TRANSFORMING CULTURE | TOGETHER

Collaborative Safety

Child Welfare

Tennessee

2010 – 2012

Tennessee DCS budget cut by $30 million, resulting in the elimination of 200 staff and caseworker positions

DCS faces Tennessee lawmakers' own investigation

Hearings to address children's deaths, increased budget

Mar. 12, 2013

"DCS is now operating with its smallest budget and case manager levels in five years, even as it grapples with far more children in its care. The number of children in DCS custody increased by 18 percent between 2010 and 2012. During the same period, DCS budget cuts eliminated 200 staff and caseworker positions and lopped $30 million from the agency's total budget."

December 2012

Coalition media group files lawsuit against DCS to obtain information relating to child death cases, garnering national media attention

Media groups file lawsuit against Tenn. children's agency

Dec. 19, 2012

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NASHVILLE, Tenn. (AP) — A coalition of media organizations is suing the Tennessee Department of Children's Services, alleging the agency is violating the law by not providing details about 31 children it had investigated and who died during the first six months of this year.

The lawsuit filed Wednesday is spearheaded by The Tennessean (http://tnne.ws/ZPaBPK), which has repeatedly asked DCS for the information. To date, the agency has only provided brief summaries of the deaths.

The lawsuit asks the court to order the agency to explain why the records were not provided. It also asks that the department immediately give those records to the court so a judge can review them and redact any confidential information and for the records to then be opened to the public for review.

January 2013

DCS fires two executive directors on the same day agency officials appear in court for hearing on media coalition lawsuit

DCS fires executive directors Debbie Miller, Alan Hall

Firings conveyed little explanation

Jan. 10, 2013

Two executive-level Department of Children's Services staffers — whose duties at the agency included reviewing the deaths of children — were fired Tuesday.

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News
News Government - State

Continuing coverage of the Department of Children's Services

Dismissed were:

- Debbie Miller, 61, executive director of family and child well-being, who oversaw medical and behavioral health and education for children in custody and independent living for teens that age out of DCS custody; and
- Alan Hall, 47, executive director of performance and quality improvement, who oversaw department policies, licensing and accountability, and who led the department's internal audit.

Department spokeswoman Molly Sudderth said Miller's position was eliminated as part of a restructuring. Hall will be replaced. The Tennessean asked why Hall was dismissed, and Sudderth did not give an answer.

January 2013

State legislators call for DCS to be investigated in wake of agency not releasing child death records sought in media coalition lawsuit

Rep. Mike Turner demands investigation into DCS, cites 'secrecy'

'It is well past time that we have a full accounting of problems,' he says

Jan. 11, 2013

One of the state's top-ranking lawmakers has called for an immediate investigation into the Department of Children's Services, saying the matter is urgent and citing the department's refusal to release records concerning the deaths of children in its care.

Thirty-one Tennessee children died in the first half of 2012 after coming to the attention of the state's child protective agency.

On Thursday, House Democratic Caucus Chairman Mike Turner sent letters to Gov. Bill Haslam, House Speaker Beth Harwell and Lt. Gov. Ron Ramsey — the state's top three

February 2013

DCS Commissioner Kate O'Day resigns amidst continuing controversy over agency's handling of child death cases

DCS commissioner O'Day resigns amid scrutiny of deaths

Updated: Tue 12:32 PM, Feb 05, 2013

Home / Headlines List / Article

NASHVILLE, Tenn. (WVLT/AP) -- The commissioner of the Tennessee Department of Children's Services has resigned amid scrutiny of how her agency was handling cases of children who died after investigations of abuse and neglect.

"Kate has informed me that she felt the time was right to step down," Haslam said. "Gov. Bill Haslam announced in a news release Tuesday that Kate O'Day had decided to resign because of concerns that she had become the focus of attention rather than the children the agency is meant to serve."

I appreciate Kate's service to this administration and to our state. She has done a lot of good work in identifying longstanding problems that have hampered the department, and we will build on those efforts as we move forward."

Jim Henry named head of Tennessee's Department of Children's Services

May 22nd, 2013 | by Staff Report | in Local Regional News | Read Time: < 1 min.

NASHVILLE - Gov. Bill Haslam on Tuesday named Jim Henry as the permanent head of the state's troubled Department of Children's Services.

Photo by Associated Press/Times Free Press.

Henry has been working as acting commissioner after the abrupt departure in February of then-Commissioner Kate O'Day, whose department has been engulfed in controversies over inadequate protections for children, children's deaths and questions about how investigations have been handled.

Henry, a former state lawmaker, already was commissioner of the Department of Intellectual and Developmental Disabilities and has been holding down a dual role at Children's Services as well as Intellectual and Development Disabilities, working to bring order back to DCS operations.

The governor today also named Debra Payne as the new commissioner of Intellectual and

February 2014

Tennessee Governor Bill Haslam proposes plan to increase DCS budget by$6.4 million and to hire 89 additional caseworkers

Gov. Bill Haslam proposes DCS funding increase

Anita Wadhwani, The Tennessean 8:53 a.m. EST February 10, 2014

For the second year, the embattled Department of Children's Services is getting budget help from Gov. Bill Haslam.

(Photo: WSBT)

For the second year, the embattled Department of Children's Services is getting budget help from Gov. Bill Haslam.

The governor is proposing a $6.4 million state funding increase for the agency charged with investigating child abuse and neglect and running the state's foster care system and programs for delinquent youth.

The proposed budget increase would allow the department to hire 49 more child protective service workers and 40 family services caseworkers, buy 2,000 electronic tablets for caseworkers to use in the field, increase payments to foster parents and invest more in adoption programs.

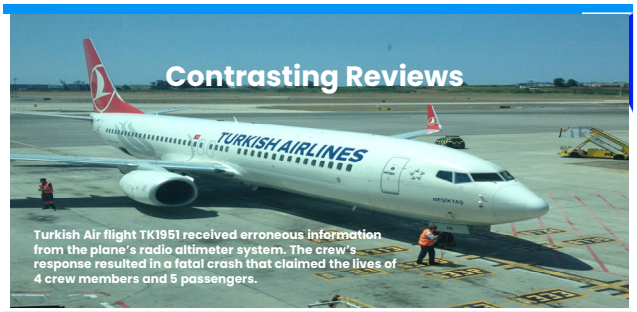
What's Next?

Time for Something New

NEWS

Tennessee child welfare officials draw on lessons from aviation, call for "safety culture"

Contrasting Reviews



Turkish Air flight TK1951 received erroneous information from the plane's radio altimeter system. The crew's response resulted in a fatal crash that claimed the lives of 4 crew members and 5 passengers.

Contrasting Reviews

A 2 y/o girl left unattended by her foster parents drowns in the family's swimming pool.

Expert Findings

- The Captain had close to 11,000 hours on the Boeing 737 alone. This combination of training standards and experience is apparently not enough **to protect crews from the subtle effects of automation failures** during automated, human-monitored flight.
- The documentation and training available for flight crews of the Boeing 737NG leaves important **gaps in the mental model that a crew may build up about** which systems and sensor inputs are responsible for what during an automatically flown approach.

(Dekker, 2009)

Expert Findings

- It is indisputable that OKDHS was **well aware of the hazard associated with the pool.**
- The home **should never** have been approved without a specific and shared understanding between OKDHS and the foster parents about the pool.
- The pool **should have been** removed or a suitably protective fence **should have been** placed around it.
- **No children should ever** have been placed in the home before one of these things happened.
- By **failing to ensure** that this hazard was either removed or mitigated, OKDHS **violated** CWLA and COA standards and its own policy.

Two Views of Safety

OLD VIEW vs. NEW VIEW

Important Features

- Human Error
  - What was the worker's role?
- Causation
  - How did this happen?
- Methods of Learning
  - How will we learn?

What was the worker's role?

HUMAN ERROR

Old View

- We believe people are the cause of failure
- Our learning ends with bad practice
- Our safety interventions target people
- We assume people should do better with what they have
- We treat people as a problem to control

New View

- We believe failure is a consequence of deeper problems
- Our learning starts with practice deviation
- We understand that better system design promotes better outcomes
- Our interventions target the context of work
- We realize that people are why our systems work

How did this happen?

CAUSATION

Old View

- Oversimplify Causation
- Focus on the Bad
- Biased by Outcome

Oversimplify Causation

- We assume there is a linear trajectory of events
  - Walk back string of events
  - Single causal path
- We assume there is a single cause
  - Stop at the visible cause
  - Typically, people
- Example
  - Root Cause Analysis
  - Domino Model

Focus on the Bad

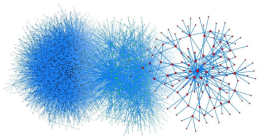
- Bad Systems = Bad Outcomes
  - We are less likely to consider system components not labeled “bad”
  - Our learning stops when the broken component(s) is found
  - We assume direct causal connection between identified problem and outcome
  - We most easily attribute faults to a worker

Biased by Outcome

- We assume Cause and Effect are proportional
  - If the outcome is very bad, then the work prior must have been very bad
- Our responses are impacted by the severity of the outcome
  - Bad outcomes promote reactionary responses
  - Good/benign outcomes may not promote a reaction to begin with

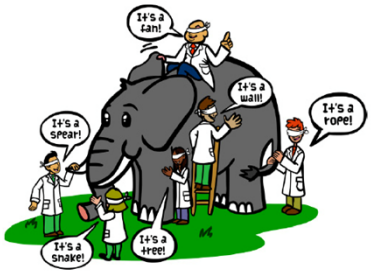
New View

- Understand Systems Thinking
- Embrace Complexity



Systems Thinking

- We avoid understanding and fixing component parts in isolation
  - e.g., success of training is determined by curriculum, teaching quality and roll out
- We focus on how system components interact
  - e.g., success of training also considers access to training, staff shortages, pressure to fill positions, varying interpretation, work as imagined vs work as done



Embrace Complexity

- We must understand the complexity of our work
  - Systems are made of many different components
    - People, partners, guidance, regulations, political change, etc.
  - Systems are made of the tangible and intangible
    - Tracking metrics vs how metrics make people feel in their job

Embrace Complexity

- Our explanations of events reflect this complexity
  - Avoid simple explanations
  - Discuss local workplace environmental features
    - e.g., workload, efficiency pressures, staffing, guidance
  - Discuss high level system features
    - e.g., budget, initiatives, statute, regulation
  - Make connections

How will we learn?

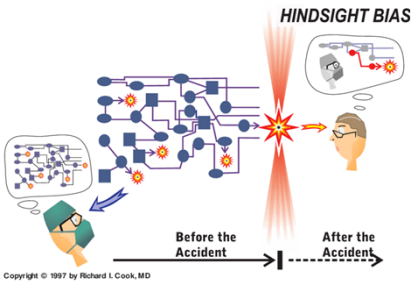
METHODS OF LEARNING

Old View

- Have Hindsight Bias
- Rely on Counterfactuals
- Try to Assign Blame

Hindsight Bias

- We assume workers should have known what we know now
  - We know what is going to happen (outcome knowledge), we have all information available, and we have benefit of time
  - We oversimplify how decisions are made
- We simplify how events happen



Counterfactuals

- We use language of “should have” “could have” “if only”
  - Proposes possible alternate set of events
  - Assumes better outcome
- We stop the learning at these statements
  - This indicates worker failure, so we stop exploring
- We communicate our judgement more than explain what happened

Assign Blame

- We prioritize the goal of identifying the cause of an incident
  - We identify cause to achieve our goals
- We are most likely to identify people as a cause
  - Based on data available and procedure, this is the most easily constructed cause

New View

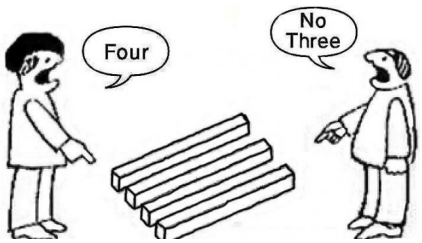
- Access Second Stories
- Value Multiple Perspectives
- Understand Work as Done

Access Second Stories

- We go beyond the first story
  - First story is what we see in practice
- We ask questions that help us understand the "why" and "how"
  - Understand work as done
  - Prioritize explanation that captures system barriers
- We change the narrative
  - Change the fixing strategy

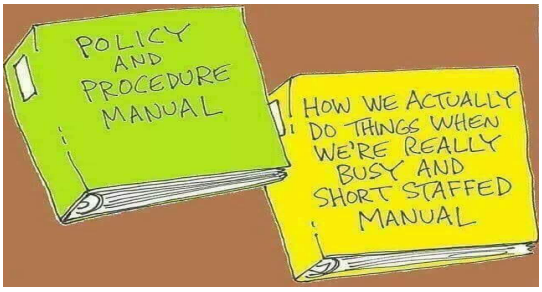
Multiple Perspectives

- We gather varying perspectives to better understand how our system works as a whole
  - Systems function within a social context
  - People can best explain their own work environment
- We realize that the less perspective we have the more assumptions we need to make
  - This leads to oversimplification
  - Rarely accounts for the disconnect between work as imagined vs work as done



Understand Work as Done

- We understand that deviation from work as imagined is normal in complex systems
  - Resource constraints, efficiency pressures, conflicting guidance makes adaption a necessity
- We prioritize the study of the environmental features that make this deviation seem necessary
  - We address the environment, not always the person
  - Not all adaptation is bad



What will we fix?

SYSTEMS IMPROVEMENT

Old View

- Rely on Quick Fixes
- Add to the System

Quick Fixes

- We rely on fixes that are easier to implement
  - e.g., policy, training, compliance, discipline
  - Note: Not all quick fixes are bad
- Our focus is typically occupied with changing people
  - We miss the opportunity to impact environmental influences
  - We are more likely to see recurrence

Adding to the System

- We make work more difficult to get done
  - We add tasks, compliance, forms that exhaust more time and resources
- We unintentionally make our systems more complex
  - Added difficulty in managing time pressures and compliance tasks impacts quality

New View

- Target System Change
- Prepare for Unintended Consequences

System Change

- Our focus is directed at improving the context of work
  - This prioritizes resource constraints, demands, pressures, teaming
- We realize change may need to occur outside of our control
  - This allocates time to talking about centralized change, statute change, community partner engagement

Unintended Consequences

- We ask questions about how unintended outcomes may occur and protect against that
  - Ask questions to who the change will affect
- We remain adaptable
  - When unintended consequences occur, be prepared to change strategy

SAFETY AS A BUREAUCRACY

Safety as a Bureaucracy

- Compliance based
- Less attention is allocated to the reason why the numbers exist
- Current Realities
  - Case Closures
  - Med Errors
  - Timeliness
  - Documenting
- Examples
  - Logging
  - ACE

Safety as a Bureaucracy

- Effect on operational accountability
  - Work is shifted towards:
    - Paperwork/tools
    - Documentation
    - Meeting quotas
- Loss of operational expertise
  - Less time to spend in practice
    - Seeing families
    - Providing supports
  - Less time supervising
    - Supervisors focus on operational efficiency goals
    - Mentorship declines

KEY CONCEPTS

Key Concepts

- Safety Culture
- Second Story
- Hindsight Bias

Safety Culture

- Represented by:
  - The values of an organization
  - The organizational structures that reflect those values
  - The language of an organization

Safety Culture

- Practically seen within:
  - How an agency learns and improves
  - How an agency treat staff that contribute to the safety process
  - When the boss hears the bad news
    - Can they handle the truth?

Second Story

- Highlights the “how” and “why” behind practice
- Prioritizes a story that captures systemic influences into normal work

Hindsight Bias

- Oversimplifies decisions and events when we know what happened
- As a retrospective outsider
  - You have more information
  - You have outcome knowledge
  - You are on a different timescale
- Don't be this character…

IMPORTANCE OF LANGUAGE

Importance of Language

- Remove
  - Cause
  - Error/Mistake
  - Failure
  - Blame
  - Should/could/would

Importance of Language

- Cause
  - Simplistic
  - Incompatible with complexity
  - Instead
    - Influences

Importance of Language

- Error/Mistake
  - Attributed “after the fact”
  - Retrospective attribution
  - Focus on negatives
  - Instead
    - Explain decision making
    - Provide explanation and context

Importance of Language

- Failure
  - Retrospective attribution
  - Focus on negative
  - Instead
    - Provide explanation and context
    - Adverse event

Importance of Language

- Blame
  - Retrospective judgment
  - Simplistic
  - Cultural effects
  - Instead
    - Accountability
      - Forward Looking

Importance of Language

- Should have/could have/if he or she would have
  - Counterfactual
  - Inhibits learning
  - Instead
    - Provide explanation and context

Normative Language

- Demonstrates bias and judgement rather than useful explanations
- It communicates subjective statements
  - Inappropriate decision
  - Poor quality
  - Not thorough
- Judge versus curious learner
- Interpreted as blaming

Normative Language

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Agency Response Example

Case: Social workers charged with child abuse in case involving torture and killing of an 8-year-old boy

- Four County social workers have been charged with felony child abuse in connection with the 2012 death of the 8-year-old, who was tortured and killed even though authorities had numerous warnings of abuse in his home.
- County prosecutors allege that county Department of Children and Family Services employees allowed a vulnerable boy to remain at home and continue to be abused.

Agency Response Example

Agency Response:

- Director Statement: "In our rigorous reconstruction of the events surrounding the boys death, we found that four of our social workers had failed to perform their jobs. I directed that all of them be discharged. I want to make it unambiguously clear that the defendants do not represent the daily work, standards or commitment of our dedicated social workers, who, like me, will not tolerate conduct that jeopardizes the well-being of children."

Agency Response Example

Case: Three male children — ages 2 months old and 5 and 8 years old were found in a closet full of miscellaneous items.

- The youngest boy's body was in a suitcase.
- The children appeared to have been stabbed to death and parts of their bodies dismembered.
- DCS agency had multiple contacts with the family of the 3 slain boys

Agency Response Example

Agency Response:

- Director Statement: "It is a sad day as we reflect on the gruesome nature of what occurred. We grieve as a community, trying to understand why three innocent souls have been taken. We grieve as an organization, suffering the loss of children whom we knew. When a child is murdered, it's common to ask if something could have been done to prevent such a tragedy. At DCS, we ask ourselves those questions because we take the responsibility of protecting children very seriously.

Agency Response Example

Agency Response:

- "We offer our deepest sympathies to the family and pray for the peace of the departed. I ask all of us to respect, support, and commend the dedicated men and women of DCS and Law Enforcement who do the unimaginable. Who do, when no one else can or will. Who comfort the afflicted, protect the weak, and wipe the tears; who then go find a private place to shed their own."

Collaborative Safety Model

SUPPORTING ORGANIZATIONAL CHANGE

Systems Review

- Supports understanding of safety science and review of work from a systems approach
- Derived from systems mapping techniques commonly used in safety analysis
- Identifies opportunities for system wide change and improvement

Systems Review

- Does not add additional work
  - Embedded into existing processes
- Use in the areas of:
  - Service Reviews
  - Incident Reviews
  - Metrics and Performance
  - Other Continuous Quality Improvement Efforts

Systems Review Examples

- Face to Face contacts
- Timeliness to permanency
- Documentation
- Staff injury
- Delays in service delivery
- Difficulty in accessing records
- Coordination of services

Systems Review

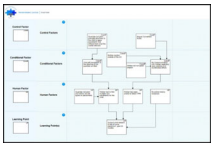
- Key Features
  - Human Factors Debriefings
  - Systemic Mapping
  - Systems Analysis Tool
  - Technology Integration
    - Systems Mapping Tool
    - SCIR Reporting System

Human Factors Debriefing

- Conducted by Reviewer
- Characteristics of Debriefing
  - Voluntary
  - Supportive
  - Safe
- Uses Human Factors Techniques
  - Understands decisions made in context
  - Explores Local Rationality
    - Attentional Dynamics
    - Knowledge Factors
    - Strategic Factors

Systemic Mapping

- Multidisciplinary
- Based on AcciMap model
- Explores identified Learning Points and their influences at different levels of the system
  - Frontline Staff
  - Agency Leadership
  - CQI
  - External
  - Government/Legislative
  - Ad Hoc Members as needed



Systems Analysis Tool

- Identifies Underlying Systemic Themes
- Targets resources and interventions during recommendation process

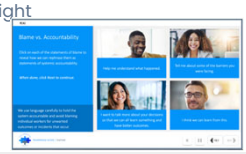
INTEGRATION INTO EVERYDAY OPERATIONS

Integration into Everyday Operations

- Management and supervision guided by Safety Science
- Changes how we:
  - Talk about work
  - Support quality work
  - Meet metrics
  - Treat staff
  - Support teamwork
  - Promote psychological safety

Integration into Everyday Operations

- Leadership/Management/Supervisors
  - Learning Labs
- eLearns
- Front-Line, Licensing, QA, Other Oversight
  - Advanced Practical Training



WASHOE COUNTY

Collaborative Safety Partner Agency Data

RETENTION

Retention Data

- Tennessee DCS (CY 2014 - CY 2015)
  - Shelby County (Memphis)
    - 400% improvement in turnover
  - Mid Cumberland Region
    - 250% improvement in turnover
  - Davidson County (Nashville)
    - 93% improvement in turnover

Retention Data

- Heritage Christian Services
  - (CY 2017- CY 2019)
    - 2017: 43% turnover
    - 2019: 29% turnover
- Arizona Department of Child Safety
  - (CY 2015 - CY 2018)
    - 2015: 60% turnover
    - 2018: 25% turnover

Retention Data

- Minnesota Department of Human Services (CY 2016 - CY 2018)
  - 2016: 18% turnover
  - 2019: 5% turnover
- Hennepin County HHS (Minneapolis) (CY 2016 - CY 2018)
  - 2016: 20% turnover
  - 2018: 7% turnover

CULTURE CHANGE

Culture Change Data

- Enhanced Accountability
  - Created a more neutral and shared way of talking and thinking about critical incidents
  - Shifted language in the workplace from emphasis on individual accountability and laying blame on particular individuals to the systemic nature of the processes and practices involved in child protective services

MINNESOTA

Culture Change Data

- Improved Communication
  - This shift to a shared, neutral, systemic language improved communication between the regions/counties and the state
  - Created a systemic way of looking at the agency that opened the whole organizational work structure for inspection, analysis and improvement
- Improved Media Response
  - There was a shift from language of blame to one that emphasized system analysis and institutional improvement

MINNESOTA

Minnesota Pre CS

StarTribune

Dayton called Pope County's handling of Eric's case a "colossal failure," and said they should have followed through with the requirement to notify law enforcement of maltreatment reports.

"That's just inexcusably and immorally negligent," he said.

Minnesota Post CS

"County child welfare workers work hard to protect children every day, and strive to meet the best interests of children and their families. It is frustrating when the public only hears one side of the story," said Minnesota Department of Human Services Commissioner Emily Piper in a statment.

"I can say with confidence that county child welfare workers are doing their best, day in and day out," Piper said in her statement. "It's a difficult situation to remove children from their parents' custody and such decisions are not made lightly. The preference is to place children with family members when possible."

FINAL DISCUSSION

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