HB5767

LRB09618229KTG33604b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB5767

Introduced 2/9/2010, by Rep. Jay C. Hoffman

SYNOPSIS AS INTRODUCED:

20 ILCS 515/20
20 ILCS 515/45

Amends the Child Death Review Team Act. Requires the Director of Children and Family Services to submit specified reports in response to a child death investigation to the State Representative and State Senator in whose legislative districts the case arose. Provides that by January 1, 2012 (rather than January 1, 2010), the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the Child Death Investigation Task Force together with any recommendations for statewide implementation of a protocol for the investigation of all sudden, unexpected, or unexplained child deaths.

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A BILL FOR

AN ACT concerning State government.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Child Death Review Team Act is amended by changing Sections 20 and 45 as follows:

(20 ILCS 515/20)

Sec. 20. Reviews of child deaths.

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

(1) A ward of the Department.

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

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

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

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

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

cases of serious or fatal injuries to a child identified under the Children's Advocacy Center Act.

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

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

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

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

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

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

(c) A child death review team shall review a child death as soon as practical and not later than 90 days following the completion by the Department of the investigation of the death under the Abused and Neglected Child Reporting Act. When there has been no investigation by the Department, the child death review team shall review a child's death within 90 days after obtaining the information necessary to complete the review from

the coroner, pathologist, medical examiner, or law enforcement agency, depending on the nature of the case. A child death review team shall meet at least once in each calendar quarter.

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

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

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

(f) Within 180 days after the Director submits a report

under subsection (e) concerning the implementation of a recommendation, the Director shall submit a further report to the chairperson of the team that made the recommendation, ~~and~~ to the chairperson of the Executive Council, and to the State Representative and State Senator in whose legislative districts the case arose. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to the recommendation.

(Source: P.A. 95-405, eff. 6-1-08; 95-527, eff. 6-1-08; 95-876, eff. 8-21-08; 96-328, eff. 8-11-09.)

(20 ILCS 515/45)

Sec. 45. Child Death Investigation Task Force; pilot program. The Child Death Review Teams Executive Council may, from funds appropriated by the Illinois General Assembly to the Department and provided to the Child Death Review Teams Executive Council for this purpose, or from funds that may otherwise be provided for this purpose from other public or private sources, establish a 3-year pilot program in the Southern Region of the State, as designated by the Department, under which a special Child Death Investigation Task Force will be created by the Child Death Review Teams Executive Council to develop and implement a plan for the investigation of sudden, unexpected, or unexplained deaths of children under 18 years of age occurring within that region. The plan shall include a protocol to be followed by child death review teams in the

review of child deaths authorized under paragraph (a)(5) of Section 20 of this Act. The plan must include provisions for local or State law enforcement agencies, hospitals, or coroners to promptly notify the Task Force of a death or serious life-threatening injury to a child, and for the Child Death Investigation Task Force to review the death and submit a report containing findings and recommendations to the Child Death Review Teams Executive Council, the Director, the Department of Children and Family Services Inspector General, the appropriate State's Attorney, and the State Representative and State Senator in whose legislative districts the case arose. The plan may include coordination with any investigation conducted under the Children's Advocacy Center Act. By January 1, 2012 ~~2010~~, the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the pilot program together with any recommendations for statewide implementation of a protocol for the investigation of ~~investigating~~ all sudden, unexpected, or unexplained child deaths.

(Source: P.A. 95-527, eff. 6-1-08; revised 10-30-09.)