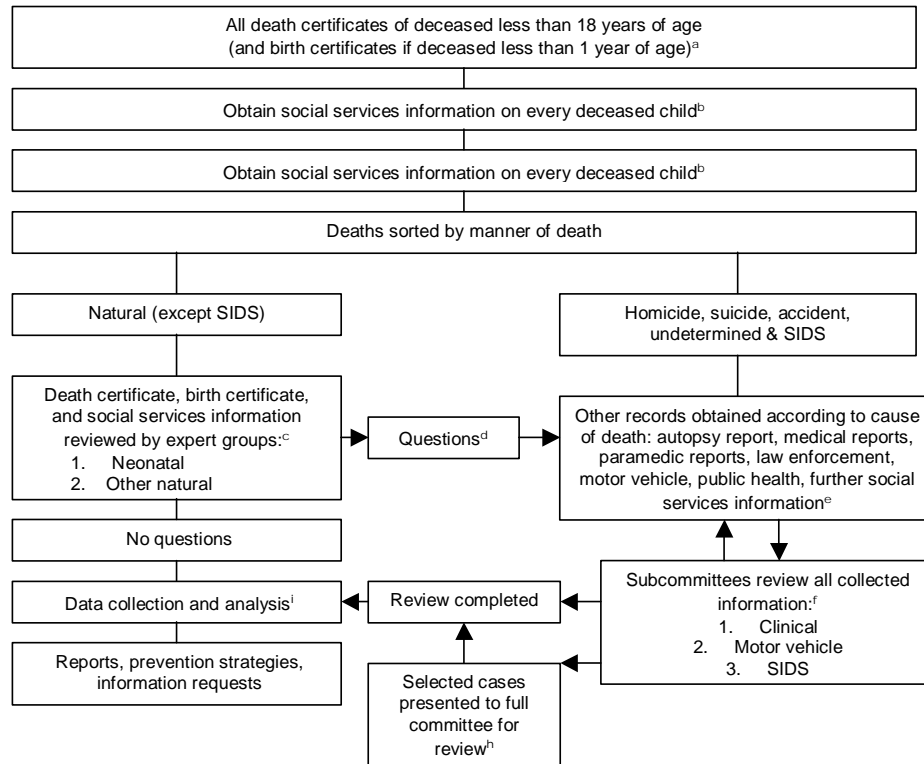


# State Review Team Process

## Colorado Child Fatality Review Process



### 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.

# Missouri's Local Review Process

