TN Tennessee State Government

Applying Safety Science to Child Protection

Michael Cull, Deputy Commissioner
TN Dept. of Children's Services

September 15, 2016

Safety Culture in Child Welfare

A **safety culture** is one in which organizational values, attitudes, and behaviors support an engaged workforce and reliable care delivery.

Leaders in a safety culture:

- Strive to balance systems and individual accountability; and
- Value open communication, transparency, and continuous learning and improvement.

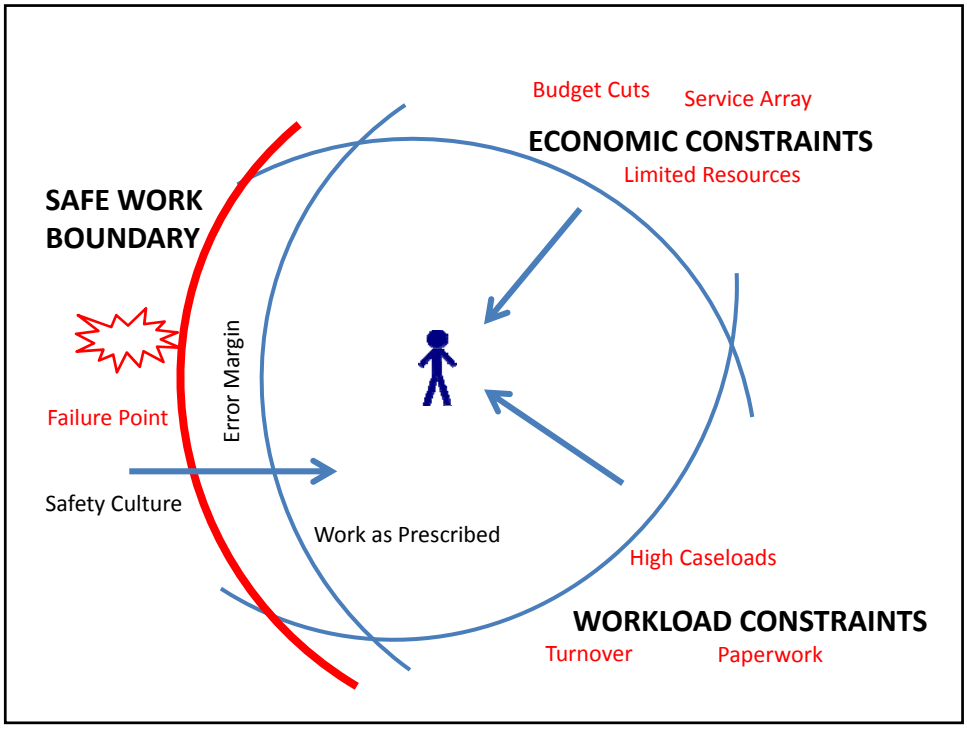
Teams in a safety culture

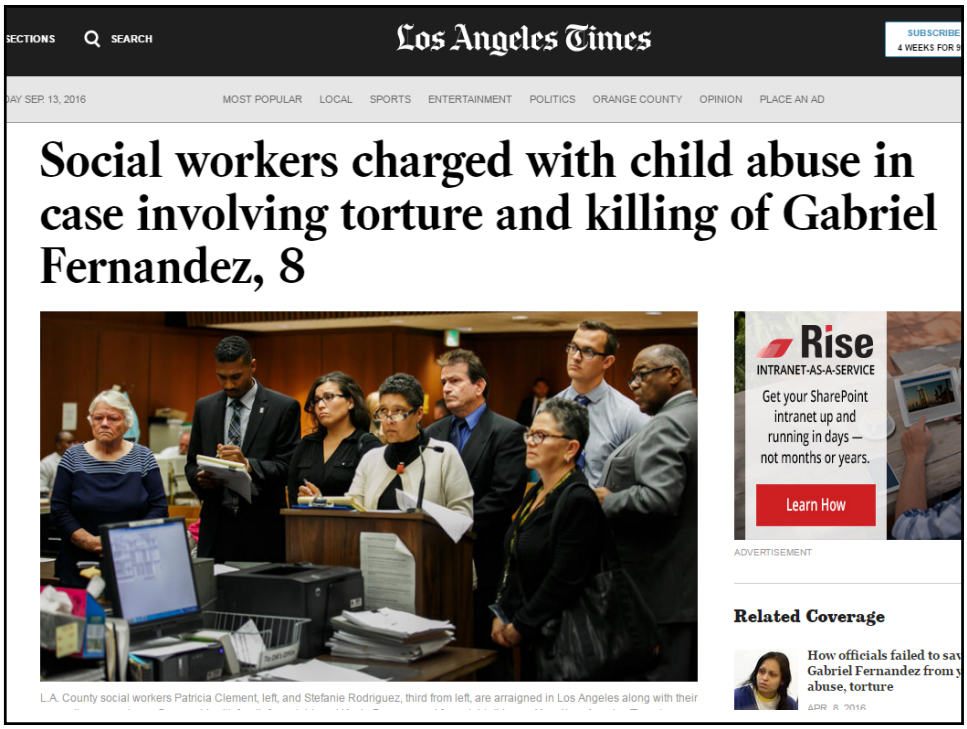
- Monitor themselves, their colleagues, and their system for stress
- Anticipate and respond to unexpected events

Cull, Rzepnicki, O'Day, & Epstein (2013)


Good Choice
Bad Choice


DRF 649


Budget Cuts
Service Array
ECONOMIC CONSTRAINTS
Limited Resources
SAFE WORK BOUNDARY
Error Margin
Failure Point
Safety Culture
Work as Prescribed
High Caseloads
WORKLOAD CONSTRAINTS
Turnover
Paperwork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L.A. County social workers Patricia Clement, left, and Stefanie Rodriguez, third from left, are arraigned in Los Angeles along with their
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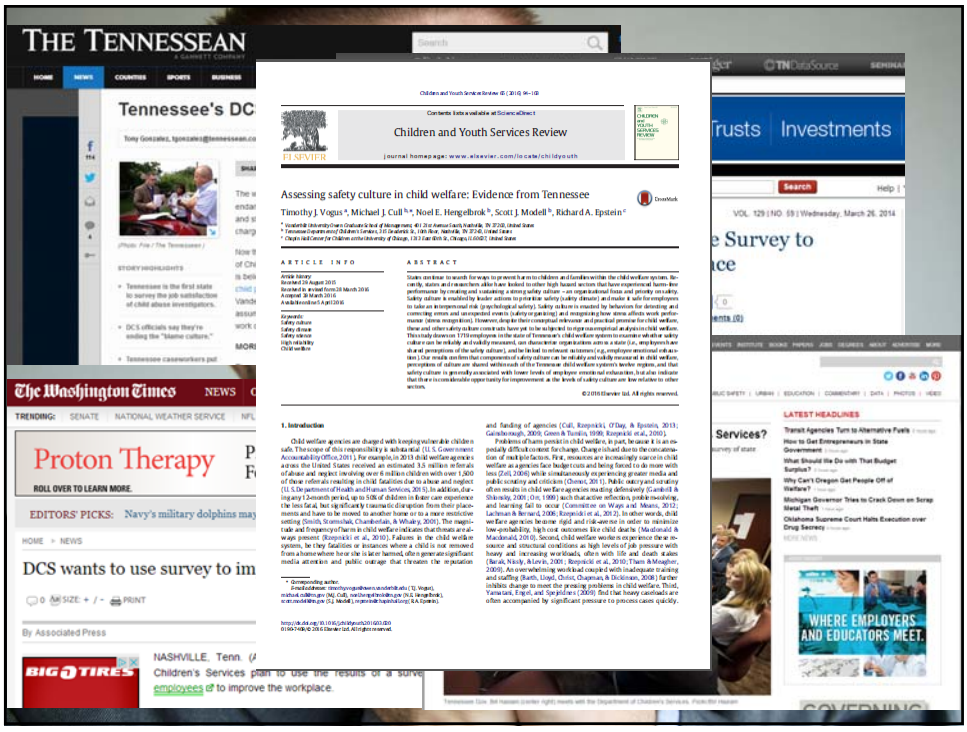
Measuring Our Safety Culture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Children and Youth Services Review
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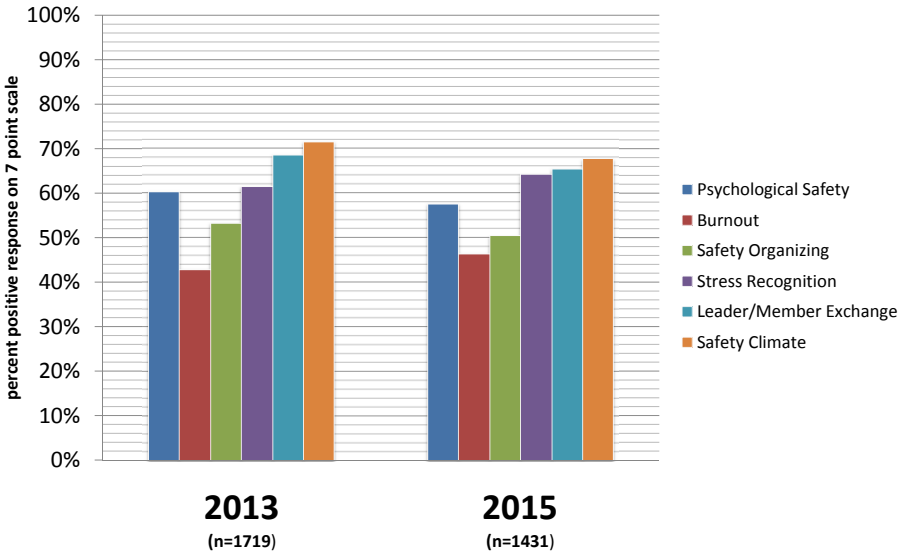
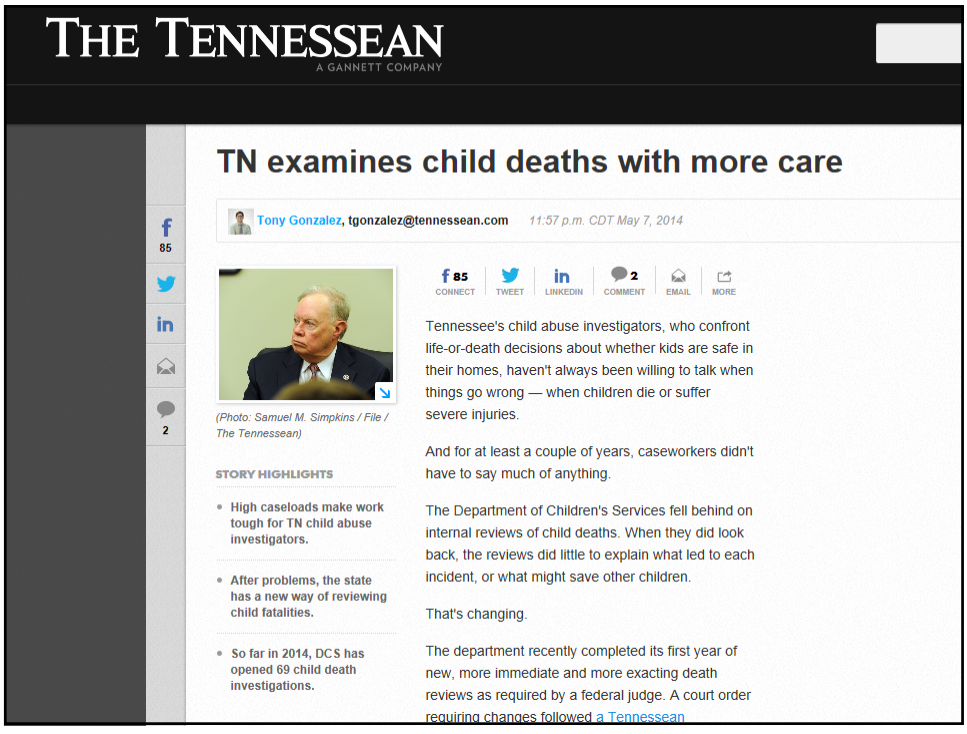
WHERE EMPLOYERS AND EDUCATORS MEET.



Year to Year Comparison – All Regions, All Staff



THE TENNESSEAN
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TN examines child deaths with more care

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

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(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.

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

CDR Review Criteria

1. A child was **in DCS custody** at the time of death;
2. DCS had contact with the child or family within **three (3) years preceding** the child's date of death;
3. The child's death has been **substantiated for abuse**; OR
4. The Commissioner, Medical Director or the Deputy Commissioner of the Office of Child Safety requests a review.

Four Important Elements

1. Analysts trained to think like Human Factors engineers
2. Data gathering and timeline development
3. Individual debriefings with involved staff and collaterals
4. Team-based process mapping


Debriefings
348 Conducted
625 Findings

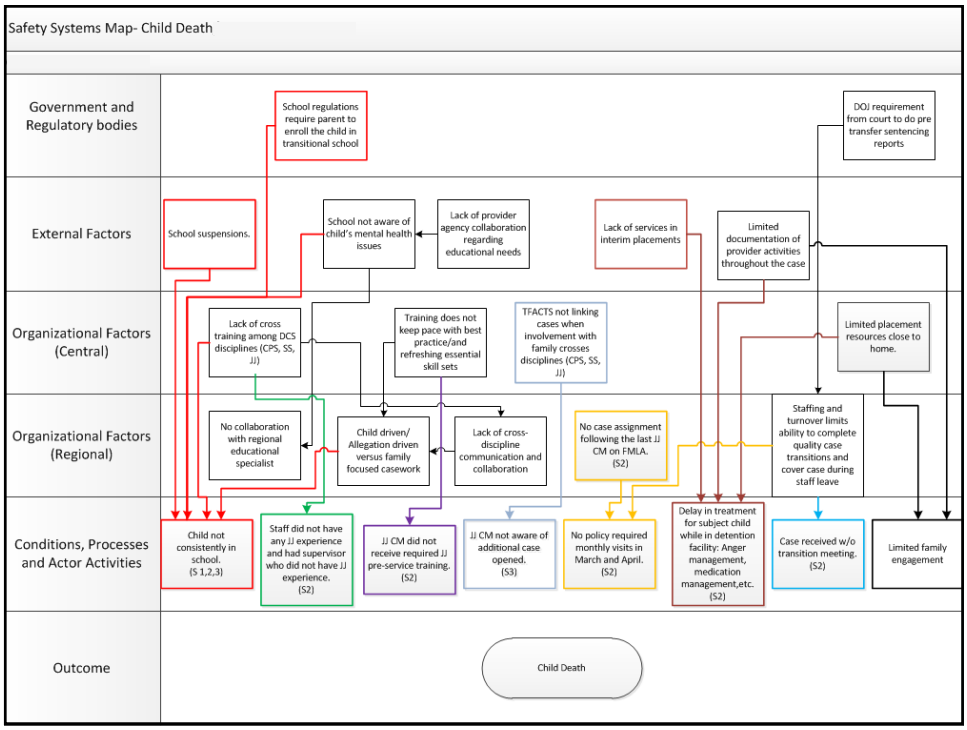

Safety Systems Map- Child Death
Government and Regulatory bodies
External Factors
Organizational Factors (Central)
Organizational Factors (Regional)
Conditions, Processes and Actor Activities
Outcome
School regulations require parent to enroll the child in transitional school
DOJ requirement from court to do pre transfer sentencing reports
School suspensions.
School not aware of child's mental health issues
Lack of provider agency collaboration regarding educational needs
Lack of services in interim placements
Limited documentation of provider activities throughout the case
Lack of cross training among DCS disciplines (CPS, SS, JJ)
Training does not keep pace with best practice/and refreshing essential skill sets
TFACTS not linking cases when involvement with family crosses disciplines (CPS, SS, JJ)
Limited placement resources close to home.
No collaboration with regional educational specialist
Child driven/ Allegation driven versus family focused casework
Lack of cross-discipline communication and collaboration
No case assignment following the last JJ CM on FMLA. (S2)
Staffing and turnover limits ability to complete quality case transitions and cover case during staff leave
Child not consistently in school. (S 1,2,3)
Staff did not have any JJ experience and had supervisor who did not have JJ experience. (S2)
JJ CM did not receive required JJ pre-service training. (S2)
JJ CM not aware of additional case opened. (S3)
No policy required monthly visits in March and April. (S2)
Delay in treatment for subject child while in detention facility: Anger management, medication management,etc. (S2)
Case received w/o transition meeting. (S2)
Limited family engagement
Child Death

Table 1: Custody Status

Custody Status (n=123)	n	%
Deaths		
Custody	10	11
Non-Custody	85	89
Near Deaths		
Custody	1	4
Non-Custody	27	96

Figure 2: Age

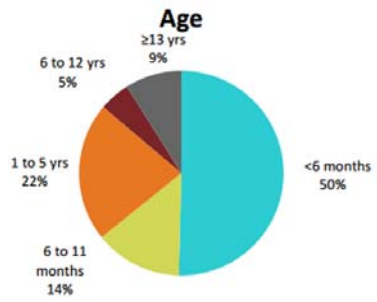


Figure 3: Gender

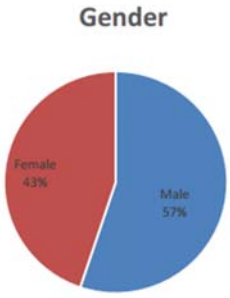
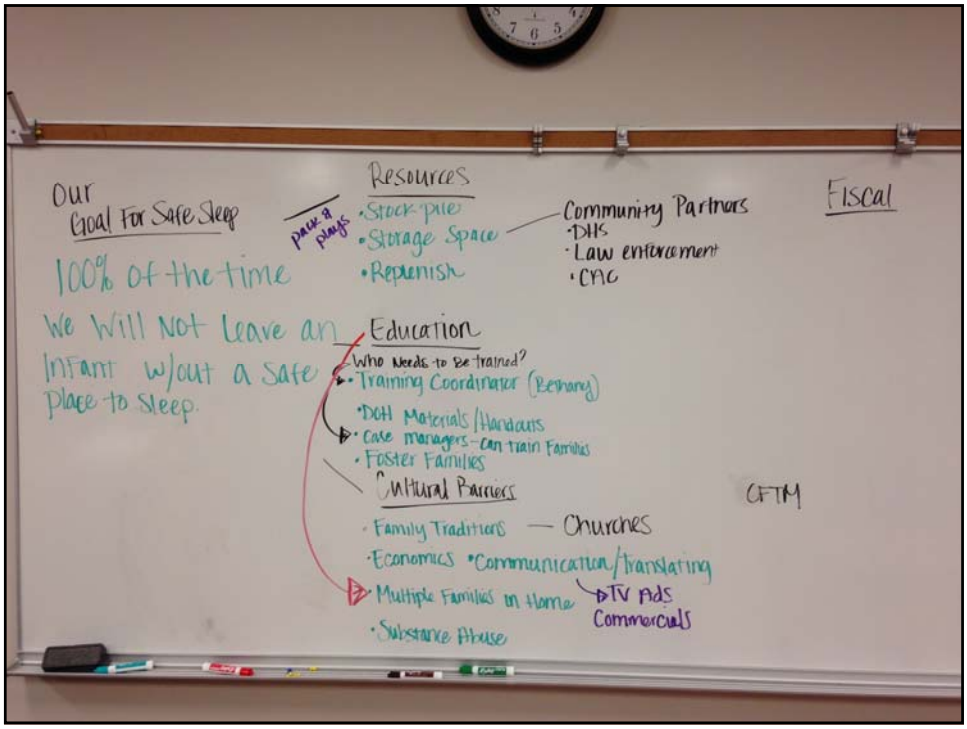
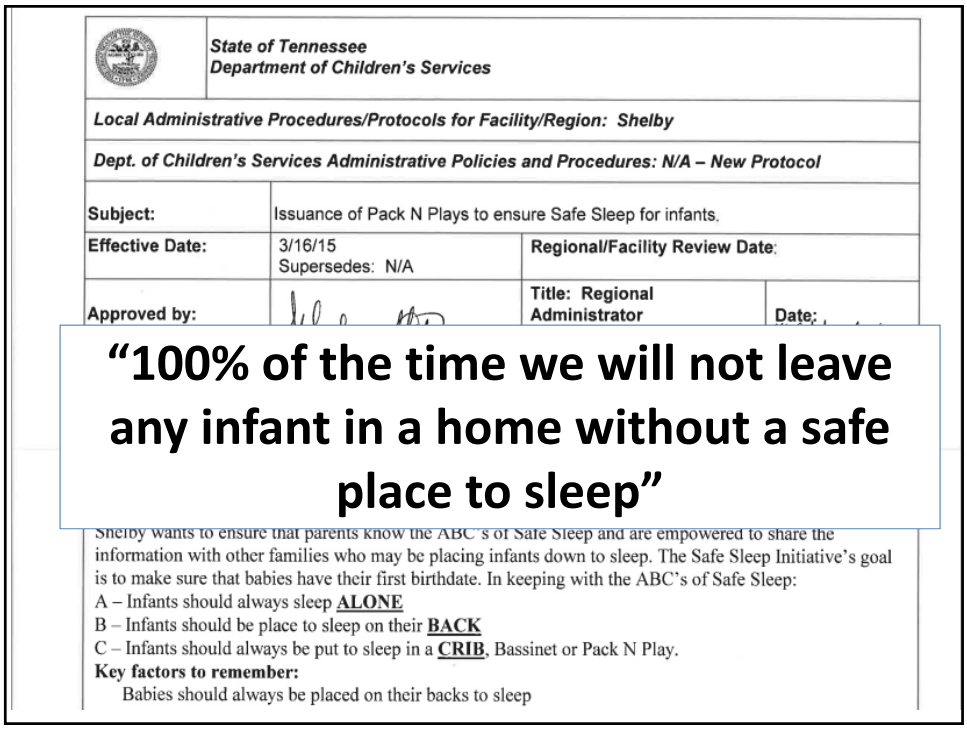


Table 6: Cause of Death

Cause of Death (n=95)	n	%
Medical	28	29
Child abuse/Non-accidental trauma	0	0
Motorized vehicle	4	4
Weapon	4	4
Drowning	1	1
Blunt Force trauma	6	6
Poisoning/Overdose	5	5
Fire/Burn	1	1
Inadequate care/Neglect	0	0
NAS	0	0
Acute Life threatening event	0	0
Suffocation/Strangulation/Asphyxiation infants	21	22
Suffocation/Strangulation/Asphyxiation age 1-18 years	5	6
Fall Injury	0	0
Other	4	5
Unable to determine	16	17





State of Tennessee
Department of Children's Services

Local Administrative Procedures/Protocols for Facility/Region: Shelby

Dept. of Children's Services Administrative Policies and Procedures: N/A – New Protocol

Subject:	Issuance of Pack N Plays to ensure Safe Sleep for infants.		
Effective Date:	3/16/15 Supersedes: N/A	**Regional/Facility Review Date:**	
Approved by:		**Title: Regional Administrator**	**Date:**

"100% of the time we will not leave any infant in a home without a safe place to sleep"

Shelby wants to ensure that parents know the ABC's of Safe Sleep and are empowered to share the information with other families who may be placing infants down to sleep. The Safe Sleep Initiative's goal is to make sure that babies have their first birthdate. In keeping with the ABC's of Safe Sleep:

A – Infants should always sleep **ALONE**

B – Infants should be place to sleep on their **BACK**

C – Infants should always be put to sleep in a **CRIB**, Bassinet or Pack N Play.

Key factors to remember:

Babies should always be placed on their backs to sleep

Questions?