Oregon's State Child Death Review and Prevention Team

CHARTER

2022

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INTRODUCTION

This Charter was developed by and for the State Child Death Review and Prevention Team. Within this document, the State Child Death Review and Prevention Team will be referred to as the state team and the County Child Death Review Teams will be referred to as county teams.

MISSION

The mission of the state team is to serve Oregon by reducing preventable child deaths.

STATUTORY AUTHORITY

ORS 418.748 states:

"The Oregon Health Authority, in collaboration with the Department of Human Services, shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations, and take actions involving statewide issues.

The statewide interdisciplinary team may recommend specific cases to a (county) child fatality review team for its review under ORS 418.785.

The statewide interdisciplinary team shall provide recommendations to (county) child fatality review teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases."

PURPOSE

The purpose of the state team is to better understand the circumstances surrounding child deaths occurring in Oregon to prevent future child deaths and serious injuries. The team accomplishes this through:

- Reviewing data gathered from collaborative, multidisciplinary, comprehensive case reviews.
- Supporting county teams where the reviews primarily occur.
- Tracking data-driven trends, improvement opportunities, and recommendations.
- Advocating for equitable prevention strategies at the community, local, state, and national levels.
- Informing continuous quality improvement within Oregon's larger child death review system.

OBJECTIVES

1. Support accurate identification and uniform reporting of the cause and manner of child deaths.

2. Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts within the family serving system.
3. Achieve quality, equitable investigation of child deaths consistent with national standards.
4. Design and implement cooperative, standardized protocols for the review of child deaths.
5. Ensure accurate, complete, and timely data entry in the National Fatality Review - Case Reporting System.
6. Review county team prevention recommendations and support prevention efforts.
7. Identify needed changes in legislation, policy, and practices, and recommend expanded efforts in child health and safety to prevent child deaths and serious injuries.

BACKGROUND

Oregon's State Child Death Review and Prevention Team (state team) is an interdisciplinary team. The state team exists within a larger child death response system comprised of professionals working to understand and prevent unexpected child death in Oregon and across the nation. The state team is charged with supporting county child death review teams (county teams) and collecting and analyzing child death information to support local and statewide prevention efforts.

Oregon Revised Statute (ORS) established the state team in 1989, county teams in 1991 and the state technical assistance team in 1995. The technical assistance team supports both the state and county teams and is housed in the Injury and Violence Prevention Program in Oregon Health Authority's Public Health Division.

GUIDING PRINCIPLES

EQUITY

The state team acknowledges generations-long social, economic, and environmental inequities result in adverse health outcomes. Systematic oppressions affect communities differently and may have a greater influence on health outcomes than either individual choices or one's ability to access health care. Some of the reviewed child deaths are not the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of one or more of their identities can also contribute to a child's death. When reviewing individual cases and interpreting the data, it is critical not to lose sight of these systemic, avoidable, and unjust factors. These factors perpetuate the inequities we observe in child deaths across populations in Oregon. It is critical that state team members and the system's, members represent, including state data systems, identify and understand the life-long inequities that persist across groups to eradicate them. Reducing health disparities through policies, practices, and organizational systems can help improve opportunities for all Oregonians.

The interdisciplinary state team commits to:

- Review and support the review of all death cases from a health equity lens and engage in difficult discussions that arise. Structural racism, interpersonal racism, and discrimination will be noted as findings.
- Regularly review data to identify populations with disproportionate outcomes.
- Make ongoing efforts to have state team membership reflect the diversity in Oregon communities.
- Evaluate our own biases and prejudices and engage in ongoing equity trainings.
- Support and promote equitable child death investigation.

HEALTH

The state team recognizes social determinants of health, including but not limited to poverty, food insecurity, housing instability, a lack of access to medical care (physical and mental health care), parental educational status, and systemic racism play a role in child deaths in Oregon. The state team commits to bringing social determinants of health to the forefront of team discussions and recommendations.

RIGHTS OF CHILDREN

The state team embraces a child rights-based approach to death investigation, review, and prevention. This includes (1) the basic rights to life, survival, and development of one's full potential; (2) protection from harm; and (3) having an active voice. Consistent with the United Nations Convention on the Rights of the Child, the state team, "respects and promotes the human dignity and the physical and psychological integrity of children as rights-bearing individuals, rather than perceiving them primarily as victims" (https://www.unicef.org/child-rights-convention/convention-text).

TRAUMA-INFORMED

The death of any child is a tragedy. The state team seeks to honor the trauma that results from the death of a child for the family and the community through all the activity and output of the team. As part of the work of the state team, the team will mindfully consider and seek to improve (1) how systems are, or are not, addressing the trauma of child death; and (2) the supports available to caregivers, community members, and county teams in managing trauma related to child death.

The state team recognizes the impact participation in child death reviews has on the emotional wellbeing of team members. To remain trauma-informed and responsive, the team will continue to take steps to support wellness of team members, which may include:

- Training opportunities regarding trauma and responding to secondary trauma.

- Taking intentional breaks during team meetings to engage in activities which support managing the impact of exposure to traumatic material.
- Actively working to create a safe culture focused on learning that encourages open communication and emotional support among team members without judgment.

SAFETY CULTURE

The state team values open communication, curiosity, continuous learning and improvement, and each team member's perspective, professional knowledge, lived experience, and expertise. The state team seeks to create an environment and culture that is free of blame and shame, where mistakes are opportunities for improvement, and individual accountability is balanced with systems accountability.

While disagreements between members are sometimes unavoidable, if navigated with care, they may help the team to function effectively and support quality work. It is the responsibility of the state team co-chairs to support and foster productive exchanges and dialogue between team members.

ORGANIZATIONAL STRUCTURE

The state team acts as the center of the child death review system in Oregon. This includes serving as support and oversight for Oregon's county teams.

While the state team's effectiveness depends on its membership forming a statewide interdisciplinary team, ORS 418.748 provides responsibility for the state team to the Oregon Heath Authority (OHA) and Oregon Department of Human Services (ODHS). As a result, co-chair positions are assigned to representatives of OHA and ODHS.

The state technical assistance team as outlined in ORS 418.706, provides staff support for the state team and technical assistance to the county teams. The state technical assistance team operates out of Oregon Health Authority, Public Health Division, Injury Violence and Prevention Program.

MEMBERSHIP

RECRUITMENT

The state team commits to ongoing recruitment of team members with a focus on team diversity and representation and seeks the support of active members in identifying and recruiting individuals who may bring value to the work of the team through their professional associations, personal experience, and expertise.

ONBOARDING

When a new team member is identified, the co-chairs will initiate the onboarding process with the assistance of the state technical assistance team. State team onboarding activities include but are not limited to:

- Dissemination of orientation materials to include team charter, recent annual reports, meeting minutes for two prior meetings, the National Center for Child Death Review Program Manual for Child Death Review, and a link to the Oregon Child Death Review and Prevention website.
- An initial onboarding virtual meeting with one or both co-chairs to discuss team member roles and responsibilities including active participation requirements, associated time commitment, and the onboarding timeline. If the onboarding member is replacing an existing member, the existing member will also participate.
- Co-chairs will create and send an email to the state team introducing the new team member.
- Observing a state team and county team meeting prior to team membership, whenever possible.
- Completion of a voluntary diversity questionnaire.
- A post-meeting check in between the co-chairs and the new team member after the new team member attends their first state team meeting.

ROLES AND RESPONSIBILITIES

The state team is comprised of individuals who hold one of three roles: co-chair, core team member or designee, and state technical assistance team member. Roles and responsibilities may shift over time and with agreement of the team member and co-chairs. However, all members regardless of role share the following responsibilities:

- Review and abide by the state team charter.
- Actively uphold the guiding principles, mission, and purpose of the state team.
- Actively and consistently engage with the team during state team meetings.
- Adequately prepare for state team meetings by completing necessary activities, such as document review, research, communication with county teams, completion of action items from prior meeting, or any other work required to support state team efforts.
- Participate in recommended trainings independently and during team meeting. Team members are encouraged to participate in and share learnings from training offered through their parent agency. When training relevant to child death review and prevention is available, the training information will be shared with the team.
- Share information openly and honestly within the state team.
- Share information with and from others in represented role.

- Protect the confidentiality of information by not sharing identifying information of the family and any law enforcement, health care, child protective services, or other protected information with anyone outside the child death review process.
- Use respectful, strengths-based, person-centered language when discussing children and families whose experience is shared through the child death review process, as well as when conversing with other team members. This includes the ongoing critical self-reflection necessary for the recognition of team members' individual biases and privileges.
- Understand that team membership is a long-term commitment with an associated workload and time commitment.
- Continuously work to strengthen relationships and improve communication with county teams.

DESIGNEES

Effective child death review requires a variety of perspectives. As such, state team members are asked to identify a designee should they be unable to attend a team meeting. When a designee cannot be identified, it is the member's responsibility to ensure alternative means for contributing to the agenda items. When possible, communication from the member to co-chairs informing of the need for a designee should occur at least one week prior to the team meeting. Team members may also choose to provide the co-chairs a letter authorizing an individual to serve as a permanent designee.

REPRESENTATION IN MEMBERSHIP

To support the commitment to policy and system improvement, state team members should have an ability to impact statewide change through role, connections, or access to and support from their represented group. When a permanent designee is assigned, the designee may represent a local connection to the work but will maintain a statewide connection through the member. Members will be selected for their subject matter expertise gained through education, work experience, and/or lived experience.

The state team is committed to diversity among team members and utilizes a voluntary diversity questionnaire as an assessment tool to inform recruitment efforts. The state team will continue to utilize this tool annually or as needed to fulfill the goal of ongoing reflection and growth toward creating a diverse team that represents perspectives and lived experiences of the Oregonians served by the broader child and family serving system.

The state team recognizes the sovereignty of Oregon Tribal Nations and continues to seek out opportunities to engage tribes in child death review and prevention efforts in a manner determined by the Oregon Tribal Nations.

The state team will at a minimum seek to include members representing the following perspectives and roles:

- Oregon Health Authority, Public Health Division, Injury and Violence Prevention Program, co-chair
- Oregon Department of Human Services, Child Welfare, Child Fatality Prevention and Review Program, co-chair
- Sheriff's Association
- Chiefs of Police
- Oregon State Police
- Department of Public Safety Standards and Training
- Office of the State Fire Marshall
- Oregon District Attorneys Association
- State Medical Examiner
- Oregon Child Abuse Solutions
- Oregon Pediatric Society
- Early Learning Division, Office of Childcare (Department of Early Learning and Care)
- Oregon Department of Education
- County Team Lead
- County Team Coordinator
- Oregon Department of Justice, Child Abuse Multidisciplinary Intervention (CAMI) Fund Coordinator
- Oregon Department of Justice, Child Advocacy Division
- Oregon Youth Authority
- Oregon Health Authority, Public Health Division, Maternal and Child Health
- Oregon Health Authority, Health Systems Division, Behavioral Health
- Oregon Health Authority, Public Health Division, Emergency Medical Services
- Oregon Department of Human Services, Office of Developmental Disabilities Services
- County Health Department medical provider
- Oregon Tribal Nations
- Oregon Council Against Domestic and Sexual Violence
- Safe Kids
- Oregon Child Development Coalition
- Oregon Association of Hospitals and Health Systems
- Faith Leader
- Oregon Health & Science University, Office of Rural Health
- Oregon Infant Mental Health Association

- Toxicologist
- Oregon Health & Science University, Doernbecher's Children's Hospital, Tom Sargent Safety Center
- Legacy Health Systems, Injury Prevention
- Family Support and Connections
- Oregon Council for Behavioral Health
- Pediatrician
- Coordinated Care Organizations
- Child and Adolescent Psychiatry
- Oregon Medical Board
- Oregon State Board of Nursing
- Oregon Board of Naturopathic Medicine
- Mental Health and Addiction Certification Board of Oregon
- Oregon Vital Records
- Oregon Department of Transportation

The state technical assistance team members, although not state team members, support the work of the state and county teams, and participate in the state team meetings.

EXITING THE TEAM

A state team member may end their membership for a variety of reasons, including change in role, and inability to meet the roles and responsibilities of a team member.

It is expected that any team member exiting the team will participate in an offboarding process as follows:

- When possible, if a team members become aware of their need to exit the team, they will communicate this to the co-chairs prior to their final meeting.
- The co-chairs provide an opportunity to receive feedback from the exiting team member.
- The exiting team member will work with the co-chairs to identify a possible replacement.
- When a replacement has been approved, the exiting team member will work with the co-chairs to develop a transition plan to support onboarding of a replacement. The transition plan will include:
    - Conversation regarding team responsibilities and time commitments will occur between the co-chairs and the exiting and onboarding team members.
    - Determination of when the transition between exiting and onboarding team members will occur.
    - Communication with any counties assigned to the exiting team member to inform them of the change.

- Exiting team member to participate in an exit interview with a co-chair to gather information to support overall program improvement.
- Removal of exiting member from future communications and confirmation the exiting member has disposed of all state team review materials or information not relevant to their job duties at their parent agency.

LOGISTICS

MEETING SCHEDULE

The state team will have half day meetings that occur at least quarterly.

MEETING LOCATION

To ensure inclusivity and access to statewide experts, the state team will be held virtually for the foreseeable future. The co-chairs will communicate any change in meeting format.

GUESTS/INTERNS

Periodically, the state may consider inviting guests to participate in or present at a state team meeting. Guests may include individuals with a particular expertise, case specific knowledge, or those for whom the experience would provide educational or professional development. Guests at state team meetings will be oriented to the team's purpose and guiding principles and must complete a statement of confidentiality prior to participation.

DECISION-MAKING PROCESS

The state team uses a consensus-based decision-making model where the co-chairs identify decision-making junctures, encourage open dialogue, and facilitate the decision-making process. Should the team fail to reach consensus, all members are provided an opportunity to provide feedback to the co-chairs, who weigh information and come to a final decision on behalf of the team.

CONFIDENTIALITY

State team members will sign and return a statement of confidentiality. Members will periodically be asked to provide a new signed statement.

The state technical assistance team will obtain and maintain the confidentiality agreements, ensuring no individual attends the state team meeting without a signed and returned confidentiality agreement. State team guests are required to complete a statement of confidentiality prior to participation in meetings.

ACCESSIBILITY

For the benefit of the state team and each member and guest, it is imperative all members and guests can fully participate in the state team process. The state team is committed to ensuring the accessibility needs of team members and guests are met during team meetings and with team communication. Prior to meetings members and guests will be asked what can be done to make participation easier. Actions taken may include but are not limited to:

- Including an accommodation statement in meeting invitations.
- Holding meetings via a virtual platform that provide a variety of means of participation including audio, visual, and dial-in via conference phone number.
- Co-chairs will ensure the chat box is monitored, read aloud the author and questions/comments to be addressed, and offer use of the chat box as an alternative method of communication during meetings.
- Providing captioning or live sign language or translation services as needed.
- Distributing communication in a minimum of 14-point font.

CASE REVIEW

SCOPE OF REVIEW

Child deaths which come under the purview of the state team include unexpected deaths of individuals under the age of 18 years including deaths as the result of maltreatment, suicide, or unexpected injury. Any questions or disagreements regarding the appropriateness of a child death review will be addressed by state team co-chairs.

CASE SELECTION

While review of individual child deaths occur at the county level, the state team may conduct a formal child death review in the following circumstances:

- A county is requesting assistance in reviewing a death due to insufficient resources to conduct a review.

- When the co-chairs determine an additional review is necessary to understand system improvement opportunities.
- When the co-chairs determine the review will serve as a learning opportunity for state team members.

To ensure access to a review, the state team will prioritize requests for review from counties with insufficient resources to conduct their own.

REVIEW PROCESS

Any state team member bringing forward a death for team review will do the following to ensure a quality death review occurs:

- Utilize the child death case summary abstract and disseminate to team members at least two weeks prior to the review.
- Identify individuals whose participation would provide value to the review and inform co-chairs and technical assistance team members at least 10 business days prior to the review.
- Review and utilize quality practice guidelines for conducting child death reviews available through the National Center for Child Fatality Review and Prevention.
- Present case information with a strengths-based, person-centered framework that seeks to identify opportunities for improvement while considering the totality of the family's experience with the broader child and family serving system rather than focusing on individuals or specific actions.

COUNTY TEAMS

COMMUNICATION WITH COUNTY TEAMS

Communication between county teams and state team primarily occur through regular contact resulting from the technical assistance team duties, administration of the Child Abuse Multidisciplinary Intervention funds, and co-chair contact.

COUNTY SUPPORT

State team members are strongly encouraged to participate in the critical work of supporting county teams.

County Support Goals:

- Enhance communication between the county and state death review teams.
- Support and encourage the county in the completion of death reviews.

- Increase the understanding of the purpose and value of the death reviews.
- Remove barriers to completing death reviews.
- Ensure Oregon has data on child deaths to inform prevention and intervention.

DATA

DATA COLLECTION

Data collection will occur through regularly scheduled data imports from the National Fatality Review-Case Reporting System (NFR-CRS), the data system supporting Child Death Review and Fetal and Infant Mortality Review teams across the country. Collection of data through the NFR-CRS is facilitated by the state technical assistance team. The County Support Program will serve as an additional means to ensure the timely and accurate entry of information into NFR-CRS by county teams.

DATA SHARING

The state team members will engage in data sharing with other Oregon child death review professionals and national partners as needed to fulfill the objectives of the state team and pursuant to ORS 418.747(13).

IDENTIFICATION OF TRENDS

Using their unique expertise and connection with county teams, state team members are responsible for identifying trends in Oregon child deaths using available data and through discussion with county teams.

PREVENTION

PREVENTION RECOMMENDATIONS & SUPPORT OF PREVENTION EFFORTS

A foundational purpose of the state team is the creation of child death prevention strategies based on data obtained during child death reviews occurring throughout Oregon. The state team addresses the status of current statewide prevention efforts, identifies gaps in child death prevention, and develops additional plans and strategies as needed as part of the team's core work pursuant to ORS 418.748.

ENGAGEMENT OF COUNTY TEAMS IN PREVENTION

County teams are vital partners in the work of child death prevention in Oregon. Using available data, the state team will make efforts to partner with county teams to identify, develop, and implement prevention efforts occurring both at a local level and statewide level.

LEGISLATION AND PUBLIC POLICY

The state team recognizes the limitations placed on some team members, such as their ability to participate in lobbying activities, because of their employment. The state team co-chairs, along with impacted team members, will ensure that state team actions are not in violation of such restrictions.

Despite restrictions, there are opportunities for many members to impact legislation and public policy through legislative concepts, policy option packages, and other means. Members are encouraged to reach out to the state team for potential partnership and support for such opportunities.

COORDINATION WITH OTHER REVIEWS

The state team will continue to explore opportunities to coordinate child death reviews with county teams and death reviews occurring as part of the ODHS Child Welfare's Child Fatality Prevention and Review program.

Additionally, the state team will make efforts to engage and learn from other death reviews in Oregon, including but not limited to domestic violence, sex trafficking, overdose, suicide, firearm, and maternal mortality and morbidity.

OUTPUTS

ANNUAL REPORT

The state team publishes an annual report regarding child death reviews conducted in Oregon. This report focuses on child death reviews known to the state team that occurred during the prior calendar year and is issued no later than 6 months after the end of the year. The annual report is provided to the Governor's Office and ODHS and OHA leadership. The report is published on the Oregon Child Death Review and Prevention web pages.

The report contains but is not limited to the following:

- The number of known child deaths for the applicable year.
- The manner and/or cause of death in such deaths.
- The age, gender, race, ethnicity, and geographic areas of child deaths for the applicable year.
- Identified local and statewide trends.
- The status of local and statewide prevention efforts stemming from current and previous annual reports.

ANNUAL CONFERENCE

The state team will host an annual (virtual or in-person) conference to enhance the work of the county teams and to offer an opportunity for networking and sharing of expertise between individuals conducting child death reviews within Oregon.

WEBSITE

The state team will maintain a webpage on the OHA website with child death review and prevention information and resources.