Safe Systems Analysis FAQ

The Child Fatality Prevention & Review Program (CFPRP) joined the National Partnership for Child Safety (NPCS) in early 2020. The NPCS is a collaborative focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities[1]. In Oregon Child Welfare, this work happens through safe systems analysis.

What is safe systems analysis?

Safe systems analysis is a critical extension of Oregon's child fatality review process and is conducted by the CFPRP Safe Systems Coordinator(s). Through case file review, participation in the Critical Incident Review Team (CIRT), and follow-up supportive inquiry, the coordinator is able to gather important information about what influences common casework problems, also known as improvement opportunities. The information is then synthesized and rated using the Safe Systems Improvement Tool (SSIT).

What is the SSIT?

The Safe Systems Improvement Tool (SSIT) [2] is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of the SSIT is to support a culture of safety, improvement, and resilience. The SSIT is an effective assessment tool for use in critical incident reviews and provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework (Cull, Lindsey, & Epstein, 2019).

The SSIT is organized into four domains. The family domain is rated similar to the CANS and captures family and child characteristics around the time of the critical incident. The other three domains are nested to measure influencing factors at the professional, team, and environment levels.

When is safe systems analysis conducted?

Safe systems analysis is conducted in all cases reviewed by the CIRT and in some discretionary reviews. Safe systems analysis explores improvement opportunities (IOs) identified through the review processes. In cases where no improvement opportunities are identified, the safe systems

[1] National Partnership for Child Safety Charter: NPCS Charter

[2] SSIT Reference Guide: 2022 SSIT Reference Guide

analysis is brief and only involves documenting family characteristics in the family domain of the SSIT. When improvement opportunities are identified, all four domains of the SSIT are completed.

What are improvement opportunities?

Improvement opportunities (IOs) represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review. Those IOs are then explored in safe systems analysis. At times, additional IOs are identified through the process and added to the exploration.

In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Since quality improvement resources are finite, considering the frequency and proximity of an IO is important to balancing if, when, and to what degree an agency advances a system improvement effort.

Who is involved in safe systems analysis?

The Safe Systems Coordinator reviews the file, participates in CIRT follow-up meeting, and consults with the CIRT coordinator in order to gather relevant information and determine whether or not to offer safe systems debriefings before completing the SSIT. If debriefings are to be offered, the caseworker(s) and supervisor(s) with recent or substantial contact with the family may be involved. Program managers, MAPS and other child welfare professionals may also be invited to participate. Occasionally external partners may be invited to participate as well.

What are safe systems debriefings?

Safe systems debriefings are the mechanism for gathering more individualized information from those who experienced the outcome in the local office/community.

Debriefings are completely voluntary, one-on-one meetings, lasting about 90 minutes. The coordinator uses supportive inquiry to engage with the child welfare professional. It is the goal of debriefings to promote healing and learning at both the individual and system level.

Are safe systems debriefings completed in every case?

Debriefings are not completed in every case. When improvement opportunities are identified through the CIRT or discretionary review process, the safe systems coordinator evaluates the circumstances of the case and may offer debriefings if there was an open CPS assessment or case with the family in the year prior. Because resources are somewhat limited, whether or not to

offer debriefings depends on availability of the coordinator as well as nature of the IO and its relevance to system challenges currently under exploration.

What happens to the information gathered during debriefings?

The information gathered during debriefings is evaluated along with all other information gathered through the CIRT or discretionary review process and then synthesized through the SSIT. The results of SSITs are aggregated, utilizing frequency and proximity of improvement opportunities as well as frequency of influencing factors in the professional, team, and environment domains to shape strategies for both system improvement and prevention efforts. Recommendations resulting from safe systems analysis may be presented to ODHS executive leadership for review and approval.