DEPARTMENT OF HUMAN SERVICES

Collaborative Safety Model
State of Minnesota
Child Safety and Permanency Division

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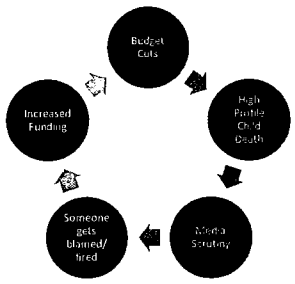
Today and Tomorrow

- Child Welfare across the U.S.
- MN's Journey away from a Culture of Blame and towards a Culture of Safety and Accountability
- Collaborative Safety Model
- Scientific Underpinnings of Safety Science
- Implementation of the Model in MN

~~Blame Culture~~

How Minnesota got here

Child Welfare Across America



Georgia

Georgia

Updated: 8:57 a.m. Thursday, April 12, 2012 | Posted: 8:36 a.m. Thursday, April 12, 2012

Hit hard by budget cuts, DFCS strains as workload jumps

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Photos: Agency faces funding cuts

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Phil Skinner

By Shannon McCaffrey and Craig Schneider
The Atlanta Journal-Constitution

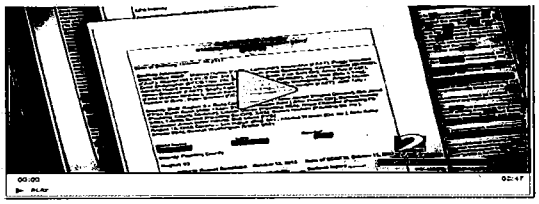
More abused and neglected children are getting state protection under an aggressive new policy mandate, but deep budget cuts are threatening efforts to help those children and their families heal, The Atlanta Journal-Constitution has found.

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.

Georgia

Posted: 9:14 p.m. Tuesday, Nov. 5, 2013

DFCS investigating alleged child abuse deaths



Related

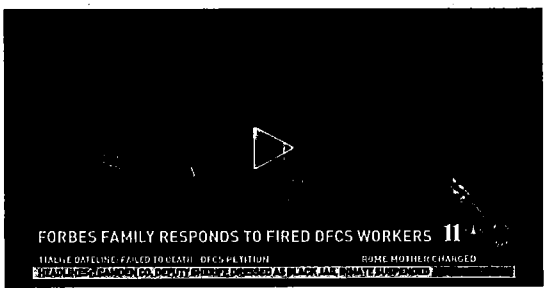
Father charged with murder claimed boy drowned

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

Two DFCS employees fired after two child deaths



Georgia

New DFCS director starts Monday

Gov. Nathan Deal announced a change of leadership in the troubled Division of Family and Children Services that includes a new director. | Alive News

Georgia

Local 6:00 AM THU NOVEMBER 14, 2013

Deal Proposes $27M DFCS Funding Boost

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By MICKELL 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.

Florida

Florida

Budget Cuts Lead to Loss of Staff at DCF

Gov. Scott is cutting nearly 500 positions in the Department of Children and Families

Tuesday, May 24, 2011 | Updated 10:38 AM EDT

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Rick Scott

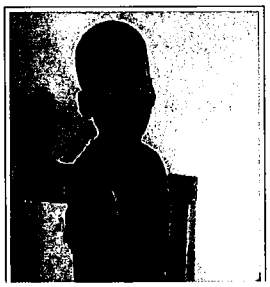
The Department of Children and Families is cutting nearly 500 positions to save the state $48 million as Gov. Rick Scott tries to balance the state budget and slash spending by nearly $4 billion, the agency said Monday.

Secretary David Wilkins said critical services will not be affected. About half the positions will come from three state hospitals: Florida State Hospital, Northeast Florida State Hospital and

Florida

CHILD WELFARE

DCF roiled by another child's death



BY CAROL MARBIN MILLER
CMARBIN@MIAMIHERALD.COM

For the fourth time in six weeks, the state Department of Children & Families is investigating the death of a Florida child who, only weeks or months earlier, had drawn the attention of agency administrators.

The latest to die is Ezra Raphael, age 2. Police say they were "summoned" to Ezra's home at 15664 NE 10th Ct. in North Miami Beach, at 11:08 p.m. last Thursday to check on a "sick and unresponsive child." When paramedics arrived, police said in a statement, they found Ezra unconscious on the dining room floor. The toddler was pronounced dead shortly after he arrived at Jackson North Medical Center.

Florida

INNOCENTS LOST

FLORIDA'S UNDERCOUNT OF CHILD ABUSE DEATHS

The state says abuse and neglect deaths are receding after a spike. But are they? And, if so, by how much? A closer look at the numbers.

BY CAROL MARBIN MILLER AND AUDRA D.S. BURCH

Florida

POLITICS

Florida DCF head David Wilkins resigns

BY CAROL MARBIN MILLER AND MARY ELLEN KLAS
CMARBIN@MIAMIHERALD.COM

David Wilkins, Florida's top child welfare and social services administrator, resigned Thursday amid an escalating scandal over the recent deaths of four small children who had a history of involvement with child-abuse investigators.

Wilkins is leaving the agency to "pursue opportunities in the private sector and to provide more attention" to a foundation he leads, Gov. Rick Scott said in a statement.

Wilkins, who became the governor's longest-serving agency head, served as secretary of the Department of Children & Families since Scott's inauguration in 2011. But in recent months, Wilkins became mired in a simmering controversy over the deaths of four youngsters in a six-week period, all but one from Miami-Dade and Broward counties. A fifth child, also from Miami, nearly died from a lacerated liver after the agency failed to act when the infant suffered a broken thigh bone months earlier.

Florida

LEGISLATURE 2014

House, Senate settle on $47 million in new money for child welfare

The Miami Herald and WLRN hosted a town hall meeting to discuss Innocents Lost, the investigative series that looked at 477 Florida child deaths by abuse or neglect that occurred over a six-year span.

BY MARY ELLEN KLAS
HERALD/TIMES TALLAHASSEE BUREAU

TALLAHASSEE — With breakneck speed, House and Senate budget negotiators met Tuesday and agreed to $47.8 million in new money for child welfare, far below what child advocates had hoped for but with more money for treatment services than either chamber had originally sought.

The proposal also gives the governor only about $21 million of the $39 million he had asked for to expand child protection services.

The agreement may be only preliminary, said Senate President Don Gaetz, R-Niceville, who said budget negotiators may find additional funds for child welfare programs as they work to finish their $75 billion budget this week.

Tennessee

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."

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.

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

Written by The Tennessean

FILED UNDER

News
News Government - State

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

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

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

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 Times: < 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.

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.

Photo by Associated Press/Times Free Press

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

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: WSMV)

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.

Minnesota

Child Protection Hit Hard with Budget Cuts

MPRnews | Sections Members More

Child protection among losers in first round of budget cuts

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

LISTEN Story audio

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."

Public Outcry Over the Death of Eric Dean

Star Tribune

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.

Legislative Activity

Cub ★Star Tribune

Lawmakers: Child-protection system failed Eric Dean

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

A New Future for Cystic Fibrosis.

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New Leadership

TODAY ★Star Tribune

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.

A New Future for Cystic Fibrosis.

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More Money

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

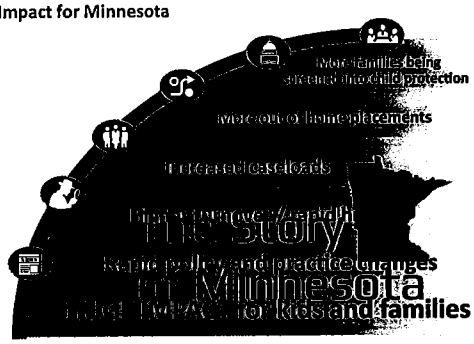
New money is being dedicated to improving child protection in Minnesota.

"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.

Impact for Minnesota

- 93 Recommendations
- Culture of Blame/Fear
- Defensive Practice

Impact for Minnesota



HEALING

- Address 2015 Legislation that governs the On-Site Child Fatality/Near Fatality Review Process
- It's a Partnership
- It had to be different-and as stated by one *Child Protection Local Agency Leader- Safety Leadership Institute Attendee*

"Minnesota's Child Protection System needs healing."

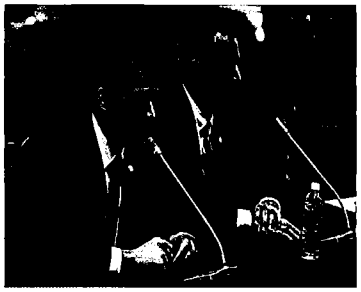
- And so began our work with Collaborative Safety

Collaborative Safety-Who they are

TRANSFORMING CULTURE | TOGETHER

NEWS

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



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Smith deserves some
#Tigers

Collaborative Safety Model

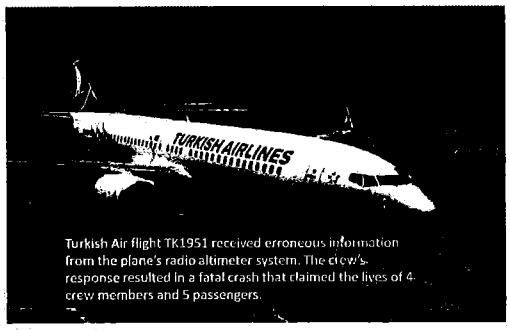
- Moves away from blame and toward a system of accountability that focuses on identifying underlying systemic issues to improve Child Welfare Systems
- Used by other Safety Critical Industries such as Aviation and Healthcare
- Based In Human Factors and Systems Safety (Safety Science)
  - Integrates Behavioral Analysis, Forensic Interviewing, and Trauma Informed Science
- Includes a robust, scientific, trauma-informed review process
- Review process is embedded within a larger framework to support and advance a safety culture.

JUST CULTURE

Key Operating Principles

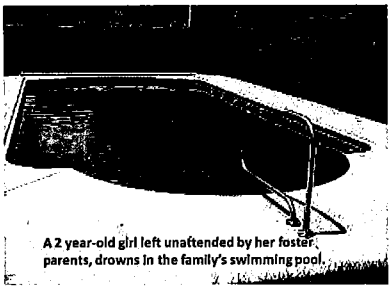
- Staff come to work to do a good job everyday-they care deeply about the work they do.
- We all make decisions that makes sense to us at the time based upon our environment and the system we are working within.
- That environment/system influences our decisions and behaviors.
- In Child Welfare across the Unites States, we know that staff can not follow every policy, every procedure, and every task on every case-there is just too much!

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 year-old 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

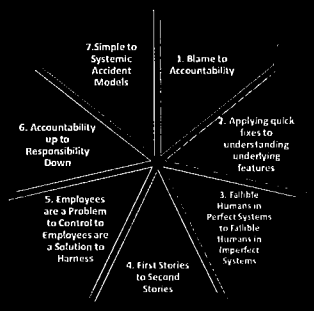
- It is indisputable that OKDHS was **well aware of the hazard associated with the pool.**
- The home **should never** have been approved without a specific and shared understanding between OKDHS and the foster parents about the pool.
- The pool **should have been** removed or a suitably protective fence **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.**

Goad, 2011

[redacted]

Old View	New View
• Human as Cause	• Human as Solution
• Accountability Up	• Responsibility Down
• Learning Ends with Human	• Learning Begins with Human
• Quick Fixes	• Underlying Systemic Issues
• First Story	• Second Story

7 Transitions to a Safety Culture



Scientific Underpinnings

Cultivating a Culture of Learning

In a healthy system, there is no blame.

- Michael J. Schmoker -

Transition 1. Blame to Accountability
To understand how to learn and improve as an organization.

Blame Actually Decreases Accountability

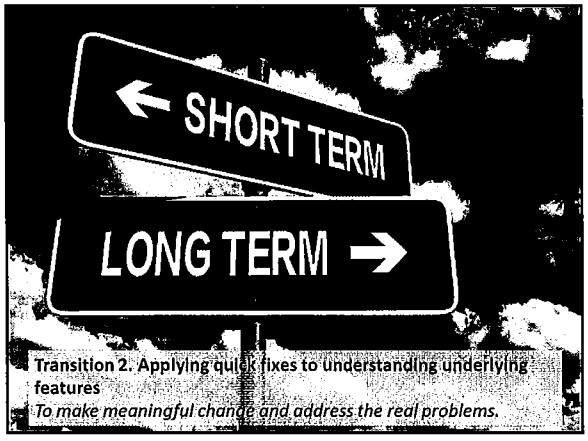
- Hold ourselves and our system less accountable
- Inverse relationship between blame and accountability
- Shuts down the learning process
- Need to hear from those that experience the event

~~BLAME~~
SOLUTION

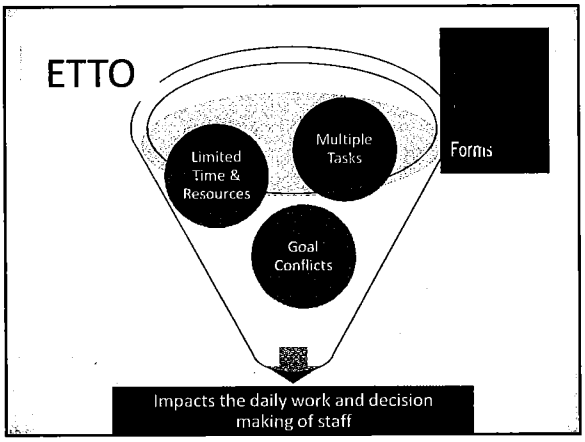
Dr Brené Brown on Blame

Integrating Safety Science into Everyday Work

- Understand from those that experienced the event/outcome?
  - Barriers/challenges/ways to improve
- Individual and system accountability
- Not about shifting blame
- My role-vulnerability
- Use of language

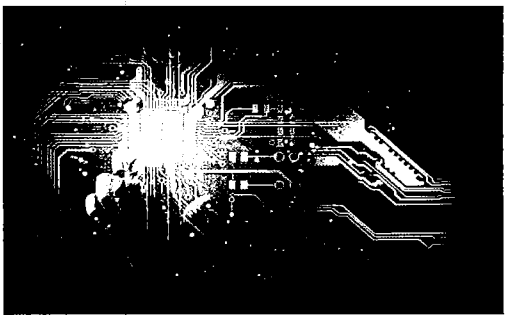


Transition 2. Applying quick fixes to understanding underlying features
To make meaningful change and address the real problems.



Integrating Safety Science into Everyday Work

- Pause, gain perspectives, and learn
- Move away from adding more and "try harder" recommendations
  - Features of our system that support or don't support work- including coordinating activities
- Give attention to the underlying systemic features that make it difficult for staff in any part of our system achieve success
- Recommendations are not made off of one case
  - Critical Incident or otherwise
- Move away from Program Improvement Plans
- Move away from adding more checklists, bull training

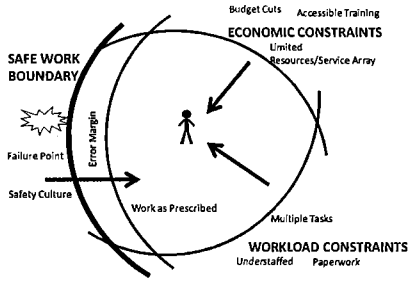


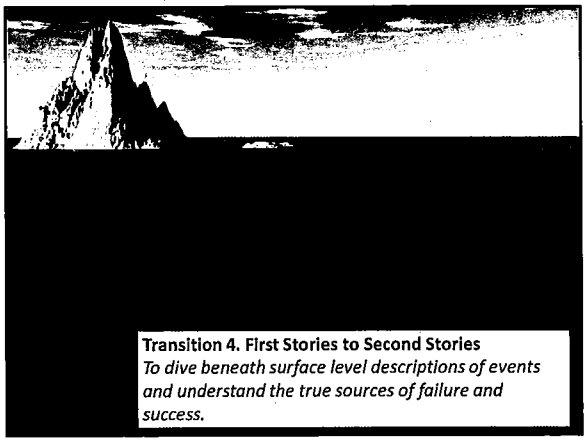
Transition 3. Fallible Humans in Perfect Systems to Fallible Humans in Imperfect Systems
To learn the role of the system on organizational outcomes.

Integrating Safety Science into Everyday Work

- Our system is not designed perfectly
- Understand systems role/pressures on staff's ability to carry out work
- Need to be systemic versus mechanistic
- Need to understand the connections and complex interplay between staff and the system
- Most complex social system that exists
- Multiple perspectives

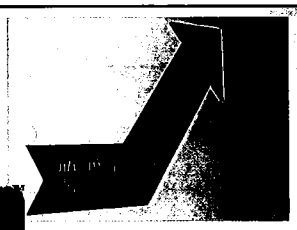
Competing Contingencies

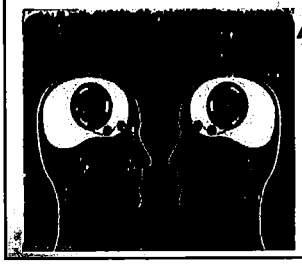




Transition 4. First Stories to Second Stories
To dive beneath surface level descriptions of events and understand the true sources of failure and success.

Rational Choice Theory





Local Rationality-Understanding Decision Making in Context

Local Rationality-Attentional Dynamics

Child Welfare

- Constantly tracking multiple threads of activity
- Actions and assessments are deeply intertwined
- This informs decision making
- Tangible cues and intangible cues

Attentional dynamics wants to know:

- How we know where to focus attention/risks or issues most relevant?
- What pressures and demands influenced the focus of attention?

Attentional Dynamics

Local Rationality-Knowledge Factors

Possession of knowledge isn't enough:

- Knowledge factors studies the activation and application of that knowledge in dynamic situations
- Managing complex and often incomplete information
- Sources of Knowledge-how does this guide the work:
  - Laws
  - Polices
  - Guidance
  - Training
  - Histories

Local Rationality-Strategic Factors

Strategic factors:

- Focus is on goal conflicts
- Goal conflicts are the rule
- Not the exception

Competing Contingencies are always present

- ETTO

Local Rationality-Strategic Factors

Common trade offs in child welfare

- Remove child or leave with family
- Sacrificing time with family to complete other administrative tasks
- Allocating time to higher priority cases
- Efficiency of working case and the thoroughness of assessment/investigation
- Addressing all issues with family or stay strict to referral

Integrating Safety Science into Everyday Work

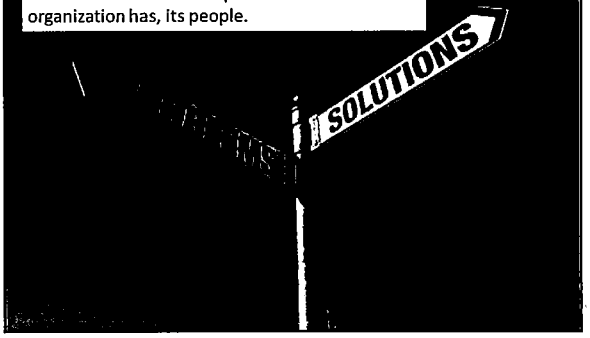
- There is always a second story
- Trauma informed approach-what happened?
- First Stories should not exist without the second story-both are important
- Staff are making trade off decisions everyday to best accomplish the work
- Support staff in seeking the second story from families
- Examples

Local Rationality-Strategic Factors

Trade offs are constant in child welfare systems

- Frontline staff are constantly:
  - Shifting between goals
  - Choosing one goal over another
  - Weighing benefits between goals
  - Abandoning some goals
  - Embracing other goals

Transition 5. Employees are a Problem to Control
to Employees are a Solution to Harness
To make use of the most powerful resource an organization has, its people.



Integrating Safety Science into Everyday Work

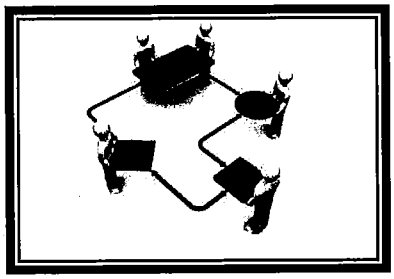
- Typical responses of checklists/procedures can be a means to control staff
- Bumper pads
- It is our staff that keeps our system afloat
- Listen to staff and defer to frontline expertise
- **The solution to us becoming better comes from those that operate it**
  - **They gave us the best ideas on how to improve**

Transition 6. Accountability Up to Responsibility Down
Shift from a focus on compliance to support

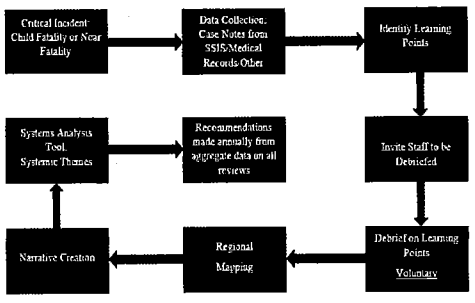
Integrating Safety Science into Leadership

- Typical approach – "good performer" = meets agency metrics
  - Monthly Face to face visits, face to face contact within timeframes
  - Not achieved = remind again
- Safety Science approach
  - Responsibility to create an environment around you that supports success in meeting agency goals/metrics
  - Team's role and the organization's role

Transition 7. Simple to Systemic Accident Models
To use accident models that are compatible with the complex world we work in.



Minnesota's Systemic Critical Incident Review Process



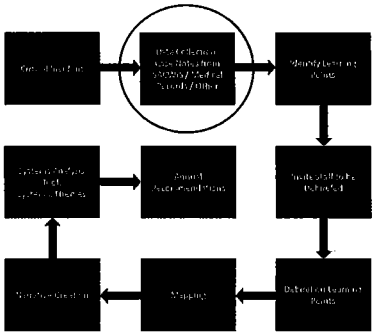
Legal Protections-Key Difference from Local Reviews

- MN State Statute 256.01 Subd. 12a. (b)
- Moved away from asking "what could someone/an agency/part of the systems have done to prevent the fatality/near fatality"
- Learning points are often not associated with the fatality/near fatality
  - Learning and improving outcomes for all children and families within Child Welfare
- Don't "serve" people up

Systemic Critical Incident Review Process

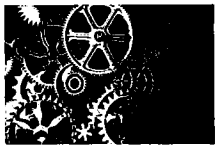
Robust & Scientific Process
Built using Safety Science and designed for Minnesota's Unique Needs

Data is Collected



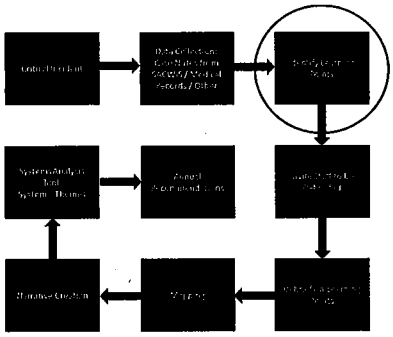
Data Collection

- Case Specific Information
  - SACWIS system
  - Hard Copy Case File
  - Medical Records
  - Other



- Conducted by CMR Staff and Child Welfare Trained Peer Reviewer

Identification of Learning Points



Learning Points

Consists of:

- Improvement opportunities
- Work that goes outside of policy and best practices/expectations
- Other

Factual/non-bias, and relevant

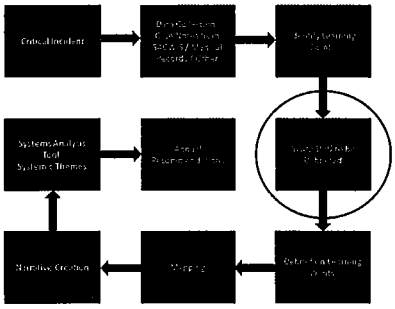
- THE FIRST STORY
- Opportunities to learn
- WYLFWYF

Opportunities

Examples:

- Background checks, Safety planning, Placement decisions/timelines, Face-to-Face contact, Medical records, etc.

Staff are Invited to be Debriefed



Review encompasses Human Factors and Systems Safety

Human Factors Debriefing

- Explores Local Rationality
- Attentional Dynamics- *Environmental cues "red flags"*
- Knowledge Factors- *Sources of information*
- Strategic Factors-*Competing goals*

Safety Systems Mapping

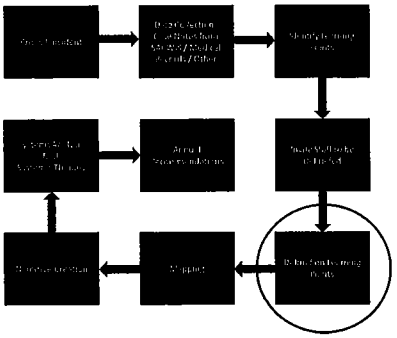
- Analyzes complex system
- Understands systemic influences on child welfare practice

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

Human Factors Staff Debriefing

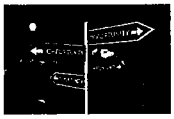
- Includes reviewer and:
  - Case specific worker or
  - Supervisor or
  - Other relevant staff

Human Factors Debriefing

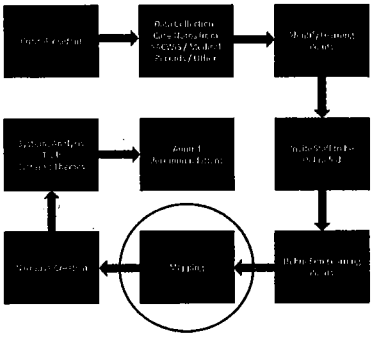


Human Factors Debriefing

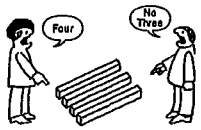
- Conducted by Safety Analyst
- Characteristics of Debriefing
  - Voluntary
  - Supportive
  - Safe
- Uses Human Factors Techniques
  - Understands decisions made in context
  - Explores Local Rationality
    - Attentional Dynamics
    - Knowledge Factors
    - Strategic Factors
- Acts as immediate learning opportunity for involved staff



Systems Mapping



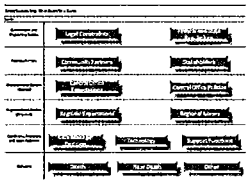
Accounts for Complexity



Incorporates Multiple Perspectives

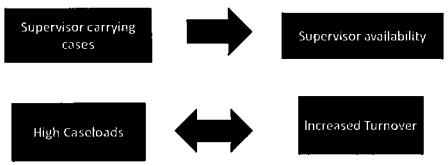
Systems Mapping

- Multidisciplinary
- Based on AcciMap model
- Explores identified learning points and their influences at different levels of the system
  - Frontline
  - Local Agency
  - State/DHS
  - External
  - Government/Legislative



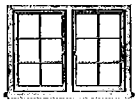
Mapping Process

- Influences on learning point(s) are placed in boxes
  - Boxes can connect across multiple levels
  - Boxes can connect on the same level

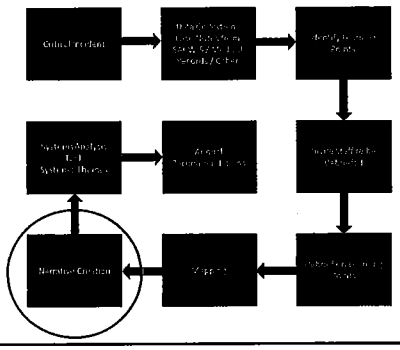


Remember Mappings are:

- **A Window into how our system is functioning**
  - Adaptive tangled layered network that is operating under multiple influences across levels of our system
- **Not to capture what happened in terms of the outcome of the case or what could have/would have been done in the case**
- **An opportunity to understand, learn and improve all outcomes for children and families within our Child Welfare System.**



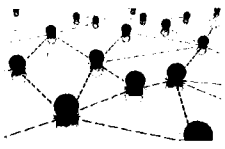
Narrative Creation



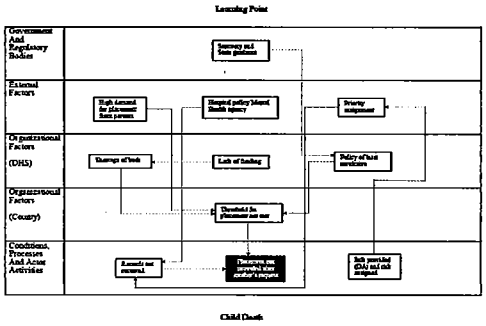
Narrative Creation

- Created by CMR Staff
- Derived from Mapping process
- Turns Mapping product into contextual narratives
- Scored with Systems Analysis Tool

Example Map and Narrative



Map

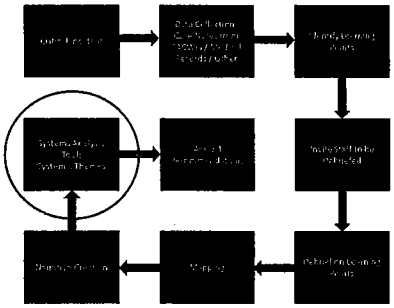


Narrative Example

Narrative:

The decision for placement not being provided, per the mother's request, was influenced by the agency's threshold for placement not being met. The development of this threshold was shaped by local and state policy and guidance that supports and encourages least restrictive interventions prior to placement. The agency's threshold for placement was also affected by the shortage of residential beds and lack of funding for placement services. In addition, there has been an increase in parents calling to request placement opposed to exhausting least restrictive interventions first. Contributing factors that further supported the agency's threshold for placement not being met in this case included the fact that the child was not actively suicidal and a hospital was not recommending placement at the time of the request. Furthermore, the agency believed the child's needs were being met through his engagement with other service providers.

Systems Analysis Tool



Systems Analysis Tool Application

- Communimetric Tool that is Scored by the CMR Team
- Identifies Underlying Systemic Themes
  - Examples:
    - Teamwork/Coordinating Activities
    - Procedural Drift
    - Prescribed Practices/Policies
    - Service Availability
    - Knowledge Gap
    - Supervisory Support
    - Tools/Technology/Equipment
- **Targets resources and interventions during annual recommendations process**

Systems Analysis Tool Example

Systems Analysis Tool

Medical Records	(0)	1	2	3	
Policies	0	1	(2)	3	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. • Least Restrictive – Minnesota Statutes Chapter 260C and Minnesota Rules, parts 9560.0223 and 9560.0545; Children's Mental Health Act, sections 245.487, 245.487 and 245.4876 • 10 Best Interest Factors – 260C.212, Subdivision 2
Production Pressure	0	1	(2)	3	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.
Service Array	(0)	1	2	3	
Stress	(0)	1	2	3	
Supervisory Support	(0)	1	2	3	
Procedural Drift	(0)	1	2	3	

Systems Analysis Tool Example

Systems Analysis Tool

Case ID:

Influence

0 – No evidence 1 – Minimal Evidence 2 – Evidence 3 – Substantial

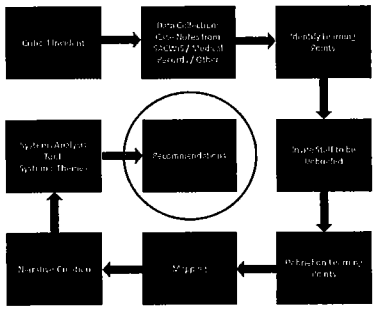
Themes	Influence				Narrative (required if rating 2 or 3)
Cognition	0	1	(2)	3	Common practice in this agency are for child protection workers to grant law enforcement's assessment of safety as law enforcement are the only ones able to place children on hold, which guides the need for the agency to conduct safety planning. The social worker presumed the grandmother was a safe caregiver as the family arrangement with the grandmother, who lived 2 hours away, had already been decided as safe by law enforcement for the sibling children.
Demand-Resource Mismatch	0	1	(2)	3	These directives including implementation of a Rapid Consultation line and creation of a DHS CP Screen-out Review Team. This screening oversight by DHS resulted in increased screened in reports by the agency and thus, an increase in worker caseloads. This increase resulted in prioritization of case duties other than safety planning in this case, as safety had already been assessed by law enforcement. In addition to this, there was heightened media coverage on DHS policy changes, influencing defensive practices by the agency which likely supported the agency in screening in cases out of fear of liability.
Documentation	(0)	1	2	3	

Systems Analysis Tool Example

Systems Analysis Tool

Equipment/Tools/Technology	(0)	1	2	3	
Teamwork/Coordinating Activities	(0)	1	2	3	
Knowledge Gap	(0)	1	2	3	
Medical	(0)	1	2	3	
Prescribed Practice	(0)	1	2	3	
Production/Efficiency Pressure	0	1	(2)	3	Further influencing the worker in not safety plan was that during this time, limited funding for CP positions impacted the local agency's overall staffing levels.
Service Availability	(0)	1	2	3	
Supervisory Support	0	1	(2)	3	Additionally, the worker had limited availability for supervisor consultation as the supervisor was working cases as well.
Procedural Drift	(0)	1	2	3	

Recommendations



Recommendation Development

- Based on Systems Analysis Tool
- Created by Safety Action Group
  - Comprised of:
    - Agency Leadership
    - Critical Incident Review Team Representative (Safety Analyst)
- Designed for System-Wide change
  - Examples:
    - Policy
    - Resource Allocation
    - Collaboration/coordination within and outside agency
    - Fiscal acquisition processes

Other Key Concepts

- **Awareness of Bias**
  - Hindsight Bias-outcome knowledge and not in real time
    - 3 Reasons why the decision may have made sense
  - Severity Bias-same decisions different outcome
    - Use of language and responses
  - Proximity Bias-close to the outcome
    - Challenge reactions to proximity
- **Importance of Language**

Importance of Language

- **Artifact of system**
  - Organizational beliefs
    - Human Error
    - Causation
  - Organizational goals
    - Safety
    - Outward projection
    - Fiscal
    - Efficiency

Importance of Language

- Organizational learning
  - Methods used
  - Tools and structures in place
- Organizational improvement
  - Dedication to quality
  - Response to failure

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

- **Remove should have/could have/if he or she would have**
  - Counterfactual-don't actually know if they would have, etc.-Not helpful....
  - Inhibits learning
  - **Instead Use**
    - Provide explanation and context

"Don't should on yourself and others!"

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. 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."

Safety Culture Practices

- Way of thinking and behaving that supports continued organizational and systems change-ultimately leading to an improvement in outcomes for clients served
- The science and framework allows for engagement and change at every level (top to bottom alignment) so more people are impacted in meaningful ways
- Supportive and safe environment to have conversations
  - Means we have more conversations not less-we put more on the table

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DATA
OUTCOMES OF COLLABORATIVE SAFETY IMPLEMENTATION IN MINNESOTA

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- Qualitative research design of in-depth interviews and thematic analyses of data
- Enhanced Accountability
  - Questions were asked about what the CS model had brought to their organizations, both

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Enhanced Accountability

- Before the CS model, the language in the workplace emphasized individual accountability and laid blame on particular individuals when anything went wrong.
- The CS model brought a language that shifted the focus from the individual to the systemic nature of the processes and practices involved in child protective services.

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Enhanced Accountability

- The focus with the CS model is how to help workers to see individual acts of tragedy as problems of a systematic nature, opening the entire work structure to analysis and improvement.
- Paradoxically this does not cut out or reduce individual accountability. Quite the opposite.
  - "Even though I have now a much broader understanding of all of the influences, they can at least say, yeah, all this other stuff was going on, and maybe I did or didn't do this piece and I could do that differently next time, but I also have a broader sense of how the system impacts and what other system changes can be explored as a result of whatever. So, for me, I found increased buy in from staff in terms of their own accountability."

Improved Media Response

- This shift from language of blame to one that emphasizes system analysis and institutional improvement can be seen in the differences in the media pre and post Collaborative Safety

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Improved Communication between County and State

- Another positive change the CS model brought to the Minnesota child welfare system was linkage at the inter-agency (i.e., state and county) level.
- This shift to a shared, neutral, systemic language improved communication between different levels of CPS in the state.
- This more systemic way of looking at the world opens the whole organizational work structure for inspection, analysis and potentially improvement.
- Study participants noted the attempt to create "a safety culture" is still a work in progress.
  - Creating a common understanding of culture
  - People talk about having to put on their "collaborative safety hat"
  - The use of blame has not been entirely abandoned

Summary of Results

- Clear changes in:
  - Improved understanding of individual vs. holistic accountability
  - Improved responses to the media and media responses
  - Improved communication between county and state
- Still on the journey

Turnover / Retention

- Tennessee DCS Snapshot
  - Shelby County (CY 2014 – CY2015)
    - 400% improvement in vacancy rate (turnover)
  - Mid Cumberland Region (CY 2014 – 2015)
    - 250% improvement in vacancy rate
  - Davidson County (Nashville) (CY 2014 – 2015)
    - 93% improvement in vacancy rate
- Heritage Christian Services Snapshot
  - 2017: 57% retention
  - 2019: 71% retention

Turnover / Retention

- Arizona DCS Snapshot
  - 2015: 50-60%
  - 2018: 20-25%
- Hennepin County DHS (Minneapolis) Snapshot
  - 2016: 20%
  - 2018: 7%
- Minnesota DHS
  - 2016: 18%
  - 2019: 5%

What we have heard:

- *Illuminates the multiple, complex stories behind child welfare work* ~***Local Agency Director***
- *"This is a way of doing things that, if appropriately rolled out and followed through by the State, could transform how we operate in MN and make MN children safer."* - ***County Director***

"If it weren't for you and this process, I'd have quit this job."- ***Front line child protection worker that experienced a critical incident.***

*"We are now part of the solution".-**Child Welfare Supervisor***

"This type of partnership is what we have been waiting ***Welfare Supervisor***

What we have heard:

"In a time when we are having more difficulty recruiting and keeping child protection social workers, this kind of effort is so important to respect social workers during these extra-traumatizing events and not further traumatize them through our response processes." - ***Child Protection Manager***

"I found this approach to child welfare practice to be something missing from how local level/front line staff should be treated and how local level administrators can be more supportive of their staff. I think the spread of this approach will transform child welfare in a very positive way. I wish when I was in direct practice our leaders could have utilized this approach, I still may be in direct practice!" - ***DHS Leader***

Where we were.....

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.

Where we are.....

Thousands of parents show support of child protective services lawsuit against Minnesota

Nora G. Hertel, **Saint Cloud Times** Published 6:50 a.m. CT Aug. 2, 2018 | Updated 8:37 a.m. C

Buy Photo

(Photo: Dave Schwarz, [illegible])

Correction: This story has been updated to correct the status of Robin Stratman's husband.

LITTLE FALLS — Robin Stratman moved two of her children out of Minnesota to maintain custody of them. Amanda Weber did the same thing. And so did

"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.

Where we are.....

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."

Systemic Critical Incident Process Results

Mapping Team Feedback from Participants

- "It's an engaging process that obtains feedback from everyone, from the front line staff to the Director."
- "It was nice to be able to talk about how it felt personally to have a critical incident occur on an assigned case and how Collaborative Safety fit into it all. It was kind of cathartic, too!"
- "Thank you for including me in the Region 6 team. I find the process amazing and I'm so glad DHS is fully invested in this initiative. I'm privileged to be a part of it (for as long as you'll have me!)."
- " You guys do an amazing job facilitating the group and opening it up to a safe and meaningful discussion."
- "The mapping session was not blame-focused and looked at how we all can improve systems versus pinning the blame on someone."
- "The mapping session looked at how obstacles can get in the way of our work and further, it looked at the other systems that we have to work through in a case."

Systemic Critical Incident Process Results

Mapping Team Feedback

- "I am so proud of the work Minnesota has done involving the safety collaborative. After our last regional mapping we had in Redwood Falls- we had our regional supervisor meeting the week after that and I talked about the CFSR workgroup and the process for that and I can't tell you how excited supervisors are about this change and these new ideas/frameworks the state is putting in place. I wasn't quite sure what people thought of the mapping as I know a few supervisors thought the whole process would be stupid and I kept trying to convince them that they would like it but they were unsure about that…however, after being a part of it they were sold on it. The whole safety collaborative model is great, but these types of mappings also allow us as supervisors to learn things and develop a different view on situations!"

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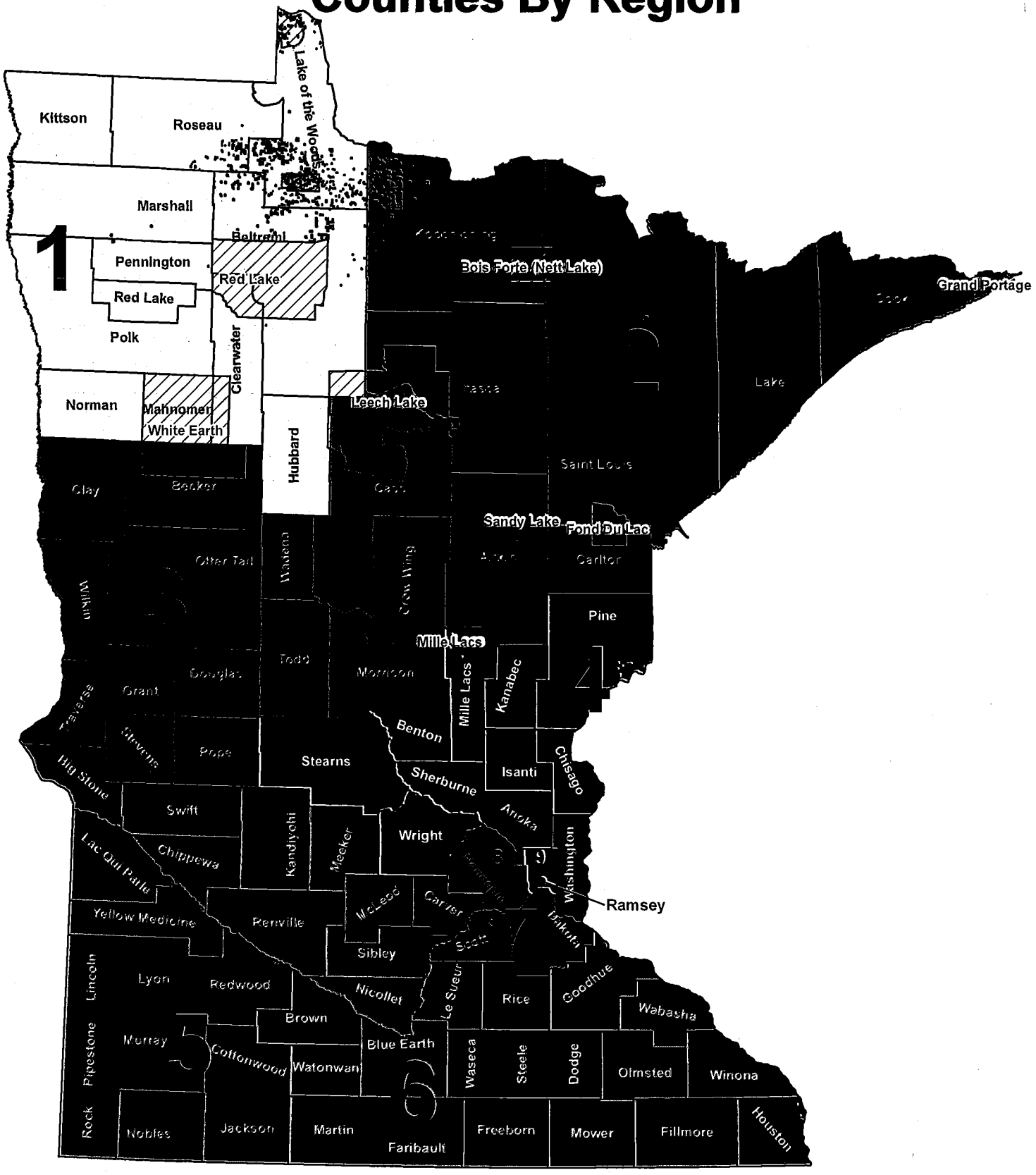
Thank you for your commitment and dedication to Child Welfare!
We are all in this together!

Systemic Critical Incident Review
Counties By Region



DHS-CSP-April 2018, R. Hartneck