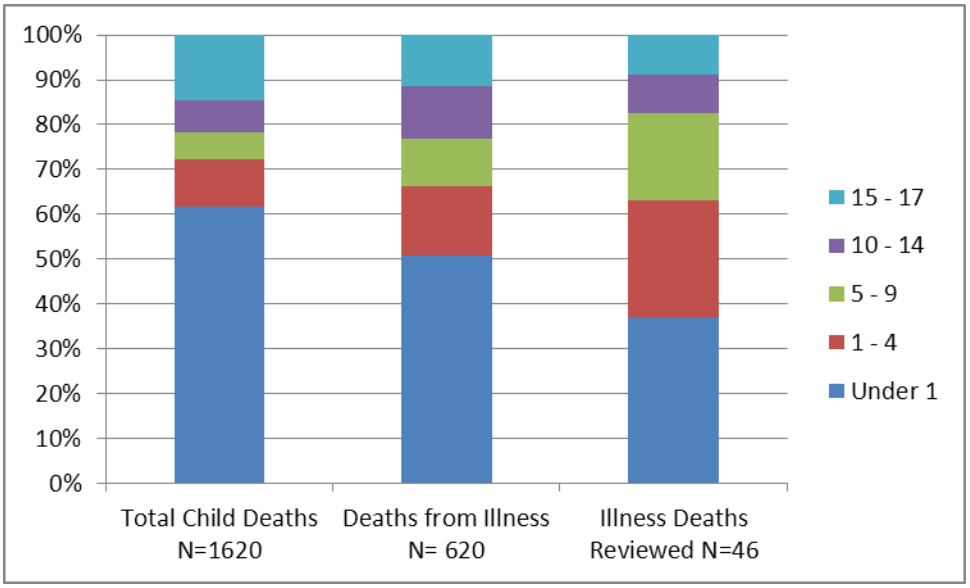


Figure 11. Child Deaths Due to Illness by Age (2010)



Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature (or preterm) birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as "very preterm" (less than 32 weeks gestation) and moderately preterm (32 – 36 weeks gestation). In Illinois, deaths in this category include aborted pregnancies where a death certificate was completed, but not fetal deaths. The manner of death associated with prematurity is most often determined to be natural. However, if an infant is born prematurely due to maternal injury, the manner of death may be ruled accidental or homicide.

Background

Premature birth is closely associated with low birth weight. According to the U.S. Department of Health and Human Services, period of gestation and birth weight are the two most important predictors of neonatal mortality. Low birth weight babies (less than 2,500 grams) and very low birth weight babies (less than 1,500 grams) are more likely to die during the first four weeks of life than babies weighing more than 2,500 grams. Infants born at the lowest birth weights and gestational ages have a large impact on infant mortality.

In Illinois, 1 in 8 babies (12.7% of live births) was born preterm and 2.2% were very preterm in 2008.[11] After a rise in preterm births earlier in the decade, the rate has slowly and steadily decreased from 13.3% to 12.4% between 2006 and 2009. The rate of preterm birth in Illinois is highest for black infants (18.5%), followed by Hispanics (12.2%), Native Americans (11.9%), whites (11.8%), and Asians (10.7%).[12] A number of risk factors have been associated with preterm birth: maternal age, history of preterm birth, multifetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity, and elevated blood pressure.[13] 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 SCR

Prematurity has been a leading cause of child death and has either been the second largest or the largest category in the past 10 years (ranging from 431to 620 deaths per year). The lowest number of deaths from prematurity in the past decade occurred in 2009, although there was a slight rise in 2010 (Figure 12).

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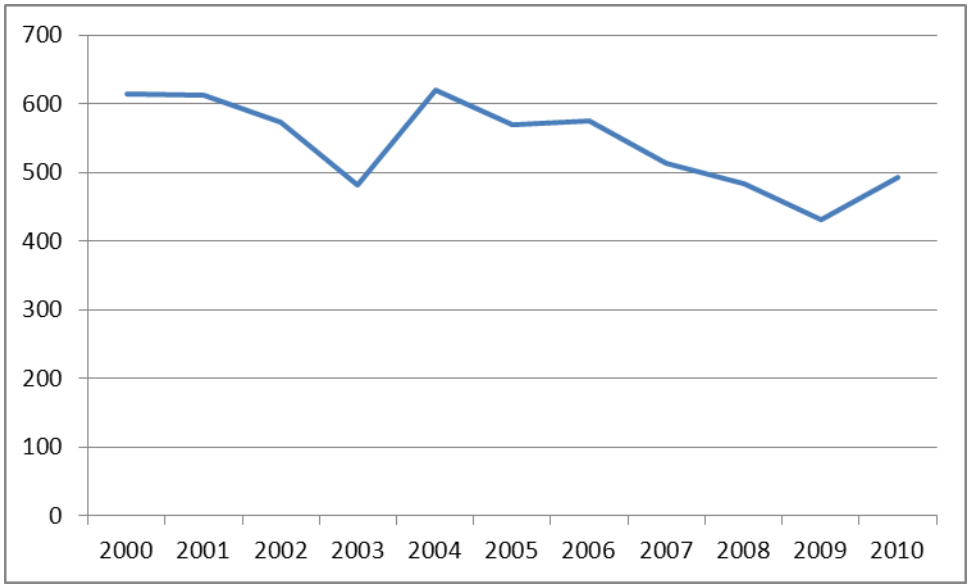
[11]National Center for Health Statistics. *Illinois prematurity data.* Retrieved from http://www.marchofdimes.com/peristats/tlanding.aspx?dv=lt&reg=17&top=3&lev=0&slev=4

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

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

Figure 12. Child Deaths Due to Prematurity



Of the 1,490 total child deaths in 2009, 431 (29%) were related to premature birth; in 2010, 493 of the 1,622 total child deaths (30%) were related to premature birth.

- Over 99% of the deaths in this category were the result of natural causes.
- The majority of children who die from prematurity were boys (56-60%).

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 10 of the 245 child deaths reviewed by CDRTs (4%) were related to premature birth; in 2010, 13 of the 208 child deaths reviewed by CDRTs (6%) were related to premature birth. Of the premature deaths reviewed, 60-67% were male.

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 eye witness account. If there is no such evidence, these types of suffocation deaths may be listed as SUID, SIDS, or undetermined deaths. Thus, the actual number of deaths due to suffocation may be under-reported.

Background

In 2009, 1,859 children ages 17 and under in the U.S. died from accidental airway obstruction.[14] Of these children, 53% were less than one year of age and 61% were ages four and under. In fact, airway obstruction is the leading cause of accidental death among infants under one year. Young children are especially vulnerable to airway obstruction injury and death due to the small size of their upper airways, their relative inexperience with chewing, and their natural tendency to put small objects in their mouths. Additionally, infants' inability to lift their heads or extricate themselves from tight places puts them at greater risk. Most infant deaths due to suffocation are directly related to an unsafe sleeping environment (e.g., soft bedding and pillows, infants sleeping on couches or adult beds).[15]

Toddlers and preschoolers are also at high risk for choking and strangulation deaths. Because they are more active, they can more easily become tangled in cords and gain access to small objects. The majority of childhood choking injuries are associated with food.[16]

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[14] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

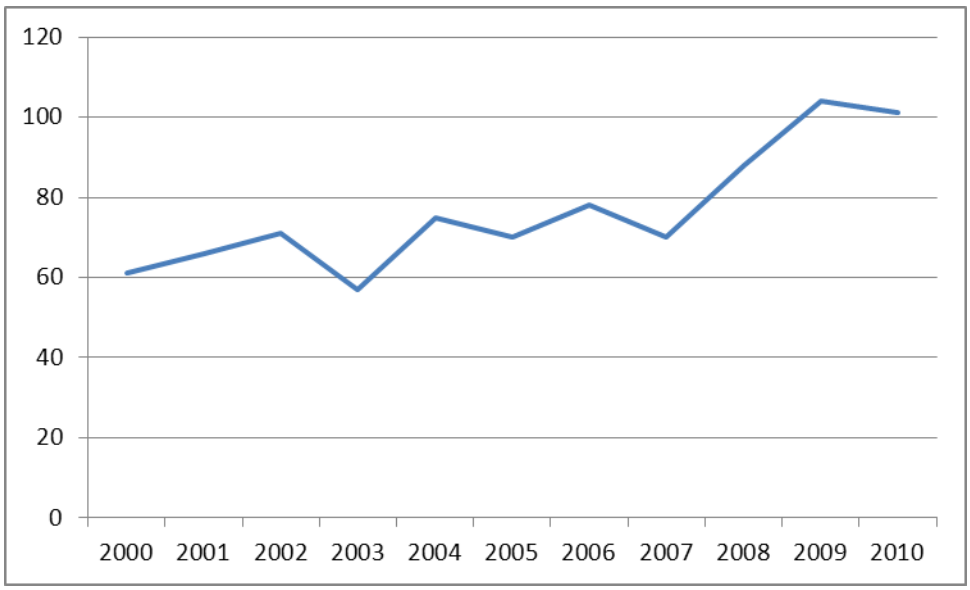
[15] Safe Kids Worldwide. (2012). *Suffocation and choking safety*. Retrieved from http://www.safekids.org/our-work/research/fact-sheets/choking-and-suffocation-prevention-fact-sheet.html

[16] Ibid.

Illinois Data – Total Child Deaths Reported to the SCR

There has been a rise in deaths from suffocation in the past 10 years from 61 in 2000 to 101 in 2010 (Figure 13).

Figure 13. Child Deaths Due to Suffocation



In 2009, 104 of the 1,490 total child deaths reported to the SCR (7%) were related to suffocation; in 2010, 101 of the 1,622 total child deaths (6%) were related to suffocation.

- The manner of the suffocation deaths was varied: 53 to 60% were accidental, 22 to 23% were suicides, 2 to 6% were homicides, and 12 to 18% were undetermined.
- The majority of children who died from suffocation were boys (57-68%).
- Infants under one year are the largest group in this category, accounting for 55 to 62% of the deaths.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 66 of the 245 deaths reviewed by CDRTs (27%) were related to suffocation; in 2010, 41 of the 208 reviewed deaths were from suffocation (20%).

- The slight majority (58-61%) of the reviewed suffocation deaths were male. The proportion of males in reviewed suffocation deaths was very similar to the proportion of males who died from suffocation.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (71-77%). The proportion of reviewed suffocation deaths was higher than

the proportion of deaths from suffocation for children under the age of one in both 2009 and 2010 (Figure 14 and 15).

Figure 14. Child Deaths Due to Suffocation by Age (2009)

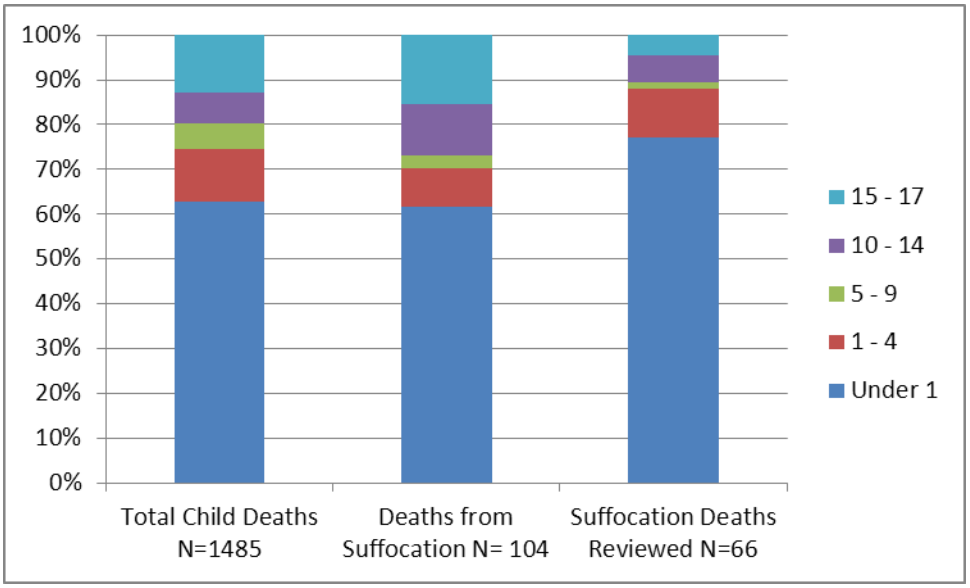
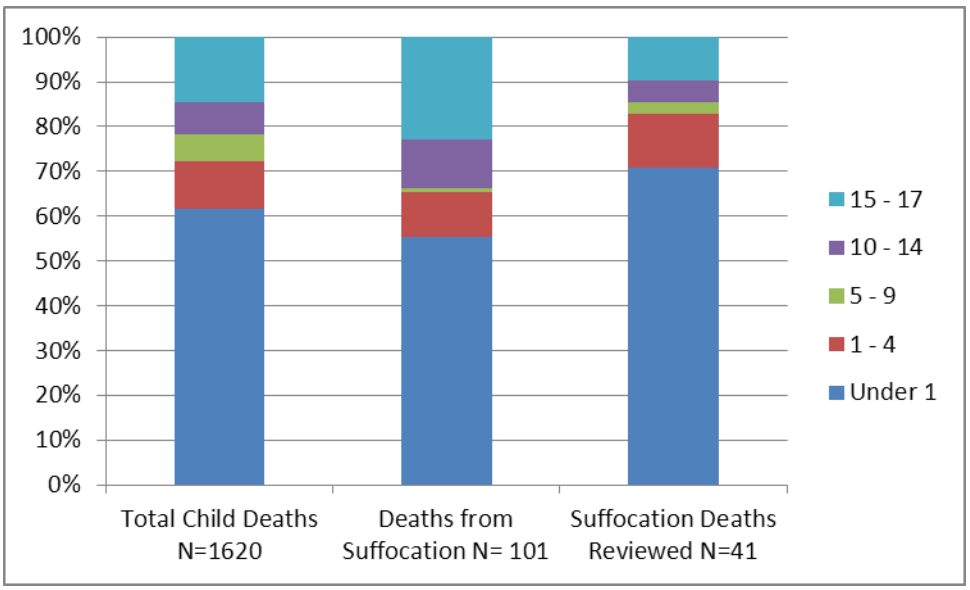


Figure 15. Child Deaths Due to Suffocation by Age (2010)



Firearm

Definition

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

Background

According to data from the Center for Disease Prevention and Control, 1,392 firearm deaths occurred in 2009 (the latest year for which data are available) among children under 18 years of age in the United States.[17] The vast majority (75%) of these deaths are youth between the ages of 15 and 17. However, race of decedent also is a factor. Black males ages 15 to 19 are almost five times as likely as their white peers and more than twice as likely as their Hispanic peers to be killed by a firearm. Between 1979 and 2006, the yearly number of firearm deaths of white children and teens decreased by about 40%, while deaths of black children and teens increased by 55%.[18]

Firearms include several manners of deaths. Homicides and suicides are the second and third leading causes of death, respectively, among teens ages 15 to 19. Firearms were the instrument of death in 85% of teen homicides and 43% of teen suicides in 2007. Males ages 15 to 19 are about four times more likely than females to die from suicide, (11.1 compared with 2.5 per 100,000, respectively, in 2007), and more than six times more likely to die from homicide (17.6 compared with 2.8 per 100,000, respectively).[19]

Although some firearm deaths are homicides and suicides, other firearm deaths are accidents. Children and adolescents are involved in 55% of accidental deaths from firearms in the U.S. The majority of the injuries occur to children playing with or showing the weapons to friends. The easy availability of firearms is believed to be the number one risk factor for unintentional firearm deaths.[20]

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[17] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

[18] Children's Defense Fund. (2010). *Protect children, not guns.* Retrieved from http://www.childrensdefense.org/child-research-data-publications/data/protect-children-not-guns.html

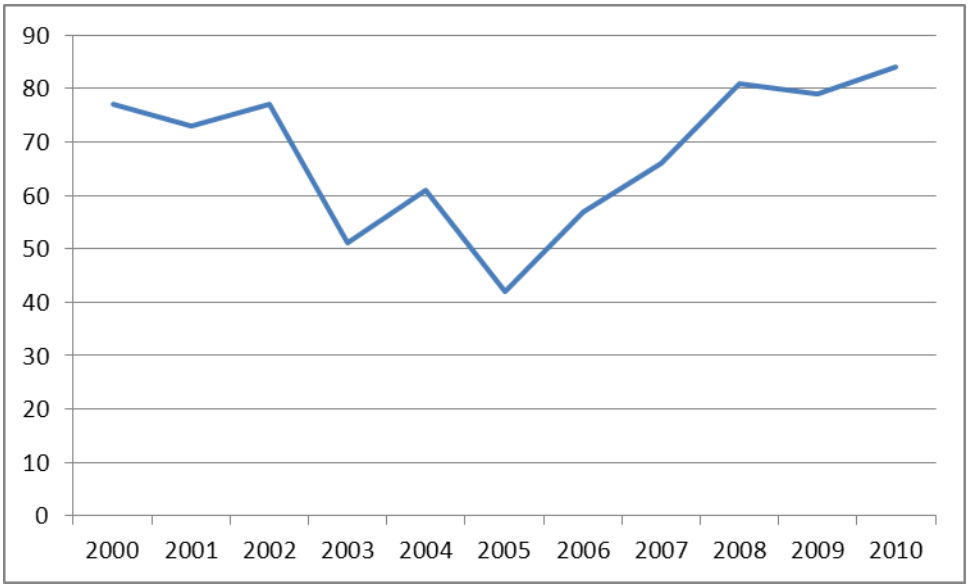
[19] Child Trends. (2010). *Teen homicide, suicide, and firearm deaths.* Retrieved from http://www.childtrendsdatabank.org/?q=node/124

[20] National MCH Center for Child Death Review. (n.d.). *Accidental firearm - Fact sheet*. Retrieved from http://www.childdeathreview.org/causesaf.htm

Illinois Data – Total Child Deaths Reported to the SCR

After dropping in the first part of this decade, child deaths from firearms have steadily risen since 2005 (Figure 16). In 2010 there were 84 child deaths from firearms, which is the highest number in the past 11 years.

Figure 16. Child Deaths Due to Firearms



In 2009, 79 of the 1,490 total child deaths reported to the SCR (5%) were related to firearms. In 2010, 84 of the 1,622 total deaths (5%) were related to firearms.

- Homicides accounted for 76 to 84% of the firearm deaths, suicides accounted for 13%, and accidents accounted for 1 to 2%.

- As shown in Figures 17 and 18, deaths due to firearms overwhelmingly occurred among boys (87-92%).

- Children between 15 and 17 years of age are largely over-represented in firearm deaths when compared to total child deaths (see Figures 19 and 20). In 2009, 86% of firearm deaths occurred in children aged 15 to 17, and in 2010, 79% of firearm deaths were children ages 15-17. As shown in Figures 19 and 20, children between ages 10 to 14 years have the second largest percentage of deaths by firearms (6-11%).

Illinois Data – Deaths Reviewed by CDRTs

In 2009, only 2 of the 245 deaths reviewed by the CDRTs (less than 1%) were related to firearms; in 2010, 9 of the 208 reviewed deaths (4%) were related to firearms.

- In 2009, there was one reviewed death of an infant under one year old and one reviewed death of a fifteen year old. In 2010, the firearm deaths reviewed by CDRTs were fairly evenly distributed among children of different age groups: 15-17 years (33%), 10-14 years (33%), 5-9 (22%), and 1-4 (11%). A smaller proportion of older teens were reviewed when compared to the proportion of 15 to 17 year olds who died due to firearms (see Figures 19 and 20).

Figure 17. Child Deaths Due to Firearms by Gender (2009)

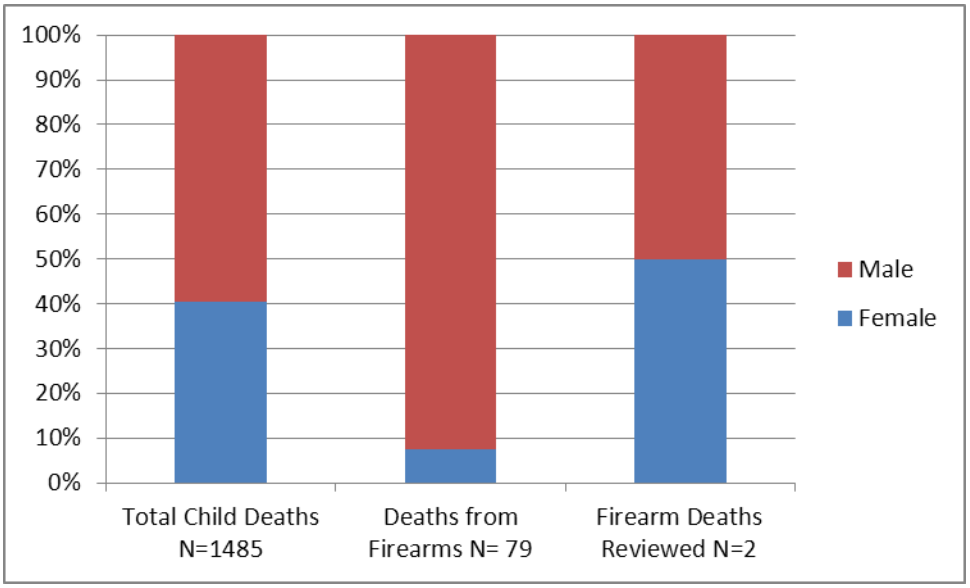


Figure 18. Child Deaths Due to Firearms by Gender (2010)

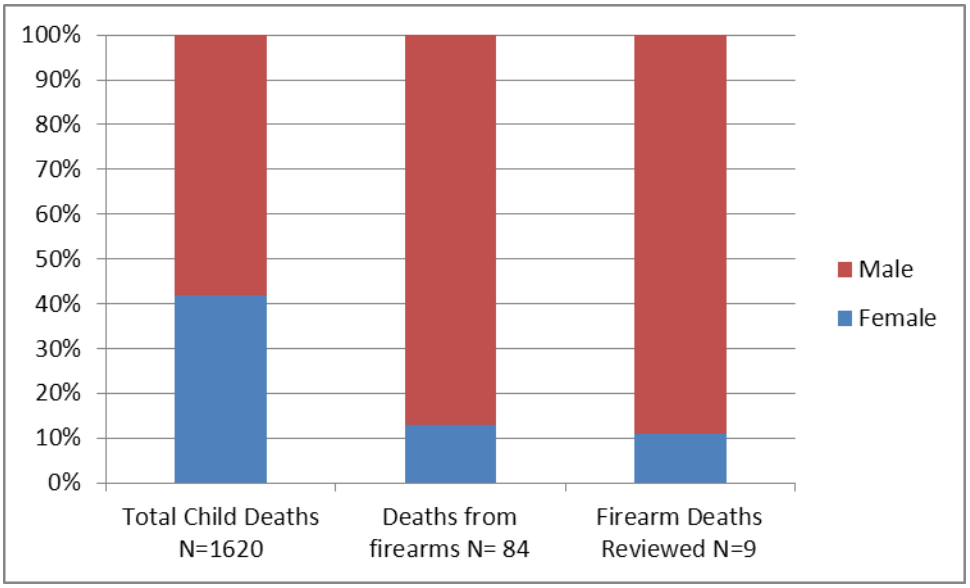


Figure 19. Child Deaths Due to Firearms by Age (2009)

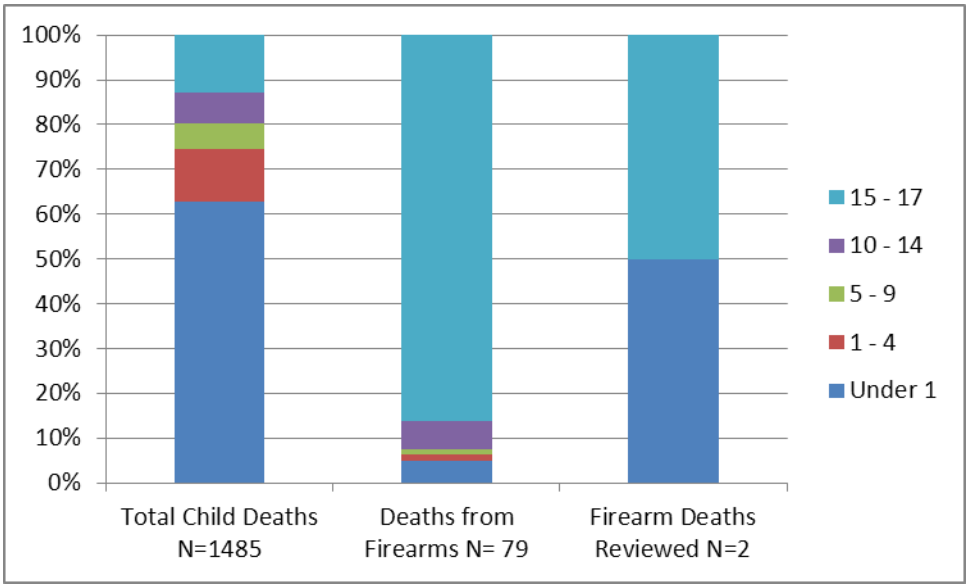
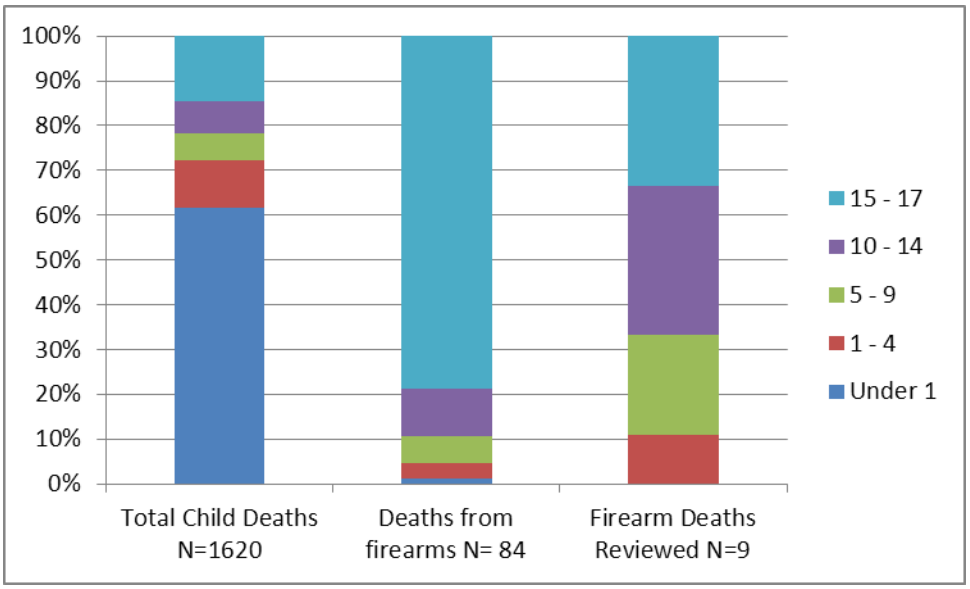


Figure 20. Child Deaths Due to Firearms by Age (2010)



Vehicular Accident

Definition

Included in this category are all deaths occurring to children who are drivers, passengers, pedestrians, or occupants of other forms of vehicles such as bicycles, snowmobiles, motorcycles, ATVs, sleds, trains, etc. The manner of death is usually accidental, but can include deaths ruled to be suicides or homicides as well.

Background

Nationally, a total of 1,062 children died in motor vehicle crashes in 2009. This is a 1% increase from 2008 but a 71% decline from 1975. In 2009, 71% of child motor vehicle crash deaths were passenger vehicle occupants, 19% were pedestrians, and 5% were bicyclists. Child pedestrian and bicyclist deaths each declined by 88% since 1975. Passenger vehicle child occupant deaths in 2009 were 46% lower than in 1975. Even though child deaths in motor vehicle crashes have declined since 1975, crashes still cause about 1 of every 3 injury deaths among children younger than 13, and are the leading cause of death for those children ages 3 to 12 combined. Since most crash deaths occur among children traveling as passengers, proper restraint use can reduce these fatalities. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about a third.[21]

A total of 3,466 teenagers ages 13 to 19 died in motor vehicle crashes in 2009. This is 60% fewer than in 1975 and 15% fewer than in 2008. About 2 out of every 3 teenagers killed in motor vehicle crashes in 2009 were males. In 2009, 83% of teenage motor vehicle crash deaths were passenger vehicle occupants. The others were pedestrians (7%), motorcyclists (4%), bicyclists (2%), riders of all-terrain vehicles (2%), and people in other kinds of vehicles (2%).[22]

In the United States, teenagers drive less than most adults (only drivers who are over the age of 70 drive less), but their numbers of crashes and crash deaths are disproportionately high. In the United States, the crash rate per mile driven for 16 to 19 year-olds is 4 times the risk than that for older drivers. Risk is highest at age 16. In fact, the crash rate per mile driven is twice as high for 16 year-olds as it is for 18 to 19 year-olds. Crash rates for teenagers are high largely because of their immaturity combined with driving inexperience.[23]

Distracted driving is often the cause of fatal accidents. Reaching for a moving object increases the risk of a crash or near-crash by nine times, drowsiness by four times, looking at an external object by four times, reading by three times, dialing a cell phone by nearly three times, and talking or listening on a hand-held device by 1.3 times. For teen drivers, the most

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[21] Insurance Institute for Highway Safety. (2009). *Fatality facts 2009: Children.* Retrieved from http://www.iihs.org/research/fatality_facts_2009/children.html

[22] Insurance Institute for Highway Safety. (2009). *Fatality facts 2009: Teenagers.* Retrieved from http://www.iihs.org/research/fatality_facts_2009/teenagers.html

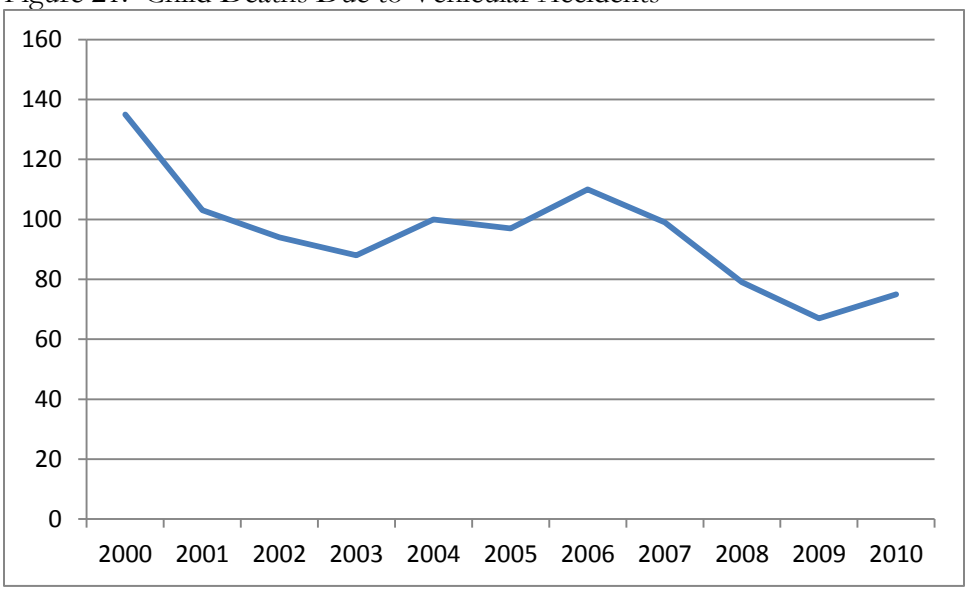
[23] ibid

common distraction is using a cell phone. Other common sources of distraction for teen drivers are riding with peers and drowsiness.[24]

Illinois Data – Total Child Deaths Reported to the SCR

The number of child deaths from vehicular accidents has declined over the past decade and 2009 had the lowest number of deaths from vehicular accidents since 2000 (see Figure 21).

Figure 21. Child Deaths Due to Vehicular Accidents



In 2009, 67 of the 1,490 total child deaths reported to the SCR (4%) were related to vehicular accidents; in 2010, 75 of the 1,622 total child deaths (5%) were related to vehicular accidents.

- A large majority (81% in 2009 and 92% in 2010) of these deaths were accidental, and a small portion were homicides (7% in 2009, 4% in 2010) and suicides (1%).
- More boys (61-64%) had deaths related to vehicular accidents.
- Older children (15-17) made up the largest proportion of vehicular accident deaths (42% in 2009 and 57% in 2010). Children under the age of one made up the smallest proportion of vehicular deaths (3-6%). The percentage of children in other age groups was between 9% and 19% (see Figures 22 and 23).

[24] Child Trends. (2010). *Distracted driving*. Retrieved from www.childtrendsdatabank.org/?q=node/376 on March 7, 2010.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 8 of the 245 deaths reviewed by CDRTs (3%) were related to vehicular accidents; in 2010, 9 of the 208 reviewed deaths (4%) were related to vehicular accidents.

- 38% of the reviewed deaths in this category were boys in 2009 and 78% were boys in 2010.
- A large proportion of vehicular decedents in the age group of 5-9 had cases that were reviewed (Figure 22 and 23).

Figure 22. Child Deaths Due to Vehicular Accidents by Age (2009)

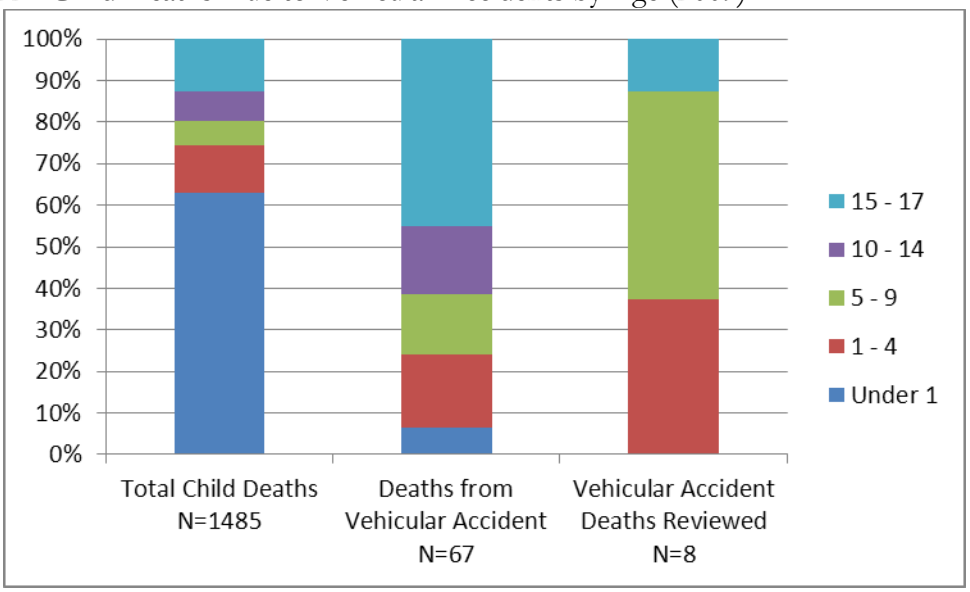
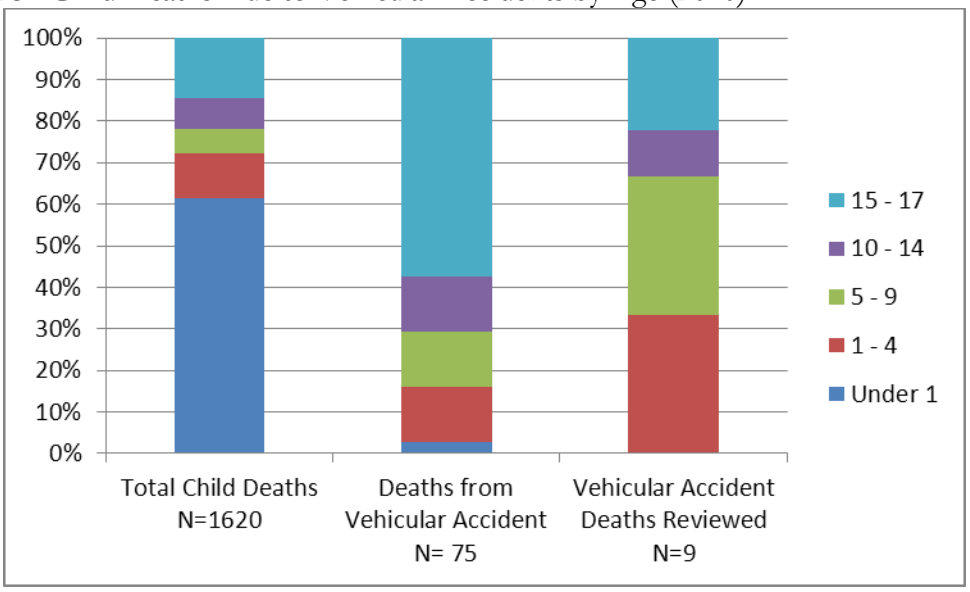


Figure 23. Child Deaths Due to Vehicular Accidents by Age (2010)



Injuries

Definition

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

Background

Child maltreatment (including abuse and neglect) is one cause of death from injuries. In 2010, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,537 fatalities from child maltreatment. The number of reported child fatalities due to child abuse and neglect has fluctuated during the past five years. The national fatality rate per 100,000 children in the population was 2.32 for FFY 2009 and 2.07 for FFY 2010. Younger children are more vulnerable to death as the result of child abuse and neglect. Four-fifths (79.4%) of all child fatalities were younger than four years old. Child fatality rates from child maltreatment decreased with age. Four-fifths (79.2%) of child fatalities were caused by one or more parents. Perpetrators without a parental relationship to the child (e.g., other relatives, foster parents, legal guardians, etc.) accounted for 12.5% of fatalities.[25]

One recent study found that 10% of child deaths that were determined to be unintentional (accidental) had a history of maltreatment. This suggests that children with histories of maltreatment are at higher risk for accidental injury leading to death.[26]

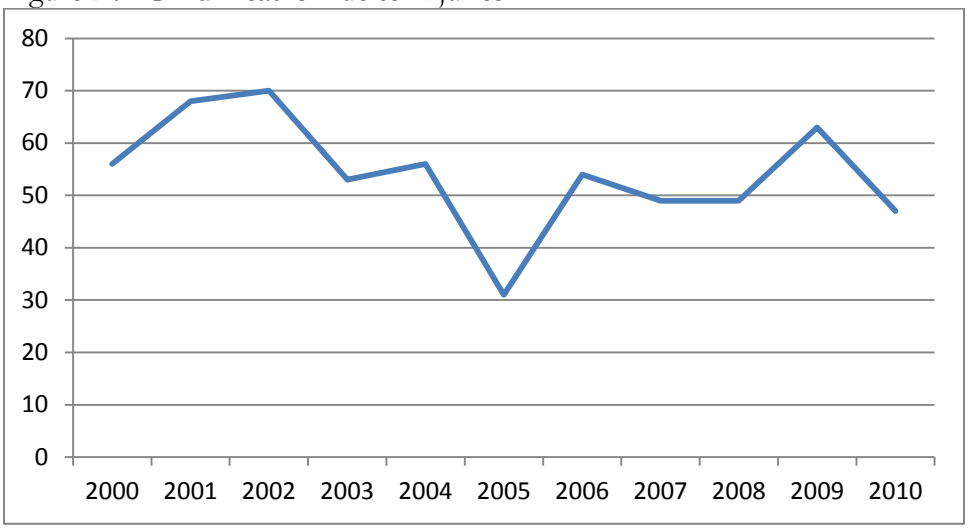
Illinois Data – Total Child Deaths Reported to the SCR

There have been between 31 and 79 child deaths from injuries per year since 2000 in Illinois (Figure 24).

[25] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2010). *Child maltreatment, 2010.* Washington, DC: Government Printing Office.

[26] Parks, S.E., Mirchandani, S. R., & Hellesten, J. History of maltreatment among unintentional injury death; Analysis of Texas child fatality review data, 2005-2007. *Injury Prevention Supplement, pi4*.

Figure 24. Child Deaths Due to Injuries



In 2009, 63 of the 1,490 total child deaths reported to the SCR (4%) were related to injuries; and in 2010, 47 of the 1,622 total deaths (3%) were related to injuries.

- 30 to 40% of these injury deaths were classified as accidents and 55 to 65% were homicides.
- Males were more likely to die from injuries (63-66%).
- Younger children are more vulnerable to death from injuries: 23-30% of injury deaths are among children under the age of one and an additional 23-37% are among children between the ages of 1 and 4. Older children experienced injury-related deaths at lower, but not insignificant, rates: 10-11% among children 5 to 9 years; 6-17% among those 10 to 14 years; and 16-26% among those between 15 and 17 years of age.
- The majority of homicide injuries involved younger children. In 2009, 42% of accidental injuries involved children 4 and under, whereas 75% of homicidal injuries involved children 4 and under. In 2010, 21% of accidental injuries were children 4 and under, whereas 69% of homicidal injuries were among this age group.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 34 of the 245 (14%) deaths reviewed by CDRTs were related to injuries; in 2010, 21of the 208 reviewed deaths (10%) were related to injuries (See Figures 25 and 26).

- The vast majority of the reviewed cases involved young children 4 years and under (86-97%).
- Most of the reviewed injury deaths were male (59-67%).

Figure 25. Child Deaths Due to Injuries by Age (2009)

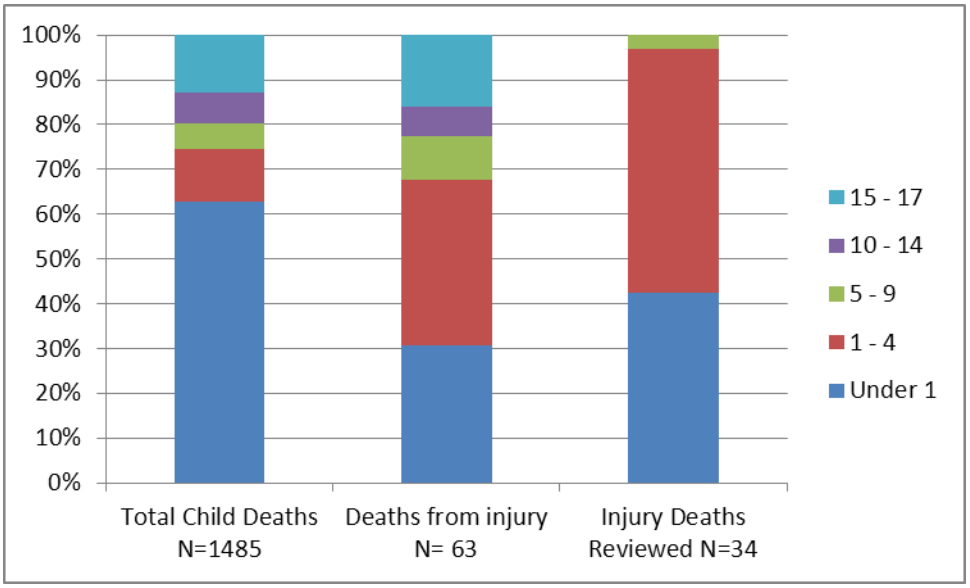
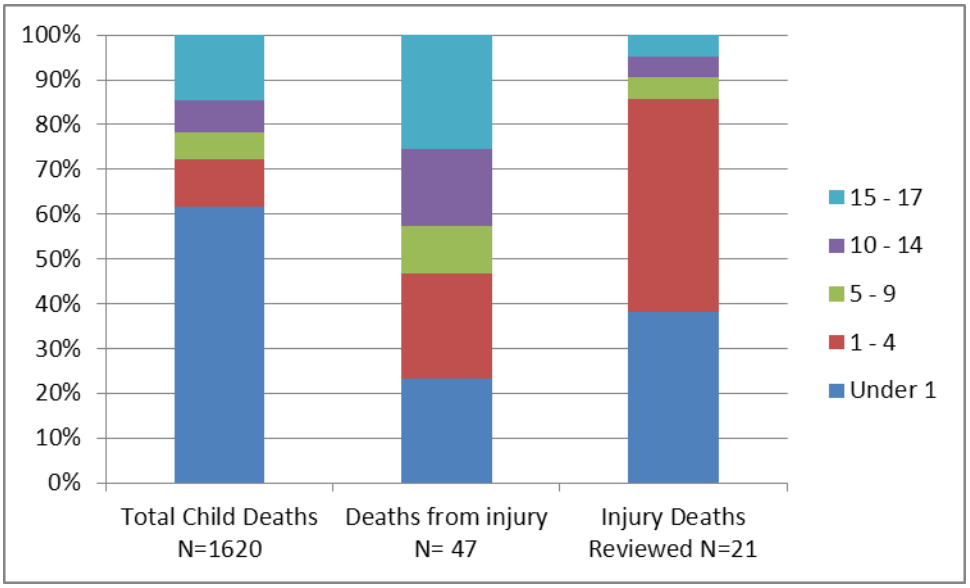


Figure 26. Child Deaths Due to Injuries by Age (2010)



Undetermined Deaths

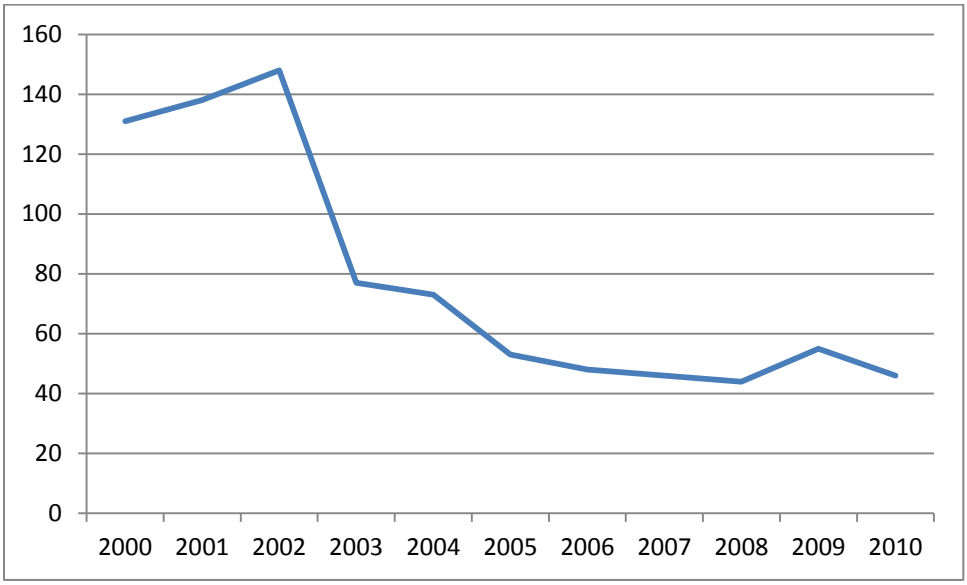
Definition

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

Illinois Data – Total Child Deaths Reported to the SCR

The number of undetermined deaths for children was over 130 per year for 2000-2002 but has dropped since then and has ranged between 44 to 55 per year since 2005 (Figure 27).

Figure 27. Child Deaths with Undetermined Cause of Death



In 2009, 55 of the 1,490 total child deaths reported to the SCR (4%) had an undetermined cause of death. In 2010, 46 of the 1,622 total deaths (3%) had an undetermined cause of death.

- Deaths due to undetermined causes were more common for boys (54-58%).
- Children under the age of one represent 78-87% of deaths in this category; an additional 9-20% of decedents from undetermined causes were between one and four years.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 31 of the 245 deaths reviewed by CDRTs (13%) had an undetermined cause of death; in 2010, 14 of the 208 reviewed deaths (7%) were related to undetermined causes.

- Almost all of the reviewed deaths due to undetermined causes occurred among young children; 86-90% were under one year of age.

Sudden Infant Death Syndrome (SIDS) and Unknown Infant Deaths[27]

Definition

Each year in the United States, more than 4,500 infants die suddenly of no immediately obvious cause. These deaths are called Sudden Unexpected Infant Deaths (SUID). Half of the SUID deaths are due to Sudden Infant Death Syndrome (SIDS).

For a medical examiner or coroner to determine the cause of an SUID death, an investigator needs to conduct a thorough investigation including examination of the death scene, a review of the infant's clinical history, and a complete autopsy needs to be performed. After an investigation some deaths are attributed to various causes such as suffocation, poisoning, or metabolic disorders.[28] Even after a thorough investigation, some unexpected deaths have an unexplained or unknown cause.

SIDS is the sudden death of an infant under age one that cannot be explained after a thorough investigation has been conducted. SIDS is the leading cause of deaths among infants aged 1–12 months. Sometimes the cause of death is unexplained and it is unknown whether the cause is SIDS or something else, these are labeled unknown.[29] Both explained and unexplained infant deaths can be associated with unsafe sleep environments (See insert on Safe Sleep).

The Centers for Disease Control and Prevention (CDC) launched an initiative in 2004 to improve the investigation and reporting of Sudden Unexpected Infant Death (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.

Background

SIDS is the leading cause of death among infants aged one to twelve months. According to data at the National Center for Health Statistics, 2,353 infants in the U.S. died due to SIDS in 2008.[30] Largely because of the national Back to Sleep Campaign, SIDS rates declined in the 1990s. However, one study suggests that since 1999, certain deaths previously classified

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[27] In previous CDRT reports 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. For this report the category previously defined as SUID will be called Unknown Infant Death. Unknown is the description of the same category used by CDC.

[28] Center for Disease Control and Prevention. (2011). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome.* Retrieved from http://www.cdc.gov/sids/

[29] Ibid.

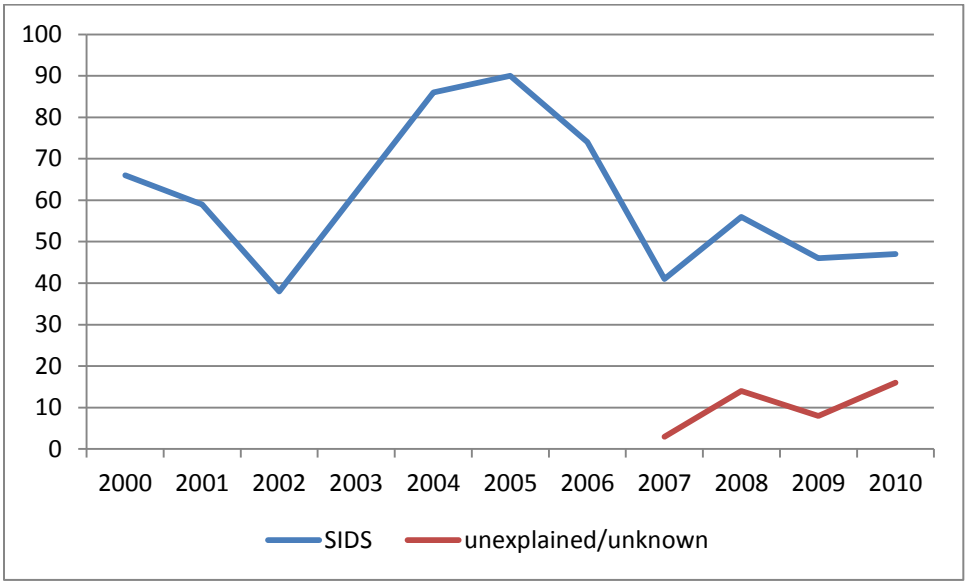
[30] Center for Disease Control and Prevention National Center for Health Statistics. (2011). *Compressed Mortality File.* Retrieved from http://wonder.cdc.gov/cmf-icd10.html

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]

Illinois Data – Total Child Deaths Reported to the SCR

There have been between 38 and 90 child deaths from SIDS per year since 2000 with the highest numbers (86-90) being in 2004 and 2005 (Figure 28). Infant deaths from unknown causes (called SUID in previous reports) were added as a category in 2007 and the highest number of unknown deaths occurred in 2010.

Figure 28. Child Deaths Due to SIDS and Unknown Causes



In 2009, 46 of the 1,490 total child deaths reported to the SCR (3%) were related to SIDS; in 2010, 47 of the 1,622 total child deaths (3%) were related to SIDS. In 2009 there were 8 infant deaths that were from unknown/unexplained causes and 16 in 2010. These unknown/unexplained deaths accounted for less than 1% of the total child deaths in each year.

- More boys (57-66%) than girls (34-43%) had deaths related to SIDS.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 21 of the 245 (9%) deaths reviewed by CDRTs were related to SIDS; in 2010, 10 of the 208 reviewed deaths (5%) were related to SIDS.

- 50-57% of the SIDS deaths reviewed by the CDRTs were boys.

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

Special Review of Safe Sleep

In 1992, the American Academy of Pediatrics (AAP) released its recommendation that infants be placed for sleep on their backs in order to reduce the incidence of sudden infant death syndrome (SIDS). The incidence of SIDS declined for the few years after their 'back to sleep' campaign, but this decline has plateaued in recent years. Conversely, other causes of sudden unexpected infant death during sleep (sleep-related deaths), including suffocation, asphyxia, and entrapment, and ill-defined or unspecified causes of death have increased. The increase in non SIDS infant sleep deaths has increased most noticeably since 2005.[32] Many of the risk factors for SIDS and other sleep related deaths are similar.[33] Therefore the new AAP recommendations focus on a safe sleep environment which would reduce the risk of all sleep-related infant deaths, including SIDS. The National Institute of Health formally expressed support for infant safe sleep recommendations on October 18, 2011.

Summary and Strength of Recommendations

Level A recommendations: based on good and consistent scientific evidence

1. Back to sleep for every sleep
2. Use a firm sleep surface
3. Room-sharing without bed-sharing is recommended
4. Keep soft objects and loose bedding out of the crib
5. Pregnant women should receive regular prenatal care
6. Avoid smoke exposure during pregnancy and after birth
7. Avoid alcohol and illicit drug use during pregnancy and after birth
8. Breastfeeding is recommended
9. Consider offering a pacifier at nap time and bedtime
10. Avoid overheating
11. Do not use home cardiorespiratory monitors as a strategy for reducing the risk of SIDS
12. Expand the national campaign to reduce the risks of SIDS to include a major focus on the safe sleep environment and ways to reduce the risks of all sleep related infant deaths, including SIDS, suffocation, and other accidental deaths; pediatricians, family physicians, and other primary care providers should actively participate in this campaign

Level B recommendations-based on limited or inconsistent scientific evidence

1. Infants should be immunized in accordance with recommendations of the AAP and Centers for Disease Control and Prevention
2. Avoid commercial devices marketed to reduce the risk of SIDS
3. Supervised, awake tummy time is recommended to facilitate development and to minimize development of positional plagiocephaly

[32] Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. *Pediatrics, 128,* 1030–1039. Retrieved from doi: 10.1542/peds.2011-2284.
[33] Ibid

Level C recommendations- based primarily on consensus and expert opinion

1. Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse the SIDS risk-reduction recommendations from birth
2. Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising
3. Continue research and surveillance on the risk factors, causes, and pathophysiological mechanisms of SIDS and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths entirely

Sudden Unexpected Infant Death (SUID) is a term that describes an unexpected infant death. "After a thorough case investigation, many of these sudden unexpected infant deaths may be explained. Poisoning, metabolic disorders, hyper or hypothermia, neglect and homicide, and suffocation are all explainable causes of SUID."[34] Some SUIDs do not have an explanation after careful investigation and these are either identified as SIDS or unknown. In order to better monitor SUIDs, a case registry has been developed and is being piloted in several states. This SUID case registry was part of a collaborative effort between Centers for Disease Control and Prevention (CDC) and the National Center for Child Death Review, to collect accurate and consistent population-based data about the circumstances and events associated with SUID cases. This surveillance system will allow researchers and program planners to develop prevention strategies and interventions to reduce infant deaths. [35]

Bed sharing

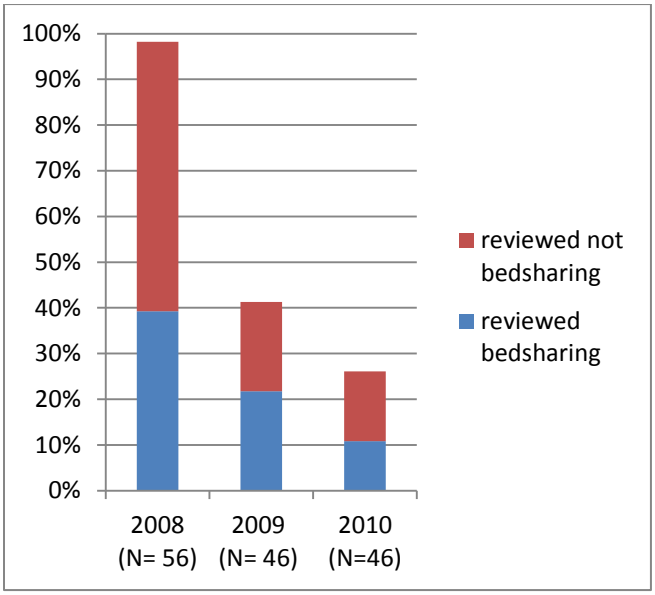
Part of the safe sleep recommendations (number three from the box above) is that infants should room share without bed sharing. Bed sharing has been identified as the culprit in 190 deaths reviewed by the CDRT in Illinois between 2008 and 2010. There are three categories that are most associated with infant sleep deaths, SIDS, Suffocation and Unexplained/Unknown infant deaths. Bed sharing was a factor in a large portion of deaths in these three categories.

A large portion (98%) of SIDS cases were reviewed in 2008 and a smaller portion of SIDS cases were reviewed in 2009 (41%) and in 2010 (26%). A substantial portion of reviewed cases of SIDS deaths included bed sharing as a factor in the death (40-53%) for the three years (Figure 29).

[34] Center for Disease Control and Prevention. (2011). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome.* Retrieved from http://www.cdc.gov/sids/

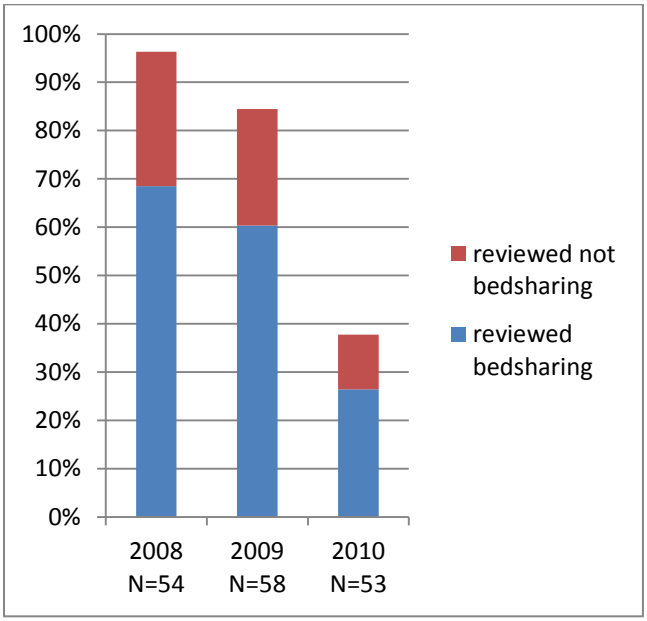
[35] Shapiro-Mendoza, C.K., Camperlengo, L.T., Kim, S.Y., & Covington, T. (2012). The sudden unexpected infant death case registry: A method to improve surveillance. *Pediatrics, 128,* 1030-1039. Retrieved from doi: 10.1542/peds.2011-2284

Figure 29. Percentage of SIDS Deaths that Were Reviewed, with and without Evidence of Bed Sharing.



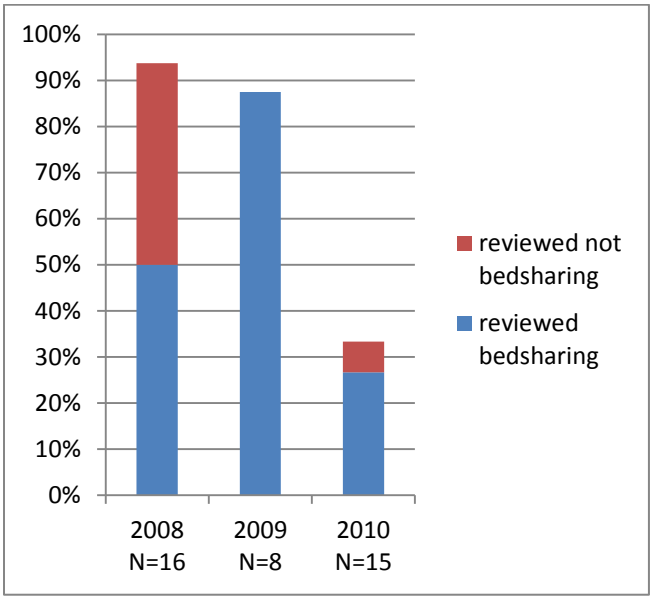
For infants less than one year of age, there were many cases of suffocation deaths while in sleeping situations at the time of unresponsiveness. The majority of these suffocation deaths were reviewed in 2008 and 2009 (96% and 84%). A smaller percentage of these suffocation deaths were reviewed in 2010 (38%). For all three years, 70% to 71% of reviewed suffocation cases had evidence of bed sharing (Figure 30).

Figure 30. Percentage of Cases Reviewed for Children under 1 in Sleeping Situations, and Determined to Have Died from Suffocation, with and without Evidence of Bed Sharing



Bed sharing was a component in the majority of reviewed deaths from unknown/unexplained causes for children under the age of 1 who were in sleeping situations at time of unresponsiveness. The majority of deaths in this group were reviewed in 2008 and 2009 (94% and 88%) and 33% of them were reviewed in 2010 (Figure 31).

Figure 31. Percentage of Cases Reviewed for Children under 1 in Sleeping Situations, and Determined to Have Died from Unexplained/Unknown Causes, with and without Evidence of Bed Sharing



In addition, many of the undetermined deaths included decedents under the age of 1 and in sleeping situations at the time of unresponsiveness. Many of these deaths (26-53% of reviewed cases) were also for infants who were bed sharing.

Drowning

Definition

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

Background

Drowning is the second major cause of unintentional injury death among children ages 1 to 17. In 2009, 912 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 58% of these deaths.[36]

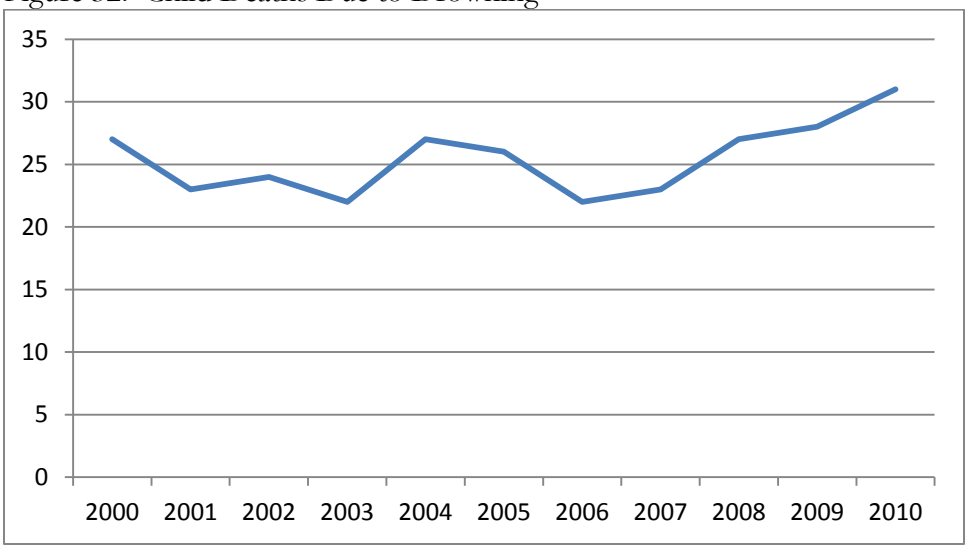
Swimming pools are the most common site for a drowning to occur among children between the ages 1 and 4 years. Eighty-four percent of drowning deaths among children ages 5 and under occur at a home, while 45% of fatalities among children ages 5 to 14 occur at a public pool. Male children have a drowning rate twice that of female children. Black children ages 5 to 14 have a drowning rate three times that of their white counterparts.[37]

According to a national study of drowning-related incidents involving children, a parent or caregiver claimed to be supervising the child in nearly nine out of ten child drowning-related deaths.[38]

Illinois Data – Total Child Deaths Reported to the SCR

Since 2000, there have been between 22 and 31 deaths from drowning per year (Figure 32).

Figure 32. Child Deaths Due to Drowning



[36] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

[37] Safe Kids Worldwide. (2011). *Drowning and water-related safety fact-sheet 2011.* Retrieved from http://www.safekids.org/our-work/research/fact-sheets/drowning-prevention-fact-sheet.html.

[38] Cody, B.E., Quraishi, A.Y., Dastur, M.C., & Mckalide, A.D. (2004.) Clear danger: A national study of childhood drowning and related attitudes and behaviors. Retrieved from http://www.safekids.org/assets/docs/ourwork/research/research-report-safe-kids-week-2004.pdf

The years with the most deaths due to drowning were 2009 and 2010. In 2009, 28 of the 1,490 total child deaths reported to the SCR (2%) were related to drowning. In 2010, 31 of the 1,622 total child deaths (2%) were related to drowning.

- Most of the drowning deaths were accidental (77-86%), and the rest were primarily undetermined.
- More boys (61-74%) died from drowning than girls.
- Children between the ages of 1 and 4 were at highest risk for drowning-related deaths followed by children between 15 and 17.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 10 of the 245 deaths reviewed by CDRTs (4%) were related to drowning; in 2010, 13 of the 208 reviewed deaths (6%) were related to drowning.

- In 2009, 60% of the reviewed drowning deaths were male and 69% of reviewed deaths in 2010 were male.
- Most of the reviewed deaths related to drowning occurred among young children: 69-70% of decedents were between 1 and 4 years of age.

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 405 deaths among children between 1 and 17 years in 2009.[39] Fifty-one percent of fire deaths occurred in children 4 and under.

Home fires account for nearly 90% of all fire-related fatalities. Home cooking equipment is the leading cause of residential fires and injuries from residential fires. Smoking materials (e.g., cigarettes) were less frequently causes of fires but were the leading cause of home fire-related deaths. Another source of fires is children playing with fire. The mean age of children who start fires is just over 6 years old. In 2008, 70 civilians were killed in fires started by children playing with fire, with 65% of the victims being children less than 5 years of age.[40]

The single most important factor in reducing child fire fatalities is the presence of a working smoke detector. Forty percent of home fire deaths occur in the 4% of U.S. homes without a smoke alarm. Access to fire professionals is also important. Death rates from fire in rural communities are more than twice the national average.

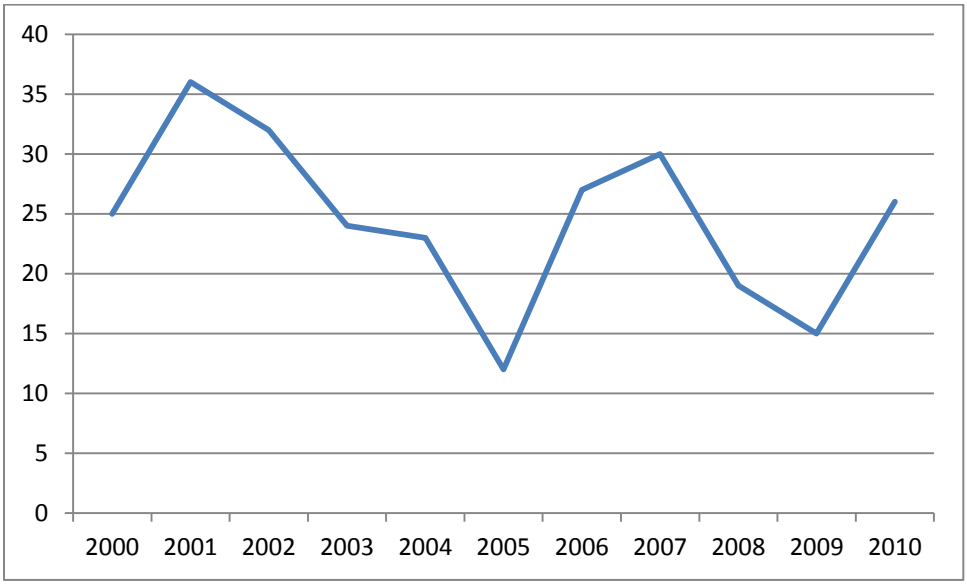
Illinois Data – Total Child Deaths Reported to the SCR

There have been between 12 and 36 child deaths from fire per year since 2000 (Figure 33).

[39] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

[40] Safe Kids Worldwide. (2011). *Fire safety in the USA fact-shee,t 2011.* Retrieved from http://www.safekids.org/our-work/research/fact-sheets/fire-prevention-fact-sheet.html

Figure 33. Child Deaths Due to Fires



In 2009, 15 of the 1,490 total child deaths reported to the SCR (1%) were related to fires and in 2010, 26 of the 1,622 total deaths (2%) were related to fires.

- The majority of deaths (67-81%) attributable to fire were accidental; 20% were homicides in 2009 and 4% were homicides in 2010, and (13-15%) were undetermined.

- There were slightly more girls (53%) that died from fire in 2009 and slightly more boys (62%) that died from fire in 2010.

- Young children were most at risk of fire-related deaths: 40-54% of the deaths in this category were among children aged 1 to 4, and the remaining fire-related deaths were fairly equally distributed among the other age categories.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 8 of the 245 deaths reviewed by CDRTs (3%) were related to fires; in 2010, 11 of the 208 reviewed deaths (5%) were related to fires.

- In 2009, the reviewed deaths were scattered among children 12 and under, and in 2010, 73% of reviewed deaths were children between 1 and 4 years.

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

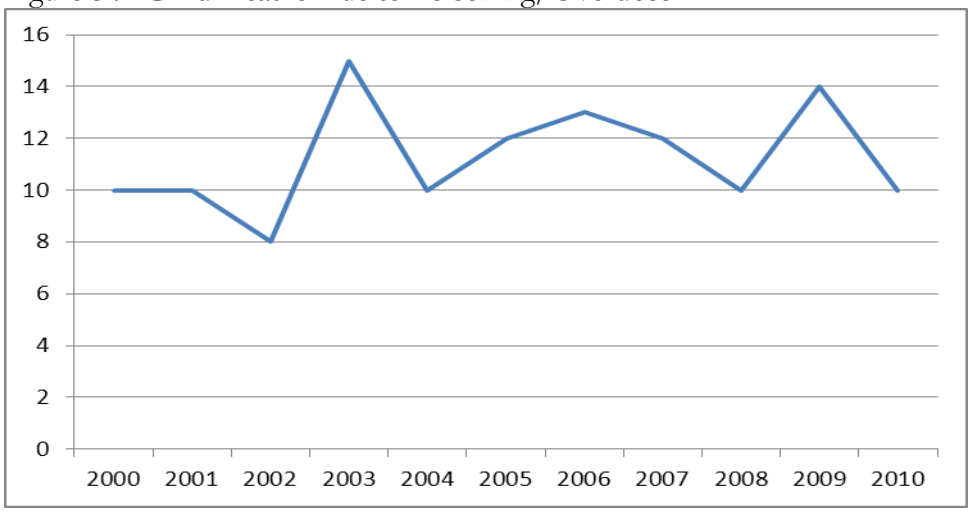
In 2009, 467 children under 18 years died of poisoning in the United States.[41] The majority of these deaths occurred in children 15 to 17 years of age (64%). The age group with the second most frequent number of deaths by poisoning was children under 4 (21%) with children between 4 and 15 accounting for 10% of poisoning deaths.

In 2010, more than 68,000 U.S. children were treated in emergency departments for unintentional poisoning-related incidents; almost 72% of those treated were under 5 years of age. The majority of poisoning cases among children under age 5 treated in U.S. hospital emergency departments were due to ingestion of oral medications. Among pediatric exposures, there has been a decrease in the exposures to cough and cold medicines but an increase in exposure to analgesics (pain killers) since 2006.[42] 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 SCR

Between 8 and 14 children died from poisoning per year since 2000 (Figure 34).

Figure 34. Child Deaths Due to Poisoning/Overdose



[41] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

[42] Safe Kids Worldwide. (2011). *Poison prevention fact-sheet, 2011.* Retrieved from http://www.safekids.org/our-work/research/fact-sheets/poison-prevention-fact-sheet.html

In 2009, 14 of the 1,490 total child deaths reported to the SCR (1%) were related to poisonings or overdoses; in 2010, 10 of the 1,622 total deaths (<1 %) were related to poisoning or overdose.

- In 2009, 10 of the 14 deaths (71%) were determined to be accidents, 1 death was a homicide and 1 was a suicide (7% each), and 2 deaths were undetermined (14%). In 2010, 3 of the 10 deaths were accidents, 3 were suicides, 1 was homicide, 1 was natural, and 2 were undetermined.

- Boys (60-71%) were more likely to die due to poisoning or overdose than girls.

- The majority of the deaths in this category (64-70%) were among youth between the ages of 15 and 17 years.

Illinois Data – Deaths Reviewed by CDRTs

In 2009, 5 of the 245 deaths reviewed by CDRTs (2%) were related to poisoning/overdose; in 2010, 2 of the 208 reviewed deaths (1%) were related to fires.

- About an equal percentage of reviewed deaths were boys and girls (40-50%).

- Three of the 5 deaths reviewed in 2009 were of children between the ages of 2 and 5, and in 2010, 1 was less than 1 year old and the other was 14 years of age.

Uncommon Death Categories: Other, Scalding Burn, SUCD

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

Other

As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2009, 4 deaths fell in this category, and in 2010, 11 deaths fell in this category. The majority of the deaths in this category were reviewed: 3 of the 4 deaths in 2009 were reviewed and 7 of the 11 deaths were reviewed in 2010.

Scalding Burn

There was 1 scalding burn death in 2009 and 2 scalding burn deaths in 2010. The scalding burn death was not reviewed in 2009 but both scalding burn deaths were reviewed in 2010.

SUCD (Sudden Unexplained Child Death)

There was 1 SUCD in 2009 and it was reviewed. There were no SUCDs in 2010.

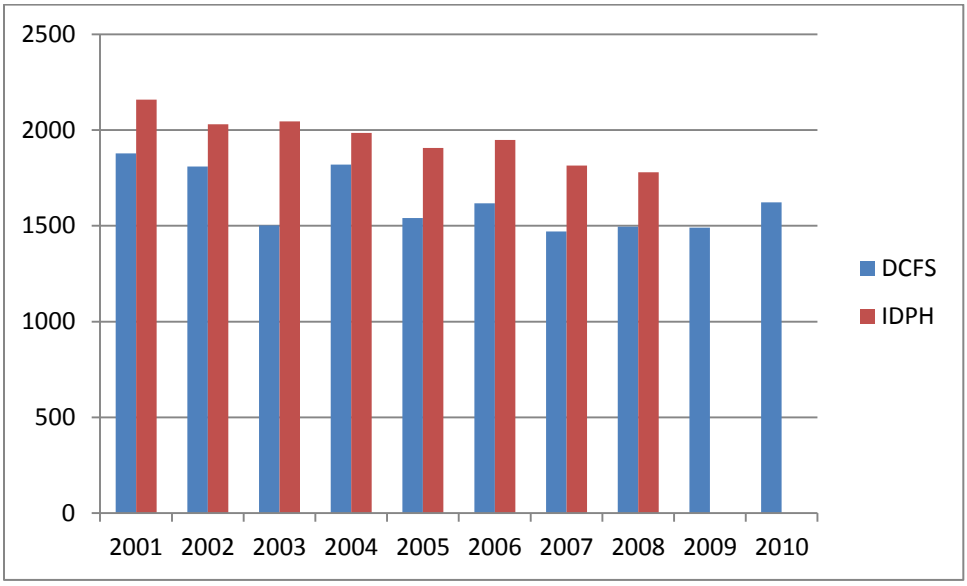
Chapter 4 Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths from 2000 to 2010, which allows for an analysis of the trends in Illinois child deaths over time. As with the yearly analyses, it is important to remember that information on child deaths contained in the CDRT database is based on completed death certificates sent by county registrars and coroners to the Department of Children and Family Services. The Illinois Vital Records Act was amended in 1998 to state that local registrars shall transmit monthly a copy of all death certificates of persons under 18 years of age who have died within the month to the State Central Register (SCR) of the Department of Children and Family Services (see Appendix C). Unfortunately, many local registrars do not send child death information to the DCFS State Central Register as required by the Vital Records Act (see Appendix D for a breakdown of reported deaths by county). The importance of this requirement cannot be overstated, as only those child death certificates sent to the SCR are entered into the CDRT database and analyzed for this report. If large numbers of child deaths are not included, it diminishes the ability of the CDRTs to analyze and understand child death in Illinois and make sound recommendations for preventing future deaths. There are some counties which have never reported child deaths to CDRT, even though Illinois Department of Public Health (IDPH) has records of child deaths occurring each year (see appendix D). Other counties have regularly underreported child deaths.

A comparison between the total numbers of deaths reported to DCFS versus the total deaths reported to IDPH is shown in Figure 35.[43] These comparisons reveal that anywhere from 73% (in 2003) to 91% (in 2004) of the child deaths reported to the IDPH are also reported to DCFS. Thus, the number of child deaths contained in the CDRT database for a given year should be considered a subset of the total deaths in that year. When looking at trends in child death over time, the general direction of the trends should be the focus rather than the exact number of deaths that occurred. The numbers presented in Figure 35 reveal that the total number of child deaths (reported by IDPH) in Illinois has been generally decreasing from 2001 to 2008.

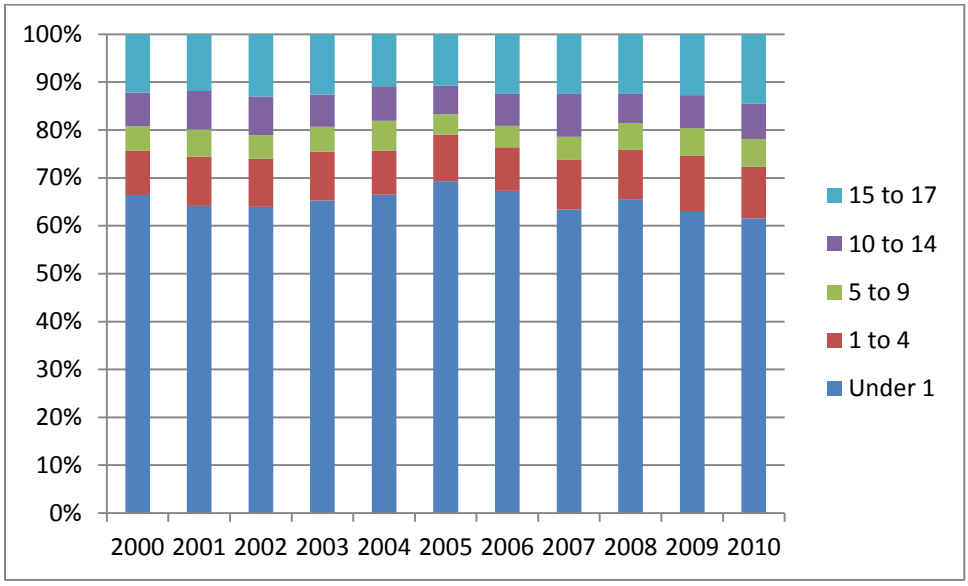
[43] The number of deaths reported to IDPH in 2009 and 2010 was unavailable at the time of this report.

Figure 35. Total Child Deaths Reported to DCFS and IDPH, 2001 – 2010



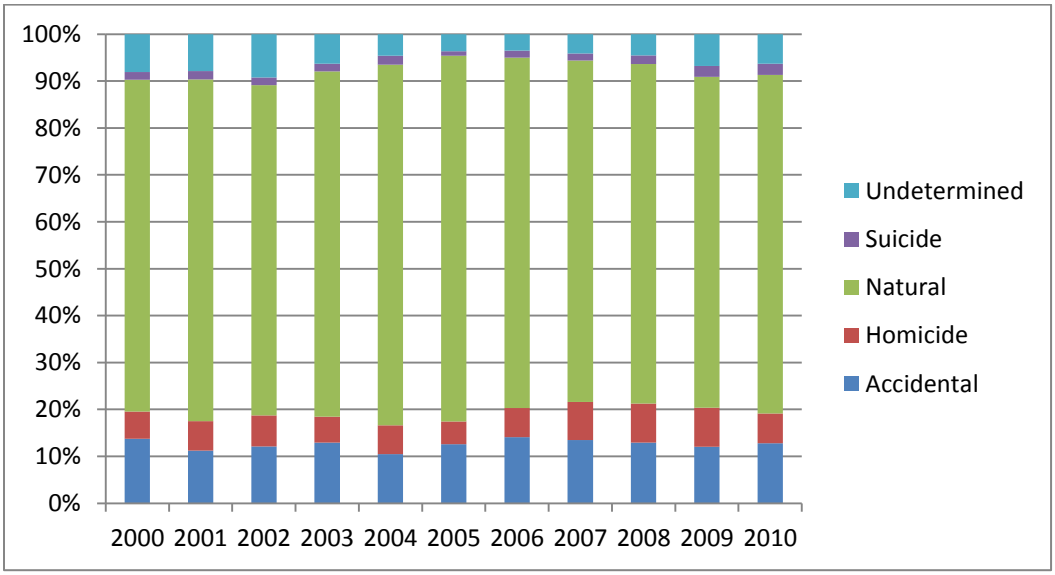
The total child deaths reported to DCFS from 2000 to 2010 is broken down by age group in Figure 36. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another, so that the sum for each year is 100%. This type of graph allows us to compare the percentages of each category across multiple years, so that we can determine, for example, if the percentage of infant deaths is increasing, decreasing, or staying the same. As Figure 36 shows that the *number* of deaths in each age group has fluctuated slightly from year to year, but the percentage of total deaths in each age group is generally stable over the 11 year period: infants under 1 year comprise 62-69% of all child deaths, children between 1 and 4 years comprise 9-12%, children between 5 and 9 years add another 4-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are the final 11-15%. Note that 2010 has the lowest percentage of infants (62%) and the highest percentage of 15-17 year olds (15%) during this time frame. This may be a reflection of the change in population of the state with the highest proportion of children being 15 to 17 and a smaller proportion of Illinois population being infants in 2010 (Figure 4 in chapter 2).

Figure 36. Total Child Deaths (reported to DCFS) in Illinois by Age Group, 2000 – 2010



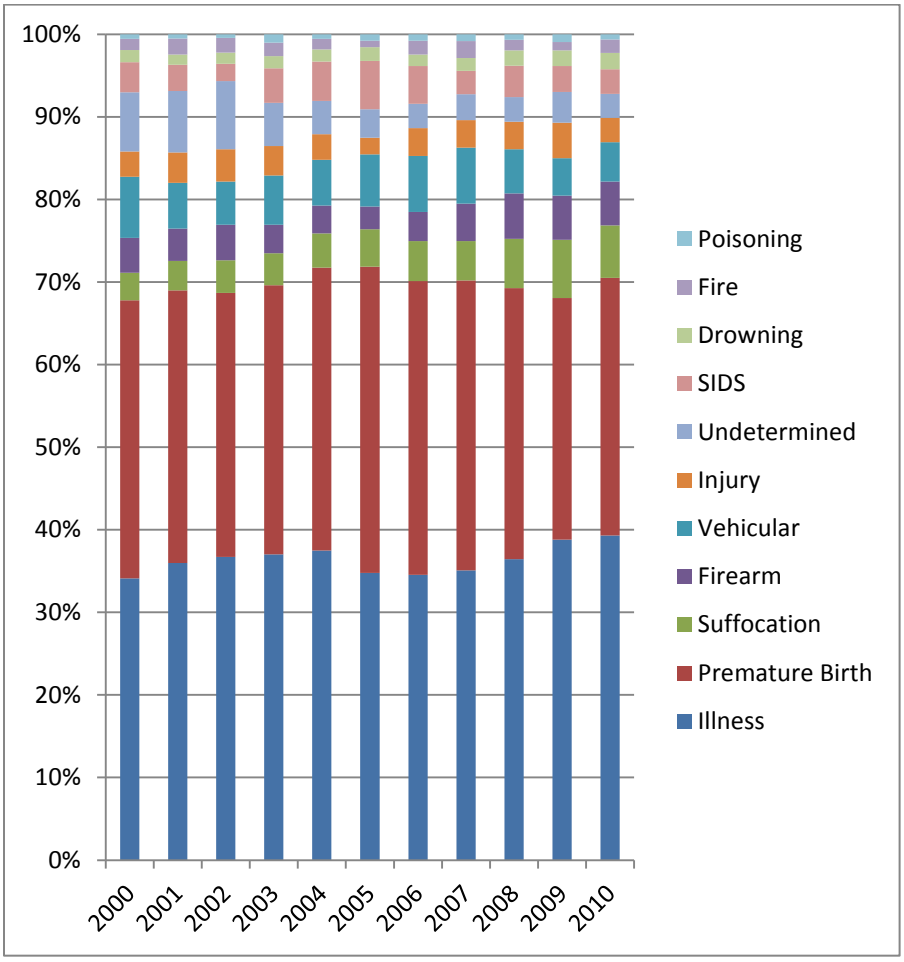
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 71-78% natural, 1-2% suicide, and 4-9% undetermined (see Figure 37).

Figure 37. Total Child Deaths (reported to DCFS) in Illinois by Manner of Death, 2000 – 2010



A similar analysis was done for category of death (see Figure 38). The percentage of child deaths related to each category of death remained fairly stable across the time period.

Figure 38. Total Child Deaths (reported to DCFS) in Illinois by Category, 2000 – 2010



Appendix A – Child Death Review Team Act

Illinois Compiled Statutes
Executive Branch
Child Death Review Team Act
20 ILCS 515/

(20 ILCS 515/)

(20 ILCS 515/1)

Sec. 1. Short title. This Act may be cited as the Child Death Review Team Act.

(Source: P.A. 88-614, eff. 9-7-94.)

(20 ILCS 515/5)

Sec. 5. State policy. The following statements are the policy of this State:

(1) Every child is entitled to live in safety and in health and to survive into adulthood.

(2) Responding to child deaths is a State and a community responsibility.

(3) When a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death, the provision of services to surviving family members, and the development and implementation of measures to prevent future deaths from similar causes. The response may include court action, including prosecution of persons who may be responsible for the death and juvenile proceedings to protect other children in the care of the person responsible for the care of the child who died.

(4) Professionals from disparate disciplines and agencies who have responsibilities for children and expertise that can promote child safety and well-being should share their expertise and knowledge so that the goals of determining the causes of children's deaths, planning and providing services to surviving children and non-offending family members, and preventing future child deaths can be achieved.

(5) A greater understanding of the incidence and causes of child deaths is necessary if the State is to prevent future child deaths.

(6) Multidisciplinary and multi-agency reviews of child deaths can assist the State and counties in (i) investigating child deaths, (ii) developing a greater understanding of the incidence and causes of child deaths and the methods for preventing those deaths, and (iii) identifying gaps in services to children and families.

(7) Access to information regarding deceased children and their families by multidisciplinary and multi-agency child death review teams is necessary for those teams to achieve their purposes and duties.

(Source: P.A. 88-614, eff. 9-7-94.)

(20 ILCS 515/10)

Sec. 10. Definitions. As used in this Act, unless the context requires otherwise: "Child" means any person under the age of 18 years unless legally emancipated by reason of marriage or entry into a branch of the United States armed services.

"Department" means the Department of Children and Family Services.

"Director" means the Director of Children and Family Services.

"Executive Council" means the Illinois Child Death Review Teams Executive Council.

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/15)

Sec. 15. Child death review teams; establishment.

(a) The Director, in consultation with the Executive Council, law enforcement, and other professionals who work in the field of investigating, treating, or preventing child abuse or neglect in that sub-region, shall appoint members to a child death review team in each of the Department's administrative sub-regions of the State outside Cook County and at least one child death review team in Cook County. The members of a team shall be appointed for 2-year terms and shall be eligible for reappointment upon the expiration of the terms. <u>The Director must fill any vacancy in a team within 60 days after the vacancy occurs.</u>

(b) Each child death review team shall consist of at least one member from each of the following categories:

(1) Pediatrician or other physician knowledgeable about child abuse and neglect.

(2) Representative of the Department.

(3) State's attorney or State's attorney's representative.

(4) Representative of a local law enforcement agency.

(5) Psychologist or psychiatrist.

(6) Representative of a local health department.

(7) Representative of a school district or other education or child care interests.

(8) Coroner or forensic pathologist.

(9) Representative of a child welfare agency or child advocacy organization.

(10) Representative of a local hospital, trauma center, or provider of emergency medical services.

(11) Representative of the Department of State Police.

Each child death review team may make recommendations to the Director concerning additional appointments.

Each child death review team member must have demonstrated experience and an interest in investigating, treating, or preventing child abuse or neglect.

(c) Each child death review team shall select a chairperson from among its members. The chairperson shall also serve on the Illinois Child Death Review Teams Executive Council.

(d) The child death review teams shall be funded under a separate line item in the Department's annual budget.

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/20)

Sec. 20. Reviews of child deaths.

(a) Every child death shall be reviewed by the team in the sub-region which has primary case management responsibility. The deceased child must be one of the following:

(1) A ward of the Department.

(2) The subject of an open service case maintained by the Department.

(3) The subject of a pending child abuse or neglect investigation.

(4) A child who was the subject of an abuse or neglect investigation at any time during the 12 months preceding the child's death.

(5) Any other child whose death is reported to the State central register as a result of alleged child abuse or neglect which report is subsequently indicated.

A child death review team may, at its discretion, review other sudden, unexpected, or unexplained child deaths, and cases of serious or fatal injuries to a child identified under the Child Advocacy Center Act.

(b) A child death review team's purpose in conducting reviews of child deaths is to do the following:

(1) Assist in determining the cause and manner of the child's death, when requested.

(2) Evaluate means by which the death might have been prevented.

(3) Report its findings to appropriate agencies and make recommendations that may help to reduce the number of child deaths caused by abuse or neglect.

(4) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect.

(5) Make specific recommendations to the Director and the Inspector General of the Department concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

(c) A child death review team shall review a child death as soon as practical and not later than 90 days following the completion by the Department of the investigation of the death under the Abused and Neglected Child Reporting Act. When there has been no investigation by the Department, the child death review team shall review a child's death within 90 days after obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner, or law enforcement agency, depending on the nature of the case. A child death review team shall meet at least once in each calendar quarter.

(d) The Director shall, within 90 days, review and reply to recommendations made by a team under item (5) of subsection (b). With respect to each recommendation made by a team, the Director shall submit his or her reply both to the chairperson of that team and to the chairperson of the Executive Council. The Director's reply to each recommendation must include a statement as to whether the Director intended to implement the recommendation.

The Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or non-implementation of the recommendations.

(e) Within 90 days after the Director submits a reply with respect to a recommendation as required by subsection (d), the Director must submit an additional report that sets forth in detail the way, if any, in which the Director will implement the recommendation and the schedule for implementing the recommendation. The Director shall submit this report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council.

(f) Within 180 days after the Director submits a report under subsection (e) concerning the implementation of a recommendation, the Director shall submit a further report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to the recommendation.

(Source: P.A. 90-239, eff. 7-28-97; 90-608, eff. 6-30-98.)

(20 ILCS 515/25)

Sec. 25. Team access to information.

(a) The Department shall provide to a child death review team, on the request of the team chairperson, all records and information in the Department's possession that are relevant to the team's review of a child death, including records and information concerning previous reports or investigations of suspected child abuse or neglect.

(b) A child death review team shall have access to all records and information that are relevant to its review of a child death and in the possession of a State or local governmental agency, including, but not limited to, information gained through the Child Advocacy Center protocol for cases of serious or fatal injury to a child. These records and information include, without limitation, birth certificates, all relevant medical and mental health records, records of law enforcement agency investigations, records of coroner or medical examiner investigations, records of the Department of Corrections concerning a person's parole, records of a probation and court services department, and records of a social services agency that provided services to the child or the child's family.

(Source: P.A. 91-812, eff. 6-13-00.)

(20 ILCS 515/30)

Sec. 30. Public access to information.

(a) Meetings of the child death review teams and the Executive Council shall be closed to the public. Meetings of the child death review teams and the Executive Council are not subject to the Open Meetings Act (5 ILCS 120), as provided in that Act.

(b) Records and information provided to a child death review team and the Executive Council, and records maintained by a team or the Executive Council, are confidential and not subject to the Freedom of Information Act (5 ILCS 140), as provided in that Act. Nothing contained in this subsection (b) prevents the sharing or disclosure of records, other than those produced by a Child Death Review Team or the Executive Council, relating or pertaining to the death of a minor under the care of or receiving services from the Department of Children and Family Services and under the jurisdiction of the juvenile court with the juvenile court, the State's Attorney, and the minor's attorney.

(c) Members of a child death review team and the Executive Council are not subject to examination, in any civil or criminal proceeding, concerning information presented to members of the team or the Executive Council or opinions formed by members of the team or the Executive Council based on that information. A person may, however, be examined concerning information provided to a child death review team or the Executive Council that is otherwise available to the public.

(d) Records and information produced by a child death review team and the Executive Council are not subject to discovery or subpoena and are not admissible as evidence in any civil or criminal proceeding. Those records and information are, however, subject to discovery or a subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

(Source: P.A. 92-468, eff. 8-22-01)

(20 ILCS 515/35)

Sec. 35. Indemnification. The State shall indemnify and hold harmless members of a child death review team and the Executive Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the team or Executive Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act (5 ILCS 350/1 et seq.).

(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/40)

Sec. 40. Illinois Child Death Review Teams Executive Council.

(a) The Illinois Child Death Review Teams Executive Council, consisting of the chairpersons of the 9 child death review teams in Illinois, is the coordinating and oversight body for child death review teams and activities in Illinois. The vice-chairperson of a child death review team, as designated by the chairperson, may serve as a back-up member or an alternate member of the Executive Council, if the chairperson of the child death review team is unavailable to serve on the Executive Council. The Inspector General of the Department, ex officio, is a non-voting member of the Executive Council. The Director may appoint to the Executive Council any ex-officio members deemed necessary. Persons with expertise needed by the Executive Council may be invited to meetings. The Executive Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year, renewable term. The Executive Council must meet at least 4 times during each calendar year. At each such meeting, in addition to any other matters under consideration, the Executive Council shall review all replies and reports received from the Director pursuant to subsections (d), (e), and (f) of Section 20 since the Executive Council's previous meeting. The Executive Council's review must include consideration of the Director's proposed manner of and schedule for implementing each recommendation made by a child death review team.

(b) The Department must provide or arrange for the staff support necessary for the Executive Council to carry out its duties. The Director, in cooperation and consultation with the Executive Council, shall appoint, reappoint, and remove team members. From funds available, the Director may select from a list of 2 or more candidates recommended by the Executive Council to serve as the Child Death Review Team Executive Director. The Child Death Review Teams Executive Director shall oversee the operations of the child death review teams and shall report directly to the Executive Council.

(c) The Executive Council has, but is not limited to, the following duties:

(1) To serve as the voice of child death review teams in Illinois.

(2) To oversee the regional teams in order to ensure that the teams' work is coordinated and in compliance with the statutes and the operating protocol.

(3) To ensure that the data, results, findings, and recommendations of the teams are adequately used to make any necessary changes in the policies, procedures, and statutes in order to protect children in a timely manner.

(4) To collaborate with the General Assembly, the Department, and others in order to develop any legislation needed to prevent child fatalities and to protect children.

(5) To assist in the development of quarterly and annual reports based on the work and the findings of the teams.

(6) To ensure that the regional teams' review processes are standardized in order to convey data, findings, and recommendations in a usable format.

(7) To serve as a link with child death review teams throughout the country and to participate in national child death review team activities.

(8) To develop an annual statewide symposium to update the knowledge and skills of child death review team members and to promote the exchange of information between teams.

(9) To provide the child death review teams with the most current information and practices concerning child death review and related topics.

(10) To perform any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

(c-5) The Executive Council shall prepare an annual report. The report must include, but need not be limited to, (i) each recommendation made by a child death review team pursuant to item (5) of subsection (b) of Section 20 during the period covered by the report, (ii) the Director's proposed schedule for implementing each such recommendation, and (iii) a description of the specific changes in the Department's policies and procedures that have been made in response to the recommendation. The Executive Council shall send a copy of its annual report to each of the following:

(1) The Governor

(2) Each member of the Senate or the House of Representative whose legislative district lies wholly or partly within the region

covered by any child death review team whose recommendation is addressed in the annual report.

(3) Each member of each child death review team in the State.

(d) In any instance when a child death review team does not operate in accordance with established protocol, the Director, in consultation and cooperation with the Executive Council, must take any necessary actions to bring the team into compliance with the protocol.

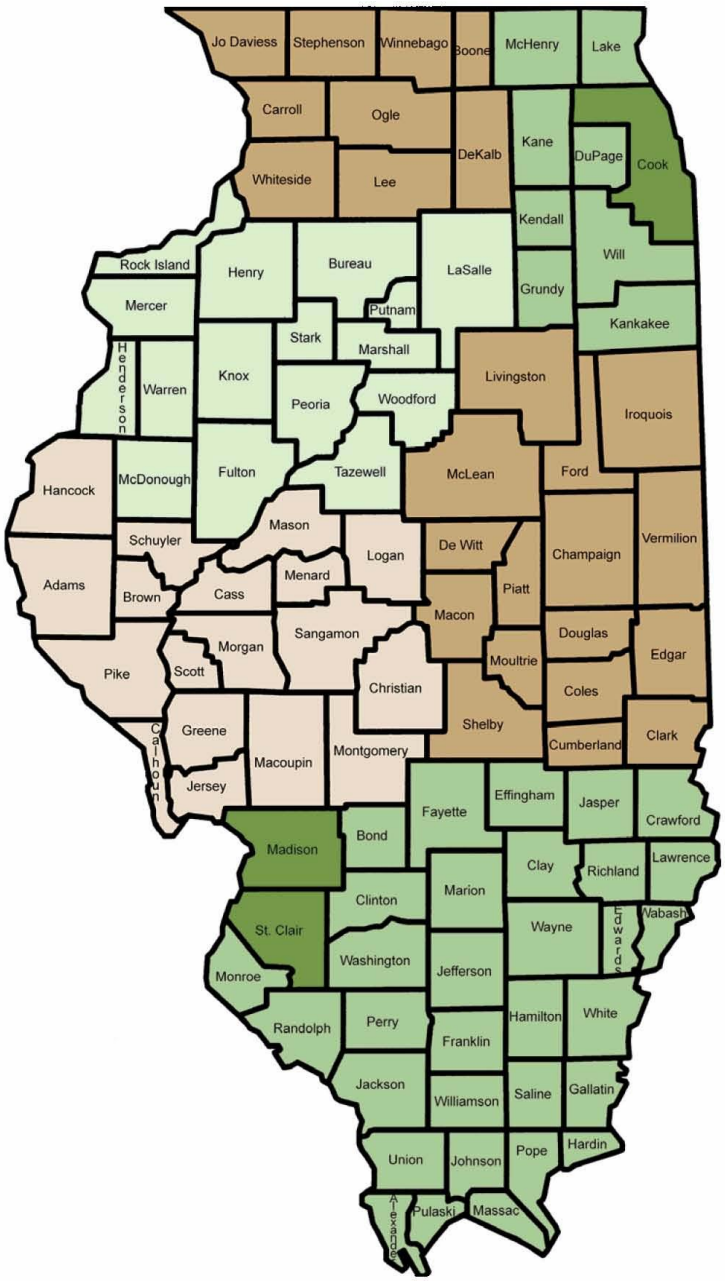
(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/45 new)

Sec. 45. Child Death Investigation Task Force; pilot program. The Child Death Review Teams Executive Council may, from funds appropriated by the Illinois General Assembly to the Department and provided to the Child Death Review Teams Executive Council for this purpose, or from funds that may otherwise be provided for this purpose from other public or private sources, establish a 3-year pilot program in the Southern Region of the State, as designated by the Department, under which a special Child Death Investigation Task Force will be created by the Child Death Review Teams Executive Council to develop and implement a plan for the investigation of sudden, unexpected, or unexplained deaths of children under 18 years of age occurring within that region. The plan shall include a protocol to be followed by child death review teams in the review of child deaths authorized under paragraph (a)(5) of Section 20 of this Act. The plan must include provisions for local or State law enforcement agencies, hospitals, or coroners to promptly notify the Task Force of a death or serious life-threatening injury to a child, and for the Child Death Investigation Task Force to review the death and submit a report containing findings and recommendations to the Child Death Review Teams Executive Council, the Director, the Department of Children and Family Services Inspector General, the appropriate State's Attorney, and the State Representative and State Senator in whose legislative districts the case arose. The plan may include coordination with any investigation conducted under the Children's Advocacy Center Act. By January 1, 2010, the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the pilot program together with any recommendations for statewide implementation of a protocol for the investigating all sudden, unexpected, or unexplained child deaths.

(Source: P.A. 95-527, eff. 6-1-08.)

Appendix B – Child Death Review Team Regional Map



Appendix C – Vital Records Act

Illinois Compiled Statutes
410 ILCS 535/

(410 ILCS 535/8) (from Ch. 111 1/2, par. 73-8)

Sec. 8. Each local registrar shall:

(1) Appoint one or more deputies to act for him in his absence or to assist him. Such deputies shall be subject to all rules and regulations governing local registrars.

(2) Appoint one or more subregistrars when necessary for the convenience of the people. To become effective, such appointments must be approved by the State Registrar of Vital Records. A subregistrar shall exercise such authority as is given him by the local registrar and is subject to the supervision and control of the State Registrar of Vital Records, and shall be liable to the same penalties as local registrars, as provided in Section 27 of this Act.

(3) Administer and enforce the provisions of this Act and the instructions, rules, and regulations issued hereunder.

(4) Require that certificates be completed and filed in accordance with the provisions of this Act and the rules and regulations issued hereunder.

(5) Prepare and transmit monthly an accurate copy of each record of live birth, death, and fetal death to the county clerk of his county. He shall also, in the case of a death of a person who was a resident of another county, prepare an additional copy of the death record and transmit it to the county clerk of the county in which such person was a resident. In no case shall the county clerk's copy of a live birth record include the section of the certificate which contains information for health and statistical program use only.

(6) (Blank).

(7) Prepare, file, and retain for a period of at least 10 years in his own office an accurate copy of each record of live birth, death, and fetal death accepted for registration. Only in those instances in which the local registrar is also a full time city, village, incorporated town, public health district, county, or multi-county health officer recognized by the Department may the health and statistical data section of the live birth record be made a part of this copy.

(8) Transmit monthly the certificates, reports, or other returns filed with him to the State Registrar of Vital Records, or more frequently when directed to do so by the State Registrar of Vital Records.

(8.5) Transmit monthly to the State central register of the Illinois Department of Children and Family Services a copy of all death certificates of persons under 18 years of age who have died within the month.

(9) Maintain such records, make such reports, and perform such other duties as may be required by the State Registrar of Vital Records.

(Source: P.A. 89-641, eff. 8-9-96; 90-608, eff. 6-30-98.)

Appendix D – Illinois Child Deaths by County

	2002 Deaths		2003 Deaths		2004 Deaths		2005 Deaths		2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths	
County	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**	**DCFS**	**IDPH**
Adams	2	4	0	4	0	5	0	6	1	8	8	11	1	10	6		6	
Alexander	1	2	0	1	0	0	0	0	0	1	0	1	0	1	1		0	
Bond	0	0	0	1	2	2	1	1	0	0	0	0	1	1	0		0	
Boone	0	1	0	1	0	1	0	3	0	0	0	0	0	3	3		1	
Brown	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0		0	
Bureau	1	1	4	5	9	8	4	4	2	4	2	2	1	2	5		6	
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
Carroll	1	1	0	0	0	0	0	0	1	1	0	0	0	1	1		2	
Cass	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0		0	
Champaign	46	50	38	39	44	45	52	53	32	47	3	39	21	36	42		36	
Christian	2	2	5	5	2	2	9	10	2	2	0	0	3	4	4		4	
Clark	1	1	0	1	0	0	1	1	1	1	0	0	1	1	0		0	
Clay	0	0	1	1	1	1	0	0	0	0	0	0	0	1	0		1	
Clinton	0	0	3	4	2	5	0	2	0	3	0	3	3	4	1		3	
Coles	1	2	1	2	1	1	0	6	0	8	0	3	0	4	3		5	
Cook	1117	1211	907	1261	1150	1162	878	1,116	1,014	1,141	926	1,066	908	1,010	768		887	
Crawford	1	1	0	1	0	2	0	0	0	1	0	1	1	1	0		2	
Cumberland	1	1	0	0	0	0	0	2	1	1	0	0	3	2	2		2	
DeKalb	8	12	3	4	5	10	2	4	1	14	4	5	3	3	5		4	
Dewitt	0	0	0	3	0	0	0	1	0	2	0	1	0	0	2		0	
Douglas	0	0	0	1	2	2	0	0	0	0	0	0	0	0	0		1	
Dupage	104	109	80	81	111	111	112	116	93	95	97	99	76	81	65		89	
Edgar	1	1	3	3	1	1	1	1	2	3	0	1	1	2	0		0	
Edwards	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0		0	
Effingham	0	2	0	6	5	5	1	6	3	4	0	7	5	6	1		0	
Fayette	0	2	0	1	1	3	1	1	0	1	0	1	0	0	0		1	
Ford	0	1	0	4	0	1	2	2	1	1	1	1	3	3	1		1	
Franklin	0	4	5	5	3	2	3	0	1	0	3	3	3	3	4		5	
Fulton	5	6	6	6	4	4	0	0	2	2	5	5	0	0	3		4	
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
Greene	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0		0	
Grundy	7	7	6	6	2	5	1	3	2	3	0	5	3	4	3		5	
Hamilton	1	1	1	1	1	1	0	0	3	3	1	1	3	3	0		1	
Hancock	0	1	0	1	1	2	0	0	0	1	0	0	0	2	2		0	
Hardin	0	0	0	1	0	1	1	1	0	0	0	1	0	0	0		2	
Henderson	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0		0	
Henry	3	3	1	1	3	3	3	3	1	1	4	4	2	2	2		4	
Iroquois	0	0	0	4	1	2	1	1	0	0	0	2	0	1	0		3	
Jackson	0	14	0	5	0	3	0	8	0	4	3	4	8	8	9		4	
Jasper	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0		2	
Jefferson	0	8	0	3	0	0	0	1	1	2	0	3	1	4	1		9	
Jersey	0	0	0	1	0	2	0	1	0	1	1	3	0	2	0		1	

Jo Daviess	2	2	1	1	0	0	2	2	3	3	0	1	0	0	0		0	
Johnson	1	1	0	0	0	2	0	0	0	1	1	0	0	0	0		0	
Kane	44	53	21	46	32	38	50	56	44	61	37	46	59	57	55		44	
Kankakee	21	19	11	11	16	16	15	15	14	14	9	9	8	13	5		8	
Kendall	1	2	1	4	0	2	3	3	1	1	6	6	6	6	2		1	
Knox	0	2	4	5	3	2	4	4	5	5	3	3	4	4	2		7	
Lake	35	43	24	39	33	57	17	34	35	58	17	37	26	38	34		31	
LaSalle	0	12	0	7	0	14	0	8	0	9	0	8	0	9	7		8	
Lawrence	3	3	2	2	1	1	1	1	1	1	0	0	1	3	1		6	
Lee	4	2	3	3	1	1	2	1	0	1	0	2	0	1	3		1	
Livingston	0	6	0	9	0	7	0	3	0	4	0	5	2	5	2		3	
Logan	3	3	6	6	2	1	0	0	0	0	0	0	7	8	6		0	
Macon	13	13	21	21	12	12	14	14	18	18	15	16	18	21	15		11	
Macoupin	0	5	0	2	3	3	0	1	0	1	0	1	0	0	2		2	
Madison	19	26	10	21	5	29	6	22	8	20	14	19	21	25	16		15	
Marion	0	1	1	4	0	2	2	7	2	2	4	4	4	3	3		3	
Marshall	0	0	0	0	0	1	0	0	0	1	0	0	0	0	3		2	
Mason	0	1	2	2	1	1	0	1	0	3	0	0	0	0	0		2	
Massac	1	1	2	2	2	3	1	2	1	1	1	1	1	1	4		0	
McDonough	4	5	3	3	1	2	0	4	0	2	0	0	0	1	1		2	
McHenry	6	6	14	14	17	17	15	15	9	10	23	24	14	19	11		7	
McLean	10	12	6	9	10	11	14	18	12	16	11	10	14	14	5		9	
Menard	0	0	0	2	0	1	0	3	0	0	0	0	0	1	1		1	
Mercer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		1	
Monroe	1	1	1	1	1	1	1	1	1	1	1	1	0	0	2		0	
Montgomery	1	3	2	5	1	1	1	3	2	2	3	3	0	1	1		3	
Morgan	2	2	1	2	1	2	2	2	0	1	1	1	0	2	1		2	
Moultrie	0	0	1	1	0	0	2	2	1	1	0	0	3	3	0		1	
Ogle	2	2	2	3	2	3	3	4	2	2	3	3	4	4	3		2	
Peoria	94	95	103	104	106	107	86	87	92	97	51	77	49	86	76		81	
Perry	3	4	0	2	0	0	0	0	2	3	1	4	2	3	0		4	
Piatt	0	2	0	0	0	1	0	0	0	0	0	1	0	2	0		0	
Pike	0	0	0	3	0	2	0	0	0	2	0	0	0	0	0		2	
Pope	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0		0	
Pulaski	0	1	0	0	0	1	0	0	0	0	0	0	0	0	2		0	
Putnam	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2		0	
Randolph	2	2	1	4	1	1	1	2	0	0	1	4	0	0	1		1	
Richland	1	1	0	0	3	3	4	4	1	3	0	0	1	3	1		1	
Rock Island	12	14	13	15	8	8	17	17	4	4	19	19	12	12	18		12	
Saline	0	0	0	1	1	2	1	1	3	3	2	2	2	2	4		4	
Sangamon	44	46	55	58	68	71	57	58	45	52	48	54	32	46	51		46	
Schuyler	0	2	0	1	0	0	0	0	0	3	0	0	0	0	0		4	
Scott	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0		0	
Shelby	0	0	4	4	0	0	0	0	3	3	1	1	3	3	2		1	
Stark	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
St. Clair	29	27	28	29	29	26	22	29	23	35	14	29	7	26	26		18	
Stephenson	3	4	5	7	8	9	5	5	1	2	3	4	4	5	4		5	
Tazewell	4	4	7	7	3	4	9	10	6	9	3	5	4	7	2		2	
Union	0	2	0	5	0	1	0	1	0	0	2	2	0	0	2		3	

Vermillion	5	7	0	2	4	4	8	9	3	4	9	12	1	6	13		7	
Wabash	0	0	0	3	0	1	0	2	0	0	0	1	0	2	3		0	
Warren	0	1	0	2	0	1	0	1	0	1	0	0	0	1	0		1	
Washington	4	4	1	2	0	1	0	1	0	1	0	1	0	0	0		2	
Wayne	1	1	1	1	0	0	0	0	1	1	1	2	0	1	1		1	
White	1	1	0	1	0	0	0	0	0	0	0	0	0	0	1		1	
Whiteside	0	2	0	1	2	5	1	5	1	4	0	6	0	3	7		3	
Will	42	42	26	28	49	50	35	36	40	41	42	43	42	38	44		38	
Williamson	1	8	4	6	6	6	8	1	6	2	4	9	8	9	6		5	
Winnebago	80	78	48	70	31	57	54	57	61	75	58	65	71	78	59		61	
Woodford	1	1	1	1	0	0	1	1	1	2	0	0	1	1	1		2	
Unknown	6	0	2	0	5	0	3	0	0	0	0	0	0	0	18		1	
Out of State	–	–	–	–	–	–	–	–	1	0	4	0	13	0	27		53	
Total	1,809	2,029	1,502	2,045	1,820	1,985	1,540	1,906	1,617	1,948	1,470	1,815	1,495	1780	1490		1622	

Appendix E – Child Death Review Team Recommendations and DCFS Responses

Key:
PP = Primary Prevention recommendation
DCFS = DCFS recommendation
OS = Other System recommendation

2009 Recommendations and Responses		
Number	**CDRT Recommendation**	**DCFS Response**
DCFS-1	Team recommends that DCFS modify SACWIS to add a field with the following questions: 1. Was screening attempted with the State's Attorney's Office? 2. Was screening rejected or approved? This should be done in a way that QA could easily track data by county.	DCFS agrees to track this for one year and give CDRT Exec Council quarterly reports. DCFS also agreed to look into adding this to SACWIS.
DCFS-2	Team recommends that DCFS explore expanding the parenting assessment team in the Northern Region modeled after Cook County.	DCFS will explore expanding the parenting assessment team in the Northern Region.
DCFS-3	Team recommends that DCFS modify SACWIS to add a field with the following questions: 1) Was screening attempted with the SA office? and 2) Was screening rejected or approved? This should be done in a way that QA could easily track data by County.	DCFS agrees to track this for one year and give Quarterly reports to Exec Council. DCFS also agreed to look into the possibility of adding this to SACWIS.
DCFS-4	Team recommends that DCFS do a memorandum of understanding to all staff that addresses the concern of co sleeping and the importance of appropriate sleeping arrangements. This would include a crib, pack and play or bassinet with nothing in it and child on its back. IF the family cannot afford the above items, the Department will either provide one currently in supply or purchase one with exception to payment and	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting and have it out to the Exec Council in time for Council to bring to the next meeting.

	purchase and invoice voucher. This information should be provided to all DCFS investigative, intact and placement staff.	
DCFS-5	Team recommends that DCFS will ensure that managers meet with their respective teams to discuss the purpose of death review, the importance of preparation and the importance of knowing the specific dynamics of the case/investigation.	DCFS agrees to create an in-house protocol regarding CDRT.
DCFS-6	Team recommends that DCFS require hotline call takers to make a statement to every caller that if more information is obtained, that the caller calls the hotline back with additional information relevant to concerns about the abuse and neglect. If this is a death case, this should receive special emphasis.	DCFS agrees to draft a directive and statement that call-takers can state to reporters asking that they call again with any additional information
DCFS-7	When DCFS investigator or an intact worker is in a home where there is an infant and there is no crib or pack and play to provide a safe sleeping environment for the infant, it is not sufficient for the DCFS investigator or Intact worker to note it on the home safety checklist, provide the family with a brochure and tell them not to bed share. Immediate action needs to be taken to address safety risk and a solution to the safety risk noted on the home safety checklist must be in place immediately and prior to the DCFS investigator or intact worker leaving the home for the evening.	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting and have out to Exec Council in time for Council to bring comments to the next Director meeting
DCFS-8	When DCFS investigator or an intact worker is in a home where there is an infant and there is no crib or pack and play to provide a safe sleeping environment for the infant, it is not sufficient for the DCFS investigator or intact worker to note it on the home safety checklist, provide the family with a brochure and tell them not to bed share. Immediate action	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting and have out to Exec Council in time for Council to bring comments to the next Director meeting

	needs to be taken to address safety risk and a solution to the safety risk noted on the home safety checklist must be in place immediately and prior to the DCFS investigator or intact worker leaving the home for the evening. Similarly, if there is a child in the home that is developmentally equivalent to an infant, the investigator or intact worker must take immediate action to provide the household with a bed or crib, whichever is necessary and appropriate for the child's safety. Additionally the investigator or intact worker must explain to the family that the child should never share a bed with an adult or other child. DCFS investigator or intact worker must provide a bed or crib for safe sleeping of the developmentally delayed child before the DCP investigator or intact worker leaves the home for the evening.	
DCFS-9	When a child is taken into DCFS custody, the Department personnel shall secure from the Illinois Department of Public Health, all newborn screens performed by that agency, including but not limited to genetic and hearing screens. The results of those screens shall remain a permanent part of the child's medical history/record. New recommendation: When a child is taken into DCFS custody, the Department, through its agents (e.g. Health Works, etc) shall immediately secure from the Illinois Department of Public Health, all newborn screens performed by that agency, including but not limited to genetic and hearing screens. The results of those screens shall remain a permanent part of the child's	Director agreed to find out where DCFS is with E-Health passport.

	medical history/record.	
DCFS-10	Procedure Section 301.120 should be amended as follows to include language about mental health.	DCFS agrees. The suggested language falls under: Sharing appropriate information with the Caregiver.
DCFS-11	In cases of severe head trauma, DCFS should seek the opinion of doctors with expertise in child abuse.	DCP reviewed this case in SACWIS. This 3 month old resides in the suburbs of Chicago. The child was taken for a second opinion requested by parents. The 2nd opinion was given by a doctor who is now part of our MPEEC program. For Cook, DCFS has MPEEC program that is mandated for allegation 2, head injuries, for cases of children up to 36 months of age who reside in city of Chicago. For severe cases of children over 36 months or outside the city, cases may be referred for an evaluation on a case by case basis. Also, investigators can request second opinions. There is no injury or age criteria and children can reside outside the city of Chicago. MPEEC coordinates a multidisciplinary investigation of severe physical abuse for children up to 36 months in Chicago and provides medical expert consultation and written opinion. Education of DCFS personnel, other medical professionals, and police investigators on medical diagnoses of child abuse for Downstate similar programs include: MERIT (Rockford), Pediatric Resource Center (Peoria), CMRN Children's Medical Resource Network (Carbondale), Springfield CART, Child Abuse Response Team.
DCFS-12	DCFS should remind DCP about safe sleep arrangements and ensure that there are cribs where the family is staying	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting and have out to Exec Council in time for Council to bring comments to the next Director meeting.
DCFS-13	When DCFS is aware that a caregiver is a drug user and they are moving from home to home, DCFS should make sure wherever the caregiver is temporarily located, that they ensure	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting and have out to Exec Council in time for Council to bring

	that safe sleeping arrangements are in place. (Safe sleeping: the baby sleeping by itself, on back, no soft bedding)	comments to the next Director meeting.
DCFS-14	In addition to the OIG recommendation, it is further recommended that prior to placement, the placement worker will contact the licensing worker to determine what pets are in the home or on the property. If there are dogs in the home, the licensing worker will accompany the placement worker to the home to assess risk factors based on the age and developmental level of the child, the child's behaviors, any history of fear of animals by the child, the dog's general behavior around children, size, breed and number of dogs.	DCFS agrees. Rule Section 300.30 Procedure 300.50 CERAP Factor : -CFS 2025 Home Safety Checklist for Intact and permanency worker; -CFS 2026 Home Safety Checklist for parents and Caretakers; -CFS 2027 Home Safety Checklist for Investigator Specialist; have been modified and the drafts are in process.
DCFS-15	CDRT would like this case to be used as a training tool statewide.	Pattern of chronicity of injuries
DCFS-16	The team recommends that DCFS be made aware of this case. The team stresses the importance of DCFS following through with the training of investigators regarding Coroner/ME rulings of manner of death and that DCFS should not use that in neglect cases.	DCFS agrees. They are in the process of working with the Coroners to do training.
DCFS-17	There have been supervisory vacancies in Granite City for 2 years and there have been numerous people detailed and temporarily assigned to supervisory positions. The lack of continuity may very well have contributed to the death of this child. The team recommends that these supervisory positions be filled and there should be exceptions to the hiring freezes.	DCFS reported that all positions have been filled at this time.
DCFS-18	SACWIS currently requires a contact with the case worker on a current open case, but does not currently require contact with an investigator assigned to the pending case. The team recommends that DCFS	DCFS will explore the feasibility of SACWIS being required to have contact with an assigned investigator to a pending case.

	change policy/procedure to include that SACWIS requires contact with an investigator assigned to a pending case.	
DCFS-19	DCFS should ensure that the DCFS policy that is already in place regarding morning reports is followed. Morning Reports must be completed the next morning after it comes to the attention of the worker. The policy is currently not being consistently followed; therefore, DCFS needs to implement a plan of correction to ensure policy is followed.	DCFS agrees. DCFS will ensure that the policy for morning reports is followed and that morning reports will be completed the next morning after it comes to the attention of the worker.
DCFS-20	DCFS should change policy to require that all morning reports are screened by SCR for content of abuse/neglect. If an investigation of abuse/neglect is warranted, SCR should turn information into an abuse/neglect report.	Morning reports already come to the DCFS managers. Every DCFS manager receives the morning reports. SCR does not get investigative training.
DCFS-21	OIG Error Reduction training should be mandated for intact workers. The training should include: a) The appropriate collection and review of medical, psychiatric records and information; b) Reminder of who the client is, i.e. the child not the parent; c) Services to pregnant women to prepare the home for the birth of the baby in an open service case; d) Substance abuse training and what happens to substance abuse infants. A better understanding of above can lead to better performance.	DCFS will send out a reminder of this. There will be a cooperative effort between Coroner's Association and DCFS.
DCFS-22	1. DCFS, when requesting information from police, should request the entire investigative police file, not just the police report. 2. CDRT requests that DCFS add to its protocol that if DCFS determines, during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the	1. DCFS agrees to send staff a memo educating them on the difference between the entire investigative police file and the police report and what they should ask for. 2. DCFS agrees. DCFS will change procedure 300 safe sleep appendix 300 for comment. DCFS will inform investigative staff to indicate for allegation 60 risk of harm if DCFS

	time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and knowingly did not follow the safe sleep recommendations, the case shall be indicated for 60 Risk of Harm at a minimum.	determines during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and knowingly did not follow the safe sleep recommendations. DCFS also agreed to inform investigative staff that if the caretaker at the time had consumed alcohol or drugs, the death could be indicated for 51, death by neglect. DCFS agreed to inform the administrative law judges of this decision.
DCFS-23	Team would like DCFS to look into the feasibility of after hours drug screening.	The Director agrees that there should be after hours drug testing available but due to budget restraints, it is not feasible. The Director stated that it is more important that there are more places for drug testing during the day so that people do not have to go as far for testing.
DCFS-24	When DCFS is doing a death investigation on children under the age of one, it should be protocol that DCFS work with the Police and Coroner office and request that a death scene reenactment be completed. If the Police and Coroner are unwilling to do a scene reenactment then DCFS should do their own.	DCFS currently has procedures (300.100) (5) in place for Investigators to follow as it relates to scene investigation's/reenactment (i.e. Observing Environment). The investigator worker may observe those specific areas of the home reasonably related to the allegation. For example, the investigator worker shall not remove any items from the child's environment. However, photographs may be taken in accordance with procedures 300.110(h). If items are needed for physical evidence, the investigative worker shall contact the local law enforcement agency for assistance.
DCFS-25	Team requests that DCFS revise Procedure 300 Section 300.5 under initial investigation task referrals to law enforcement and state's attorney's to include the	DCFS agrees. Procedure 300 section 300.5 has been revised. The Exec Council reviewed and approved the revision.

	documentation of the SACWIS investigative summary being sent to the State's Attorney and include documentation that follow-up with the State's Attorney was completed. The documentation should include the State's Attorney's decision and reason for their decision.	
DCFS-26	The team recommends that Procedure 300 Appendix G Child Endangerment Risk Assessment Step 5 Safety Plan be reviewed with special consideration given to the age of the safety plan participants. The team would like DCFS to consider the possibility of setting an age minimum for safety plan participants.	Procedure 300 Appendix (G) Child Endangerment Risk Assessment step 5 Safety Plan has been reviewed and the Department believes that it clearly outlines the role and responsibilities (i.e. age minimum) of the Safety Plan participants with special attention to the Safety Plan Assessment Team (SPTA) meeting. NO changes are necessary at this time.
DCFS-27	Due to the need to utilize the resources of the investigative teams wisely and efficiently, the following proposal is meant to address the resource and time wasted on investigations that do not qualify under the law or Rule 300/Procedure 300. Currently, a number of reports that are investigated each year do not actually meet the necessary criteria But once they have been accepted by the hotline and entered into the system, they must be investigated. Even an initial unfounded investigation requires approximately 4 - 10 hours of work (minimum). If these reports could be reviewed and unqualified prior to having the resources expended on them, more time would be afforded the appropriate cases that need investigation. We are proposing that when a hotline is taken by SCR and the assigned office investigations supervisor feels that it is not a report that meets the criteria for a report, the Investigations Supervisor will	DCFS disagrees with the recommendation made. IL DCFS is way below the national average of accepting hotline calls as reports. DCFS does not feel that accepting calls that should not be taken is a problem. Council agreed.

	alert the Child Protection Manager. The Child Protection Manager will immediately review the report and determine if the report meets the criteria set by ANCRA, Rule/ Procedure 300 and if it does not, they will unqualify the report prior to it being assigned to an investigator	
DCFS-28	In this case, DCFS called police to go out for a well-child check but did not go out themselves. In cases where SCR directs the on call responsive to be immediate response, DCFS should use police to ascertain safety in a more immediate manner but in no case should DCFS fail to act independently.	DCFS agrees and has begun to consistently address this issue with DCP staff at our Statewide Administrators weekly meetings.
OS-1	Team recommends that the Illinois Hotel Association be sent an e-mail with the drowning information requesting that they send out to all hotels.	No response required from DCFS. CDRT contacted the Hotel and Lodging Association through their website. 2 hotels contacted us requesting prevent drowning material.
OS-2	Team recommends that SIDS of IL request all OBGYN have Safe Sleep posters in their exam rooms and waiting rooms in English and Spanish.	No DCFS response is required. This is an Exec Council responsibility. SIDS stated that the program services committee of SIDS is willing to send out order forms to all OB/GYN offices in IL but must wait until new budget is submitted to see if funding is available.
OS-3	The team recommends that a letter be sent to the New Coroner Association President. The letter will ask President of Coroner Association to remind all coroners of the importance of filling out the Coroner/Medical Examiner Report Form in all sleep related deaths for infants and sending this form to the SIDS/Infant Mortality Program, Illinois Department of Public Health.	Does not need to go to the Director. This will be included with 2 other recommendations made to the Coroners Assoc.
OS-4	Team is requesting a legislative change so that when parent's rights have been terminated involuntarily and or they have been found to be unfit, that DCFS sequence is not expunged regardless of the number	DCFS will research what might trigger for them to look at. Discussion that legal division will decide if scheduled for termination of rights. DCFS will report back to Exec Council after researched.

	of years that have passed since the last indicated report.	
OS-5	Team will write a letter to this hospital letting them know the protocol on children that are DOA.	NO DCFS response necessary.
OS-6	Team will write a letter to CPD asking to allow the SVU detectives to continue with children homicides in place of turning it over to homicide detectives or asking them to work together on children homicide cases.	NO DCFS response necessary.
OS-7	The court should require testimony to be taken at the shelter care hearing to determine if there is an urgent and immediate necessity to remove the child from the home. The court should also require testimony to be taken when the return of the child to the parents is contemplated.	This is completed. The lead Judge in Madison County agreed and it has been implemented.
OS-8	The team request that the Exec Council write a letter to the Coroner's Association requesting that all autopsies of children under the age of two be performed by a board certified forensic pathologist and there be a death scene investigation done by the Coroner and/or other law enforcement official.	No response needed from DCFS. Exec Council is responsible for recommendation. Exec Council approved the letter on 10/8/10. The letter will be sent out.
OS-9	Team will write a letter to the CEO at the hospital, Risk Management, the OBGYN nurse manager and the physician office reminding them that they are mandated reporters and when they have a mother test positive for drugs/alcohol at birth, DCFS hotline must be called. Also, if mother tests positive for drugs/alcohol, the baby should be tested.	NO DCFS response necessary.
OS-10	A letter should be sent to the Coroner's regarding the importance of death scene investigations in all sleep related deaths.	No response needed from DCFS. Exec Council is responsible for recommendation.

2010 Recommendations and Responses

Number	CDRT Recommendation	DCFS Response
DCFS-1	Team recommends that DCFS purchase cameras for all investigators. If a camera is not available for an investigator and the situation requires pictures, then DCFS investigator should call the police and request pictures.	DCFS agrees to purchase cameras or cell phones with cameras for all investigators.
DCFS-2	Team recommends that DCFS procedure be amended in cases of suspicious bruising in children under age 3. Child must be seen by a doctor within 24 hours.	This is already in DCFS Policy
DCFS-3	A referral form for medical evaluation CANTS 65 A should include body chart and or photos taken by the investigator.	DCFS agrees to attach photos to the medical evaluation CANTS 65 form when they send to the doctor.
DCFS-4	Team recommends when a parent agrees to transfer guardianship to a relative, an intact case shall be opened with the family and remain open until the guardianship transfer is complete. DCFS should provide other necessary services to the family during this time.	Intact is voluntary. As long as family agrees, DCFS will keep it open. If family refuses, DCFS cannot continue.
DCFS-5	The team request that DCFS not close a death case until the final death certificate is obtained.	This is already in policy. This will be re-emphasized in training with coroners.
DCFS-6	CDRT request that DCFS add to its protocol that if DCFS determines during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and did not knowingly follow the safe sleep recommendations, the case shall be indicated for 60 Risk of	DCFS agrees. DCFS will change procedure 300 safe sleep appendix 300 for comment. DCFS will inform investigative staff to indicate for allegation 60 risk of harm if DCFS determines during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and knowingly did not follow the safe sleep recommendations. DCFS also agreed to inform investigative staff that if the

	Harm at a minimum.	caretaker at the time had consumed alcohol or drugs, the death could be indicated for 51 death by neglect. DCFS agreed to inform the administrative law judges of this decision.
DCFS-7	When DCFS investigator or an intact worker is in a home where there is an infant and there is no crib or pack and play to provide a safe sleeping environment for the infant, it is not sufficient for the DCFS investigator or Intact worker to note it on the home safety checklist, provide the family with a brochure and tell them not to bed share. Immediate action needs to be taken to address safety risk. A solution to the safety risk must be noted on the home safety checklist and must be in place immediately and prior to the DCFS investigator or intact worker leaving the home for the evening. If a crib, or pack and play, is not available for any reason, the investigator or intact worker must provide information to the family about safe alternative sleeping arrangements.	DCFS agrees to put a safe sleep practice in place prior to leaving the home. DCFS will continue to order Pack n Plays and monitor supplies.
DCFS-8	The DCFS definition for allegation 81, Non-Organic Failure to Thrive, needs to be evaluated and rewritten, the definition needs to reflect that the allegation needs to be indicated in cases where there are both components of organic and non-organic. If one child in the home is being checked for non-organic failure to thrive, all young in the home also need to be evaluated medically. Carried over to next meeting.	DCFS agrees to change the language in the definition for allegation 81. DCFS agreed to bring the language back to CDRT Exec Council for approval. There was discussion that it should not be default but based on fact and science. DCFS agrees. This will be added to procedure/policy.
DCFS-9	When a child in a home has significant physical trauma, all other children in the home should	This is partially addressed and required in procedure for allegation 11. After the Director

	be examined.	meeting, DCFS agreed to look at the case and make amendments to response as needed.
DCFS-10	In Cook County, when a caretaker has a history of substance abuse, has been indicated and is being referred for intact family services, they should be referred to the Intact Family Recovery Program. In the Southern Region, the worker should contact Service Intervention for information on recovery coaches.	DCFS disagrees with the recommendation. DCFS stated the recommendation should be that there needs to be follow through. DCFS does not want to put it in policy because there would be too many referrals and would not be able to handle the load. DCFS wants this to be a state wide recommendation and not just for Cook County. This will be taken back to the team for revision of the recommendation.
DCFS-11	DCFS should consider using this case as a teaching tool for investigators because this death was preventable. Two issues were identified in this case: 1) The DCFS intact worker and the DCFS investigator could have communicated better and this communication could have identified the high level of risk that was present in the home, and 2) The perpetrator (male paramour) in the home was overlooked by the investigator, and was never listed as possible perpetrator of the abuse. The perpetrator was known by police as a very violent man.	DCFS agrees. They will look at the case and find out the details and use as a teaching tool.
DCFS-12	Team requests that all advanced specialists be required to take the supervisor training and successfully complete the competency test. Failure to do so would deem them ineligible for the assignment of the TA supervisor position.	DCFS cannot do this because it would be in violation of the union contract.
DCFS-13	Team requests that DCFS review the policy regarding TA supervisors and contemplate revision of the policy prior to the	This is not policy. This is a contract. DCFS can negotiate with the union. The union has the right to refuse.

	next union contract review as it is apparent to the team that the short supervisory period for TA consistently results in poor case outcomes.	
DCFS-14	When there is DCFS investigation and there is suspicion of serious psychological/cognitive impairment of the caretaker, a psychological evaluation must be pursued if there is no record of a previous psychological evaluation completed. DCFS should go through all possible avenues to obtain and review the records.	DCFS agrees.
DCFS-15	Team requests that DCFS begin collecting data regarding deaths and what TA supervisor was assigned. Team requests that DCFS does a CWS referral on this family and offer services to this family. Team is concerned about the welfare of the other children in the home.	DCFS agrees.
DCFS-16	Team requests that all advanced specialists be required to take the supervisor training and successfully completing the competency test and failure to do so would deem them ineligible for the assignment of the TA supervisor position.	DCFS cannot do this because it would be in violation of the union contract.
DCFS-17	Team requests that DCFS review the policy regarding TA supervisors and contemplate revision of the policy prior to the next union contract review as it is apparent to the team that the short supervisory period for TA consistently results in poor case outcomes.	This is not policy. This is a contract. DCFS can ask the union but the union has the right to refuse.
DCFS-18	Team requests that DCFS begin collecting data that can be easily obtained regarding deaths where TA supervisor was assigned. DCFS should do a CWS referral	DCFS agrees.

	on this family and offer services to this family. Team is concerned about the welfare of the other children in the home.	
DCFS-19	If DCFS asked for consultation from medical professional in complicated medical case, the medical professional should be required to provide a written consultation.	DCFS nurse does a write up but it is not in SACWIS. OIG will check to make sure this was done when they investigate the case.
DCFS-20	DCFS shall develop a written protocol as to who deals with pending investigations when the investigator is absent for 3 days.	DCFS will look at the case and see about doing this.
DCFS-21	CDRT requests that DCFS add to its protocol that if DCFS determines, during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and knowingly did not follow the safe sleep recommendations, the case shall be indicated for 60 Risk of Harm at a minimum.	DCFS agrees. DCFS will change procedure 300 safe sleep appendix 300 for comment. DCFS will inform investigative staff to indicate for allegation 60 risk of harm if DCFS determines during the investigation of a child's death due to unsafe sleep practices, that the caregiver of the child at the time of death or at the time the child was placed in the unsafe sleep environment, has received prior information, education, documentation regarding safe sleep recommendations from hospital staff, schools, DCFS and knowingly did not follow the safe sleep recommendations. DCFS also agreed to inform investigative staff that if the caretaker at the time has consumed alcohol or drugs, the death could be indicated for 51 death by neglect. DCFS agreed to inform the administrative law judges of this decision.
DCFS-22	Team recommends a SACWIS change where DCFS is able to pull information by address. Team recommends that there be a dialog between current investigator and any investigator that has pending or past investigation with that family/address.	DCFS disagrees because they already have a process for this. ANCRA says the prior unfounded is not to be used to indicate a report. With DCFS soundex, names and all addresses current and past show up. It is DCFS procedure to check all names living at residence. DCFS can also call police and ask all contacts at that home.
DCFS-23	The team recommends that a notification be sent out to DCFS workers emphasizing the	DCFS is working on a draft procedure. DCFS agreed to have the draft completed prior to the December 10, 2010 meeting

	importance of talking about the safe sleep brochures. It is recommended that the notification include bed sharing statistics.	and have out to Exec Council in time for Council to bring comments to the next Director meeting
DCFS-24	Team recommends that DCFS be trained that Coroner's ruling of Accidental or Undetermined does not mean that DCFS should automatically unfound the case.	DCFS agrees. They will add this to the training with Coroners.
DCFS-25	Team recommends that DCFS investigators be trained on the difference between SIDS and SUDI.	DCFS agrees. They will add this to the training with Coroners.
DCFS-26	Team recommends that there be a dialog between current investigator and any investigator that has pending or past investigation with that family/address.	DCFS disagrees because they already have a process for this. ANCRA says the prior unfounded is not to be used to indicate a report. With DCFS soundex, names and all addresses current and past show up. It is DCFS procedure to check all names living at residence. DCFS can also call police and ask all contacts at that home.
DCFS-27	DCFS should consider using this case as a teaching tool for investigators because this death was preventable. Two issues were identified in this case: 1) The DCFS intact worker and the DCFS investigator could have communicated better and this communication could have identified the high level of risk that was present in the home, 2) The perpetrator (male paramour) in the home was overlooked by the investigator, and was never listed as possible perpetrator of the abuse. The perpetrator was known by police as a very violent man.	DCFS agrees. They will look at the case and find out the details and use as a teaching tool.
OS-1	The team would like to recommend that SIDS of Illinois, Inc. send out letters including sample brochures to all OBGYNs in the state asking them to discuss safe sleep with pregnant women and fathers prior to them giving	The Council agreed with this recommendation but discussed that CDRT recommendation should not be tied into financial. This recommendation will not be sent to the Director.

	birth. If the OBGYNs do not want to discuss safe sleep, they could possibly keep safe sleep brochures in all waiting rooms for expectant mothers and fathers to read.	
OS-2	The team recommends that a letter be sent to President of Coroner Association. The letter will strongly suggest that he recommend to all coroners to call in all unexpected children's deaths into the DCFS hotline even if it is believed to be an accident. The reason for this call is because depending upon the accidental death, there may be a component of caregiver neglect.	Council agreed that since there were 3 recommendations at this meeting made regarding letters to the Coroners Association, that all 3 recommendations would be combined in one letter.
OS-3	Team recommends that a letter be written to a Coroner's Association requesting that Coroners call the primary care physician on all deaths of children under the age of 18. Team recommends that DCFS modify procedure 300 on death cases that the primary care physician must be notified as well as attending physician of record.	This recommendation was approved and this recommendation and two others will be included in one letter to the Coroner's Association. Council agreed to invite head of Coroner' Association to the next in-person Exec Council meeting after the Symposium. Does not need to go to the Director. This recommendation was approved at the meeting, however, after the meeting it was discovered that this is already in DCFS procedure and in this case the primary care physician was called. The primary physician did not return the call but was called by the Dept. This child had been in the hospital most of the time and DCFS did get all medical information from those doctors caring for the child. Council agreed that this recommendation would be taken back to the team.
OS-4	A letter should be sent to all Coroners requesting that when the baby is bed sharing with anyone it should be documented on the death certificate for statistical purposes.	DCFS believes that CDRT Exec Cncl would be more appropriate to write the letter.
OS-5	DCFS should remind Coroners of	No further follow up. No DCFS

	the age limit to call DCFS. Coroners may not think to call in on teenagers. Exec. Council will send out the letter.	implementation needed. Exec Council will send letter out to all coroners and chiefs of police.
OS-6	Talk to Exec Council about IL adopting the "Bad Parent List" that has been adopted by other states.	Council agreed to discuss this further. Exec Director will contact Shannon Stotenburg-Wing of Michigan and request more info about their program.