

Collaborative Safety Model

May 31, 2019

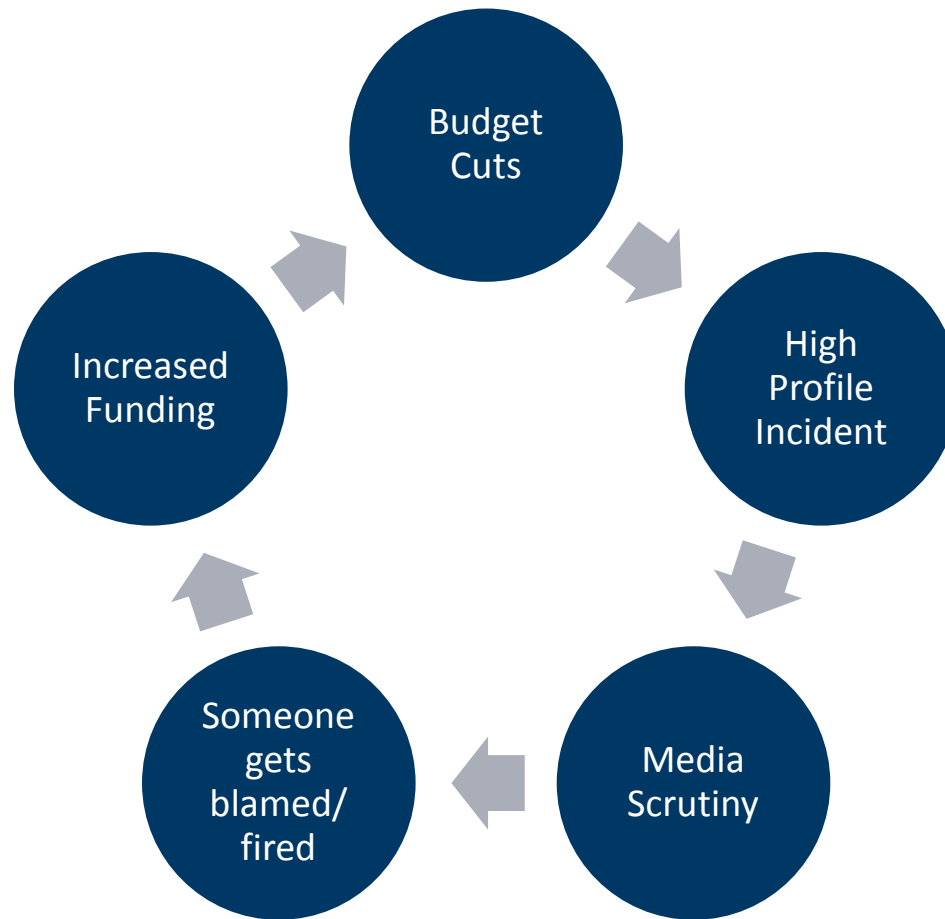
Charles Young, DHS – Disability Services

Aric Gregg, DHS – Disability Services

Overview

- DSD launched a pilot to learn systemic influences of critical incidents
- DHS Child & Safety Permanency uses the same review model
- Goals:
 - culture change
 - reduction in critical incidents
 - system improvements
 - support direct support staff in a complex system
- Pilot Counties: Blue Earth, Hennepin & St. Louis
 - Only incidents occurring in those counties in 245D settings

Human Services Across America



Old View – Bad Apple Theory

- Systems are set up to not fail
- Humans are the cause of most errors
- Systems should identify the ‘bad apples’ and remove them



**System response
cycle example:
Georgia**

Child welfare – Georgia

Updated: 9:57 a.m. Thursday, April 12, 2012 | Posted: 5:38 a.m. Thursday, April 12, 2012

Hit hard by budget cuts, DFCS strains as workload jumps

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By [Shannon McCaffrey](#) and [Craig Schneider](#)

The Atlanta Journal-Constitution

More abused and neglected children are getting state protection under an aggressive new policy mandate, but deep budget cuts are threatening efforts to help those children and their families heal, The Atlanta Journal-Constitution has found.

The Division of Family and Children Services lost 28 percent of its state funding for child welfare services over five years and is bracing for the loss of millions in federal dollars. Now, under a new regime, DFCS is emphasizing children's safety by opening thousands of additional investigations and taking hundreds more children into foster care.

DFCS investigating alleged child abuse deaths

News | Nov 05, 2013

By Alexis Stevens, The Atlanta Journal-Constitution

Eric Forbes and Emani Moss lived 60 miles apart. But together, their tragic deaths allegedly at the hands of their parents could spark changes for the state agency responsible for protecting children.

Georgia's Department of Human Services Division of Family and Children Services said late Tuesday it is investigating its own actions in the lives of the two children.

Two DFCS employees fired after two child deaths



FORBES FAMILY RESPONDS TO FIRED DFCS WORKERS



6:05

57°

11ALIVE DATELINE: FAILED TO DEATH | DFCS PETITION

ROME MOTHER CHARGED

HEADLINES: CAMDEN CO. DEPUTY SHERIFF DRESSED AS BLACK JAIL INMATE SUSPENDED

Another child welfare leader likely leaving

Sept 20, 2017

By Craig Schneider, The Atlanta Journal-Constitution

State child protection director Bobby Cagle, who brought a rare sense of stability if not optimism to the long-troubled Division of Family and Children Services, is likely leaving to take a similar job in Los Angeles.

His departure would leave the agency once again facing a void in leadership, having gone through about 10 directors in 20 years.

Local

6:00 AM THU NOVEMBER 14, 2013

Deal Proposes \$27M DFCS Funding Boost

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By [MICHELL ELOY](#)

Gov. Nathan Deal says he wants to expand the Division of Family and Children Services.

His plan, which will be introduced in his upcoming FY2015 budget proposal, calls for hiring about 500 DFCS case workers and supervisors and increasing the division's budget by nearly \$27 million over the next three years.



**Critical incidents:
Old view responses**

New York – Incident

Hidden camera leads to charges against 17 workers at nursing home

Rachel Kingston, News & Reporter
Published: April 25, 2014, 9:05 pm



The 17 employees are charged with first degree falsifying business records, first degree endangering the welfare of an incompetent or physically disabled person and willful violation of public health laws.

New York – Agency Response

The facility at Michigan Avenue and High Streets in Buffalo's Medical Corridor, is operated by Kaleida Health and serves both adult and pediatric patients.

Kaleida Health said in a statement Thursday that it “has terminated 17 employees for neglectful care of one resident. This behavior, and lack of appropriate care, is unacceptable and will not be tolerated. When we were made aware of the situation, we took action.” Kaleida Health, through its office of internal Audit and Compliance, has been working cooperatively with the Attorney General's office on this investigation.”

At a Springfield home owned by Sparc, a caregiver forgot to give a man his anti-seizure medication before sending him to a day program in 2013. The man suffered a major seizure, turned blue and was treated at a hospital.

Illinois – Agency Response

Sparc's chief operating officer, Ryan Dowd, said his company fired the caregiver and added more surveillance cameras in its group homes and switched from paper to electronic medication records.

California – Incident

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.

California – Agency Response

Agency (Director) Response to Media:

“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.

Minnesota – Budget cuts, Feb. 2011

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Child protection among losers in first round of budget cuts

Tom Scheck · St. Paul, Minn. · Feb 9, 2011

Politics



LISTEN Story audio

4min 6sec

Leaders of the the new Republican majorities in the Minnesota Legislature have pledged to balance the state budget by cutting spending.

They've also said those spending cuts would not impact the state's most vulnerable residents, but their first budget bill may break that promise.

Among a package of \$900 million in cuts is \$13 million a year in funding for Child and Community Service Assistance grants.

The House is scheduled to take up the measure this afternoon.

Counties rely on the funding for a variety of programs, but in the state's most populous county, it's used primarily for child protection.

"The state simply isn't stepping up to its responsibility in terms of funding the most vulnerable," said Deborah Huskins is the Human Services and Public Health Area Director for Hennepin County.

"If you look at the big picture, there's a whole lot of areas that would be happy with flat spending. It's all relative here."

Minnesota – Incident in 2014

CTIONS | 

 **StarTribune**

Eric Dean: The boy they couldn't save

Special report: On 15 occasions, day-care workers and others told Pope County authorities that they suspected Eric Dean was being hurt. But it was not enough. His death exposes the failure of a system charged with protecting the youngest Minnesotans.

By **Brandon Stahl** Star Tribune | SEPTEMBER 1, 2014 — 2:38PM



Minnesota – System Response I (Sept 2014)

SECTIONS | 

Cub

 **StarTribune**

STATE + LOCAL

Lawmakers: Child-protection system failed Eric Dean

Legislators in both parties insist that child protection must do a better job.

By **Brandon Stahl** Star Tribune | SEPTEMBER 4, 2014 — 12:12AM



A photo of Eric Dean, taken by a special education teacher, was presented during the trial of Amanda Peltier, his stepmother.

Minnesota – System Response II (Nov 2014)

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 **StarTribune**

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STATE + LOCAL

State names new official to head child protection

The appointment of James Koppel comes amid reports of repeated failures of state's child protection system.

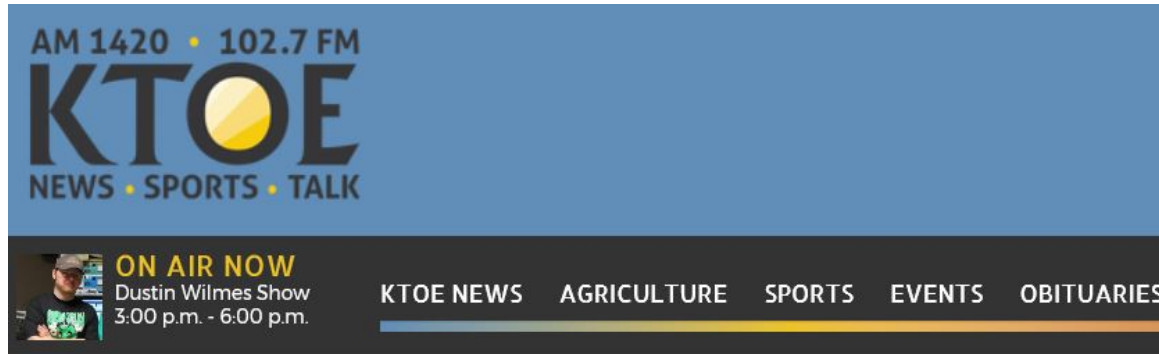
By **Chris Serres** Star Tribune | NOVEMBER 27, 2014 — 6:19AM



, DML -

Jim Koppel, the new head of child protection services,

Minnesota – System Response III (June 2015)



Minnesota counties to get increase in child protection service funding

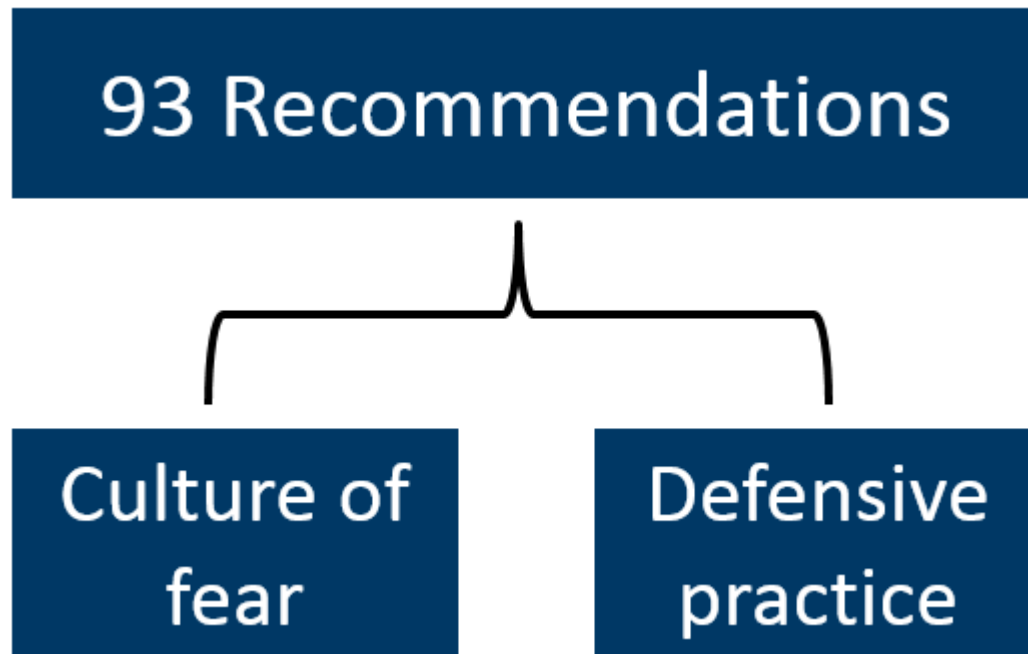
Written by Wendy Wilde on June 26, 2015

Minnesota counties to get increase in child protection service funding

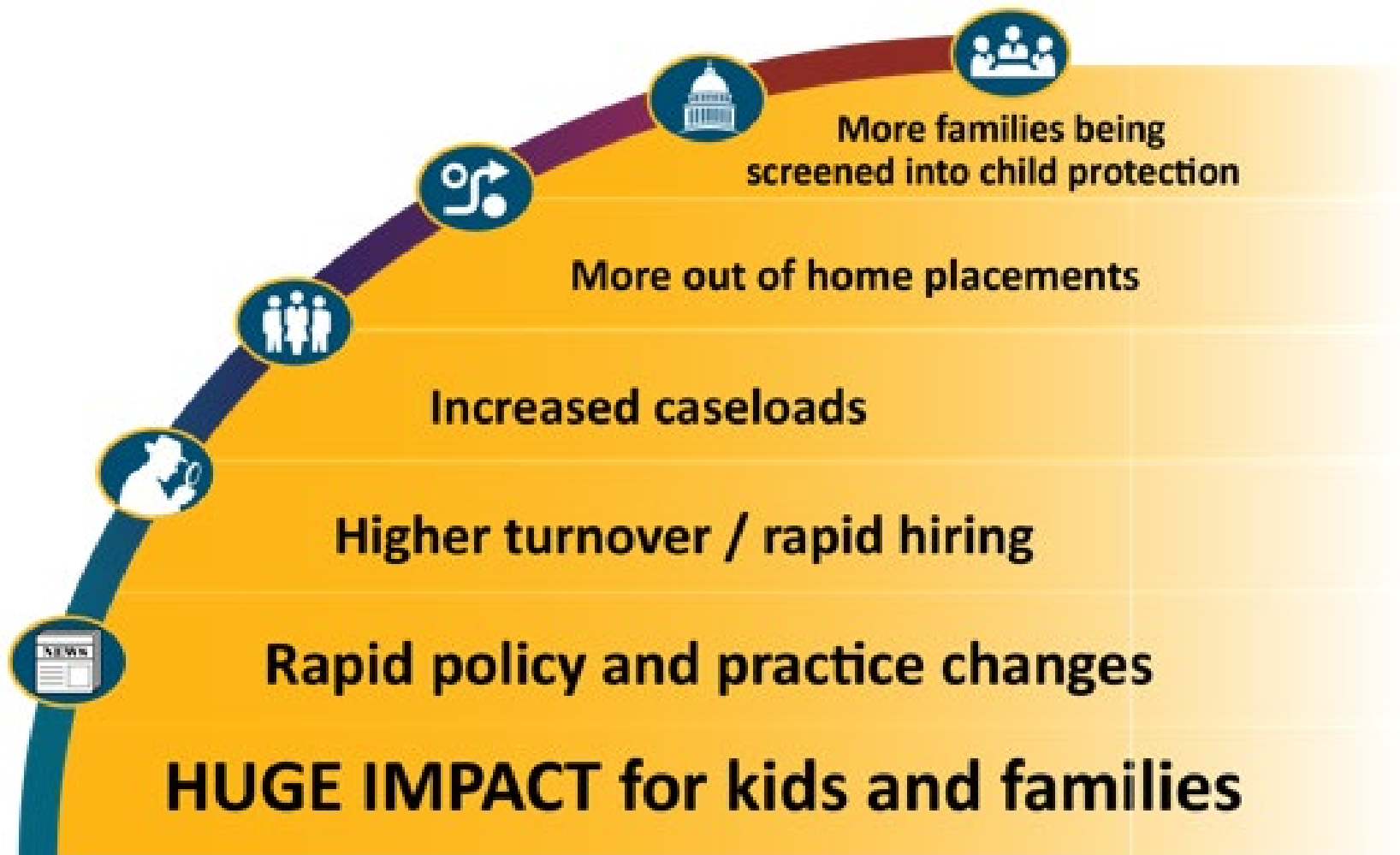
New money is being dedicated to improving child protection in Minnesota.

“In order to implement the reforms that the task force was recommending that was in my legislation, we have had to cut the state’s portion of child protection services by about 41 million every year. For close to ten years, we have cut the state’s portion of resources that go to counties to support child protection. So, there’s a huge variation of money being spent that way because it’s property taxes that have to fill the gap,” says State Senator Kathy Sheran of Mankato. She says some counties have used property taxes to fund the services while others have cut back. The new funding should help to improve child protection across the state.

One case...

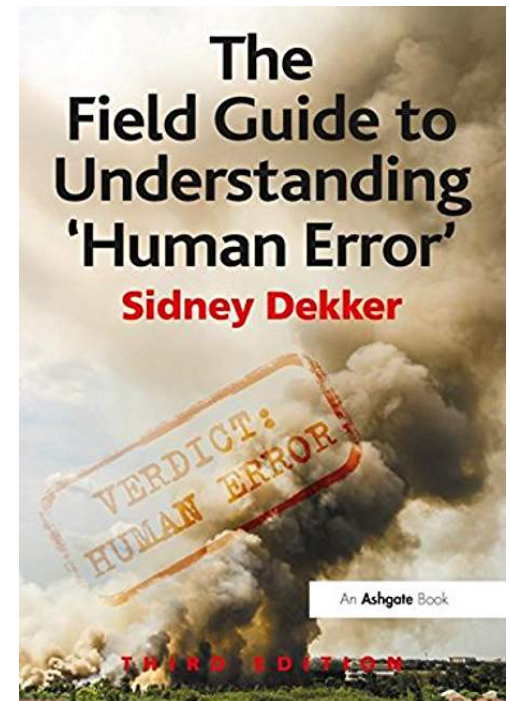


Culture of fear & defensive practice



Time for something new: Collaborative Safety

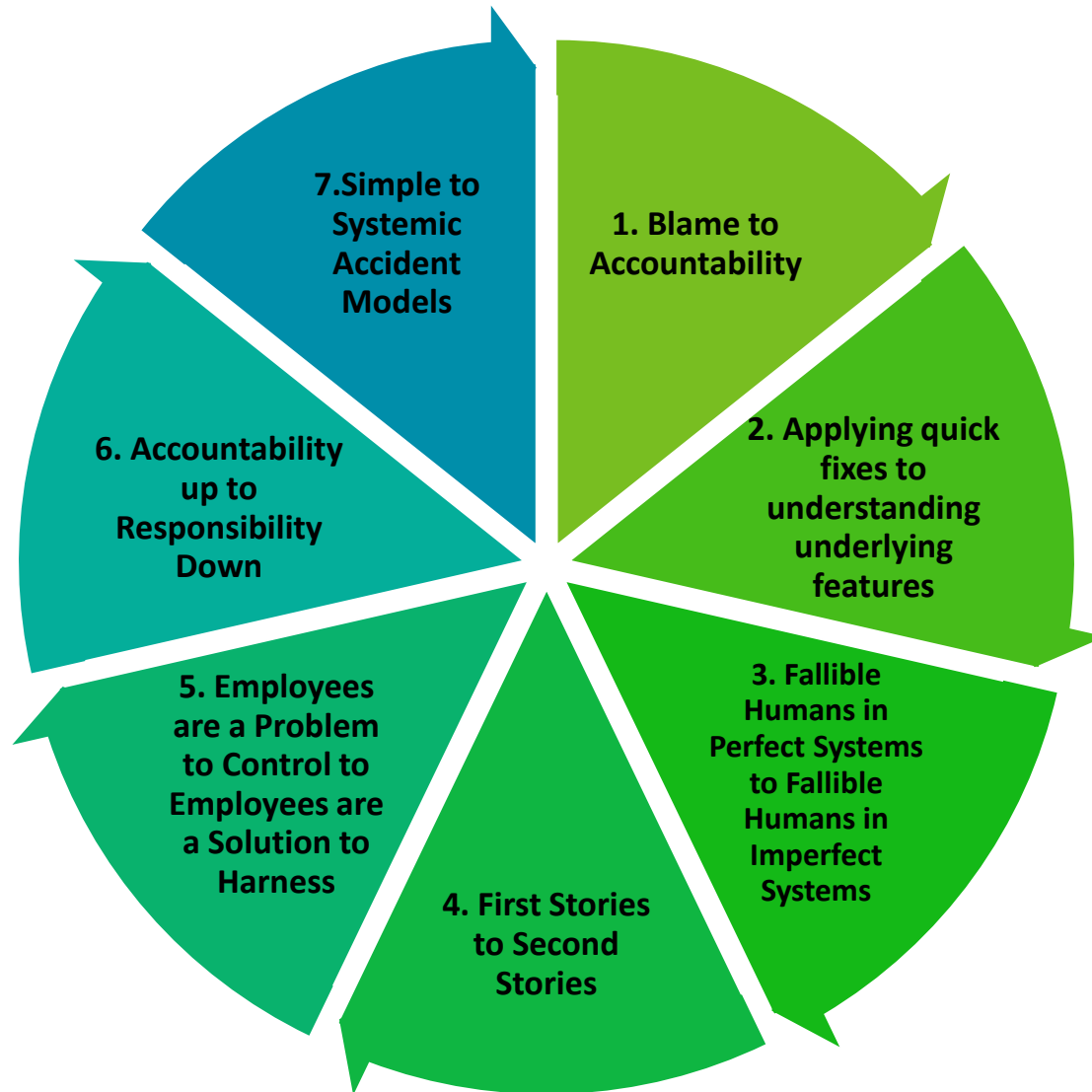
- Based in Human Factors and Systems Safety (Safety Science)
- Used by other Safety Critical Systems such as Aviation, Healthcare, and Nuclear Power
- Integrates Behavioral Analysis, Forensic Interviewing, and Trauma Informed Science
- Includes a robust, scientific, trauma-informed review process



Time for something new: Collaborative Safety II

- Moves away from blame and toward a system of accountability
- Focuses on identifying underlying systemic issues to improve Human Services systems
- Review process is embedded within a larger framework to support and advance a safety culture.

7 Transitions to a Safety Culture



#1: Blame to accountability

- To understand how to learn and improve as an organization.
- Blame actually decreases accountability
- Hold ourselves and our system less accountable
- Inverse relationship between blame and accountability
- Shuts down the learning process
- Need to hear from those that experience the event

Brené Brown on Blame

RSA
SHORT



#2: Applying quick fixes to understanding underlying features

- To make meaningful change and address the real problems
- Move away from immediate responses such as:
 - More training
 - More forms
 - More policies
 - Recommend that people “try harder”
- Step back and understand that there are features of our system support or do not support our work



#3: Fallible humans in perfect systems to... fallible humans in imperfect systems

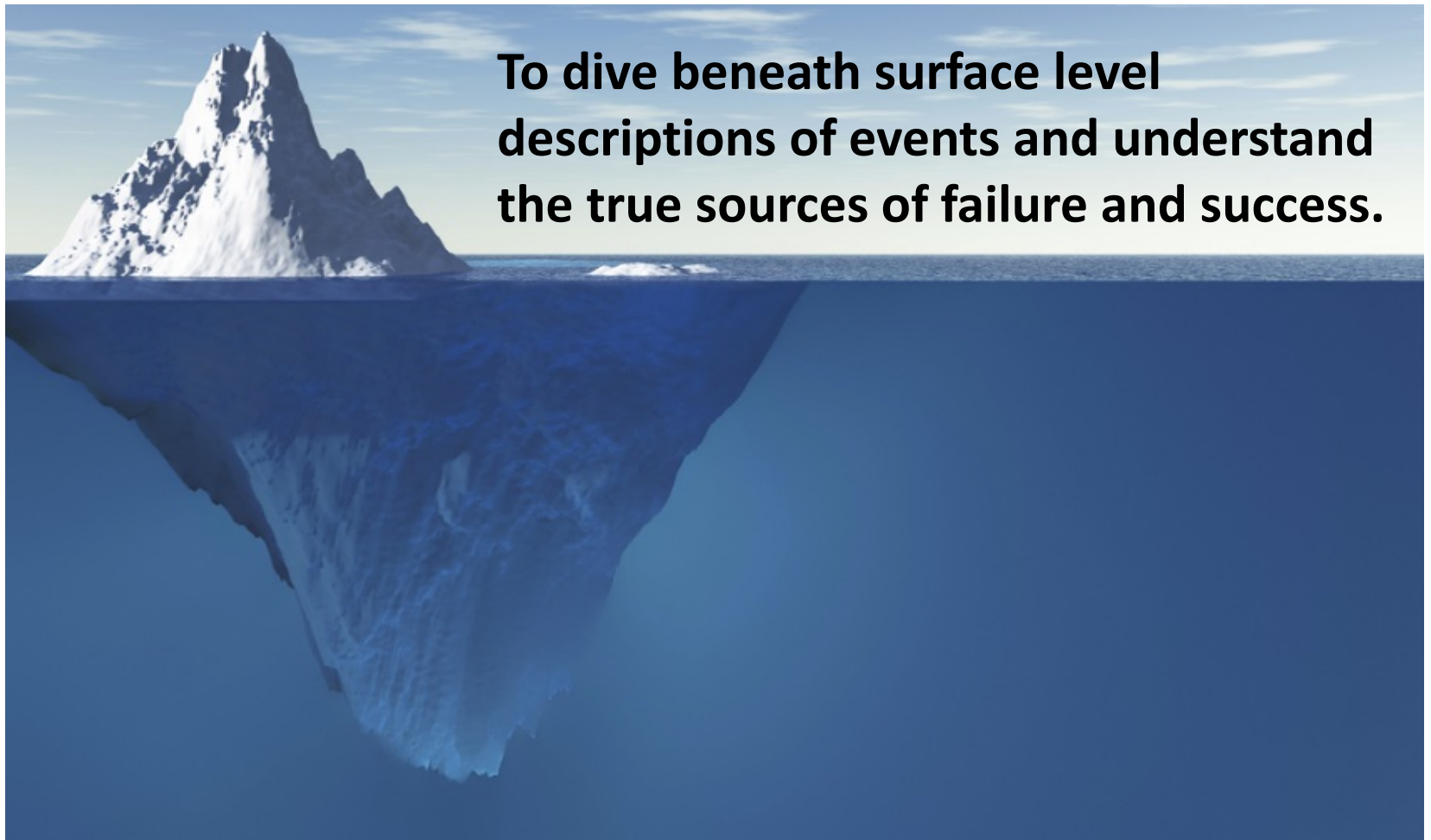
Hawaii's false missile alarm



Competing Contingencies

- To learn the role of the system on organizational outcomes
- A number of competing contingencies:
 - Fiscal
 - Policies
 - Procedures
 - Agency initiatives
 - Legal
 - Legislative
 - Quality of life
 - Many more...

#4: First stories to second stories



Local Rationality

Rational Choice Theory



Understanding Decision Making in Context



- Knowledge
- Attention
- Goals

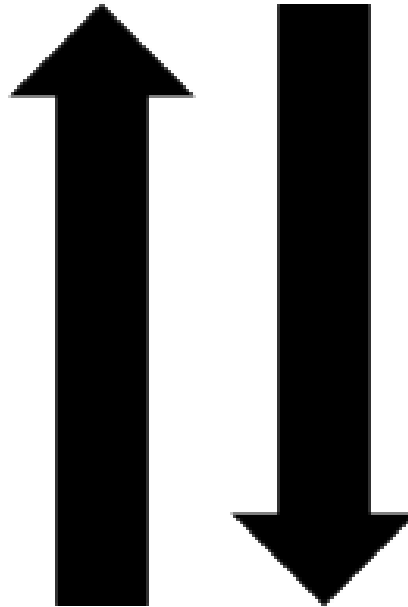
#5: Employees are a problem to control to... employees are a solution to harness



- Embracing new view that recognizes imperfect systems
 - Creating an environment where communication is encouraged
-
- Learning from 'near misses'
 - Withhold quick fixes, step back and try to understand the complexity and interplay of systemic features

#6: Accountability up to responsibility down

Shift from a focus on compliance to support



#7: Simple to System Accident Models



To use accident models that are compatible with the complex world we work in.

Why use Collaborative Safety?

We need to understand together how individuals operate and make decisions in our system and how our system influences decisions and those operating our disability services.

Culture change and expected outcomes from the Collaborative Safety Model

- Improved staff engagement and staff retention
- Increased accountability and improved systems in place
- Increased public trust
- Improved outcomes for people served
- A robust and proactive response to critical incidents
- A responsive system dedicated to learning
- Improved outcomes from a system dedicated towards improving the reliability and safety of provided services
- Increased trust in the provision of care

Expected Outcomes – Turnover/Retention

- Tennessee DCS Snapshot
 - Shelby County
2014-2015 – 400% improvement in vacancy rate (turnover)
 - Davidson County (Nashville)
2014-2015 – 93% improvement in vacancy rate
- Arizona DCS Snapshot
 - 2015: 50-60%
 - 2018: 20-25%
- Minnesota, Hennepin County Snapshot
 - 2016: 20%
 - 2018: 7%

Critical incidents: New view responses

Tennessee: Use of model, May 2014

THE TENNESSEAN

A GANNETT COMPANY

TN examines child deaths with more care

 **Tony Gonzalez**, tgonzalez@tennessean.com 11:57 p.m. CDT May 7, 2014



(Photo: Samuel M. Simpkins / File / The Tennessean)

STORY HIGHLIGHTS

- High caseloads make work tough for TN child abuse investigators.
- After problems, the state has a new way of reviewing child fatalities.
- So far in 2014, DCS has opened 69 child death investigations.

f 85 | **85** | **2** | **2**

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Tennessee's child abuse investigators, who confront life-or-death decisions about whether kids are safe in their homes, haven't always been willing to talk when things go wrong — when children die or suffer severe injuries.

And for at least a couple of years, caseworkers didn't have to say much of anything.

The Department of Children's Services fell behind on internal reviews of child deaths. When they did look back, the reviews did little to explain what led to each incident, or what might save other children.

That's changing.

The department recently completed its first year of new, more immediate and more exacting death reviews as required by a federal judge. A court order requiring changes followed [a Tennessean](#)

Tennessee: Agency Response, April 2016

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DCS makes 'massive turnaround,' nears end of 15-year case

Anita Wadhvani, awadhvani@tennessean.com 2:51 p.m. CT April 11, 2016

402


f TWEET LINKEDIN COMMENT EMAIL MORE



(Photo: Submitted)

More than 15 years of federal court oversight of Tennessee's foster care system is nearing an end, with the Department of Children's Services demonstrating in court Monday that it has complied with all orders.

The case began in 2000, when attorneys for the New York-based advocacy agency Children's Rights filed suit over the state's treatment of kids in foster care. Named after "Brian A" — a 9-year-old boy



Tennessee: Federal Court Response, 2016

“The child death review process is well designed, transparent and appropriately implemented, a court report said, noting the previous system relied on hand counts to custody deaths. Last year, the department reviewed 123 child deaths or near death. Now the department is able to see patterns and take preventative measures. In one example, the department is now making more safe sleep furniture available to families after noticing a pattern of infant deaths because families lacked such equipment.”

DCS Commissioner Bonnie Hommrich said Monday that, “We are elated at what we’ve accomplished.” Hommrich promised the agency would keep making improvements even after the legal case ends and said the agency has been able to deploy nurses, educational experts and other professionals to serve foster children in a way that “focuses on their whole life.”

Arizona – Incident, 2016

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

Arizona – Agency Response 1

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. But our powers are limited; we cannot predict the future; and people, can at times, do awful things. 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."

The story stopped that day.

Arizona – Agency Response 2

How Arizona Fixed Its Broken Child Welfare System in 2 Years

The state attracted national attention for its failure to prevent and address child abuse and neglect. Since then, massive changes have led to massive improvements.

BY J.B. WOGAN | APRIL 27, 2017



Greg McKay has been director of the Arizona Department of Child Welfare.

We've implemented what we call "a safety culture." We're not going to talk about people as failures as much as the systemic and process failures that lead to outcomes that we would like to be different. That's had a huge impact. Our turnover rates are now in the mid-20s.

Minnesota: Old view response



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: New view response

"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 statement.

Minnesota: New view response II

Removing a child from home is never just one person's decision. Social workers and other staff work on the front lines, and a judge makes the ultimate custody decision.

“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.”

Overview of the Collaborative Safety Model in Disability Services

- Duplicating approach used by DHS Child & Safety Permanency
- Review critical incidents – seek out systemic influences
 - Pilot Counties: Blue Earth, Hennepin & St. Louis
 - Only incidents occurring in those counties
- Culture change: from blame to accountability
- Support direct support staff in a complex system

Trainings and Pilot Project

Trainings to learn about Safety Science...

- Orientations
- Safety Leadership Institutes

This pilot project will conduct critical incident reviews in...

- Blue Earth, Hennepin, St. Louis counties
- 245D licensed settings

MN's Collaborative Safety Review Structure

Critical incident types...

- Elopement
- Medication error
- Staff sleeping on duty
- Use of prone restraint
- Wheelchair safety

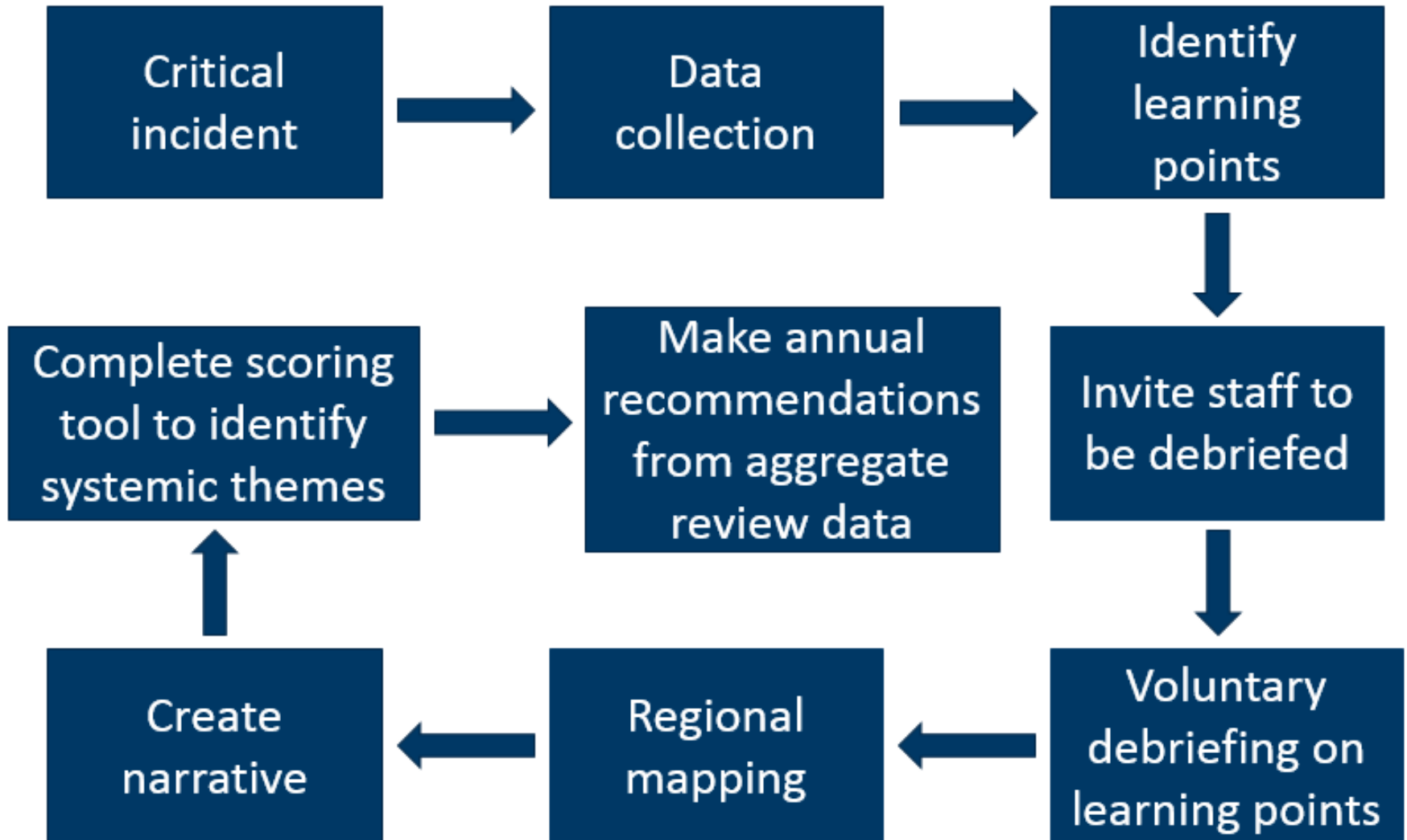
Data for the case reviews originates from...

- Behavior Intervention Report Form (BIRF)
- DHS Licensing Investigations

Safety Analyst Review Team

- Group of 10 individuals from DHS and pilot counties
- Completed 4-day training
- Responsible for leading the review process for cases
- Will review 5 new cases a month
- Pilot timeline: May 15, 2019 to December 31, 2019

Minnesota's Collaborative Safety Review Process



Human Factors Debriefing

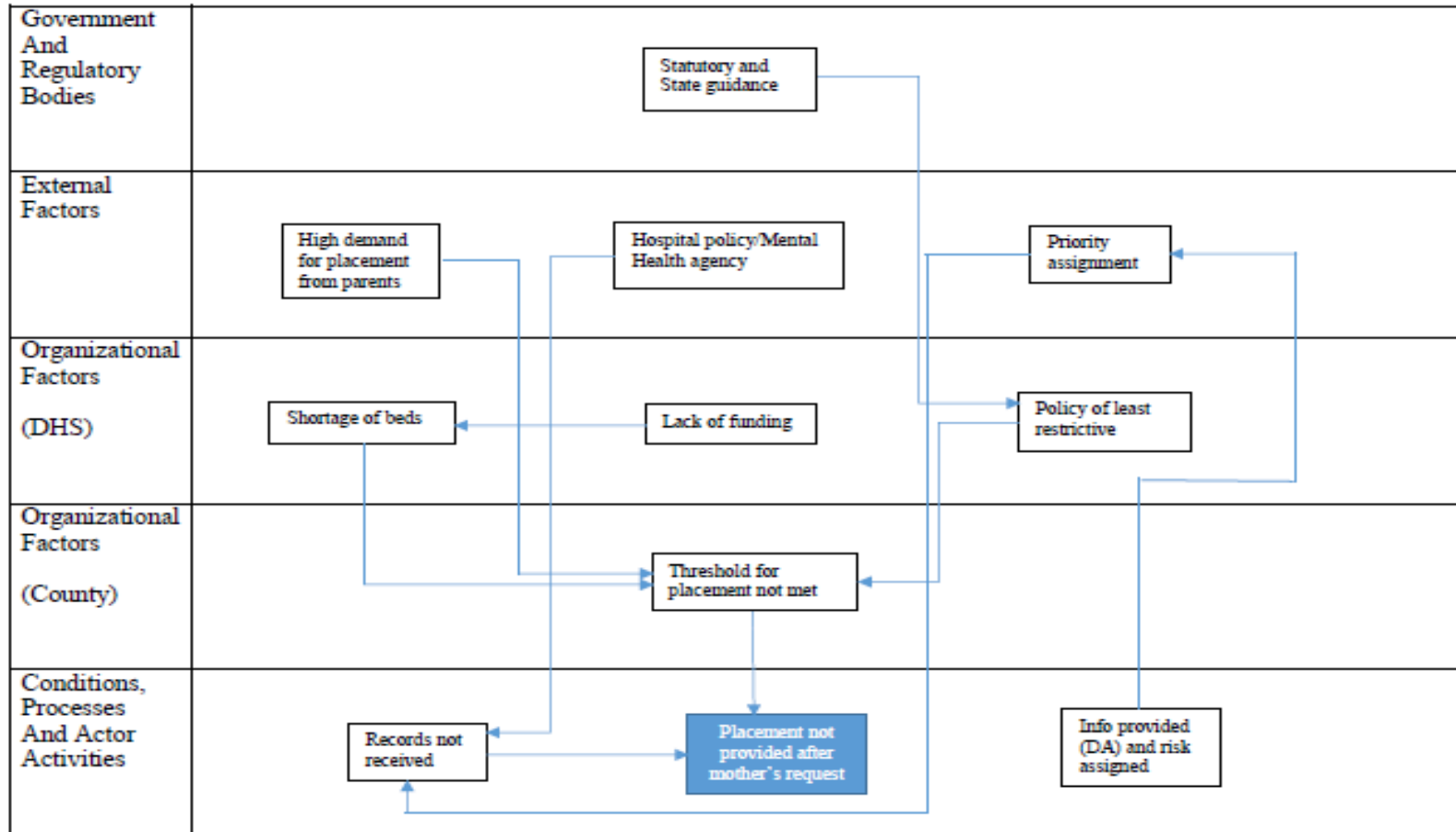
- Voluntary 1:1 debriefing
- Purpose: learning about local rationality
 - The “why” behind someone’s decisions or actions
 - Not a value judgment about right or wrong
 - People make decisions that are locally rational given a number of complex variables

Systems Mapping

- Uses technical case data and human factors data
- Create a clear and relevant picture of the event within context
- Allows for the exploration of any issues from a systems perspective
- Mapping teams will be created to carry out this work.
 - Including staff from provider organizations, lead agencies, and DHS (DSD, Licensing, Investigations)

Map Example

Learning Point



Child Death

- Create 1-2 paragraphs of detailed context
- Explains how identified influences played a specific role in the critical incident
- The map is used to create the narrative
 - Comprehensive story

Systemic Analysis

- Identifies and captures relevant systemic influences such as:
 - Prescribed practice
 - Knowledge gap
 - Demand-resource mismatch
 - Production pressure
 - Documentation
 - Fatigue, etc.
- Aggregated and used to develop recommendations

Systems Analysis Tool Example

Systems Analysis Tool

	0	1	2	3	
Medical Records Policies	0	1	2	3	<p>Learning Point 1: The development of the agency's threshold for placement was shaped by local and state policy and guidance that supports and encourages least restrictive interventions prior to placement. In addition, the child's needs did not meet the threshold for placement.</p> <ul style="list-style-type: none"> • Least Restrictive – Minnesota Statutes Chapter 260C and Minnesota Rules, parts 9560.0223 and 9560.0545; Children's Mental Health Act, sections 245.467, 245.457 and 245.4876 • 10 Best Interest Factors – 260C.212, Subdivision 2
Production Pressure	0	1	2	3	<p>Learning Point 2: Due to the multiple tasks required during this case, the worker had discretion to prioritize competing caseload tasks. As a result, the decision to complete a safety plan was a lower priority task in this case because there was no indication the child was suicidal and that a safety plan was needed.</p>
Service Array	0	1	2	3	
Stress	0	1	2	3	
Supervisory Support	0	1	2	3	
Procedural Drift	0	1	2	3	

- Began case reviews May 15, 2019
- Currently offering trainings about safety science and the review model
 - June 11: Duluth
 - June 12: Brooklyn Center
- Review about 30-40 cases in 2019
- Initial pilot project ends December 31, 2019
- Continuation and expansion: TBD



Questions and Discussion

Thank you!

Charles Young, DHS

Aric Gregg, DHS