

Illinois Child Death Review Teams

A Partnership for
Protecting Children

Annual Report 2002

In cooperation with



Illinois Child Death Review Teams: A Partnership for Protecting Children

2002 Annual Report

MISSION

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

Submitted to:

The Honorable Rod R. Blagojevich, Governor, State of Illinois
Illinois State Senate
Illinois House of Representatives

August 2004

Illinois Child Death Review Teams

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Mary Loken, Ph.D. – Vice Chairperson

Executive Council

September 2004

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Neil Hochstadt
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Diane Scruggs
Cook County Team B

Dan Cuneo
East St. Louis Subregion

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Shaku Teas
Aurora Subregion

Deanna St. Germain
Marion Subregion

Team Coordinators

Yvette Reed
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Cook County Child Death Investigations Liaison

Sharon O'Connor

The Honorable Rod Blagojevich, Governor of the State of Illinois

The Honorable Members of the 93rd General Assembly

It is my privilege to submit to you the annual report of the Illinois Child Death Review Program.

In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review cases of unexpected and unexplained deaths of children age seventeen years or younger who have been known to the Department of Children and Family Services (DCFS) as well as the deaths of other children who died unexpectedly.

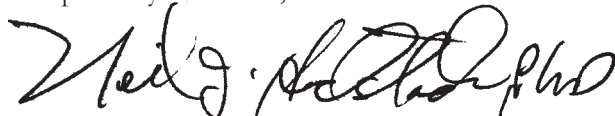
This report summarizes the findings of the cases reviewed by Illinois' CDRTs and presents the recommendations made to the Director of DCFS, and to other agencies. Many important contributions to the welfare of children were made this year including the water safety campaign which emerged from a recommendation made by the Aurora team.

We wish to thank Bryan Samuels, Director of DCFS, and the staff of the child death review program, for their cooperation and for providing the resources necessary to support the efforts of the more than one hundred and fifty volunteer experts who conduct child death reviews in Illinois. The work of these experts has made Illinois' child death review program one of the best in the country.

At the heart of this report is the remarkable effort of the more than one hundred and fifty experts who volunteer their time and expertise to make the child death review program an independent and positive force for Illinois' children. Special thanks go to the members of the Executive Council who not only serve as Chairpersons of each team but volunteer additional time to serve on the Council. A summary of the accomplishments of the Executive Council is included. All team members are to be congratulated and thanked for their contributions to the well being of children in this state.

Lastly, we thank Governor Blagojevich and the members of the General Assembly for the opportunity to make such an important contribution to the safety and welfare of children.

Respectfully submitted,



Neil J. Hochstadt, Ph. D.

Chairman, Executive Council

Illinois Child Death Review Teams

Director, Behavioral Sciences Department and Clinical Support Services, La Rabida Children's Hospital and Professor, The University of Chicago, Department of Pediatrics

Rod R. Blagojevich
Governor



Bryan Samuels
Director

Illinois Department of Children & Family Services

Dear Reader,

When a child in Illinois dies of a preventable cause, community members have cause for concern. Unfortunately, deaths resulting from child abuse, parental neglect, and preventable accidents are all too common.

In Illinois, the Child Death Review Teams continue to be an integral part of the effort to eliminate child deaths that could have been avoided. These nine teams, which consist solely of dedicated volunteers who donate their time and energy, review the details of numerous child deaths each year. By critically examining the available information about a child's death and discussing it with other team members with expertise in more than a dozen different disciplines, child death review teams have made recommendations for prevention efforts as well as policy changes that have undoubtedly made the children of Illinois safer.

I continue to appreciate the vital role that these team members play in protecting children. I am pleased to have this opportunity to commend them and their work.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bryan Samuels".

Bryan Samuels
Director, Department of Children
and Family Services

Acknowledgments

This report would not be possible without the dedication and unwavering support of the more than 150 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams.

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

Members of the CDRT Executive Council Annual Report Subcommittee, including Deanna St. Germain, Diane Scruggs, Lorinda Lamken, Mary Loken, and Neil Hochstadt, spent considerable time editing this annual report and providing additional background information on child death review in Illinois.

Sherry Barr and Yvette Reed, the Child Death Review Team Program Coordinators, have worked tirelessly to coordinate child death review team activities and served as invaluable assets during data analysis and report writing.

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

Finally, the Illinois Child Death Review Teams owe much to the dedicated professionals who served on the Cook County Child Fatality and Serious Injury Review Committee (1987-1995) and the Illinois Child Fatality Task Force (1994-1995). Members of these two groups provided the guidance, impetus, and technical expertise to establish statewide child fatality review teams in 1995.

Illinois Child Death Review Team

Executive Council

Neil Hochstadt Ph.D
Chairman
Cook County, Illinois

Mary Frisk Loken, Ph.D.
Vice-Chairwoman
Springfield, Illinois

Aurora

Dr. Shaku Teas, Chair
Dr. Timothy Brown, Vice-Chair

Champaign

Dr. Kathleen Buetow, Chair
Duane Northrup, Vice-Chair

Cook County A

Dr. Neil Hochstadt, Chair
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Peoria

Dr. John R. Day, Chair
Kathleen Bailey, Vice-Chair

Rockford

Lorinda Lamken, Chair
Lisa Tomasino, Vice-Chair

Springfield

Dr. Mary Frisk Loken, Chair
James D. Stone, Vice-Chair

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 2002

In 2002, 1,765 children under 18 died in Illinois. This represents the number of death certificates received by the Department of Children and Family Services' (DCFS) State Central Register (SCR) and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the SCR; therefore, this number is a low estimate of the actual number of child deaths that occurred in Illinois during 2002¹.

Of the total child deaths reported to DCFS:

- 58% were boys and 42% were girls
- 64% were infants under one year, 10% were young children between 1 and 4 years, 13% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years
- 56% were Caucasian, 36% were African-American, 3% were Hispanic, 2% were Asian, and 3% were of other or unknown racial background

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

- 72% were attributable to natural causes
- 12% were accidental
- 6% were homicides
- 1% were suicides
- 9% were undetermined

When these deaths were examined by the cause of death listed in the death certificate:

- 37% were related to illness
- 33% were related to premature birth
- 20% were related to various types of injuries, such as vehicular accidents (5%), firearms (4%), drownings (1%), fires (2%), suffocations (3%), and other types of injuries (4%)
- 2% were related to Sudden Infant Death Syndrome (SIDS)
- 8% were due to undetermined causes

Child Deaths Reviewed by the CDRTs

There were 170 child deaths mandated for review by the CDRTs during 2002 because the children (or their families) were involved with the child welfare system within a year prior to the child's death. Of the deaths mandated for review by CDRTs:

- 54% were boys and 46% were girls

¹ The Illinois Department of Public Health estimates that the number of child deaths in 2002 was 2029.

- 54% were infants under one, 28% were young children between one and four years, 11% were older children between 5 and 14 years, and 7% were youth between 15 and 17 years
- 44% were Caucasian, 53% were African-American, and 1% were Hispanic

When reviewed deaths were examined by manner of death:

- 37% were attributed to natural causes
- 22% were due to accidents
- 24% were homicides
- less than 1% were suicides
- 16% were undetermined

When reviewed deaths were examined by cause of death from the death certificate:

- 26% were related to illness
- 6% were related to premature birth
- 52% were related to various types of injuries, such as vehicular accidents (3%), firearms (4%), drowning (8%), fires (6%), suffocations and overlaying (13%), and other types of injuries (18%)
- 5% were related to Sudden Infant Death Syndrome (SIDS)
- 9% were due to undetermined causes and 2% were due to causes not specified in others categories

CDRT Recommendations to Prevent Child Deaths

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

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

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

In 2002, there were 72 recommendations made by the CDRTs. Most of the recommendations (41) focused on DCFS policy and procedures, followed by case-specific recommendations (18), recommendations for other agencies or systems (8), and primary prevention strategies (5). A complete list of CDRT recommendations (excluding case-specific recommendations²) and the corresponding DCFS responses is provided in Appendix D.

² Case-specific recommendations do not require a response from DCFS and are not listed in the appendix.

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■ Introduction ■

“Fatal child abuse and neglect is a nationwide problem. Not only is the number of deaths due to child maltreatment far too high, but also an alarming percentage of these deaths occur among children known to the child protection system. As a result, the work of child fatality/death review teams takes on added importance...When integrated into the child protection and child welfare systems, child death review teams make important contributions to the protection of children through the identification of case specific interventions, the formulation of prevention strategies, and the development of public policy designed to prevent child fatalities and serious injuries due to maltreatment and other preventable causes.”

The death of a single child due to preventable causes serves as a powerful reminder that there is much to be done to protect children from harm.

Source: Hochstadt, N. (in press). Child Death Review Teams: A Vital Component of Child Protection, *Child Welfare*.

The death of a single child due to preventable causes serves as a powerful reminder that there is much to be done to protect children from harm. In 2002, there were 1,765 total child deaths in Illinois³. Many of these deaths were preventable.

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

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

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

³ This represents the number of death certificates received by the CDRTs and entered into the CDRT database. However, not all counties in Illinois reported their child deaths to the CDRTs; therefore, this number does NOT represent the total number of child deaths that occurred in Illinois during 2002. The Illinois Department of Public Health estimates that the number of child deaths in 2002 was 2,029.

■ 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 (and amended by P.A. 90-239 on July 28, 1998; see Appendix A for copy of the amended Act). Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This Committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

The Illinois Child Death Review Team Act created a partnership among many agencies, organizations, and professionals across the state that serve and advocate for children.

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

Child Death Review Team Composition

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

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

- Pediatrician or other physician knowledgeable about child abuse and neglect
- Representative, manager or administrator from the DCFS Division of Child Protection
- 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
- Medical examiner, 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

Teams may make recommendations to the DCFS Director concerning additional professionals to serve on their team as needed. Team members, who are volunteers, are appointed to the team for two years and are eligible for reappointment upon expiration of their term. Each team elects a Chairperson and Vice-chairperson from their members.

Child Death Review Team Executive Council

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

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

In addition to these primary responsibilities, the CDRT Executive Council achieved a number of additional accomplishments during 2004 (NOTE: Although the information on child deaths in this report describes child deaths that occurred in 2002, information on CDRT policies, procedures, and activities is current.):

- Development of a successful working relationship between the CDRTs and the new DCFS administration
- Revision of the CDRT operating protocol to reflect "best practice" in the field. The revised protocol provides better guidelines for all teams and ensures uniform practices among teams throughout the state
- Development and approval of ethics guidelines for CDRT members as part of the revised protocol and best practices (passed on July 23, 2004)
- Completion of the *Illinois Child Death Review Teams Annual Report 2001* and preparation of the 2002 annual report in collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign

*The Child Death
Review Team
Executive Council
serves as the voice of
child death review in
Illinois.*

- Attendance at the very successful 8th annual symposium in Springfield, which included an orientation for new team members
- Sponsorship of a presentation by Teri Covington and Sara Rich from the National Center for Child Death Review in Michigan. This presentation helped bring the Executive Council up-to-date on national issues related to child death review
- Transition and improvement of the CDRT database to a more flexible system that will provide additional information about child deaths and allow team Chairpersons better access to reports
- Support for the work of Kathleen Monahan from Children’s Memorial Hospital on a research proposal to establish a state and national violence and trauma registry for children
- Collaboration with several Illinois state agencies, including DCFS, the Department of Human Services, the Department of Public Health, Prevent Child Abuse Illinois and the Red Cross, to complete a public awareness campaign to prevent child drowning. This initiative emerged from recommendations made by the Aurora child death review team
- Conclusion of the work of the task force on Chicago’s Infant Homicides, drawn from Cook A and Cook B CDRTs and chaired by Neil J. Hochstadt, the final report of which was then presented to the CDRT Executive Council, the Chicago Police Department, DCFS and the Mayor’s Office
- Participation in the Illinois Morbidity and Mortality Review Support Program, a project of the Illinois Department of Human Services that includes four separate review processes: fetal and infant mortality review; perinatal mortality review; maternal mortality review and child death review
- Participation of CDRT chairpersons Neil J. Hochstadt and Diane Scruggs in the federal Child and Family Services Review of DCFS
- Development of new procedures for ensuring timely DCFS responses to CDRT recommendations, including an electronic tracking system and monthly meetings of the DCFS Associate Deputy Directors to review CDRT recommendations
- Continued participation in the Citizen’s Review Panel
- CDRT Executive Council members Shaku Teas and Diane Scruggs continued to represent the CDRT Executive Council on the Statewide Quality Council

DCFS serves as a direct link between review teams and the state’s child protection policy makers.

DCFS Roles and Responsibilities

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

Illinois Child Death Review Process

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

Purpose of Child Death Review

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

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

Other responsibilities of the CDRT include:

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

The overarching mission of child death review is to reduce the number of preventable child deaths in Illinois.

Child Death Review Procedures

Figure 1 delineates the child death review process in Illinois.

Although county registrars are required to submit copies of all child death certificates to DCFS, many do not.

After a child (age 17 or younger) death occurs, a coroner, medical examiner, or other physician/pathologist completes the death certificate. At this point, the county registrars are required by the Illinois Vital Records Act to send a copy of the death certificate to the DCFS State Central Register (SCR). Unfortunately, although county registrars are required to submit copies of all child death certificates to the SCR, many do not. In 2002, 2,029 child deaths were reported to the Illinois Department of Public Health⁴ (IDPH), compared to the 1,765 child deaths reported to the SCR (Appendix C presents the number of deaths reported to both DCFS and IDPH by county). Thus, it is clear that many county registrars are not complying with the Vital Records Act. The importance of this requirement cannot be overstated, as only those child death certificates sent to the SCR are entered into the CDRT database and analyzed for this report. If large numbers of child deaths are not included, it diminishes the ability of the CDRTs to analyze and understand child death in Illinois and make sound recommendations for preventing future deaths.

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

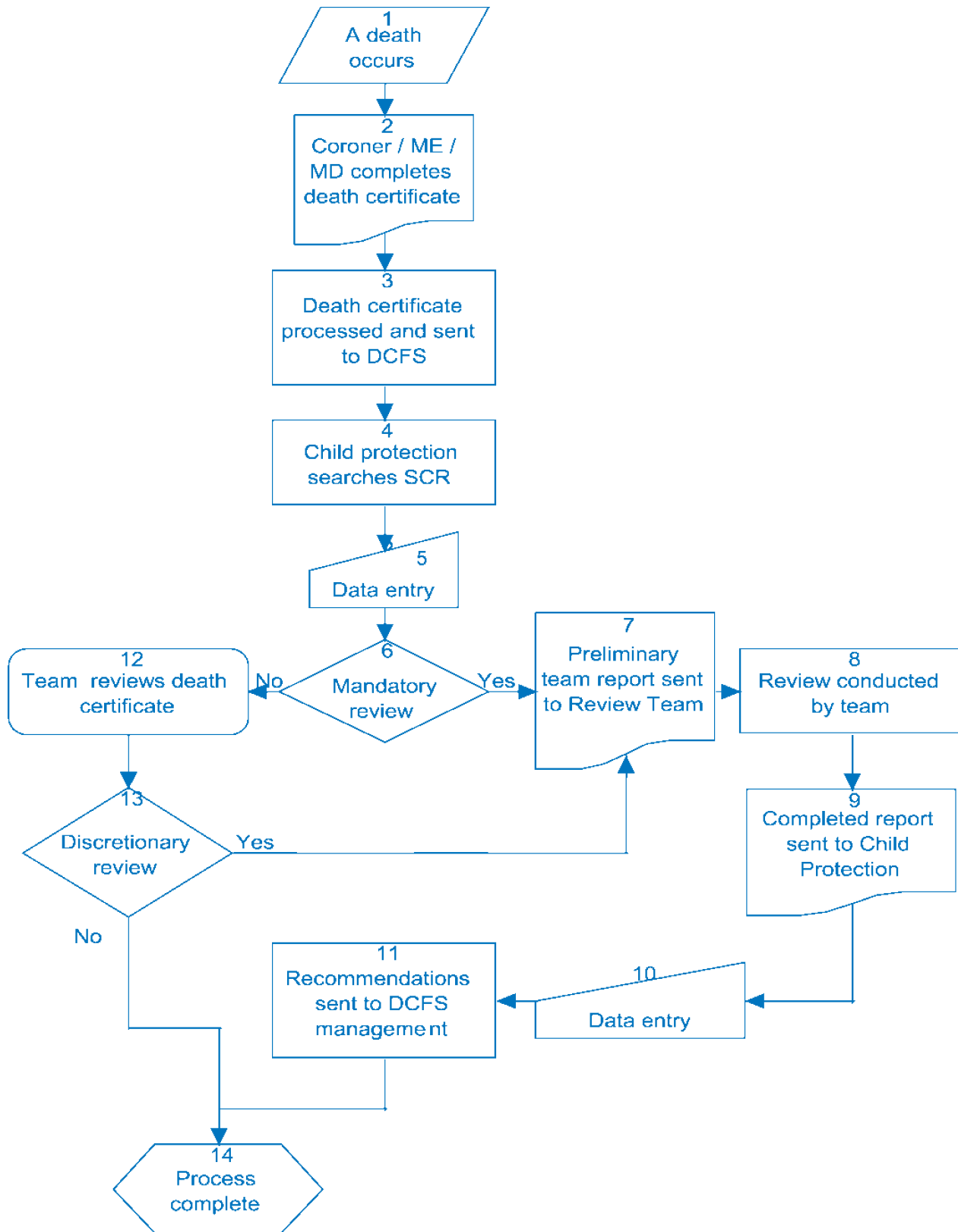
- A ward of DCFS
- The subject of an open DCFS service case
- The subject of a pending child abuse or neglect investigation
- The subject of an abuse or neglect investigation during the preceding 12 months
- Any other child whose death is reported to the DCFS State Central Register as the result of indicated child abuse or neglect

CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18 at their discretion.⁵

⁴ This information was obtained via email from the Illinois Department of Public Health. Specific breakdowns for child deaths by child gender, age, and race were not available, nor was information on the cause of death.

⁵ In addition to mandated reviews and discretionary reviews, CDRTs are required to review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the mandated reporter may ask for a CDRT or other local multidisciplinary team to review the report. The team will review all pertinent information and make a recommendation to DCFS. There were no reviews of this nature requested in 2002.

Figure 1: Child Death Review Flowchart



Information from the death certificates received by the SCR is entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is sent to the appropriate CDRT for review and completion.

According to the Child Death Review Team Act, reviews must be timely. Specifically, each CDRT shall meet at least once in each calendar quarter. In addition, the CDRT must review a case as soon as is practical and not later than 90 days following the completion of an 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.

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.

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

After the CDRT report form is completed, it is sent back to DCFS for entry into the CDRT database. All recommendations are sent to the Director of DCFS, who must review and reply to recommendations (except case-specific) within 90 days of receipt.

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

Confidentiality of CDRT Information

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

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

■ Chapter 2: Illinois Child Deaths 2002 ■

What do we know about the child deaths that occurred in Illinois during 2002?

To answer this question, there are three important sets of numbers that need to be compared: 1) the total population of children in Illinois, 2) the population of total child deaths in Illinois during 2002, and 3) the child deaths that were reviewed by the CDRTs during 2002.

Comparing the children who died to the total child population in Illinois can add to our understanding of how characteristics such as gender, age, and race are associated with child deaths and how children that die differ from those in the general child population in Illinois. However, it is important to note that this report bases its analysis on the total child deaths reported to DCFS by county registrars and coroners. Estimates provided by the Illinois Department of Public Health (see Appendix C for breakdowns by county) suggest that the child deaths reported to DCFS represent about 87% of all child deaths that occurred in 2002.

Child deaths reported to DCFS represent about 87% of all child deaths that occurred in 2002.

Further analysis of the characteristics of children in the third group, child deaths reviewed by the CDRTs, can increase our understanding of the types of deaths experienced by children involved in the child welfare system in Illinois, and how these might differ from the total child deaths. When making this comparison, it is very important to remember that **the population of children in child welfare in Illinois differs from the total child population in Illinois** on a number of characteristics. According to the FY2002 DCFS annual report, over 47% of the children indicated for abuse or neglect were five years of age or younger. This is much higher than the number of children in that age range in the total child population in Illinois. In addition, about 37% of the children indicated for abuse or neglect were African-American, which is much higher than the general child population in Illinois (19%). Thus, **the child welfare population in Illinois is over-represented by young children and African-American children when compared to the total child population in Illinois.** It is therefore likely that deaths reviewed by the CDRTs, which come from this population, will also be over-represented on these two characteristics.

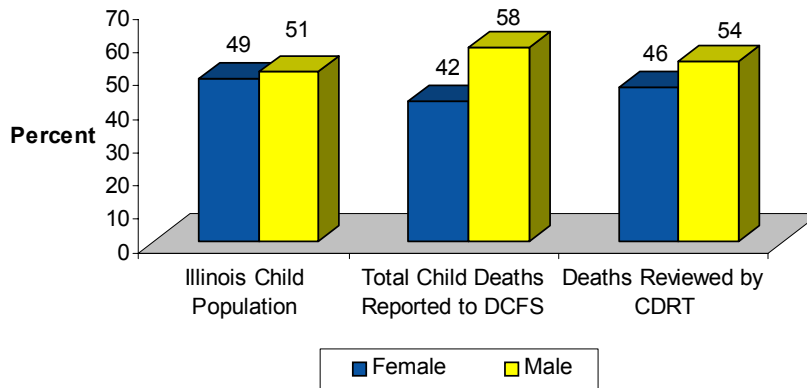
With this information in mind, the following provides a brief look at the three groups.

- According to Census 2000 data, there were approximately 3.2 million children under the age of 18 in Illinois, or about 26% of the total Illinois population.
- There were 1,765 child deaths reported to the Illinois CDRT database in 2002. This includes deaths due to all causes, preventable and non-preventable.
- There were 170 child deaths reviewed by the CDRTs in 2002.

Child Deaths Examined by Gender

According to information from the 2000 Census, 51% of the Illinois child population is male and 49% is female. This can be compared to the gender breakdown for total child deaths reported to the CDRT in 2002 and child deaths that were reviewed by the CDRT (Figure 2). In both of these groups, boys were more likely to die than girls.

Figure 2. 2002 Illinois Child Deaths by Gender



Child Deaths Examined by Age

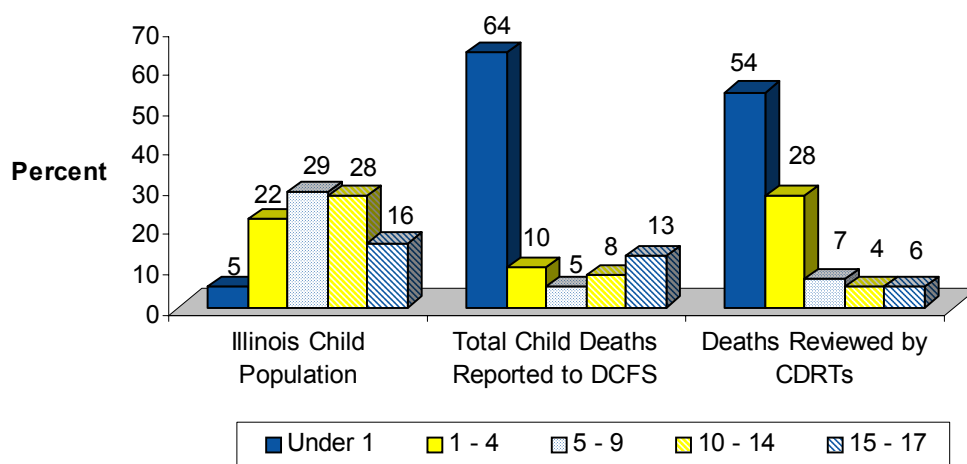
When considered by age group, 5% of Illinois children are less than one year of age, 22% are between 1 and 4 years, 29% are between 5 and 9 years, 28% are between 10 and 14 years, and 16% are between 15 and 17 years.

However, when the total Illinois child deaths reported to DCFS in 2002 are examined by age (Figure 3), it becomes clear that infants less than one year old are especially vulnerable – 1,129 of the 1,765 deaths (64%) occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). The remaining deaths were fairly evenly distributed among the other age groups: 177 (10%) were between 1 and 4, 87 (5%) were between 5 and 9, 143 (8%) were between 10 and 14, and 229 (13%) were between 15 and 17.

When the deaths reviewed by the CDRTs are examined by age group, infants under one year are again over-represented – 92 of the 170 reviewed deaths (54%) occurred in this age group. There were also a large number of deaths reviewed among children between one and four years (48 of 170, or 28%). There were comparatively fewer reviewed deaths among children between 5 and 9 years (12 of 170, or 7%), 10 and 14 years (7 of 170, 4%) and 15 through 17 years (11 of 170, 7%).

When the total Illinois child deaths reported to DCFS in 2002 are examined by age, it becomes clear that infants less than one year old are especially vulnerable.

Figure 3. 2002 Illinois Child Deaths by Age Group



When the total Illinois child deaths reported to DCFS are examined by race, it becomes clear that African-American children are at an increased risk of death when compared to their numbers in the general population.

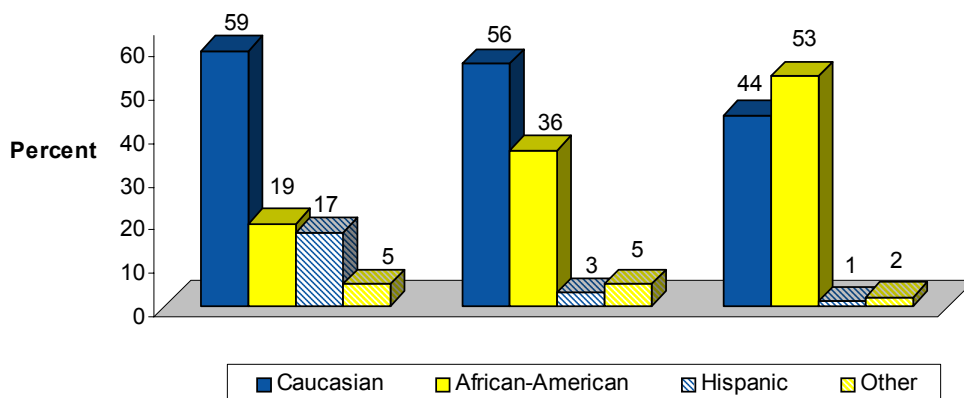
Child Deaths Examined by Race

According to 2000 Census data, 59% of Illinois children are Caucasian, 18.5% are African-American, 17% are Hispanic/Latino, and 5% are of another racial background.

However, when the total Illinois child deaths reported to DCFS are examined by race, it becomes clear that African-American children are at increased risk of death when compared to their numbers in the general population – 635 of the 1,765 (36%) children that died during 2002 were African-American compared with roughly 19% in the general child population. Conversely, the total number of deaths among Hispanic children (45 of 1,765, 3%) was much lower than their numbers in the general population (17%). The number of Caucasian children who died in 2002 (993 of 1,765, 56%) was roughly equivalent to their proportion in the general child population (59%).

When deaths mandated for review by the CDRTs are examined by race, it is clear that compared to both the Illinois child population (19%) and total child deaths (36%), an even greater proportion of the deaths reviewed by the CDRTs are African-American children (90 of 170, 53%). However, when interpreting this result it is very important to remember that the child welfare population in Illinois is disproportionately African-American, which accounts for some of the over-representation, but not all of it.

Figure 4. 2002 Illinois Child Deaths by Race



Child Deaths Examined by Manner and Category

The CDRT Executive Council has identified 12 specific categories of death (plus additional categories for undetermined/other deaths) for review. 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 deaths 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.

It is also important to distinguish between the “category of death” and the “manner of death,” a term used by medical examiners or coroners to classify how the death arose:

- Natural – the death was a result of natural causes such as illness or birth defect
- Accident – the death was the result of an accidental injury
- Homicide – the death was the intentional result of another person’s actions
- Suicide – the death was the result of intentional actions of the decedent
- Undetermined – the manner of death has not been determined

Child deaths in Illinois (reported to DCFS) that occurred in 2002 are examined by category of death in Table 1. The majority of total child deaths were related to either illness (37%) or premature birth (33%). The other categories accounted for the remaining 30% of the total child deaths, ranging from vehicular accidents (5%) to shaken baby syndrome, poisoning/overdose, and overlay (< 1% each).

Next, deaths reviewed by CDRTs (i.e., children involved in child welfare) are examined by category. Illness was the most common factor of death (26%), followed by injuries (18%). This category includes injuries not covered in the other categories, such as burns and falls, as well as inflicted injuries of abuse and neglect. The remaining deaths are distributed fairly evenly among the other categories.

The majority of child deaths in 2002 were related to either illness (37%) or premature birth (33%).

Table 1. Category of Death – Total Child Deaths* versus Deaths Reviewed by CDRT

Category of Death	Total Child Deaths*		Deaths Reviewed by CDRTs	
	Number of deaths	%	Number of deaths	%
Illness	655	37	44	26
Premature Birth	574	33	11	6
Vehicular Accident	83	5	5	3
Firearm	68	4	6	4
Injuries	68	4	30	18
Suffocation	60	3	19	11
Overlaying	8	<1	3	2
Sudden Infant Death Syndrome	38	2	9	5
Fire	31	2	10	6
Drowning	23	1	13	8
Overdose/Poisoning	6	<1	0	0
Shaken Baby Syndrome	1	<1	1	<1
Undetermined	147	8	16	9
Other	3	<1	3	2
Total	1,765		170	

*These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths in 2002.

Total child deaths that occurred during 2002 and were reported to DCFS are examined by manner of death in Table 2 and Figure 5. The majority of child deaths were attributable to natural causes (72%). Accidents accounted for 12% of the total child deaths, 6% were homicides, 1% were suicides, and 9% were undetermined.

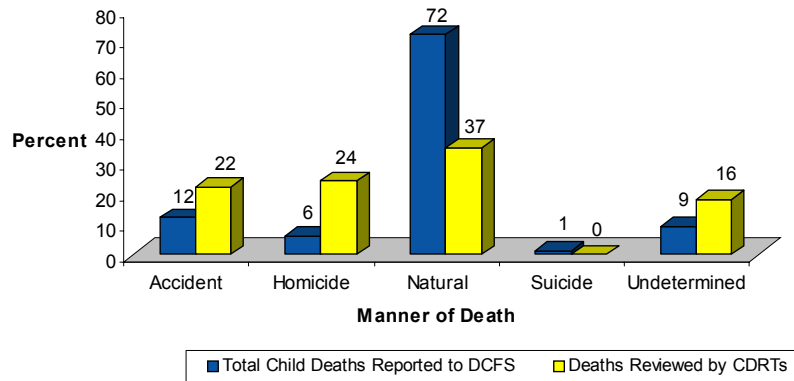
The numbers are quite different for the child deaths reviewed by CDRTs. A much smaller number were attributable to natural causes (37%), while much larger numbers were attributable to homicides (24%) and accidents (22%).

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

Category of Death	Total Child Deaths*		Deaths Reviewed by CDRTs	
	Number of deaths	%	Number of deaths	%
Accident	206	12	37	22
Homicide	109	6	41	24
Natural	1,263	72	63	37
Suicide	24	1	1	<1
Undetermined	163	9	28	16
Total	1,765		170	

*These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths in 2002.

Figure 5. Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs



Finally, it is interesting to examine the manner of child death juxtaposed with the categories of death (Table 3). For instance, it appears that the majority of accidental child deaths in 2002 were related to vehicular accidents, followed by injuries and suffocations. Most homicides involved either firearms or other inflicted injuries, and hanging was the most frequent method of suicide. Almost all child deaths due to natural causes were the result of illness, premature birth, or sudden infant death syndrome (SIDS).

Table 3. 2002 Total Child Deaths* – Manner of Death by Category of Death

Category of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
Illness	2 ^{1,2}	0	653	0	0	655
Premature Birth	0	1 ³	572	0	1	574
Undetermined	0	1 ⁴	5 ³	0	141	147
Vehicular Accident	79	0	0	4	0	83
Firearm	1	62	0	4	1	68
Injury	35	29	0	1	3	68
Suffocation	34	9	0	14	3	60
Sudden Infant Death Syndrome	0	0	33	0	5 ⁶	38
Fire	24	3	0	0	4	31
Drowning	18	2	0	1	2	23
Overlaying	7	0	0	0	1	8
Overdose/Poisoning	5	0	0	0	1	6
Shaken Baby Syndrome	0	1	0	0	0	1
Other	1 ⁷	1 ⁸	0	0	1 ⁹	3
Total	206	109	1,263	24	163	1,765

*These are child deaths reported to DCFS. Not all counties comply with the requirement to report child deaths to DCFS, so this number is a low estimate of Illinois child deaths in 2002.

¹reaction to OTC drugs

²equipment failure related to cardiopulmonary arrest

³maternal gunshot injury

⁴undetermined on autopsy record

⁵medical certificates of death (not from coroner) automatically classified as natural deaths

⁶manner of death left blank on death certificate

⁷heatstroke – child left in car

⁸neglect – malnutrition

⁹malnutrition/poor nutritional support with unknown intent

Chapter 3: Child Deaths Reviewed by Category

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

For each category section, the following information is presented:

By examining the characteristics of the children who die by the specific cause of death, more explicit and useful recommendations for preventing future child deaths can be made.

- Category definition – describes the types of deaths that are included
- Background information – information regarding national statistics or research findings, if available
- Illinois data on total child deaths – this includes deaths reported to DCFS
- Illinois data on child deaths reviewed by the CDRTs
- Charts comparing the total Illinois child population, total child deaths, and deaths reviewed by the CDRTs by child gender (when noteworthy), age, and race

Once again, there are two important facts to remember about these analyses. The first is that not all child deaths in Illinois are reported to DCFS as required by statute. Thus, the number of total child deaths, and any analyses using this number, will be an estimate of the true number of child deaths in Illinois. Second, it is important to remember that **the deaths reviewed by the CDRTs are not a representative sample of all child deaths in Illinois**. The deaths reviewed by CDRTs include children involved with the child welfare system in Illinois, a population of children that is over-represented by African-American children and young children. Thus, any group of children selected from this population (such as child deaths) will be more likely to include young, African-American children than a similar group selected from the general Illinois child population.

Illness

Definition

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

Background

A death due to illness can result from one of many serious health conditions, such as congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart or respiratory disorders, and infections. Many of these conditions are not believed to be preventable in the same way that accidents, homicides, and suicides are preventable⁶. In some illnesses, such as asthma, infectious diseases, and some screenable genetic disorders, fatalities may be preventable.

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 655 (37%) of the 1,765 total child deaths reported to DCFS were related to illness.

- The vast majority of these deaths (653 or > 99%) were attributable to natural causes; two illness deaths were accidental.
- Slightly more boys (54%) than girls (46%) had deaths related to illness, which is consistent with the total child population in Illinois (51% and 49%, respectively).
- Children under the age of one were the largest group who died from illness (57%) and were over-represented in this category as they account for only 5% of the child population in Illinois.

Although more Caucasian children died from illness than African-American children (62% versus 31%, respectively), African-American children are over-represented in this group compared to their numbers in the total Illinois child population (18.5%). Deaths from illness among Hispanic children (2%) are much lower than their numbers among the Illinois child population (17%).

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 44 (26%) of the 170 child deaths reviewed by CDRTs were related to illness.

- All of these deaths were attributable to natural causes.
- More girls than boys had deaths related to illness (55% versus 45%).
- Children under one represent 57% of the illness deaths reviewed by CDRTs, while children between one and four years represent an additional 23% of the reviewed deaths in this category.
- 23 of the 44 illness deaths (52%) reviewed by the CDRTs involved Caucasian children and 20 deaths (45%) involved African-American children. One of the reviewed deaths (2%) involved a Latino child.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 6 and 7.

Children under the age of one were the largest group who died from illness (57%) and were over-represented in this category as they account for only 5% of the child population in Illinois.

⁶Michigan Family Independence Agency. (2002). *Child Deaths in Michigan*

Figure 6. 2002 Child Deaths Due to Illness – by Age

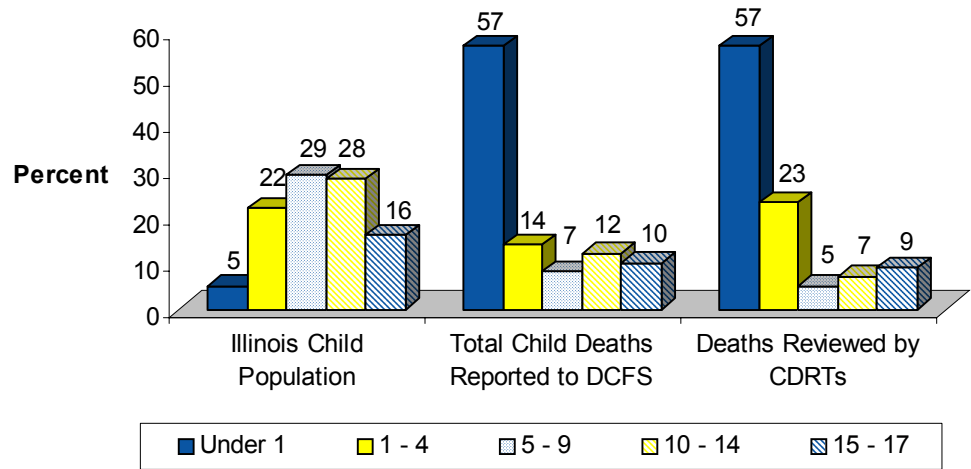
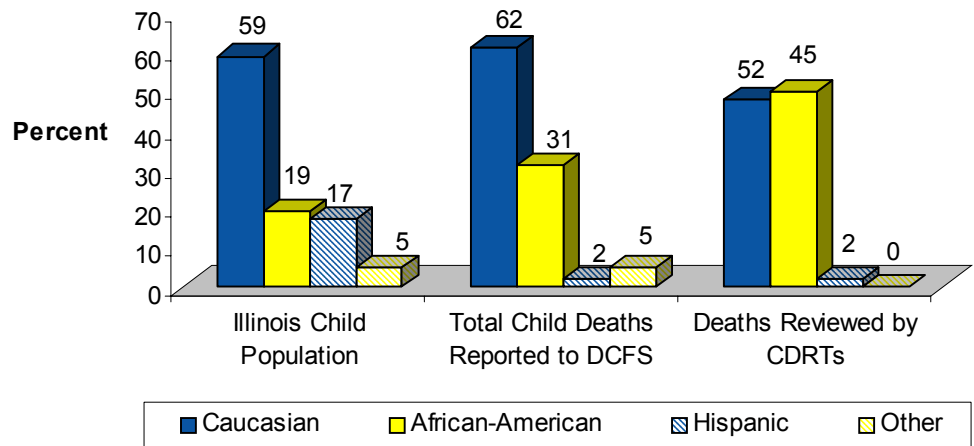


Figure 7. 2002 Child Deaths Due to Illness – by Race



Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature birth, a birth is *generally* determined premature if it occurs before the thirty-sixth week of gestation. It includes aborted pregnancies where a death certificate was completed, but does not include fetal deaths. The manner of death associated with prematurity is most often determined to be natural. However, if an infant is born prematurely due to maternal injury, the manner of death may be ruled accidental or homicide.

Background

Premature birth is closely associated with low birth weight. According to the U.S. Department of Health and Human Services, low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight⁷.

While vast improvements have been made in treating premature infants, preventing pre-term and low birth weight babies is still a challenge. Several risk factors have been associated with prematurity: cigarette smoking during pregnancy, maternal substance use or abuse during pregnancy, elevated blood pressure, prior pre-term births, and certain pregnancy complications.⁸ Other risks include genital tract infections, stress, depression, and other psychological factors.⁹ For reasons not fully understood, pre-term births are twice as likely among African-American women as Caucasian women.

Early access to quality prenatal care can prevent pre-term birth and increase the likelihood that babies are born at normal birth weights.

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 574 (33%) of the 1,765 total child deaths reported to DCFS were related to premature birth.

- Over 99% of the deaths in this category were the result of natural causes.
- More boys (55%) than girls (45%) had deaths related to premature birth (compared to 51% versus 49% in the total child population).
- Although more Caucasian children died from premature birth (52%) than either African-American children (37%) or Hispanic children (4%), African-American children are over-represented in this group because they comprise only 18.5% of Illinois children.

Although there is no single, agreed-upon measure that is used to define premature birth, a birth is *generally* determined premature if it occurs before the 36th week of gestation.

⁷ USDHHS Maternal and Child Health Bureau. *Child Health U.S.A.* 2000.

⁸ Michigan Family Independence Agency. (2002). *Child Deaths in Michigan*.

⁹ Ibid.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 11 (6%) of the 170 child deaths reviewed by CDRTs were related to premature birth.

- Six of the 11 reviewed deaths in this category were girls (55%) and five (45%) were boys.
- There were an equal number of reviewed deaths (5) among both African-American children and Caucasian children. One of the reviewed deaths (10%) involved a Latino child.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender and race are presented in Figures 8 and 9.

Figure 8. 2002 Child Deaths Due to Premature Birth – by Gender

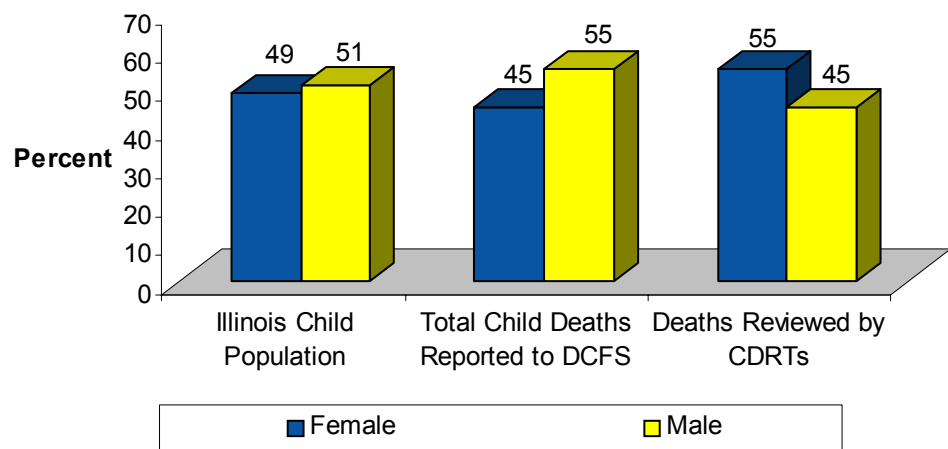
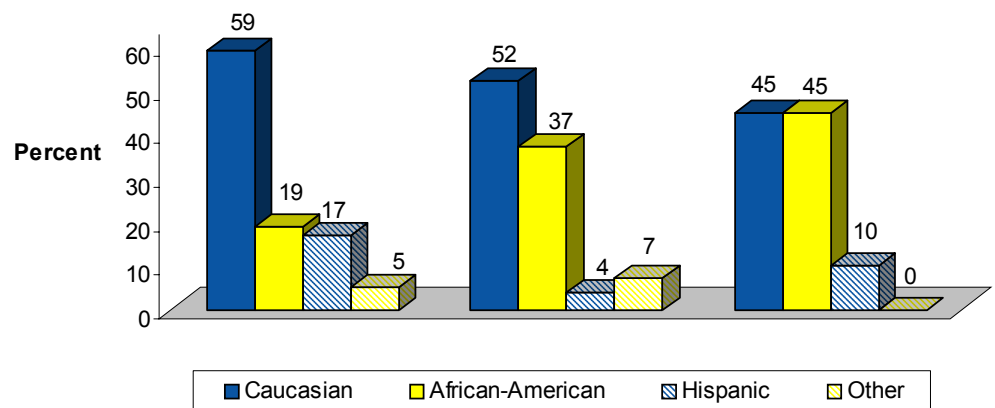


Figure 9. 2002 Child Deaths Due to Premature Birth – by Race



Vehicular Accident

Definition

Included in this category are all deaths occurring to children who are drivers, passengers, pedestrians, or occupants in 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

Vehicular accidents are the leading cause of injury death among older adolescents. Two out of five deaths among U.S. teens are the result of a motor vehicle crash.¹⁰

Young drivers represent about 7% of the licensed drivers in the United States, while representing 14% of all drivers involved in fatal crashes and 17% of all drivers involved in police-reported crashes.¹¹ While young drivers are over-represented in fatal crashes, driver fatalities for this age group decreased by 11% between 1990 and 2000. For young males, driver fatalities dropped by 16%, compared to a 4% increase for young females. The resultant representation is 73% male and 27% female.¹² Over one fifth of the young drivers killed in vehicular accidents were intoxicated.¹³

For children who are passengers in cars, research has shown that lap/shoulder safety belts, when used, reduce the risk of fatal injury to front seat occupants (age 5 years and older) of passenger cars by 45% and the risk of moderate to critical injury by 50%. In addition, properly installed child safety seats reduce fatal injury by 71% for infants (less than 1 year old) and by 54% for toddlers (1-4 years old) in passenger cars.¹⁴

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 83 (5%) of the 1,765 total child deaths reported to DCFS were related to vehicular accidents.

- A large majority (95%) of these deaths were accidental; the remaining 5% were suicides.
- More boys (69%) than girls (31%) had deaths related to vehicular accidents; boys are therefore over-represented in this category (only 51% of the Illinois child population is male).

Vehicular accidents are the leading cause of injury death among older adolescents. Two out of five deaths among U.S. teens are the result of a motor vehicle crash.

¹⁰ Insurance Institute for Highway Safety. *Fatality Facts: Teenagers*. Arlington (VA): The Institute; 2002 [cited 2002 April 1]. Available from: URL: www.iihs.org/safety_facts/fatality_facts/teens.htm

¹¹ Department of Transportation National Highway Traffic Safety Administration. *Traffic Safety Facts 2000: Young Drivers*. [cited 2003 March 12] Available from URL: <http://www.nhtsa.dot.gov>

¹² IBID

¹³ IBID

¹⁴ Department of Transportation National Highway Traffic Safety Administration. *Traffic Safety Facts 2000: Children*. [cited 2003 March 12] Available from URL: <http://www.nhtsa.dot.gov>

- Children between 15 and 17 represent the biggest group involved in deaths related to vehicular accidents, consisting of 55% of these deaths. Children between 10 and 14 are the second largest group in this category (27%), and children under 10 years represent the remaining 17% of vehicular deaths.
- Of children who died from vehicular accidents, 77% were Caucasian, 19% were African-American, and 3% were Hispanic, Asian, or “other” racial background. Thus, Caucasian children are over-represented in this category of death when compared to their numbers in the general Illinois child population (59%).

Illinois Data – Deaths Reviewed by CDRTs

In 2002, five of the 170 deaths (3%) reviewed by CDRTs were related to vehicular accidents.

- Boys represent 100% of the deaths reviewed by CDRTs.
- One of the five reviewed deaths was an infant under one year (20%), two deaths were young children between one and four years (40%), one child was between 5 and 9 years (20%), and one was between 15 and 17 years (20%).
- The vehicular deaths reviewed by CDRTs were about equally split between Caucasian (40%) and African-American (60%) children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender, age, and race are presented in Figures 10, 11, and 12.

Figure 10. 2002 Child Deaths Due to Vehicular Accidents – by Gender

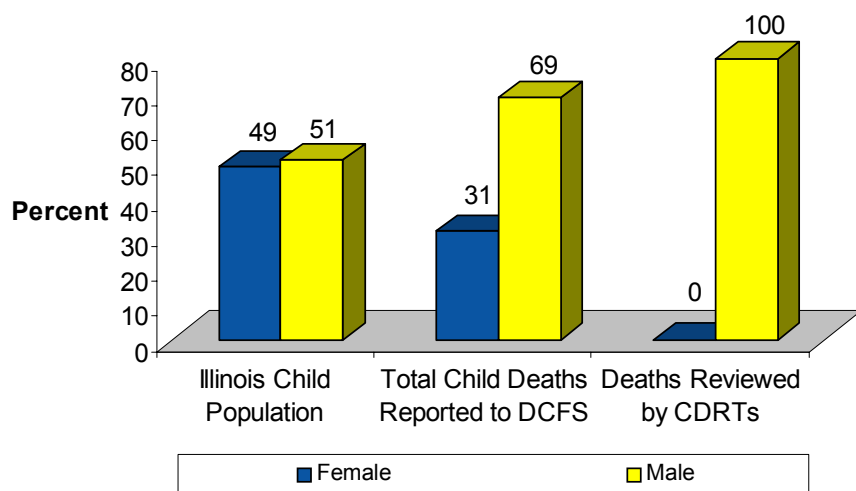


Figure 11. 2002 Child Deaths Due to Vehicular Accidents – by Age

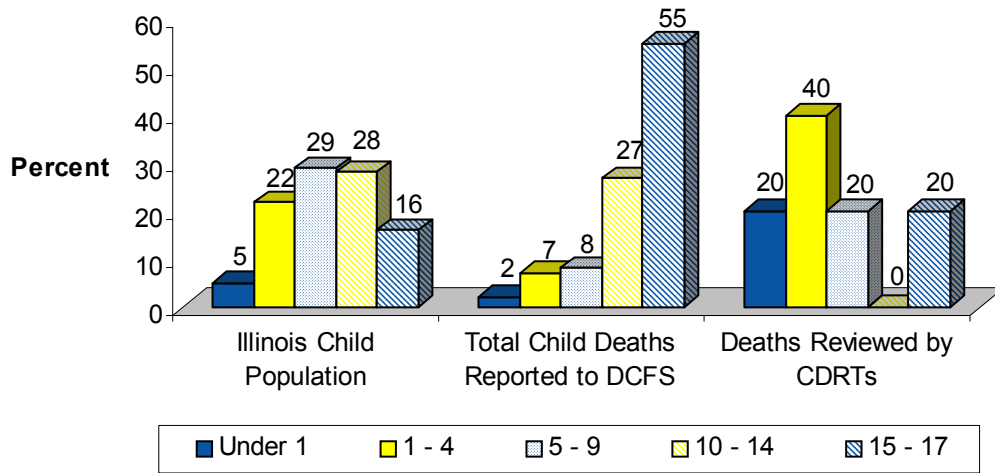
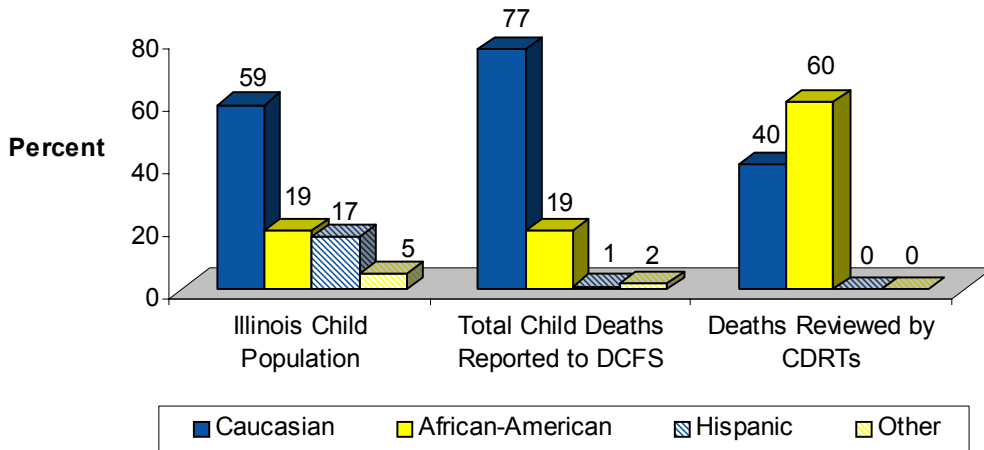


Figure 12. 2002 Child Deaths Due to Vehicular Accidents – by Race



Firearms

Definition

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

Background

In 2000, 1,544 firearms deaths occurred among children under 18 years of age in the United States.¹⁵ Firearm deaths can be unintentional, suicide, or homicide.

Homicide and suicide are the second and third leading causes of death among teens after accidental death.¹⁶ In 1999, firearms were the instrument of death in over 80% of teen homicides and 60% of teen suicides.¹⁷ Homicides are the number one cause of death among African-American and Hispanic teens.¹⁸ However, when socio-economic status is held constant, differences in homicide rates by race become insignificant.

Unintentional deaths from firearms represent less than 2% of all firearm deaths in the U.S. Of this two percent, children and adolescents are involved in 55% of the deaths. The majority of the injuries occur to children playing with or showing firearms to friends.¹⁹ Seventeen states, including Illinois, have enacted child access protection and safe storage laws that may hold adults criminally negligent for failing either to store loaded firearms in a place inaccessible to children or to use safety devices to lock guns. Safe storage laws have been shown to reduce unintentional firearm-related deaths among children by an average of 23%.²⁰

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 68 (4%) of the 1,765 total child deaths reported to DCFS were related to firearms.

- Homicides accounted for 91% of the firearms deaths, suicides accounted for 6%, accidents accounted for 1%, and 1% were undetermined.
- Deaths due to firearms overwhelmingly impact boys (82%).
- Children between 15 and 17 years of age are largely over-represented in this category; they represent 81% of the deaths but only 16.5% of the child population.

¹⁵ National Center for Injury Prevention and Control. *WISQARS Injury Mortality Report 2000*. <http://webapp.cdc.gov/cgi-bin/broker/exe> (3/12/03).

¹⁶ Child Trends (2002). *Teen Homicide, Suicide and Firearm Death*. <http://www.childtrendsdatbank.org/health/violence/70ViolentDEath.htm>

¹⁷ Child Trends (2002). *Teen Homicide, Suicide and Firearm Death*. <http://www.childtrendsdatbank.org/health/violence/70ViolentDEath.htm>

¹⁸ Centers for Disease Control and Prevention (2000). *CDC Fact Book 2000/2002*. Atlanta, GA: Department of Health and Human Services Centers for Disease Control and Prevention.

¹⁹ Michigan Family Independence Agency. (2002). *Child Deaths in Michigan*.

²⁰ National Safe Kids Campaign Protecting Communities. *Injury Facts: Firearm Injury (Unintentional)*. <http://www.safekids.org/index.cfm> (8/8/02).

Unintentional deaths from firearms represent less than 2% of all firearm deaths in the U.S. Of this two percent, children and adolescents are involved in 55% of the deaths.

- Although slightly more Caucasian children died from firearms (53%) than African-Americans children (47%), African-American children are over-represented in this category because they comprise only 18.5% of Illinois' total child population.

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, six of the 170 (4%) deaths reviewed by the CDRTs were related to firearms.

- A majority of firearm deaths reviewed by the CDRTs were boys (67%).
- Half of the firearm deaths reviewed by CDRTs were among children between 15 and 17 years; the other deaths were equally distributed among children between 1 and 4 years, 5 and 9 years, and 10 to 14 years.
- Of the firearm deaths reviewed by CDRTs, 67% were Caucasian and 33% were African-American.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender, age, and race are presented in Figures 13, 14, and 15.

Figure 13. 2002 Child Deaths Due to Firearms – by Gender

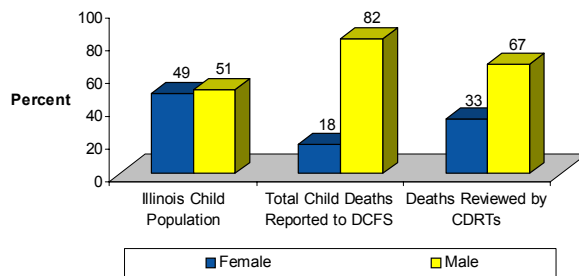


Figure 14. 2002 Child Deaths Due to Firearms – by Age

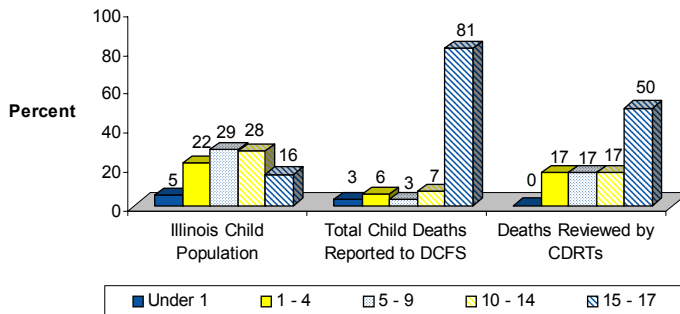
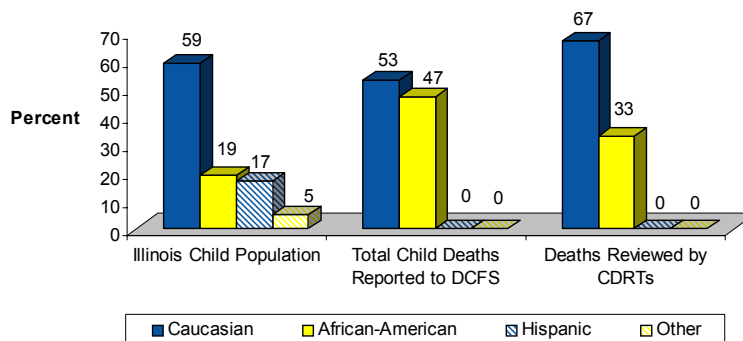


Figure 15. 2002 Child Deaths Due to Firearms – by Race



Injuries

Definition

This category includes deaths due to all types of injuries not covered in other categories of death. These injuries may be intentionally inflicted upon a child by him/herself (suicide) or others (homicide), or may be unintentional (accidents). Injuries in this category include, but are not limited to: sexual and physical assaults, falls, and electrocutions.

Background

Nationally, unintentional injuries are the leading cause of death in children over one year of age.²¹ According to the Center for Disease Control (CDC), there were 12,040 child deaths due to injury in 2000 (17.08 per 100,000).²² In general, males are more likely than females to die of injury.²³

Injuries kill more adolescents than all diseases combined.²⁴ At least one adolescent dies of an injury every hour of every day. Infants are more likely to be fatally injured if they are of low birth weight, premature, or male.²⁵ The injury rate for African-Americans is higher than that for nearly all other racial and ethnic groups.²⁶

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 68 (4%) of the 1,765 total child deaths reported to DCFS were related to injuries.

- 51% of the deaths due to injury were classified as accidents, 43% were homicides, 1% were suicides, and 4% were undetermined.
- Equal numbers of boys (50%) and girls (50%) died of injuries.
- Infants under one year were the most vulnerable to death from injuries (26%), followed closely by young children between the ages of 1 and 4 (24%), children 10 to 14 years (20%), youth between 15 and 17 years (18%), and children between 5 and 9 years (12%).

Of children who died from injury, 49% were Caucasian, 47% were African-American, 1% were Hispanic, 1% were Asian, and 1% were of unknown racial background.

²¹ Center for Disease Control and Prevention. (1993) *Injury mortality: national summary for injury mortality data 1984-1990*. Atlanta, GA: Center for Disease Control and Prevention.

²² CDC & P WISQARS *Injury Mortality Report, 2000*. Available on-line: <http://webapp.cdc.gov/cgi-bin/broker.exe>

²³ Center for Disease Control and Prevention. (1993) *Injury mortality: national summary for injury mortality data 1984-1990*. Atlanta, GA: Center for Disease Control and Prevention.

²⁴ Center for Disease Control and Prevention. (1993). *Injury mortality: national summary for injury mortality data 1984-1990*. Atlanta, GA: Center for Disease Control and Prevention.

²⁵ American Academy of Pediatrics (1999). *Pediatrics, May, 1999*. American Academy of Pediatrics.

²⁶ National Center for Injury Prevention and Control (2002). *Activity Report 2002: CDC's Unintentional Injury Prevention Program*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Nationally,
unintentional injuries
are the leading cause of
death in children over
one year of age.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 30 of the 170 (18%) deaths reviewed by CDRTs were related to other injuries.

- Females represented 63% of the injury deaths reviewed by CDRTs.
- Over half (53%) of the reviewed cases involved infants under one year, 30% involved children between one and four years, 10% involved children between 5 and 9 years, and 7% involved children between 10 and 14 years.
- Two-thirds of the reviewed cases (67%) involved African-American children, 27% involved Caucasian children, 3% involved Asian children, and 3% were of unknown racial background.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 16 and 17.

Figure 16. 2002 Child Deaths Due to Injuries – by Age

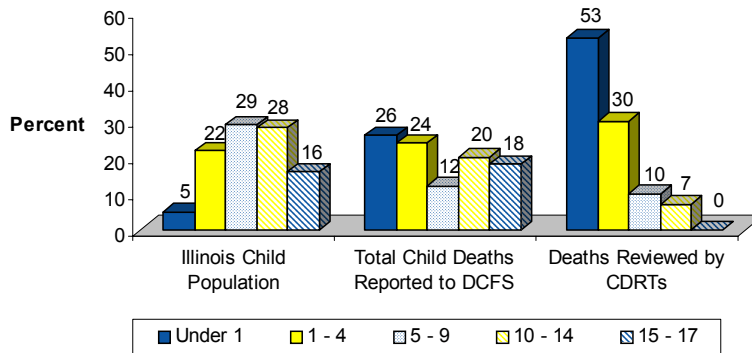
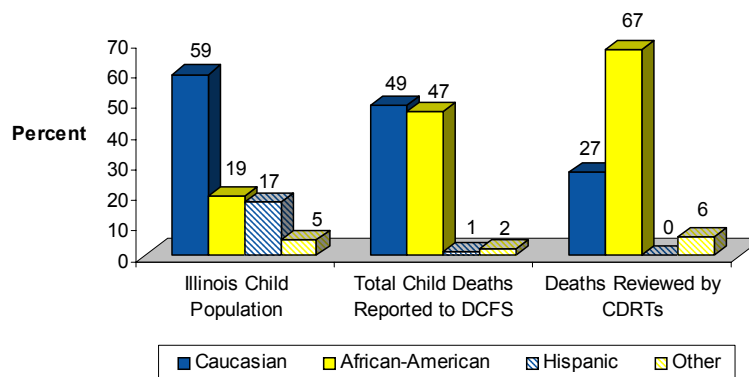


Figure 17. 2002 Child Deaths Due to Injuries – by Race



Suffocation and Overlaying

Definition

Child deaths due to suffocation result when the child is placed in a position where s/he is unable to breathe. Deaths due to suffocation can be accidents, suicides, or homicides. Most unintentional or accidental suffocations are caused by:

- Overlaying – a person sleeping with a child rolls onto the child and unintentionally suffocates the child
- Positional asphyxia – a child’s face becomes trapped in soft bedding or wedged in a small space such as between a mattress and a wall or between couch cushions
- Aspiration/choking – child chokes on an object such as a piece of food or small toy
- Confinement – a child is trapped in an airtight place such as an unused refrigerator
- Strangulation – a rope, cord, or other object tangles around a child’s neck and restricts their breathing

Food and uninflated balloons are the top two choking hazards for toddlers.

Background

The type of suffocation children experience is related to age. Overlaying and positional asphyxiation occurred more often in infants under one year. In a study of 2,178 suffocation cases documented by the Consumer Product Safety Commission between 1980 and 1997, of children who suffocated from obstructions of the nose and mouth, 80% were under seven months of age, and 70% of those overlain were younger than three months of age.²⁷

Toddlers and pre-schoolers are at higher risk for choking and strangulation deaths. Because they are more active, they can more easily become tangled in cords and gain access to small objects. Food and uninflated balloons are the top two choking hazards for toddlers²⁸.

Illinois Data – Suffocation Deaths Reported to DCFS

In 2002, 60 (3%) of the 1,765 total child deaths reported to DCFS were related to suffocations (other than overlaying).

- The manner of the suffocation deaths was varied: 57% were accidental, 23% were suicides, 15% were homicides, and 5% were undetermined.
- Deaths due to suffocation were higher for boys than girls, 57% and 43%, respectively.
- Infants under one year are largely over-represented in this category, accounting for 52% of the deaths but only 5.3% of the child population in Illinois. Youth between 15 and 17 years were the next most frequent groups (20%), followed by those between one and four (13%), 10 through 14 (13%), and 5 through 9 (2%).

²⁷ American Academy of Pediatrics. *News Release: Infants at Increased Risk of Suffocation Death: 1999*. Available online: <http://www.aap.org/advocacy/archives/mayinf.htm> (3/12/03).

²⁸ Michigan Family Independence Agency. (2002). *Child Deaths in Michigan*.

- Of children who died from suffocation, 53% were Caucasian, 37% were African-American, 5% were Asian, and 5% unknown.

Illinois Data – Suffocation Deaths Reviewed by CDRTs

In 2002, 19 of the 170 (11%) deaths reviewed by CDRTs were related to suffocations other than overlaying.

- Of the 19 suffocation deaths reviewed by CDRTs, 11 were accidents (58%), six were homicides (32%), one was a suicide (5%), and one had an undetermined manner of death (5%).
- A little over half (53%) of the reviewed suffocation deaths were female.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (63%), followed by children between one and four years (21%), youth between 15 and 17 years (11%), and those between 10 and 14 years (5%).
- Among the 19 reviewed suffocation deaths, eight were Caucasian (42%), 10 were African-American (56%), one was of unknown racial background (5%).

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 18 and 19.

Figure 18. 2002 Child Deaths Due to Suffocation – by Age

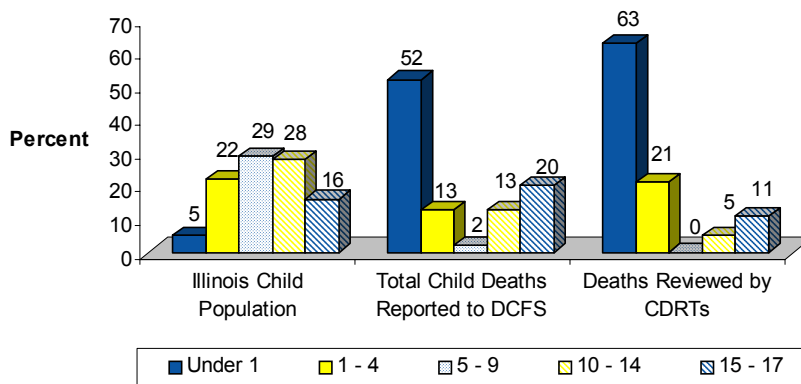
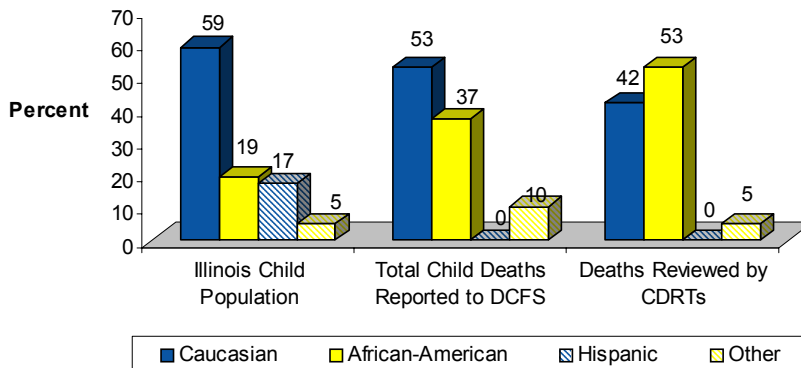


Figure 19. 2002 Child Deaths Due to Suffocation – by Race



Illinois Data – Overlaying Deaths Reported to DCFS

In 2002, 8 (< 1%) of the 1,765 total child deaths reported to DCFS were related to overlaying.

- Seven of the eight overlaying deaths were ruled accidental (88%), and one was ruled undetermined.
- Deaths due to overlaying were higher for boys than girls, 75% and 25% respectively.
- Children under the age of one accounted for all of the deaths in this category.
- 25% of the children who died from overlaying were Caucasian and 75% were African-American.

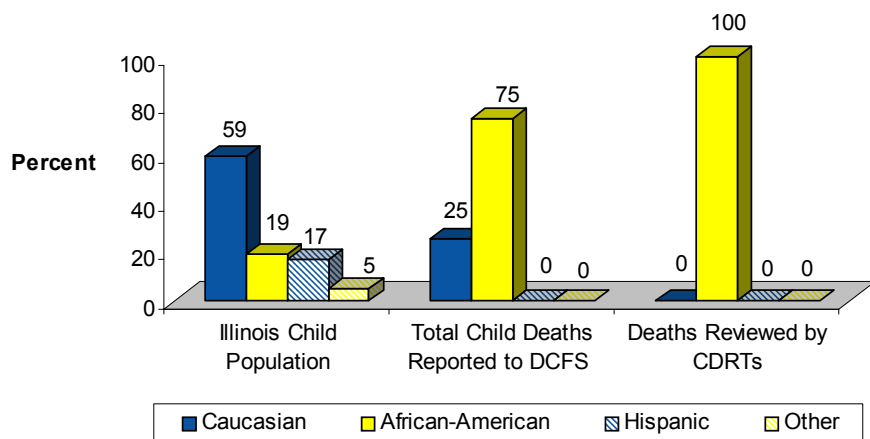
Illinois Data – Overlaying Deaths Reviewed by CDRTs

In 2002, three of the 170 deaths (2%) reviewed by CDRTs were related to overlaying.

- Boys represent two-thirds (67%) of the overlaying deaths reviewed by CDRTs.
- All of the reviewed deaths involved African-American children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by race are presented in Figure 20.

Figure 20. 2002 Child Deaths Due to Overlaying – by Race



Fire

Definition

Fire deaths include house fires, car fires, and smoke inhalation.

Background

According to the National Center on Health Statistics Data, although there has been a consistent decline in child mortality from fire over the last decade, it is still a large factor in child deaths. The fires are generally started with matches or a lighter.²⁹ Most victims actually die from smoke or toxic gases - not from burns.³⁰

Younger children (birth – 4 years) are at a significantly higher risk than older children, and African-American children are at higher risk relative to Caucasian children. This finding must be taken in the context of other studies that show a strong correlation between socioeconomic factors such as poverty and education.³¹

The single most important factor in reducing child fire fatalities is the presence of a working smoke detector. Three-fifths of fire fatalities occur in the small number of homes (7%) that lack any detectors at all.³²

The single most important factor in reducing child fire fatalities is the presence of a working smoke detector.

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 31 (2%) of the 1,765 total child deaths reported to DCFS were related to fires.

- The majority of deaths (77%) attributable to fire were accidental; 10% were homicides, and 13% were undetermined.
- More boys (61%) than girls (39%) had deaths related to fires.
- Young children were most at risk of fire-related deaths: 55% of the deaths in this category were among children five and under, 23% were among children five to nine years, 6% were among children 10 to 14, and 16% were among youth between 15 and 17.

Slightly more African-American children died due to fires than Caucasian children, 52% versus 48%, respectively.

²⁹ U.S. Fire Administration (2000). *Children and Fire in the United States: 1994-1997*. Emmitsburg, MD: Department of Homeland Security and the Federal Emergency Management Agency.

³⁰ Hall, J.R. Burns, toxic gases, and other hazards associated with fires: Deaths and injuries in fire and non-fire situations. Quincy (MA): National Fire Protection Association, Fire Analysis and Research Division; 2002.

³¹ U.S. Fire Administration (2000). *Children and Fire in the United States: 1994-1997*. Emmitsburg, MD: Department of Homeland Security and the Federal Emergency Management Agency

³² Ahrens, M. U.S. experience with smoke alarms and other fire alarms. Quincy (MA): National Fire Protection Association; 2002.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 10 (6%) of the 170 deaths reviewed by CDRTs were related to fires.

- More boys (70%) than girls (30%) had deaths reviewed by CDRTs.
- Children under five years comprise 90% of the deaths due to fire that were reviewed by CDRTs.
- One half of the reviewed deaths involved African-American children, the other half involved Caucasian children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by age and race are presented in Figures 21 and 22.

Figure 21. 2002 Child Deaths Due to Fire – by Age

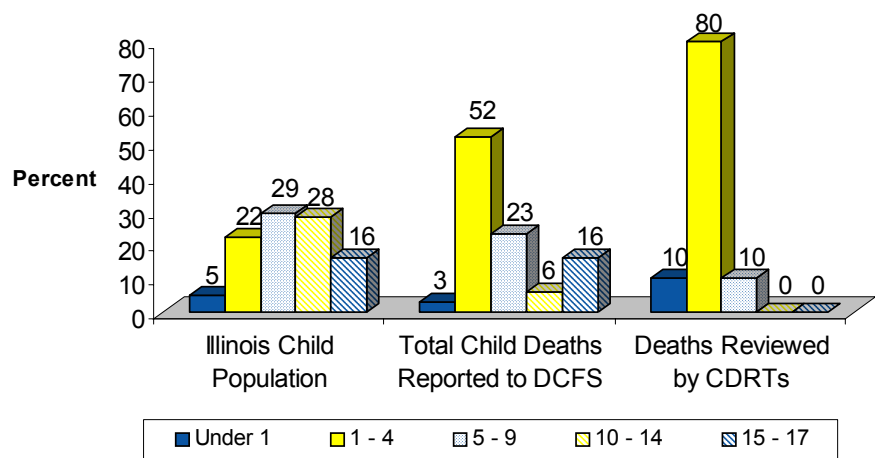
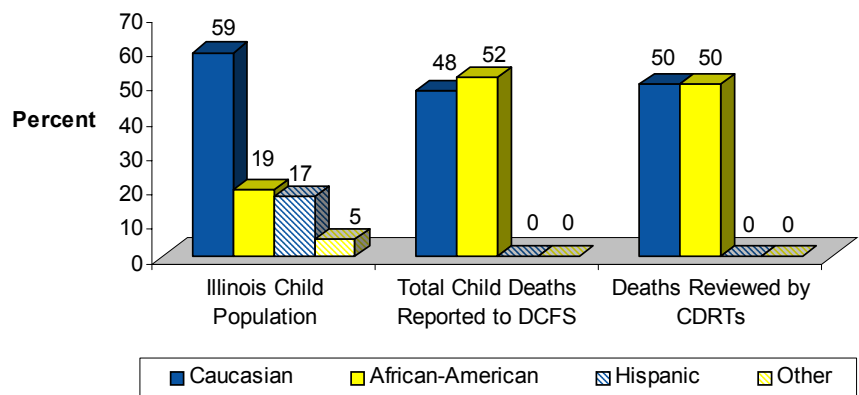


Figure 22. 2002 Child Deaths Due to Fire – by Race



Drowning

Definition

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

Background

About 350 children under 5 years drown in pools each year nationwide, and over half of these incidents occur in June, July and August. Among unintentional injuries, drowning is the second leading cause of death in this age group after motor vehicle incidents.³³

A child's age is closely related to the locations in which drowning deaths occur: Children under age one most often drown in bathtubs, children ages one to four years most often drown in swimming pools, hot tubs and spas, and older children more often drown in open bodies of water.³⁴ Toddlers are particularly vulnerable to accidental "bucket" drownings due to immature muscles in the upper body. Drowning deaths among small children are often due to lack of adult supervision or appropriate preventive measures.

Teenagers are also at risk for drowning, especially in lakes and reservoirs, where there may be no supervision and where their swimming abilities may be challenged by environmental factors. Oftentimes, teen drownings involve alcohol or other substance abuse. Alcohol use has been determined as a major contributing factor in up to 50% of drownings among adolescent boys.³⁵

The drowning rate for African American children is double the rate for Caucasian children.³⁶

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 23 (1%) of the 1,765 total child deaths reported to DCFS were related to drowning.

- Most of the 23 drowning deaths were accidental (78%), one was a suicide (4%), two were homicides (9%), and two were undetermined (9%).
- More boys (70%) than girls (30%) had deaths related to drowning.
- Children between 1 and 4 were at highest risk for drowning-related deaths (48%), followed by children between 10 and 14 (22%), those between 5 and 9 (12%), and those 15-17 and under one year (9% each).
- Of children who died from drowning, 61% were Caucasian and 39% were African-American.

Drowning deaths among small children are often due to lack of adult supervision or appropriate preventive measures.

³³ U.S. Consumer Product Safety Commission. *Press Release #01-168*, June 11, 2002.

³⁴ Centers for Disease Control and Prevention (2003). *Communication at CDC: Drowning*. <http://www.cdc.gov/communication/tips/drowning.htm>.

³⁵ National Safety Council, 1993. *Accident Facts, 1993 Ed.* Itasca, Illinois: Author.

³⁶ Centers for Disease Control and Prevention (2000). *CDC Fact Book 2000/2002*. Atlanta, GA: Department of Health and Human Services Centers for Disease Control and Prevention.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 13 of the 170 deaths (8%) reviewed by CDRTs were related to drowning.

- Boys and girls were about equally represented among the deaths reviewed by CDRTs (54% versus 46%, respectively).
- All of the reviewed drowning deaths occurred among children under 9 years: 2 (15%) were among infants under one year, 9 (70%) were among young children between one and four years, and 2 (15%) were among children between 5 and 9 years.
- 62% of the reviewed deaths involved Caucasian children and 38% involved African-American children.

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender, age and race are presented in Figures 23, 24, and 25.

Figure 23. 2002 Child Deaths Due to Drowning – by Gender

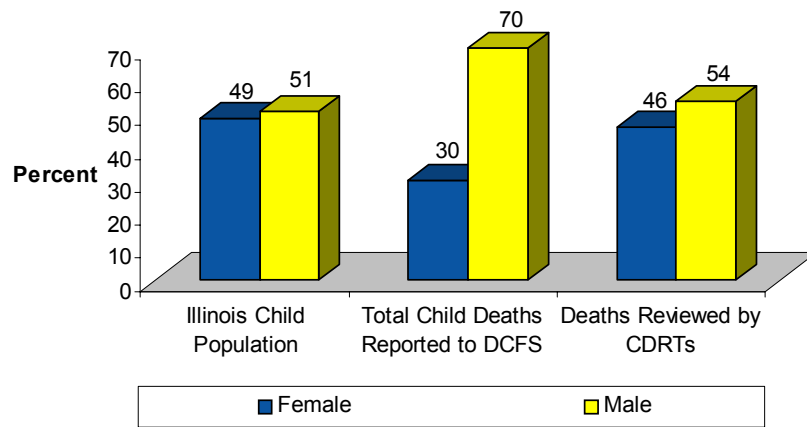


Figure 24. 2002 Child Deaths Due to Drowning – by Age

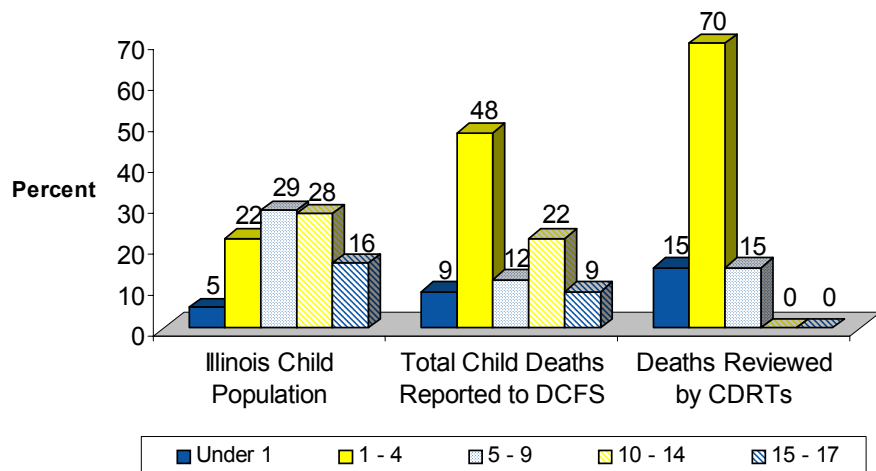
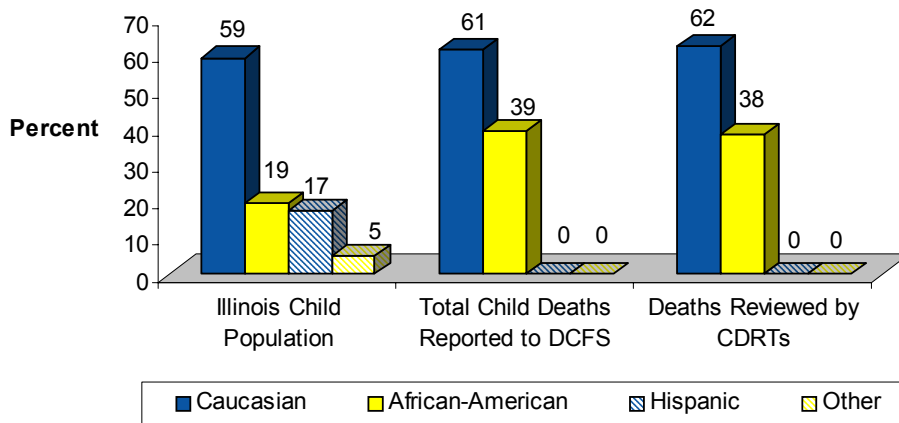


Figure 25. 2002 Child Deaths Due to Drowning – by Race



Drowning Prevention Campaign

“Get Water Wise...Supervise!” is a public water safety campaign launched in 2003 by the Illinois Department of Children and Family Services (DCFS), the American Red Cross Illinois Capital Area Chapter, Prevent Child Abuse Illinois (PCA Illinois), the Illinois Department of Human Services (DHS), and the Illinois Department of Public Health (DPH).

Entering its second year of promoting child water safety, the coalition continues to distribute informational brochures and posters, and conducts a variety of statewide activities focused on preventing childhood drowning in pools, bathtubs, lakes or other bodies of water. The drowning prevention campaign came about as a recommendation from the Illinois Child Death Review Teams. After reviewing deaths due to drowning, the team submitted recommendations to DCFS on the importance of a visible campaign to remind the public that drowning is a swift, silent occurrence that can be avoided when parents, guardians and other care providers exercise constant supervision of children in their care participating in water activities.

Events/activities based on the “Get Water Wise...Supervise!” campaign over the past two years include:

- Statewide press release sent for July 4th weekend
- Statewide press release sent for Labor Day weekend
- Water safety brochures and posters were distributed statewide to all DCFS field offices
- Press conferences held in several communities throughout the state
- Brochures and posters sent to child advocacy organizations throughout to share with their mailing lists
- Water safety displays and materials at several events

Poisoning/Overdose

Definition

Deaths due to poisoning result from the ingestion of a harmful substance, while deaths from overdose include the ingestion (either intentional or unintentional) of lethal amounts of harmful and non-harmful chemical substances (e.g., medicine, drugs).

More than 90% of poisoning cases occur in the home. The most common poisons are cleaning products, pain relievers, cosmetics, personal care products, plants and medicines.

Background

More than 90% of poisoning cases occur in the home. The most common poisons are cleaning products, pain relievers, cosmetics, personal care products, plants and medicines. About half of all poisonings among teens are classified as overdoses due to suicide attempts.

In children under five, there has been a dramatic reduction in the number of deaths from unintentional poisonings. This reduction in morbidity and mortality from childhood poisonings of preschool-aged children is related to a number of factors including: the development and widespread use of child-resistant packaging, a reduction in the number of children's aspirin contained in a bottle, the decreased use of aspirin for treatment of fever during childhood, the development of poison control centers, and better medical care for treatment of ingestions.³⁷

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, six (< 1%) of the 1,765 total child deaths reported to DCFS were related to poisonings or overdoses.

- Five of the six deaths were determined to be accidents and one death was undetermined.
- Boys were more likely to die due to overdose/poisoning than girls (67% versus 33%).
- Four of the six deaths (67%) in this category were among youth between the ages of 15 and 17, one was a child between one and four years, and one was between 10 and 14 years old.

Of children who died from overdose/poisoning, 83% were Caucasian and 17% (one child) was of unknown racial background.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, none of the deaths reviewed by CDRTs were related to overdose or poisoning.

³⁷ National Safe Kids Campaign Protecting Communities. *Injury Facts: Poisoning*. <http://www.safekids.org/index.cfm> (8/8/02).

Shaken Baby Syndrome

Definition

Shaken Baby Syndrome (SBS) is a term used to describe the constellation of signs and symptoms resulting from violent shaking of an infant or small child. It most often involves children younger than two years, but may be seen in children up to five years old. Signs and symptoms involve a spectrum of neurological signs ranging from minor (irritability, lethargy, tremors, vomiting) to major (seizures, coma, stupor, death).³⁸

Externally visible injuries are often absent; consequently, caretakers who are not responsible for the injuries may not know how they occurred.³⁹ Additionally, indications of SBS can be ambiguous; investigation is difficult and may not support a clear finding by the coroner or medical examiner. Often, the coroner will make note of the physical results of the infant being shaken. However, unless shaking is indicated as a significant factor of death, the death is not categorized as SBS in the CDRT database. Thus, it is likely that Shaken Baby Syndrome is under-reported as a cause of death in the CDRT database and report.

Unless shaking is indicated as a significant factor of death, the death is not categorized as SBS in the CDRT database.

Background

There is little information on the number of child victims of SBS. Estimates range from an annual figure as low as 600 cases per year in the United States to as high as 1,400. Until a common method for identifying cases and collecting information is established, the true incidence will not be known.

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, one (< 1%) of the 1,765 total child deaths reported to DCFS were related to shaken baby syndrome.

- This death was classified as a homicide.
- This child was male, African-American, and between 1 and 4 years.

³⁸ National Center on Shaken Baby Syndrome. www.dontshake.com (3/12/03).

³⁹ American Academy of Pediatrics. *Shaken Baby Syndrome: Rotational Cranial Injuries – Technical Report (10039)*. 2002. 108:206-210.

Sudden Infant Death Syndrome

Definition

Sudden Infant Death Syndrome (SIDS) is the unexpected and sudden death of a baby under the age of one year that remains unexplained after a thorough investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history.⁴⁰

Despite recent decreases in the incidence of SIDS, it is still responsible for more infant deaths in the United States than any other cause of death beyond the neonatal period.

Background

Despite recent decreases in the incidence of SIDS, it is still responsible for more infant deaths in the United States than any other cause of death beyond the neonatal period.⁴¹

The following have been consistently identified as risk factors for SIDS: prone sleep position, sleeping on a soft surface, maternal smoking during pregnancy, overheating, later or no prenatal care, young maternal age, prematurity and/or low birth weight and male sex. Additionally, African Americans and Native Americans have consistently higher rates of SIDS – two to three times the national average.⁴² The risk factors with the greatest potential for modification include prone sleep position, sleeping on a soft surface, maternal smoking and overheating.⁴³

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 38 (2%) of the 1,765 total child deaths reported to DCFS were related to SIDS

- More boys (63%) than girls (37%) had deaths related to SIDS.

50% of the SIDS deaths occurred among Caucasian children and 50% among African-American children.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, nine of the 170 (5%) deaths reviewed by CDRTs were related to SIDS.

- Seven of the nine SIDS deaths (78%) reviewed by the CDRTs were boys.
- Five of the reviewed SIDS deaths (56%) were African-American infants, the four other deaths were Caucasian infants (44%).

Comparisons between the total child population, total child deaths, and deaths reviewed by the CDRTs by gender and race are presented in Figures 26 and 27.

⁴⁰ Guyer, B., MacDorman, M.F., Martin, J.A., Peters, K.D., Strobino, D.M. Annual summary of vital statistics 1997. *Pediatrics*. 1998; 102:1333-1349.

⁴¹ Willinger, M., James, L.S., Catz, C. Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatric Pathology*. 1991; 11: 677-684.

⁴² American Academy of Pediatrics. Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position. *Pediatrics*. 2000. 105:650-656.

⁴³ IBID.

Figure 26. 2002 Child Deaths Due to SIDS – by Gender

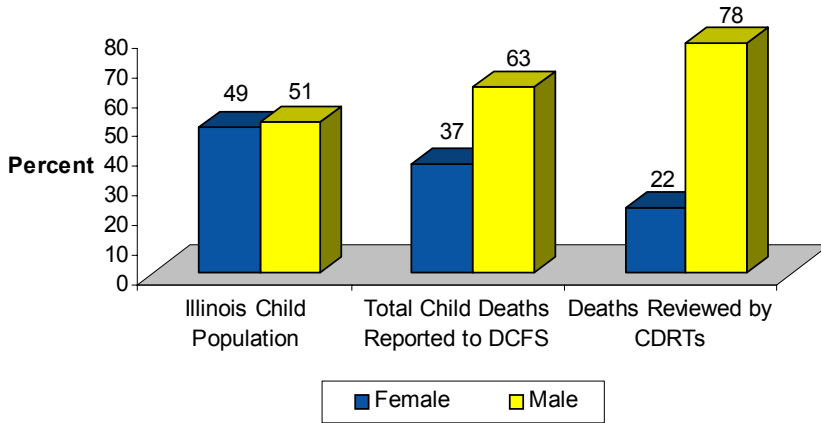
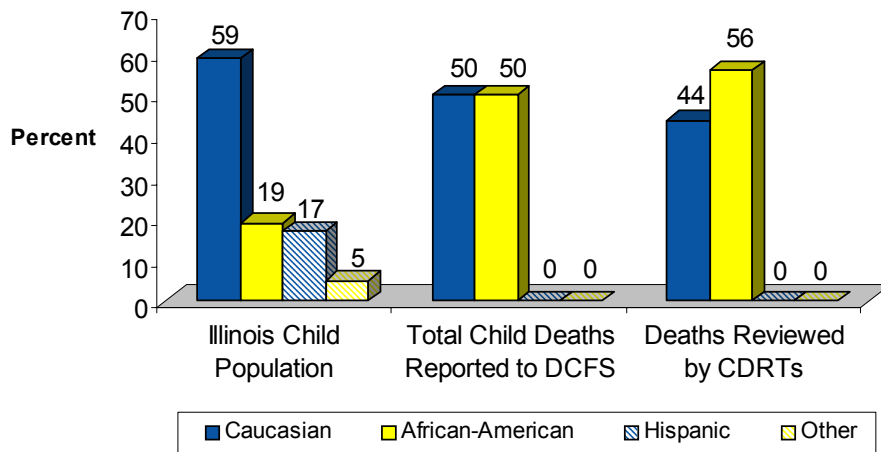


Figure 27. 2002 Child Deaths Due to SIDS – by Race



Undetermined Deaths

Definition

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

Illinois Data – Total Child Deaths Reported to DCFS

In 2002, 147 (8%) of the 1,765 total child deaths reported to DCFS had an undetermined cause of death.

- Deaths due to undetermined causes were higher for boys than girls, 67% versus 33%.
- Children under the age of one represent 56% of deaths in this category, 12% were between 1 and 4 years, 6% were between 5 and 9 years, 6% were between 10 and 14 years, and 20% were between 15 and 17 years.
- 49% of the children who died from undetermined factors were Caucasian, 45% were African-American, 3% were Asian, 1% were Hispanic, 1% were of other racial backgrounds, and 1% were unknown.

Illinois Data – Deaths Reviewed by CDRTs

In 2002, 16 of the 170 (9%) deaths reviewed by CDRTs had an undetermined cause of death.

- These reviewed deaths were equally split between boys and girls.
- Reviewed deaths due to undetermined causes were concentrated among young children – 88% involved children less than 5 years.
- A little less than half (44%) of the reviewed deaths of undetermined causes were Caucasian children and 56% were African-American children.

■ Chapter 4: Impact of Child Death Review ■

In Illinois, each CDRT submits recommendations for changes in procedures, programs, and policies based on their reviews of child deaths. These recommendations are submitted to the Director and Inspector General of DCFS, and the Director must respond to each recommendation (except for case-specific recommendations) within 90 days. Thus, the importance of CDRT recommendations – and their potential for preventing future child deaths – cannot be overstated.

Recommendations to DCFS may focus on establishing new policies and protocols, improving existing policies and protocols, raising public awareness, or increasing effectiveness of services provided to children and families. 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. Recommendations fall into four categories:

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

Recommendations often bridge more than one area, focusing on a specific case that has implications for preventing future fatalities through changes in DCFS policy, other system policy (e.g., law enforcement, coroners, state’s attorneys office, etc.), and public awareness.

Recommendations to DCFS may focus on establishing new policies and protocols, improving existing policies and protocols, raising public awareness, or increasing effectiveness of services provided to children and families.

CDRT Recommendations

In 2002, there were 72 recommendations made by the CDRTs. A complete list of these recommendations (excluding case-specific recommendations) is located in Appendix D.

The majority of the recommendations (41) focused on DCFS policy and procedures, followed by case-specific recommendations (18), recommendations for other systems (8), and primary preventions strategies (5).

DCFS System Recommendations

A DCFS system recommendation is specific to a DCFS policy, procedure, or program. In 2002, CDRTs submitted 41 DCFS system recommendations. Some of these recommendations and their corresponding responses from DCFS include:

Table 4. 2002 DCFS System Recommendations and Responses Examples

CDRT Recommendation	DCFS Response
DCFS should assure that all foster children have either a verified history of chickenpox or have received the vaccine. This is a particularly important issue for older foster children who are more vulnerable to complicated chickenpox.	The Department agrees. The chickenpox vaccine is now a required immunization for all DCFS wards except when it is considered to medically inappropriate.
The team recommends establishing a policy and protocol regarding Munchausen's Syndrome by Proxy and to support the training of hotline staff and DCFS staff on Munchausen's Syndrome by Proxy.	The Department will explore using this case as a teaching tool for SCR and direct service staff on Munchausen's by Proxy indicators. The Department would like to work with CDRT members to draft a Protocol for the investigation of alleged Munchausen's by Proxy Protocol.
Make it policy for DCFS workers who have contact with families to educate and remove pacifiers on strings around a child's neck or strings that are long enough to wrap around a child's neck. Make this part of foster parent training.	The Department is piloting a home safety checklist in the southern region. The issue related to pacifier and other similar crib hazards will be included on the checklist. Furthermore, the Department will explore including an article on infant safety in an upcoming issue of Families Now and Forever.

Other Systems Recommendations

Other system recommendations concern the policies and procedures of agencies and organizations that are involved in child safety, health, and welfare. This includes medical examiners, coroners, medical professionals, state's attorneys, and other state agencies such as the Illinois Department of Public Health. In 2002, CDRTs submitted eight recommendations concerning other systems. Some of these recommendations and their corresponding responses from DCFS include:

Table 5. 2002 Other Systems Recommendations and Responses Examples

CDRT Recommendation	DCFS Response
Team recommends that DCFS write a letter to IDPH requesting that the Department of Epidemiology provide training to NICU nurses and social service personnel in hospitals on the APORS referral criteria and services.	Attached is a letter that was sent to the Illinois Department of Public Health's Office of Epidemiology and Health Systems Development regarding this recommendation.
Team recommends that IDPH send all health care institutions the criteria regarding child death notification to coroners/ Medical Examiners Offices. Emphasis must be given on death cases that illnesses that are results of prior abuse or neglect should be reported irrespective of the time interval between death and injury.	Will forward to IDPH.

Primary Prevention Recommendations

Prevention recommendations encourage strengthening of public awareness campaigns related to child health, safety, and welfare, and other mechanisms for preventing child deaths. In 2002, CDRTs made five prevention recommendations. Some examples of these recommendations and their corresponding DCFS responses are:

Table 6. 2002 Primary Prevention Recommendations and Responses Examples

CDRT Recommendation	DCFS Response
The team recommends that DCFS request the American Red Cross to emphasize the Back to Sleep information during their Babysitting Certification Programs.	Attached is a letter that was sent to the American Red Cross regarding this recommendation.
Team recommends that DCFS, along with other agencies, move very quickly in the pursuit and establishment of a drowning prevention campaign and would like to emphasize several past recommendations on this same subject.	DCFS collaborated with the American Red Cross, Prevent Child Abuse Illinois, Illinois Department of Public Health and Illinois Department of Human Services to create the Get Water Wise...Supervise Campaign. This is a new statewide public awareness campaign to educate the public about the urgent need for adult supervision when children are in or near the water. A media launch was done in all eight regions across the state beginning on June 3, 2003. Television stations, newspapers and radio stations were in attendance at these launches. Posters and brochures (English and Spanish) have been printed and are continuing to be distributed. Each agency involved has assisted in the distribution. The Child Death Review Teams have also been asked to assist in the distribution of these items.

Appendix A

Illinois Child Death Review Team Act (PA 88-614)

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

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

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

(20 ILCS 515/5)

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

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

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

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

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

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

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

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

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

(20 ILCS 515/10)

Sec. 10. Definitions.

As used in this Act, unless the context requires otherwise:

"Child" means any person under the age of 18 years unless legally emancipated by reason of marriage or entry into a branch of the United States armed services.

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

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

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

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

(20 ILCS 515/15)

Sec. 15. Child death review teams; establishment.

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

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

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

(2) Representative of the Department.

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

(4) Representative of a local law enforcement agency.

(5) Psychologist or psychiatrist.

(6) Representative of a local health department.

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

(8) Coroner or forensic pathologist.

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

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

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

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

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

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

(20 ILCS 515/20)

Sec. 20. Reviews of child deaths.

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

- (1) A ward of the Department.
- (2) The subject of an open service case maintained by the Department.
- (3) The subject of a pending child abuse or neglect investigation.
- (4) A child who was the subject of an abuse or neglect investigation at any time during the 12 months preceding the child's death.

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

A child death review team may, at its discretion, review other sudden, unexpected, or unexplained child deaths.

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

- (1) Assist in determining the cause and manner of the child's death, when requested.
- (2) Evaluate means by which the death might have been prevented.
- (3) Report its findings to appropriate agencies and make recommendations that may help to reduce the number of child deaths caused by abuse or neglect.
- (4) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect.

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

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

(d) The Director shall, within 90 days, review and reply to recommendations made by a team under item (5) of subsection (b). The Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or non-implementation of the recommendations.

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

(20 ILCS 515/25)

Sec. 25. Team access to information.

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

(b) A child death review team shall have access to all records and information that are relevant to its review of a child death and in the possession of a State or local governmental agency. These records and information include, without limitation, birth certificates, all relevant medical and mental health records, records of law enforcement agency investigations, records of coroner or medical examiner investigations, records of the Department of Corrections concerning a person's parole, records of a probation and court services department, and records of a social services agency that provided services to the child or the child's family.

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

(20 ILCS 515/30)

Sec. 30. Public access to information.

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

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

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

(d) Records and information produced by a child death review team and the Executive Council are not subject to discovery or subpoena and are not admissible as evidence in any civil or criminal proceeding. Those records and information are, however, subject to discovery or a subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.
(Source: P.A. 92-468, eff. 8-22-01)

(20 ILCS 515/35)

Sec. 35. Indemnification.

The State shall indemnify and hold harmless members of a child death review team and the Executive Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the team or Executive Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act (5 ILCS 350/1 et seq.).
(Source: P.A. 92-468, eff. 8-22-01.)

(20 ILCS 515/40)

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

(a) The Illinois Child Death Review Teams Executive Council, consisting of the chairpersons of the 9 child death review teams in Illinois, is the coordinating and oversight body for child death review teams and activities in Illinois. The vice-chairperson of a child death review team, as designated by the chairperson, may serve as a back-up member or an alternate member of the Executive Council, if the chairperson of the child death review team is unavailable to serve on the Executive Council. The Inspector General of the Department, ex officio, is a non-voting member of the Executive Council. The Director may appoint to the Executive Council any ex-officio members deemed necessary. Persons with expertise needed by the Executive Council may be invited to meetings. The Executive Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year, renewable term. The Executive Council must meet at least 4 times during each calendar year.

(b) The Department must provide or arrange for the staff support necessary for the Executive Council to carry out

its duties. The Director, in cooperation and consultation with the Executive Council, shall appoint, reappoint, and remove team members.

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

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

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

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

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

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

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

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

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

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

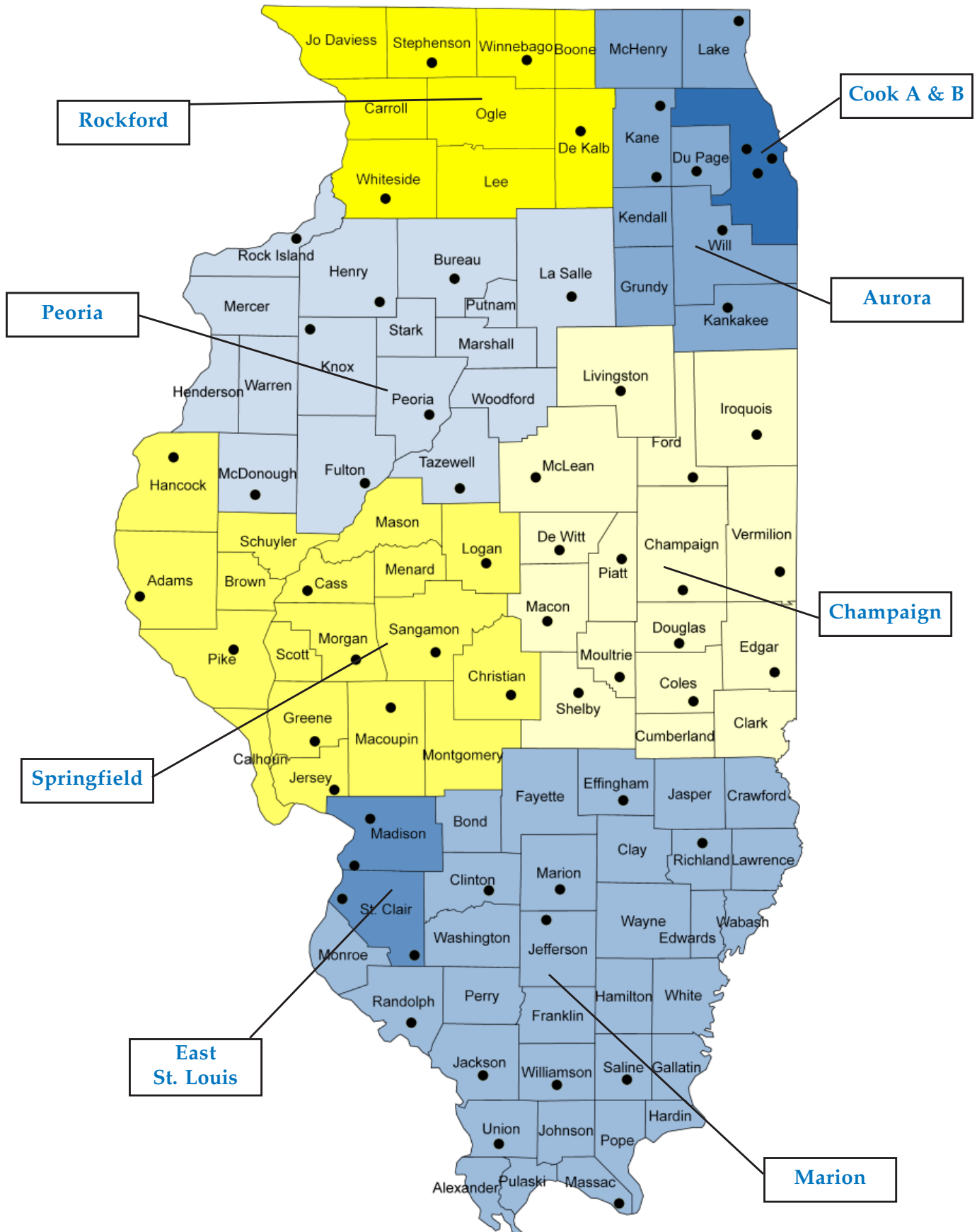
(10) To perform any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

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

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

Appendix B

Child Death Review Team Regional Map



Appendix C

Illinois Child Deaths Reported to DCFS ~ By County

County	Deaths Reported to DCFS	Deaths Reported by IDPH
Adams	2	4
Alexander	1	2
Bond	0	0
Boone	0	1
Brown	0	1
Bureau	1	1
Calhoun	0	0
Carroll	1	1
Cass	0	0
Champaign	45	50
Christian	2	2
Clark	1	1
Clay	0	0
Clinton	0	0
Coles	1	2
Cook	1096	1211
Crawford	1	1
Cumberland	1	1
DeKalb	8	12
Dewitt	0	0
Douglas	0	0
Dupage	103	109
Edgar	1	1
Edwards	0	1
Effingham	0	2
Fayette	0	2
Ford	0	1
Franklin	0	4
Fulton	0	6
Gallatin	0	0
Greene	0	0
Grundy	7	7

County	Deaths Reported to DCFS	Deaths Reported by IDPH
Hamilton	1	1
Hancock	0	1
Hardin	0	0
Henderson	0	0
Henry	3	3
Iroquois	0	0
Jackson	0	14
Jasper	0	3
Jefferson	0	8
Jersey	0	0
Jo Daviess	2	2
Johnson	1	1
Kane	43	53
Kankakee	20	19
Kendall	1	2
Knox	0	2
Lake	34	43
LaSalle	0	12
Lawrence	3	3
Lee	3	2
Livingston	0	6
Logan	3	3
Macon	13	13
Macoupin	0	5
Madison	18	26
Marion	0	1
Marshall	0	0
Mason	0	1
Massac	1	1
McDonough	4	5
McHenry	0	6
McLean	10	12
Menard	0	0
Mercer	0	0
Monroe	1	1
Montgomery	1	3

County	Deaths Reported to DCFS	Deaths Reported by IDPH
Morgan	2	2
Moultrie	0	0
Ogle	2	2
Peoria	94	95
Perry	3	4
Piatt	0	2
Pike	0	0
Pope	0	1
Pulaski	0	1
Putnam	0	0
Randolph	2	2
Richland	1	1
Rock Island	12	14
Saline	0	0
Sangamon	42	46
Schuyler	0	2
Scott	0	0
Shelby	0	0
Stark	0	0
St. Clair	28	27
Stephenson	3	4
Tazewell	4	4
Union	0	2
Vermillion	3	7
Wabash	0	0
Warren	0	1
Washington	5	4
Wayne	3	1
White	1	1
Whiteside	0	2
Will	42	42
Williamson	1	8
Winnebago	79	78
Woodford	1	1
Unknown	3	0
Total	1765	2029

Appendix D

Child Death Review Team Recommendations and DCFS Responses

DCFS System Recommendations

CDRT Recommendation	DCFS Response
<p>The team recommends that, when new and revised educational material is printed, DCFS and DHS have this information reviewed and evaluated for an appropriate reading level to ensure all parents can read and understand the information. This review is suggested for both English and Spanish materials.</p>	<p>The Department of Children and Family Services has a publication approval process that is required on materials that will be printed and distributed. The Office of Communications evaluates the material to be sure it is appropriate for the audience that it will be distributed to. The Department of Human Services Office of Communications also has a process to review and edit any materials that will be distributed to the public. In addition, DHS utilizes a computer program designed to evaluate materials to assure that individuals at a 9th grade and under level are able to understand it. The Department agrees to have the material for Child Care Choices available to families at the local DCFS offices.</p>
<p>Team recommends that DCFS workers should have the material for Child Care Choices printed by DHS available to hand out to families and should explain/review the information with the parents/caregiver.</p>	<p>Same as above.</p>
<p>DCFS should reconsider whether there should be a finding of neglect due to unsafe sleeping on ottoman and sleeping on abdomen, face down. Both are risk factors for death.</p>	<p>The Department shares the CDRT's concern about the propriety of the unfounded decision in this case and lack of referral for committee services such as BabyFold. Unfortunately once a case has been unfounded and notification of such given the Department does not have the legal authority to change the finding. Once the family was notified of the unfounded status of the case they could and did refuse services from the Department.</p>
<p>DCFS should determine whether family was offered any genetic testing and if so, did they accept or not?</p>	<p>Based on the circumstances that led to the death of the child, genetic testing would not of have been appropriate.</p>
<p>Mother should be referred to Healthy Start early in her next pregnancy.</p>	<p>Since there is not an open DCFS case with this family there is no mechanism for DCFS to know when and if mother ever becomes pregnant again.</p>
<p>There was lack of coordination of information in the investigation for example, while local DCFS did not have access to the autopsy report in spite of their request; it was available to the State Police. Should DCFS have closed this case without reviewing the autopsy report?</p>	<p>The Department should have received a copy of an autopsy report as a matter of "Best Practice" and pursuant to Department Procedure 300. However, Procedure 300 does allow for an investigative finding to be made if a copy of the autopsy is not available, to wit: "If an autopsy report is not available, a case note must be included indicating that the report was requested along with verbal statements regarding the cause and manner of death. The supervisor must review the autopsy report when it is received to ensure findings do not conflict with previously documented information received verbally."</p>
<p>Although local DCFS felt the older children were safe, the CDRT questioned the ability of this mother to care for a two-year-old. It would be useful to keep the case open or possibly refer to Baby Fold for on-going services.</p>	<p>The Department shares the CDRT's concern about the propriety of the unfounded decision in this case and lack of referral for committee services such as BabyFold. Unfortunately once a case has been unfounded and notification of such given the Department does not have the legal authority to change the finding. Once the family was notified of the unfounded status of the case they could and did refuse services from the Department.</p>

CDRT Recommendation	DCFS Response
<p>DCFS should assure that all foster children have either a verified history of chickenpox or have received the vaccine. This is a particularly important issue for older foster children who are more vulnerable to complicated chickenpox.</p>	<p>The Department agrees. The chickenpox vaccine is now a required immunization for all DCFS wards except when it is considered to medically inappropriate.</p>
<p>If worker is unable to directly access doctor records there should be a specific process to be followed to access records for specific hospitals (e.g. a list of contacts for each specific hospital).</p>	<p>There is already a process for accessing records from hospitals that are relevant to a child abuse/neglect investigation. The process is the securing of an administrative subpoena for records through Department Legal staff. Local working relationships with hospital personnel such as hospital social workers and medical records personnel can, in some cases, make records more immediately accessible to DCFS, but this is more often not the case in large urban and metropolitan hospitals. Currently, the Department is working with MPEEC (the Multi-disciplinary Pediatric Education and Evaluation Consortium) Project staff, which includes pediatricians from the major trauma center hospitals in Cook County to find solutions to, among other things, expedite the release of medical records in a more timely manner. In addition, the Associate Deputy Director for Cook County Child Protection is currently arranging in house training on specific steps to be taken in order to access important evidence.</p>
<p>Team wants to re-empathize the implementation of an environmental safety checklist, which has been developed by OIG, to be used with all families involved with DCFS.</p>	<p>Effective June 7, 2004, the Department issued Policy Guide 2004.01, Home Safety Checklists. The purpose of the Policy Guide is to issue three home safety checklists that are designed to reduce the rate of household accidents that injure children and to inform workers of the requirements for the checklists' use: CFS 2025, Home Safety Checklist for Permanency Workers; CFS 2026, Home Safety Checklist for Parents, Caregivers, Family and Friends; CFS 2027, Home Safety Checklist for Child Protective Services Workers. Attached is Policy Guide 2004.01. It specifies expectations for Permanency Workers and Child Protective Services Workers. In addition, it states that CFS 2026 is intended for use by parents, caregivers and the general public to increase awareness that household injuries are preventable. Items covered in these forms include: CFS 2025, Item #11 addresses the use of car seats, booster seats or seat belts. Item #13 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Item #18 addresses the use of baby walkers. CFS 2026, Item #11 addresses the use of car seats, booster seats or seat belts. Item #13 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Item #18 addresses the use of baby walkers. CFS 2027, Item #6 addresses the use of car seats, booster seats or seat belts. Item #9 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Proposed revisions to existing DCFS procedures and draft new procedure have been developed to address the implementation and use of the Home Safety Checklist. The proposed documents have been sent out to DCFS staff for review and comment. Once finalized, the procedures will be distributed to DCFS and POS staff for their reference.</p>
<p>Team recommends that DCFS replace Form CFS690 (12/01) of the existing Asthma protocol with the update Asthma Action Plan submitted by the National Institute of Health.</p>	<p>Paula Jaudes, M.D., Medical Director for DCFS, has reviewed the current CFS690 Asthma Action Plan as well as the National Institutes of Health's recommended Asthma Action Plan. She also consulted with Raoul Wolf, M.D., an asthma expert at La Rabida Children's Hospital and a professor in the Allergy and Immunology Section of the University of Chicago's Department of Pediatrics. It is their recommendation that the existing Asthma Action Plan format be kept, as it captures an appropriate amount of information and is less confusing than the new NIH format. The Department will continue to use the existing format for its Asthma Action Plan.</p>

CDRT Recommendation	DCFS Response
<p>The daycare provider had arrest for drugs (pot) near school ground but this did not preclude her from being licensed. DCFS must change the law in this regard.</p>	<p>Criminal convictions that bar day care licensure are statutory. Legislation amending the list of applicable crimes has been introduced. The Department will work with legislators and others in an effort to assure that the law is amended to assure that the law is amended to assure that children are safe.</p>
<p>What efforts have been made by the Department to develop or establish secure care in residential facilities in Illinois?</p>	<p>The Department has been looking into the use of Secure Care Facilities for DCFS wards. At this time, the Department has no plans to authorize a Secure Care Facility in Illinois. DCFS has announced a series of major reforms, including the implementation of a Residential Performance Unit, which will, for the first time in the Department's history, systematically monitor the performance of residential providers.</p>
<p>The team recommends that DCFS change their policy so that anytime there is two deaths ruled undetermined in the same family, under the age of two years of age, a DCFS investigation should be triggered.</p>	<p>If the caller gives a reasonable cause to suspect abuse or neglect a report is taken. The law does not allow us to initiate a child abuse and/or neglect report unless there is a suspicion of abuse or neglect. When the Coroner/Medical Examiner does not find anything at the time of an autopsy and there is nothing suspicious DCFS would take the call as an unusual death.</p>
<p>Team recommends that the allegation system for death (1,51) and substance misuse (15, 65) be modified to include that investigative staff request to the Coroner's Office that all lab specimens on mom and baby be held pending autopsy. *Note Clinical hospitals destroy specimens within 72 hours.</p>	<p>DCFS investigative staff has the responsibility to fully investigate (with supervisory direction) cases that involve allegations of death (1, 51) and substance misuse (15, 65). DCFS staff shall request from the coroner or hospital personnel who treated the child (who have to be interviewed per department procedure) that lab specimens on the infant be held pending autopsy to aid the investigation. DCFS has written a letter to the President of Illinois Hospital Association requesting that the remind the members of IHA of their responsibilities which is to immediately make a hotline report to DCFS when a newborn infant with a controlled substance present in his/her blood, urine, or meconium was if a result of medical treatment to the mother or newborn infant. In addition, hospital personnel have the responsibility to immediately report the suspicion of the above-described "neglect" to the appropriate medical examiner or coroner as well.</p>
<p>Make it policy for DCFS workers who have contact with families to educate and remove pacifiers on strings around a child's neck or strings that are long enough to wrap around a child's neck. Make this part of foster parent training.</p>	<p>The Department is piloting a home safety checklist in the southern region. The issue related to pacifier and other similar crib hazards will be included on the checklist. Furthermore, the Department will explore including an article on infant safety in an upcoming issue of Illinois Families Now and Forever.</p>
<p>Team recommends that DCFS local offices examine last contact with hospitals, police, and schools and re-establish contact to provide formal mandated reporter training.</p>	<p>DCFS staff work closely with Children's Advocacy Centers to conduct mandated reporter training for local agencies (schools, social services, daycare centers, Head Start programs, etc.). Medical resources centers supported by DCFS in Chicago, Peoria, and Anna conduct trainings on mandated reporting for medical providers and hospital staff within their services areas. DCFS plans to expand these trainings to underserved areas of the state. DCFS is also considering the feasibility of a web-based mandated reporter training that would allow individually-activated instruction and testing on reporting responsibilities.</p>
<p>Team recommends that DCFS include Back to Sleep information in the environmental safety checklist, which has been drafted by OIG. Team recommends that DCFS workers ensure that foster parents receive the same discharge information and checklist as parents receive for newborn infants leaving the hospital.</p>	<p>The Department requested Back to Sleep information from the National Institute of Child Health and Human Development. Once received the information will be distributed to DCP units statewide to be distributed to DCFS involved families with infants. Also the Foster Parent Handbook will be revised to include information on Back to Sleep. Information will be added to the handbook on safe sleeping surfaces and more specific information on taking care infants that require a specialized level of care such as Substance Exposed Infants, medically complex infants, etc. Current DCFS practice in to involve foster parents in necessary medical training and planning prior to the minor's discharge from the hospital.</p>

CDRT Recommendation	DCFS Response
<p>The team’s recommendation is to support Cook County Team A’s recommendation on establishing a policy and protocol regarding Munchausen Syndrome by Proxy and to support the training of hotline staff and DCFS staff on Munchausen Syndrome by Proxy.</p>	<p>The Department has responded to the Cook A’s recommendation related to its belief that a “protocol” for handling “the reporting, investigation, and follow-up on Munchausen’s by Proxy allegations”. The Department’s response is that the Department will explore using this case as a teaching tool for SCR and direct service staff on Munchausen’s by Proxy indicators. The Department would like to work with CDRT members to draft a Protocol for the investigation of alleged Munchausen’s by Proxy Protocol.</p>
<p>The team recommends that DCFS continue to work on interstate agreements with bordering states including Michigan.</p>	<p>Illinois is continuing to work on interstate agreements, focusing on Wisconsin and northern Indiana. Michigan does not immediately border Illinois, but Michigan will be contacted in conjunction with outreach to Indiana.</p>
<p>The team recommends that DCFS provide mandated reporter training to hospitals and provide clarification of new HIPPA regulations in regards to mandated reporting.</p>	<p>DCFS is currently preparing a handbook on issues of confidentiality that should help in clarifying HIPPA regulations with regard to mandated reporting. Medical resource centers supported by DCFS in Chicago, Peoria, and Anna conduct outreach and training to medical providers throughout the state. DCFS is considering the feasibility of a web-based mandated reporter training similar to the State Ethics training being initiated during March 2004. This training would allow individual mandated reporters to receive instruction on ANCRA (Abuse and Neglected Child Reporting Act), read several scenarios, and take a test to indicate understanding of their responsibilities.</p>
<p>DCFS to expand environmental safety checklist to include dangers of wheeled baby walkers.</p>	<p>The Environmental Safety Checklist will be revised to include dangers of wheeled baby walkers.</p>
<p>DCFS to ban all use of wheeled baby walkers in licensed daycare homes, licensed daycare centers and foster homes.</p>	<p>DCFS will ban all use of wheeled baby walkers in licensed daycare homes, licensed daycare centers and foster homes.</p>
<p>DCFS to exclude wheeled baby walkers from infant equipment purchasing procedures.</p>	<p>DCFS will exclude wheeled baby walkers from infant equipment purchasing procedures.</p>
<p>A warrant should have been sought after Sequence A to protect the child. DCFS workers should be trained on availability of this option. DCP investigators must have better training that focuses on safety of child.</p>	<p>The circumstances of when to seek a warrant and not to unfound a case before a family is located without a Due Diligent Search are covered in DCFS trainings. All DCFS investigators are required to complete foundation training before case assignment. This training includes CERAP certification, which focuses on assessing the safety of the child. In addition, DCFS investigators are required to complete two weeks of certification training (i.e. court, legal screening, etc.) plus 20 hours of refresher training every two years.</p>
<p>DCFS must broaden “undetermined” category beyond 30 days to unlimited for cases such as this. Being forced to make A sequence unfounded is misleading and led subsequent investigators in wrong direction.</p>	<p>The Child Protection Unit shall determine, within 60 days, whether the report is “indicated” or “unfounded” and report if forthwith to the central register, where it is not possible to initiate or complete an investigation within 60 days the report may be deemed “undetermined” provided every effort has been made to undertake a complete investigation. The Department may extend the period in which such determinations must be made in individual cases for additional period of up to 30 days each for good cause shown. ANCRA requirements do not allow and “undetermined” category. Good cause for extending the period for making a determination an additional 30 days may include but is not limited to the following reasons: 1) States attorneys or law enforcement officials have requested that the Department delay making a determination due to a pending criminal investigation. 2) Medical or autopsy reports needed to make a determination are still pending after the initial 60 day period. 3) The report involves an out-of-state investigation and the delay is beyond the Department’s control. 4) Multiple alleged perpetrators or victims are involved necessitating more time in gathering evidence and conducting interviews.</p>

CDRT Recommendation	DCFS Response
DCP should use administrative subpoena power to obtain information from police on violence in household.	DCFS is in negotiations with Chicago Police Department on a memorandum of understanding for sharing information.
DCFS must insure that POS agencies instruct foster parents on "Back to Sleep" recommendations and other strategies to manage difficult infants.	The Department requested Back to Sleep information from the National Institute of Child Health and Human Development. Once received the information will be distributed to DCP units statewide to be distributed to DCFS involved families with infants. Also, the Foster Parent Handbook will be revised to include information on Back to Sleep. Information was added to the handbook on safe sleeping surfaces and more specific information on taking care of infants that require a specialized level of care such as substance exposed infants, medically complex infants, etc. Current DCFS practice is to involve foster parents in necessary medical training and planning prior to the minor's discharge from the hospital.
DCFS must insure that foster parents caring for drug-exposed infants receive specialized training.	The Department has available as module #10 in the Foster/ Adopt Pride training, "Understanding the Effects of Chemical Dependency on Children and Families".
For all children who have chronic medical conditions - medically complex - there must be a case conference with medical personnel and DCFS.	Current practice for investigations requires that investigators speak with medical personnel on all cases with medical allegations. There are assigned DCP liaisons to hospitals with a child protection services unit to conference on these cases.
DCFS should "publicize" the fact that there is an appeals process for unfounded cases, especially to police and hospitals.	Police and hospital personnel are mandated reporters. The Department currently notifies mandated reporters of the appeal process within the letter that is sent to them at the conclusion of the investigation.
DCFS must develop protocol for intact family cases - Best Practices.	The Department has procedures that are currently being followed in practice, however, a committee is being formed to review Chapter 5 for conformity to Best Practice.
DCFS ensure that teen fathers are referred to PIP.	
Recommend that allegation #65, substance exposed children, automatically stay on the record for 20 years.	Indicated allegation #15/65 Substance Misuse shall be considered for retention of 20 years considering the following factors: 1) Extent of injuries. Are the injuries limited to one spot on the child's body or are there multiple injuries on many parts of the child's body? 2) Long-term effects of the injuries. Will the child be left with scar, deformities or permanent disabilities? 3) Medical treatment required. Does the child require hospitalization, surgery, emergency medical treatment or other major medical treatment as a result of the injuries? 4) Pattern or chronicity of injuries. Is there an ongoing history or pattern of harsh punishment or neglect that resulted in injury? Are there severe injuries at different stages of healing? Other factors to be considered include: age of the child; frequency; amount of substance consumption; whether the substance is illegal for general population use; degree of behavioral dysfunction or physical impairment linked to substance misuse. If none of the above factors are present, the allegations are to be retained for five years in accordance with Procedures 300, Section 300.100. Allegation #15 is an abuse allegation and #65 is a neglect allegation. Consequently, DCP has options regarding the decision in regard to retention and DCFS is not recommending changes to this rule.
When daycare referrals are denied by DCFS, a rationale must be included on the form, stating specific reasons for the denial of referral. This rationale must be sent back to workers along with the denial.	When a referral for therapeutic daycare is denied, the practice is the Field Service Manager sends a letter detailing the reasons for denial to the worker. Similarly, if the Regional Administrative Service Manager finds the referral for therapeutic daycare insufficient, a letter is sent detailing the reasons for returning the application. Revisions were made to therapeutic daycare requirements in Procedure 359 subsequent to the date of death of the minor.

CDRT Recommendation	DCFS Response
<p>This team has repeatedly emphasized the use of the safety checklist. There have been three fire deaths in this area since the initial recommendation three years ago. Training on the checklist has occurred, and OIG is involved. The team recommends this safety checklist be written into policy and procedure, and we would like a written response on this within 60 days.</p>	<p>Effective June 7, 2004, the Department issued Policy Guide 2004.01, Home Safety Checklists. The purpose of the Policy Guide is to issue three home safety checklists that are designed to reduce the rate of household accidents that injure children and to inform workers of the requirements for the checklists' use: CFS 2025, Home Safety Checklist for Permanency Workers; CFS 2026, Home Safety Checklist for Parents, Caregivers, Family and Friends; CFS 2027, Home Safety Checklist for Child Protective Services Workers. Attached is Policy Guide 2004.01. It specifies expectations for Permanency Workers and Child Protective Services Workers. In addition, it states that CFS 2026 is intended for use by parents, caregivers and the general public to increase awareness that household injuries are preventable. Items covered in these forms include: CFS 2025, Item #11 addresses the use of car seats, booster seats or seat belts. Item #13 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Item #18 addresses the use of baby walkers. CFS 2026, Item #11 addresses the use of car seats, booster seats or seat belts. Item #13 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Item #18 addresses the use of baby walkers. CFS 2027, Item #6 addresses the use of car seats, booster seats or seat belts. Item #9 addresses the baby's sleeping arrangements, and includes sharing the Back to Sleep brochure with the family. Proposed revisions to existing DCFS procedures and draft new procedure have been developed to address the implementation and use of the Home Safety Checklist. The proposed documents have been sent out to DCFS staff for review and comment. Once finalized, the procedures will be distributed to DCFS and POS staff for their reference.</p>
<p>As per the San Diego model provided by Denise Kane, OIG this model of graduated sanctions for non-compliance should be explored and implemented statewide. This would involve the DCFS Legal Division.</p>	<p>The Department will review the current policy regarding substance-affected families for revision and will consider graduated sanctions for non-compliance. If revisions are made, the policy will be issued statewide.</p>
<p>Re-empathize the child as the client, not the parents. This theme must be included as part of the initial training of DCFS new employees. Also, DCFS needs to implement an annual training for all DCFS employees on a continuous basis.</p>	<p>All DCFS training emphasizes the safety and best interests of the child. Training is provided to child welfare staff on an ongoing basis. All new staff to child welfare must complete Foundation Training, which also focuses on the safety and best interests of the child. Foundation Training emphasizes that all interventions are made with focus on the moral right of the child to have basic needs met, especially safety. However, the training also emphasizes that the child welfare professional has a responsibility to both the child and to the parent and they, in turn, have the right to expect the professional to meet those responsibilities. DCFS must see the child and parent as the client in order to achieve its goal of preventing any further harm to the child and to other children in the family, stabilize the home environment and preserve family life whenever possible.</p>
<p>DCFS investigators should request a police report along with photos of the death scene and if there is not a report available, interview the officer from the death scene and write their own report from the interview with the officer.</p>	<p>DCFS investigators are required to work with the police on Priority I investigations and to obtain the police final disposition via verbal or hand written reports. Furthermore, the investigators are required to input the police disposition on the SACWIS system before case completion. It is current practice to request photos taken at death scenes by the police.</p>
<p>Ensure that photos have been taken of the death scene.</p>	<p>When permitted by investigative authority DCFS does take their own photos, however, we cannot ensure that the investigative police agency take photographs of the death scene. The child protection teams have access to cameras and our required to take and/or obtain pictures of the alleged child victim's that sustained fatal injuries. We recommend and encourage investigators to take pictures/photos of the death scene during the investigation (if available).</p>

CDRT Recommendation	DCFS Response
<p>Team recommends that DCFS identify and utilize existing community resources in order to expand services to include psycho-social screenings, such as Ages and Stages. These screenings should be used for children. 0-6 years old who are involved in open family cases.</p>	<p>The Department of Children and Family Services has developed an integrated care system that addresses the behavioral/mental health needs of its clients. This integrated Behavioral/Mental Health Care (“BHC”) system would rationalize and interface with the systems already in place for addressing the medical, developmental and educational needs essential for ensuring the overall well being of children in DCFS custody. The BHC will include an Integrated Assessment, (“IA”) on minors in DCFS care and custody within the first 45 days after the child enters the Department. The IA includes a psychosocial screening. It is being implemented statewide in two phases. First, the identification, assessment, and intervention services provided to clients who are entering into foster care custody. The second phase is the referral of current clients with assessment and/or treatment needs for services. The first phase of the IA has been implemented in the Cook North Region. It is in various stages of roll out throughout the state and the rollout is scheduled for completion in January 2005.</p>
<p>Team recommends that DCFS workers consider prenatal care a high priority in casework and establish prenatal care into service plans.</p>	<p>DCFS does consider prenatal care a high priority in casework. DCFS Best Practices chapter 5 states that if during the course of an open intact family case the mother becomes pregnant, the worker incorporates the mother’s prenatal component into the service plan.</p>
<p>The team recommends that DCFS review and re-evaluate the current policy on monitoring POS agencies and their contracts in order to ensure that POS agencies are fulfilling contractual obligations in direct services in families.</p>	<p>Direct Service to families can only be provided when the whereabouts of the parent was not known so services could not have been provided. Monitoring of this POS agency in this circumstance occurred in several ways. Because the family was court involved, and in accordance with DCFS rules and procedure and administrative reviews a diligent search for the parent would have been done every 6 months. The agency had to report to the court at every hearing the efforts made to locate a parent and engage them in services.</p>
<p>The team recommends that DCFS request the American Red Cross to emphasize the Back to Sleep information during their Babysitting Certification Programs.</p>	<p>Attached is a letter that was sent to the American Red Cross regarding this recommendation.</p>
<p>Team recommends that DCFS write a letter to IDPH requesting that the Department of Epidemiology provide training to NICU nurses and social service personnel in hospitals on the APORS referral criteria and services.</p>	<p>Attached is a letter that was sent to the Illinois Department of Public Health’s Office of Epidemiology and Health Systems Development regarding this recommendation.</p>
<p>Team recommends that IDPH send all health care institutions the criteria regarding child death notification to coroners/ Medical Examiners Offices. Emphasis must be given on death cases that illnesses that are results of prior abuse or neglect should be reported irrespective of the time interval between death and injury.</p>	<p>Will forward to IDPH.</p>
<p>Since all unexplained deaths are reportable, (and circumstances here are not characteristic of SIDS) why did ER physician not make a report to DCFS?</p>	<p>This recommendation is not within the scope of the Department.</p>
<p>Team recommends that DCFS provide mandated reporting training to all hospitals to further empathizes responsibility of reporting abuse and neglect.</p>	<p>DCFS has written a letter to the President of the Illinois Hospital Association that they remind the members of their mandated reporting responsibilities. A link was provided to the Manual for Mandated Reporters, which was updated in 2003.</p>
<p>Although it would not have helped in this case, DCFS investigators should be encouraged to ask WIC/Health Department nurses to become more involved and increase surveillance.</p>	<p>As the recommendation states, there was no prior DCFS contact with this family prior to severe injuries and resulting in death of this child. The Department believes that it does utilize WIC/Health nurses appropriately when there is Department involvement, especially with special needs/ medically complex children identified to DCFS as at-risk children. DCFS also involves DCFS nurses in these cases.</p>

CDRT Recommendation	DCFS Response
<p>Team recommends that DCFS write a letter to DHS requesting the information on the dangers of wheeled baby walkers be included on all Home Visiting Safety Checklists.</p>	<p>DCFS will request DHS to include the dangers of wheeled baby walkers to their Home Visiting Safety Checklist.</p>
<p>Chicago Police Department must use every Domestic Violence or violence investigation in home to view children and report suspected abuse. Chicago Police must revise and coordinate its protocol with DCFS so that Chicago Police Department protocol ensures a response when called by DCFS to enter a home.</p>	<p>1) The Chicago Police Department's (CPD), reports that the tracking system data are being expanded by address. The data, currently stored at the office of communication, only dates back three months. CPD is working on providing beat officers with updated information to better determine and access the history of all 911 calls to particular address. 2) Police officers are trained to serve all occupants of a household for possible victimization anytime they respond to call for service in a home. 3) Detectives receive more specific training on determining the necessity for protective custody of children based on allegations of abuse.</p>
<p>Involve fathers (all students) in parenting classes at high schools and in juvenile detention/prisons.</p>	
<p>More advertisement should be done regarding dropping your baby at a safe place.</p>	<p>On August 17, 2001, The Abandoned Newborn Infant Protection Act, 325 ILCS2/et seq. was enacted. This Act provides a mechanism for infants to be relinquished into a safe haven. Illinois recognizes that newborn infants have been abandoned in various circumstances that are unsafe. These circumstances resulted in death or severe bodily harm to infants in Illinois. The Act also provides immunity from prosecution for child abuse, neglect or abandonment to parents as an incentive to relinquish their newborn to a safe haven. The Department is responsible for collecting and analyzing information regarding the relinquishment and placement of infants under this Act. The Department is further responsible to report any results to the Illinois General Assembly. Under the law, the Department must implement a public information campaign to promote placement alternatives for newborn infants. The Department continues to educate the public on the rights and responsibilities under the Act. The Department distributed posters and brochures in English and Spanish to public schools and private organizations and communities throughout Illinois. Specifically, letters and brochures/posters have been sent to 101 State's Attorneys' Offices; to approximately 350 Colleges and Universities; to approximately 50 adoption agencies and homeless shelters; 300 resource/counseling providers; 100 Chicago area churches and religious leaders; 100 to Municipal Mayors; 1650 middle/high schools; and over 600 to the Chicago Public Schools. In addition, various representatives of the Department attend speaking engagements to educate organizations and other state agencies about the Act. These have included the Department of Public Health's regional health offices; the Illinois Fire Chief Association Meeting; the Illinois State Bar Association Continuing Legal Education events; a Cable Television show sponsored by the Illinois State Bar Association; the Emergency Medical System Advisory Board and Trauma Advisory Board; and the Pharmacist's Association. The Department also has consulted with the Illinois Hospital Association as well as with the Metropolitan Chicago Healthcare Council on training of hospital staff throughout the state. Also sex education materials and instruction in schools are required to advise pupils of the provisions of the Act. Finally, information regarding this law is always available on the Department's web site to the public, hospitals, fire stations, and other emergency medical facilities throughout the state. The Department coordinates the public information campaign with the Illinois Hospital Association, the Illinois Department of Public Health and Save Abandoned Babies, and has been assisted by the volunteer efforts of Chicago Creative Partnership in developing a marketing campaign.</p>

CDRT Recommendation	DCFS Response
<p>Team recommends that DCFS, along with other agencies, move very quickly in the pursuit and establishment of a drowning prevention campaign and would like to emphasize several past recommendations on this same subject.</p>	<p>DCFS collaborated with the American Red Cross, Prevent Child Abuse Illinois, Illinois Department of Public Health and Illinois Department of Human Services to create the Get Water Wise....Supervise Campaign. This is a new statewide public awareness campaign to educate the public about the urgent need for adult supervision when children are in or near the water. A media launch was done in all eight regions across the state beginning on June 3, 2003. Television stations, newspapers and radio stations were in attendance at these launches. Posters and brochures have been printed and are continuing to be distributed. Posters are available in English and Spanish. Each agency involved has assisted in the distribution. The Child Death Review Teams have also been asked to assist in the distribution of these items.</p>
<p>The team recommends that DCFS write a letter to all shelters and ask them to distribute the "Back to Sleep" brochures to all mothers of infants and to post the "Back to Sleep" posters in their areas.</p>	<p>The Department distributed Back to Sleep brochures and posters to all DCFS teen parenting programs and to all city shelters in Chicago that are frequently used by DCFS involved families.</p>
<p>See if manufactures of pacifiers would put a "Do Not" warning on the pacifiers regarding tying long strings on pacifiers.</p>	<p>This recommendation is beyond the scope of the Department's purview. The committee may wish to address the issue to the Consumer Safety Products Commission. Sherry Barr can put the committee in touch with a member of the commission who is also a member of a fatality review team in another region.</p>
<p>Team recommends that DCFS move very quickly on the pursuit and establishment of a drowning prevention campaign focusing on parental supervision and would like to re-empathizes several past recommendations on this same subject.</p>	<p>DCFS collaborated with the American Red Cross, Prevent Child Abuse Illinois, Illinois Department of Public Health and Illinois Department of Human Services to create the Get Water Wise....Supervise Campaign. This is a new statewide public awareness campaign to educate the public about the urgent need for adult supervision when children are in or near the water. A media launch was done in all eight regions across the state beginning on June 3, 2003. Television stations, newspapers, and radio stations were in attendance at these launches. Posters and brochures have been printed and are continuing to be distributed. Posters are available in English and Spanish. Each agency involved has assisted in the distribution. The Child Death Review Teams have also been asked to assist in the distribution of these items.</p>
<p>Team recommends that DCFS collaborate with the American Academy of Pediatrics and the American College of Emergency Physicians, and DCFS internal legislative liaison in supporting a ban of all wheeled baby walkers in Illinois.</p>	<p>A member of the Executive Council along with a DCFS staff person should meet with the American Academy of Pediatrics and the American College of Emergency Physicians to discuss this issue.</p>
<p>Team recommends that Illinois Hospital Association remind ER's to call the Poison Control when ingestion is suspected.</p>	<p>This recommendation does not fall under the scope of the Department's mandate or authority. However, the Executive Council may wish to meet with the Hospital Association concerning this issue.</p>

