Center for the Helping Professions

Date: May 19th, 2025

From: Michael Cull, Chief Executive Officer, and Tiffany Lindsey, Chief Operating Officer, Center for the Helping Professions, Inc

To: Oregon Senate Committee on Human Services

Re: Written Testimony Relevant to HB 3795 -3

Dear Senate Committee on Human Services,

We have come to understand the details of this proposed bill (the -3 amendment) will impact how Oregon Department of Human Services determines eligibility of a critical incident for a Critical Incident Review Team (CIRT). These statutorily mandated reviews are an important public accountability measure and support both a high-quality response to critical incidents as well as a thoughtful review to prevent future tragedies. Oregon's CIRT reports are de-identified and publicly-available. As such, they include a history of the family's involvement with child welfare and can include candid accounts a caregiver's deeply personal experience on topics such as divorce, mental health, disability, job loss, and trauma – which can be unrelated to the circumstances of the critical incident itself. While de-identified, such sensitive accounts alongside critical incident information can be matched with local, national and social media to produce linked, identifiable accounts of Oregon's citizen's lives, affecting communities, parents and surviving siblings. Additionally, expanding CIRT inclusion criteria could impact the timely reporting of child fatalities as those familiar with the family - or - those who assume an incident is likely to be screened out, may be deterred from reporting due to their awareness of a public review.

We believe in learning from harm to prevent future harm. However, that learning must be grounded in key values, such as dignity, humility, and shared responsibility. The way critical incidents are defined - and especially how they are made public - must reflect those values.

Oregon Department of Human Services was among the first members of the National Partnership for Child Safety – a quality improvement collaborative of more than 40 public child welfare agencies who voluntarily share critical incident review data in an effort to reduce the rate of child fatalities. This peer-to-peer accountability model allows Oregon to

share, learn and engage in improvement work alongside a network of child welfare agencies. Child welfare agencies exist in a challenging, high-risk environment – charged with both compassionate, comprehensive prevention of harm as well as accurate, rapid detection to child danger.

We urge the Senate Committee to treat this not as a procedural update, but as a deeper policy discussion where further analysis and conversation are needed. Such study accurately reflects the gravity of what is at stake, so that learning doesn't come at the cost of candor or dignity.