TRANSFORMING CULTURE | TOGETHER

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# Child Welfare

# Time for Something New

NEWS

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

<p>IMAGE DISTRIBUTED FOR COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES â Staffers from the Tennessee Department of Childrenâs Services Offices of Child Health and Safety Noel Hengelbrok (from left), Scott Modell, and Michael Cull speak during a public meeting of the Commission to Eliminate Child Abuse and

# 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.

# Safety Science in Child Welfare

## Blame to Accountability

*To understand how to learn and improve as an organization.*


**Applying quick fixes to understanding underlying features**

*To make meaningful change and address the real problems.*

## Simple to Systemic Models of Learning

*To use models of learning that are compatible with the complex world we work in.*

# Critical Incident Reviews

## Integration of Safety Science

# Systemic Reviews

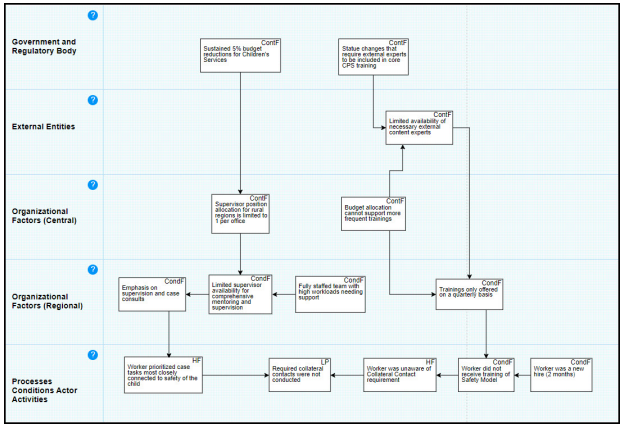
- Departs from Blame
- Integrates safety science into the learning process
- Establishes an environment that promotes staff engagement
- Values staff perspective
- Compatible with complexity of work

# Human Factors Debriefing

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

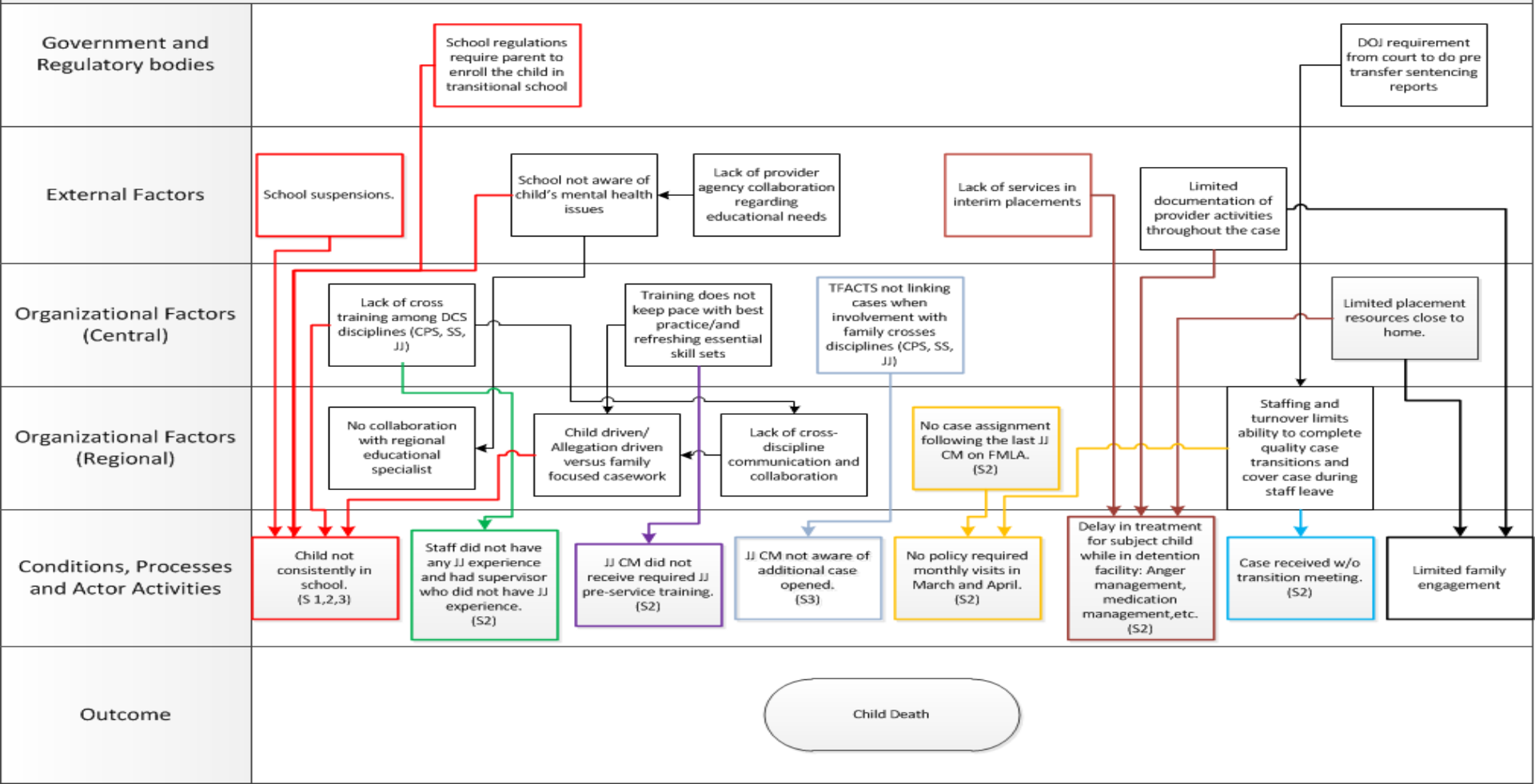
# Systemic Mapping

- Multidisciplinary
- Based on AcciMap model
- Explores identified Learning Points and their influences at different levels of the system
  - Frontline
  - District
  - Central Office
  - External
  - Government/Legislative



# Safety Systems Map- Child Death/Near Death

Case No.:



# Systemic Review Conducted for OCFS

## 5 Total Cases Reviewed

- Human Factors Debriefing
  - 8 HFD completed
- Systemic Mapping Onsite
  - 3 Days of Mapping
    - Over 240 staff/person hours (internal/external)

# Key Findings

- The Impact of the Covid-19 Pandemic,
- The Contribution of Turnover,
- The Constraints of Timeframes,
- Standby Staffing Patterns,
- Communication and Coordination with Providers,
- Difficulty Engaging Caregivers,
- Family Team Meeting Coordination, and
- Communication between Partners: Law Enforcement & Hospitals.

# Recommendations

1. It is recommended that OCFS work with a coalition of providers to support effective coordination with child welfare staff (e.g., supporting families, court and Family Team Meeting participation, sharing information, etc.) and address any identified barriers.
2. It is recommended that OCFS establish joint protocol agreements between Law Enforcement, Hospitals and Child Welfare staff when there is suspected abuse or neglect to support communication and coordination.
3. It is recommended that OCFS explore ways to support consistent practices, including role clarity and ongoing support for Family Team Meetings.
4. It is recommended that OCFS explore ways to support engagement between parents and the child welfare system, such as parent partner/parent mentor programs.
5. It is recommended that OCFS continue to examine national best practices regarding standby and after-hours practices.
6. It is recommended that OCFS examine national best practices for assessment timeframes and ensure that whatever timeframe is selected, it is compatible with the expected workload.
7. It is recommended that OCFS conduct an analysis of current work tasks required in an assessment and remove any unnecessary and/or redundant tasks.