ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR 2021

Illinois Department of DCFS Children & Family Services

SUBMITTED TO:

The Honorable JB Pritzker,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

February 2025

JB Pritzker
Governor

DCFS
Illinois Department of
Children and Family Services

Heidi E. Mueller
Director

April 8, 2025

Dear Readers,

The death of a child is always heartbreaking. When a death occurs that is preventable, it is truly tragic. When a child's death is brought to our attention, is imperative that all of us at the Illinois Department of Children and Family Services, along with our child welfare system partners, do all we can to analyze the circumstances and, where we can, take action to reduce the likelihood of recurrence.

There are nine Child Death Review Teams (CDRTs) in Illinois, made up of dedicated professionals who spend countless hours volunteering their time and expertise to review and discuss child deaths that occur each year. The results of their efforts are reflected in this Child Death Review Teams Annual Report which contains data regarding child deaths that occurred in Illinois during the 2021 calendar year. Many of these deaths were attributed to natural causes; however, it is important for us to review each of these cases to identify any opportunities for improvement and to learn where enhanced preventative measures could help prevent such incidents in the future.

The CDRTs play an important role in the effort to reduce harm to children resulting from maltreatment and neglect. Each year the department carefully reviews, and, when possible, implements the thoughtful recommendations made by the teams. The department is grateful to the CDRTs for their continued commitment to making Illinois children and youth safer and for their invaluable partnership, dedication and service.

Sincerely,

Heidi E. Mueller
Director
Illinois DCFS

Illinois Child Death Review Teams

Daniel J. Cuneo – Chairperson

Mary Joly Stein- Vice Chairperson

Executive Council

March 2025

The Honorable J.B. Pritzker, Governor of the State of Illinois:
The Honorable Members of the 104th General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2021. In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

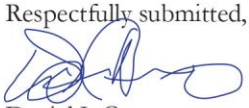
The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department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

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

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

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

Respectfully submitted,



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

ACKNOWLEDGEMENTS

This report would not be possible without the dedication and unwavering support of almost 140 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams (CDRTs). Members of the CDRT Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

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

Illinois CDRTs staff Tamara DelValley, Gail Mayer, and John Schweitzer provided the data from the CDRTs database and suggestions to CFRC staff, Dr. Steve Tran, who wrote the report. These annual reports typically lag about two years behind to ensure that all Mandatory Cases for a given calendar year are thoroughly reviewed and included. However, this particular report has been further delayed due to CDRT staff shortages contributing to delays in data entry. We appreciate the patience and understanding of all those who rely on this report and remain committed to providing a comprehensive analysis of child deaths in Illinois.

Illinois Child Death Review Team
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Tamara DelValley

CDRT Coordinator
John Schweitzer

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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 2021

In 2021, 1,278 children under 18 died in Illinois.[1] This number represents the death information received by DCFS as of May 4, 2023.

Of the total child deaths reported to CDRTs in 2021:

- 59% were males, 41% were females, and less than 1% were unknown sex;
- 56% were infants under one year, 9% were young children between 1 and 4 years, 16% were older children between 5 and 14 years, and 18% were youth between 15 and 17 years;
- 42% were White, 37% were Black, 16% were Hispanic, 3% were Asian, and 1% were of other or unknown racial/ethnic origin.

When Illinois child deaths in 2021 were examined by the manner of death:

- 60% were attributable to natural causes;
- 16% were accidental;
- 11% were homicides;
- 4% were suicides;
- 8% were undetermined;
- less than 1% were pending/unknown.

When deaths occurring in 2021 were examined by the category of death:

- 32% were related to illness;
- 28% were related to premature birth;
- 1% were related to Sudden Unexpected Infant Death (SUID);
- other categories included firearms (10%), vehicular accidents (7%), suffocations (7%), poisoning/overdose (2%), drowning (2%), fire (1%), injuries (2%), and 1% were pending;
- 6% were due to undetermined causes.
- A high number of SUID, suffocations and undetermined cases are all sleep-related deaths that are largely preventable. The exact number of sleep-related deaths cannot be determined without doing an in-depth review of all of these. Additional detail of the number of sleep-related deaths that were reviewed are in the next section.

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

2021 Child Deaths Reviewed by the CDRTs

In 2021, 213 child deaths were reviewed by the CDRTs, consisting of 151 mandatory and 62 discretionary reviews. The mandatory reviews occurred for one of several reasons: 87 were indicated death cases, 46 cases had an investigation within the year of the child's death, 9 had an indicated report at the time of death, 2 were DCFS youth in care, 1 had an open family case at the time of death, and 6 were pending DCFS investigation at the time of death.

Reviewed deaths in 2021 occurred in all CDRT regions (see Appendix A for the CDRT regional map), although there were regional differences in the percentages of child deaths that were reviewed:

- Aurora – 27 of the 159 deaths (17%) were reviewed.
- Champaign – 16 of the 63 deaths (25%) were reviewed.
- Cook – 70 of the 724 deaths (10%) were reviewed.
- East St. Louis – 15 of the 44 deaths (34%) were reviewed.
- Marion – 7 of the 27 deaths (26%) were reviewed.
- Peoria – 24 of the 91 deaths (27%) were reviewed.
- Rockford – 23 of the 75 deaths (31%) were reviewed.
- Springfield – 15 of the 73 deaths (21%) were reviewed.
- Out of State – 16 of the 22 deaths (73%) were reviewed.

Of the deaths reviewed by CDRTs in 2021:

- 53% were males and 47% were females;
- 48% were infants under 1, 21% were young children between 1 and 4 years, 21% were older children between 5 and 14 years, and 11% were youth between 15 and 17 years.
- 47% were White, 44% were Black, 7% were Hispanic, and less than 1% were Asian or of other or unknown racial/ethnic origin each.

When reviewed deaths occurring in 2021 were examined by manner of death:

- 32% were attributed to accidents;
- 27% were due to natural causes;
- 19% were homicides;
- 5% were suicides;
- 17% were undetermined.

When reviewed deaths occurring in 2021 were examined by category of death:

- 2% were related to premature birth;
- 23% were related to illness;
- 6% were related to SUID;
- Other categories were suffocations (20%), firearms (12%), vehicular accidents (7%) drowning (6%), poisoning/overdose (5%), fire (4%), and injuries (7%);
- 8% were due to undetermined causes.
- 36% of reviewed deaths were determined to be sleep-related after a review of information and data from deaths that were categorized as either SUID, suffocation, or undetermined.

Critical Areas of Focus

Sleep-related deaths and firearms-related deaths are of great concern given the high numbers and the fact that they are nearly 100% preventable. Many of the reviews conducted by the CDRTs involve unsafe sleep and fall into the categories of SUID, suffocation, or undetermined. Nationally, SUID occurs more than twice as often among Black, non-Hispanic infants, and about half as often among Hispanic infants, as compared to white, non-Hispanic infants. In Cook County, SUID occurred 14 times more often in Black infants, and 2.5 times more often in Hispanic infants when compared to White infants.[2] Sudden unexpected infant death (SUID) is the leading cause of postneonatal infant death in the United States, accounting for over 3400 deaths annually.[3] Firearm-related deaths have risen by 47% from 2018 to 2021, reaching a decade-high of 132 deaths in 2021. The Child Death Review Teams, in partnership with others, have diligently sought to increase public awareness in these areas with the goal of reducing or eliminating these types of deaths.

[2] RUSH University Medical Center & Cook County Medical Examiner's Office. (n.d.). *Sudden Unexpected Infant Death: Cook County report 2020-2021*. Retrieved from https://www.rush.edu/sites/default/files/media-documents/suid-report-20-21.pdf

[3] Howard, M. B., Dineen, R., Blakely, A., Badero, S., Solomon, B. S., & Krugman, S. (2024). Collaboration to Reduce Sudden Unexpected Infant Death with Child Fatality Review and Outreach. *Pediatrics, 154*(Suppl. 3).

Introduction

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations and safety policies that have led to a decline in infant and child mortality, too many children are still dying. In 2021, there were 1,278 child deaths in Illinois. Many of these deaths were preventable.

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

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

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

Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998, P.A. 92-468 on August 22, 2001, P.A. 95-405 and P.A. 95-527 on June 1, 2008, P.A. 95-876 on August 21, 2008, P.A. 96-328 on August 11, 2009, P.A. 96-955 on June 30, 2010, P.A. 96-1000 on July 2, 2010, P.A. 98-558 on January 1, 2014, P.A. 100-159 on August 18, 2017, P.A. 100-397 on January 1, 2018, P.A. 100-1122 on November 27, 2018, and most recently P.A. 100-733 on January 1, 2019.[4] Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

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

Purpose of Child Death Review

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

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

Other responsibilities of the CDRTs are to:

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

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

- collect data that will inform efforts to reduce child fatalities; and
- keep the Governor and Legislature apprised of the CDRTs' findings and recommendations and of legislation needed to reduce child fatalities and protect the lives of children.

Child Death Review Team Composition

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

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

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

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

Child Death Review Team Executive Council

The CDRT Executive Council is the coordinating and oversight body for child death review activities in Illinois. It consists of the chairpersons and vice-chairpersons of each of the nine CDRTs. The Executive Council meets in-person quarterly and teleconferences monthly to review the procedures and recommendations made by the teams in the examination of child deaths. The Executive Council operates pursuant to Section 40 of the Illinois Child Death Review Team Act. 20 ILCS 515/40. Executive Council responsibilities include, but are not limited to:

- serving as the voice of child death review in Illinois;
- providing oversight of regional CDRTs to ensure that their work is coordinated and in compliance with legislation and the operating protocol;

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

During 2021, the Illinois Child Death Review Teams (CDRT) accomplished several goals including the following:

- In collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign, the Illinois Child Death Review Teams Annual Report for 2020 was written and printed.
- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.
- Due to COVID-19 there was no Annual Child Death Review Teams Symposium.
- Expanding collaborative efforts with the Rush University Children's Hospital partners with the Cook County Medical Examiner's Office which is funded by the Center for Disease Control.

DCFS Roles and Responsibilities

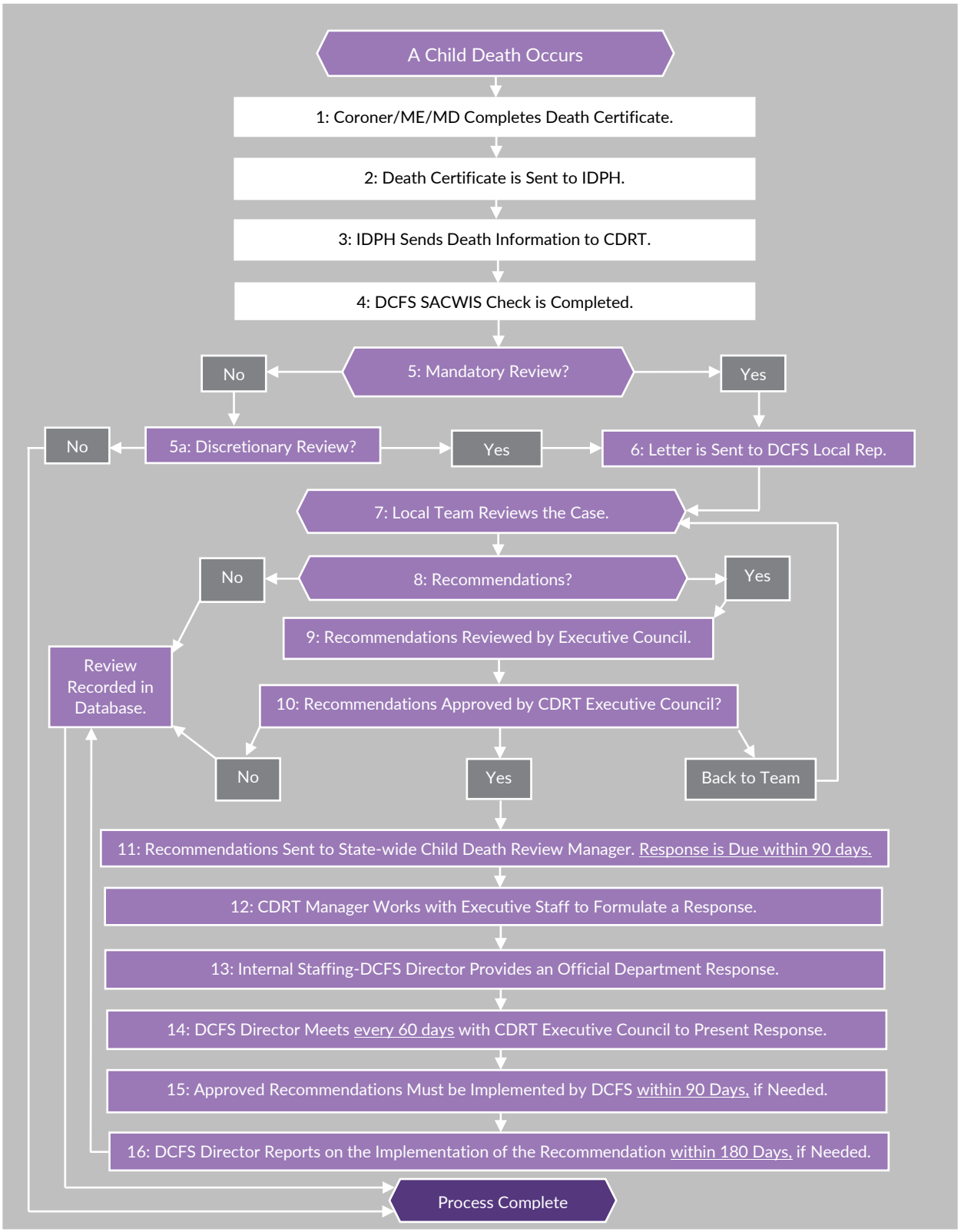
The Illinois DCFS Office of Quality Assurance provides essential administrative support and assistance to the CDRTs (i.e., the CDRT manager). In addition, the CDRT Manager serves as a direct link between the review teams and the state's child protection policy makers. The DCFS Director must review and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

Illinois Child Death Review Process

The Illinois child death review process is outlined in the CDRT Protocol for the Multi-Disciplinary Review of Child Deaths. This protocol provides a practical manual for CDRT members and ensures comparability of CDRT reviews and findings among the teams by defining: 1) the types of cases to

be reviewed, 2) the procedures used to review cases and 3) the confidentiality parameters of review findings and recommendations. The CDRT process is outlined in a flow chart in Figure 1.

Figure 1: The Child Death Review Process in Illinois



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

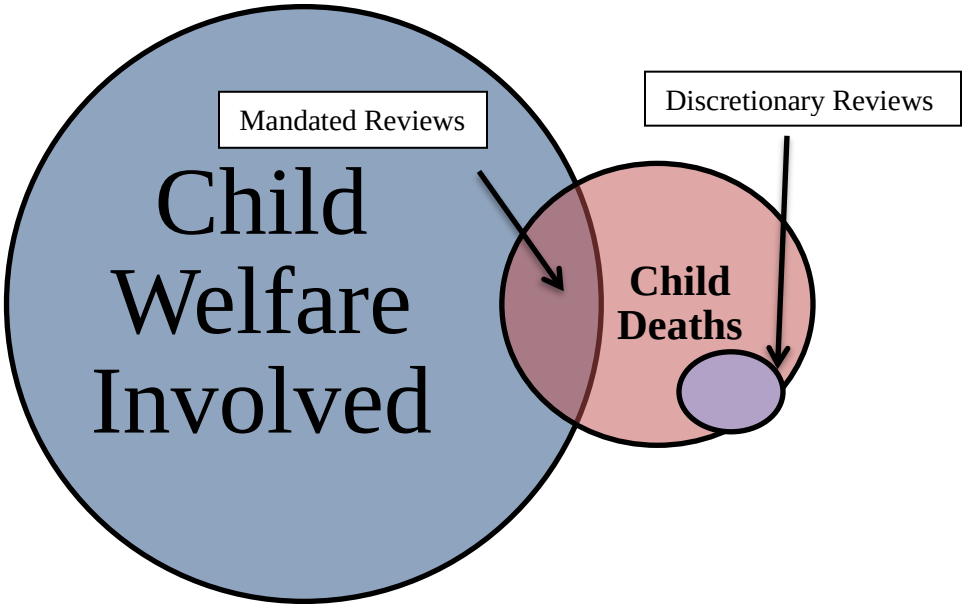
Once the death information is received by the Child Death Review Office, a search of the Statewide Automated Child Welfare Information System (SACWIS) for the child/family name is performed to identify those cases in which the child had prior involvement with DCFS. Child death review is required, or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

- a DCFS youth in care;
- not a DCFS youth in care, but the death occurred in a licensed foster home;
- the subject of an open DCFS service case;
- the subject of a pending child abuse or neglect investigation;
- the subject of an abuse or neglect investigation during the preceding 12 months; and/or
- a child whose death is reported to the Child Death Review Office as the result of indicated child abuse or neglect.

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

[5] In addition to mandated reviews and discretionary reviews, CDRTs can review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the CDRT or other local multidisciplinary team may review the report. The team will review all pertinent information and make a recommendation to DCFS.

Figure 2: Child Death Reviews



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

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

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

CDRT Access to Information

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

Confidentiality of CDRT Information

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

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

Chapter 2: Child Death Review Recommendations to Prevent Child Deaths

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

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

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

In 2021, there were 1,278 Illinois child deaths reported to Child Death Review. Child Death Review Teams reviewed 213 of these 1,278 child deaths. Ninety-four recommendations were made by CDRTs on 57 of the 213 child death cases reviewed. Of the 94 recommendations, there were 27 recommendations which focused on DCFS policy and procedures. The DCFS recommendations resulted from four types of reviews including: death indicated (12), investigation within a year of death (2), youth in care (0) and discretionary (13). There were eighteen recommendations related to other agencies or systems. These recommendations came from four types of reviews including death indicated (14), investigation within a year of death (2), youth in care (2) and discretionary (0). There were 49 case specific recommendations from four types of reviews: 18 recommendations resulted from cases where death was indicated, 24 were from discretionary reviews, 0 from youth in care cases, and 7 were from cases that had an investigation within a year of death. There was one primary prevention recommendation made as a result of 2021 child death reviews. A table of the recommendations and responses can be found in Appendix D.

Chapter 3: Illinois Child Deaths in 2021

What do we know about the child deaths that occurred in Illinois during 2021?

To answer this question, there are three sets of numbers we need to compare: 1) the total population of children in Illinois; 2) the population of total child deaths in Illinois; and 3) the child deaths that were reviewed by the CDRTs. By comparing the children who died with the general child population in Illinois, we can better understand how characteristics such as gender, age and race/ethnicity are associated with child deaths and how children who died differ from those in the general child population in Illinois. The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths (69% in 2021) are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children involved with child welfare in Illinois is more likely to be younger and Black than the total child population in Illinois. It is therefore likely that deaths reviewed by the CDRTs may over-represent these two characteristics. In order to compare 1) the total population of children; 2) the population of total child deaths; and 3) the child deaths reviewed by the CDRTs, these data are presented side-by-side throughout this report.

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

- The population of Illinois children was based on 2021 Census estimates. According to the Census data, there were approximately 2.80 million children under the age of 18 in Illinois, which constituted about 22.1% of the total Illinois population.[6]

- In 2021, there were 1,278 child deaths reported to the Illinois CDRT database. This included deaths due to all causes, preventable and non-preventable.

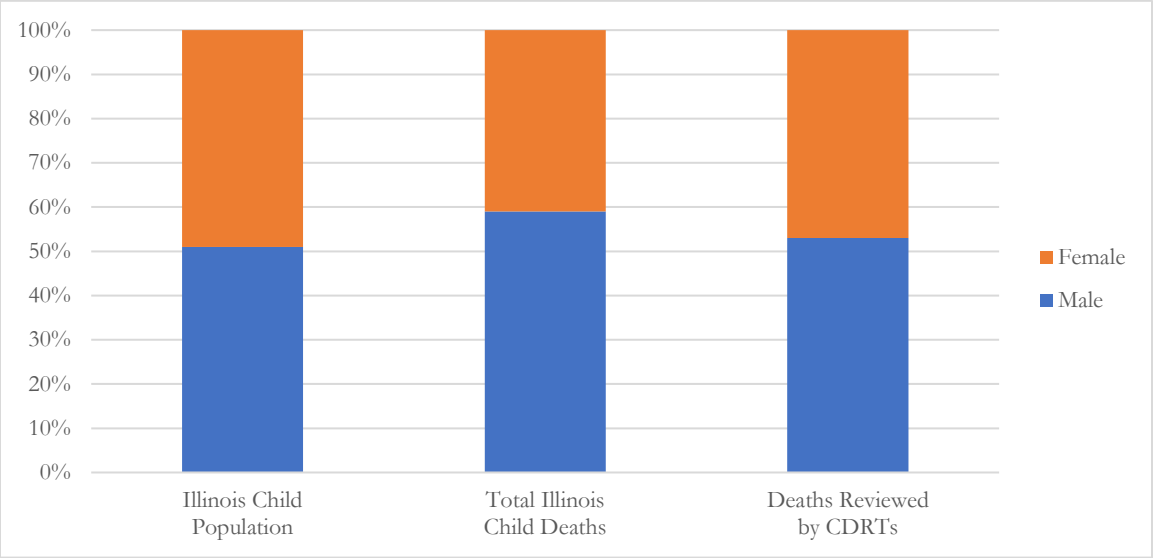
- The CDRTs reviewed 213 child deaths that occurred in 2021: 151 of these were mandated for review and 62 were discretionary reviews.

Child Deaths by Gender

According to information from the Census estimates, 51% of the Illinois child population is male and 49% is female. Males are more likely to die than females based on CDRTs data: males made up 59% of total child deaths and 53% of reviewed deaths in 2021 (see Figure 3).

[6] U.S. Census Bureau. (2023). American Community Survey: Children Characteristics. Retrieved from https://data.census.gov/cedsci/

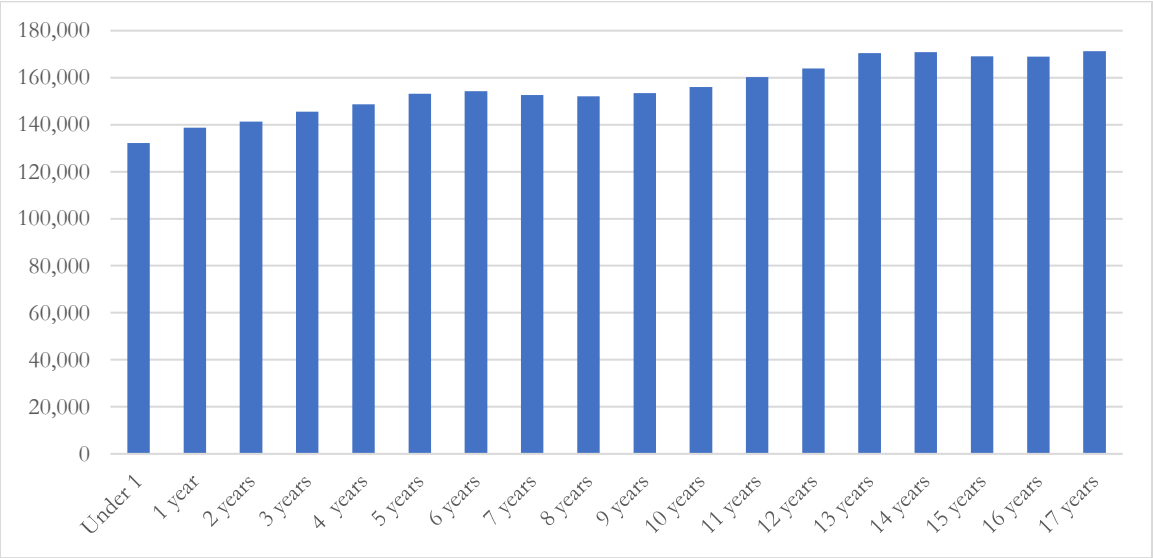
Figure 3: 2021 Illinois Child Population, Child Deaths, CDRT-Reviewed Child Deaths by Gender



Child Deaths by Age

In 2021, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the estimated 2.80 million children in Illinois under 18 years of age, 5% were less than one year, 20% were between 1 and 4 years, 27% were between 5 and 9 years, 29% were between 10 and 14 years, and 18% were between 15 and 17 years.[7]

Figure 4: 2021 Illinois Child Population by Age

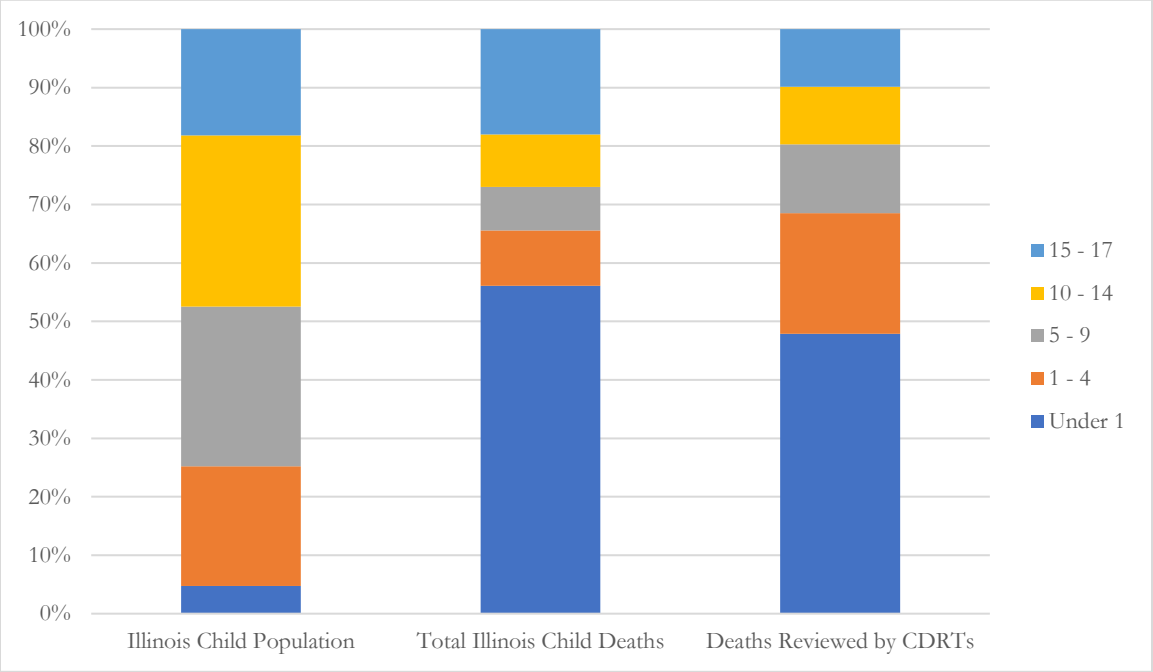


[7] U.S. Census Bureau. (2023). Annual estimates of the resident population by single year of age and sex: April 1, 2020 to July 1, 2021. Retrieved from https://www2.census.gov/programs-surveys/popest/tables/2020-2021/state/asrh/sc-est2021-syasex-17.xlsx

However, when we examine the total of Illinois child deaths reported to CDRTs by age (see Figure 5), infants less than one-year-old are especially vulnerable—56% of the total deaths in 2021 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). In 2021, 9% of the total deaths were children between 1 and 4 years, 7% were children between 5 and 9 years, 9% were children between 10 and 14 years, and 18% were between 15 and 17 years.

When we examine the deaths reviewed by the CDRTs by age group (see Figure 5), infants under one year comprised 48% of reviewed deaths in 2021. Children between 1 and 4 years make up 21% of reviewed deaths in 2021. Older children make up a smaller portion of reviewed deaths: 12% were for children aged 5 to 9 years old, 10% were for children aged 10 to 14, and 10% were for children aged 15 to 17. The Disproportionality Index for deaths of youth under age 1 is approximately 11.2 and for reviewed deaths it is approximately 9.6[8]

Figure 5: Illinois Child Deaths by Age Group



Child Deaths by Race/Ethnicity

In 2021, 61% of children in Illinois were White, 15% were Black, 5% were Asian and the remaining 18% were of other races/ethnicities (see Figure 6).[9] For reports on ethnicity, 25% self-identified as Hispanic or Latino (of any race) and 50% were White (not Hispanic or Latino). The categories for racial/ethnic origin in the CDRT report are of the following: White, Black, Hispanic, Asian, and Other/Unknown.

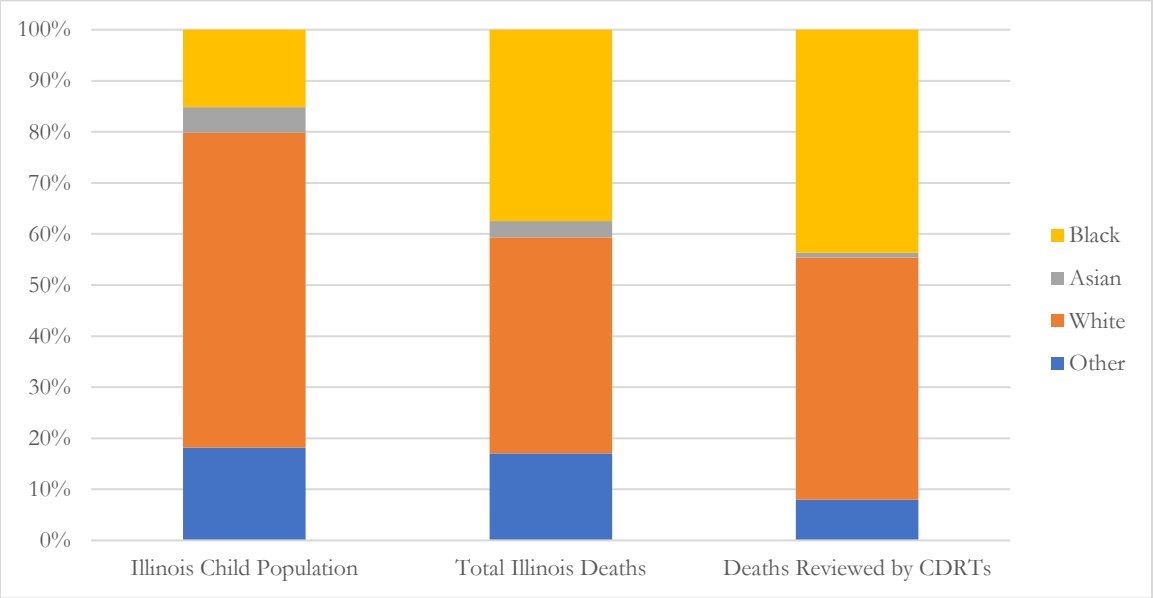
[8] The Disproportionality Index refers to the over- or under-representation of the respective age group in deaths compared to their representation in a base population.

[9] U.S. Census Bureau. (2023). 2021: ACS 5-Year Estimates Subject Tables: Children Characteristics. Retrieved from https://data.census.gov/table?q=children+under+18+illinois&tid=ACSST5Y2021.S0901

When we examine the total Illinois child deaths by race, there is a disproportion of deaths among Black children compared to their proportion in the general population: 37% of the children that died in 2021 were Black, yet they only comprise 15% in the general child population. The proportion of deaths among White children (42%) was lower when compared with their proportion in the general child population (61%). Asian children made up 3% of deaths, and children of other race/ethnicity accounted for 17% of child deaths.

Among the 213 child deaths reviewed by the CDRTs in 2021, 44% were Black children, which is larger than their proportion in the overall child population (15%). White children, Asian children, and child of other race/ethnicity made up 47%, less than 1%, and 8% of reviewed deaths, respectively (see Figure 6).

Figure 6: Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and "other" deaths. In this classification system, the category of death can be different from the proximal cause of death. For example, a child may have died of pneumonia (cause of death) that was the result of an earlier gunshot wound (category of death). By reviewing this death as a firearm death, the CDRT examining the case would make recommendations related to firearms rather than the illness that resulted from the gunshot. The use of categories can be helpful in the development of strategies, systems, and awareness campaigns to prevent child deaths.

Categories for child deaths that occurred in Illinois in 2021 are shown in Table 2. The majority of total child deaths were related to either illness (32%) or premature birth (28%). The other categories included firearms (10%), vehicular (7%), suffocation (7%), undetermined (6%), poison/overdose (2%), injury (2%), drowning (2%), fire (1%), were pending (1%), SUID (1%), and other types that accounted for less than 1% of the total deaths.

The CDRTs are far more likely to review certain categories of child deaths than others (see Table 1). In 2021, deaths reviewed by CDRTs were most likely to be illness (23%), suffocation (20%), and firearms (12%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Table 1: Child Deaths by Category of Death

Category	**Total Deaths**		**Reviewed Deaths**	
Illness	404	32%	48	23%
Prematurity	359	28%	4	2%
Firearms	132	10%	25	12%
Vehicular	93	7%	14	7%
Suffocation	86	7%	43	20%
Undetermined	71	6%	18	8%
Poison overdose	31	2%	10	5%
Injury	25	2%	15	7%
Drowning	21	2%	12	6%
Fire	19	1%	9	4%
SUID	16	1%	12	6%
Pending	13	1%	0	0%
Other/Missing	7	<1%	2	<1%
SIDS	1	<1%	1	<1%
Total	**1278**	**100%**	**213**	**100%**

Child Deaths by Manner

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

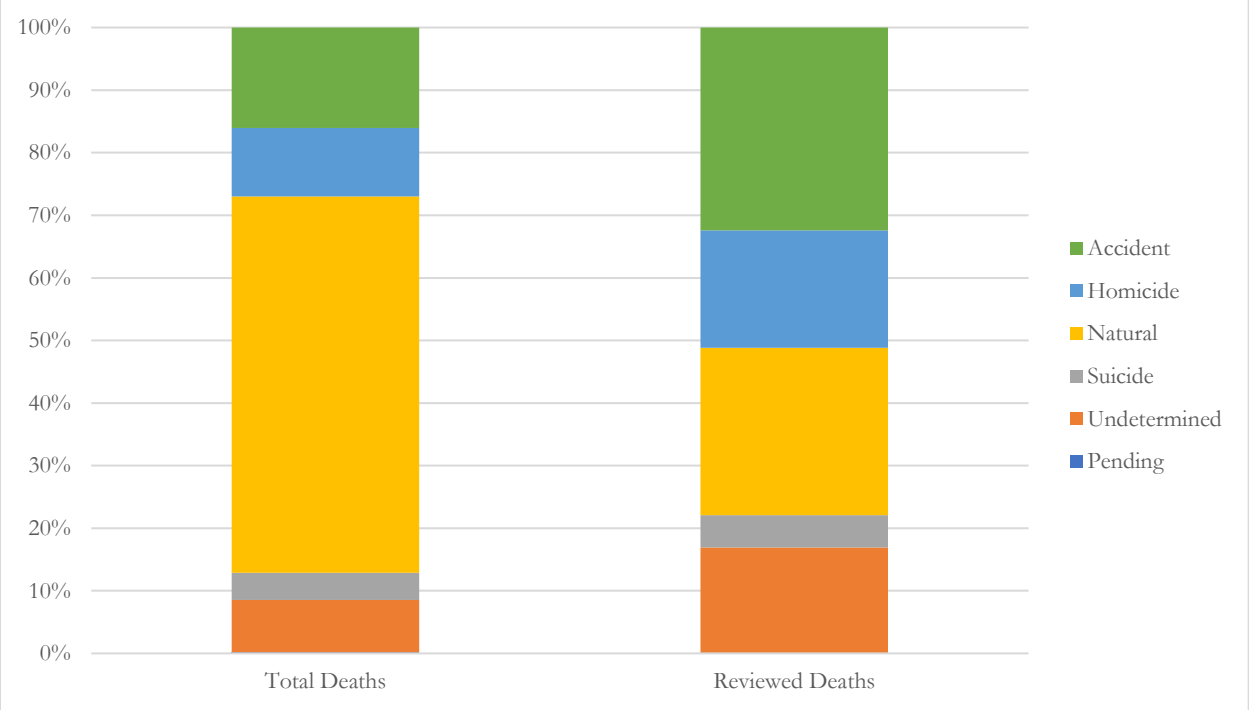
- Natural – the death was a result of natural causes such as illness, disease and/or the aging process
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm or death
- Suicide – the death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

The majority of total child deaths in 2021 were attributable to natural causes (60%), and accidents accounted for 16% of the total child deaths. In addition, 11% were homicides, 4% were suicides, 8% were undetermined, and less than 1% were still pending. Among deaths reviewed by CDRTs, 32% were accidents (32%), 27% were natural, 19% were homicides, 5 % were suicides, and 17% were undetermined (see Table 2 and Figure 7).

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

	Total Deaths		**Reviewed Deaths**	
Accident	205	16%	69	32%
Homicide	140	11%	40	19%
Natural	768	60%	57	27%
Suicide	56	4%	11	5%
Undetermined	107	8%	36	17%
Pending/Missing	2	<1%	0	0%
Total	**1,278**	**100%**	**213**	**100%**

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



Child Deaths by Category and Manner

It is important to examine the manner of child death juxtaposed with the categories of death (see Table 3). For instance, the majority of accidental child deaths are due to suffocation and vehicular accidents. Most homicides involve either firearms or other inflicted injuries. Suffocation (hanging) is the most frequent method of child/youth suicide, followed by firearms. Almost all child deaths due to natural causes are the result of illness and premature birth.

Table 3: Total Child Deaths – Manner of Death by Category of Death

Category	**Manner of Death**						
	Accident	Homicide	Natural	Suicide	Undetermined	Missing	Totals
Illness	0	1	402	0	1	0	404
Prematurity	1	1	357	0	0	0	359
Firearms	4	101	0	22	5	0	132
Vehicular	85	4	0	4	0	0	93
Suffocation	55	4	0	21	6	0	86
Undetermined	1	0	2	0	68	0	71
Poison Overdose	16	5	0	7	3	0	31
Injury	5	18	0	2	0	0	25
Drowning	20	0	0	0	1	0	21
Fire	15	3	0	0	1	0	19
SUID	1	0	4	0	11	0	16
Pending	0	0	0	0	11	2	13
Other	2	3	0	0	0	0	5
Missing	0	0	2	0	0	0	2
SIDS	0	0	1	0	0	0	1
Total	**205**	**140**	**768**	**56**	**107**	**2**	**1278**

Special Analysis: Homicide Deaths

There were 140 homicide deaths out of the 1,278 deaths in 2021, and 40 were reviewed. Many homicides involved either firearms or inflicted injuries of some kind (see Figure 8) and were disproportionally Black and older children (see Figures 9 and 10, respectively). Males made up the majority of total (80%) and reviewed (58%) deaths. Additional information on a selection of homicide deaths can be found in Appendix E, which provides additional details on the circumstances of these types of child deaths. Both injury and/or cause of death are provided when available.

Figure 8: Homicides by Category

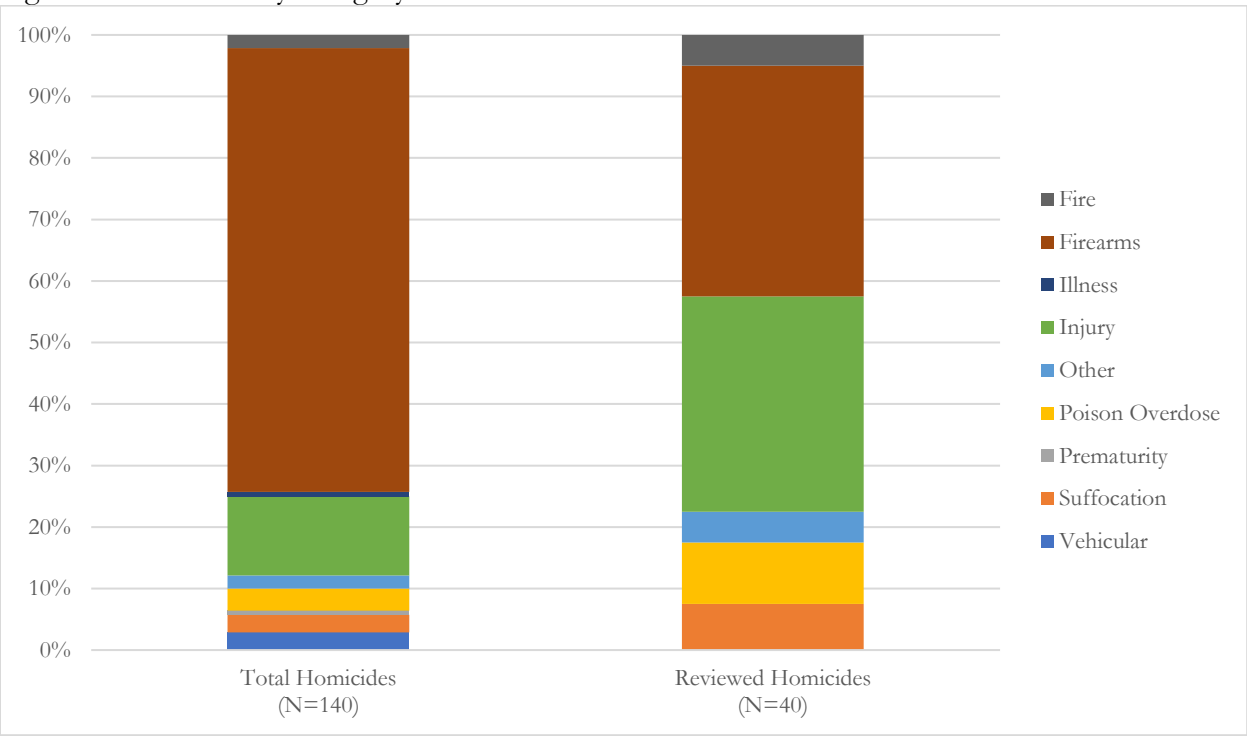


Figure 9: Homicides by Race/Ethnicity[10]

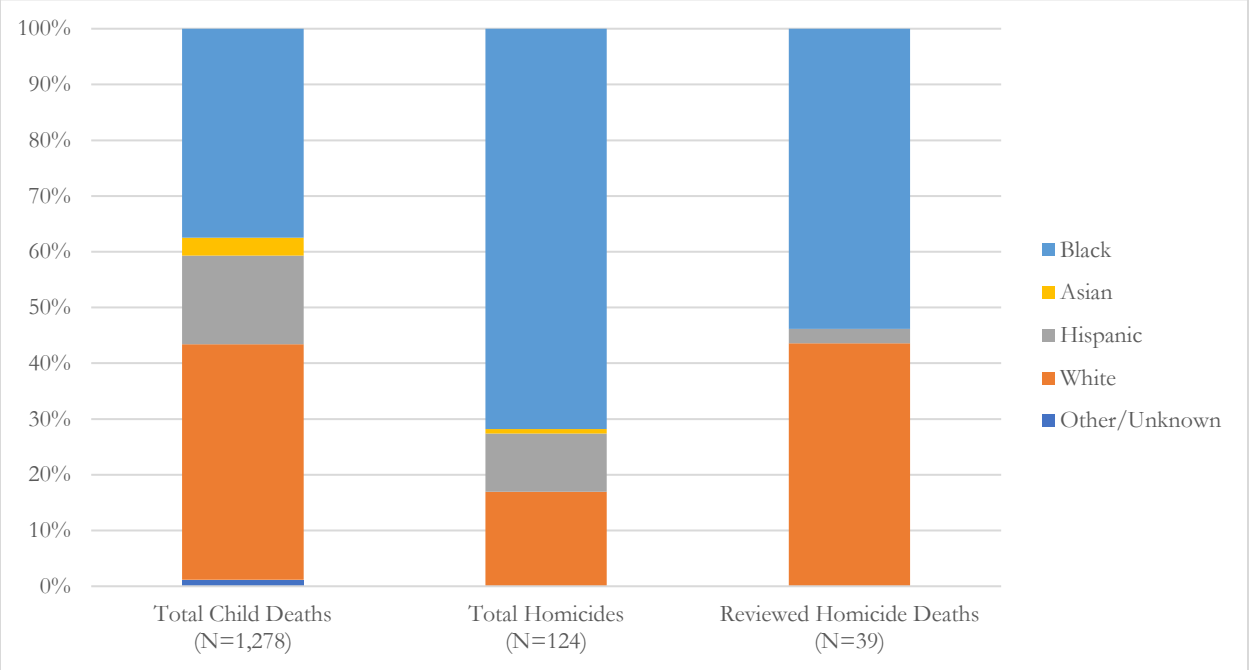
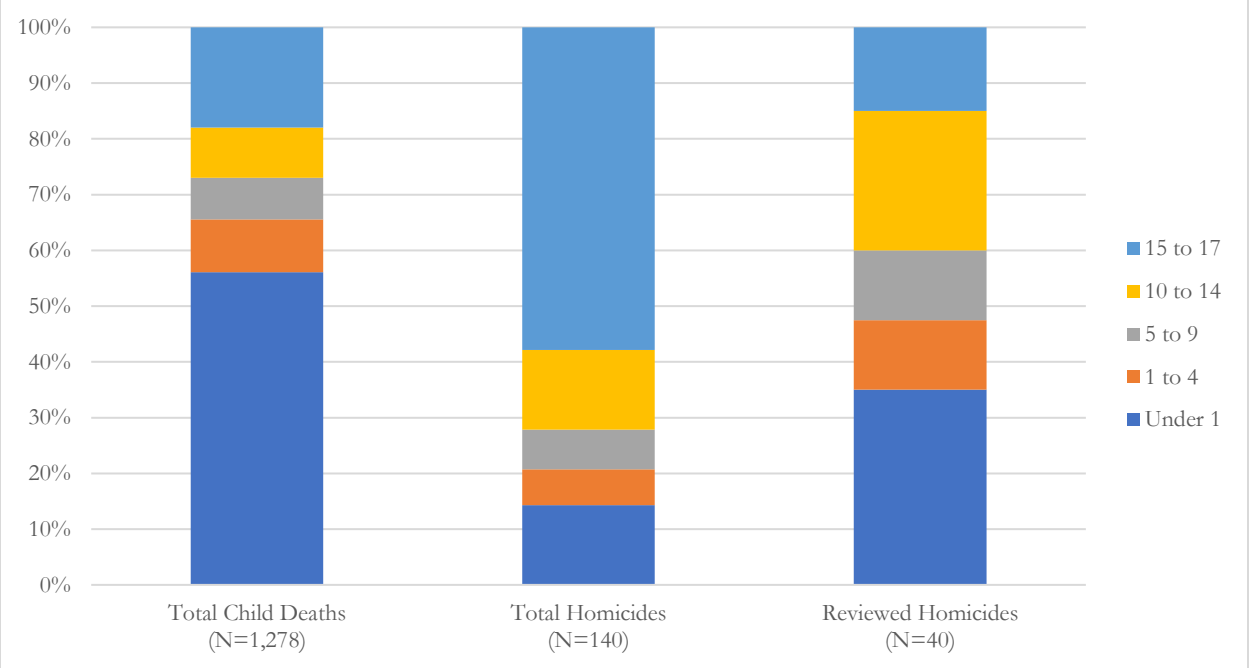


Figure 10: Homicides by Age



[10] Race/ethnicity data were not available for all homicide cases.

Chapter 4: Child Deaths by Category

To gain a more complete understanding of child deaths in Illinois, the following sections present detailed analyses for the categories of death identified by the CDRT Executive Council. By examining the characteristics of the children who die from each category of death, more explicit and useful recommendations for preventing future child deaths can be made.

Categories are presented in the order of frequency of occurrence for 2021 so that the most common categories of death are first. For each category section, the following information is presented:

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

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

Illness

Definition

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

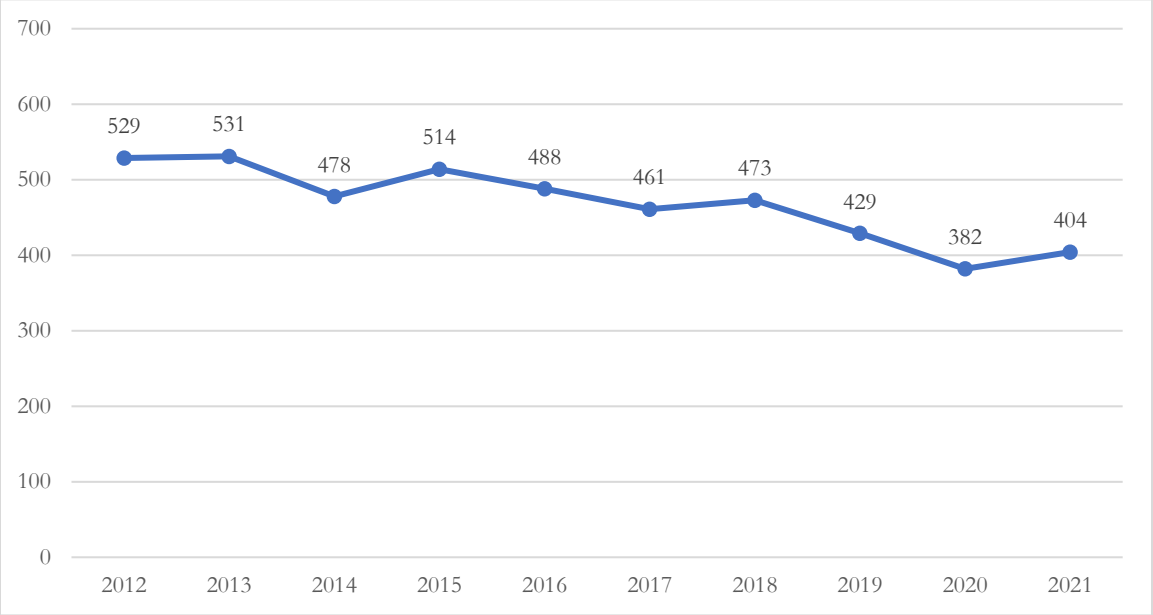
Background

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

Illinois Data—Total Child Deaths Reported to the CDRTs

Illness has been one of the largest causes of child death in Illinois, but the overall number of deaths has been steadily decreasing over the past decade. In 2021, there were 404 deaths from illness, which is the second lowest number of deaths in the observed period (see Figure 11).

Figure 11: Child Deaths Due to Illness



In 2021, 404 of the 1,278 total child deaths (32%) that were reported to CDRTs were related to illness.

- Males accounted for a slightly higher proportion of illness deaths (53%).
- Almost half of deaths from illness were among children under the age of 1 (46%), 15% of deaths from illness occurred among children 1 to 4 years old, 14% among children 5 to 9 years old, 13% among children 10 to 14 years old, and 12% among children 15 to 17 years old (see Figure 12).
- Nearly half (48%) of deaths from illness were White children, followed by Black children (28%), Hispanic children (19%), Asian children (4%), and children of Other/Unknown race/ethnicity (1%) (see Figure 13).
- Nearly all deaths (99%) from illness were attributable to natural causes, and under 1% of the remaining deaths were either homicide or undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 48 of the 213 child deaths reviewed by the CDRTs (23%) were related to illness.

- Reviewed deaths due to illness were evenly split between males and females (50% each).
- Illness-related deaths were most common in infants under 1 year old (40%) and children 1 to 4 years old (29%). Children 5 to 9 years, children 10 to 14 years, and children 15 to 17 years old accounted for 17%, 4%, and 10% of deaths, respectively (see Figure 12).

- White (48%) and Black (40%) children accounted for most of the deaths reviewed for illness, 8% were Hispanic children, one case (2%) was an Asian child, and one case was a child of Other/Unknown race/ethnicity (2%) (see Figure 13).

- All (100%) reviewed deaths that were categorized as illness were attributed to natural causes.

Figure 12: Child Deaths Due to Illness by Age

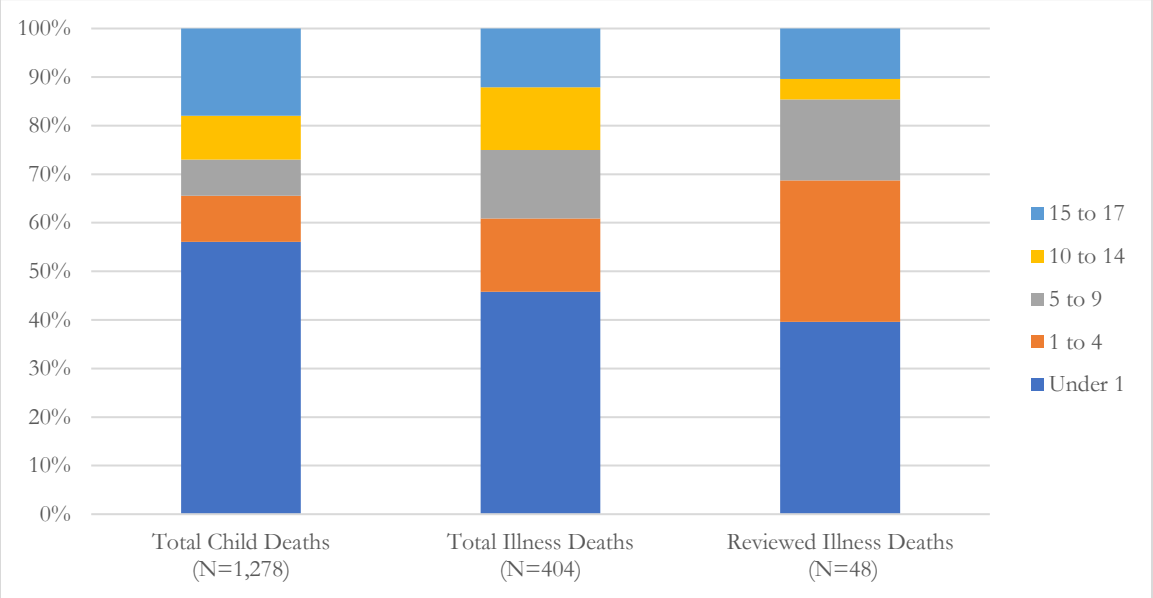
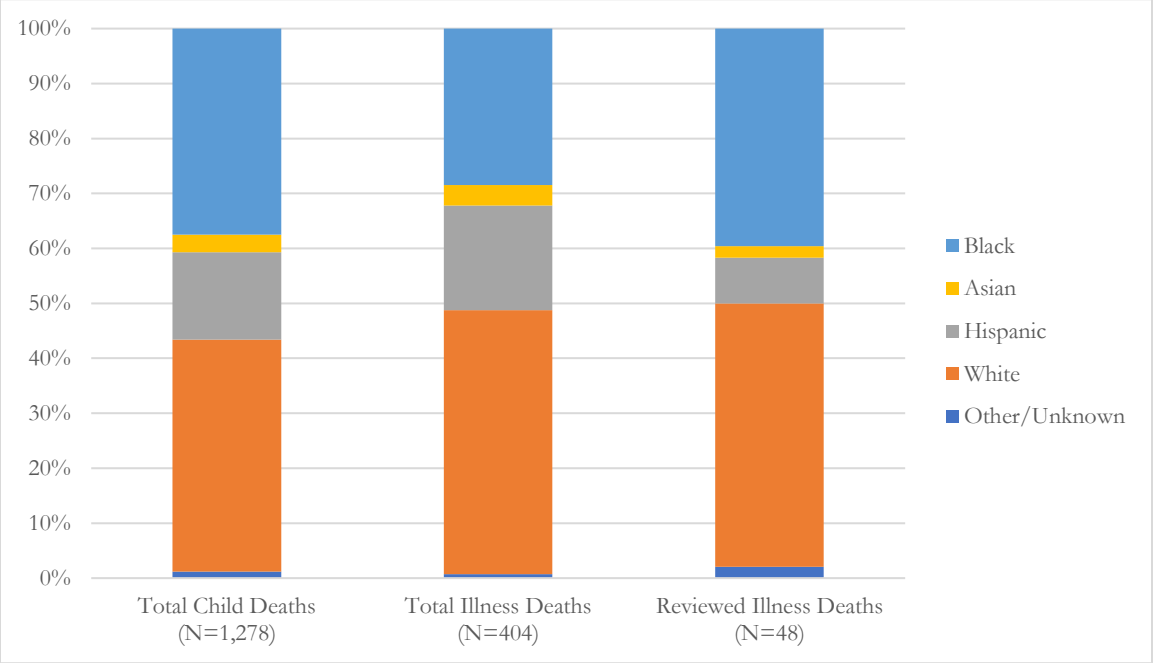


Figure 13: Child Deaths Due to Illness by Race/Ethnicity



Premature Birth

Definition

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

Background

Premature birth is closely associated with low birth weight. Low birthweight (LBW), one of the five leading causes of infant mortality, is an indicator of child health (current and future) as well as maternal health. LBW babies are more likely to have health problems during the newborn period than babies of normal weight. LBW babies may be also at greater risk for serious physical and mental health illness throughout the lifespan.[11]

In Illinois, about 1 in 9 (10.7%) babies were born preterm in 2021, compared with 10.5% in the nation, and 1 in 12 babies (8.5%) was low birthweight, which was the same as the national rate.[12] The rate of preterm birth in Illinois between 2019-2021 is highest for Black infants (14.9%), followed by American Indian/Alaska Natives (13.2%), Hispanics (10.4%), Whites (9.5%), and Asian/Pacific Islanders (9.3%).[13] 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.[14] Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

Illinois Data—Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death in Illinois and has been either the largest or second largest category in the past decade (ranging between 359 to 572 deaths per year). The number of premature deaths was 359 in 2021, the lowest number of deaths recorded in the past decade (see Figure 14).

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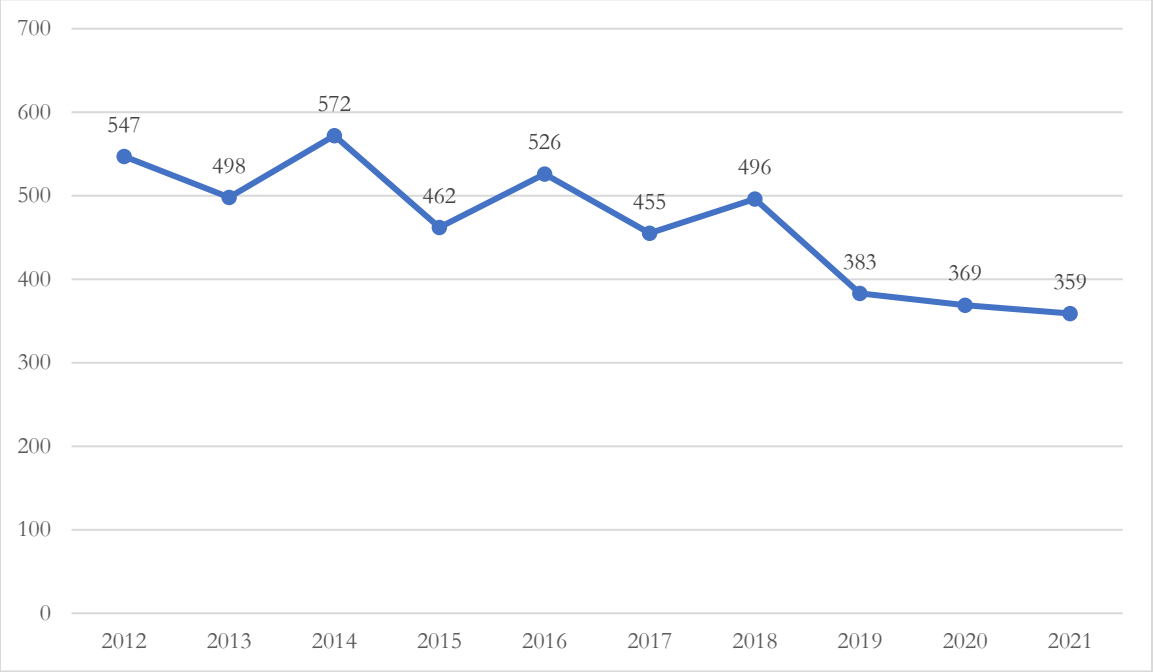
[11] America's Health Rankings (2022). 2021 Annual Report. United Health Foundation. Retrieved from https://assets.americashealthrankings.org/app/uploads/americashealthrankings-2021annualreport.pdf

[12] March of Dimes (2022). State summary for Illinois. Retrieved from https://www.marchofdimes.org/peristats/state-summaries/illinois?lev=1&obj=3&reg=99&slev=4&sreg=17&stop=55&top=3

[13] March of Dimes (2023). A profile of prematurity in Illinois. Retrieved from https://www.marchofdimes.org/peristats/reports/illinois/prematurity-profile,

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

Figure 14: Child Deaths Due to Prematurity



Out of 1,278 child deaths in 2021, 359 (28%) were related to premature birth.

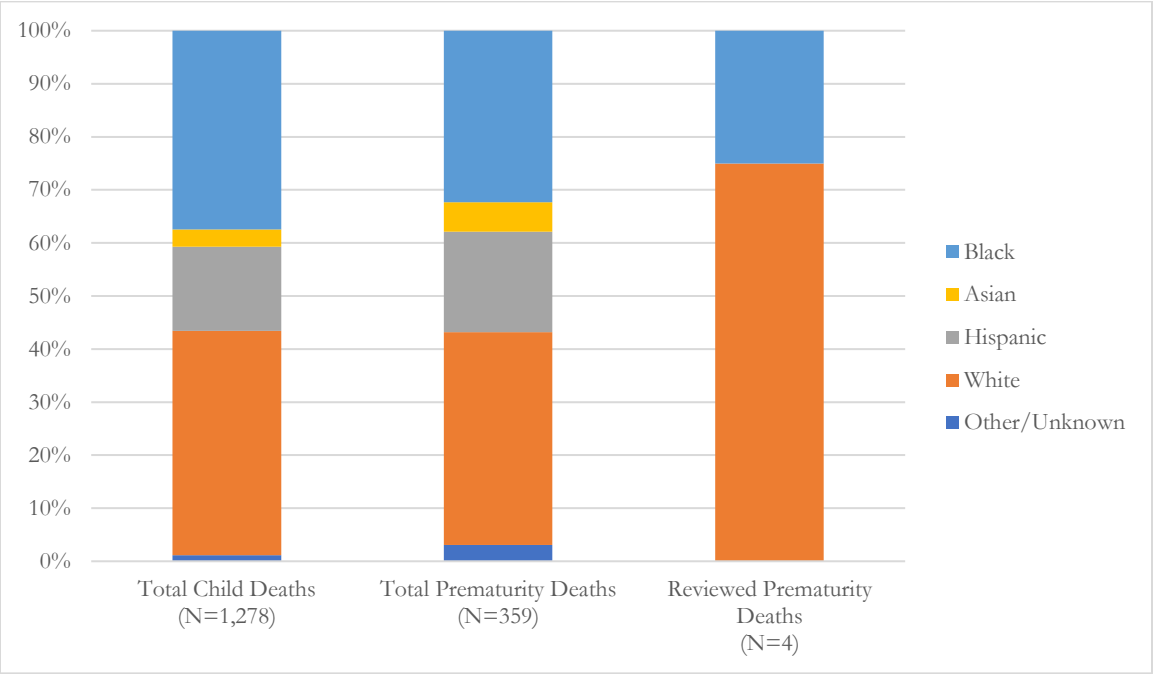
- A larger proportion of children who died prematurely were males (58%).
- The largest proportion of deaths from prematurity were White children (40%), followed by Black children (32%), Hispanic children (19%), Asian children (6%), and children of other or unknown race/ethnicity (3%) (see Figure 15).
- Nearly all deaths (99%) in this category were the result of natural causes, and the remaining cases were from accidental or homicides.

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 4 of the 213 child deaths reviewed by CDRTs (2%) were related to premature birth.

- Three (75%) of the premature deaths reviewed by the CDRTs were female.
- Three (75%) of the premature reviewed deaths were White children, and one (25%) was a Black child (see Figure 15).
- All (100%) premature reviewed deaths were due to natural causes.

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



Firearms

Definition

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

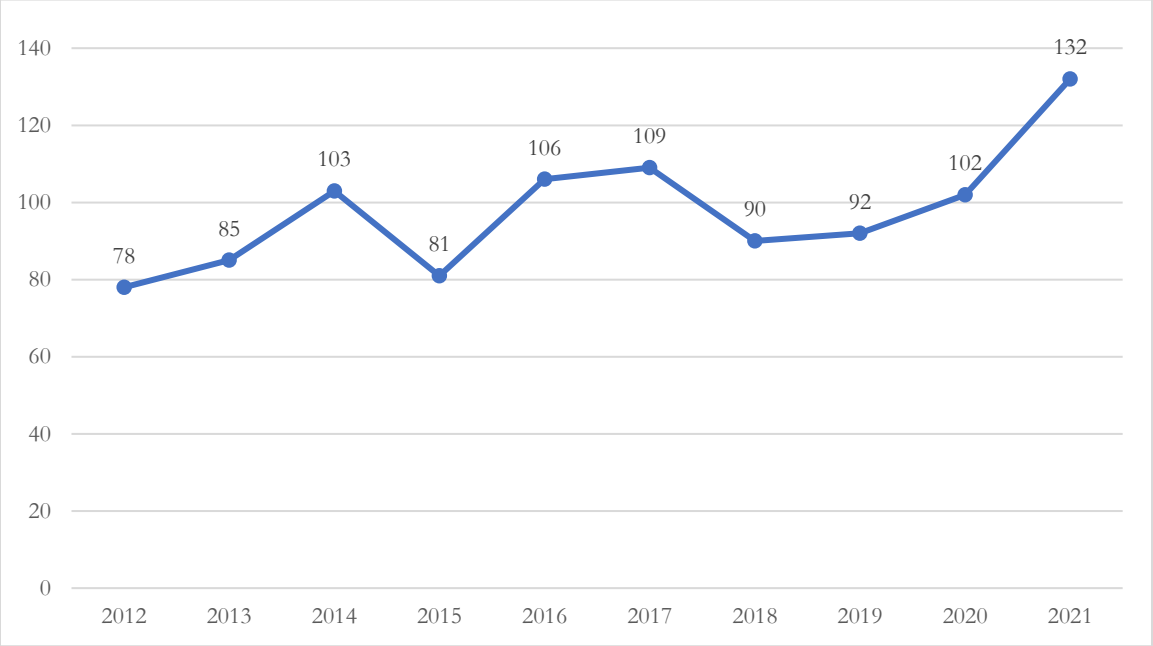
Background

According to data from the Centers for Disease Control and Prevention, an estimated 2,584 firearm deaths occurred in 2021 among children under 18 years of age in the United States. The vast majority (68%) of these deaths were youth between the ages of 15 and 17. Race of decedent and intent are also factors. For example, the crude death rate from firearms due to homicide for Black males 13 to 17 years old was over 11 times more than the rate for White males of the same age group.[15]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from firearms has fluctuated over the past several years. Firearms deaths ranged between 78 to 85 from 2011 through 2013, but there were over 100 child deaths from firearms in 2014, 2016, 2017, 2020, and has spiked to a current high of 132 in 2021.

Figure 16: Child Deaths Due to Firearms



In 2021, 132 of the 1,278 total deaths (10%) were related to firearms.

[15] Centers for Disease Control and Prevention. (2023). *WISQARS Fatal and Nonfatal Injury Reports: Injury Counts and Rates.* Retrieved from https://wisqars.cdc.gov/reports/

- Males accounted for the majority of firearm deaths (84%).

- Nearly three-quarters of firearm deaths occurred in children age 15 to 17 (71%), children age 10 to 14 were the next largest group (18%) (see Figure 17).

- 69% of the children who died from firearms were Black, 21% were White, 9% were Hispanic, and under 1% were Asian (see Figure 18).

- Homicides accounted for 77% of firearm deaths, suicides were 17%, accidents were 3%, and undetermined cases accounted for 3%.

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 25 of the 213 deaths reviewed by the CDRTs (12%) were related to firearms.

- The majority of reviewed firearm deaths were males (68%).

- Children age 10 to 14 years old accounted for the largest proportion of reviewed firearm deaths (40%), followed by youth age 15 to 17 (36%), and children age 1 to 4 and children age 5 to 9 each accounted for 12% (see Figure 17).

- Slightly over half (52%) of reviewed firearm deaths were Black children, and the remainder of deaths (48%) were White children (see Figure 18).

- The majority of firearm deaths reviewed by CDRTs were due to homicides (60%), and suicide cases (20%) were the second most common manner of death. Accidental deaths were 8%, and undetermined cases accounted for 12%.

Figure 17: Child Deaths Due to Firearms by Age

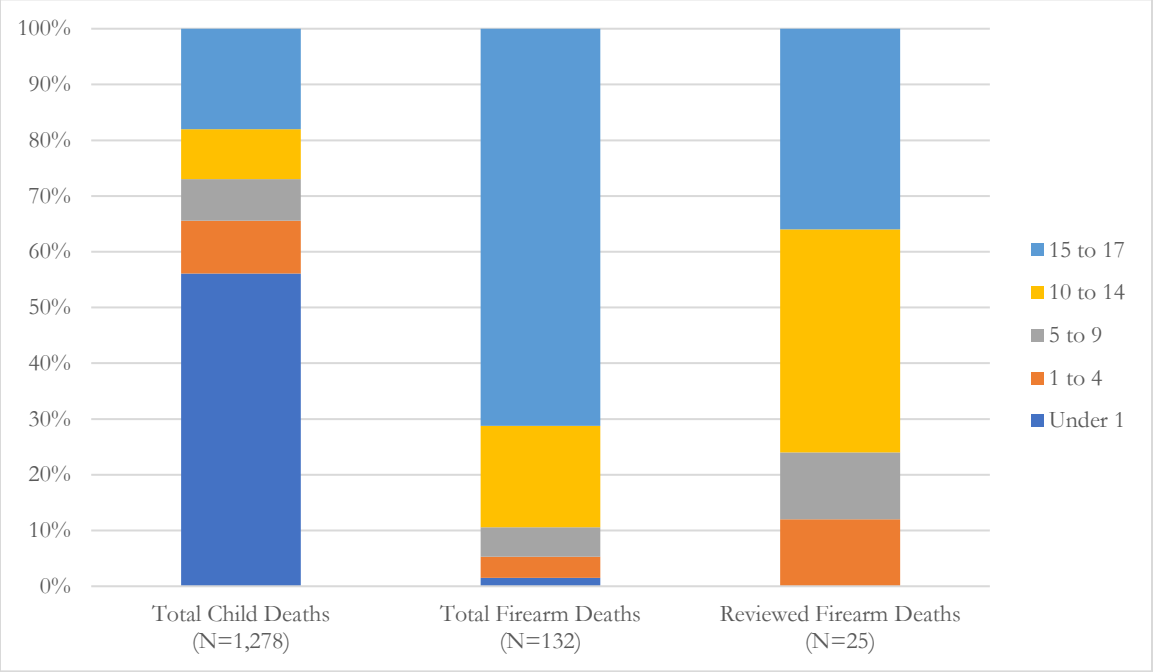
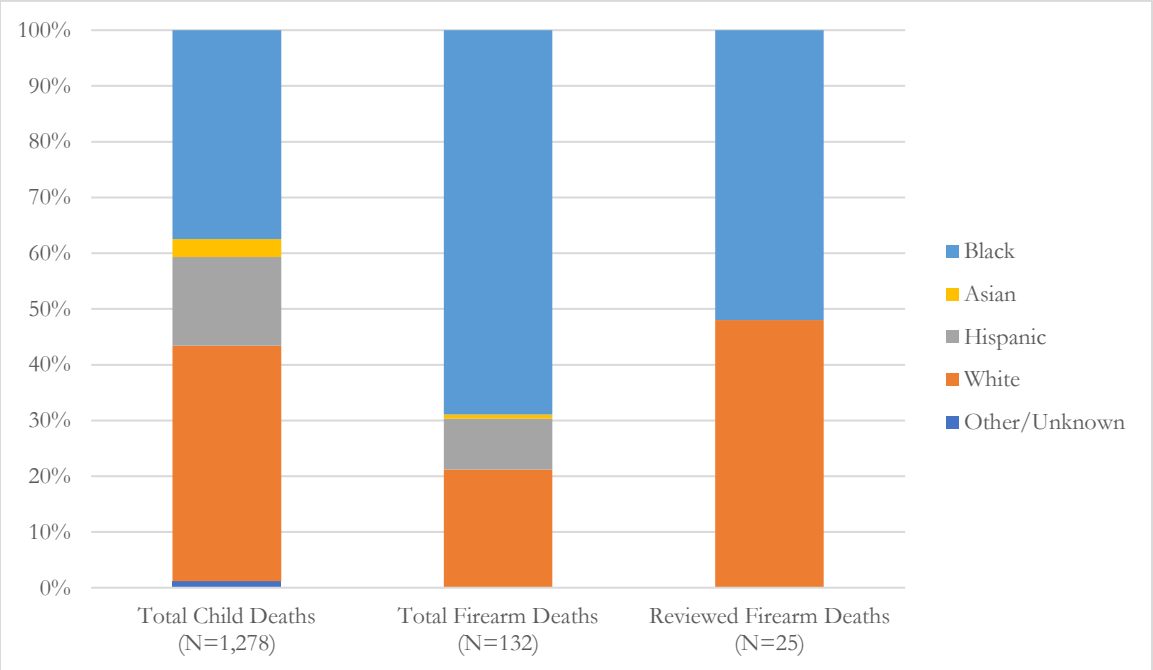


Figure 18: Child Deaths Due to Firearms by Race/Ethnicity



Vehicular Accident

Definition

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

Background

Nationally, a total of 922 children (under the age of 13) died in motor vehicle crashes in 2021.[16] There has been a significant decrease in the rate of motor vehicle crash deaths per million children under 13 since 1975. In 2021, 78% of child motor vehicle crash deaths were passenger vehicle occupants, 15% were pedestrians, 2% were bicyclists, and the remaining 5% were other/unknown. Children 12 and younger are recommended to ride in the rear seats of vehicles, and 15% percent of passenger vehicle child occupant deaths occurred in front seats in 2021, continuing a downward trend that has spanned for several decades. Seventy-five percent were in the rear seat, and 10% were in cargo/unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about one-quarter of unintentional injury deaths among children younger than 13. Most deaths from crashes are among children traveling as passenger vehicle occupants, which could potentially be reduced through proper restraint use. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about 75% for children up to age 3, and almost 50% for children ages 4 to 8.[17]

In 2021, a total of 3,058 teenagers ages 13 to 19 died in motor vehicle crashes. This is a decrease of 65% from 1975, but this was an increase of 11% from 2020. Males accounted for about two-thirds of crash deaths, but rates have decreased more for males (69%) than females (55%) since 1975. Teenagers accounted for 7% of motor vehicle crash deaths in 2021 and 9% of passenger vehicle (cars, pickups, SUVs, and vans) occupant deaths among all ages, 3% of pedestrian deaths, 4% of motorcycle deaths, 6% of bicyclist deaths and 17% of all-terrain vehicle rider deaths.[18]

In the United States, teenagers drive less than most adults, yet their number of crashes and deaths from crashes are disproportionately high. The fatal crash rate per mile driven for 16- to 19-year-olds is almost three times the rate of older drivers 20 and over, with the highest risk among teenagers ages 16 to 17.[19]

Distracted driving is often the cause of fatal accidents. The most common distraction for teen drivers is cell phone use. Other common sources of distraction for teen drivers are riding with peers

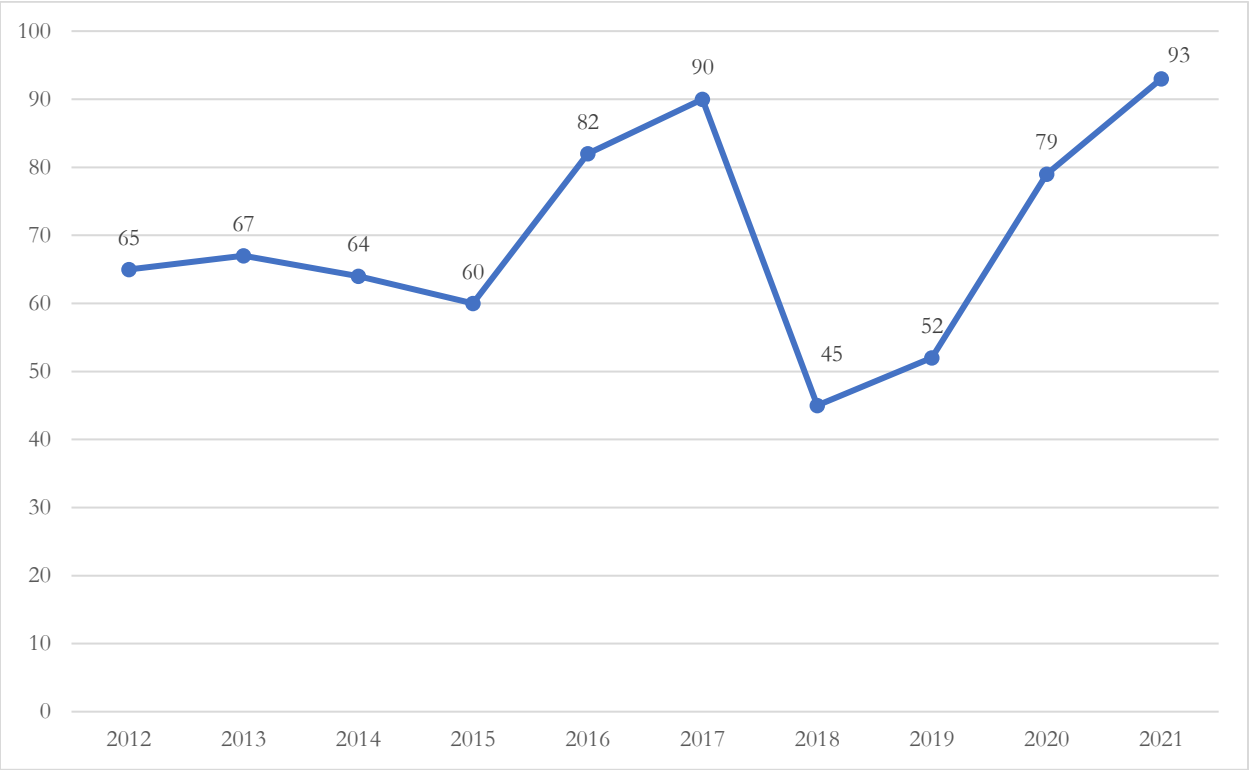
[16] Insurance Institute for Highway Safety. (2023). *Fatality facts 2021: Children.* Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/children
[17] Ibid.
[18] Insurance Institute for Highway Safety. (2023). *Fatality facts 2021: Teenagers.* Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/teenagers
[19] Ibid.

and drowsiness.[20] Another factor that affects teenage vehicular fatalities is inexperience. To address this, all states have adopted graduated licensing systems, which phase-in full driving privileges. National studies of graduated licensing found that strong laws were associated with substantially lower fatal crash rates and substantially lower insurance claim rates among young teen drivers covered by the laws.[21]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of vehicle deaths had previously fluctuated between 60 to 90 in the past decade, and there were 93 vehicle deaths in 2021 (see Figure 19).

Figure 19: Child Deaths Due to Vehicular Accidents



In 2021, 93 out of the 1,278 total child deaths reported to the CDRTs (7%) were related to vehicular accidents.

- Males accounted for 68% of vehicular accident deaths.
- Older children ages 15 to 17 made up the largest proportion of vehicular deaths (47%). Children in other age groups made up the following proportions of vehicular deaths—

[20] Children's Hospital of Philadelphia Research Institute (2023). Teen Driving Safety Research. Retrieved from https://injury.research.chop.edu/teen-driving-safety-research
[21] Insurance Institute for Highway Safety. (2023). *Fatality facts 2021: Teenagers*. Retrieved from https://www.iihs.org/topics/fatality-statistics/detail/teenagers

children under 1 year were 9%, children 1 to 4 were 11%, 5 to 9 were 13%, and 10 to 14 were 20% (see Figure 20).

- The majority (53%) of vehicular deaths were White children, followed by Black children (38%), Hispanic children (8%), and Asian children (2%) (see Figure 21).

- The majority of vehicular deaths were accidental (91%). The remaining cases were suicides (4%) and homicides (4%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 14 of the 213 deaths reviewed by the CDRTs (7%) were related to vehicular deaths.

- The majority of vehicular deaths were males (64%).

- Children under 1, children ages 1 to 4, and children ages 10 to 14 each accounted for 29% of reviewed vehicular deaths, and the remaining 14% were children ages 5 to 9. There were no reviewed vehicular deaths of older children ages 15 to 17 (see Figure 20).

- The majority of reviewed vehicular deaths were Black children (57%), and the remainder were White children (43%) (see Figure 21).

- Nearly all the reviewed vehicular deaths were accidents (93%), and one case was a suicide (7%).

Figure 20: Child Deaths Due to Vehicular Accidents by Age

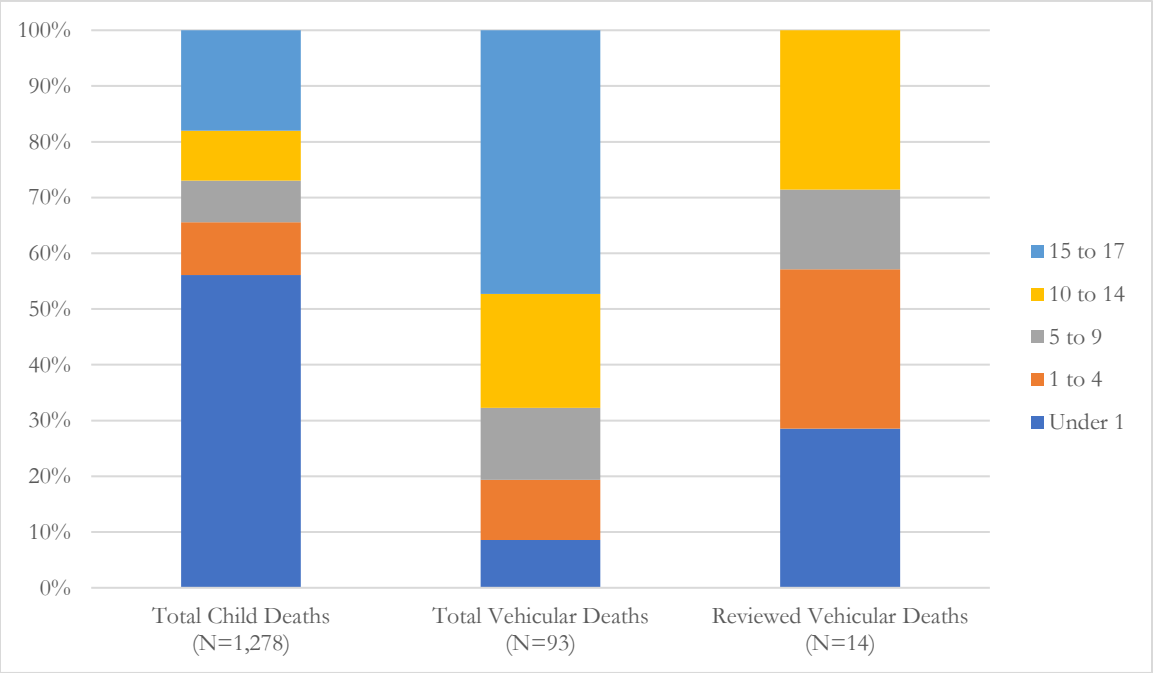
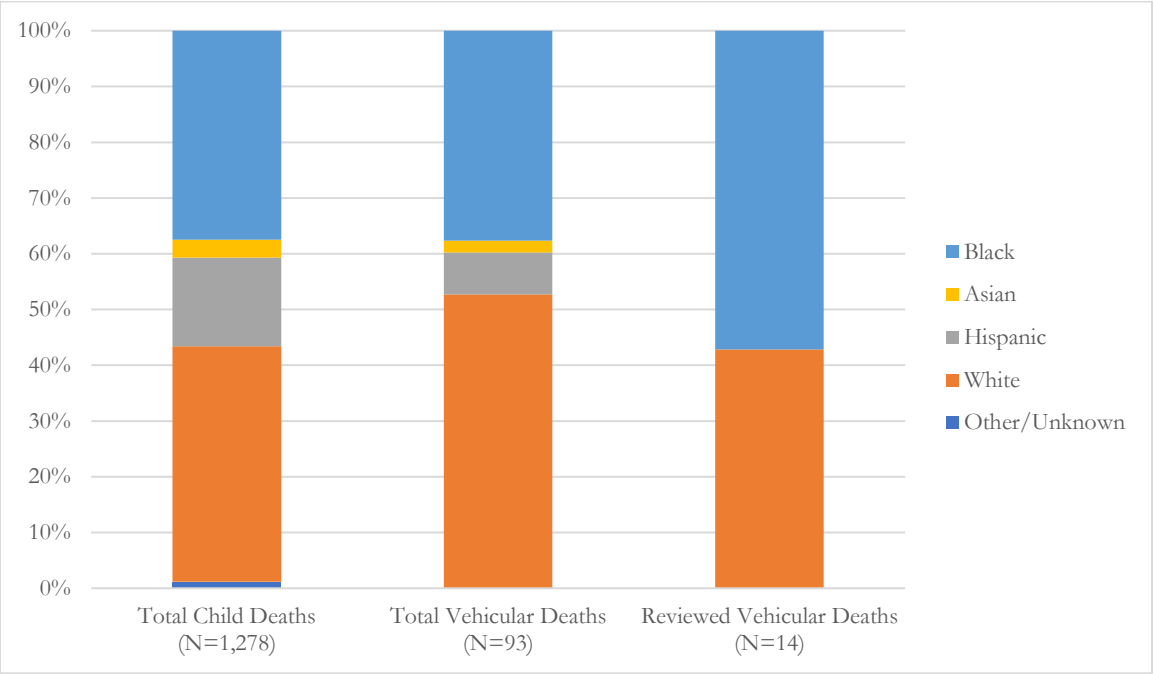


Figure 21: Child Deaths Due to Vehicular Accidents by Race/Ethnicity



Suffocation

Definition

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

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

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

Background

In 2021, 2,151 children under 18 years old in the U.S. died from suffocation.[22] Of these children, 52% were less than one year of age and 59% were ages four and under. Unintentional suffocation is the leading cause of injury-related death among infants less than one year old.[23]

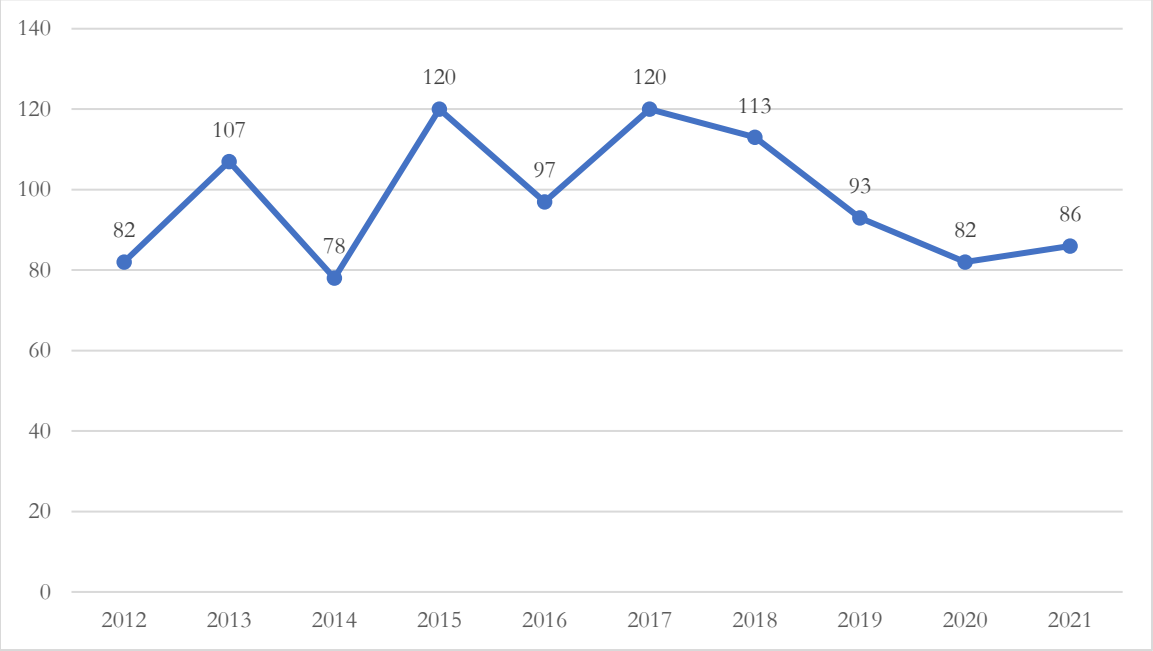
Illinois Data—Total Child Deaths Reported to the CDRTs

Suffocation deaths have fluctuated slightly in the past decade, ranging from a low of 78 to a high of 120. The number of suffocation deaths has dropped for the past several years, and there were 85 suffocation deaths in 2021, near the lowest levels within the past decade (see Figure 22).

[22] Centers for Disease Control and Prevention (2023). *WISQARS Fatal and Nonfatal Injury Reports: Injury Counts and Rates*. Retrieved from Retrieved from https://wisqars.cdc.gov/reports

[23] Safe Kids Worldwide. (2023). *Sleep Safety and Suffocation Prevention Tips*. Retrieved from https://www.safekids.org/tip/sleep-safety-and-suffocation-prevention-tips

Figure 22: Child Deaths Due to Suffocation: Child Deaths Due to Suffocation



In 2021, 86 of the 1,278 total child deaths reported to the CDRTs (7%) were categorized as suffocation.

- Males made up 50% of suffocation deaths, females were 49%, and 1% was a child of unknown gender.
- Infants under one year made up 60% of deaths. Children ages 1 to 4, 5 to 9, and 10 to 14 accounted for 10%, 2%, and 10% of deaths in this category, respectively. Older children ages 15 to 17 accounted for the second largest proportion of suffocation deaths (16%) (see Figure 23).
- Nearly half (48%) of children who died from suffocation were White, 36% were Black, 14% were Hispanic, and Asian and children of other or unknown race/ethnicity were each 1% (see Figure 24).
- Most suffocation deaths were accidental (64%) or suicides (24%). The remaining suffocation deaths were homicides (5%) or undetermined (7%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 43 of the 213 child deaths reviewed by CDRTs (20%) were related to suffocation.

- Females made up 51% of reviewed suffocation deaths, males were 47%, and one case was a child of unknown gender (2%).
- Infants under one year made up the majority of reviewed suffocation deaths (72%). Children ages 1 to 4 accounted for 12% of reviewed suffocation deaths, children 5 to 9 for 5%, children 10 to 14 for 2%, and children 15 to 17 were 9% (see Figure 23).

- Almost half (49%) of reviewed suffocation deaths were White children. Black children were 37% of reviewed suffocation deaths, Hispanic children accounted for 12%, and one case was a child of other or unknown race/ethnicity (2%) (see Figure 24).

- Most reviewed suffocation deaths were accidental (74%). Homicides accounted for 7% of reviewed suffocation deaths, suicides were 9%, and 9% were undetermined.

Figure 23: Child Deaths Due to Suffocation by Age

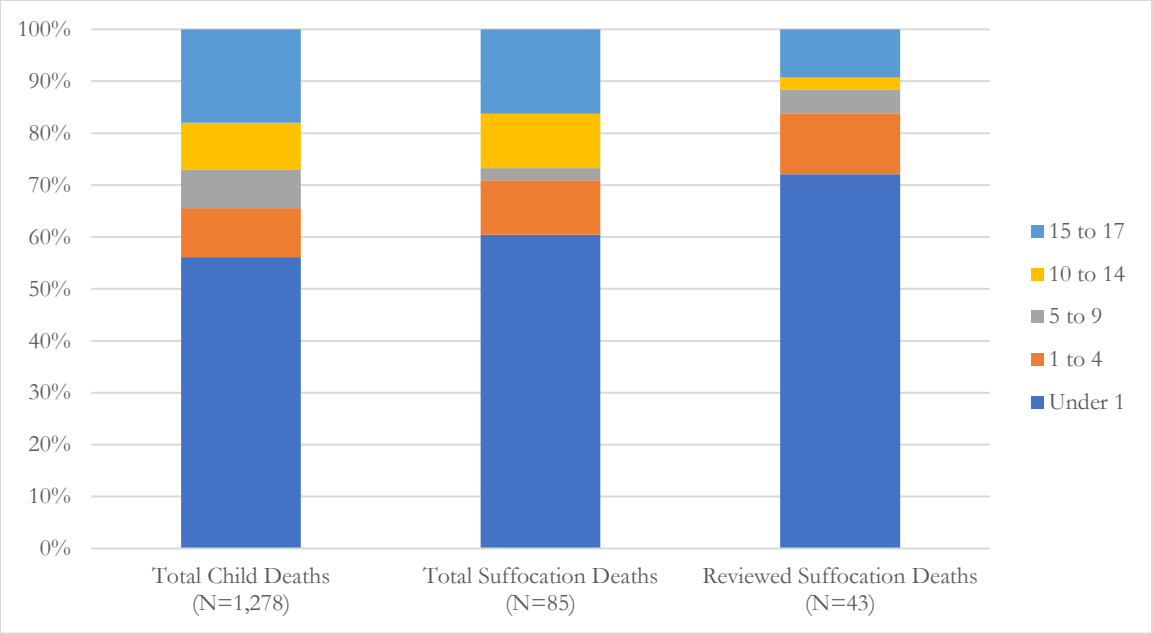
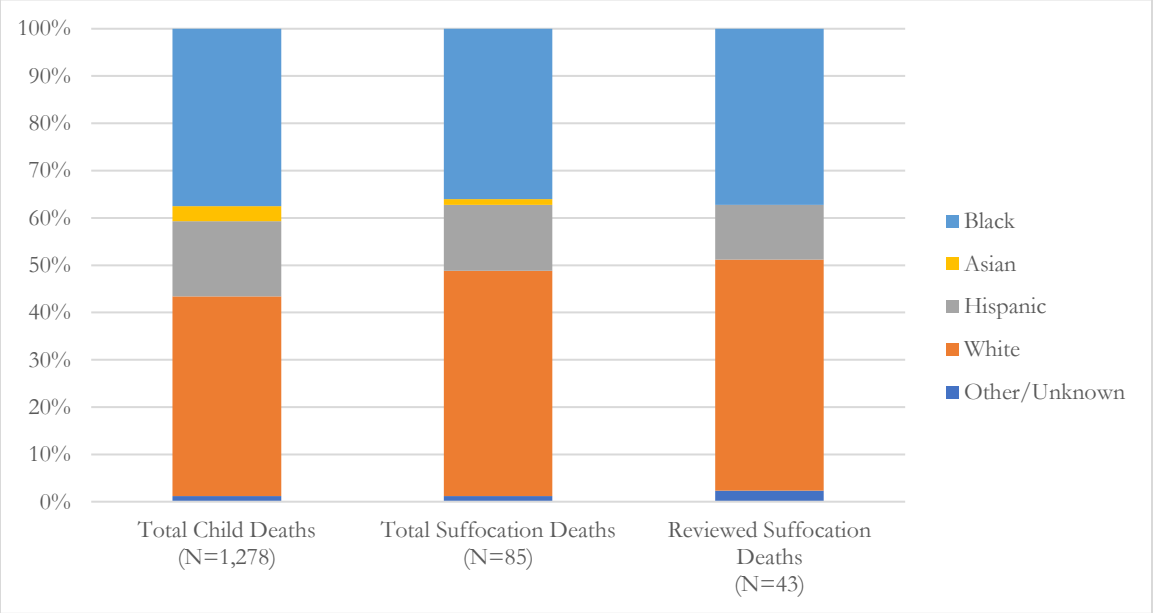


Figure 24: Child Deaths Due to Suffocation by Race/Ethnicity



Undetermined Deaths

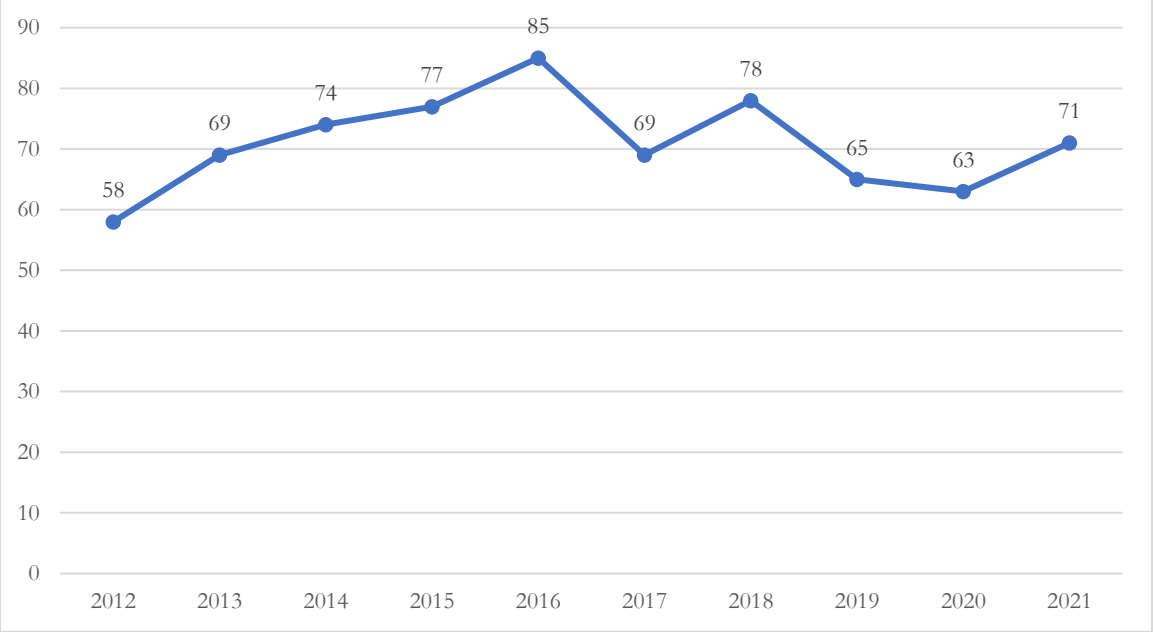
Definition

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

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of undetermined deaths in Illinois has ranged between 58 and 85 in the last decade, and there were 71 undetermined deaths in 2021 (see Figure 25).

Figure 25: Child Deaths with Undetermined Cause of Death



In 2021, 71 of the 1,278 total child deaths reported to the CDRTs (6%) had an undetermined cause of death.

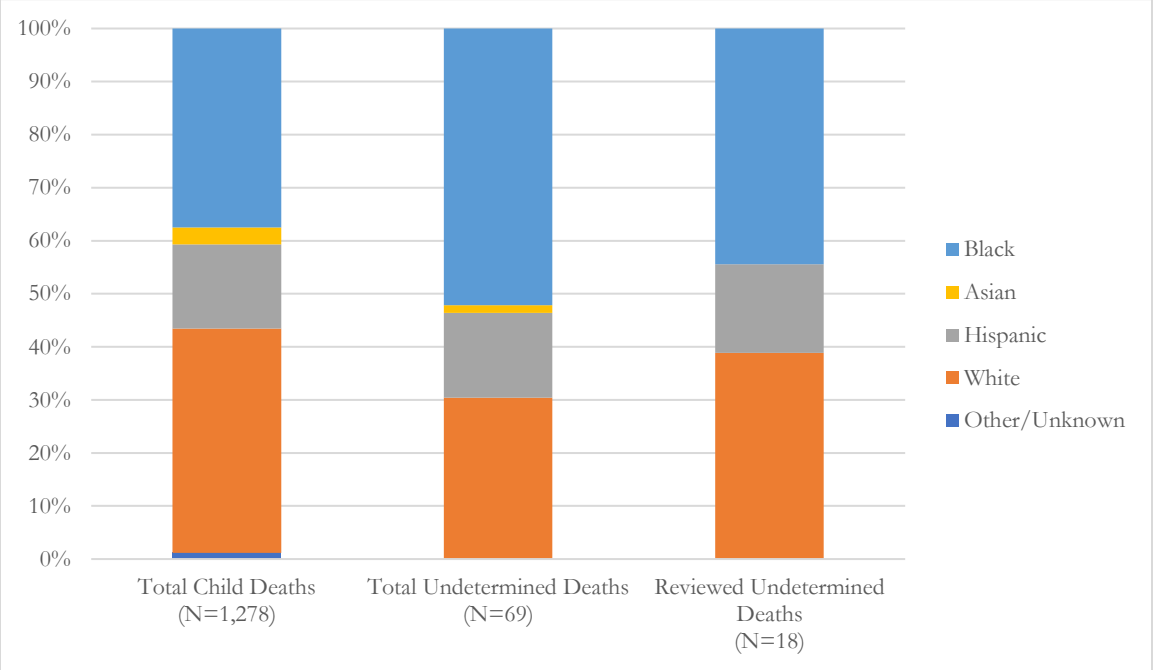
- Deaths due to undetermined causes were more common for males (56%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (93%).
- Black children accounted for the majority of undetermined deaths (54%), followed by White children (30%), Hispanic children (15%), and Asian children (1%) (see Figure 26).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 18 of the 213 deaths reviewed by CDRTs (8%) had an undetermined cause of death.

- Reviewed deaths due to undetermined causes were evenly split between males and females (50% each).
- 89% of reviewed undetermined deaths were children under age 1.
- Black children accounted for the largest proportion of undetermined deaths (44%), followed by White children (39%), and Hispanic children (17%) (see Figure 26).

Figure 26: Child Deaths with Undetermined Cause by Race/Ethnicity



Poisoning/Overdose

Definition

Deaths due to poisoning resulted 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

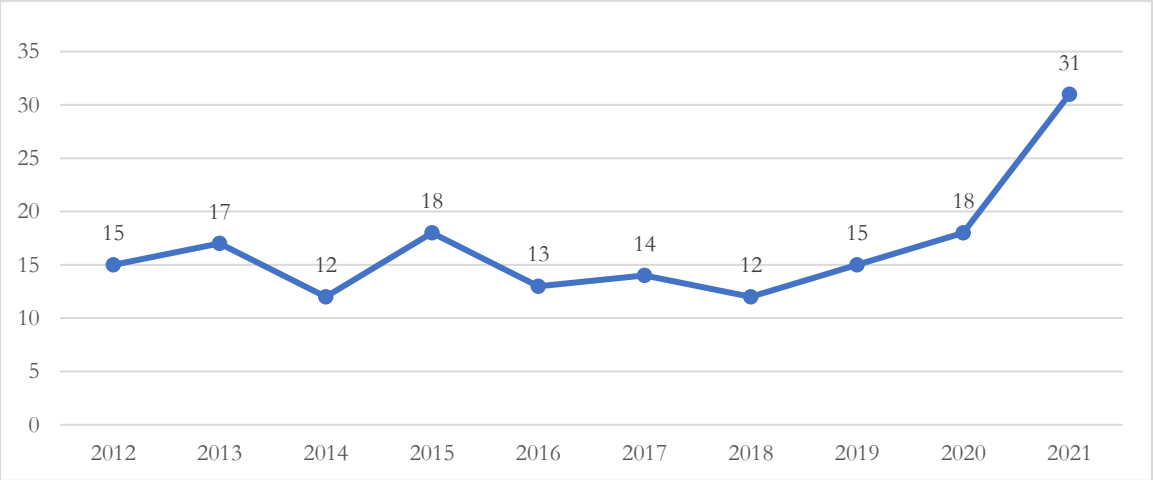
In 2021, 926 children under 18 years died of poisoning in the United States.[24] Over six in ten of these deaths occurred in children 15 to 17 years of age. Children 4 and under make up a large proportion of poisoning deaths (22%).

Each year, about 60,000 children in the United States are treated in emergency departments for unintentional medication exposure or overdose. For children under five, 95% of these visits are caused by accidental ingestion of medications and 5% are dosing errors.[25] 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

Poison/overdose deaths saw a high of 31 deaths in 2021, compared from data over the past decade (see Figure 27).

Figure 27: Child Deaths Due to Poisoning/Overdose



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

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

In 2021, 31 of the 1,278 total child deaths (2%) were related to poisonings or overdoses.

- Males made up a slight majority of poisoning or overdose deaths (52%).
- The majority of poisoning or overdose deaths were children ages 15 to 17 (58%), followed by children between 0 and 1 (19%), and children 10 to 14 (16%). The other deaths were of children between age 1 to 4 (6%), and there were no deaths of children ages 5 to 9.
- Over half of reviewed poison deaths were White children (52%), Black children were 29%, and 19% were Hispanic.
- Accidents accounted for over half (52%) of poison/overdose deaths, and the remaining cases were suicides (23%), homicides (16%), and 10% were undetermined.

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 10 of the 213 deaths reviewed by CDRTs (5%) were related to poisoning/overdose.

- Reviewed poisoning deaths were equally split between males and females (50% each).
- Children under 1 made up half (50%) of reviewed poison deaths. The other deaths were of children 1 to 4 (10%), children 10 to 14 (10%) and children 15 to 17 (30%).
- The majority of reviewed poison deaths were White children (70%), two cases were Black children (20%), and one case was a Hispanic child (10%).
- The largest proportion of poison/overdose deaths were homicides (40%), and the remaining cases were accidental (30%), suicide (10%), and undetermined (20%).

Injuries

Definition

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

Background

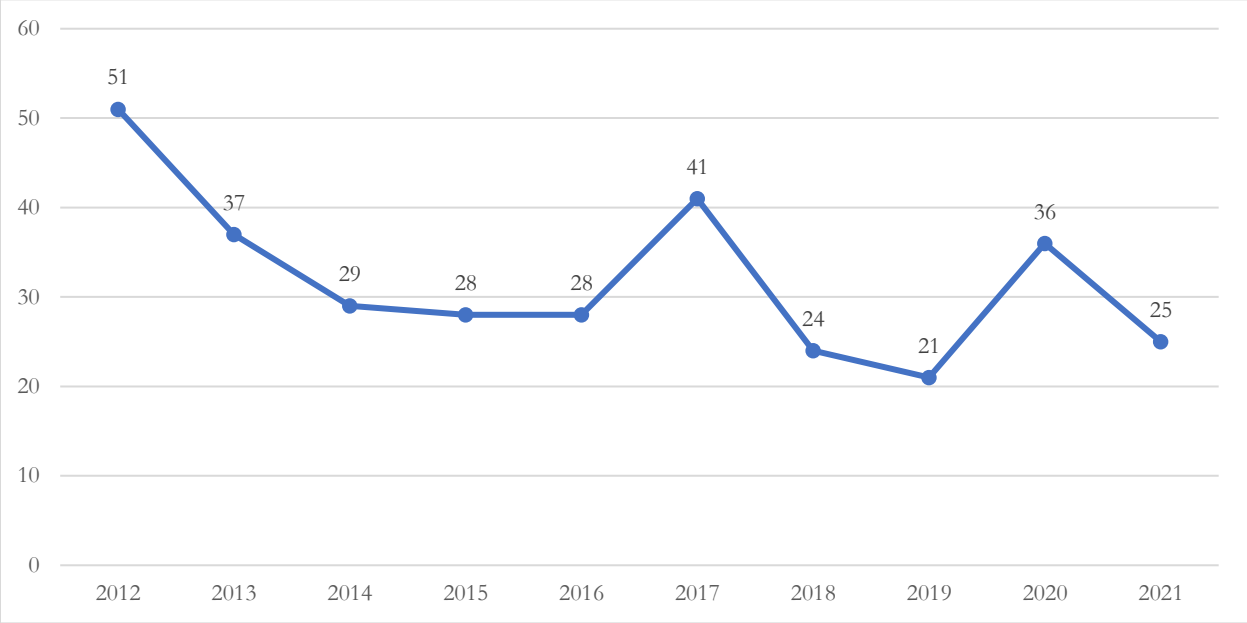
Child maltreatment (including abuse and neglect) is one cause of death from injuries. Based on 2021 data from the National Child Abuse and Neglect Data System (NCANDS), it is estimated that 1,820 children died from abuse and neglect at a rate of 2.46 deaths per 100,000 children. Younger children are the most vulnerable to die as a result of child abuse and neglect. Around 46% of child fatalities were children under one years old. In 2021, females had higher victimization rates (8.7 per 1,000) than did males (7.5 per 1,000); however, males had a higher fatality rate (3.01 per 100,000) compared to females (2.15 per 100,000). Black children had higher rates of injuries (5.60 per 100,000) compared to White children (1.94 per 100,000) and Hispanic children (1.44 per 100,000).[26] Of child maltreatment deaths, about three-quarters (77.7%) suffered neglect and 42.8% suffered physical abuse either exclusively or in combination with other maltreatment types (e.g., medical neglect, psychological abuse, sexual abuse).

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries had dropped to a low of 21 in 2019 and was 25 in 2021 (see Figure 28).

[26] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2023). *Child maltreatment, 2021*. Washington, DC: Government Printing Office. Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2021.pdf

Figure 28: Child Deaths Due to Injuries



In 2021, 25 of the 1,278 total child deaths reported to the CDRTs (2%) were related to injuries.

- Most injury deaths were males (56%).
- Children under 1 made up the largest proportion of injury deaths (44%), followed by children 1 to 4 (24%), children 15 to 17 (16%), and children 5 to 9 and children 10 to 14 each accounted for 8% (see Figure 29).
- A slight majority of reviewed injury deaths were Black children (52%), and the remainder were White children (48%) (see Figure 30).
- Most deaths related to injuries were homicides (72%). Accidents accounted for 20% of injury deaths, and suicides were 8%.

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 15 of the 213 deaths reviewed by the CDRTs (7%) were related to injuries.

- Most injury deaths reviewed by CDRTs were males (60%).
- Children under 1 made up the largest proportion of injury deaths (53%), followed by children 1 to 4 (27%), children 10 to 14 (13%), and children 5 to 9 (7%) (see Figure 29).
- A slight majority of reviewed injury deaths were White children (53%), and the remainder were Black children (47%) (see Figure 30).
- Nearly all reviewed injury deaths were homicides (93%), and 7% were accidental.

Figure 29: Child Deaths Due to Injuries by Age

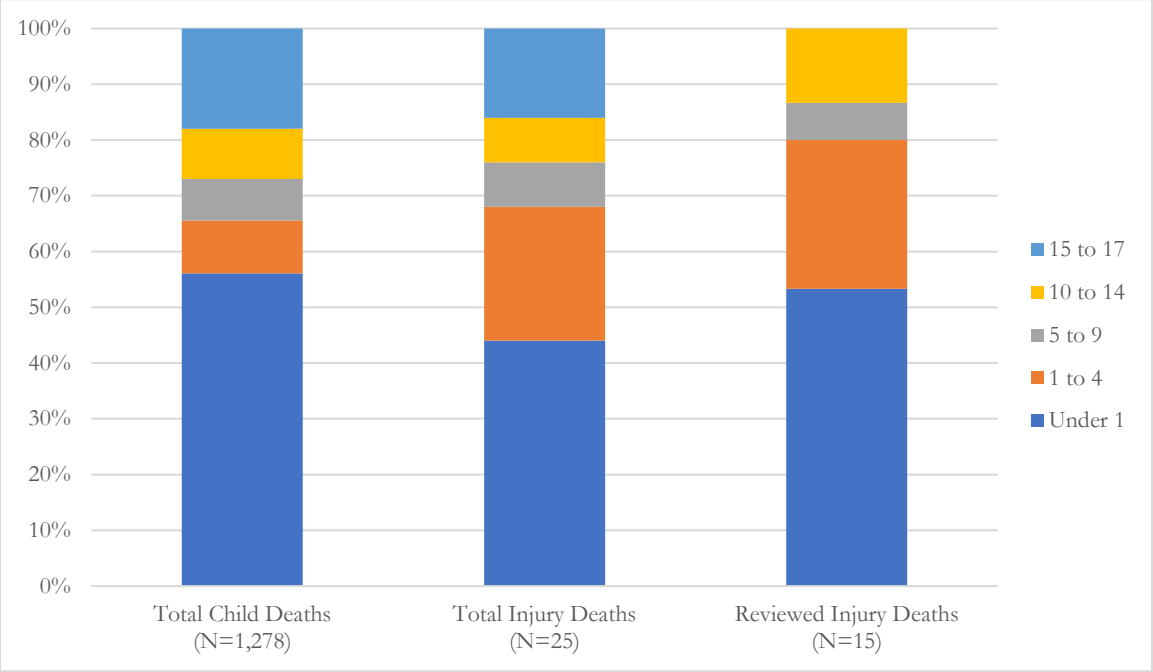
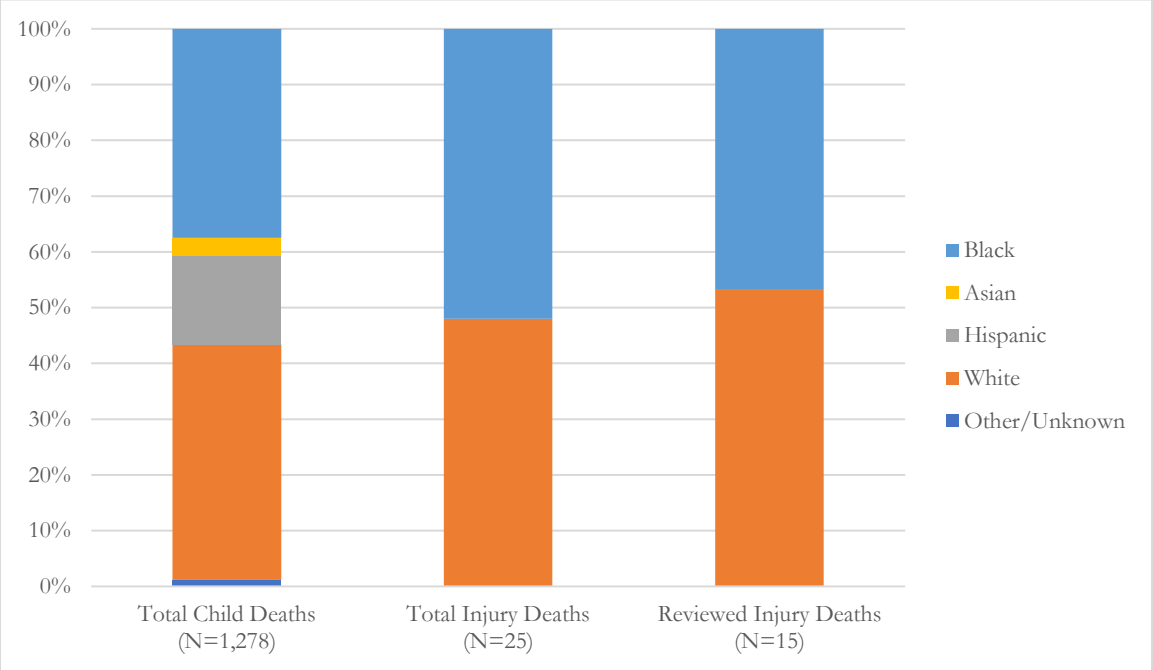


Figure 30: Child Deaths Due to Injuries by Race/Ethnicity



Drowning

Definition

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

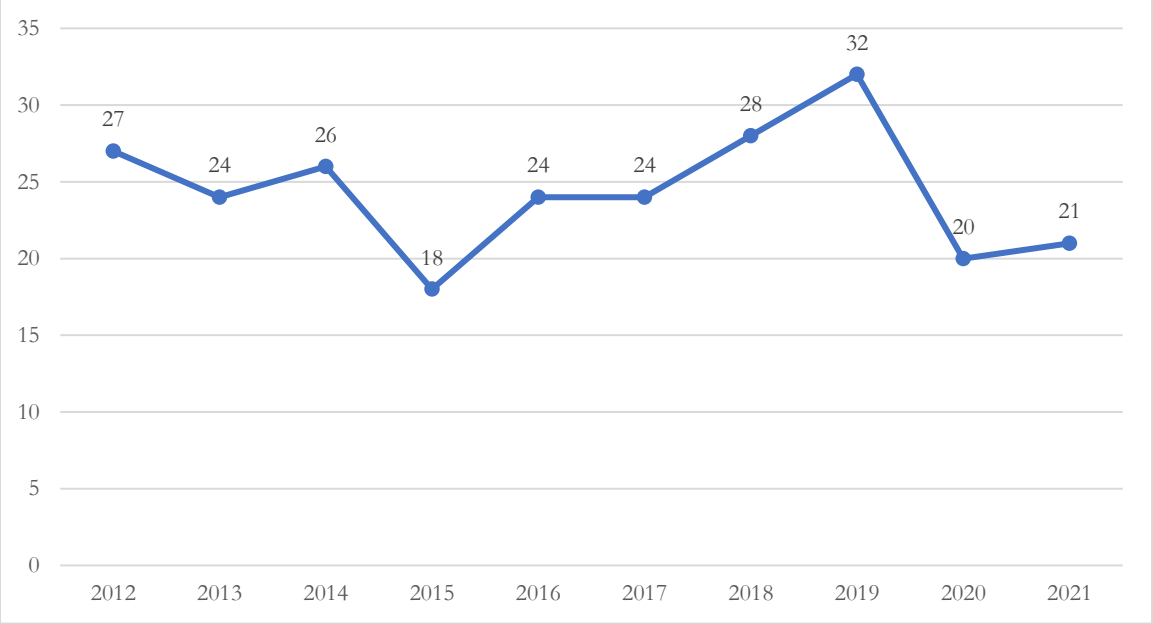
Background

In 2021, 848 children ages 17 and under died as a result of unintentional drowning in the United States. Children 4 and under accounted for 60% of these deaths,[27] and drowning is the leading cause of injury-related deaths among children in this age range and the second leading cause of unintentional injury-related death among children 5 to 14. Black children had higher drowning death rates than that of White children.[28, 29]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths from drowning have ranged between a low of 21 in 2015 and have increased in subsequent years to a high of 32 in 2019; however, the number of drowning deaths is back down in the past two years (see Figure 31).

Figure 31: Child Deaths Due to Drowning



[27] Centers for Disease Control and Prevention (2023). *WISQARS Fatal and Nonfatal Injury Reports: Injury Counts and Rates.* Retrieved from https://wisqars.cdc.gov/reports/
[28] Safe Kids Worldwide. (2021). *Swimming.* Retrieved from https://www.safekids.org/poolsafety.
[29] Centers for Disease Control and Prevention. (2022). *Drowning Facts.* Retrieved from https://www.cdc.gov/drowning/facts/index.html

In 2021, 21 of the 1,278 total child deaths reported to the CDRTs (2%) were related to drowning.

- There were slightly more drowning deaths of males (52%).
- Children 1 to 4 years of age accounted for over half of drowning deaths (57%). Children 5 to 9 years old accounted for 24%, and children 15 to 17 were 10%. There was a single drowning death both of children under 1 and for children 10 to 14 (5% each) (see Figure 32).
- Nearly half of reviewed drowning deaths were White children (48%), Black children were 29%, Hispanic were each 19%, and Asian children were 5% (see Figure 33).
- The majority of drowning deaths were accidental (95%), and one death was undetermined (5%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 12 of the 213 reviewed deaths (6%) were related to drowning.

- Reviewed drowning deaths were more likely to be of females (58%).
- Children 1 to 4 years of age accounted two-thirds of reviewed drowning deaths (67%), children 5 to 9 years old were 25%, and children under 1 were 8% (see Figure 32).
- Half of the reviewed drowning deaths were White children (50%), Black children were 33%, and Hispanic children and Asian children were each 8% (see Figure 33).
- Nearly all reviewed drowning deaths were accidents (92%), and one case was undetermined (8%).

Figure 32: Child Deaths Due to Drowning by Age

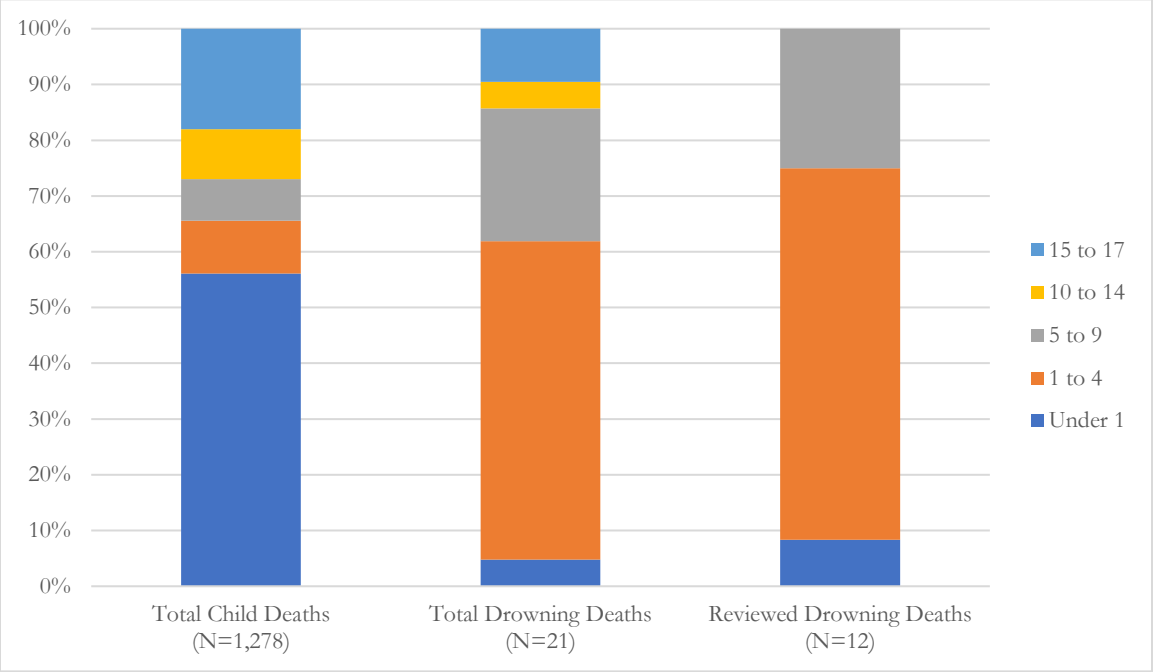
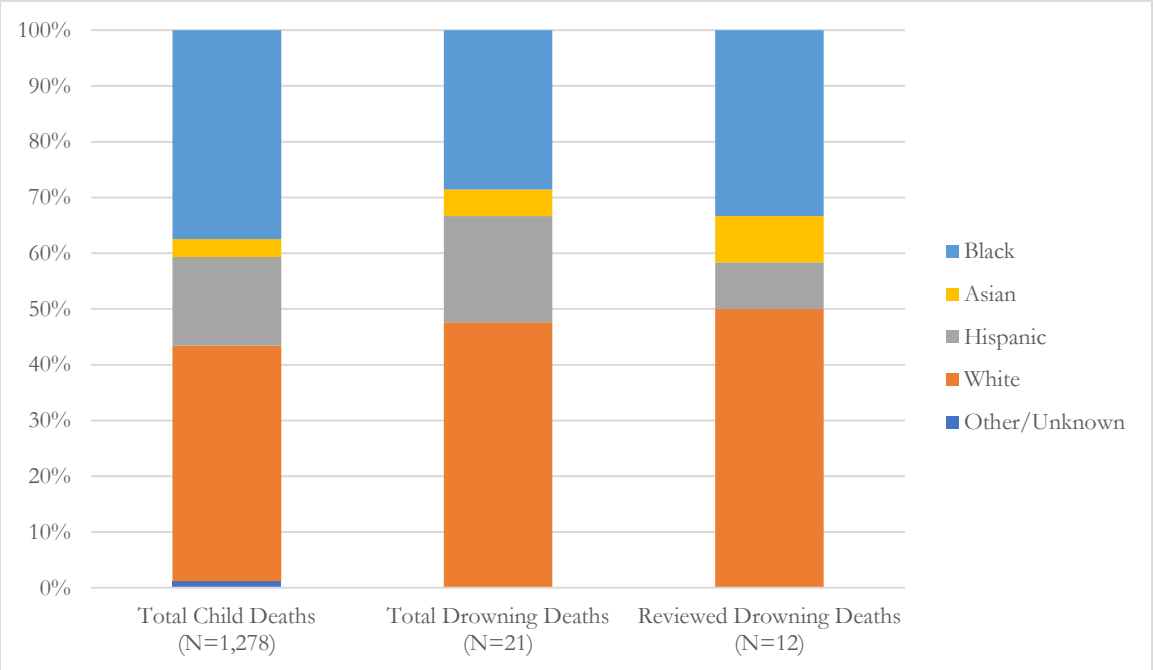


Figure 33: Child Deaths Due to Drowning by Race/Ethnicity



Fire

Definition

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

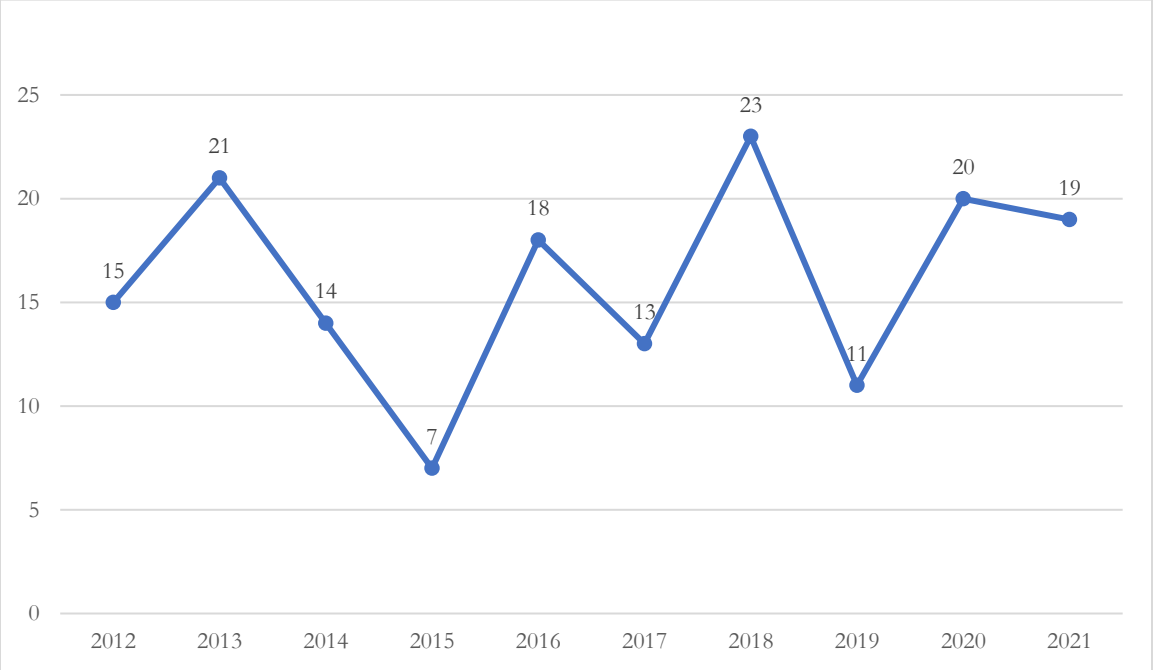
Background

In the United States, fire and burns were the cause of an estimated 328 deaths among children between 0 and 17 years in 2021. Thirty-nine percent of fire deaths occurred in children ages 4 and under.[30] A large proportion (about 87%) of fire-related fatalities are due to home fires, but functioning smoke alarms can reduce the chances of dying by almost 50%.[31]

Illinois Data—Total Child Deaths Reported to the CDRTs

The number of child deaths due to fire has ranged between a low of 7 to a high of 23 in the past decade. There were 19 deaths due to fire in 2021 (see Figure 34).

Figure 34: Child Deaths Due to Fire



[30] Centers for Disease Control and Prevention (2023). *WISQARS Fatal and Nonfatal Injury Reports: Injury Counts and Rates*. Retrieved from https://wisqars.cdc.gov/reports

[31] Safe Kids Worldwide. (2023). *Fire safety*. Retrieved from https://www.safekids.org/fire

In 2021, 19 of the 1,278 total child deaths reported to the CDRTs (1%) were related to fires.

- There were slightly more fire deaths among females (58%).
- The largest proportion of deaths from fires were children age 5 to 9 (42%), followed by children 1 to 4 (32%), children under 1 (16%), and 11% were children age 10 to 14. There were no deaths from fire of children age 15 to 17.
- Over half of the deaths due to fire were Black children (53%), Hispanic children were 26%, and White children were 21%.
- The majority of deaths attributable to fire were accidental (79%), and the remaining cases were homicides (16%) or undetermined (5%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, nine of the 213 deaths reviewed by the CDRTs were related to fire (4%).

- Five of the reviewed fire deaths were females (56%).
- The largest proportion of reviewed fire deaths were children age 5 to 9 (56%), followed by children and 1 to 4 (22%), and children under 1 and children age 10 to 14 each accounted for 11%. There were no reviewed fire deaths of children age 15 to 17.
- The majority of the deaths due to fire were Black children (89%), and one was a White child (11%).
- Two-thirds of the cases were accidental (67%), and the remaining cases were homicides (22%) or undetermined (11%)

Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)[32]

Definition

According to Centers for Disease Control and Prevention (CDC),[33] there are about 3,400 Sudden Unexpected Infant Deaths (SUID) each year in the United States. SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation. From the most recent available data from 2020, 1,389 deaths were due to Sudden Infant Death Syndrome (SIDS), which is defined as the sudden death of an infant that cannot be explained after a thorough investigation is conducted that includes a complete autopsy, examination of the death scene, and review of the clinical history. Another type of SUID is of unknown cause, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted, and the cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of "suffocation" in the report.

Cook County joined the CDC-funded Sudden Unexpected Infant Death Case Registry in 2019, adding to a national surveillance system that supports detailed analysis of SUID in participating states and jurisdictions in order to drive prevention that serves impacted communities. Rush University Children's Hospital partners with the Cook County Medical Examiner's Office (CCMEO) and the IL child death review (CDR) teams for Cook County in this effort. Their reports can be found at https://rush.edu/suid.

Special Note:
This report identifies that "nationally, SUID occurs more than twice as often among Black, non-Hispanic infants, and about half as often among Hispanic infants, as compared to white, non-Hispanic infants.

In Cook County, SUID occurred 14 times more often in Black infants, and 2.5 times more often in Hispanic infants when compared to white infants."

Background

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

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[32] 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.
[33] Center for Disease Control and Prevention. (2022). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Data and Statistics*. Retrieved from https://www.cdc.gov/sids/data.htm

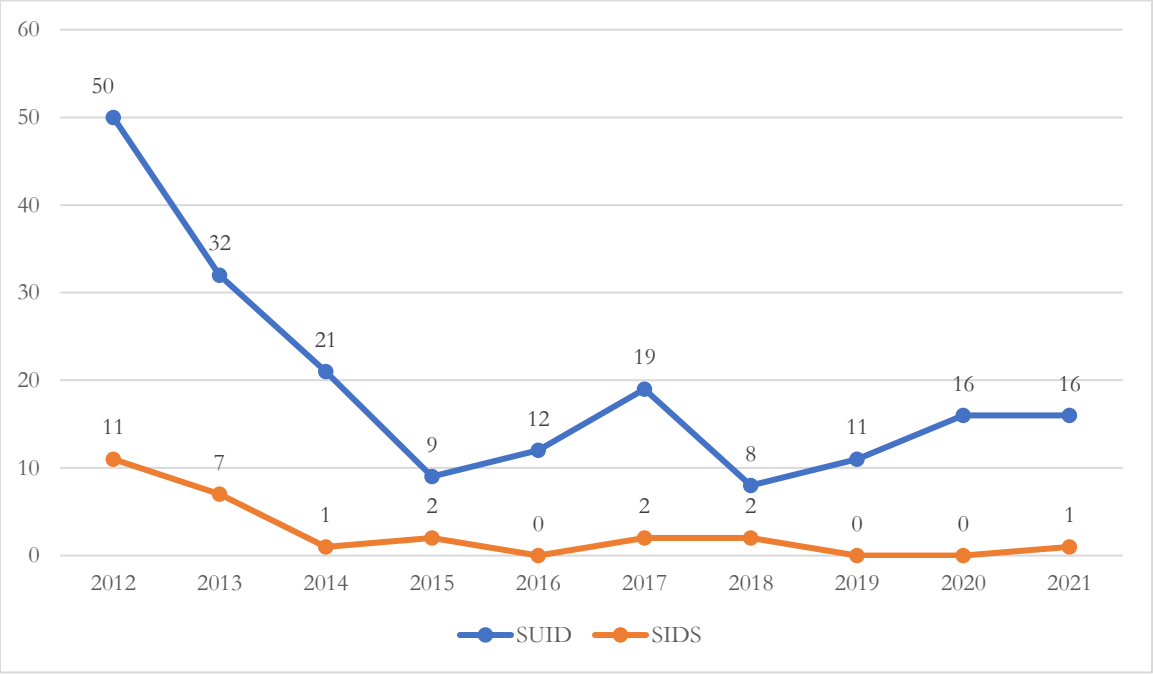
A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.[34]

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.[35]

Illinois Data—Total Child Deaths Reported to the CDRTs

Since the peak of 47 cases in 2010, SIDS has experienced a sharp decline, with a very low number of deaths occurring in recent years (see Figure 35). Infant deaths from SUID were added as a category in 2007. Child deaths due to SUID reached a peak of 50 in 2012, but since then also have a large decline.

Figure 35: Child Deaths Due to SIDS and SUID



[34] 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.

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

In 2021, 16 of the 1,278 child deaths were categorized as SUID (<1%), and there was one death from SIDS (<1%).

- The majority of SUID deaths were males (69%). The SIDS death was a female (100%).
- All SUID and SIDS deaths were infants under 1 year (100%).
- The majority SUID deaths were White children (63%), Black children were 31%, and one child was Hispanic (6%). The SIDS death was a Black child (100%).
- The majority of SUID deaths were undetermined (69%), and the remainder were natural (25%) or accidents (6%).

Illinois Data—Deaths Reviewed by the CDRTs

In 2021, 12 of the 213 deaths reviewed by the CDRTs were related to SUID (6%), and one of the SIDS cases was reviewed (<1%).

- Males made up 67% of reviewed SUID deaths. The SIDS death was a female (100%).
- All reviewed SUID and SIDS cases were infants under 1 year of age (100%).
- Over half of reviewed SUID deaths were White children (58%), Black children were 33%, and one child was Hispanic (8%). The reviewed SIDS death was a Black child (100%).
- Most SUID deaths were undetermined (75%), and the remainder were natural (17%) or accidental (8%). The SIDS death was natural (100%).

Uncommon Death Categories and Pending Cases

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

Other

As implied by this label, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism and malnourishment). In 2021, five deaths were categorized under this label.

Pending Cases

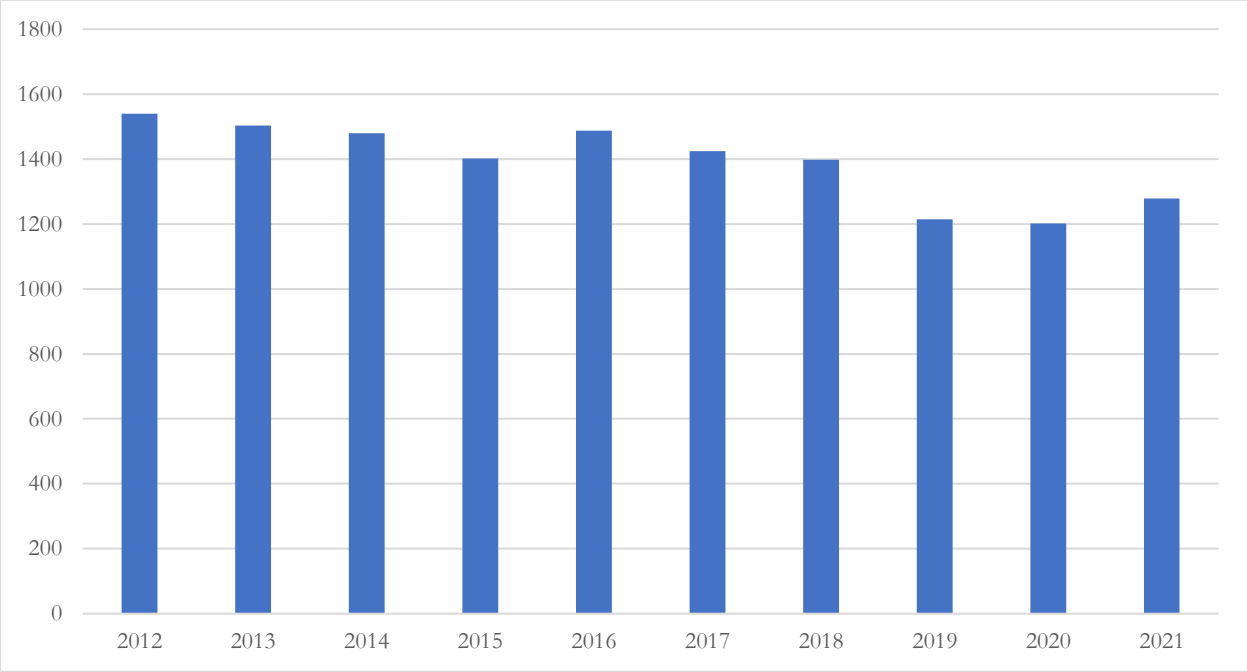
There were 13 deaths that were pending at the time of writing this report.

Chapter 5: Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths since 2000, which allows for an analysis of the trends in Illinois child deaths over time. Since 2012, the deaths reported to DCFS come from the HFS Enterprise Data Warehouse (EDW). The EDW receives the deaths from IDPH. Thus, from 2012 forward, the DCFS deaths and IDPH deaths are consolidated.

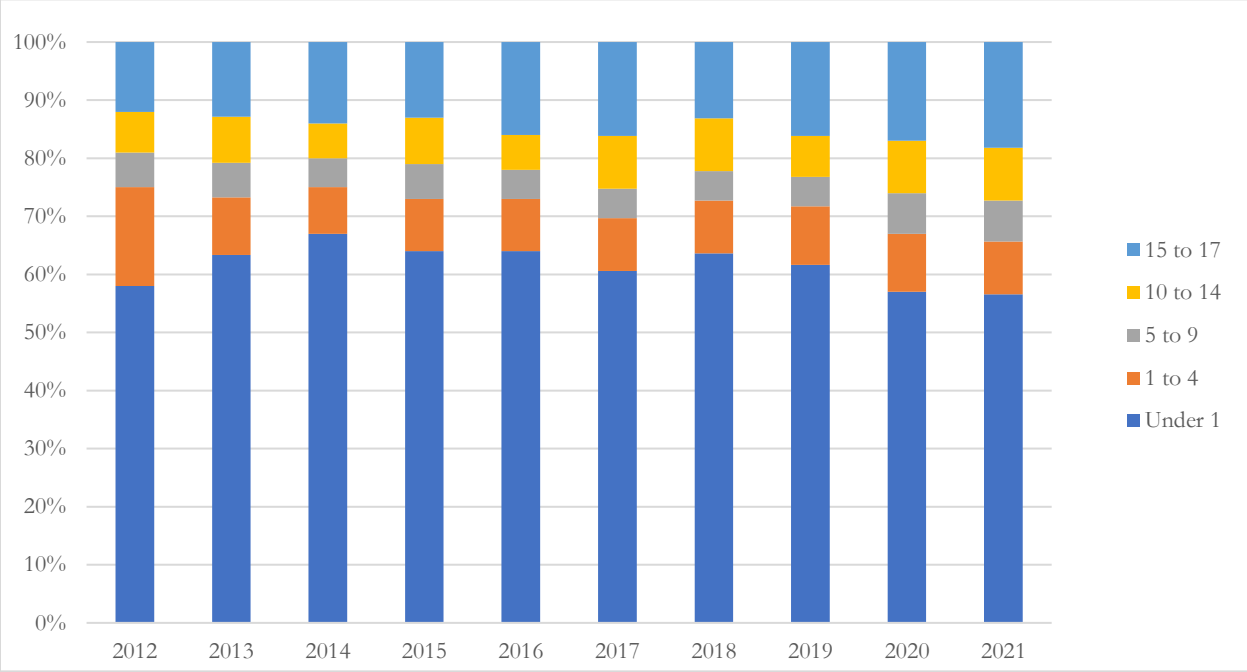
The number of total child deaths in Illinois has declined nearly every year in the past decade, from a high of 1,540 in 2012 to a current count of 1,278 in 2021 (see Figure 36).

Figure 36: Total Child Deaths Reported to DCFS, 2012-2021



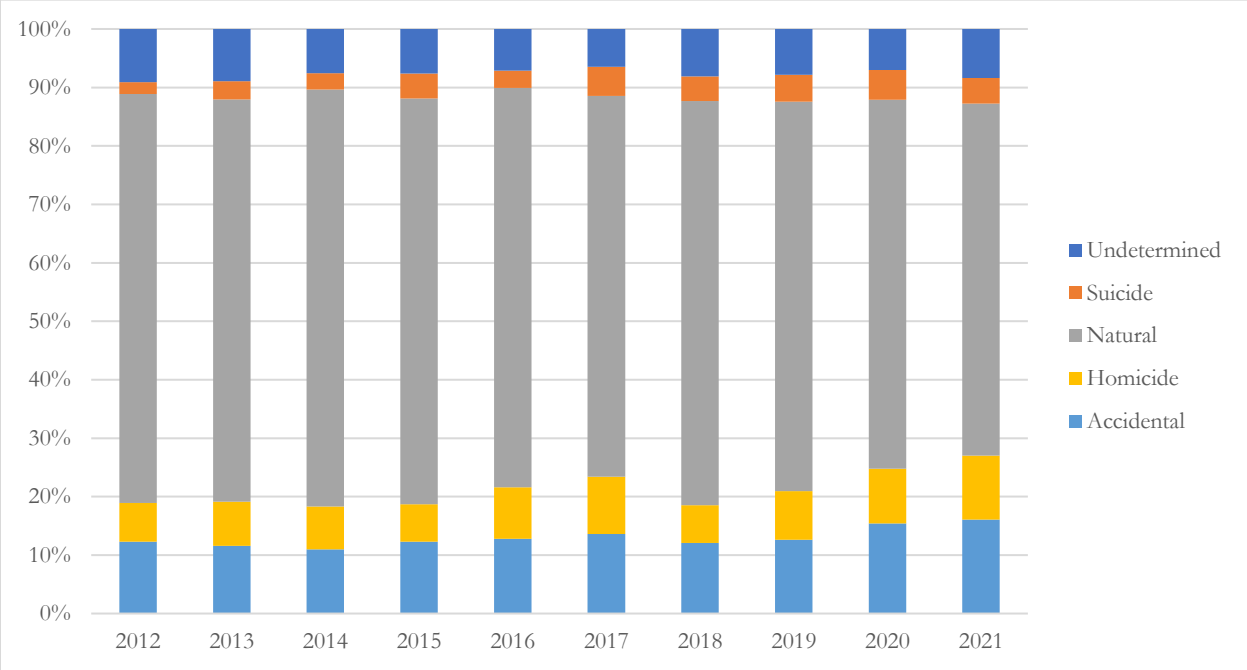
The total child deaths reported to the Child Death Review Team Unit from 2012 to 2021 is broken down by age group in Figure 37. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another so that the sum for each year is 100%. This type of graph allows us to compare the percentages of each category across multiple years, so that we can determine, for example, if the percentage of infant deaths is increasing, decreasing or staying the same. As Figure 37 shows, the percentage of total deaths in each age group is generally stable over the 10-year period: infants under 1 year comprise 56-67% of all child deaths, children between 1 and 4 years comprise 8-17%, children between 5 and 9 years add another 5-7%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are about 12-18%.

Figure 37: Total Child Deaths by Age Group, 2012-2021



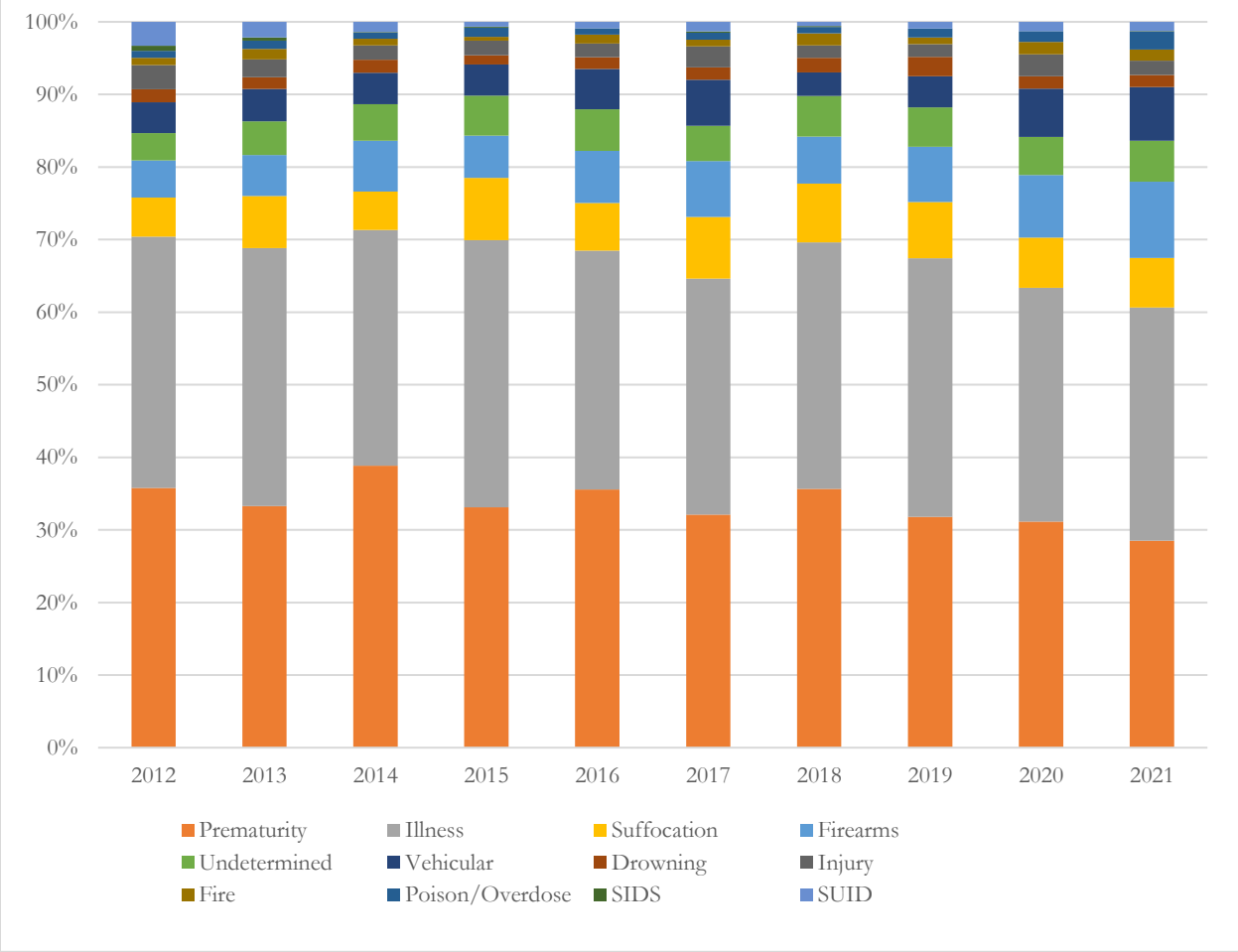
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 11-16% accidental, 6-11% homicide, 60-72% natural, 2-5% suicide, and 6-9% undetermined (see Figure 38).

Figure 38: Total Deaths by Manner of Death, 2012-2021



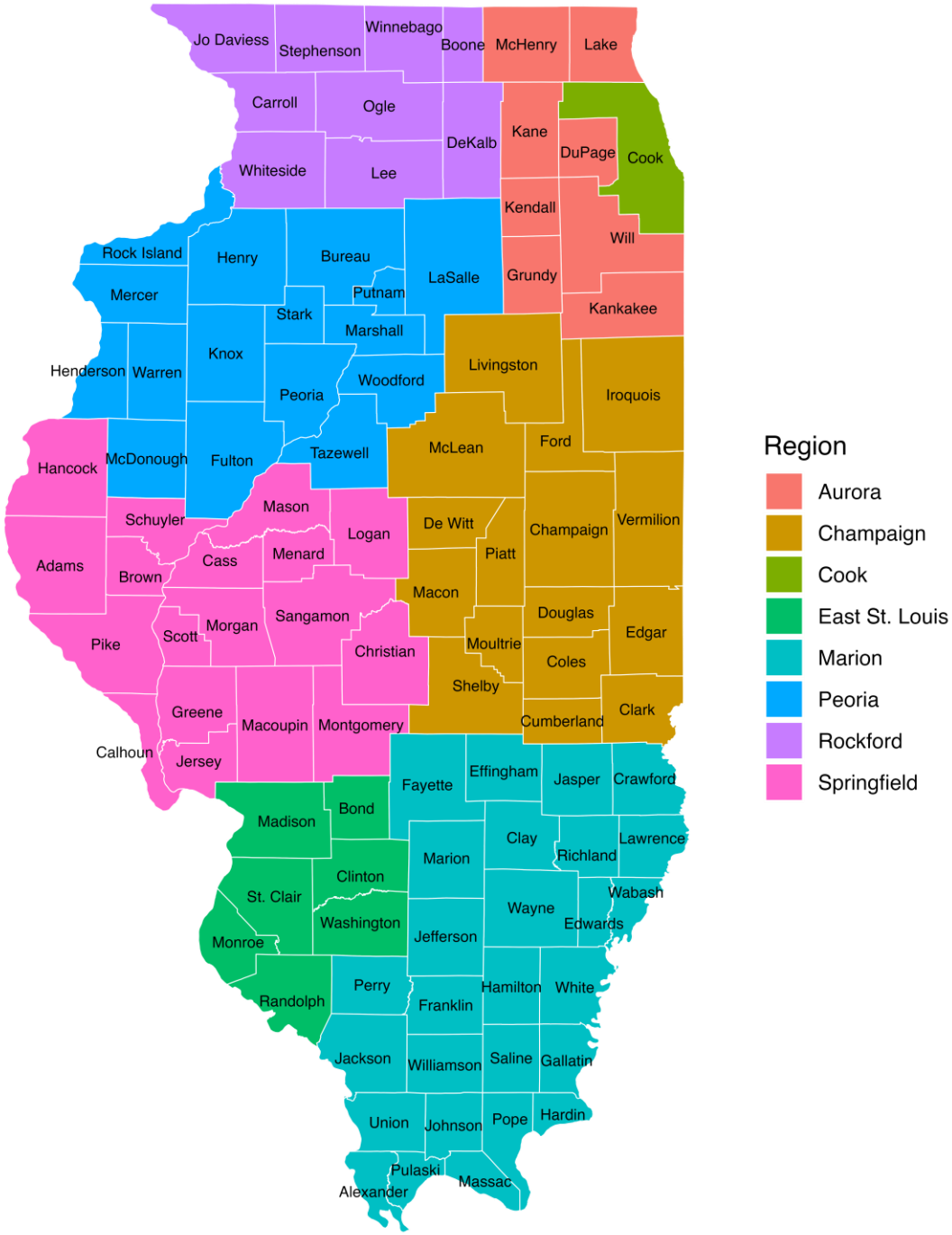
A similar analysis was done for category of death (see Figure 39). The percentage of child deaths related to each category of death across the time period varies. The major categories of deaths from prematurity (28-39%) and illness (32-37%) fluctuated over time. There was an increasing trend for deaths from firearms (5% before 2013 to a current high of 10%) and undetermined causes (4% before 2013 to 5-6% since 2013); and SIDS deaths have remained low (less than 1% since 2012). For more detailed changes within each category, please refer to the charts for specific categories in Chapter 4.

Figure 39: Total Child Deaths by Category, 2012-2021[36]



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

Appendix A – Child Death Review Teams Regional Map



Appendix B – List of CDRT Members by Region

Aurora
Jennifer Hess, MA, LCPC, **Chairperson**
Joshua Fourdyce
Jennifer Hillgoth
Catherine Hundley
Ashley Johnson
Elena Johnson
Mary E. Jones, MD, MPH
George Kopulos
Jennifer Lindt
Melissa Manrique, MD
Nancy Maruyama
Nydia Molina
Loren Richardson Carrera
Jennifer Samartano
Margaret Spoelhof
Hilary Strawn McElligott, MD
Anne Strickland
Ronald Tomalis, Special Agent
Olivia Zednick

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

Cook Team A
Daniela Silaides, **Vice Chairperson**
Seyedeh Ahadi, MPH
Janet Barnes
Kristen Bilka, MMS, PA-C
Kristine Caraballo
Felicia Clark
Margaret Conway

Cook Team A (cont.)
Dr. Kristin Escobar-Alvarenga
Brian Finley
Jill Glick, MD
Mary Henderson
Nicole Jackson, MD
Sharon Koc
Rhonda Laye
Thomas Mockler, Special Agent
Kyran Quinlan, MD, MPH
Karen Pitroda
Candice Robinson, MD, MPH
Dion Trotter
Janice Waters
Odessa Williams
Syed Zaheer
Virginia Zic-Schlomas, Sgt.

Cook Team B
Mary Joly Stein, **Chairperson**
Kim King, **Vice Chairperson**
Sweety Agrawal, PsyD
Seyedeh Ahadi, MPH
Shawnte Alexander
Rebecca Chacon, LCSW
Craig Engebretson
Lindsay Forrey, LCSW
Kathy Grzelak, MA, LCPC
Nicole Johnson, MD
William Leen, Commander (Retired)
Jose Manuel Ortiz
Michael Minniear
Alpa Patel
Anna Pesok, MD
Kass Plain
Veena Ramaiah, MD
Meredith A. Reynolds, MD
Joe Rokowski
Dr. Benjamin Soriano
Demetra Soter, MD
Annie Torres, MD
Jason Wynkoop

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

Marion
Mary Louise Cashel, **Chairperson**
Robin Hopper, **Vice Chairperson**
Tylor Barber
Lukasz Dabrowski, MD
Connie Edgar
Sarah Fager, RN
Lisa Irvin
Jennifer Lindsey
Betti Mucha
Joe Murphy
Brittany Pierce
Kathy Swafford, MD
Tammy Turner
Steve Webb, PhD
Amy Wilson-Dallas

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

Peoria (cont.)
Melissa Watkins
DCFS Liaison - Megan Sturtevant

Rockford
Joanna Deuth, **Chairperson**
Holly Peifer, **Vice Chairperson**
Rebecca Anderson
Justin Anderson
Pamela A. Borchardt
Amy Buchenau
Raymond Davis, Jr., MD
David Glessner
Allison Huntley
Fred Jones
Shannon Krueger, CPNP, SANE-P
Rebecca Wigget

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

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

Appendix C – Illinois Child Deaths by County

County	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Adams	9	5	9	9	8	6	6	2	9	3
Alexander	1	0	0	0	1	1	0	2	0	0
Bond	4	1	0	2	0	2	0	0	0	1
Boone	3	0	1	0	1	2	2	0	0	3
Brown	1	1	0	0	0	0	0	0	0	0
Bureau	2	1	3	0	2	1	0	0	4	4
Calhoun	0	0	0	0	0	0	1	0	0	1
Carroll	1	0	1	0	1	1	0	0	0	1
Cass	1	0	0	0	0	0	0	2	2	0
Champaign	29	49	38	30	45	44	44	39	27	35
Christian	2	1	1	4	2	3	1	1	1	5
Clark	1	3	0	1	1	1	1	0	0	1
Clay	1	1	0	0	3	0	2	1	1	0
Clinton	1	3	0	0	1	3	1	2	0	3
Coles	4	4	4	2	5	6	3	2	4	4
Cook	857	775	815	818	831	766	781	692	622	724
Crawford	4	4	0	1	0	4	1	1	1	0
Cumberland	1	0	0	0	1	0	0	0	0	0
DeKalb	4	9	7	3	6	7	4	8	7	11
Dewitt	0	0	3	1	0	1	3	3	1	0
Douglas	1	0	1	0	1	2	0	0	0	0
DuPage	66	70	80	63	76	56	70	67	64	49
Edgar	1	1	1	2	1	0	2	0	0	2
Edwards	1	0	1	0	0	0	0	0	0	0
Effingham	2	7	5	5	4	3	4	1	1	4
Fayette	0	2	3	1	1	1	0	2	0	0
Ford	1	2	1	0	0	1	1	2	1	0
Franklin	0	2	4	6	3	1	1	0	8	3
Fulton	3	0	0	2	2	2	2	1	1	4
Gallatin	1	0	0	0	0	0	0	0	0	0
Greene	0	0	1	0	0	4	1	1	2	3
Grundy	3	2	1	2	1	3	1	0	2	3
Hamilton	1	2	0	1	2	0	0	0	1	0
Hancock	0	1	3	0	0	1	0	1	2	0
Hardin	1	1	1	1	1	1	1	3	0	0
Henderson	0	0	0	0	0	0	0	1	0	1
Henry	2	3	3	2	5	3	1	1	2	2
Iroquois	1	1	0	0	2	2	2	2	1	2
Jackson	16	2	5	9	4	9	8	7	5	6
Jasper	0	0	0	0	1	0	0	0	0	0
Jefferson	2	6	4	2	4	2	6	0	2	3
Jersey	4	2	0	4	2	3	0	0	2	0
Jo Daviess	0	1	0	0	2	0	0	2	1	0
Johnson	2	0	0	0	0	0	0	0	3	0
Kane	42	42	44	51	46	39	45	25	22	29
Kankakee	12	10	10	6	16	9	13	7	7	9
Kendall	2	3	2	0	0	2	1	1	1	2
Knox	3	4	6	6	6	4	3	5	3	3
Lake	33	37	36	36	34	36	35	31	35	28
LaSalle	11	8	7	11	5	4	7	8	8	11
Lawrence	1	2	0	1	0	1	1	1	1	1
Lee	2	3	3	2	1	6	1	2	0	7

Livingston	3	0	4	2	3	2	2	3	2	0
Logan	3	3	1	0	3	3	1	2	0	4
Macon	7	4	12	11	7	11	7	9	15	4
Macoupin	0	5	4	2	0	2	0	1	2	1
Madison	8	12	14	18	21	18	23	15	11	14
Marion	2	5	5	10	3	4	3	3	3	2
Marshall	0	0	0	1	1	0	0	0	0	1
Mason	0	3	1	2	1	0	0	1	1	3
Massac	2	1	0	1	3	1	1	2	1	1
McDonough	1	2	0	1	0	1	3	1	0	0
McHenry	12	17	9	9	9	11	9	9	12	11
McLean	9	12	13	14	8	11	8	6	9	7
Menard	0	0	0	0	0	0	0	0	0	0
Mercer	2	6	0	1	0	1	2	0	1	0
Monroe	1	1	0	1	0	0	0	1	0	2
Montgomery	1	0	4	2	3	0	2	3	0	5
Morgan	2	3	3	0	2	4	2	2	3	1
Moultrie	1	0	0	0	0	1	0	1	0	0
Ogle	0	0	2	3	0	4	0	1	0	0
Peoria	109	72	82	63	76	83	68	65	76	52
Perry	1	3	2	1	2	0	1	1	0	0
Piatt	1	0	0	0	0	2	0	1	0	1
Pike	0	0	0	0	1	0	3	2	1	1
Pope	1	0	0	0	0	1	0	0	0	1
Pulaski	0	0	0	0	0	0	0	0	1	0
Putnam	0	0	0	1	0	0	1	0	0	0
Randolph	6	7	2	1	3	0	4	1	2	2
Richland	1	1	2	1	2	2	1	1	0	0
Rock Island	11	9	12	8	9	10	8	10	10	7
Saline	3	0	3	3	0	1	5	2	1	1
Sangamon	33	46	39	36	45	38	53	33	42	43
Schuyler	1	1	1	0	0	2	0	1	1	3
Scott	0	2	0	0	1	0	0	0	0	0
Shelby	0	2	0	2	1	2	0	0	0	0
St. Clair	21	31	26	15	15	31	17	10	21	21
Stark	0	0	0	0	0	1	0	1	0	0
Stephenson	1	2	4	3	2	5	5	3	3	5
Tazewell	3	2	7	5	3	6	7	4	3	5
Union	1	2	1	3	0	9	1	0	1	1
Vermillion	11	10	7	4	12	5	5	7	5	7
Wabash	1	0	1	0	1	0	0	1	2	0
Warren	1	1	1	1	1	1	1	4	0	1
Washington	0	1	1	0	1	0	1	0	0	1
Wayne	2	1	1	3	1	0	0	0	1	1
White	1	0	1	0	2	0	0	0	0	0
Whiteside	1	4	3	1	6	3	5	1	9	4
Will	33	34	38	24	36	34	38	29	43	28
Williamson	6	6	13	6	3	5	8	3	6	3
Winnebago	40	36	43	46	59	57	47	45	47	44
Woodford	1	4	1	2	1	0	0	3	1	0
Unknown	0	0	0	0	0	3	0	0	0	0
Out of State	47	81	12	11	12	6	0	0	12	22
Out of Country	9	0	0	0	0	0	0	0	0	0
Total	1,540	1,503	1,479	1,402	1,487	1,424	1,398	1,214	1,202	1278

Appendix D – 2021 Illinois Child Deaths Recommendations and Responses

Recommendation Types:
DCFS = DCFS recommendation
PP = Primary Prevention recommendation
CS = Case-specific recommendation
Other = Other System recommendation

Type	Recommendation	Response
DCFS	a. DCFS should review the A sequence as an educational opportunity for staff in that: i. The nature of the Hotline call (mom having a black eye caused by her boyfriend, mom citing domestic violence and feeling unsafe with the boyfriend and the need to involve hospital security because of the boyfriend's violent behavior) is such that the case probably should have been taken as an "Action Needed." By the time the case was sent to the field, the mom and baby had been discharged from the hospital, back home with the abusive boyfriend. The report did come in on-line but it is unclear if the reporter had first attempted to call the hotline and did not get through. ii. CDRT would like detailed information on how the Appeals process is conducted - what statutes or procedures govern? Who makes the decisions, based on what evidence, who presents the evidence, etc. The Indicated finding on this case was overturned despite what appears to be clear evidence of ongoing domestic violence between the mom and her boyfriend, as well as between the boyfriend and another woman as well. We would also like to have someone from the Appeals unit present at the next Annual CDRT Symposium so we can understand the process better. This matter should be discussed further with the staff handling the appeal on this case.	a)i. DCFS agrees and the SCR Administrator will handle this. a)ii. <u>Administrative Hearing Process</u> DCFS is mandated by federal regulations to have a process by which individuals who are indicated for child abuse and/or neglect can administratively appeal the indicated finding. The law in Illinois mandates that during an investigation, an investigator must gather and consider all evidence, both inculpatory and exculpatory, and make a decision to indicate a case based on the requirements of the specific DCFS allegation that is indicated after a determination that credible evidence exists. At an administrative appeal hearing, Illinois law requires that DCFS prove its case by a preponderance of the evidence. The law also recognizes that individuals whose names are placed on the State Central Register as perpetrators of child abuse and/or neglect have certain rights – such as a liberty interest in pursuing the career of their choice and a liberty interest in being with family members. There are specific time frames set forth in the DCFS administrative rules for

	b. Investigators should be commended for their excellent work on these cases.	expungement hearings. The final administrative decision must be issued within 90 calendar days of the receipt of the appeal, not counting any continuances requested by the appellant or agreed to by both parties. The Illinois Supreme Court has held that DCFS must strictly adhere to the 90-day time frame for cases indicated under the credible evidence standard. The Illinois Appellate Court has held that the two purposes to the Abused and Neglected Child Reporting Act, 325 ILCS 5/1 *et seq.* (ANCRA), are to protect abused children and to protect any person erroneously accused of abuse, noting that many provisions of ANCRA are designed to protect alleged perpetrators of child abuse and/or neglect from the damaging effects of erroneous or false reports. **Allegation 60 – Environment Injurious to Health and Welfare** Allegation 60, Environment Injurious to Health and Welfare, has been the subject of significant litigation in the past. In 2013, in *Julie Q. v. Illinois Department of Children and Family Services*, the Illinois Supreme Court found that Allegation 60 was void after the words "environment injurious" were removed from the definition of neglected child in ANCRA. Subsequent litigation alleged that DCFS failed to follow the Administrative Procedures Act and re-promulgate Allegation 60 after the *Julie Q.* decision. All of this litigation resulted in a revised Allegation 60 with specific evidentiary requirements, including the addition of the statutorily mandated language for blatant

		disregard. Amendments to ANCRA included a statutory definition of blatant disregard, which is defined as "an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm." 325 ILCS 5/3. The revised Allegation 60 also contains additional requirements and is now defined as: Environment injurious means that a child's environment creates a likelihood of harm to the child's health, physical well-being or welfare and that the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities [325 ILCS 5/3]. This allegation shall be used when the type or extent of harm is undefined but the totality of circumstances, including inculpatory and exculpatory evidence, leads a reasonable person to believe that the child's environment may likely cause harm to the child's health, physical well-being or welfare due to the parent's or caretaker's blatant disregard. Blatant disregard is defined as an incident where the real, significant and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm [325 ILCS 5/3]. This allegation of harm shall also be used when there are conditions that create a real, significant and imminent likelihood of harm to the child's health, well-being or

		welfare (i.e., domestic violence, intimidation, or a child's participation in a criminal act) and the parent or caretaker blatantly disregarded his/her parental responsibility by failing to exercise reasonable precautionary measures to prevent or mitigate the imminent risk of moderate to severe harm. With respect to allegations involving domestic violence, the revised Allegation 60 provides the following, among other things: • An incident of past or current domestic violence may qualify for an Allegation 60 if the domestic violence creates a real, significant and imminent risk of moderate to severe harm to the child's health, physical well-being or welfare and the parent or caregiver has failed to exercise precautionary measures to prevent or mitigate the risk of harm to the child. • The adult victim of domestic violence, who is the non-offending parent or caregiver, is presumed not to be neglectful or to have created an environment injurious to the child so long as he or she has exercised precautionary measures to prevent or mitigate the real, significant and imminent risk of moderate to severe harm to the child. Other factors to consider include: • The child's age • The child's medical condition, behavioral, mental or emotional problems, developmental disability or physical handicap, particularly related to his or her ability to protect himself or herself;

		• The severity of the occurrence; • The frequency of the occurrence; • The alleged perpetrator's physical, mental and emotional abilities, particularly related to his or her ability to control his or her actions; • The dynamics of the relationship between the alleged perpetrator and the child; • The alleged perpetrator's access to the child; • The previous history of indicated abuse or neglect; • The current stresses or crisis in the home; • The presence of other supporting persons in the home; and • The precautionary measures exercised by a parent or caregiver to protect the child from harm. In order to indicate an investigation for Allegation 60, an investigator should have evidence of a likelihood of harm to a child's health, physical well-being or welfare; and evidence that the likely harm to the child was a result of a blatant disregard of parent or caregiver. Where the allegation is based on domestic violence, there must be evidence that the incident of domestic violence at issue in the investigation created a real, significant and imminent risk of moderate to severe harm to the child. In addition, there is a presumption that the non-offending parent or caregiver is not neglectful if they exercised precautionary measures to prevent or mitigation the real, significant and imminent risk of moderate to severe harm to the child. **Appeal Process and Review of Cases by DCFS Legal and Division of Child Protection**

		Once an appeal is filed, the investigation is assigned to an attorney from the DCFS Office of Legal Services. At the appeal stage, the case must be proven by a preponderance of evidence, which is a legal standard higher than credible evidence. DCFS bears the burden of proof at the administrative hearing. Attorneys review the investigations upon assignment to determine that there is admissible evidence for all of the elements required by the specific allegation that is being indicated and that the case can be proven by a preponderance of the evidence. If the attorney does not believe they can meet the evidentiary burden at the administrative hearing, they may write up the case and request a review by high-level child protection and legal staff. A joint decision (child protection and legal) is made to voluntarily unfound the case based upon this review. For Allegation 60, the Department must prove, at a minimum, by a preponderance of evidence: 1. A child's environment created a likelihood of moderate to severe harm; 2. An incident of suspected neglect; 3. Real, significant and imminent risk obvious to a reasonable parent; and 4. That the parent did not take precautionary measures to mitigate the risk and protect that child from harm. DCFS is open to presenting at the Annual Symposium and requests some specific information on what the Executive Council would like addressed.

		b. DCFS agrees and will commend the investigators for their excellent work on these cases.
DCFS	1) Complex cases with chronic medical issues such as this should require a referral to the DCFS nurse. 2) This case should be looked at as to why it was not indicated for medical neglect.	1) Complex cases are currently to be referred to the DCFS Nursing Division per Procedure; 2) DCFS agrees and will review this case further.
DCFS	This case highlights the fact that DCFS often intersects with minors who are either the victims of or vulnerable for human trafficking in scenarios where the case does not ultimately become a criminal or child protection court case. Given this unique opportunity to address this population specifically, DCFS should look into providing specialized intact services for minors who are victims of human trafficking or who exhibit signs of and are at risk for human trafficking.	DCFS agrees. Human Trafficking will remain part to the training curriculum. *(MWE 3/29/21)*
DCFS	DCFS to amend any current site safety or scene investigation checklists to include checking for video surveillance cameras or other recording both public and private.	DCFS agrees that primary evidence should be gathered whenever possible. The circumstances of each case will guide the best practice of gathering both public and private video footage. At the 5/27/21 In-Person DCP meeting, staff will be reminded to check for surveillance systems, limited where the incident occurred, during the course of their investigation.
DCFS	DCFS to review this case with the involved staff as a learning opportunity. There should be clear documentation that relative caretakers are spoken to about the need to follow the visitation plan, especially when there is to be only supervised contact.	DCFS agrees and has already met with the agency at the time of the incident and reviewed critical factors that were identified in the case. DCFS agrees and is in the process of developing a Program Plan for Family Enhancement Workers to provide assistance to staff and families. These workers will not be assigned to every team but will be assigned to help with safety assessments and other case activities. They will be assigned on some higher risk cases, including when a child in the family is in foster care and a child remains in the home of the parent.

DCFS	The Department to establish a standardized marijuana intoxication level to use in their assessment of child safety. Note: this is not a new recommendation but is the same as a pending. It should be paired with that case.	1) At this time, it is the Department's opinion that adapting a universal marijuana intoxication level into its policy or procedures is not the right course of action. There is not currently a consensus in the medical community on quantifiable marijuana intoxication as it relates to the ability to provide adequate child care. DCFS is not aware of any trends indicating that states that legalized marijuana use are adopting specific THC intoxication levels with respect to child care. DCFS investigators should consider the totality of circumstances to determine the alleged perpetrator's ability to provide adequate child care at the time of the alleged incident. 2) DCFS will review the matter with the involved staff as an educational opportunity.
DCFS	The Department to establish a standardized marijuana intoxication level to use in their assessment of child safety.	1) At this time, it is the Department's opinion that adapting a universal marijuana intoxication level into its policy or procedures is not the right course of action. There is not currently a consensus in the medical community on quantifiable marijuana intoxication as it relates to the ability to provide adequate child care. DCFS is not aware of any trends indicating that states that legalized marijuana use are adopting specific THC intoxication levels with respect to child care. DCFS investigators should consider the totality of circumstances to determine the alleged perpetrator's ability to provide adequate child care at the time of the alleged incident. 2) DCFS will review the matter with the involved staff as an educational opportunity.
DCFS	DCFS should look at how this case was handled in that: i) Father was completely uncooperative with	The Regional Administrator for Central Region did a paper review of this case on 10/25/2021 regarding recommendation A. A staffing regarding lessons learned and

	services and was repeatedly physically abusive in-front of the children; ii) Children were left in mother's care despite not protecting them by repeatedly reentering into the relationship with a physically abuse partner and not getting order of protection; iii) Children were repeatedly exposed to domestic violence as an ongoing and frequent issue; iv) Mother repeatedly violated the safety plan exposing herself and the children to potential harm; 1) She violated her OP for herself with abuser; 2) She never got OP for the children; 3) She repeatedly violated safety plan and lied about it; 4) She divulged the address of the domestic violence shelter to the abuser, resulting in her dismissal from the shelter; v) Mother has a prior indicated abuse report 4-4-2019; vi) Father has a history of Domestic Violence that was founded 11-16-2015 and prior assault conviction; vii) Ongoing drug abuse by both parents with methamphetamines; vii) Mother was dismissed by contract agency from intact services because of violation of service plans despite serious ongoing issues. (presenters reported she had exhausted their services); ix) Photos show laceration on forehead of [redacted] not mentioned in notes Sequence E, F date 11.23.2020; x) Photo shows what looks like a human bite mark on [redacted] 11.23.2020 not mentioned Sequence E 11.22.2020; xi) Photo reveals what looks like a rash on [redacted] Sequence E dated 11.22.2020 not mentioned in notes; xii) Case should have been referred for Area Administrator review and possible referral to States Attorney	practice issues will be completed with the worker, agency management, APT and intact administrator once the OIG has finished its review. The following is a response to OIG recommendation B by DCFS Agency Performance Team: APT agrees with the recommendation and upon completion of the OIG review and recommendations the Department will have a discussion with the caseworker on assessment of service needs and closure assessment. Kari Rogers, Intact Statewide Administer, in the Office of Intact Family Services will assign a Management Operations Analyst (MOA) to work with this caseworker and review these areas. The supervisor is no longer at the agency. <u>Additional Note/Practice Issue:</u> For consideration, historically intact closures, both DCFS and POS, were assessed by the worker as a successful closure if the children remained intact. This is further reinforced by this measure on the dashboard as well as the performance measures in the Intact Program Plan. However, as a result of cases being closed successfully using this evaluation, there are cases such as this, that are not staffed with the Office of Intact Family Services. Policy Guide 2020.10 identifies cases with unsatisfactory closure to be staffed. This Policy Guide appears to have been put into place to catch, and perhaps prevent, closure of cases without further consultation with DCFS/DCP or the State's Attorney regarding filing a petition where significant unresolved risks issues remain. Consideration should be given to possible expansion of cases under PG2020.10 which

	B) DCFS should review how the contract agency managed this case. i) Intact services agency simply discontinued services as there were ongoing issues and mother had exhausted their services because of repeated lapses and violations of the service plan; ii) Agency needed to communicate with DCFS about the need to discontinue services and ongoing problems which should have resulted in a review by the Area Administrator.	should be a mandatory closure staffing (whether satisfactory or unsatisfactory) with Office of Intact Family Services; which could include items such as pending birth of new child, children 0-5, a SOR within the last 3 months, or certain presenting issues remaining unresolved.
DCFS	DCFS to discuss the enforceability of administrative subpoenas with the Attorney General to require agencies to comply with such subpoenas.	Administrative subpoenas are only enforceable by seeking a court order in circuit court. In order to seek enforcement of an administrative subpoena, DCFS would have to send a request for representation to the Attorney General's office with the legal justification for enforcement of an administrative subpoena. These requests are reviewed by the Attorney General's office on a case-by-case basis to determine if there is an appropriate legal basis to seek court intervention. When staff encounter barriers to gathering information on investigations, they should consult with DCFS legal. Further, the Administrative Subpoena process will be shared with all CP staff during upcoming statewide meetings in July and August and documented in meeting minutes.
DCFS	DCFS to review the case in that: a) there is no Critical Decision documented in SACWIS regarding actions needed following the birth of the child while his sibling was still in foster care; b) The hotline should have been called when the child was born since his older sibling was in foster care and the parents only had supervised contact with that sibling; and c) Whenever another child is born to a family that has children in foster care, the hotline should be called and the matter should be investigated. In situations when this occurs, DCFS	The permanency division has reviewed the request. Associate Deputy Director has discussed this with the Chief Deputy Director of Intact/Permanency, and are in agreement with the recommendations. The Associate Deputy Director reached out to the RA for her to review the case with worker and the supervisor. This review has been completed and the issues covered were documenting critical decisions in SACWIS and actions needed following the birth of a child when sibling is in foster care. The

	should consider this as an intact family case and follow guidelines required by the intact family service program.	hotline should have been called when the second child was born. The worker will need to follow policy and procedure regarding documentation. The worker will monitor and provide monthly contact when a youth is in the care of their parent(s) when sibling(s) are in foster care. When youth are in the care of parents while sibling(s) are in foster care, the hotline normal protocol should be followed. DCFS shall monitor and provide monthly contact as a minimum requirement in these situations.
DCFS	A) DCFS to review the intact case as the grandmother was used as the Safety Plan monitor despite her having a long criminal and CANTS history. B) Private agencies need to notify seek out DCFS legal when there are persisting safety concerns or violations of the safety plan. This was a case recommended to be cited in the letter to AOIC (Administrative Office of Illinois Courts) as discussed with a different case.	DCFS will staff this case with the involved agency to ensure that they do not allow persons with a history of abuse or neglect to be a safety plan monitor. When a judge makes a decision that does not appear to be in the best interest of a child, the agency will immediately consult with and seek assistance from DCFS Legal and clinical to review such matters.
DCFS	1. That DCFS instruct staff to load the Child Protector App on their DCFS issued smartphones, and for DCFS make an announcement on the DNet on the use of this app to help guide investigations, especially with questions to ask of medical providers. 2. That DCFS make the DNet available on DFS issued smartphones, with a search feature, or at least an alphabetized index, to allow staff to search information on DNet while out in the field. 3. That a CDRT workgroup will put together checklists of additional questions to ask during investigations of different types of medical neglect/injuries/deaths, such as caused by asthma, choking, diabetes and more,	On cases involving children with complex medical issues, DCFS requires that staff refer such matters to DCFS Nurses. The Child Protector App may be of use to staff but it cannot be used to bypass consultation with medical professionals. DCFS agrees to pilot the use of the Child Protector App in some areas (emersion sites???).

	and DCFS adds those checklists to the DNet. That training on the Child Protector App and the checklists of additional questions be given during Foundations training, as well as intermittently thereafter.	
DCFS	DCFS should reinforce the need for a database system to be in place which is user friendly for DCFS and Intact workers alike. Though Intact personnel do have access to SACWIS, the logistical process by which they can access prior investigations to get a full picture of the family dynamic is so complicated and cumbersome as to be impractical.	DCFS agrees that there is a need for casework staff to have a full picture of family dynamics at case opening. Currently, the Handoff Process is in place to ensure that this occurs. There is also a need to improve the electronic case file system. Plans are in place for this to occur with the implementation of the CCWIS System. Person search instructions will be updated and made available to all staff. These instructions will allow staff to get a comprehensive history of a person's involvement with the Department. An updated "Search Guide" has been developed and will be posted on the DNet so all staff have access to this. There was some discussion about Illinois Connects (new information system for DCFS). DCFS is currently working with providers to map out the system. This search process will be put into Illinois Connects. The goal is to better connect divisions to better serve kids and families.
DCFS	DCFS to look at this case and clarify with staff that minors of age 12 in the State of Illinois can themselves consent to and seek out mental health services. In this case the mother was denying DCFS access to the child, but there may be other ways to get that information to the child, through school or a letter to child at the residence, or other family members	The Department agrees to review this further. DCP and Legal developed the following document. This has been shared with the Regional Administrators with the expectation that they share this with their staff. This information will also be reinforced in upcoming trainings.
CS	DCFS to review this case further to discuss with the involved staff how the case was handled to serve as a learning opportunity for staff.	DCFS agrees and has reviewed this matter with the involved staff.
CS	DCFS to review the case and how it was handled in that the case wasn't indicated	DCFS agrees and has reviewed this matter with the involved staff.

	against the mom due to her inability or unwillingness to protect the child, given that her boyfriend had been abusive to the mom. There were prior injuries in various stages of healing and mom lied about how long she was gone, and where she went, indicating some guilt.	
CS	The Department should commend the worker for her devotion and hard work on such a challenging and emotional case. This is a great example of how early intervention by DCFS can have a positive impact in a family's life.	DCFS to commend staff member for the good work on the case.
CS	DCFS to commend for her good work on the case.	DCFS to commend staff member for the good work on the case.
CS	Department to review case and how it was handled, in that: 1) Notes about minor's prior suicidal statements were not followed up on by the mother, or by the Investigator; 2) The cousin's observations of minor taking her shoelaces out of shoes and saying she was going to tie them around her neck was not followed up on by Investigator (was this unusual? Any other observations?, etc.); 3) Mother not speaking to, or even looking in on or checking on, her 13-year-old daughter for 24 hours (6:30 p.m.-6:08 p.m. the next day) was not considered at all. Per mother, she didn't see her daughter for that entire period; and 4) Mother gave different explanations of why she finally checked minor's closet - a feeling; then a smell; then she saw closet light on. Based on re-evaluating these pieces, it is possible that mother should have been indicated.	DCFS agrees and will review this with the involved staff by May 23rd.
CS	DCFS to review the case as a learning opportunity for the involved staff.	DCFS Agrees and will review this case with the involved staff.
CS	1) DCFS to commend the worker for her good work on this case and her thorough investigation; 2) The Department to explore expanding resources to workers given the pandemic.	1) DCFS agrees and will commend the staff member for her good work on this case. 2) DCFS agrees that the pandemic has added addition stressors on staff and will continue to reinforce the need for additional

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

CS	DCFS to commend investigator for his preparation and work on this case.	DCFS to commend the staff member for his good work on the case.
CS	DCFS to review this case and how it was handled after the 2018 indicated case and multiple out of state cases. Many red flags were noted during both the A and B sequence, but not followed up on and fully assessed. The 2018 case could have been referred to intact or perhaps screened in, maybe for an Order of Protection. This B case should have been indicated and screened in.	DCFS agrees and will review this case as an educational opportunity for the involved staff.
CS	The worker did a great job on this case and in her presentation. The worker should be commended for her excellent work.	DCFS to commend the staff member for her good work on the case.
CS	Investigator to be commended for his outstanding job on this case.	DCFS to commend the staff member for his good work on the case.
CS	DCFS to commend investigator for his preparation and work on this case.	DCFS to commend the staff member for his good work on the case.
CS	In a case where, through previous investigations serious domestic violence issues were uncovered and court screening was not sought, DCFS to review this case and how this was handled. The history of domestic violence should have warranted earlier and more thorough intervention. Additionally, given that at the death of this minor, he was diagnosed with a skull fracture which gave rise to concerns regarding physical abuse to the surviving twin, the twin sibling should have been fully medically examined.	DCFS agrees to review this case with the involved staff as an educational opportunity.
CS	DCFS to review this case with the on-call worker and supervisor as a learning opportunity. Allowing caregiver to care for the child was inappropriate given his criminal history, alleged drug use, alleged gang involvement and a prior indicated report.	DCFS agrees to review this case with the on-call worker and supervisor.
CS	DCFS should seek formal agreements with bordering counties and/or states in order to better coordinate investigations and services.	DCFS agrees to review this case with the involved staff as an educational opportunity.
CS	DCFS to commend the worker for her good work on the case.	DCFS agrees and will commend the staff member for her work on this case.

CS	DCFS to review the case and how it was handled in that the older stepbrother was not questioned in detail. Why was it not indicated since the gun was not secured. Team to write a letter to the police and ME bout calling in all child deaths.	This case was reviewed by Child Protection leadership and the Crisis Intervention Team at the time of the death and was discussed with the assigned staff. Child Protection leadership has since discussed specifically the value in having an in-depth interview with the victim's 25-year-old brother.
CS	That DCFS look at this case and how it was handled, in that: a. The B sequence should have been indicated; there were well documented repeated failures by the mother to get her son the needed medical and dental care during 2019 and 2020. The record shows the C sequence came in on 3.13.20. The 4.22.20 contact notes with 2 separate medical professionals state that Michael had oral surgery on 2.28.20 but it is unclear whether he got the needed neurological follow-up. b. A DCFS Nursing referral was done on the B Sequence, but there was no real plan to make sure that mom followed up needed medical care, including neurology, orthopedics and dental. This child was in ongoing dental pain for months. A doctor opined that "for sure this was medical neglect." c. Mom accepted Intact during the B investigation but as soon as it was Unfounded, she refused to continue. Cases should not be Unfounded when there is sufficient credible evidence to support the allegation. The evaluation should not be based on any current or future behavior once the hotline call comes in. Procedures 300 should be amended to state, for all allegations, that "Any decision to Unfound shall never be based on what the parent or caretaker does	a & b: DCFS should remain involved with families where there is a medically complex child either within the pending investigation, or an open intact family case. This should remain until the physician with medical expertise on the child's medical condition has reported the concern for medical neglect has been mitigated. c. DCFS agrees. d. The finding of medical neglect should be based on the facts that resulted in the allegation and not on the caregiver's actions after the investigation was initiated. Our CPSWs must make a finding of whether or not the circumstances warranting the allegation are sufficient evidence of medical neglect based on the medical provider's opinion. e. DCFS developed a form for medical providers to complete regarding allegations of medical neglect. f. The opinion could be accepted from mid-level providers (nurse practitioner, physician assistant etc) as long as they are providing direct care to the child.

	to mitigate the abuse or neglect AFTER the Hotline call comes in; any current or prospective changes in behavior do not negate prior Blatant Disregard". d. Medical Neglect should not require the opinion of an MD to Indicate; when the factors in Allegation 79 are objectively present, this doesn't require a Medical Opinion. In this case, in the B sequence, there was clear evidence of mother's ongoing failure to get this minor the needed medical and dental care. Further, as soon as the case was Unfounded, she stopped Intact Services. In cases like this, there was complete documentation that there was "complete noncompliance" with needed medical care, that medications were available to help the minor with his severe conditions, but the family "wasn't interested", etc. There should be an assessment of the factors laid out in Allegation 79, resulting in either Indicated or Unfounded, without the input of a MD. There are many other health professionals now involved in medical care; DCFS should be able to accept the opinion of an RN, PA or NP instead of an MD as to the existence or absence of medical neglect.	
CS	DCFS to review this case further as an educational opportunity. Given the coroner's report, the blankets and the blanket over the mouth-the team felt this rose to a level of blatant disregard and the case should have been indicated for #51.	DCFS agrees to review this case with the involved staff as an educational opportunity.
CS	#1. DCFS to review the case in that: a) the treating physician was not interviewed on the D sequence; b) there should have been a referral to the CAC for a forensic interview on the D sequence. Staff should be reminded of the critical need to conduct	#1. DCFS agrees and will review this case with the involved staff by May 31st. The Department recently implemented a process by which all cases involving Medical Neglect Allegation are reviewed on a weekly

	forensic interviews; c) the workers seemed to minimize the condition of the home in the sequences prior to the death; and d) many family risk factors were overlooked. #2. The team to write a letter to the primary care physician regarding the failure to fully understand and report medical neglect.	basis by Management to provide direction and to seek the involvement of DCFS Nursing staff as needed. The Department is also working closely with DSCC, training staff to reach out to them on all medically complex cases. DSCC leadership has presented to Child Protection, and we plan to make this a routine part of our Child Protection agenda with our child protection supervisors. #2. This recommendation pertains to the local team.
CS	Worker to be commended for her great presentation and work on this case.	DCFS agrees and will commend the staff member for her great presentation and work on this case.
CS	In this case involving a specialized foster mother who failed to fill necessary prescriptions related to the deceased's heart condition post-transplant, was observed to have poor bonding with the deceased prior to death, and who is also adoptive mother to another child with a special medical condition related to organ transplant, DCFS should cease placement of foster children in her home, regardless of the outcome of the appeal to the indicated finding.	Denial of license is subject to due process including an opportunity to correct the violation of licensing standards. So, there should a finding of violation of licensing standards and failure to correct such. Even then, they have appeal rights and we should present our case. If the DCP investigation is unfounded or thrown out in appeal, we cannot use it as reasons for denial of license. This foster parent surrendered her license on 3/10/21. As a result of the GAL complaint an involuntary hold was placed on the home of the foster parent on 10/26/20. The licensing supervisor at UCAN, confirmed that a licensing investigation was initiated; however, the foster parent was uncooperative and she voluntarily surrendered her license. Due to the foster parent surrendering her licensing while there is a hold on her home, she would need to wait 5 years to reapply as a Quality Care Concerns Applicant. Below is the section of the Child Care Act that addresses this.

		(225 ILCS 10/6) (from Ch. 23, par. 2216) Sec. 6.(d) If a foster family home license (i) is revoked, (ii) is surrendered for cause, or (iii) expires or is surrendered with either certain types of involuntary placement holds in place or while a licensing or child abuse or neglect investigation is pending, or if the Department refuses to renew a foster home license, the foster home may not reapply for a license before the expiration of 5 years following the Department's action or following the expiration or surrender of the license.
CS	Worker to be commended for his excellent work on this investigation and during the presentation to CDRT. He should be considered as a trainer as the CDRT team consistently has seen good work from him.	DCFS agrees and will commend the staff member for his excellent work.
CS	DCFS to review the case in that the surviving children were not taken to a doctor for observation per protocol for a death investigation.	DCFS agrees and will review this with the involved staff as an educational opportunity. Policy will be reviewed to make sure this is a critical decision that is to be documented in SACWIS.
CS	A) DCFS to review the A and B sequences in that: 1) The child's medical complexities played a factor in these cases, but were not fully investigated; 2) The medical providers should have been contacted and medical records obtained; 3) The Investigators treated the child's medical complexities as a reason that the parents were not at fault, instead of the reason that the parents should have taken extra caution; 4) Medical neglect allegations should have been added to the death investigation and both the A and B sequences should have been indicated. B) As a policy, DCFS should keep medical neglect cases involving medically complex children open until all recommended medical follow up has occurred or when	The permanency division has reviewed the request. Associate Deputy Director has discussed this with the Chief Deputy Director of Intact/Permanency and are in agreement with the recommendations. The Associate Deputy Director reached out to the RA for her to review the case with worker and the supervisor. This review has been completed and the issues covered were documenting critical decisions in SACWIS and actions needed following the birth of a child when sibling is in foster care. The hotline should have been called when the second child was born. The worker will need to follow policy and procedure regarding documentation. The worker will monitor and provide monthly contact when a youth is in the care of their parent(s) when sibling(s) are in foster care.

	there is a clear and consistent pattern that the parents are following up on all needed medical care. The primary care physician and any specialists should determine if a clear and consistent pattern has been established. C) DCFS should conduct a training on the investigation of Medical Neglect cases. CDRT will assist with preparing this training.	When youth are in the care of parents while sibling(s) are in foster care, the hotline normal protocol should be followed. DCFS shall monitor and provide monthly contact as a minimum requirement in these situations.
CS	A) DCFS to look at the Intact case in regard to the decision to close the case given the circumstances surrounding the case. B) Could the States Attorney's Office provide a training or guidance on what is needed to file on medical neglect cases? C) Explore the possibility of developing a document for medical personnel to complete when investigators are reaching out on allegations of medical neglect. This would walk medical professionals through the essential statutory elements of medical neglect and allow them to comment if such are not present. This could potentially enhance the investigative process and streamline the information gathering, sharing process between physicians and DCFS investigators. D) Determine if any follow-up regarding failure to report occurred (UIC-DSCC, child's physician/specialist). Should the team consider writing a letter to the medical providers and agencies involved.	In regard to Recommendation A: Prior to case closure, cases where there are significant unresolved issues will be screened for court intervention. Intact providers will follow revised procedure 302.388 which states all medically complex cases will be staffed regardless of successful or unsuccessful case closure. The Department will staff the case with Regional Administrator and Community-based providers will staff their cases with the Office of Intact Family Services, Management Operations Analyst (MOA).
CS	The staff member is to be commended for her work on the case. The investigation was very thorough and she worked collaboratively with several other professionals involved in the case. Her presentation to the Child Death Review Team was excellent.	DCFS agrees and will commend the staff member for her thoroughness and collaboration on the case as well as her excellent presentation to the Team.
CS	Commend involved staff members for their great work on the case. Their investigation was very thorough and they did a great job following up on several aspects of the case.	DCFS agrees and will commend the involved staff members for their great work and thoroughness on this case.

CS	DCFS to look at this case and how it was handled in terms of foster placement for this child. This was a very troubled family. DCFS to look at process(es) for residential treatment placement.	DCFS agrees and will review this case with the involved staff. APT agrees with this recommendation and reviewed this case and discussed initial concerns with the agency at the time of the youth's overdose. Of note, The Department did not take a A/N report against the caretaker for the death of this child in her home. The police did not investigate it as a criminal case. The OIG did not review this case related to the death of a YIC. However, APT has concerns that the system barriers related to getting our teens into a higher level of care lead this agency to justify due to lack of resources allowing this youth to stay with family who have their own history related to substance abuse and mitigated risks because he was a teen. The supervisor has left this POS agency (worker and Supervisor). With permission of CDRT we would like to share CDRT report with LSSI management related to practice training issues. 2. The CIPP is a family and child centered process that supports the stabilization of youth and supports recommendation for higher levels of treatment. The goal, for the CIPP process, is to ensure that the facilitator reaches out to the casework team to identify key adults and providers in the youth's life who support the youth, youth's family and caregiver. This includes helping to remove barriers to service provision, ensuring timely follow-thru with the plan and assessing when the team may need to reconvene due to the youth's acuity and/or needs. If a youth returns to the placement in at the time of the CIPP, a 30-Day follow up is to be scheduled to review how this youth is doing and review progress in with the action plan. In addition, the facilitator reviews to determine if any subject matter experts should be invited to participate. In this

		youth's case, that would be, at a minimum, the Substance Use Disorder specialist. The CIPP process is currently under revision to become a more clinically focused process focusing on a youth's current clinical presentation, past treatment efforts, strengths and needs, along with a review of level of treatment and current service needs.
CS	DCFS to review the case with the involved staff for educational discussion purposes.	DCFS agrees and will review the case with the involved staff for educational/discussion purposes.
CS	DCFS to review the case as a learning opportunity as the staff should have spoken to the medical staff that treated child's heart condition.	DCFS agrees to review this case as a learning opportunity for the involved staff.
CS	Review investigative steps with worker for continued support when completing death investigations a. Importance of building timelines b. Importance of viewing videos.reviewing police reports a. If digital electronic files are too large to send, Investigators should arrange to view with the assigned officer at the police department c. Importance of including investigation details in the report.case nates (examples: describe the scene in detail, include reference to scene re-enactment or if not done circumstances why, reference any specific times noted in video evidence.police report relevant to timeline, reference any review of products contributing to.involved in death to include if product was.not used per instructions or with awareness of any safety precautions.age restrictions)	DCFS agrees with agrees with 1-3. Recommendation 4 will be considered.

	Forward information regarding product involved in child death to Consumer Report (number reportedly posted at various placed in offices). DCFS to review this case as a learning opportunity as it does not appear the AA and RA were consulted on this case. DCFS to complete the Death Investigation Training and make it mandatory for all DCFS investigators.	
OTHER/PP	For DCFS to ensure there is a water safety campaign in the spring.	DCFS will do a campaign in the spring. We will send a press release, create a PSA and make officials available for interviews. We will post on social media at the start of the campaign and then regularly throughout the summer, with an emphasis before holiday weekends such as Memorial Day or July 4th, and may increase posts in extreme heat events that will likely result in more residents relying on pools, rivers and lakes for recreation.
OTHER	Team to send a letter to the school reminding about the need to call reports in.	Letter sent.
OTHER	A positive urine test for drugs should be followed up with a blood draw. This recommendation should go to the Illinois Hospital Association.	No response needed from DCFS.
OTHER	Team to send a letter to the medical providers on the C sequence to do a morbidity and mortality review as there may have been more that could have been done in their assessment. No recommendations for DCFS.	Letter sent. No response needed from DCFS.
OTHER	Team to write a letter to the Head of the Southern Illinois Child Death Investigative Task Force asking that he reach out to the Pulaski Co. States Attorney, sheriff and coroner to discuss utilizing the Task Force in child death investigations. A letter should also go to the coroner to remind that office to call in all child deaths (regardless if abuse or neglect is suspected) into the DCFS hotline.	Letter sent. No DCFS response was needed.
OTHER	Team to send a letter to the foster parent commending them.	Letter sent. No response needed from DCFS.

OTHER	1) The team should write a letter to Missouri DCFS asking that they review this case as a learning opportunity; 2) The team should refer this case to the Missouri Child Death Review Teams asking that they review this case further as one of their discretionary reviews; 3) Pair this case with another case from the Rockford team as this situation further demonstrates the need for improved collaboration across State lines.	Letter sent.
OTHER	Team to write a letter to the coroner, hospital, medical personnel and police department to remind them to call the hotline on all child deaths.	Letter sent.
OTHER	Mandated reporters should call all deaths into the hotline. (Note: this is already a requirement). A reminder should go out to mandated reporters that this is a requirement.	Currently the Mandated Reporter Training is being updated. It is not, nor has it ever been, a requirement to call in all child deaths to the hotline. Mandated Reporter are only required to call in those deaths where there is a suspicion of abuse or neglect.
OTHER	Team to write a letter to the coroner, hospital, medical personnel and police department to remind them to call the hotline on all child deaths.	DCFS agrees with agrees with 1- 3. Recommendation 4 will be considered.
OTHER	Team to write a letter to the coroner, hospital, medical personnel and police department to remind them to call the hotline on all child deaths.	Letter sent.
OTHER	Recommendation(s): 1) The team should write a letter to Missouri DCFS asking that they review this case as a learning opportunity; 2) The team should refer this case to the Missouri Child Death Review Teams asking that they review this case further as one of their discretionary reviews; 3) Pair this case with that of K.Q. from the Rockford team as this situation further demonstrates the need for improved collaboration across State lines; 4) Carry the case over to the next meeting to see if criminal charges are filed. If no	DCFS agrees to look at this further and will refer this matter to the Workgroup currently working to revise Procedures 300. The Department will seek to add direction to staff when such barriers arise. This will be addressed at the next Statewide DCP leadership meeting.

	charges are filed, the team may have additional recommendations.	

Appendix E – Homicide Deaths

Category	Age	Race/Ethnicity	**Cause of Injury/Death**
Fire	0	White	Injury Cause: Infant died as a result of injuries she suffered in a fire at her residence. Cause of Death: Thermal injuries and carbon monoxide inhalation structure fire
Fire	9	Black	Injury Cause: Arson. Cause of Death: Complications of carbon monoxide toxicity inhalation of smoke and soot house fire.
Fire	11	Black	Injury Cause: Arson. Cause of Death: Inhalation injuries inhalation of products of combustion house fire due to arson.
Firearms	0	Hispanic	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	5	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds of head.
Firearms	5	White	Injury Cause: Gunshot wound of the head. Cause of Death: Gunshot wound of the head.
Firearms	7	White	Injury Cause: Gunshot wounds of the head and back. Cause of Death: Gunshot wounds of the head and back.
Firearms	8	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of the chest.
Firearms	8	Black	Injury Cause: Shot multiple times. Cause of Death: Multiple gunshot wounds.
Firearms	9	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of the head
Firearms	12	Black	Injury Cause: Shot by other(s). Cause of Death multiple gunshot wounds of head.
Firearms	12	Black	Injury Cause: Shot by other. Cause of Death: Gunshot wound of face.
Firearms	13	Black	Injury Cause: Gunshot wound of the head by another. Cause of Death: Gunshot wound of the head.
Firearms	13	Black	Injury Cause: Shot by other(s). Cause of Death gunshot wound of head.
Firearms	14	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.

Firearms	14	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of the back.
Firearms	14	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wounds of head.
Firearms	14	Black	Injury Cause: shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	14	Hispanic	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	14	Hispanic	Injury Cause: Shot by other. Cause of Death: Gunshot wound of head.
Firearms	14	Hispanic	Injury Cause: Shot by police. Cause of Death: Gunshot wound to the chest.
Firearms	14	White	Injury Cause: Shot by assailant. Cause of Death: Multiple gunshot wounds.
Firearms	14	White	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	15	Black	Injury Cause: He was getting off of the bus and was shot by another person. Cause of Death: Gunshot wound of the back involving the chest and neck.
Firearms	15	Black	Injury Cause: Shot by another person(s) with a firearm(s). Cause of Death: Multiple gunshot wounds.
Firearms	15	Black	Injury Cause: Shot by another person(s) with a firearm(s). Cause of Death: Multiple gunshot wounds.
Firearms	15	Black	Injury Cause: shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	15	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound to face.
Firearms	15	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound to the torso.
Firearms	15	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	15	Black	Injury Cause: Shot by other. Cause of Death: Gunshot wound of head.
Firearms	15	Black	Injury Cause: Shot by other.

			Cause of Death: Gunshot wound to the head.
Firearms	15	Black	Injury Cause: Shot by others. Cause of Death: Gunshot wound of head.
Firearms	15	Black	Injury Cause: Shot multiple times. Cause of Death: Multiple gunshot wounds.
Firearms	16	Black	Injury Cause: Gunshot wound of neck. Cause of Death: Gunshot wound of neck.
Firearms	16	Black	Injury Cause: Gunshot wound of the head. Cause of Death: gunshot wound of the head.
Firearms	16	Black	Injury Cause: Said suffered gunshot wound of the head by another. Cause of Death: Gunshot wound of the head.
Firearms	16	Black	Injury Cause: Said suffered multiple gunshot wounds by another. Cause of Death: Multiple gunshot wounds.
Firearms	16	Black	Injury Cause: Shot by other person during illicit drug transaction. Cause of Death: Gunshot wound of abdomen shot by another person.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Complications of gunshot wound of head.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of chest.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of the back.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	16	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds of head.

Firearms	16	Black	Injury Cause: Shot by other. Cause of Death: Complications of gunshot wound to the head.
Firearms	16	Black	Injury Cause: Shot by others. Cause of Death: Multiple gunshot wounds.
Firearms	16	Black	Injury Cause: Shot. Cause of Death: Gunshot wound to head.
Firearms	16	Hispanic	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound to the chest.
Firearms	16	Hispanic	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	16	Hispanic	Injury Cause: Shot by other. Cause of Death: Gunshot wound of right arm into chest.
Firearms	16	Hispanic	Injury Cause: Shot. Cause of Death: Multiple gunshot wounds.
Firearms	16	White	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of torso.
Firearms	17	Black	Injury Cause: Said suffered multiple gunshot wounds by another. Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by an assailant with a firearm. Cause of Death: Gunshot wound of the head.
Firearms	17	Black	Injury Cause: Shot by another person while sitting in a motor vehicle. Cause of Death: Gunshot wound of head shot by another person.
Firearms	17	Black	Injury Cause: Shot by another person(s) with a firearm(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by another person. Cause of Death: Gunshot.
Firearms	17	Black	Injury Cause: Shot by assailant(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other person(s). Cause of Death: Injuries of spinal cord, carotid artery, heart, lungs, liver, and bones. Gunshot wounds of head, neck, torso, and upper extremities.

Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Complications of remote shotgun wound.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of head.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of neck.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Gunshot wound of the back.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot by other. Cause of Death: Gunshot wound to back.

Firearms	17	Black	Injury Cause: Shot by other. Cause of Death: Gunshot wound to neck.
Firearms	17	Black	Injury Cause: Shot by other. Cause of Death: Gunshot wound to abdomen.
Firearms	17	Black	Injury Cause: Shot multiple times. Cause of Death: Multiple gunshot wounds.
Firearms	17	Black	Injury Cause: Shot while sitting on front step of apartment complex. Cause of Death: Gunshot wound of abdomen shot by another person.
Firearms	17	Black	Injury Cause: Subject was victim of gunshot wound to the head. Cause of Death: Gunshot wound of the head.
Firearms	17	Asian	Injury Cause: Shot by other(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	Hispanic	Injury Cause: Gunshot wound related. Cause of Death: Multiple gunshot wounds.
Firearms	17	Hispanic	Injury Cause: Shot by assailant(s). Cause of Death: Multiple gunshot wounds.
Firearms	17	White	Injury Cause: Subject received gunshot wound from another individual. Cause of Death: Gunshot wound of the neck involving the chest.
Illness	3	Black	Injury Cause: Medical and physical neglect by parent(s). Cause of Death: Coronavirus NL63 pneumonia.
Injury	0	Black	Injury Cause: Abuse. Cause of Death: Closed head injuries abuse.
Injury	0	Black	Injury Cause: blunt force trauma to the head. Cause of Death: Cranio-cerebral injuries blunt force trauma.
Injury	0	Black	Injury Cause: Multiple injuries inflicted by other(s). Cause of Death: Multiple injuries child abuse.
Injury	0	White	Cause of Death: Subdural hematoma outside/inside brain with abnormal bleeding and retinal hemorrhaging.
Injury	0	White	Injury Cause: Child abuse. Cause of Death: Multiple injuries child abuse.
Injury	0	White	Injury Cause: Intentional blunt force trauma to the head.

			Cause of Death: Blunt force head trauma physical abuse.
Injury	0	White	Injury Cause: Sustained head trauma leaving him with physical deficits resulting in his death. Cause of Death: Complications of traumatic head injury.
Injury	0	White	Injury Cause: Said suffered abusive head trauma by another. Cause of Death: Abusive head trauma.
Injury	1	Black	Cause of Death: Brain tissue injury/bleeding around the brain skull fractures multi-organ injuries.
Injury	1	Black	Injury Cause: Assaulted by other(s). Cause of Death: Blunt force head injuries.
Injury	2	Black	Injury Cause: Closed head injuries due to abuse. Cause of Death: Closed head injuries abuse.
Injury	2	White	Injury Cause: Abused by other(s). Cause of Death: Multiple injuries child abuse.
Injury	2	White	Injury Cause: Child abuse. Cause of Death: Abdominal sepsis traumatic rupture of the duodenum child abuse.
Injury	8	Black	Injury Cause: Deceased was strangled, stabbed, and beaten. Cause of Death: Strangulation.
Injury	10	White	Cause of Death: Sharp force injury of neck.
Injury	13	White	Injury Cause: Sustained non-accidental head trauma at 7 months of age due to child abuse. Cause of Death: Complications of blunt force head trauma child abuse.
Injury	15	Black	Injury Cause: Unknown. Cause of Death: Multiple blunt and sharp force injuries of head assaulted by other person(s).
Injury	17	Black	Injury Cause: Stabbed and incised by other(s). Cause of Death: Multiple sharp force injuries.
Other	1	Black	Cause of Death: Cardiopulmonary arrest due to possible hypothermia.
Other	2	Black	Injury Cause: Found unresponsive in vehicle following suicide attempt my mother. Cause of Death: Carbon monoxide toxicity inhalation of motor vehicle exhaust within an enclosed space.
Other	6	Black	Cause of Death: Hypothermia.
Poison Overdose	0	Black	Injury Cause: Cause of Death methadone toxicity.

Poison Overdose	0	White	Cause of Death: Methamphetamine intoxication.
Poison Overdose	0	White	Injury Cause: Combined drug toxicity in 1 month old. Cause of Death combined drug (despropionyl fentanyl, fentanyl, and acetyl fentanyl) toxicity.
Poison Overdose	1	Black	Injury Cause: found unresponsive by parent. Cause of Death: Fentanyl and diphenhydramine intoxication.
Poison Overdose	1	White	Injury Cause: She was at home with her father when she was found unresponsive. Cause of Death overdose of oxycodone.
Prematurity	0	Black	Injury Cause: said suffered complications of extreme prematurity due to maternal cardiac arrest due to gunshot wound. Cause of Death: Complications of extreme prematurity maternal cardiac arrest from a gunshot wound.
Suffocation	0	Hispanic	Injury Cause: Suffocated by other. Cause of Death: Asphyxia.
Suffocation	1	Black	Cause of Death: Asphyxia due to wedging between a bed and wall.
Suffocation	1	Hispanic	Injury Cause: Suffocated by other. Cause of Death: Asphyxia.
Suffocation	8	White	Injury Cause: Undetermined. Cause of Death suffocation.
Vehicular	1	Black	Injury Cause: Rear-end motor vehicle crash. Cause of Death: Blunt force injuries of the head motor vehicle collision.
Vehicular	10	Black	Injury Cause: Said suffered blunt force head trauma due to being struck by a motor vehicle. Cause of Death: Blunt force head trauma bicyclist struck by motor vehicle.
Vehicular	16	White	Injury Cause: He was the driver of a vehicle struck by another vehicle traveling at a very high rate of speed. Cause of Death: Blunt trauma of the chest motor vehicle crash.
Vehicular	17	Hispanic	Injury Cause: Passenger of motor vehicle that was being chased by another motor vehicle which resulted in the passenger's motor vehicle striking a parked semi-truck. Cause of Death: Multiple injuries motor vehicle striking parked semi-truck chase by another motor vehicle.