



Vision for Transformation: Guiding Principles

Child Fatality Prevention & Review Program



The Child Fatality Prevention and Review Program's mission is to improve child safety by identifying determinants of child maltreatment fatalities and collaborating with child and family serving systems to employ equitable, innovative and data informed strategies for systemic change.

Supporting families and promoting prevention

- Trauma-informed approach
- Seek diverse perspectives and prioritize cultural responsiveness
- Promote a culture of safety
- Strength-based system improvement recommendations focused on better outcomes for children and families
- Engagement with community to listen and focus on being more responsive to the needs of families
- Honor children who lost their lives, value the voices of families through the staff who serve them
- Multi-generational approach to address factors that contribute to safety concerns and the cycles of child maltreatment
- Outreach and engagement with community to find resources where families naturally go when needing assistance
- Collaborating with early support services with small interventions: *engaging ODHS contracted nurses, ART/FIT, funding for safe sleep options; providing education; father's groups*
- Addressing the individual needs of each family, providing appropriate services through a Plan of Care

Enhancing our staff and infrastructure

- Committed to equity, inclusion, accessibility, transparency and diversity in recruitment and building of the CFPRP program
- Committed to a strong anti-racism approach, including utilization of an anti-racism tool
- Recognize the importance and the struggle in dismantling systemic racism
- Unlearn behavior that has oppressed people of color in a white supremacist culture
- Create a culture of psychological safety that values and enhances individual, team and system well-being
- High, clear expectations and accountability for our work
- Regularly practice the 6 habits of a healthy team:
 1. Spend time identifying what could go wrong
 2. Talk about mistakes and ways to learn from them
 3. Test change in everyday work activities
 4. Develop an understanding of who knows what and communicate clearly
 5. Appreciate colleagues and their unique skills
 6. Make candor and respect a precondition to teamwork
- Respect and empower staff as the experts in child safety and support their expertise
- Develop culture carriers to expand on creating a safety culture within child welfare

Enhancing the structure of our system by using data with continuous quality improvement

- Identify opportunities for education, procedural guidance, policies, and prevention strategies through intentional data gathered from fatalities, near fatalities, and serious physical injuries
- Complete human factor debriefs which help identify system improvement opportunities
- Use of accurate and relevant data to support system improvement strategies
- Use of the Safe Systems Improvement Tool (SSIT) to gather aggregate data, develop reports and holistically understand the child welfare system to help steer larger system improvement recommendations
- Utilize existing data in comparison with statewide and localized case practice trends to focus on information that supports key goals. Existing data reports reviewed on a regular basis include: *recurrence of maltreatment, foster care re-entry, CFSR, CPS & Permanency Fidelity Reviews*
- Enhancement of CIRT process by using post CIRT surveys to evaluate and improve our process

Leveraging Relationships

The Child Fatality Prevention and Review Program has focused on building and strengthening relationships with community partners and ODHS partners. The relationships have focused on equity, transparency, collaboration, and supporting families without the involvement of the child welfare system. Some of the partnerships include:

- Domestic Violence & Sexual Assault Coordinators and Domestic Violence and Sexual Assault Coalition
- Oregon Parenting Education Collaborative
- Oregon Health Authority
- County child fatality review teams and the State medical examiner's office
- Self-Sufficiency
- Project Nurture
- Tribal Affairs and Tribal Nations
- Local office staff and leadership re: CIRTs and Safety Culture
- OHSU
- ORCAH