State Review Team Process

Colorado Child Fatality Review Process

All death certificates of deceased less than 18 years of age
(and birth certificates if deceased less than 1 year of age)

Obtain social services information on every deceased child

Obtain social services information on every deceased child

Deaths sorted by manner of death

Natural (except SIDS)

Questions

Homicide, suicide, accident, undetermined & SIDS

Other records obtained according to cause of death: autopsy report, medical reports, paramedic reports, law enforcement, motor vehicle, public health, further social services information

Subcommittees review all collected information

Clinical, Motor vehicle, SIDS

No questions

Data collection and analysis

Reports, prevention strategies, information requests

Review completed

Selected cases presented to full committee for review

Notes:

Colorado Child Fatality Review Process

a. Birth and death certificates are obtained through the Colorado Dept of Public Health and Environment, Division of Health Statistics and Vital Records.

b. Social services information is obtained by searching two statewide databases: 1) Child Welfare Services Tracking (CWEST), 2) Central Registry, which has information on all founded cases of abuse or neglect. These are searched by child’s name, any known AKAs, siblings’ names and parents’ names.

c. “Neonatal” expert group reviews all natural child deaths occurring at less than 28 days of age. “Other Natural” expert group reviews all other natural manner deaths (except SIDS).

d. If the expert groups have questions about any death that has been signed out as natural manner (except SIDS), the case is passed to the clinical subcommittee for more in-depth review. The questions are:
   - Inadequate or inaccurate death certificate?
   - Inadequate death investigation?
   - Access to/adequacy of medical care?
   - Preventable death?

e. Records (autopsy, medical, paramedic, law enforcement, motor vehicle, public health and further social services info) are obtained as necessary and available for review by clinical / other subcommittees.

f. “Clinical” subcommittee reviews all homicide, suicide, accident (except motor vehicle-related) and undetermined manner deaths, as well as any natural, motor vehicle or SIDS deaths referred back from expert and other clinical groups. “Motor Vehicle” subcommittee reviews all motor vehicle-related deaths. “SIDS” subcommittee reviews all SIDS deaths.

g. On occasion, the clinical subcommittee review raises more questions and further information is requested.

h. Cases selected for presentation to the full Child Fatality Review Committee are: all cases of neglect or abuse; cases which highlight system failures or policy issues (the committee may recommend strategies for avoiding such failures in the future); some cases which suggest preventive strategies; cases which suggest new death patterns; and cases for which the clinical subcommittee requests the broader professional expertise of the full committee.

i. Data is collected and analyzed through the data subcommittee and the Colorado Department of Public Health and Environment. Preventable deaths precipitate collection of additional data.

Tools for Teams
Missouri’s Local Review Process

Any child, birth through age 17, who dies will be reported to the coroner/medical examiner.

The coroner/medical examiner conducts a death scene investigation, notifies the Child abuse hotline and completes Data Form 1. The coroner/medical examiner, along with a certified child-death pathologist will determine the need for an autopsy.

If an autopsy is needed, a certified child-death pathologist performs it. Results are brought to the child fatality review panel by the coroner/medical examiner, if reviewable criteria are met.

If the death is not reviewable, Data Form 1 is completed by the coroner/medical examiner. This person sends the Data Form 1 to the chairperson of the child fatality review panel for co-signature. The chairperson sends the Data Form 1 to the state STAT within 48 hours.

State STAT reviews for accuracy and completeness; signs and sends Data Form 1 to STAT which links it to the Department of Health and Senior Services birth and death data.

If the death is reviewable, the coroner/medical examiner sends the Data Form 1 to the chairperson of the child fatality review panel for co-signature. This person sends the form to STAT within 48 hours. The person refers the death to the child fatality review panel.

The chairperson schedules the panel meeting as soon as possible. The panel reviews the circumstances surrounding the death and takes appropriate actions. The Data Form 2 is completed, co-signed by the chairperson and sent to STAT within 60 days. Within ten days of completion of the review, filing of criminal charges or the determination of criminal charges not being filed, the final report must be sent to STAT.

STAT links Data Forms 1 and 2 to the Department of Health and Senior Services birth and death data. Panel members pursue the mandates of their respective agencies.