

## Examining Child Deaths in Illinois: Highlights from the FY2021 Child Death Review Team Annual Report

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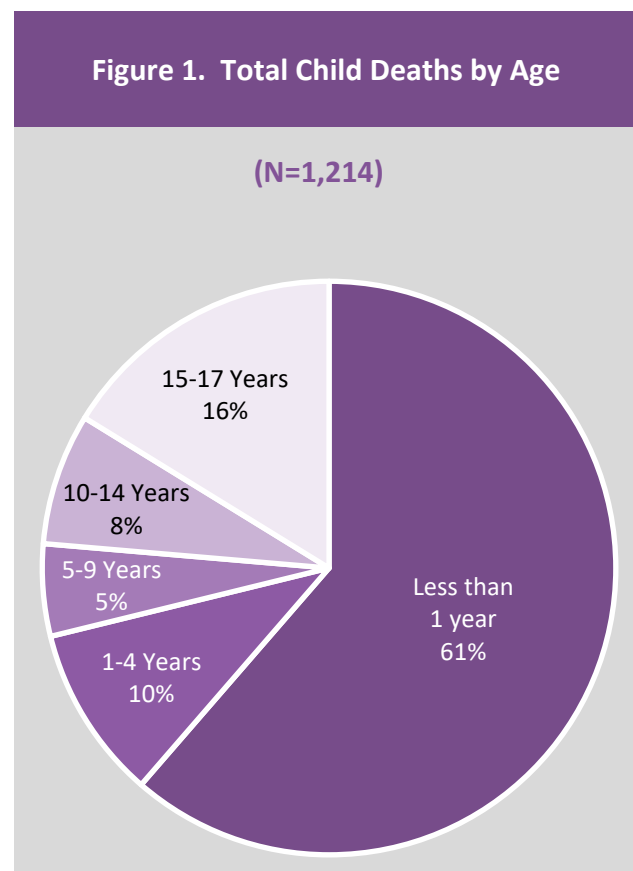
As part of the national movement to reduce preventable child deaths, Illinois established regional Child Death Review Teams (CDRTs) back in 1996. These multi-disciplinary teams meet monthly, bi-monthly, or quarterly to review the circumstances of certain child deaths to determine if there were means by which the death could have been prevented. Not all child deaths in Illinois are reviewed by a CDRT; a child death review is mandated if the child's family was involved with the Department of Children and Family Services (DCFS) within a year prior to the child's death, and other child deaths may be reviewed at the CDRT's discretion. For each review, the members of the CDRT examine the circumstances of the child's death to determine if it could have been prevented through reasonable means. If so, recommendations are sent to the DCFS Director, who must review and reply to each recommendation within 90 days.

Data on all child deaths and those reviewed by the CDRTs each year are compiled and included in the CDRT annual report, which is written by the Children and Family Research Center at the University of Illinois. To better understand the types of children that are most vulnerable, the CDRT annual report examines both total and reviewed child deaths by child age, gender, and race, as well as by the manner and category of death. This research brief highlights the findings from the most recent CDRT annual report on child deaths that occurred in Illinois in 2019.

### *Examining Total Child Deaths by Age*

Although they represent only 5% of the total child population in Illinois (U.S. Census Bureau, 2021), infants less than one year old accounted for 61% of the 1,214 child deaths in Illinois in 2019 (see Figure 1). This over-representation among infants is due to the large number of deaths that occur each year

Figure 1. Total Child Deaths by Age



related to premature birth and congenital anomalies. Children are much more likely to die during the first year of life than at any other age; the death rate for children less than one year old in the United States is more than 11 times higher than that for children ages 15 to 19 years, the age group with the next highest death rate (Child Trends, 2019).

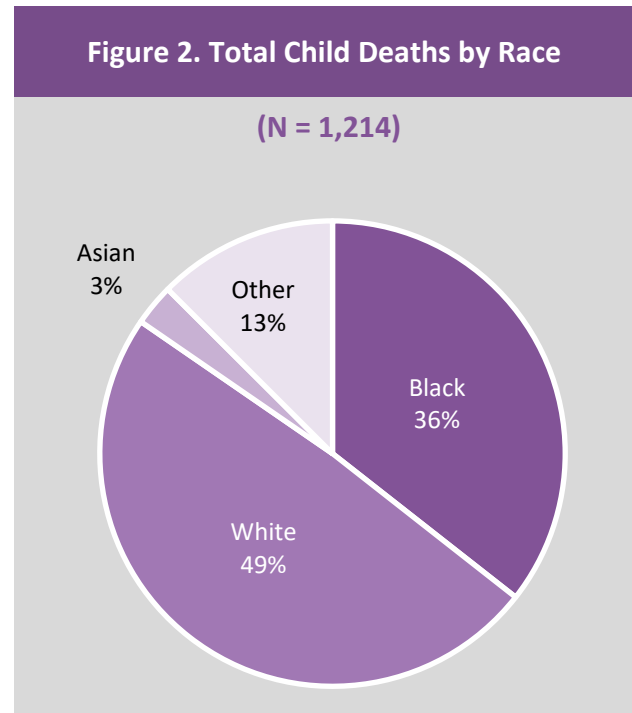
### ***Examining Total Child Deaths by Race/Ethnicity***

In 2019, 66% of children in Illinois were White, 15% were Black, 5% were Asian, and 14% were of other race/ethnicities. A quarter of children identified as Hispanic or Latino (of any race), and 51% were White (not Hispanic or Latino) (U.S. Census Bureau, 2021). When total Illinois child deaths are examined by race/ethnicity, we see that Black children are over-represented compared to their percentage in the child population; Black children made up 36% of child deaths in 2019 but only 15% of the child population in Illinois (see Figure 2). Conversely, deaths among White children were under-represented compared to their representation in the Illinois child population (49% versus 66%).

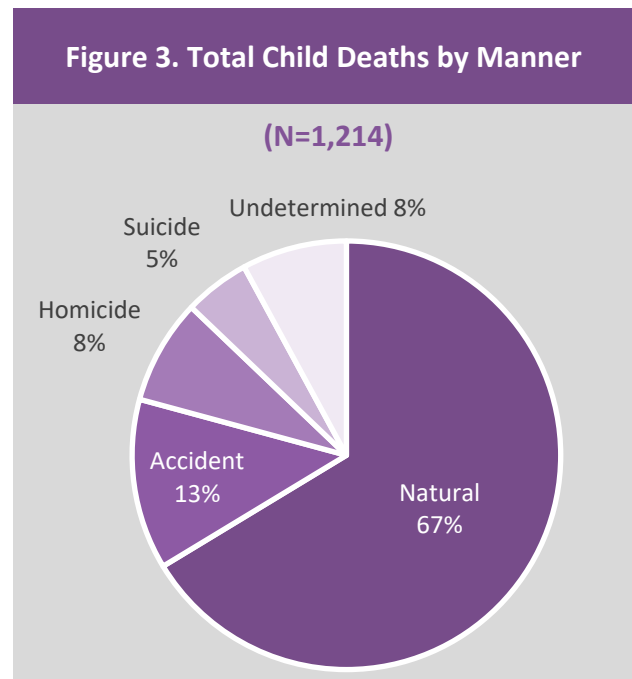
### ***Examining the Manner and Cause of Child Deaths***

Manner of death is a categorization used by medical examiners, coroners, and physicians when completing a death certificate to clarify the circumstances of death. In most states, including Illinois, manner of death is classified into one of five categories: natural causes, accident, homicide, suicide, and undetermined. The majority of Illinois child deaths in 2019 were due to natural causes (67%), followed by accidents (13%), undetermined causes (8%), homicides (8%), and suicides (5%; see Figure 3).

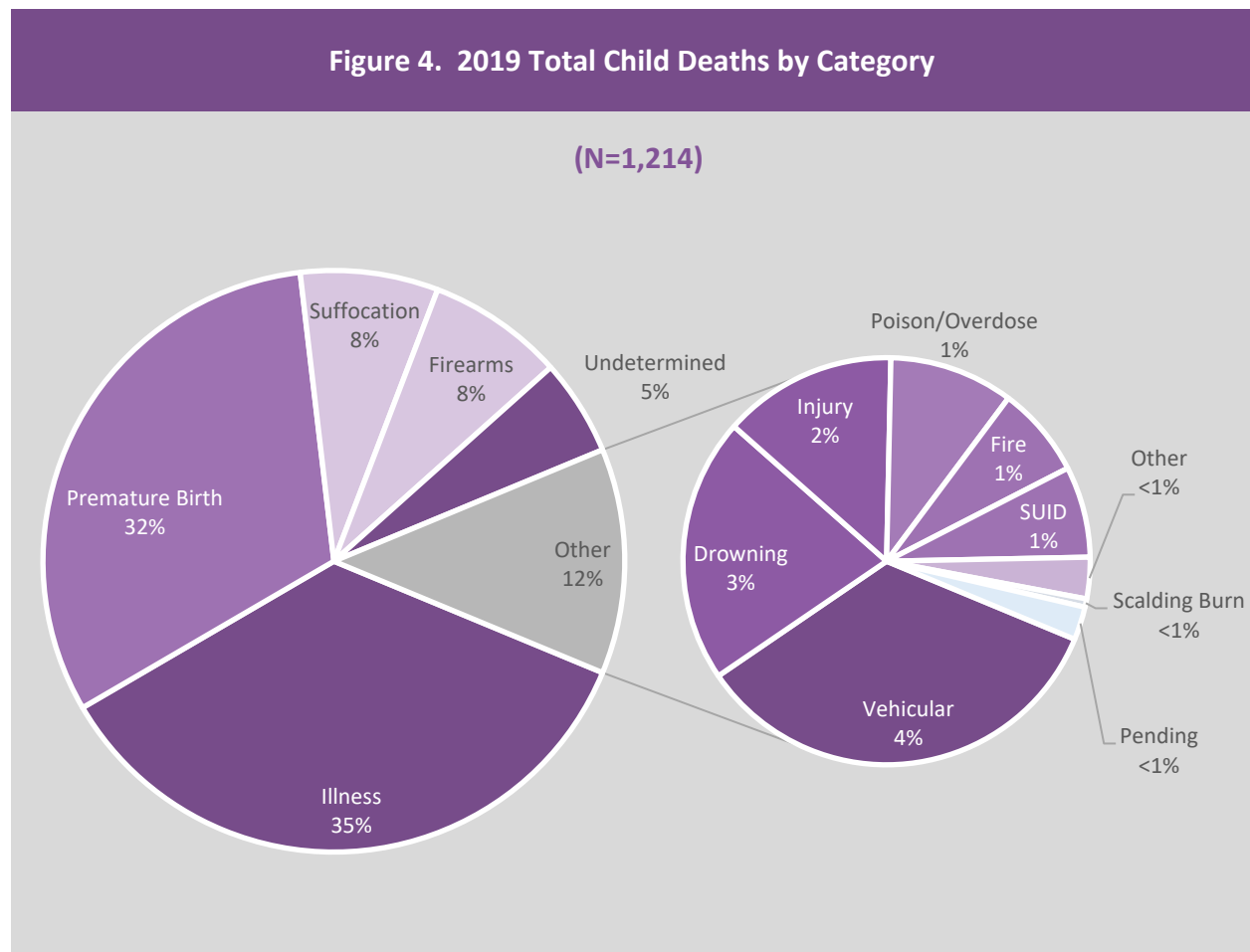
**Figure 2. Total Child Deaths by Race**



**Figure 3. Total Child Deaths by Manner**



The CDRT Executive Council has identified 13 specific categories of death that are used during their reviews, along with categories for undetermined and “other” deaths. In this classification system, the category of death can be different from the proximal cause of death. For example, a child may have died of pneumonia (cause of death) that was the result of an earlier gunshot wound (category of death). The use of categories can be helpful in the development of strategies, systems, and awareness campaigns to prevent child deaths. Illness (35%) and premature birth (32%) accounted for the majority of child deaths in 2019, followed by suffocation (8%), firearms (8%), and undetermined causes (5%). Deaths in the remaining categories were less frequent and together accounted for 12% of total child deaths (Figure 4).



Note: SUID is Sudden Unexpected Infant Death.

Examining the manner and category of death together can provide additional insight into the patterns of child deaths in Illinois (see Table 1). For instance, the majority of accidental child deaths are due to suffocation or vehicular accidents, followed by drownings, injury, fire, and poison/overdose, while most homicides involve either firearms or other inflicted injuries. Hanging (suffocation) is the most frequent method of child/youth suicide, followed by firearms. Almost all child deaths due to natural causes are the result of illness or premature birth.

**Table 1. 2019 Total Child Deaths – Manner of Death by Category of Death**

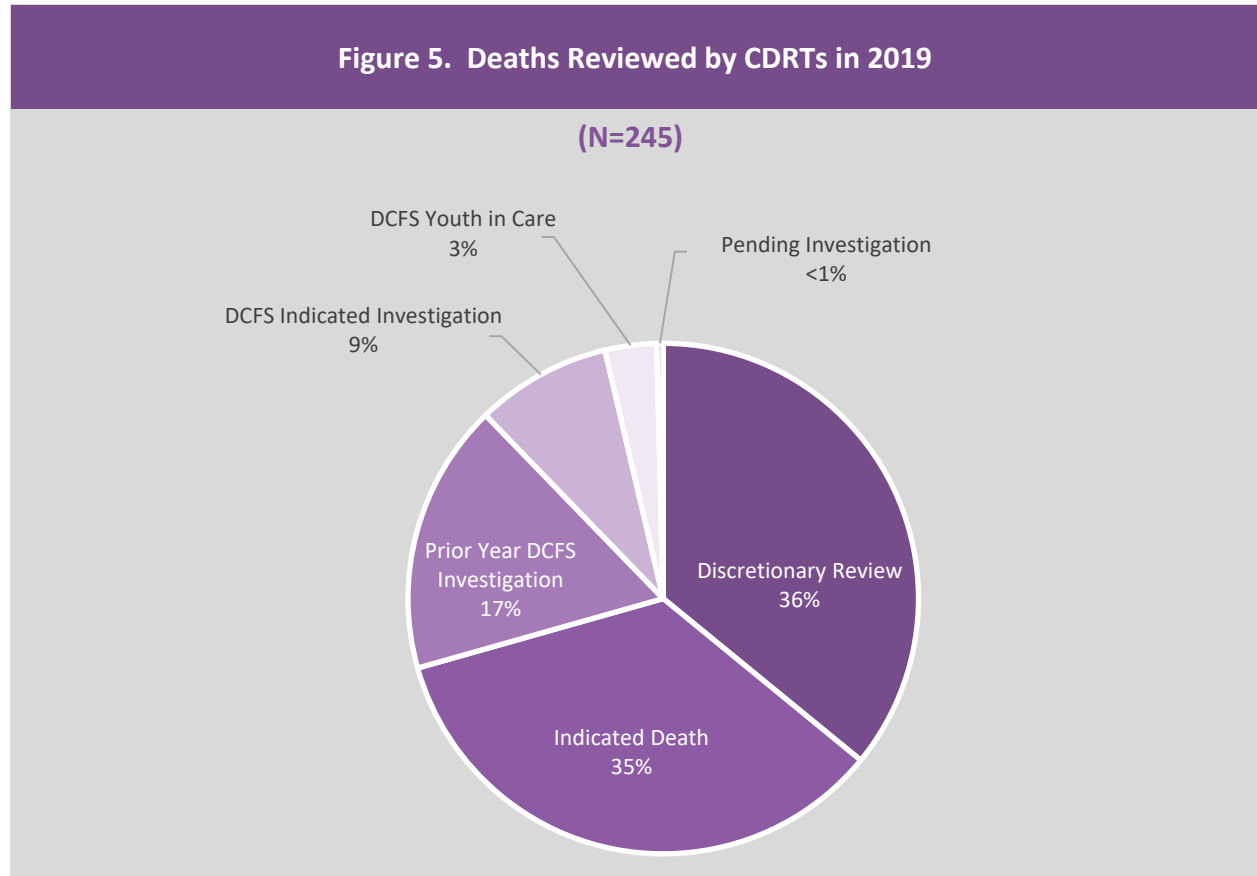
| CATEGORY OF DEATH | MANNER OF DEATH |            |            |           |              |              |
|-------------------|-----------------|------------|------------|-----------|--------------|--------------|
|                   | Accident        | Homicide   | Natural    | Suicide   | Undetermined | Total        |
| Illness           | 0               | 1          | 423        | 0         | 5            | 429          |
| Premature Birth   | 1               | 0          | 380        | 0         | 2            | 383          |
| Suffocation       | 60              | 5          | 0          | 22        | 6            | 93           |
| Firearms          | 2               | 71         | 0          | 16        | 3            | 92           |
| Undetermined      | 0               | 0          | 2          | 0         | 63           | 65           |
| Vehicular         | 42              | 3          | 0          | 7         | 0            | 52           |
| Drowning          | 25              | 2          | 0          | 1         | 4            | 32           |
| Injury            | 6               | 14         | 0          | 0         | 1            | 21           |
| Poison/Overdose   | 5               | 1          | 0          | 9         | 0            | 15           |
| Fire              | 6               | 3          | 0          | 0         | 2            | 11           |
| SUID              | 4               | 0          | 2          | 0         | 5            | 11           |
| Other             | 1               | 1          | 2          | 1         | 0            | 5            |
| Scalding Burn     | 1               | 0          | 0          | 0         | 0            | 1            |
| SIDS              | 0               | 0          | 0          | 0         | 0            | 0            |
| SUCD              | 0               | 0          | 0          | 0         | 0            | 0            |
| Pending           | 0               | 0          | 0          | 0         | 4            | 4            |
| <b>TOTAL</b>      | <b>153</b>      | <b>101</b> | <b>809</b> | <b>56</b> | <b>95</b>    | <b>1,214</b> |

### *Deaths Reviewed by CDRTs in 2019*

CDRTs are mandated to review the death of any child age 17 or younger if the child was:

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

There were 245 child deaths reviewed by a CDRT in 2019, consisting of 157 mandatory and 88 discretionary reviews. The mandatory reviews occurred for one of several reasons: 85 were indicated death cases, 42 cases had an investigation in the year before the child's death, 21 were indicated investigations, 8 were DCFS youth in care, and 1 case was pending DCFS investigation at the time of death (see Figure 5).



### ***CDRT Recommendations to Prevent Child Deaths***

Child deaths are a serious concern in Illinois as well as nationally, and considerable attention is focused on developing effective prevention strategies. CDRT recommendations are an important mechanism for preventing child deaths. In Illinois, CDRTs can make four types of recommendations:

- Case-specific recommendations include immediate actions which must be taken on a specific child welfare case, usually related to the siblings of the deceased child still living in the home.
- Primary prevention recommendations focus on public awareness and education issues.
- DCFS system recommendations focus on DCFS programs, policies, and procedures.
- Other system recommendations focus on agencies or systems outside of the parameter of DCFS (e.g., public health, hospitals, state's attorneys' office).

CDRTs made a total of 85 recommendations related to 57 reviewed child death cases in 2019. Thirty-eight recommendations focused on DCFS policy and procedures, 8 focused on agencies or systems, 39 were related to specific cases, and none were related to primary prevention. Some examples of DCFS system recommendations and the DCFS response are shown in Table 2. For a full list of the recommendations made by the CDRTs in 2019 and the associated responses from DCFS, please refer to the annual report (Illinois Department of Children and Family Services, 2021).

**Table 2. Examples of CDRT Recommendations and DCFS Responses**

| CDRT Recommendation  | DCFS Response  |
|--|--|
| <p>Team recommends DCFS send a letter to the Illinois Chief of Police Association and police academy to remind and educate police that DCFS allegations 60 and 10 includes domestic violence. Police need to know that DCFS will take domestic violence calls.</p>   | <p>DCFS agrees. The letter will also be sent to the Chicago Police and the State Police.</p>   |
| <p>With the upcoming changes in the law regarding marijuana, the Department should come up with criteria for handling cases where marijuana is used.</p>   | <p>A policy guide was issued related to this matter. DCFS will continue to address this on an ongoing basis. The key issue for DCFS to assess in all matters pertaining to substance use/abuse is the caretaker’s capacity to parent. This issue is addressed in each of the allegations in DCFS Rule 300, Appendix B. Prior to this change in the law, DCFS did send out reminders related to this issue.</p> |
| <p>DCFS needs to have standard guidelines on safe sleep.</p>   | <p>DCFS agrees and will be addressing this.</p>  |
| <p>DCFS to look at caseloads and hire more investigators. Further, the complexity of a case needs to be considered in how cases are counted and assigned. The more complex a case, the more time it will take. Factors that make a case more complex include, but are not limited to:</p> <ol style="list-style-type: none"> <li>1. Non-verbal victims;</li> <li>2. Later sequence investigations;</li> <li>3. Number of children in the family/household;</li> <li>4. Corollary criminal investigation;</li> <li>5. More serious injuries, and/or repeated injuries;</li> </ol> | <p>DCFS agrees. Caseloads are analyzed on an on-going basis and job postings are almost continual. These are frequently posted on the D-Net. Fortunately, the State Budget has allowed for DCFS to continue to expand its workforce. Numerous factors, including those listed in the recommendation, are considered when supervisors assign cases.</p>   |

|   |   |
|---|---|
| <p>DCFS staff should be reminded that a forensic interview can be done on cases of physical abuse. These requests can be made by DCFS investigators and not just law enforcement.</p>                 | <p>DCFS agrees. DCFS will use a child’s age and the nature of the allegation to determine the need for a forensic interview and if it is appropriate. DCFS will collaborate with the Statewide Director of the Children’s Advocacy Center to provide clarity regarding the age and other circumstances connected to this.</p> |
| <p>DCFS to add to the home safety checklist crib sharing/bed sharing questions regardless of age.</p>   | <p>DCFS agrees that this is an ongoing issue. The Home Safety Checklist does ask if “the infant sleeps alone in a crib or bassinet.” DCFS will discuss this matter further with staff to stress the importance of this.</p>   |
| <p>DCFS should resume the Death Investigations statewide training as soon as possible, and to record the same so that it will be available remotely for incoming staff at any time in the future.</p> | <p>DCFS agrees.</p>   |
| <p>There should be a separate allegation regarding unsafe sleep deaths. There are many of these cases and there is inconsistency in DCFS indicating/unfounding such cases.</p>                        | <p>The Department agrees that this is a concern and is currently addressing this and other matters in its response to the Safe Sleep standing agenda item.</p>  |

**Recommended Citation**

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**Related Publications**

Illinois Department of Children and Family Services. (2021). *The Illinois Child Death Review Team Annual Report — 2019*. Springfield, IL: Author.

Fuller, T., & Tran, S.P. (2020). *Understanding Child Death Review in Illinois*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Tran, S.P., & Fuller, T. (2021). *Trends in Illinois Child Deaths Between 2010 and 2019*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

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