



ILLINOIS CHILD DEATH REVIEW TEAMS:  
A PARTNERSHIP FOR PROTECTING CHILDREN

# ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR  
2014



## MISSION

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

Illinois Department of  
**DCFS**  
Children & Family Services

## SUBMITTED TO:

The Honorable Bruce Rauner,  
Governor, State of Illinois  
Illinois State Senate  
Illinois House of Representatives  
JANUARY 2016

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# Illinois Child Death Review Teams

Lawrence T. Solava – Chairperson

John C. Milhiser- Vice Chairperson

## Executive Council

January 2016

The Honorable Bruce Rauner, Governor of the State of Illinois:  
The Honorable Members of the 99<sup>th</sup> General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2014. In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All of the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

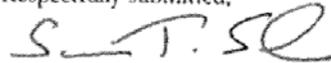
The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department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

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

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

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

Respectfully submitted,



Lawrence T. Solava  
Chairperson, Executive Council  
Illinois Child Death Review Teams

Myra D. West, Chair  
Jody Gleason, Vice Chair  
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Bruce Rauner  
Governor

George H. Sheldon  
Acting Director

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Dear Readers,

It is my commission to present the 2016 Illinois Child Death Review Teams Annual Report. The information in the report includes the data for the child deaths that occurred during calendar year 2014.

In Illinois, 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. DCFS takes these recommendations very seriously, and is committed to using these recommendations to better protect the children of Illinois.

The child death review process is an example of all of us sharing the responsibility for advocating for children who otherwise would not have a voice. This process is only possible because of the commitment and support of hundreds of caring professionals across the state who volunteer their time and expertise to review and discuss prevention strategies to reduce child injury and death.

The Department of Children and Family Services thanks the members of the CDRT for their efforts and we look forward to working with these dedicated individuals in the future.

Sincerely,



George H. Sheldon  
Acting Director

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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 Tamara Skube and Bernadette Emery provided the data from the Child Death Review Team database and suggestions to Dr. Saijun Zhang. Children and Family Research Center staff Dr. Saijun Zhang and Dr. Tamara Fuller wrote the report.

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# EXECUTIVE SUMMARY

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

## Illinois Child Deaths in 2014

In 2014, 1,479 children under 18 died in Illinois.<sup>1</sup> This number represents the death information received by CDRTs.

Of the total child deaths reported to DCFS in 2014:

- 56% were boys and 44% were girls;
- 67% were infants under one year, 8% were young children between 1 and 4 years, 11% were older children between 5 and 14 years, and 14% were youth between 15 and 17 years.<sup>2</sup>

When Illinois child deaths in 2014 were examined by the manner of death:

- 71% were attributable to natural causes;
- 11% were accidental;
- 7% were homicides;
- 3% were suicides;
- 8% were undetermined.

When deaths occurring in 2014 were examined by the category of death:

- 39% were related to premature birth;
- 32% were related to illness;
- 2% were related to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID);
- 22% were related to various types of injuries, such as firearms (7%), suffocations (5%), vehicular accidents (4%), drowning (2%), fires (1%), poisoning/overdose (1%), and other types of injuries (2%);
- 5% were due to undetermined causes.

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<sup>1</sup> The Illinois Department of Public Health reports all death data to the Enterprise Data Warehouse that is managed by Healthcare and Family Services (HFS). The total number of child deaths is based on the death information that DCFS received from HFS as of 9/11/2015.

<sup>2</sup> Due to rounding, some percentages in the report may not add up to 100%.

## 2014 Child Deaths Reviewed by the CDRTs

In 2014, 154 child deaths were reviewed by the CDRTs, including 141 mandatory and 13 discretionary reviews. The mandatory reviews occurred for one of several reasons: 84 were indicated death cases, 39 cases had an investigation in the year before the child's death, 7 were indicated investigations, 6 were DCFS wards, 4 were open DCFS cases, and 1 involved an open DCFS investigation at the time of death.

Reviewed deaths in 2014 occurred in all CDRTs regions (see Appendix A for the CDRT regional map), although there were regional differences in the percentages of child deaths that were mandated for review:

- Aurora – 11 of the 220 deaths (5%) were reviewed.
- Champaign – 14 of the 84 deaths (17%) were reviewed.
- Cook – 71 of the 815 deaths (9%) were reviewed.
- East St. Louis – 7 of the 43 deaths (16%) were reviewed.
- Marion – 9 of the 52 deaths (17%) were reviewed.
- Peoria – 15 of the 122 deaths (12%) were reviewed.
- Rockford – 8 of the 64 deaths (13%) were reviewed.
- Springfield – 10 of the 67 deaths (15%) were reviewed.
- In addition, 9 of 12 deaths (75%) that were out of state were reviewed.

Of the deaths reviewed by CDRTs in 2014:

- 57% were boys and 43% were girls;
- 48% were infants under one, 26% were young children between 1 and 4 years, 14% were older children between 5 and 14 years, and 12% were youth between 15 and 17 years.

When reviewed deaths occurring in 2014 were examined by manner of death:

- 30% were attributed to accidents;
- 21% were due to natural causes;
- 19% were homicides;
- 3% were suicides;
- 28% were undetermined.

When reviewed deaths occurring in 2014 were examined by category of death:

- 3% were related to premature birth;
- 18% were related to illness;
- 6% were related to SUID;
- 56% were related to various types of injuries, such as firearms (5%), suffocations (19%), vehicular accidents (6%), drowning (8%), fire (3%), poisoning/overdose (3%), and other types of injuries (12%);
- 14% were due to undetermined causes and other types of causes (2%).

# 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 2014 there were 1,479 child deaths. Many of these deaths were preventable.

Nine regional Child Death Review Teams (CDRTs) were established by Illinois statute in 1994 and implemented throughout the state in 1995 in an effort to better understand the reasons for child deaths. In 1999, the CDRTs produced the first annual report summarizing team findings and presenting recommendations for reducing preventable child deaths. The CDRT annual report is presented to the Governor, the Illinois Legislature, and other interested parties in a continued effort to understand and reduce preventable child deaths in Illinois.

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

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

# Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998 and more recently by P.A. 95-0405 on August 24, 2007 and P.A. 95-0527 on August 28, 2007.<sup>3</sup> Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This Committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

The Illinois Child Death Review Team Act created a partnership among many agencies, organizations, and professionals across the state that serve and advocate for children. In particular, it established a strong working relationship between the Child Death Review Teams (CDRTs) and the Illinois Department of Children and Family Services (DCFS) Division of Child Protection.

## 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 CDRTs sub-regions is located in Appendix A.

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

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

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

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

## **Child Death Review Team Executive Council**

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

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

During 2015, 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 2014 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 policies or procedures will be revised or new policies or procedures will be developed.
- The 19th Annual Symposium was held at the Hilton Springfield at Springfield, Illinois on April 23 -24, 2015. There were a total of 76 attendees. The presentations included: 1) Anne Devaud (Licensed Clinical Psychologist/Cook County Juvenile Court Clinic), Kristen Bilka (MMS, PA-C/University of Chicago Comer Children's Hospital), Joan Pernecke (Chief Child Protection/Cook County State's Attorney's Office), & Cook A Case Specific Presentation; 2) Joan Pernecke (Chief Child Protection/Cook County State's Attorney's Office), DCFS Procedure 300 Overview; and 3) Lt. Colonel Dave Grossman, Safe Schools, Healthy Students.

## **DCFS Roles and Responsibilities**

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

## **Illinois Child Death Review Process**

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

## **Purpose of Child Death Review**

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

- Evaluate the means by which the death might have been prevented.
- Report findings and recommendations to appropriate agencies.
- Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect.

- Make specific recommendations to the Director and Inspector General of DCFS concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

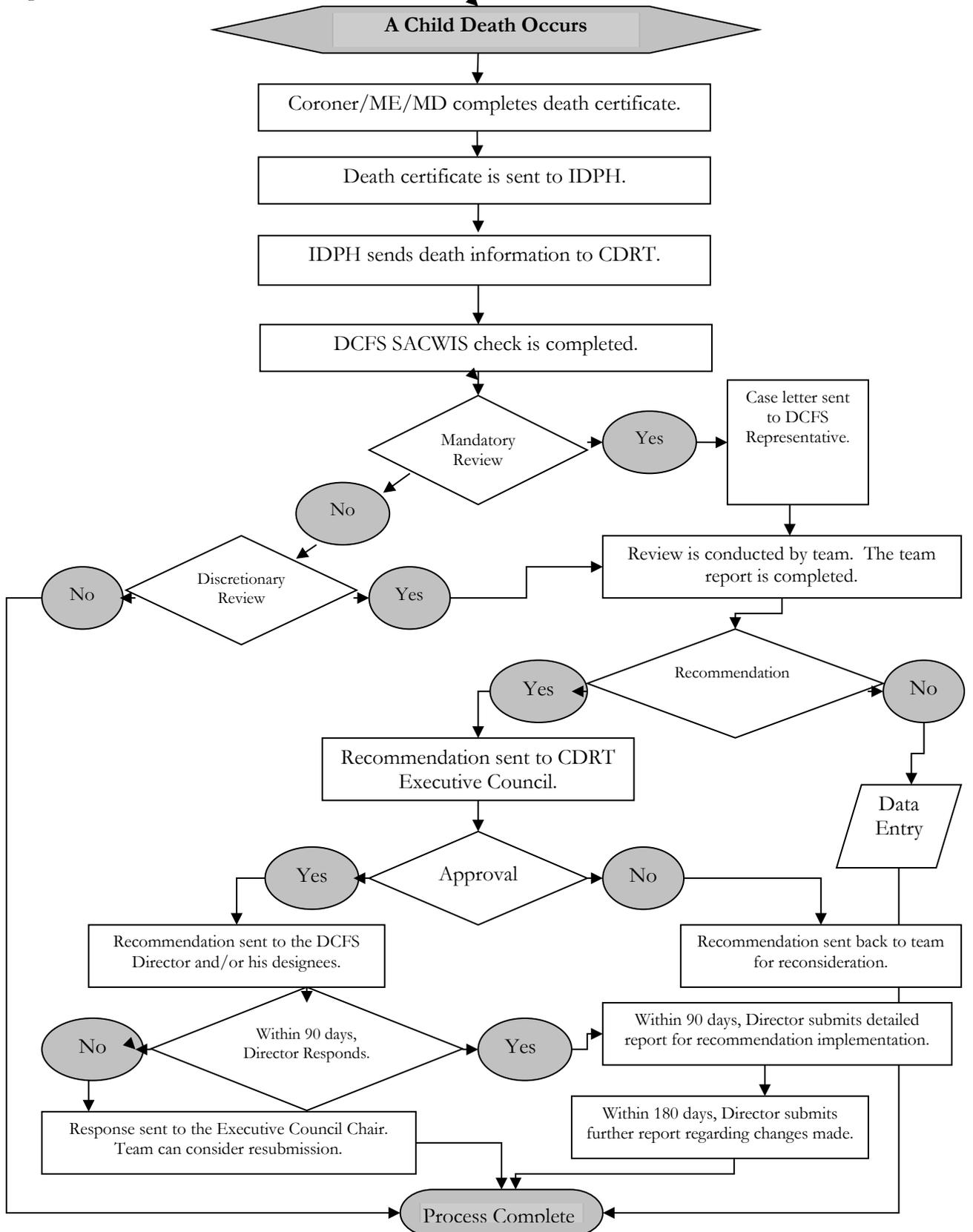
Other responsibilities of the CDRTs are to:

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

The Child Death Review Team process is outlined in a flow chart in Figure 1.

# Child Death Review Procedures

Figure 1: The Child Death Review Process in Illinois

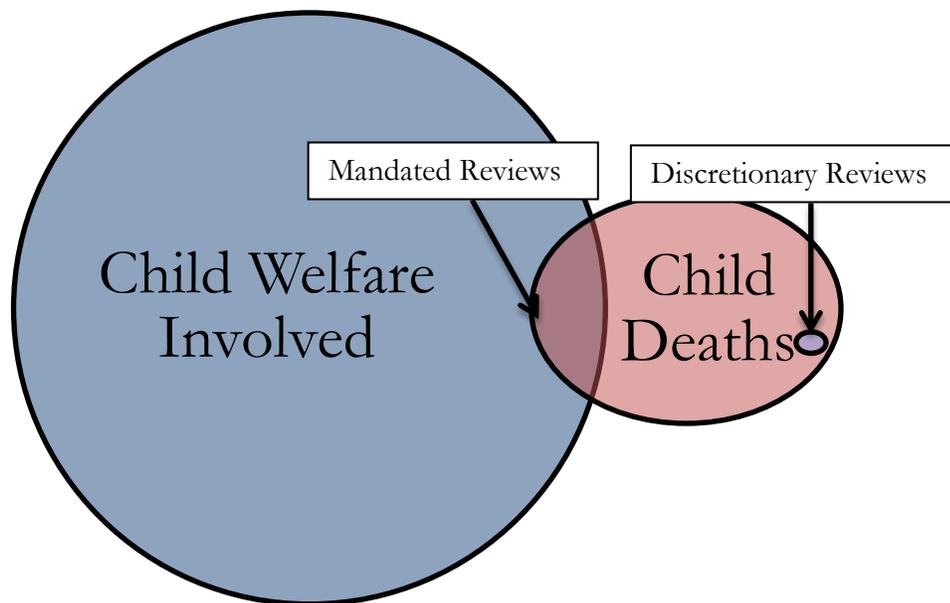


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the death certificate to the Illinois Department of Public Health (IDPH). IDPH electronically provides the Child Death Review Office with the information.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

Once the death information is received by the Child Death Review Office, a search of the Statewide Automated Child Welfare Information System (SACWIS) for the child/family name is performed to identify those cases in which the child had prior involvement with DCFS. Child death review is required, or *mandated*, for all child deaths in which there was prior family involvement with DCFS within the prior year (see Figure 2). Specifically, CDRTs are required to review the deaths of all children aged 17 or younger if the deceased child was:

- a 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 the Child Death Review Office as the result of indicated child abuse or neglect.

Figure 2: Child Death Reviews



CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18, as well as cases of serious or fatal injuries to a child identified under the

Child Advocacy Center Act.<sup>4</sup> These reviews are called discretionary reviews (Figure 2). Information from the death certificates received by the CDRTs is electronically entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is completed at the CDRT meeting.

According to the Child Death Review Team Act, reviews must be timely. Specifically, each CDRT shall meet at least once in each calendar quarter. In addition, the CDRT must review a case as soon as is practical and not later than 90 days following the completion of an investigation by DCFS. When there has been no investigation by DCFS, the CDRT must review the case within 90 days of obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner, or law enforcement agency.

All CDRTs use the same report form to collect information, record findings, and list recommendations. This form details the circumstances of the child death. As a part of the child death review, a CDRT may submit recommendations to DCFS that are intended to prevent additional child fatalities through reasonable means. Recommendations are not always necessary in cases where the death was unpreventable through reasonable means or if no changes are needed to existing programs or practices.

After the Child Death Review Team Report is completed at the team meeting, the Child Death Review Office enters all information into the Child Death Review Database. All recommendations are sent to the Executive Council for approval. If the Executive Council approves a recommendation from a Team, this recommendation is presented to the Director of DCFS for review at the bi-monthly Director and Executive Council meeting. The Director must review and reply to recommendations (except case-specific) within 90 days of receipt. The Director shall submit his or her reply both to the chairperson of that team and to the chairperson of the Executive Council. The Director's reply to each recommendation must include a statement as to whether the Director intended to implement the recommendation.

## **CDRT Access to Information**

According to the Child Death Review Team Act, DCFS personnel are required to provide the CDRTs with all records and information in their possession that are relevant to the team's review of a child's death, including information concerning previous DCFS investigations and information gained through the Child Advocacy Center protocol for cases of serious or fatal injuries. In addition, a CDRT has access to all records and 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

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<sup>4</sup> 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 2014.

medical and mental health records, law enforcement agency records, Department of Correction parole records, probation and court services records, and social service agency records regarding services to the child or family.

## **Confidentiality of CDRT Information**

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

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

## Chapter 2: Child Death Review

### Recommendations to Prevent Child Deaths

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

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

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

There were 42 “system-level” recommendations made by the CDRTs on deaths occurring in 2014, almost all of which (36) focused on DCFS policy and procedures (see Table 1). The DCFS recommendations resulted from 5 types of reviews including: death indicated (15), indicated report at time of death (3), investigation within a year (6), DCFS wards (2), and discretionary review (10). There were 5 recommendations related to other systems made from 2 types of reviews including: death indicated (4) and investigation within a year of death (1). There was 1 primary prevention recommendation from a review of a DCFS ward that occurred in 2014.

There were 23 case-specific recommendations in 2014 (see Table 1). Thirteen of the case-specific recommendations resulted from cases where death was indicated, 6 were from cases that had an investigation in the year before the death, 1 was from a case that had an indicated report at the time of death, 1 was from a case in which the child was a DCFS Ward, and 2 case specific recommendations were from discretionary reviews.

Key:

DCFS = DCFS recommendation

OS = Other System recommendation

PP = Primary Prevention recommendation

CS = Case-specific recommendation

Table 1: 2014 Recommendations and Responses

	<b>Recommendation</b>	<b>Response</b>
DCFS-1	Under the policy of DCFS not investigating unsafe sleep deaths. Team is requesting that DCFS develop a method for CDRT to obtain access to police and hospital information on these deaths.	DCFS disagreed. Absent a pending child abuse and neglect investigation, DCFS does not have the authority to gather records from medical or law enforcement on a family. Families with open service cases can authorize DCFS to gather those records but their written consent is required. DCFS does not have authority to access those types of records on behalf of CDRT. It was discussed at the meeting that IDPH would have these records as they look at deaths of children under the age of 1 year. It was also discussed that Coroners would have this information.
DCFS-2	Team recommends that DCFS do a full and timely investigation on all deaths of wards. Team recommends that the investigation be done by a DCFS investigator.	DCFS disagreed. In order for DCFS to investigate a situation, the situation must meet the criteria for an abuse/neglect report. Child protection investigators do not have authority to investigate a DCFS ward death unless the factors meet a criterion for an allegation. Law enforcement, medical providers, caseworkers, child welfare agency administrators and other child service providers are all mandated reporters. If there is a reason to believe that abuse/neglect contributed to the death of a ward, those parties are all mandated to call the hotline. DCFS Licensing also has the authority to investigate a situation such as this asthma- related death.
DCFS-3	Team requests that DCFS/POS call the pharmacy to get a refill history on medical neglect cases. Team discussed that they have seen several cases where the refill history has not been obtained from the pharmacy.	DCFS agreed to add language to the medical neglect allegation as part of the Procedure 300 revision which requires staff to obtain the prescription refill records if a lack of prescribed medication is a contributing factor to the alleged medical neglect.
DCFS-4	Team requests that DCFS take all unsafe sleeping related deaths as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.

DCFS-5	When a case is unfounded, Team recommends that DCFS create a system where Child Death Review and the Office of the Inspector General have access to these reports in order to properly complete the legislatively mandated review.	DCFS response: per ANCRA (Abuse and Neglect Child Reporting Act) (325 ILCS 5/7.7), unfounded reports are maintained as follows: DCFS shall maintain in the central register for 3 years a listing of unfounded reports involving the death of a child, the sexual abuse of a child, or serious physical injury to a child as defined by DCFS rules. If an individual is the subject of a subsequent investigation that is pending, DCFS shall maintain all prior unfounded reports pertaining to that individual until the pending investigation has been completed or for 12 months, whichever time period ends later. DCFS shall maintain all other unfounded reports for 12 months following the date of the final finding.
DCFS-6	Team recommends that DCFS change their current practice of not taking unsafe sleeping deaths as investigations. Team requests that DCFS take unsafe sleeping death reports as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendations of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level. In addition DCFS is involved in the Collaborative Improvement and Innovation Network Committee that focuses on reducing the infant mortality rate in IL.
DCFS-7	Team recommends that DCFS add an allegation to their allegation system for unsafe sleeping deaths when there are no drugs or alcohol involved. Allegation should be less than 50 years retention.	DCFS disagreed. DCFS has accepted and implemented the recommendations of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-8	Team requests that DCFS take all unsafe sleeping related deaths as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-9	Team requests that DCFS conduct training on how to prepare and present for CDRT meetings. This investigator did not know any details of this case and gave incorrect information.	DCFS agreed. Training will be completed with this worker regarding how to present at CDRT. CDRT requirements and the investigation were reviewed with the worker. The involved worker is not to attend any CDRT meeting without the PSA in attendance. The PSA has been directed to review all case material with the worker. There is no “training” regarding CDRT

		preparation and requirements. There is a document regarding expectations that was reviewed with the involved worker. The investigation was reviewed and discipline is in process for the worker and the TA who approved it. Charges have been drafted by Labor Relations and pre-disciplinary meetings have been set.
DCFS-10	Team requests that CDRT staff have access to investigation photographs so they can add them to the document transfer system.	DCFS agreed. CDRT received access to photos in SACWIS.
DCFS-11	Team requests that DCFS add allegation 11 for any child under the age of 12 months with bruises and any child under the age of 24 months with multiple bruises to the serious harms list.	Department will take this under advisement. DCFS will conduct an assessment of resources and the potential number of cases to determine the impact of adding the suggested population of children to the serious harms list. Karlees law out of Oregon was brought up. DCFS will reach out to other state welfare agencies to find out how they handle this. DCFS sent request out via SLO process with no response from other states. DCFS responded that all staff are adequately trained to handle all investigations and are capable of managing allegation 11 reports regardless of age of victim; adding more allegations to serious harms list in Cook would require additional headcount for those teams which may not be the best utilization of headcount in Cook.
DCFS-12	Team recommends that DCFS add to policy that when there is an indicated injury, the police should be notified and relevant documents provided to police.	DCFS agreed. Law enforcement shall be notified verbally and in writing as needed and in consultation with the supervisor, thus leaving the decision to the supervisor to notify law enforcement. Procedure 300 will be revised to include that investigators are required to notify law enforcement on infants less than 12 months with bruises, on any child under 24 months with multiple bruises, or when there is a Subsequent Oral Report on a child under 3 years of age where a previous finding of abuse was entered. This revision was forwarded to Office of Policy on 10/15/14 for inclusion

		in revised Procedure 300.
DCFS-13	Team requests that DCFS should again track cases involving marijuana use by the parent or caretaker in order to determine its frequency and impact on child safety.	DCFS' authority to investigate allegations involving substance abuse by a parent is outlined in ANCRA and limited to those substances identified as controlled substances in the Illinois Controlled Substances Act (720 ILCS 570/102). Cannabis/marijuana is NOT identified as a controlled substance. Therefore an infant born with marijuana in his/her system does not meet the criteria for an indicated finding of a substance exposed infant under Option C of allegation 15/65.
DCFS-14	Team requests that DCFS develop a protocol for safe sleep and take unsafe sleep deaths as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-15	Team requests that DCFS investigate unsafe sleep deaths and accept the CDRT proposal guide to indicating these reports.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-16	Team recommends that DCFS have more consistency in what is indicated and what is unfounded. Team requests that DCFS develop a protocol guideline to ensure that there is consistency in cases across the state.	DCFS disagreed. DCFS Investigators followed procedures. Every investigation is unique, and CPIs must analyze all information and apply the appropriate procedures in making decisions. The application of the procedures provides the framework for consistency.
DCFS-17	Given that DCFS procedures require all children to be interviewed separately, in the event that a parent/guardian refuses, a request to the State's Attorney should be made to obtain a court order to allow the child to be interviewed.	According to procedures, the investigator has the ability to meet with the local state's attorney and request a court order to interview a child. If there are immediate and urgent safety issues, the investigator has the authority to take protective custody to interview a child. DCFS will ensure this is clarified in the new Procedure 300.

DCFS-18	<p>Team requests that DCFS retrain staff on the difference between the ME/Coroners manner of death and DCFS indicating a report. Team does not feel that the previous training completed was sufficient. Team would like DCFS to develop new training that accurately teaches DCFS staff that coroner's manners of death should not determine DCFS indicating or unfounding a case. Police determination should also not determine this. Team suggests that DCFS work with coroners/ME to develop the training and possibly assist in the training. This training should be for all current investigators and supervisors statewide and included in the foundation training and refresh training.</p>	<p>DCFS agreed. Procedure 300 is currently in process of being updated. Additional and definitive processes are being embedded into this update to address consistent application and improve the quality of investigations, including requirements in death investigations. Training on these updates will be provided.</p>
DCFS-19	<p>Team recommends that DCFS develop training for law enforcement regarding what law enforcement's responsibilities are in assisting DCFS. Training could include:</p> <ul style="list-style-type: none"> <li>- the guidelines for being a mandated reporter and what behaviors and observations rise to the level of calling the abuse hotline;</li> <li>- their role in assisting DCP workers, when needed, in taking protective custody</li> <li>- what law enforcement's</li> </ul>	<p>DCFS agreed with this recommendation. DCFS is proposing in-person training. The plan is to work with the Law Enforcement Training and Standards Board to facilitate the development of one-day training for law enforcement that covers mandated reporting, working with child protection and changes to ANCRA related to human trafficking. The training will initially be conducted through 2 mobile training units (Chicago area and Central Illinois).</p> <ul style="list-style-type: none"> <li>• The evaluations and feedbacks from participants will be used to make any revisions to the training.</li> <li>• The training will be recorded so it can also be uploaded onto the Law Enforcement Training and Standards Board website. The Board reaches over 40,000 officers a year for trainings.</li> </ul>

	<p>overall supportive interactions should be with DCFS staff.</p> <p>This training should be recorded on a CD/DVD to be sent with a cover letter requesting that it be given to all new recruits in the Academy and bi-annually to all personnel after that as well as to all detectives and sergeants. The CD/DVD can be used repeatedly by various law enforcement agencies throughout the state. This CD/DVD should include a primer on what the different functions of DCFS personnel are, the divisions of Investigations, Intact, Caseworkers, Clinical, the chain of command in each division, as well as how the process works (e.g., the processes including hotline call, investigation, indication, appeal, case opening to intact families, case screening with SAO, and case filing in CP court).</p>	
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DCFS-20	<p>Team recommends that when DCFS puts a safety plan in place, DCP should ensure that there is a crib or pack n play, not a makeshift bed, prior to the child being given to the person identified in the safety plan.</p>	<p>DCFS response: Regarding Pack n Play and crib, DCFS agreed with what’s being asked of DCFS, but this affects all regions. There are cases whereby babies are not listed on CANTS; investigators do not keep Pack n Play pens in their trucks—they are issued upon request. The following information is from Appendix K, which may be not appropriate for every family and is offered for guidance only -</p> <p>Possible temporary safe sleep solutions might include, although are not limited to:</p> <ul style="list-style-type: none"> <li>• An opened container-type item large enough and structurally sound enough for the infant. This might include an empty drawer removed from the dresser, a low-sided box with bottom and all sides secured, etc. Only light-weight (baby) blankets should be used, if parents/caregivers insist some sort of cushion is needed. However, no pillows, thick blankets, stuffed animals, thick clothing, other bedding etc., should be used.</li> <li>• A safe firm low surface (floor) out of the path of foot traffic—not situated immediately to the side of parents/caregivers’ bed where infant could be stepped on and away from small children and animals;</li> <li>• A pallet on the floor with light-weight blankets;</li> <li>• An uncluttered area where nothing could fall into the sleep area on top of the infant restricting breathing;</li> <li>• Parents/caregivers should be cautioned against sleeping with the infant on a couch, easy chair, etc., as these are not an acceptable temporary solution.</li> </ul>
DCFS-21	<p>Team requests that DCFS retrain staff on the difference between the Coroners/ME manners of death and DCFS indicating a report. Team does not feel that the previous training completed was sufficient. Team would like DCFS to develop new training that</p>	<p>DCFS agreed to issue practice reminder to Cook Area administrators and supervisors regarding difference between DCFS finding decisions and cause of death determinations made by ME/Coroners. Additional training and guidelines on this issue will be in Procedure 300 revisions and will be provided to all staff statewide.</p>

	<p>accurately teaches DCFS staff that Coroners/ME's manners of death should not determine DCFS indicating or unbounding a case. Police determination should also not determine this. Team suggest that DCFS work with Coroners/ME to develop the training and possible assistance in the training. This training should be for all investigators statewide.</p>	
DCFS-22	<p>Team recommends that DCFS take unsafe sleeping deaths as investigations.</p>	<p>DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.</p>
DCFS-23	<p>Team recommends that a replacement letter go out to Coroners to clarify DCFS policy.</p>	<p>DCFS will take under advisement. DCFS will look at the original letter and determine if another letter should go out. Team asked when this will be done and DCFS said prior to next meeting. After consultation with legal staff, Operations Bureau Chief determined another letter is not necessary or advisable.</p>
DCFS-24	<p>Team recommends that DCFS create an allegation for unsafe sleeping and follow CDRT recommendations for indicating these reports.</p>	<p>DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.</p>
DCFS-25	<p>Team recommends that DCFS train staff on indicating unsafe sleeping deaths. Included in this training should be that accidental manners from the Coroners are not grounds for unbounding these deaths.</p>	<p>Even though DCFS disagreed with the recommendation, Acting Deputy confirmed with Division of Training that this issue will be included in Procedure 300 training curriculum which will be delivered beginning February 2015.</p>
DCFS-26	<p>Team requests that the Director of DCFS touch base with the Director of IDPH to work on a meeting with DCFS, IDPH and CDRT to</p>	<p>DCFS Director will contact the Director of IDPH. He is very much aware of the issue. Director will attempt to set up a meeting. DCFS agreed to let the council know what IDPH is already doing. A public service announcement will go out on safe sleep.</p>

	discuss Safe Sleep education.	DCFS Director spoke to IDPH Director. TV ad is in progress.
DCFS-27	Team requests that DCFS develop a protocol for safe sleep and take unsafe sleep deaths as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-28	Team requests that DCFS make a protocol for safe sleep and take unsafe sleep deaths as investigations.	DCFS disagreed. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-29	Team recommends that DCFS make a protocol for safe sleep and take unsafe sleep deaths as investigations.	DCFS disagreed. DCFS accepted and implemented the recommendation of the Office of Inspector General. DCFS will stay abreast of changes that occur on a national level.
DCFS-30	Team requests that DCFS look at statistics of previous death cases where families have refused services.	DCFS disagreed. This family had a safe sleep environment for the baby but chose to co-sleep and the infant died from overlay by the parent. The home conditions were poor and case was indicated for environmental neglect but parents had corrected those conditions at time of investigation closure. DCFS is unsure what Team believes will be gained in cases like this, where services were refused after the death of a child. There is no record this family had been offered/refused services prior to the death of this child.

DCFS-31	Team requests that DCFS look at the licensing standards for infants less than 12 months of age and consider decreasing the number of children that can be in a home when an infant is placed.	DCFS agreed to have DCFS foster home licensing unit review the licensing standards. Response from the licensing unit: We are all in agreement that the Illinois standards, as currently written, are appropriate and should not be revised. There are adequate safeguards already in place to ensure child safety. Safeguards include a review and approval of any recommendation to waive the capacity requirements by DCFS clinical, licensing, the Director, and in some instances the involved caseworkers and foster parents. Reducing the capacity in Illinois foster homes would decrease the number of available beds for children in foster care without increasing child safety. The tragic death that occurred in the attached Death Review Report and Recommendations was not the result of the number of children placed in the foster home. Rather, it was a blatant disregard by the foster mother of the doctor's orders for her NOT to engage in co-sleeping with the baby. DCFS has already begun the process of amending the licensing standards to expressly prohibit foster parents from sleeping in the same bed as a foster child (co-sleeping.) We have also begun discussions with the PRIDE training unit to include a specific training module in the pre-service curriculum that will address the dangers and prohibition on co-sleeping.
DCFS-32	Team requests that DCFS investigate all co-sleeping death cases.	DCFS is changing the position on this issue and is in the process of implementing. DCFS will once again investigate unsafe sleep deaths.
DCFS-33	Team recommends that DCFS increase education to mandated reporters about reporting risk to newborn babies based on history of mother's previous DCFS involvement even when no direct abuse to newborn is noted. Team encourages in-person training be considered for mandated reporters (in	DCFS agreed with recommendations to address this issue on a statewide level, by incorporating information around drug testing at birth and prior history into mandated reporter training, both the online training as well as when training is provided in-person.

	particular physicians).	
DCFS-34	<p>Team recommends that for the home and safety checklist, there should be a sentence added about firearms. All adults and children in the home should be asked about a gun and not just the caretaker. If police checks show weapon occurrences, everyone should be asked. Caretakers should be educated on how the gun should be in a lock box away from children and the ammunition in a separate place.</p>	Awaiting DCFS response.
DCFS-35	<p>Team recommends that DCFS child protection staff request a drug screen be completed immediately in all unexpected deaths.</p>	<p>DCFS will further explore the feasibility of Child Protection staff conducting immediate drug testing. Currently, DCFS can request a drug drop if there is a current investigation and there are suspicions by the investigator, or reported by law enforcement or coroner or there is an admission by the caretaker. In order for drug drops to be performed timely in the late evening, Investigators can work with law enforcement to determine if a specimen can be obtained through a local hospital.</p>
DCFS-36	<p>On child death investigations, when the child is in an unsafe sleep situation, Team requests that DCFS ask the question to the caregiver why they had the child in an unsafe sleeping environment even after they were told not to. Team requests DCFS track this data.</p>	<p>DCFS disagreed. This investigation was reviewed. The assigned investigator and law enforcement did a thorough interview with the mother and a detailed scene investigation of the home environment. While it is not documented whether the mother was specifically asked why she chose to co-sleep on the night in question, there were detailed questions which established she had been drinking and was under the influence of alcohol at the time she went to bed with the twins. This report was indicated for death by neglect because the mother was under the influence when she chose to co-sleep with her child. In this particular evidence, the mother's use of alcohol impaired her ability to make a good</p>

		<p>decision regarding sleeping arrangements for her children.</p> <p>In a review of a multitude of death investigations involving co-sleeping, it is consistently found that staff do inquire whether a safe sleep environment was available and if the parent was educated about safe sleeping environment if one existed. Investigators reporting to Child Death Review Teams should be able to share this information if it was gathered. Perhaps the CDRT could add this question to their tracking tool if they feel there is a need to track this information. DCFS does not have sufficient staffing or data system which would allow for tracking of this specific question. In addition, many co-sleeping deaths are not taken as abuse/neglect allegations, so DCFS would not be able to gather objective data on all co-sleeping deaths. Therefore, DCFS disagreed with this recommendation.</p>
OS-1	<p>Team requests that a letter be written and sent to the hospital requesting the hospital create a protocol about not signing a death certificate and sending body to ME when they are not aware of the history of the child.</p>	<p>No response needed from DCFS. Team member will write the letter.</p>
OS-2	<p>Team request that Safe Haven work with all high schools in IL to ensure that Safe Haven is discussed in health classes in schools and that posters are placed in public schools.</p>	<p>DCFS has a long standing relationship with Safe Haven and has been working with them since 2001. DCFS partners with Safe Haven to provide public awareness of the Abandoned Newborn Infant Protection Act, commonly referred to as the Baby Safe Haven Law. DCFS designed and provided posters and brochures to the high schools. In addition, on April 8, 2015 DCFS sent correspondence to Regional School Superintendents to remind them that Illinois School Code requires that information about the Abandoned Newborn Infant Protection Act be included in school health education classes for students in grades 6-12. Teaching tools were also provided to the schools. Enclosed with the letter were brochures, posters and information</p>

		provided on how to order additional copies for distribution to school districts in that region. In addition, the Director sent correspondence to the State Superintendent of Education and the Secretary of Education offering DCFS assistance with educating students and faculty regarding the Baby Safe Haven Law.
OS-3	Team requests that a letter be written and sent to the St. Elmo police Chief and the Fire Chief to remind them that they are mandated reporters.	No response needed from DCFS. Team Chairperson will write the letter.
OS-4	Team requests that a letter be composed and sent to the hospital about creating a protocol for informing DCFS of developments.	No response needed from DCFS. Team Chairperson will write the letter.
OS-5	Team requests that a letter be written to the presiding judge of probate division, reminding the judge that there is training available.	No response needed from DCFS. Team Chairperson will write the letter.
PP-1	Team recommends that DCFS do a public service announcement in the month of April regarding drowning prevention.	DCFS agreed. DCFS Director, along with representatives from the Red Cross, Illinois Department of Natural Resources and Illinois Association of Park Districts, conducted a Drowning Prevention Press Conference on May 20, 2015. DCFS issued a press release and recorded a public service announcement.
CS-1	Team requests that DCFS look at this case because it was closed prior to the ME final ruling. Team is concerned that investigations are closed before receiving the cause and manner of death.	DCFS agreed to review this case. DCFS spoke to the AA on the case in Feb. He acknowledged that they did complete the case prior to the ME final ruling. They understand that they should wait. However, they felt they had credible evidence and made this decision. DCFS reiterated the need for following policy and procedures.

CS-2	<p>Team requests that DCFS look at this case and how it was handled. Issues include no mental health screen, no medical documentation, no DCFS nurse referral, and no interview with primary care physician. Investigator did not check to see if mom was RN, and worker did not check LEADS.</p>	<p>DCFS agreed. This may be a systemic issue. There was a CPAS covering the team (PSA on medical leave) at the time of assignment and approval without input of the AA. It contained #60 and was solely based upon mother's contentious relationship with agency caring for her child at the time. This may be a systemic issue but, perhaps certain case dynamics should automatically be discussed with another PSA or the AA if a team is covered by a CPAS. DCFS will pursue formal corrective action regarding the worker and CPAS. Minimally, the following non-compliances were present: no LEADS; no exploration of mother's suspected mental health status and verification of mother's ability to care for the child (status as an RN; verbalized fear of caring for the child; mental health, etc.); no Regional Nurses referral as required in 302, App O; no discharge plan involvement; no contact with Kane County LE and ASA regarding mother's arrest and charges for threatening agency staff.</p>
CS-3	<p>Team requests that DCFS review this case and how it was handled and that DCFS utilize this case as a training tool.</p>	<p>DCFS agreed to look at this case. Multiple concerns were found and appropriate corrective action has been taken. Processes have been put in place to increase supervision and timely assignment. DCFS agreed to use this case as a training tool. Trainings/processes have been implemented within the regions based on the issues found in this case. Similar case dynamics are being used in statewide Serious Harms Training under development by the Office of the Inspector General.</p>
CS-4	<p>Team requests that DCFS look at this case and how it was handled by the POS agency.</p>	<p>DCFS agreed to look at this case and how it was handled. The investigations were reviewed by DCFS Child Protection Administration and no practice implications were noted. A meeting was held with the POS to discuss the issues with the service case where issues and red flags were not appropriately identified and/or addressed. A meeting has also occurred with current service provider for the children in care (after the death of the child) to discuss and assess the concerns raised around visitation and substance abuse issues.</p>

CS-5	Team requests that DCFS review how this case was handled notable by lack of investigation as to medical neglect. In addition, Team recommends that DCFS review how the POS agency handled the information after the hotline did not take the call. Did the POS agency follow the asthma policy?	The call floor worker did not take an allegation because the caseworker clearly identified the grandma had been administering breathing treatments to the child throughout the day. The decision to NOT accept a report was appropriate based on the information provided by the caseworker. All POS staff at the agency site will receive comprehensive education related to asthma as well as in depth training on the asthma protocol.
CS-6	Team recommends that DCFS look at this case and how it was handled, specifically sequence A and the first hotline call.	DCFS agreed to do this. This case will be reviewed by the Cook Regional Administrator and Area Administrator. This investigation will be specifically addressed with the worker and PSA of record regarding deficiencies prior to 12/31/14. While there are deficiencies, there are not necessarily any noted procedural violations. Part of the problem with this investigation is the brief timeframe it was with the worker prior to the child's death. The A-sequence was reported 4/16/14, assigned on 4/17/14 (same day all principal parties except the infant's father were interviewed) and child died on 4/22/14, 5 days after assignment. Legitimately, there is no note discussing the safety plan with the grandmother and mother, including instructions for the parent to NOT to attempt to remove the child and for the GM to contact police and DCFS (in that order) if she did. Information gathered prior to child's death could have been more comprehensive. There was no effort to interview the father but it is unknown if that would have occurred later in the investigation. Clarification of what mother meant when she said she "stayed" with grandmother could have been sought. It should be pointed out that public aid listed given address as mother's residence.
CS-7	Team requests that DCFS look at this case and how it was handled. Team is concerned that this child was in a pool alone and was only 18 months old.	DCFS agreed. This investigation will be reviewed with the primary investigator and approving PSA as a teaching/learning opportunity. The need to assess the contributing factors that lead to the drowning incident will be specifically

	<p>The parents were outside of the pool and on a deck. The floatation device was not size appropriate and was noted that it should not be used as a floatation device. Team is concerned that this was unfounded.</p>	<p>discussed.</p>
CS-8	<p>Team requests that DCFS look at this case and how the POS agency handled it. Team requests that DCFS provide feedback to the POS agency. Team is concerned about the potential risk to the children.</p>	<p>DCFS agreed. On October 9, 2014 DCFS personnel met with POS staff to address the concerns from the Child Death Review Team. APT monitor completed a review of the file. Notes were found to be current. Mother continues to be on home monitoring device. The mother completed parenting classes in August. Mother is receiving counseling. She attends 2 times weekly. Mother has been in therapy about 1 month or so, but no report is available yet. Mother has completed a substance abuse assessment through SEDAC, no recommendations reported. Worker will follow up and provide updated information. All three girls are in the home of the parents. The girls have been interviewed away from parents and have not disclosed any abuse or unusual incidents. Two of the girls are in school. The 3 year old is currently on a waiting list. They have been provided with beds and clothing. The father is at home and remains in hospice care; he receives nursing services on a daily basis. His medication is kept in a closet away from the children in a lock box. This family is being seen weekly in their home. No concerns are being reported regarding the children's safety and well-being. Family has housing and lives in a family building. The DCFS Regulation and Monitoring staff instructed the agency to provide parenting coaching, protective daycare and a counseling consult for all the children to address issues of grief and loss of sibling as well as in pending death of their father. The Regulation and Monitoring worker will confer with the supervisor on this case on a monthly basis.</p>
CS-9	<p>Team requests that DCFS</p>	<p>DCFS agreed. DCFS will look into this case</p>

	look at this case and how it was handled. This case should have been referred to intact and it was not.	and how it was handled. There were issues noted and policies not followed. The investigator has since retired. The supervisor is still working with DCFS. The AA reviewed everything with the supervisor. The supervisor will review the investigation, violations and expected actions with the PSA of record and provide documentation of the meeting.
CS-10	Team requests that DCFS look at the A sequence on 5/20/14 that was indicated on grandmother and how it was handled because the investigator assisted grandmother in obtaining guardianship even though the children were not in school and not being home schooled. Grandmother was in a wheelchair and later DCFS investigators said that Grandmother was definitely not capable of caring for children.	DCFS agreed. This investigation will be reviewed with the primary investigator as a teaching/learning opportunity. Specifically, procedures regarding background checks will be discussed as well as the need to conduct a thorough assessment and not looking at the investigation in isolation.
CS-11	Team requests that DCFS look at this case. A safety plan was put in place but no Pack n Play was provided for the infant.	DCFS agreed to look at this case.
CS-12	Team requests that DCFS look at this case and how it was handled because there was no alcohol assessment done and there is another child still in the home. DCFS also should look into why the hotline would not take the hotline call made by the worker when the 9 year old child was returned to the home.	DCFS agreed. All 3 investigation sequences were reviewed. The A and B sequences were reported on 3/2/14 and 4/13/14, respectively, and both completed on 5/6/14. A substance abuse assessment was completed on the A sequence on 3/21/14. The mother's whereabouts were unknown after this time and she was not available for further contacts during the B sequence on which custody of child was taken. Mother did not participate in the shelter care hearing. A substance abuse referral cannot be made for an absent parent. There was no evidence that the 10 year old should have been removed or that she was at risk due to the conflict between her mother and brother. Child was residing with her father on the B sequence and he stated that

		<p>mother neither resided with him nor was he aware of her current address. He did state she visited his home and took the minor to and from school on occasion. The investigator on the A and B sequences left messages regarding court with the sibling's father. Father stated that he was already caring for his child and did not want her to go into care. As she had a viable parent with whom she was already residing, there was no urgent and immediate necessity to pursue custody of the sibling. Mother was not available during C sequence reported 6/9/14 but she was also arrested due to the altercation precipitating custody of child. The child died a few weeks after this sequence was reported. After the death, the mother was cooperative with service recommendations. After a review of the investigation, there are no factors indicating these investigations were not handled in accordance with established policies and procedures.</p>
<p>CS-13</p>	<p>Team requests that DCFS review this case. The last indicated report is called an A sequence and it appears that there was no previous involvement. Team is concerned about the chronology. SCR did not do a thorough data search. This should have led to prior reports. The A sequence should have been D sequence. Because of the background, it was not referred to intact care and it may have been had they known the background.</p>	<p>DCFS agreed. They will look at this case and how it was handled. The case was sent to the link/merge expert for a double look. If a case has unknowns, it cannot be linked which was part of the problem initially with this case. Secondly, the field did not request a merge once they identified the unknown subjects. Finally the call floor worker also missed the link so there were mistakes in many arenas.</p> <p>The A sequence at intake was reported with all unknown subjects, in which subject names were not known so would not have been able to be linked to priors. CPI should have requested it to be linked as a Subsequent Oral Report once subject names were known.</p> <p>The B sequence at intake indicates that all subject names were known and were linked. However, the call floor worker did not note the discrepancy of the link of A versus other priors and automatically linked to new SCR number that was started with the A.</p> <p>If the CPI had requested the A to be re-linked as a SOR once the subject names were known, that would have corrected this</p>

		<p>and the B would have been linked correctly, but the call floor worker also could have seen the error in linking when the B sequence was taken.</p>
<p>CS-14</p>	<p>Team requests that DCFS monitoring look at how the POS handled this case due to the fact the urine drops were not completed, thorough review of prior arrest and convictions, no follow-up with what the order of protection was about, no follow-up on the girlfriend for her order of protection, child and family team meeting not held.</p>	<p>DCFS agreed to look at this case. Agency Performance and Monitoring reviewed the case and met with the agency regarding issues found. Corrective action was put in place. A review of the record and discussion with the agency revealed that there were concerns regarding the follow-up by the agency regarding the order of protection, LEADS/prior conviction information as well as ensuring drops being completed as needed. APT reports that the record shows that Child and Family Team Meetings occurred in August, November and March.</p>

CS-15	Team requests that DCFS look at this case and how it was handled.	<p>DCFS agreed. DCFS will look into this case and how it was handled. DCFS has reviewed the investigation and found no fault with how it was handled. 1) Investigators were instructed to pinpoint the responsible party and it was the mother, who placed the child in the bed with her three siblings. The father did not go into the room and did not “reside” in the home based upon his and mother’s statements. However, per mother’s statements, the child either slept in the bed with her or the children. 2) The worker requested LEADS. The information did not reveal the “extensive arrest and conviction record” mentioned in the CDRT response form. This may be a systemic and serious issue if our LEADS line has different information than what can be obtained by the Office of Inspector General or CDRT. The investigation’s confirmed report had no prior criminal history for the father. It is unknown what could have contributed to the extreme variance in criminal history. However, there is no information that his criminal and drug history (noted in the CDRT report) contributed in any way to the child’s death.</p>
CS-16	Team requests that DCFS train the investigator and supervisor in this case.	<p>There is no information via the investigation review indicating the PSA and worker require any additional training. However, this case will be used as a training tool and at that training, the supervisor and investigator will participate.</p>

CS-17	Team requests that DCFS look at this case and how it was handled by both DCFS and the POS agency. Team requests that DCFS follow up accordingly to what is found and include it to training to all parties if needed.	DCFS agreed to look at this case and how it was handled by both DCFS and the POS. APT has reviewed the casework services provided by the private foster care provider. Training has been provided to the worker and supervisor of this case. Training covered areas including: who should be included in an Integrated Assessment, CERAP milestones and safety planning, when domestic violence assessment/classes are needed, when to add new household members to SACWIS/CYCIS, refresher on meeting with all members of the household and children away from caretakers, refresher on safety/risk in the home and addressing risk/safety, refresher for caseworker, supervisor and Program Director on when a hotline call should be made, and refresher on involvement in an active investigation and requirements of mandated reporting.
CS-18	Team requests that DCFS review this case to determine if DCFS policy and procedure were followed in obtaining all relevant medical records and if the medical records were reviewed.	DCFS agreed. This case was reviewed by the Regional Administrator. The investigator failed to make contact with medical professionals involved with the child. This case will be reviewed with the approving AA, PSA and investigator involved.
CS-19	Team will write a letter commending DCFS for a job well done.	No response needed.
CS-20	Team would like to report this doctor to Medical Board for failure to report to DCFS the infants' condition of failure to thrive.	This was referred to DCFS Legal. Upon further review, DCFS and the Office of the Inspector General did not refer this doctor to the Medical Board because there were no grounds to do so.
CS-21	Team requests that DCFS use this case as a training tool to all investigative staff.	DCFS agreed. The investigation was presented at all the Cook staff meetings in December.
CS-22	Team requests that DCFS look at this case and how the first investigation was handled. DCFS should look at the safety net in place to prevent this abuse from happening.	DCFS agreed. The case was used as a training tool and presented to the field during the month of April. The Office of the Inspector General completed the review and DCFS is proceeding with appropriate action for the involved staff. The investigator was fired and the supervisor received a 30 day suspension. Staff will

		provide the supervisor with one-on-one training regarding conducting investigations.
CS-23	Team requests that DCFS look at this case and how it was handled because the death was unfounded and the father admitted to using drugs.	DCFS agreed. The area administrator reviewed the case with the investigator. Discussion included that the Coroners/ME's decision on the causes and manners of deaths do not dictate DCFS final determination on indicating or unfounding a case.

## Chapter 3: Illinois Child Deaths in 2014

What do we know about the child deaths that occurred in Illinois during 2014?

To answer this question, there are three 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 who died differ from those in the general child population in Illinois.

The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths (92% in 2014) are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children involved with child welfare in Illinois is more likely to be younger and African-American than the total child population in Illinois. It is therefore likely that deaths reviewed by the CDRTs may over-represent these two characteristics. In order to compare 1) the total population of children, 2) the population of total child deaths, and 3) the child deaths that were reviewed by the CDRTs, these data are presented side by side throughout this report.

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

- The population of Illinois children was based on the 2010 Census. According to Census 2010 data, there were approximately 3.13 million children under the age of 18 in Illinois, which constitutes about 24.4% of the total Illinois population.<sup>5</sup>
- In 2014, there were 1,479 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.
- There were 154 child deaths that occurred in 2014 that were reviewed by the CDRTs – 141 of these were mandated for review and 13 were discretionary reviews.

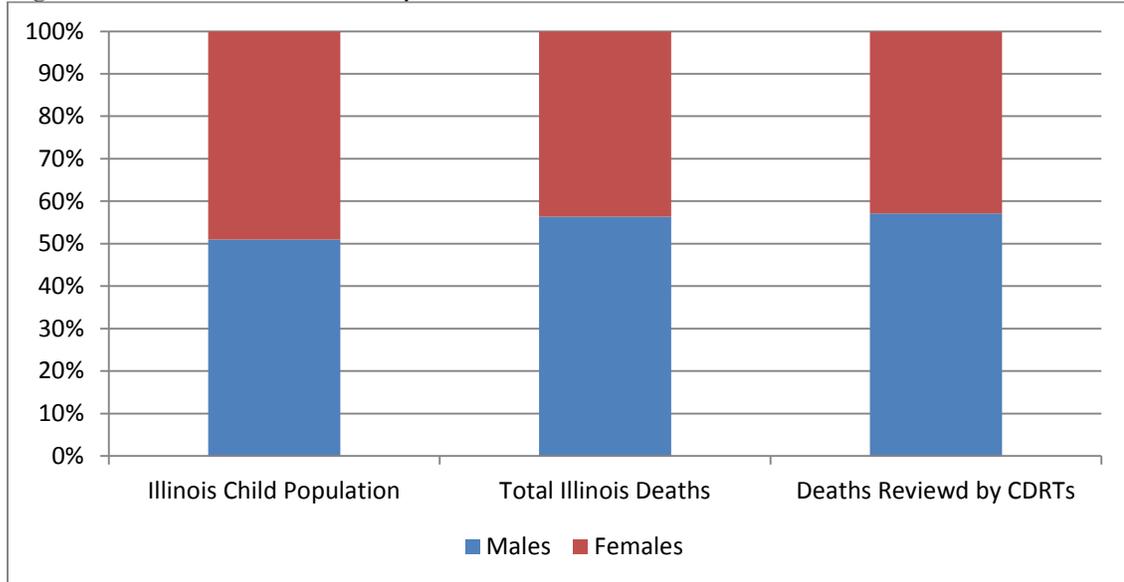
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<sup>5</sup> U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from [http:// www. factfinder2.census.gov](http://www.factfinder2.census.gov).

## 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 56% of total child deaths in 2014. More deaths reviewed were also boys: 57% of reviewed deaths were boys in 2014 (see Figure 3).

Figure 3: Illinois Child Deaths by Gender

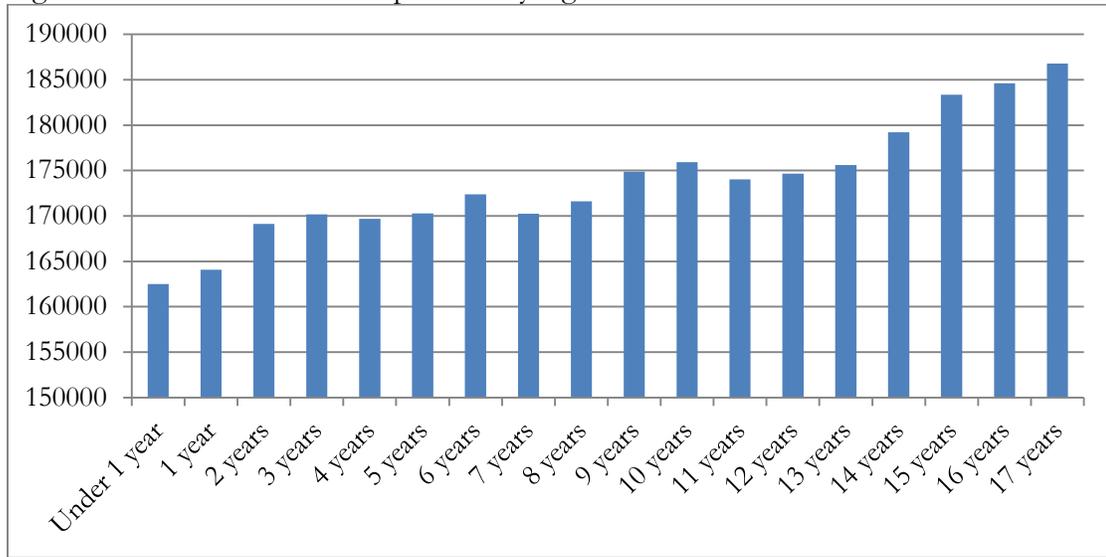


## Child Deaths by Age

In 2010, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 3.13 million children in Illinois under 18 years, 5% were less than one year of age, 22% were between 1 and 4 years, 27% were between 5 and 9 years, 28% were between 10 and 14 years, and 18% were between 15 and 17 years.<sup>6</sup>

<sup>6</sup> U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from <http://www.factfinder2.census.gov>.

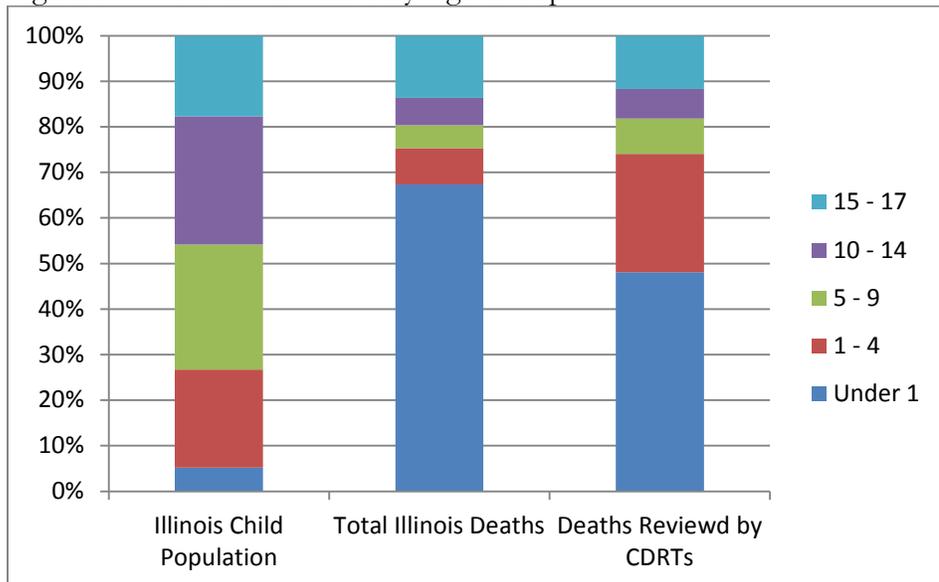
Figure 4: 2010 Illinois Child Population by Age



However, when the total Illinois child deaths reported to CDRTs are examined by age (see Figure 5), it shows that infants less than one year old are especially vulnerable – 67% of the total deaths in 2014 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 2014, 8% of the total deaths were children between 1 and 4 years, 5% were children between 5 and 9 years, 6% were children between 10 and 14 years, and 14% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group (see Figure 5), infants under one year are again over-represented; they comprised 48% of reviewed deaths in 2014. Children between 1 and 4 years made up 26% of reviewed deaths in 2014. Older children make up a smaller portion of reviewed deaths: 8% of reviewed deaths were for children aged 5 to 9 years old, 6% of reviewed deaths were for children aged 10 to 14, and 12% of reviewed deaths were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



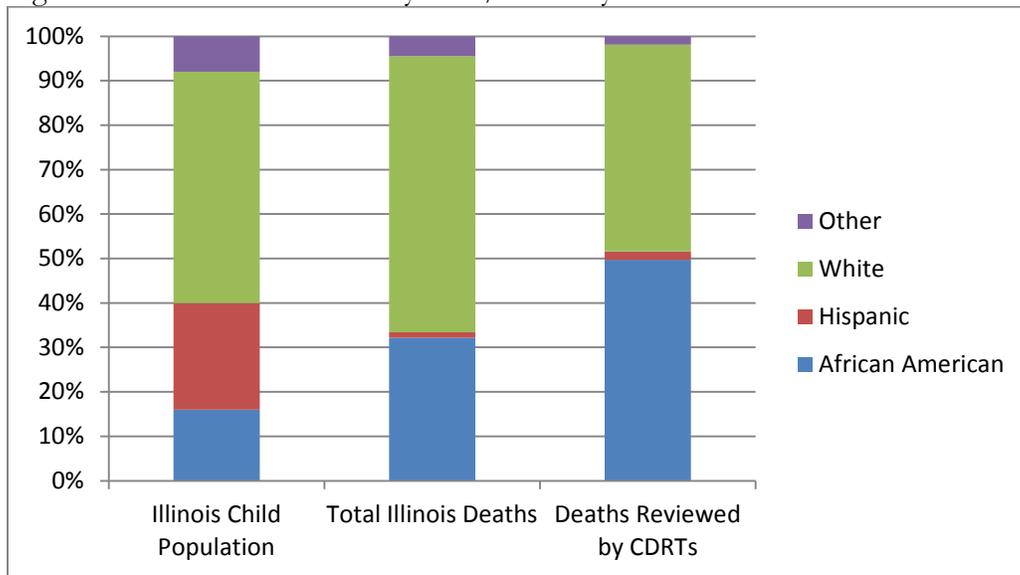
## Child Deaths by Race

In 2014, there were 3 million children 17 and younger in Illinois, of whom 52% were White, 24% were Hispanic, 16% were African American, and 8% were of another race/ethnicity (see Figure 6).<sup>7</sup>

However, when the total Illinois child deaths are examined by race, it is evident that African-American children are at higher risk of death when compared to their numbers in the general population: 26% of the children that died in 2014 were African-American compared with roughly 16% in the general child population. The proportion of deaths among Caucasian children (70% in 2014) was also higher when compared with their proportion in the general child population (52%). Conversely, deaths among Hispanic children (1% in 2014) were infrequent compared to their numbers in the general population (24%) (Figure 6).

Among the 154 child deaths reviewed by the CDRTs in 2014, 40% were African American children, which is larger than their proportion in the overall child population (16%) or the total child deaths that occurred in 2014 (26%) (see Figure 6).

Figure 6: Illinois Child Deaths by Race/Ethnicity



## Child Deaths by Category

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and “other” deaths. In this classification system, the category of death can be different from the proximal cause of death. For example, a child may have died of pneumonia (cause of death) that was the result of an earlier gunshot wound (category of death). By reviewing this death as a firearm death, the CDRT examining

<sup>7</sup> U.S. Census Bureau. (2010). Children characteristics 2010 – 2014 American Community Survey 5-year estimates. Retrieved from [http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_14\\_5YR\\_S0901&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S0901&prodType=table).

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 2014 are shown in Table 2. The majority of total child deaths were related to either premature birth (39%) or illness (32%). The other categories included firearms (7%), suffocation (5%), undetermined (5%), vehicular accidents (4%), injury (2%), drowning (2%), SUID (1%), fire (1%), poisoning/overdose (1%), and a few cases of SIDS and other types that accounted for less than 1% of the total deaths respectively. There were no deaths due to Sudden Unexplained Child Death (SUCD) and scalding burn in 2014.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Prematurity	572	39%	5	3%
Illness	478	32%	27	18%
Firearms	103	7%	8	5%
Suffocation	78	5%	30	19%
Undetermined	74	5%	22	14%
Vehicular	64	4%	10	6%
Injury	29	2%	18	12%
Drowning	26	2%	13	8%
SUID	21	1%	10	6%
Fire	14	1%	4	3%
Poison/Overdose	12	1%	4	3%
Other	4	<1%	3	2%
SIDS	1	<1%	0	<1%
SUCD	0	0%	0	0%
Scalding burn	0	0%	0	0%
Total	1476*	100%	154	100%

\*Note: there were 3 “pending” cases in total deaths at the time of the report.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 2). In 2014, deaths reviewed by CDRTs were most likely to be related to suffocation (19%), illness (18%), undetermined (14%), injury (12%), drowning (8%), vehicular (6%), and SUID (6%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

## Child Deaths by Manner

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

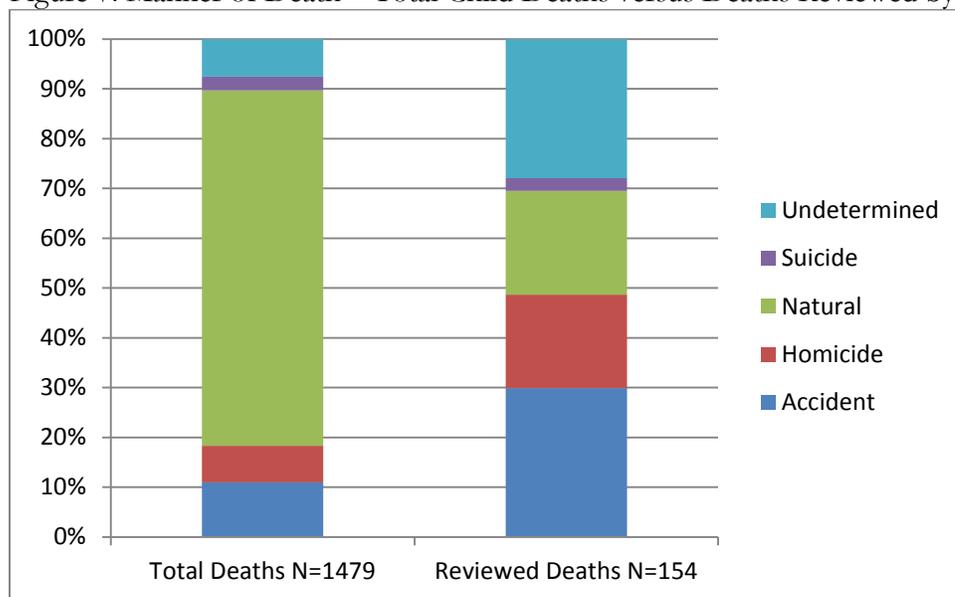
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death
- Suicide – the death was the result of an intentional, self-inflicted act committed to do self-harm or death
- Undetermined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

The majority of total child deaths in 2014 were attributable to natural causes (71%), and accidents accounted for 11% of the total child deaths. In addition, 7% were homicides, 3% were suicides, and 8% were undetermined. When compared to total child deaths, deaths reviewed by CDRTs are much more likely to be accidents (30%), undetermined (28%), and homicides (19%); and much less likely to be due to natural causes (21%) (see Table 3 and Figure 7).

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

	Total Deaths		Reviewed Deaths	
	N	Percent	N	Percent
Accident	162	11%	46	30%
Homicide	109	7%	29	19%
Natural	1055	71%	32	21%
Suicide	41	3%	4	3%
Undetermined	112	8%	43	28%
Total	1479	100%	154	100%

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



## Child Deaths by Category and Manner

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

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

Category of Death	Manner of Death					Totals
	Accident	Homicide	Natural	Suicide	Undetermined	
Prematurity	0	0	570	0	2	572
Illness	1	0	476	0	1	478
Firearms	1	80	0	21	1	103
Suffocation	51	5	2	16	4	78
Undetermined	0	0	0	0	74	74
Vehicular	54	4	0	2	4	64
Injury	10	16	0	0	3	29
Drowning	25	0	0	0	1	26
SUID	1	1	6	0	13	21
Fire	11	0	0	0	3	14
Poison/Overdose	7	1	0	2	2	12
Other	1 <sup>1</sup>	2 <sup>2</sup>	0	0	1 <sup>3</sup>	4
Pending	0	0	0	0	3	3
SIDS	0	0	1	0	0	1
Scalding burn	0	0	0	0	0	0
SUCD	0	0	0	0	0	0
Total	162	109	1055	41	112	1479

Note: <sup>1</sup> Hyperthermia; <sup>2</sup> Starvation; <sup>3</sup> Malnourished and failure to thrive

## Special Analysis: Homicide Deaths

There were 109 homicide deaths out of the 1,479 deaths in 2014. We know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. In addition, we know that 64% of homicides were youth age 15 to 17 and that 82% of the victims were male. Additional information on homicide deaths allows for a more complete understanding of the circumstances of these types of child deaths. The deaths are presented by frequency of homicide category.

Table 5: Homicide Deaths

Category	Age	Circumstance	Perpetrator
Firearms	4	Gunshot wound to head and abdomen	Unknown
	5	Gunshot wound to head	Unknown
	6	Gunshot wound to head	Unknown
	9	Multiple gunshot wounds	Unknown
	11	Gunshot wound to head	Unknown
	13	Gunshot wound to face	Unknown
	13	Gunshot wound to chest	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Gunshot wound to back	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Gunshot wound to trunk	Unknown
	15	Multiple shotgun wounds	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to head	Unknown
	15	Gunshot wound to abdomen	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to head	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to abdomen	Unknown
	15	Gunshot wound to head	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to head	Unknown
	15	Gunshot wound to chest	Unknown
	15	Multiple gunshot wounds	Unknown
	16	Gunshot wound to head	Unknown
	16	Gunshot wound to chest	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to head	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to head	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to head	Unknown
	16	Gunshot wound to head	Unknown
	16	Gunshot wound to back	Unknown
	16	Gunshot wounds to chest and abdomen	Unknown
	16	Gunshot wound to back	Unknown



	Infant	Craniocerebral injuries blunt force head trauma and thermal burns; child abuse	Paramour
	1	Subdural hematoma closed head injury assault; child abuse	Paramour
	1	Multiple inflicted injuries; child abuse	Paramour
	1	Multiple injuries of the head, chest, abdomen and back; blunt force trauma; child abuse	Paramour
	2	Multiple blunt force injuries; child abuse	Father
	2	Non-accidental blunt force head injuries	Unknown
	2	Homicidal violence; child abuse	Mother & paramour
	3	Multiple injuries; child abuse	Mother
	3	Stab wound to chest	Unknown
	3	Multiple injuries; child abuse and neglect	Father, mother, & cousin
	7	Multiple stab and incised wounds; child abuse	Father
	11	Multiple sharp force injuries; child abuse	Sister
	11	Peritonitis ruptured stomach blunt force trauma; child abuse	Mother & step father
Suffocation	Infant	Suffocation; child abuse	Step mother
	Infant	Asphyxiation; exposure to elements; child abuse and neglect	Mother
	1	Asphyxia suffocation; child abuse and neglect	Babysitter
	1	Seizure disorder hypoxic ischemic encephalopathy; suffocation in a car seat	Unknown
	17	Asphyxia strangulation	Unknown
Vehicular	Infant	Multiple traumatic injuries due to vehicle accident	Mother
	7	Multiple traumatic injuries due to vehicle accident	Unknown
	7	Intracranial and subdural hemorrhage closed head injury due to vehicular incident	Unknown
	16	Craniocerebral injuries due to vehicle accident	Unknown
Other	Infant	Starvation; child neglect	Mother
	6	Malnutrition starvation	Unknown
Poison/ overdose	2	Methadone ingestion; methadone toxicity; child abuse and neglect	Step father
SUID	Infant	Sudden unexpected death in infancy history of co-sleeping; child abuse and neglect	Mother & father

# Chapter 4: Child Deaths by Category

To gain a more complete understanding of child deaths in Illinois, the following sections present detailed analyses for the categories of death identified by the CDRT Executive Council. By examining the characteristics of the children who die from 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 2014 so that the most common categories of death are first. For each category section, the following information is presented:

- Category definition describes the types of deaths that are included.
- Background information provides national statistics or research findings, if available.
- Illinois data on total child deaths reported to the CDRTs.
- Numbers of deaths within each category over the past 10 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender and age of three groups: 1) the total child deaths, 2) deaths from a specific category, and 3) reviewed deaths from that category. There is no comparison across race/ethnicity within individual categories because of the data limitation.

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

# Premature Birth

## Definition

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

## Background

Premature birth is closely associated with low birth weight. 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. Preterm birth is often associated with low birth weight. Low birthweight (LBW), the second leading cause of infant mortality, is an indicator of child health (current and future) as well as maternal health. LBW babies are more likely than babies of normal weight to have health problems during the newborn period. LBW babies may be also at greater risk for health conditions such as diabetes and heart disease as adults<sup>8</sup>. Following many years of increases, the national preterm birth rate declined continuously, from 12.8% in 2006 to 11.4% in 2013.<sup>9</sup>

In Illinois, about 1 in 9 babies (11.7% of live births) was born preterm in 2013.<sup>10</sup> Between 2003 and 2013, the rate of infants born preterm in Illinois declined nearly 8%. The rate of preterm birth in Illinois is highest for African American infants (16.8%), followed by Native Americans (14.0%), Hispanic (12.1%), whites (10.5%), and Asians (10.5%).<sup>11</sup> A number of risk factors have been associated with preterm birth: maternal age, history of preterm birth, multi-fetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity, and elevated blood pressure.<sup>12</sup> Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

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<sup>8</sup> America’s Health Rankings (2015). A call to action for individuals and their communities. United Health Foundation (2014 Edition). Retrieved from <http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas%20Health%20Rankings%202014%20Edition.pdf>

<sup>9</sup> Federal Interagency Forum on Child and Family Statistics (2015). *America’s children: key national indicators of well-being, 2015*. Retrieved from <http://stacks.cdc.gov/view/cdc/32090>.

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

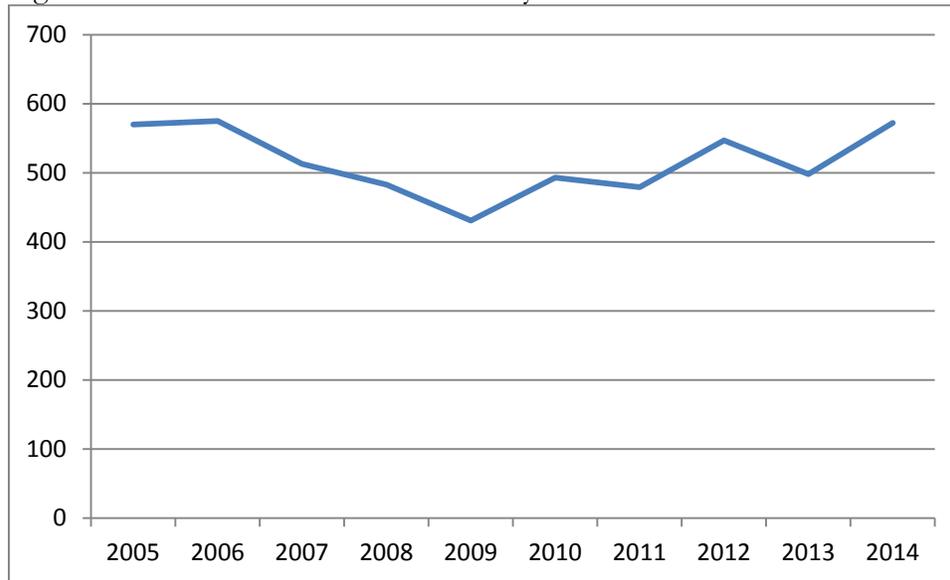
<sup>11</sup> National Center for Health Statistics. *Illinois prematurity data*. Retrieved from <http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4>.

<sup>12</sup> Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America’s health: State rankings, 2004 Edition*. United Health Foundation.

## Illinois Data – Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death and has either been the second largest or the largest category in the past 10 years (ranging from 431 to 575 deaths per year). There was a decreasing trend in deaths due to prematurity during 2005-2009, but the trend reversed after 2009(see Figure 8).

Figure 8: Child Deaths Due to Prematurity



Of the 1,479 total child deaths in 2014, 572 (39%) were related to premature birth.

- A slight majority of children who died from prematurity were boys (51%).
- Nearly all deaths (570) in this category were the result of natural causes, and only 2 deaths were undetermined.

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 5 of the 154 child deaths reviewed by CDRTs (3%) were related to premature birth.

- The majority (3) of the premature deaths reviewed by the CDRTs were males.
- 4 of the premature deaths reviewed by the CDRTs were the result of natural causes, and 1 was undetermined.

# Illness

## Definition

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

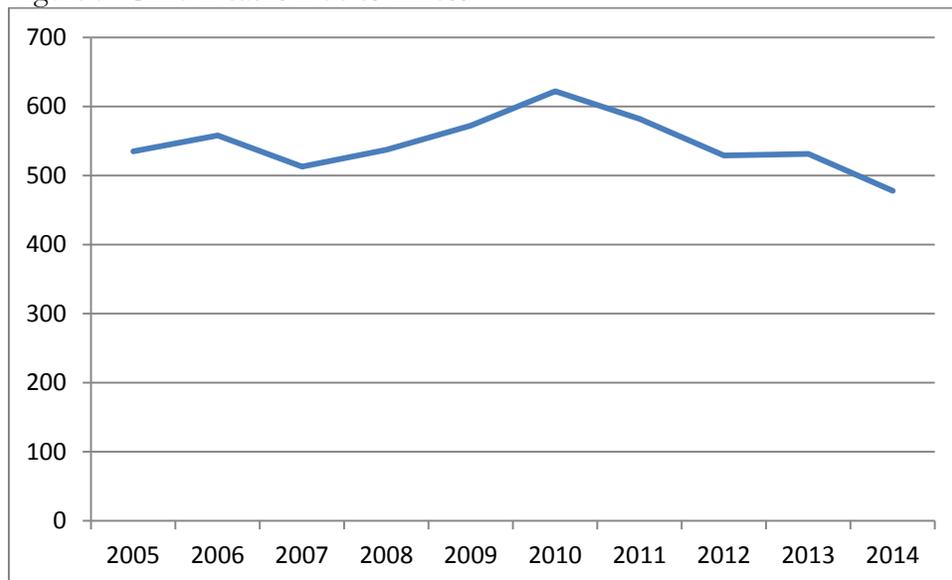
## Background

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

## Illinois Data – Total Child Deaths Reported to the CDRTs

For the past decade, illness has been one of the largest causes of child death. The number of deaths from illness peaked at 622 in 2010 and has since declined to 478 in 2014 (see Figure 9).

Figure 9: Child Deaths Due to Illness



In 2014, 478 of the 1,479 total child deaths (32%) reported to CDRTs were related to illness.

- A slight majority of children who died from illness were male (54%).

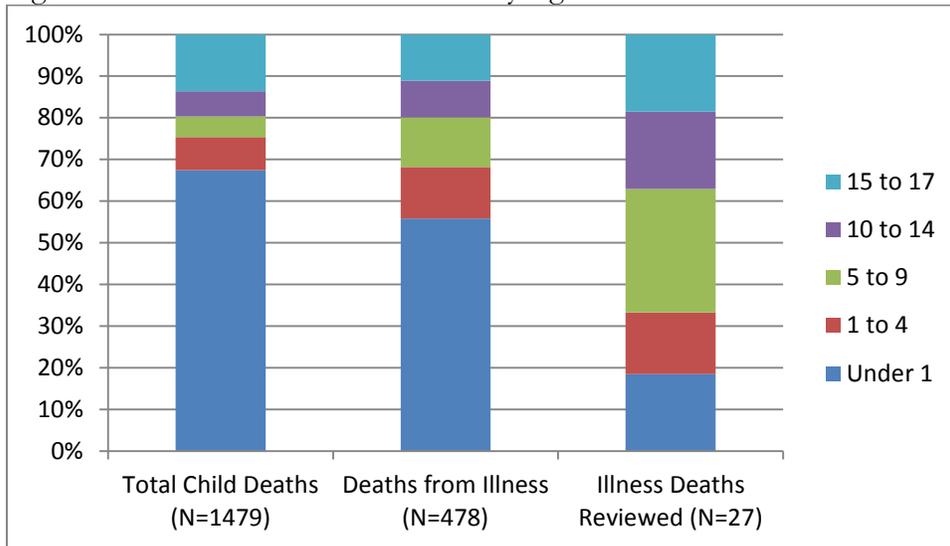
- A little more than half of deaths from illness were among children under the age of one (56%); 12% of deaths from illness occurred among children 1 to 4 years old, 12% occurred among children 5 to 9 years old, 9% occurred among children 10 to 14 years old, and 11% occurred among children 15 to 17 years old (see Figure 10).
- Over 99% of these deaths (476) were attributable to natural causes, except one death was due to accident and another one was due to undetermined causes.

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 27 of the 154 child deaths reviewed by the CDRTs (18%) were related to illness.

- Slightly more than half (56%) of the reviewed deaths related to illness were boys.
- Compared with total child deaths due to illness, infants under 1 year old (19%) were less likely to be reviewed, but children 5 to 9 years old (30%) were more likely to be reviewed (see Figure 10).
- All reviewed deaths that were categorized as illness were natural deaths.

Figure 10: Child Deaths Due to Illness by Age



# Firearm

## Definition

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

## Background

According to data from the Center for Disease Prevention and Control, 1,258 firearm deaths occurred in 2013 among children under 18 years of age in the United States.<sup>13</sup> The vast majority (68%) of these deaths were youth between the ages of 15 and 17. However, race of decedent is also a factor. In 2013, the homicide rate for African American male teens was more than 20 times higher than the rate for white male teens.<sup>14</sup>

Firearms include several manners of deaths. Suicides and homicides are the second and third leading causes of death, respectively, among teens age 15 to 19 (after unintentional injury). Firearms were the instrument of death in 87% of teen homicides and 42% of teen suicides in 2013. In two-thirds of the homicides, the murderer was over 18.<sup>15</sup> A recent national study from the *Journal of Pediatrics* found that the most-rural counties have virtually identical pediatric firearm mortality compared with the most-urban counties. The most-rural counties had higher rates of pediatric firearm suicide and unintentional firearm death but lower homicide rates when compared with the most-urban counties.<sup>16</sup>

## Illinois Data – Total Child Deaths Reported to the CDRT's

Child deaths from firearms steadily increased from 42 in 2005 to 83 in 2008 and have remained fairly level until 2012, but increased substantially in the past two years (see Figure 11).

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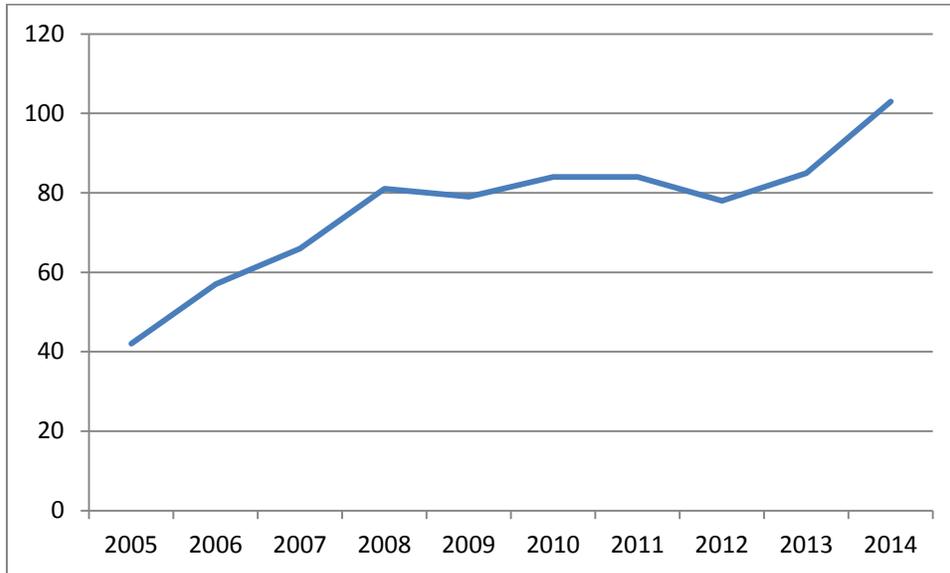
<sup>13</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2015). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

<sup>14</sup> Child Trends. (2015). *Teen homicide, suicide, and firearm deaths*. Retrieved from <http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths>

<sup>15</sup> Ibid.

<sup>16</sup> Nance, M. L., Carr, B. G., Kallan, M. J., Branas, C. C., & Wiebe, D. J. (2010). Variation in pediatric and adolescent firearm mortality rates in rural and urban US counties. *Pediatrics*, 125, 1112 -1118.

Figure 11: Child Deaths Due to Firearms



In 2014, 103 of the 1,479 total deaths (7%) were related to firearms.

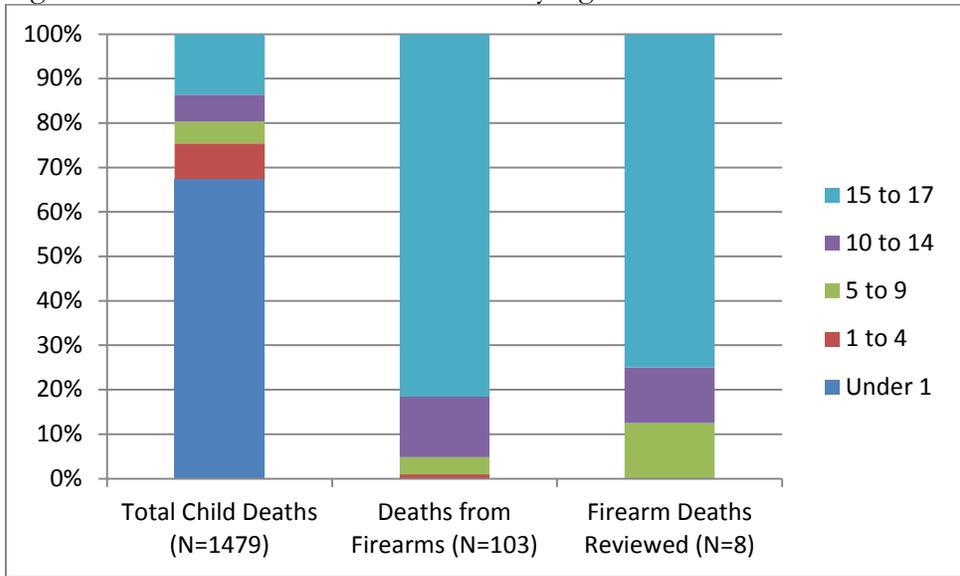
- Deaths due to firearms overwhelmingly occurred among boys (92%).
- Children between 15 and 17 years of age were largely over-represented in firearm deaths when compared to total child deaths. In 2014, 82% of firearm deaths occurred in children aged 15 to 17 (see Figure 12).
- Homicides accounted for 78% of the firearm deaths, suicides accounted for 20%, and accidents and undetermined causes accounted for the remaining 2%.

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 8 of the 154 deaths reviewed by the CDRTs (5%) were related to firearms.

- Nearly all reviewed deaths due to firearms were boys (7 deaths).
- The majority of firearm deaths reviewed by CDRTs involved youth 15 to 17 years old (6 deaths)(see Figure 12).
- The firearm deaths reviewed by CDRTs were mostly due to homicides (6 deaths), with the remaining due to suicide (1 death) and undetermined causes (1 death).

Figure 12: Child Deaths Due to Firearms by Age



# Suffocation

## Definition

Child deaths due to suffocation result from obstruction of the airway from a variety of causes. Deaths due to suffocation can be accidents, suicides, or homicides. Most unintentional or accidental suffocations are caused by:

- Choking – food or another small object blocks the internal airway.
- Positional asphyxia – a child’s external airway (i.e., nose and mouth) is blocked by objects or materials such as soft bedding, pillows, bumper pads, etc., or the child becomes wedged in a small space such as between a mattress and a wall or between couch cushions.
- Overlaying – a person sleeping with a child rolls onto the child and unintentionally suffocates the child.
- Confinement – a child is trapped in an airtight place such as an unused refrigerator.
- Strangulation – a rope, cord, or other object becomes wrapped around a child’s neck and restricts breathing.

When examining the information on child deaths due to suffocation, it is important to note that many medical examiners or coroners will not list an infant death as suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eyewitness account. If there is no such evidence, these types of suffocation deaths may be listed as unknown infant deaths, SIDS, or undetermined deaths. Thus, the actual number of deaths due to suffocation may be under-reported.

## Background

In 2013, 2,033 children ages 17 and under in the U.S. died from suffocation.<sup>17</sup> Of these children, 52% were less than one year of age and 61% were ages four and under. Accidental suffocation is the leading cause of injury-related death among infants less than one year old, and 70% of suffocation deaths among infants are from accidental suffocation or strangulation in bed.<sup>18</sup>

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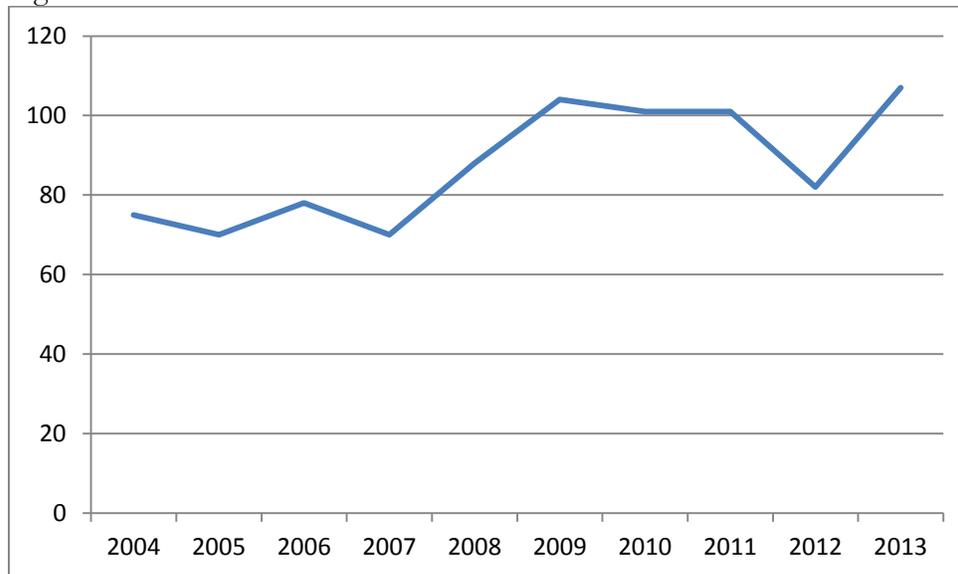
<sup>17</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2015). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

<sup>18</sup> Safe Kids Worldwide. (2015). *Suffocation Prevention and Sleep Safety*. Retrieved from <http://www.safekids.org/suffocation-prevention-and-sleep-safety>

## Illinois Data – Total Child Deaths Reported to the CDRTs

There has been a general upward trend in the number of deaths from suffocation in the past 10 years, with the peak occurring in 2014 (see Figure 13).

Figure 13: Child Deaths Due to Suffocation



In 2014, 78 of the 1,479 total child deaths reported to the CDRTs (5%) were related to suffocation.

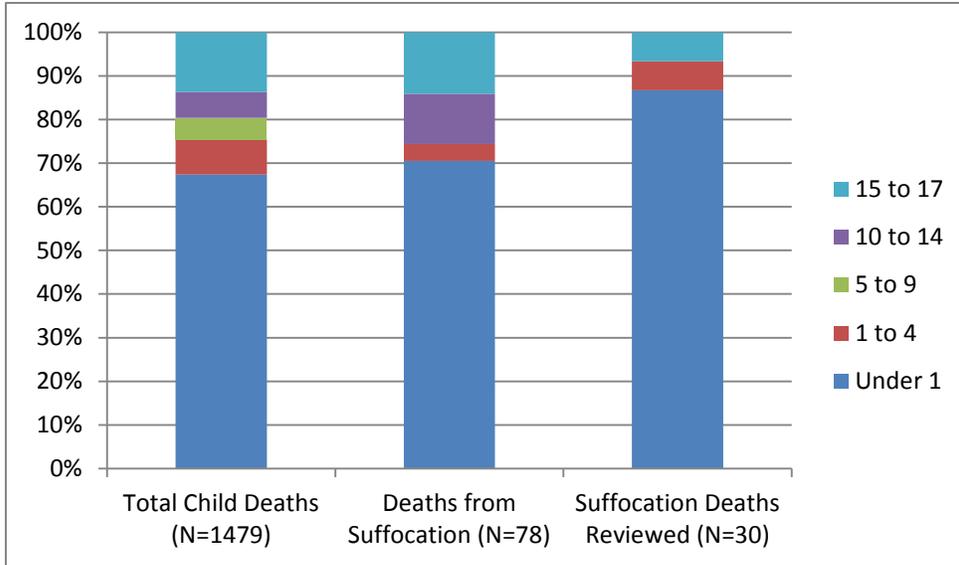
- The majority of children who died from suffocation were boys (60%).
- Infants under one year were the largest group in this category, accounting for 71% of the deaths (see Figure 14).
- The manner of the suffocation deaths varied: 65% were accidental, 21% were suicides, 6% were homicides, 5% were undetermined, and 3% were natural.

## Illinois Data – Deaths Reviewed by CDRTs

In 2014, 30 of the 154 deaths reviewed by CDRTs (19%) were related to suffocation.

- Slightly more than half (53%) of the reviewed suffocation deaths were boys.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (87%). Infant deaths were over represented in the reviewed child deaths due to suffocation, when compared to the proportion of total infant deaths due to suffocation in 2014 (see Figure 14).
- Most (70%) of the reviewed deaths due to suffocation were accidental.

Figure 14: Child Deaths Due to Suffocation by Age



# Undetermined Deaths

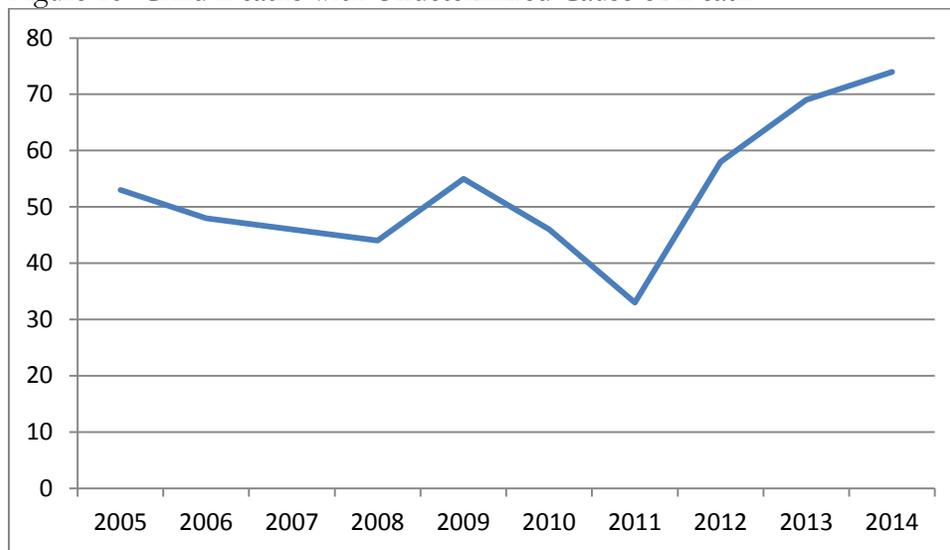
## Definition

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 CDRTs

The number of undetermined deaths for children dropped from 53 in 2005 to 33 in 2011, but there has been a significant increase in the number of undetermined deaths since 2011 (see Figure 15).

Figure 15: Child Deaths with Undetermined Cause of Death



In 2014, 74 of the 1,479 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

- Deaths due to undetermined causes were slightly more common for boys (61%).
- All deaths due to undetermined causes were children under the age of 1 (93%) and 1 to 4 years old (7%).

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 22 of the 154 deaths reviewed by CDRTs (14%) had an undetermined cause of death.

- The majority of reviewed deaths due to undetermined causes were boys (59%).
- All reviewed deaths due to undetermined causes were children under the age of 1 (82%) and 1 to 4 years old (18%).

# Vehicular Accident

## Definition

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

## Background

Nationally, a total of 939 children (under the age of 13) died in motor vehicle crashes in 2013.<sup>19</sup> The rate of motor vehicle crash deaths per million children under 13 has decreased 78% since 1975. In 2013, 68% of child motor vehicle crash deaths were passenger vehicle occupants, 22% were pedestrians, and 4% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 87% and 92%, respectively. Passenger vehicle child occupant deaths in 2013 were 54% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Fifteen percent of the passenger vehicle child occupant deaths in 2013 occurred in front seats, down from 46% in 1975. Seventy-five percent were in the rear, and the rest occurred in cargo or unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about 1 of every 4 unintentional injury deaths among children younger than 13. Most crash deaths occur among children traveling as passenger vehicle occupants, and proper restraint use can reduce these fatalities. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about three-quarters for children up to age 3, and almost half for children ages 4 to 8.<sup>20</sup>

A total of 2,524 teenagers ages 13 to 19 died in motor vehicle crashes in 2013. This is 71% fewer than in 1975 and 11% fewer than in 2012. About 2 out of every 3 teenagers killed in crashes in 2013 were males. In 2013, teenagers accounted for 9% of motor vehicle crash deaths. They comprised 9% of passenger vehicle (cars, pickups, SUVs, and vans) occupant deaths among all ages, 5% of pedestrian deaths, 3% of motorcyclist deaths, 10% of bicyclist deaths, and 15% of all-terrain vehicle rider deaths.<sup>21</sup>

In the United States, teenagers drive less than most adults but the oldest people, but their numbers of crashes and crash deaths are disproportionately high. In the United States, the fatal crash rate per mile driven for 16 to 19 year-olds is nearly 3 times the rate for drivers ages 20 and over. Risk is highest at ages 16 to 17. In fact, the fatal crash rate per mile driven is nearly twice as high for 16 to 17 year-olds as it is for 18 to 19 year-olds.<sup>22</sup>

Distracted driving is often the cause of fatal accidents. For teen drivers, the most common distraction is using a cell phone. Other common sources of distraction for teen drivers are

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<sup>19</sup> Insurance Institute for Highway Safety. (2015). *Fatality facts 2013: Children*. Retrieved from <http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety>.

<sup>20</sup> Ibid.

<sup>21</sup> Insurance Institute for Highway Safety. (2015). *Fatality facts 2013: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

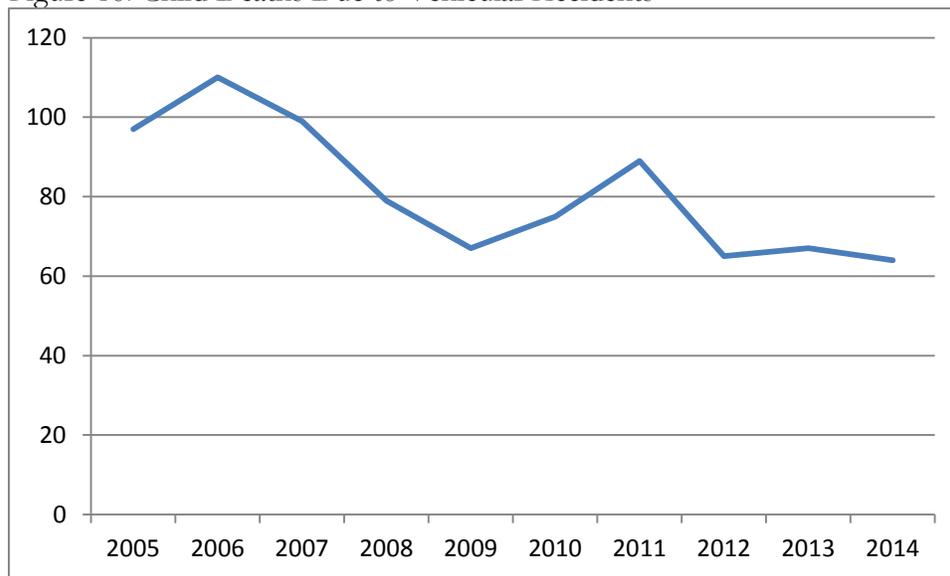
<sup>22</sup> Ibid.

riding with peers and drowsiness.<sup>23</sup> Another factor that affects teenage vehicular fatalities is inexperience. In order to address this, all states have adopted graduated licensing systems, which phase in full driving privileges. National studies of graduated licensing found that strong laws were associated with substantially lower fatal crash rates and substantially lower insurance claim rates among young teen drivers covered by the laws.<sup>24</sup>

## Illinois Data – Total Child Deaths Reported to the CDRTs

After dropping from a high of 110 vehicular deaths in 2006 to a low of 65 in 2012, the number of deaths due to vehicular accidents in 2014 remained similar to that of 2013 (see Figure 16).

Figure 16: Child Deaths Due to Vehicular Accidents



In 2014, 64 of the 1,479 total child deaths reported to the CDRTs (4%) were related to vehicular accidents.

- More boys (58%) had deaths related to vehicular accidents.
- Older children (15 to 17) made up the largest proportion of vehicular accident deaths (61%). Children of 5 to 14 years old accounted for 27% of the deaths, and the remaining 13% of the deaths were children 4 years old and younger (see Figure 17).
- A large majority (84%) of these deaths were accidental, and small portions were homicides (6%), undetermined (6%), and suicide (3%).

<sup>23</sup> Child Trends. (2015). *Distracted driving*. Retrieved from <http://www.childtrends.org/?indicators=distracted-driving>.

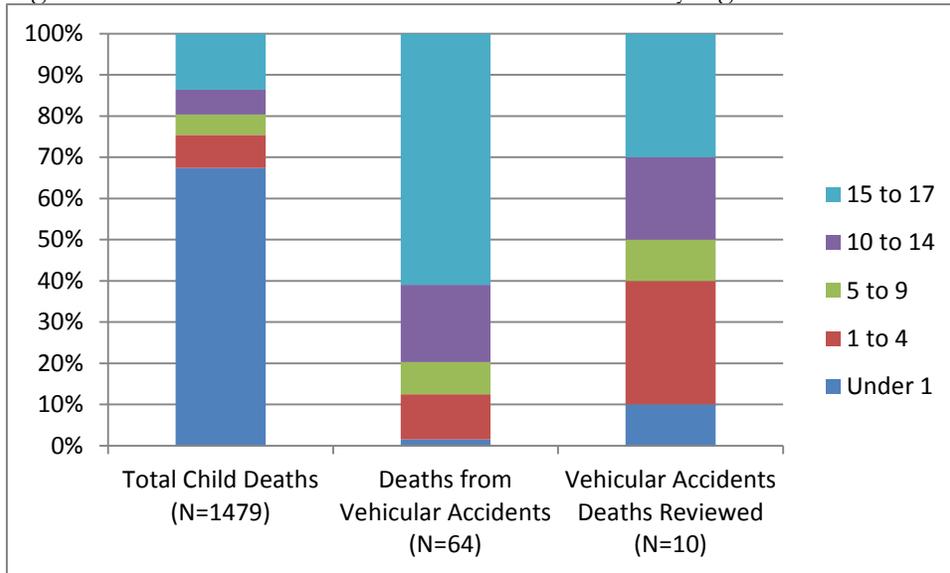
<sup>24</sup> Insurance Institute for Highway Safety. (2015). *Fatality facts 2013: Teenagers*. Retrieved from <http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers>.

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 10 of the 154 deaths reviewed by the CDRTs (6%) were related to vehicular accidents.

- 70% of the reviewed deaths in this category were males.
- The reviewed deaths related to vehicular accidents include 40% of 4 years old and younger, 30% of 5 to 14 years old, and 30% of 15 to 17 years old (see Figure 17).
- 70% of the reviewed deaths in this category were accidental.

Figure 17: Child Deaths Due to Vehicular Accidents by Age



# 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 2013, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,484 fatalities from child maltreatment. For FY 2013, a nationally estimated 1,520 children died from abuse and neglect at a rate of 2.04 per 100,000 children in the population. Younger children are the most vulnerable to death as the result of child abuse and neglect. Nearly three-quarters (73.9%) of all child fatalities were younger than 3 years and the child fatality rate mostly decreased with age. About four-fifths (78.9%) of child fatalities were caused by one or both parents.<sup>25</sup> Of the children who died, 71.4% suffered neglect and 46.8% suffered physical abuse either exclusively or in combination with maltreatment type.<sup>26</sup>

## Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries fluctuates from year to year, with no clear increasing or decreasing trend (see Figure 18).

Figure 18: Child Deaths Due to Injuries



<sup>25</sup> U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2015). *Child maltreatment, 2013*. Washington, DC: Government Printing Office. Retrieved from <http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf#page=15>.

<sup>26</sup> Ibid.

In 2014, 29 of the 1,479 total child deaths reported to the CDRTs (2%) were related to injuries.

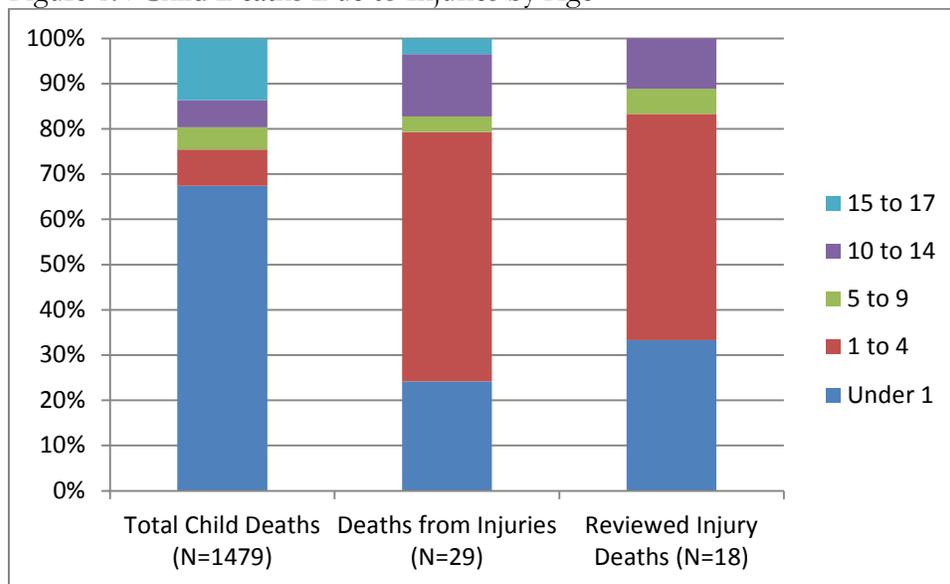
- 55% of decedents from injuries in 2014 were male.
- Younger children were more vulnerable to death from injuries: 79% of injury deaths were among infants and children 1 to 4 years old (see Figure 19).
- The majority (55%) of the injury deaths were due to homicides, with the remaining due to accidents (34%) and undetermined causes (10%).

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 18 of the 154 deaths reviewed by the CDRTs (12%) were related to injuries.

- 56% of the reviewed injury deaths were male.
- The vast majority (83%) of the reviewed cases involved young children 4 years and under (see Figure 19).
- Most (78%) of the reviewed injury deaths were due to homicides, with the remaining due to accidents (11%) and undetermined (11%).

Figure 19: Child Deaths Due to Injuries by Age



# Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)<sup>27</sup>

## Definition

According to Center for Disease Control (CDC),<sup>28</sup> each year in the United States, about 4,000 infants die suddenly and unexpectedly. These deaths are called Sudden Unexpected Infant Deaths (SUID). Half of the SUID deaths are due to Sudden Infant Death Syndrome (SIDS), which is defined as the sudden death of an infant that cannot be explained after a thorough investigation is conducted that includes a complete autopsy, examination of the death scene, and review of the clinical history. Another type of SUID is unknown cause death, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted and cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of “suffocation” in the report.

## Background

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

A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.<sup>29</sup>

Exposure to secondhand smoke is a factor that increases the probability of SIDS. Since 2005, the percentage of children ages 0 to 6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, the percentage of children ages 0 to 6 living in homes where someone smoked regularly was 6%, compared with 27% in 1994.<sup>30</sup>

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<sup>27</sup> In previous CDRT reports (2007-2008) SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Center for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained.

<sup>28</sup> Center for Disease Control and Prevention. (2015). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Retrieved from <http://www.cdc.gov/sids/>.

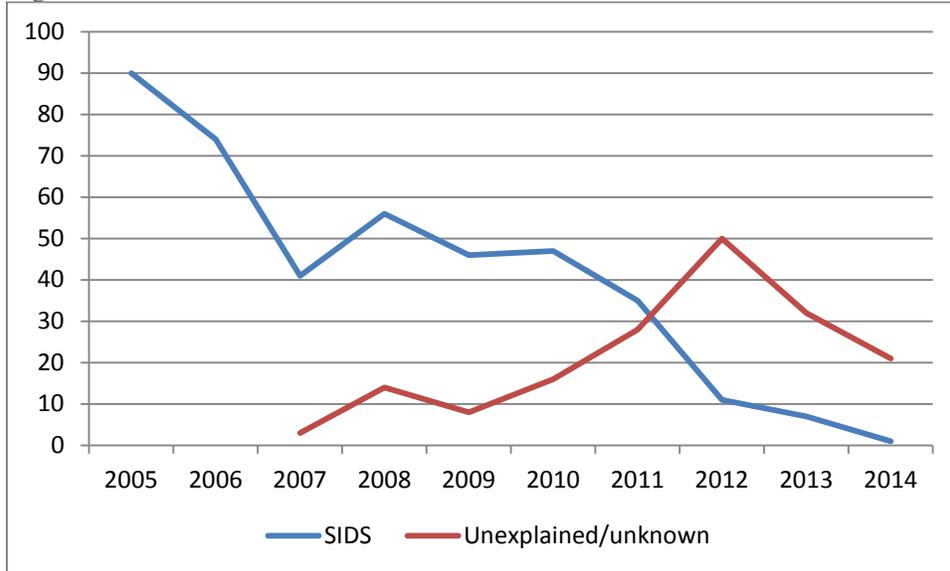
<sup>29</sup> Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, 163, 762-769.

<sup>30</sup> Federal Interagency Forum on Child and Family Statistics (2015). *America's Children: Key National Indicators of Well-Being, 2013*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://childstats.gov>.

## Illinois Data – Total Child Deaths Reported to the CDRTs

Since the peak of 2005, SIDS has generally experienced a sharp decline, with the lowest number of SIDS deaths in 2014 (see Figure 20). Infant deaths from SUID were added as a category in 2007, and child deaths due to SUID have increased from 11 in 2007 to 50 in 2012. However, the SUID also continues a sharp decline since 2013.

Figure 20: Child Deaths Due to SIDS and SUID



In 2014, 1 of the 1,479 total child deaths reported to the CDRTs (<1%) were related to SIDS, and 21 deaths (1%) were categorized as SUID.

- The 1 death related to SIDS was a girl, and the majority (57%) of the deaths related to SUID were boys.

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, none of the 154 deaths reviewed by the CDRTs was related to SIDS and 10 were from SUID.

- Half of the reviewed SUID cases were boys.

# Drowning

## Definition

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

## Background

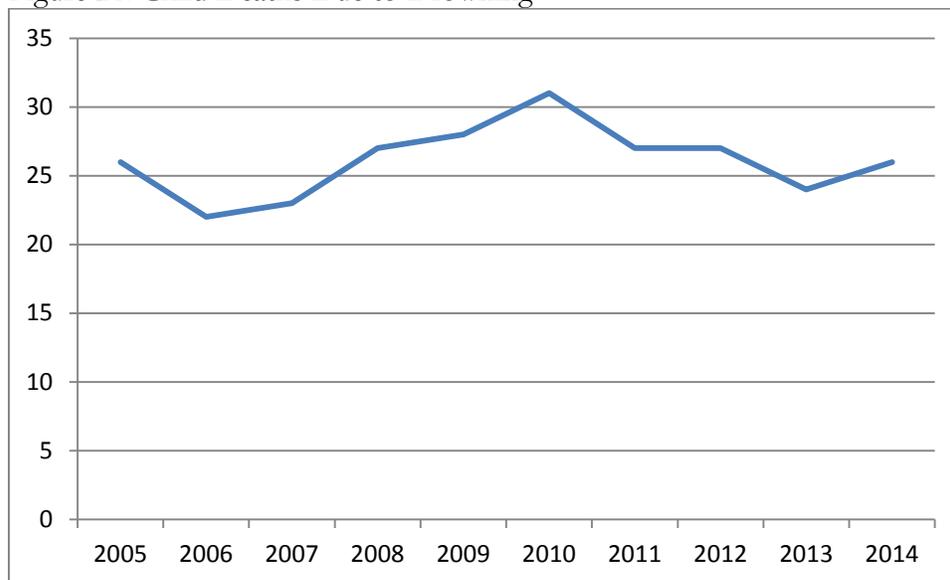
In 2013, 804 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 55% of these deaths.<sup>31</sup>

The majority of infant drowning deaths happen in bathtubs or large buckets. Swimming pools are the most common site for a drowning to occur among children between the ages of 1 and 4 years, and about 3/4 of pool submersion deaths occur at a home. African American children ages 5 to 14 years old have a drowning rate 2.8 times greater than that of white children.<sup>32</sup>

## Illinois Data – Total Child Deaths Reported to the CDRTs

Since 2005, there have been between 22 and 31 deaths from drowning per year (see Figure 21).

Figure 21: Child Deaths Due to Drowning



<sup>31</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2015). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from [http://www.cdc.gov/injury/wisqars/fatal\\_injury\\_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html).

<sup>32</sup> Safe Kids Worldwide. (2015). *Swimming and Boating Safety Fact Sheet 2015*. Retrieved from <http://www.safekids.org/fact-sheet/swimming-and-boating-safety-fact-sheet-2015-pdf>.

In 2014, 26 of the 1,479 total child deaths reported to the CDRTs (2%) were related to drowning.

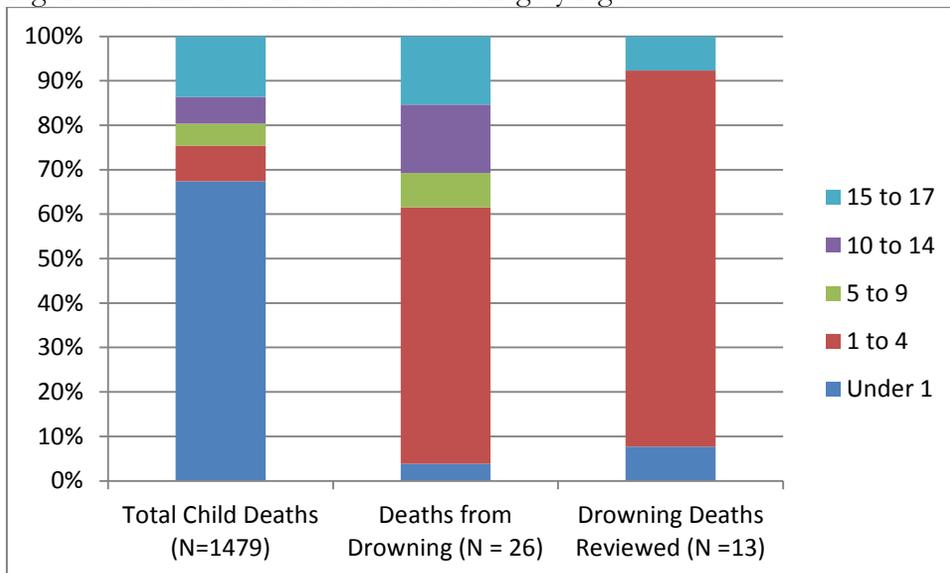
- More boys (62%) died from drowning than girls.
- Children 4 years old and under accounted for 62% of the deaths, children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 8%, 15%, and 15% of deaths due to drowning respectively (See Figure 22).
- Most of the drowning deaths were accidental (96%), and the rest were undetermined (4%).

## Illinois Data – Deaths Reviewed by the CDRTs

In 2014, 13 of the 154 reviewed deaths (8%) were related to drowning.

- Most (54%) of the reviewed drowning deaths were male.
- Most (93%) of the reviewed deaths related to drowning occurred among children 4 years old and younger, with the remaining (7%) at the age of 15 to 17 years old (See Figure 22).
- Most (92%) of the reviewed drowning deaths were due to accidental causes.

Figure 22: Child Deaths Due to Drowning by Age



# Fire

## Definition

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

## Background

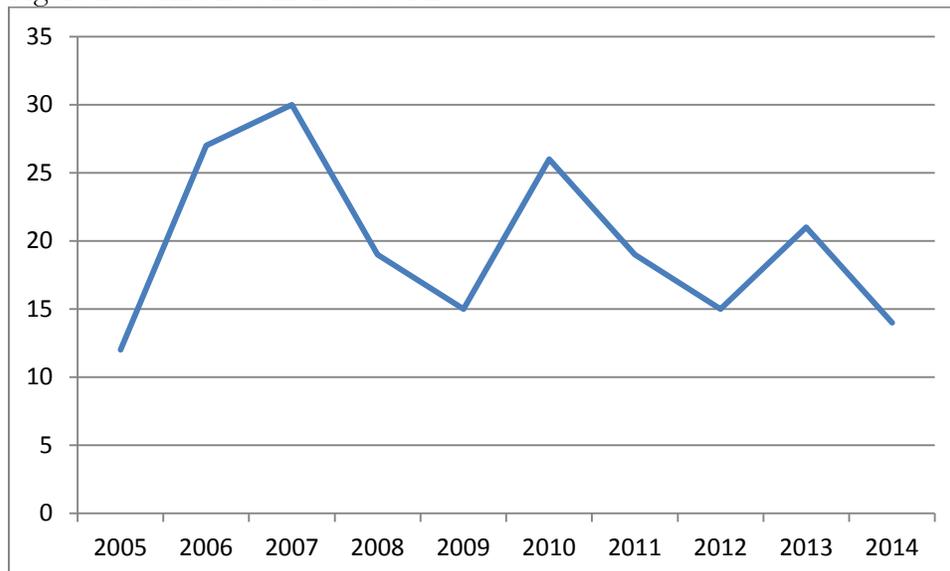
In the United States, fire and burns were the cause of 348 deaths among children between 0 and 17 years in 2013. Forty seven percent of fire deaths occurred in children 4 and under.<sup>33</sup> Death rates per million among children 14 and under has decreased 51% from 2004-2013.<sup>34</sup>

Home fires account for 87% of all fire-related fatalities in 2013. Working smoke alarms reduce the chances of dying in a fire by nearly 50%.<sup>35</sup>

## Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from fire have fluctuated over the decade from 2005 to 2014, typically falling between 15 and 25 (see Figure 23).

Figure 23: Child Deaths Due to Fire



<sup>33</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2015). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

<sup>34</sup> U. S. Fire Administration, (2015). *Child Fire Death Rates and Relative Risk (2004-2013)* Retrieved from [http://www.usfa.fema.gov/statistics/estimates/trend\\_child.shtm](http://www.usfa.fema.gov/statistics/estimates/trend_child.shtm).

<sup>35</sup> Safe Kids Worldwide. (2015). *Fire safety*. Retrieved from <http://www.safekids.org/fire>.

In 2014, 14 of the 1,479 total child deaths reported to the CDRTs (1%) were related to fires.

- There were slightly more boys (57%) that died from fire.
- Children 4 years old and younger accounted for 57% of deaths due to fire, and children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 14%, 21%, and 7% of deaths due to fire respectively.
- The majority of deaths (79%) attributable to fire were accidental, and 21% were undetermined.

## **Illinois Data – Deaths Reviewed by the CDRTs**

In 2014, 4 of the 154 deaths reviewed by CDRTs were related to fires (3%).

- 2 of the decedents were boys.
- All of the decedents were children 1 to 4 years old.
- 2 of the reviewed deaths were due to accidents, and another 2 were due to undetermined causes.

# 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 2013, 349 children under 18 years died of poisoning in the United States.<sup>36</sup> The majority of these deaths occurred in children 15 to 17 years of age (60%). The age group with the second most frequent number of deaths by poisoning was children under 4 (25%), with children between 4 and 15 accounting for 15% of poisoning deaths.

Each year 60,000 U.S. children are treated in emergency departments for unintentional medication exposure or overdose. For children under five, 95% of these visits are caused by accidental ingestion of medications, and 5% are dosing errors.<sup>37</sup> The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

## Illinois Data – Total Child Deaths Reported to the CDRTs

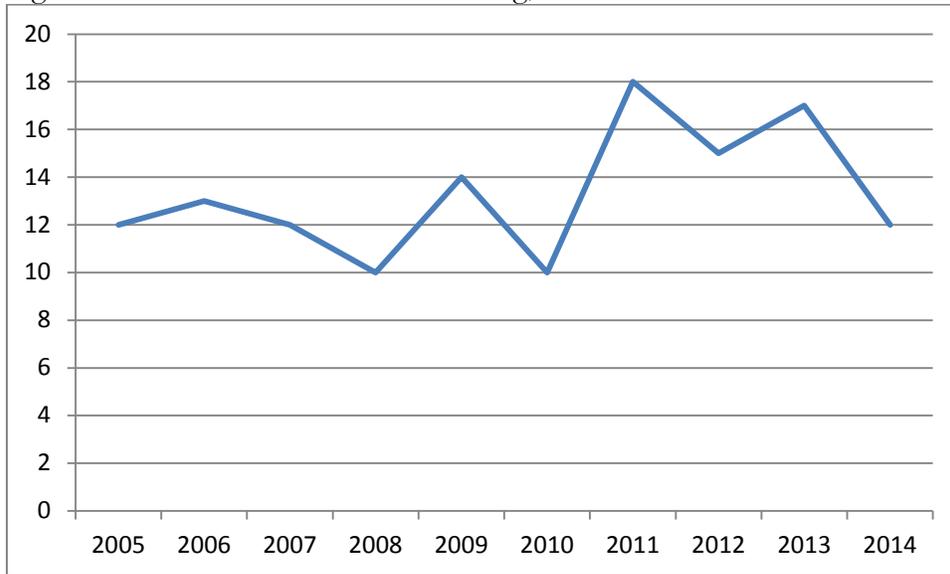
Between 10 and 18 children died from poisoning per year since 2005, and there is no clear pattern over time (see Figure 24).

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<sup>36</sup> Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2015). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>.

<sup>37</sup> Baker JM, Mickalide, AD. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on safe medication*. Washington, DC: Safe Kids Worldwide.

Figure 24: Child Deaths Due to Poisoning/Overdose



In 2014, 12 of the 1,479 total child deaths reported to the CDRTs (1%) were related to poisonings or overdoses.

- Girls (58%) were slightly more likely to die from poisoning or overdose than boys.
- 9 of the deaths (75%) were children of 15 to 17 years old, and 3 deaths were children of 1 to 4 years old.
- 7 of the deaths (58%) were determined to be accidents, 1 death was a homicide, 2 were suicides, and 2 were undetermined.

### **Illinois Data – Deaths Reviewed by the CDRTs**

In 2014, 4 of the 154 deaths reviewed by the CDRTs were related to poisoning/overdose.

- The majority (3 deaths) of the decedents were girls.
- The majority (3 deaths) of the decedents were children of 1 to 4 years old.

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

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

## **Scalding Burn**

There was no scalding burn death in 2014.

## **Sudden Unexplained Child Death (SUCD)**

There was no SUCD in 2014.

## **Other**

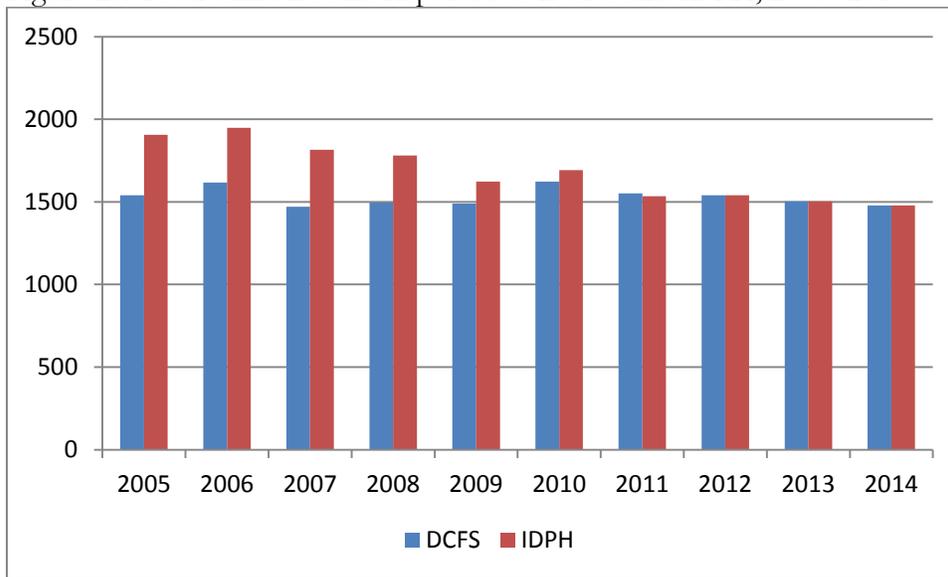
As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2014, 4 deaths fell in this category and 3 of them were reviewed.

## Chapter 5: Trends in Illinois Child Deaths

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

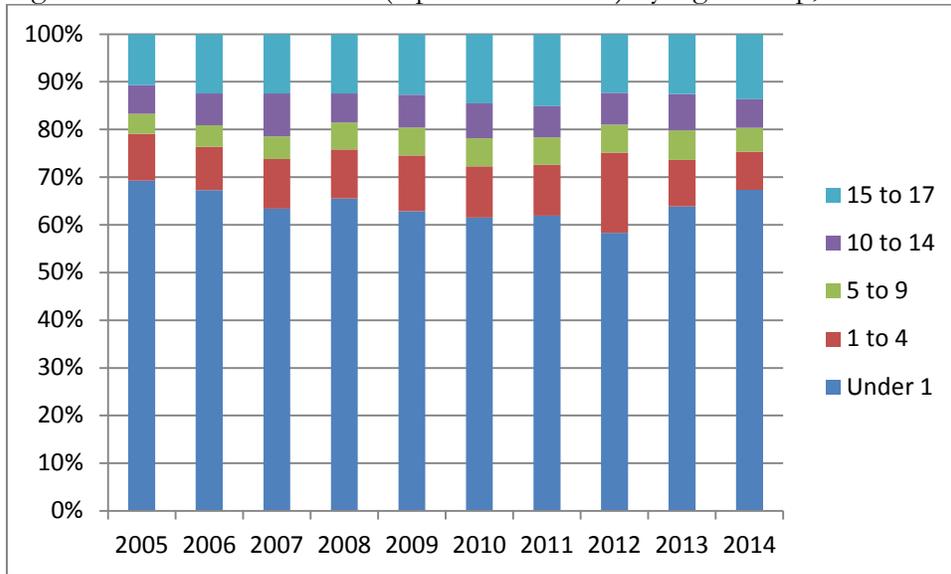
The total number of deaths in Illinois (reported by IDPH before 2012) the CDRTs have tracked has generally declined from 1,906 in 2005 to 1,479 in 2014 (see Figure 25).

Figure 25: Total Child Deaths Reported to DCFS and IDPH, 2005–2014



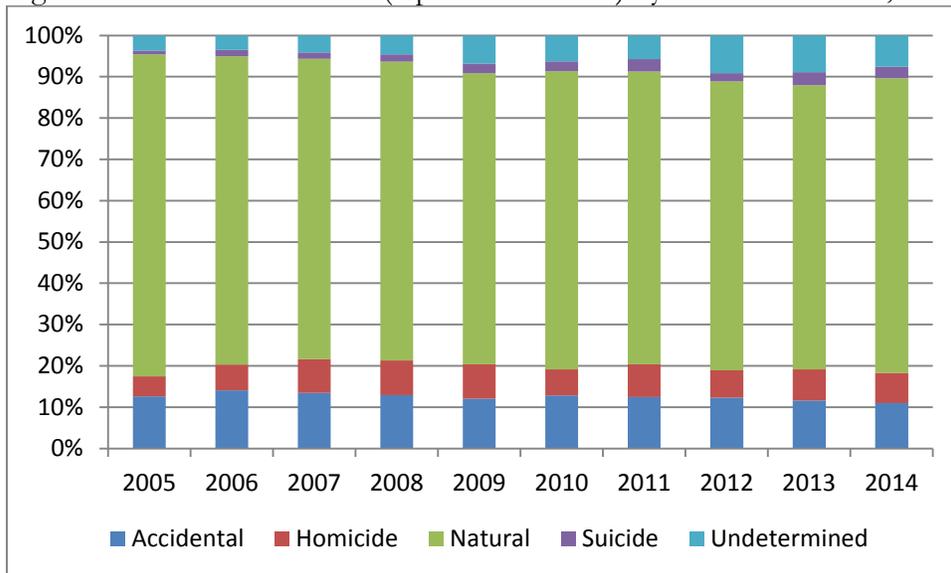
The total child deaths reported to the Child Death Review Team Unit from 2005 to 2014 is broken down by age group in Figure 26. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of 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 26 shows, the percentage of total deaths in each age group is generally stable over the 10 year period: infants under 1 year comprise 58-69% of all child deaths, children between 1 and 4 years comprise 9-17%, 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%.

Figure 26: Total Child Deaths (reported to DCFS) by Age Group, 2005–2014



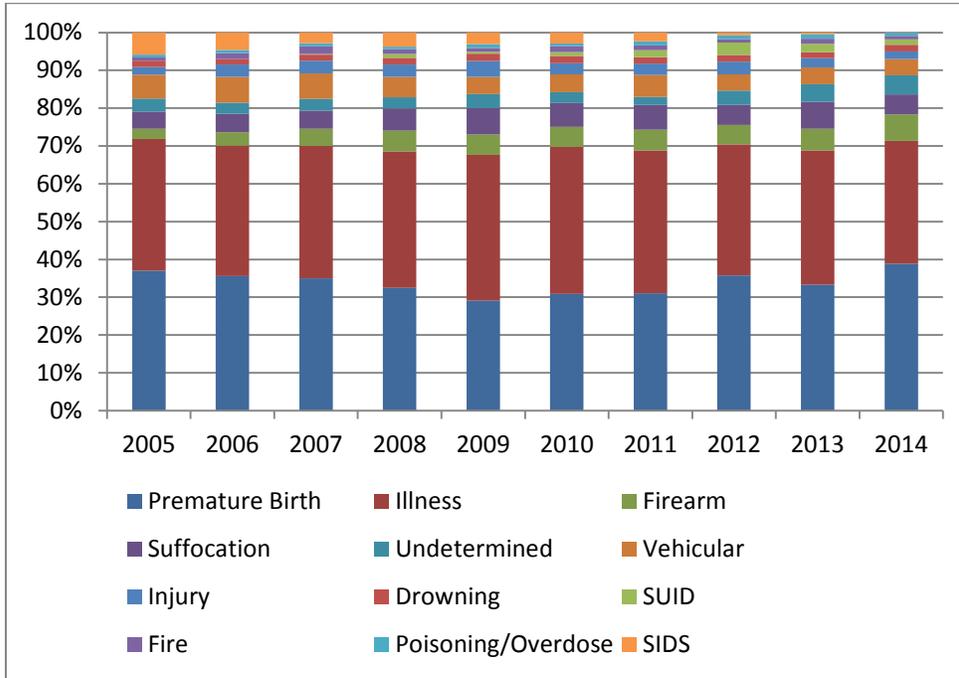
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 69-78% natural, 1-3% suicide, and 4-9% undetermined (see Figure 27).

Figure 27: Total Child Deaths (reported to DCFS) by Manner of Death, 2005–2014



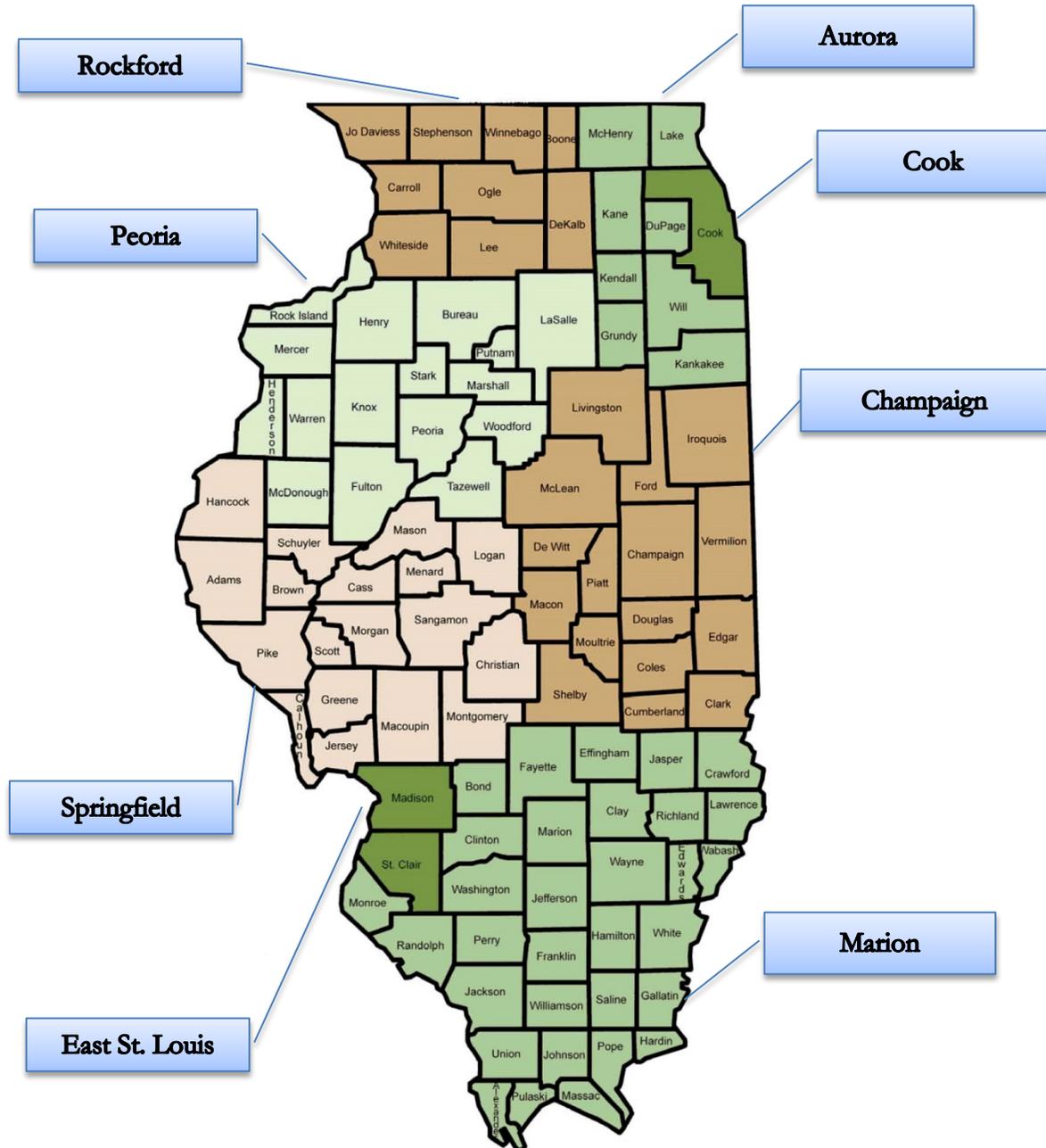
A similar analysis was done for category of death (see Figure 28). The overall percentage of child deaths related to each category of death remained relatively stable across the time periods. In order to see changes within category, please refer to charts for specific categories in Chapter 4.

Figure 28: Total Child Deaths (reported to DCFS) by Category, 2005–2014<sup>38</sup>



<sup>38</sup> Notice that 4 rare categories are not included in this chart: pending, other, scalding burn, and SUCD.

# Appendix A – Child Death Review Team Regional Map



# Appendix B – List of CDRT Members by Region

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## Aurora

Myra West, PsyD, **Chairperson**  
Jody Gleason, **Vice-Chairperson**  
Cathleen De La Mar  
Patrick Dempsey  
Carmel Finnegan  
Mary E. Jones, MD, MPH  
Dawn Livorsi, LCSW  
Jeff Parsons  
Loren Richardson Carrera  
Anne Strickland  
Dan Thomas  
DCFS Staff – Carole Ruzicka

## Champaign

Lawrence Solava, **Chairperson**  
Donald F. Davison, Jr., MD, **Vice-Chairperson**  
Kathleen Carney Buetow, MD  
Kim Cessna  
Jackie Dever  
Kimberly S. Fitton  
Doey Gordon  
Lise Jankowski, RN  
Patricia Metzler, RN, TNS, SANE – A & P  
Alex F. Meyer, Sgt.  
Susan Elaine Minyard, PhD  
Duane Northrup  
Judy Osgood, PhD  
James Owens  
Cindy Patterson  
Jamie Perry  
Rush Record  
Julie Runyon  
Bryant Seraphin, Lt.  
DCFS Staff – Maria Miller

## Cook Team A

Joan M. Pernecke , **Chairperson**  
Kristen Bilka, MMS, PA-C, **Vice-Chairperson**  
Ponni Arunkumar, MD  
John Brassil  
Anne Chambers, Sgt.  
Felicia Clark  
Stephanie Cornette, PC, PsyD  
Anne Devaud, PsyD  
Kristin Escobar-Alvarenga, MD  
Jill Glick, MD  
Gabriela Lagos, LCPC  
Eileen Payonk  
Char Rivette  
Norell Rosado, MD  
Kimberly Souder  
Kelley Thornton  
Dion Trotter  
Kavita Vankineni, MD  
Latanja Watkins, MD  
Syed Zaheer  
Yvonne M. Zehr  
Virginia Zic-Schlomas, Sgt.  
DCFS Staff – Ann Marakis

**Cook Team B**

Diane Scruggs, **Chairperson**  
Kathy Grzelak, MA, LCPC, **Vice-Chairperson**  
Sweety Agrawal, PsyD  
James R. Burton  
George Canellis  
Karla Chaplin, Sgt.  
Eric Eason, MD  
Angela Evans, MPH, RN, BSN  
Lindsay Forrey, LCSW  
Marjorie Fujara, MD, FAAP  
Trenton Hubbard, MD  
Mary Joly Stein  
Tracy Kruger, RN, CPNP-PC  
Michele Lorand, MD  
Denika Means, MD  
Edward Nowak  
Theresa Olson  
Evelyn Polk-Green, M.S.ED.  
Veena Ramaiah, MD  
Benjamin Soriano, MD  
Annie Torres, MD  
Valencia Williams, PsyD  
Eimad Zakariya, MD  
DCFS Staff – James Robinson

**East St. Louis**

Daniel Cuneo, PhD, **Chairperson**  
Carole A. Presson, Lt., **Vice-Chairperson**  
David Bivens, Sgt.  
Cathy Daesch, ATR-BC, LCPC, ICDVP  
Judy Dalan  
Joseph Edwards, Chief  
Beth Horner, PhD  
Carolyn Hubler  
Gilda Johnson  
Francis Jones, RN  
David C. Norman, MD  
Lynn Shelton, RN  
DCFS Staff – Valda Haywood

**Marion**

Chad Brown, Sgt., **Chairperson**  
Mary Louise Cashel, **Vice-Chairperson**  
Leah Brown  
Tambra Cain  
Kathy Clark  
Jessica Cullum  
Scott Deming, Sgt.  
Connie Edgar  
Jay Goble  
Chris March  
Michael S. O’Leary, Lt.  
Jamie Penrod  
Melissa Presser  
Linda Reiss  
Kathy Swafford, MD  
Dawn Tondini  
Steve Webb, PhD  
Sheryl L. Woodham, MSW, LCSW  
DCFS Staff – Bob Cain

**Peoria**

Ruth Lane, **Chairperson**  
Judy Guenseth, **Vice-Chairperson**  
America Bunker, RN  
Jerry Brady  
Susan Bordenave-Bishop, MD  
Gregg M. Cavanaugh, M/Sgt.  
Stefanie Clarke, BSN, RN, CPEN  
Cindy Fisher  
Marcy O'Brien  
Channing Petrak, MD  
Juli Smith, MSW  
Michele Verda, PhD  
Timothy Wilkins  
DCFS Staff – Jim Marmion

**Rockford**

Joanna Deuth, **Chairperson**  
Dave Watson, **Vice-Chairperson**  
Pamela A. Borchardt  
Amy Buchenau  
Raymond Davis, Jr., MD  
David Glessner  
Leah Hantke, RNC, MS, WHNP  
Marilyn Hite Ross  
Nicole Luster  
Angela Mathews  
Rachel McIntyre  
Holly Peifer  
Pam VanderVinne, RN/CMC  
Rebecca Wigget  
DCFS Staff – Angela Harris

**Springfield**

John C. Milhiser, **Chairperson**  
Cinda Edwards, **Vice-Chairperson**  
Careyana Brenham, MD  
Roy Harley  
John Hayes  
Shirley Johnson  
Stephanie Lake  
Dana Oltmanns  
Nathaniel Patterson, MD  
Lindsey Reichert  
Jim Stone  
John Yard  
DCFS Staff – Jason Cummins

## Appendix C – Illinois Child Deaths by County

County	2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths	2014 Deaths
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH*	DCFS	IDPH*	DCFS	IDPH*	CDRTs**	CDRTs**	CDRTs**
Adams	1	8	8	11	1	10	6	5	6	5	4	3	9	5	9
Alexander	0	1	0	1	0	1	1	1	0	2	0	0	1	0	0
Bond	0	0	0	0	1	1	0	0	0	1	2	2	4	1	0
Boone	0	0	0	0	0	3	3	3	1	1	4	2	3	0	1
Brown	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0
Bureau	2	4	2	2	1	2	5	5	6	5	1	1	2	1	3
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	1	1	0	0	0	1	1	1	2	2	0	0	1	0	1
Cass	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0
Champaign	32	47	3	39	21	36	42	36	36	33	43	37	29	49	38
Christian	2	2	0	0	3	4	4	4	4	3	3	2	2	1	1
Clark	1	1	0	0	1	1	0	0	0	1	2	2	1	3	0
Clay	0	0	0	0	0	1	0	0	1	1	0	0	1	1	0
Clinton	0	3	0	3	3	4	1	1	3	3	2	1	1	3	0
Coles	0	8	0	3	0	4	3	5	5	2	5	6	4	4	4
Cook	1,014	1,141	926	1,066	908	1,010	768	832	887	920	857	824	857	775	815
Crawford	0	1	0	1	1	1	0	0	2	1	2	1	4	4	0
Cumberland	1	1	0	0	3	2	2	3	2	2	0	0	1	0	0
DeKalb	1	14	4	5	3	3	5	3	4	3	5	5	4	9	7
Dewitt	0	2	0	1	0	0	2	2	0	0	1	1	0	0	3
Douglas	0	0	0	0	0	0	0	0	1	1	1	1	1	0	1
Dupage	93	95	97	99	76	81	65	62	89	76	73	68	66	70	80
Edgar	2	3	0	1	1	2	0	0	0	0	1	1	1	1	1
Edwards	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Effingham	3	4	0	7	5	6	1	1	0	1	8	7	2	7	5
Fayette	0	1	0	1	0	0	0	0	1	0	1	1	0	2	3
Ford	1	1	1	1	3	3	1	0	1	1	0	0	1	2	1
Franklin	1	0	3	3	3	3	4	4	5	3	2	1	0	2	4
Fulton	2	2	5	5	0	0	3	4	4	4	0	0	3	0	0
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Greene	0	1	0	0	0	1	0	0	0	1	0	1	0	0	1
Grundy	2	3	0	5	3	4	3	4	5	5	3	2	3	2	1
Hamilton	3	3	1	1	3	3	0	0	1	1	1	1	1	2	0
Hancock	0	1	0	0	0	2	2	1	0	0	1	1	0	1	3
Hardin	0	0	0	1	0	0	0	0	2	2	1	2	1	1	1
Henderson	0	3	0	0	0	0	0	1	0	0	0	0	0	0	0
Henry	1	1	4	4	2	2	2	3	4	4	4	2	2	3	3
Iroquois	0	0	0	2	0	1	0	0	3	3	1	1	1	1	0
Jackson	0	4	3	4	8	8	9	8	4	5	8	6	16	2	5
Jasper	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0
Jefferson	1	2	0	3	1	4	1	1	9	9	7	6	2	6	4
Jersey	0	1	1	3	0	2	0	0	1	2	2	3	4	2	0

Jo Daviess	3	3	0	1	0	0	0	0	0	0	4	4	0	1	0
Johnson	0	1	1	0	0	0	0	2	0	3	0	3	2	0	0
Kane	44	61	37	46	59	57	55	53	44	41	45	42	42	42	44
Kankakee	14	14	9	9	8	13	5	5	8	8	8	8	12	10	10
Kendall	1	1	6	6	6	6	2	2	1	1	1	1	2	3	2
Knox	5	5	3	3	4	4	2	2	7	8	10	10	3	4	6
Lake	35	58	17	37	26	38	34	47	31	47	35	40	33	37	36
LaSalle	0	9	0	8	0	9	7	7	8	9	9	8	11	8	7
Lawrence	1	1	0	0	1	3	1	1	6	4	4	2	1	2	0
Lee	0	1	0	2	0	1	3	5	1	1	2	2	2	3	3
Livingston	0	4	0	5	2	5	2	2	3	3	5	2	3	0	4
Logan	0	0	0	0	7	8	6	5	0	0	2	2	3	3	1
Macon	18	18	15	16	18	21	15	15	11	10	13	13	7	4	12
Macoupin	0	1	0	1	0	0	2	2	2	3	0	0	0	5	4
Madison	8	20	14	19	21	25	16	20	15	13	13	11	8	12	14
Marion	2	2	4	4	4	3	3	6	3	9	5	9	2	5	5
Marshall	0	1	0	0	0	0	3	2	2	1	0	0	0	0	0
Mason	0	3	0	0	0	0	0	0	2	1	0	0	0	3	1
Massac	1	1	1	1	1	1	4	2	0	0	0	0	2	1	0
McDonough	0	2	0	0	0	1	1	2	2	2	1	1	1	2	0
McHenry	9	10	23	24	14	19	11	11	7	6	11	9	12	17	9
McLean	12	16	11	10	14	14	5	6	9	10	13	12	9	12	13
Menard	0	0	0	0	0	1	1	1	1	1	0	0	0	0	0
Mercer	0	0	0	0	0	0	0	0	1	1	1	1	2	6	0
Monroe	1	1	1	1	0	0	2	2	0	1	1	1	1	1	0
Montgomery	2	2	3	3	0	1	1	0	3	3	3	2	1	0	4
Morgan	0	1	1	1	0	2	1	1	2	2	0	1	2	3	3
Moultrie	1	1	0	0	3	3	0	0	1	1	4	4	1	0	0
Ogle	2	2	3	3	4	4	3	3	2	1	1	1	0	0	2
Peoria	92	97	51	77	49	86	76	93	81	80	76	75	109	72	82
Perry	2	3	1	4	2	3	0	0	4	4	0	0	1	3	2
Piatt	0	0	0	1	0	2	0	0	0	0	1	1	1	0	0
Pike	0	2	0	0	0	0	0	0	2	2	0	0	0	0	0
Pope	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0
Pulaski	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0
Randolph	0	0	1	4	0	0	1	1	1	1	1	1	6	7	2
Richland	1	3	0	0	1	3	1	1	1	1	2	2	1	1	2
Rock Island	4	4	19	19	12	12	18	17	12	9	12	11	11	9	12
Saline	3	3	2	2	2	2	4	2	4	3	1	1	3	0	3
Sangamon	45	52	48	54	32	46	51	48	46	43	38	46	33	46	39
Schuyler	0	3	0	0	0	0	0	0	4	0	6	0	1	1	1
Scott	0	0	0	1	0	1	0	2	0	0	0	0	0	2	0
Shelby	3	3	1	1	3	3	2	5	1	2	0	0	0	2	0
Stark	23	35	14	29	7	26	26	28	18	16	18	15	21	31	26
St. Clair	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephenson	1	2	3	4	4	5	4	4	5	4	2	2	1	2	4
Tazewell	6	9	3	5	4	7	2	2	2	3	3	2	3	2	7
Union	0	0	2	2	0	0	2	2	3	3	1	1	1	2	1

Vermillion	3	4	9	12	1	6	13	14	7	6	8	6	11	10	7
Wabash	0	0	0	1	0	2	3	2	0	0	0	0	1	0	1
Warren	0	1	0	0	0	1	0	1	1	1	1	1	1	1	1
Washington	0	1	0	1	0	0	0	0	2	2	1	1	0	1	1
Wayne	1	1	1	2	0	1	1	1	1	1	1	1	2	1	1
White	0	0	0	0	0	0	1	1	1	1	1	1	1	0	1
Whiteside	1	4	0	6	0	3	7	6	3	5	4	3	1	4	3
Will	40	41	42	43	42	38	44	47	38	35	28	26	33	34	38
Williamson	6	2	4	9	8	9	6	5	5	5	10	9	6	6	13
Winnebago	61	75	58	65	71	78	59	48	61	49	51	43	40	36	43
Woodford	1	2	0	0	1	1	1	2	2	2	3	3	1	4	1
Unknown	0	0	0	0	0	0	18	0	1	0	0	1	0	0	0
Out of State	1	0	4	0	13	0	27	81	53	117	46	97	47	81	12
Out of country	-	-	-	-	-	-	-	-	-	-	-	-	9	0	0
Total	1,617	1,948	1,470	1,815	1,495	1,780	1,490	1,622	1,622	1,692	1,551	1,535	1,540	1,503	1,479

\*Death numbers for IDPH are for facility of death

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