Kentucky

Department for Community Based Services

System Safety Review Process

Contents

Introduction

KRS 620.050 requires that the Cabinet for Health and Family Services (CHFS/cabinet) conduct an internal review of any case where child abuse and neglect has resulted in a fatality or near fatality and the cabinet had prior involvement with the child or family. This statute also requires that the cabinet submit an annual report by September 1 to the governor, the General Assembly, and the state child fatality review team; this report is to include a summary of the internal reviews and an analysis of historical trends.

In 2019, the Department for Community Based Services (DCBS/department) partnered with Collaborative Safety to develop a new internal review process known as the Culture of Safety, System Safety Review (SSR). The SSR process uses safety science to guide the analysis of critical incidents and the response to areas identified for improvement. Industries such as aviation, healthcare, and nuclear power champion this approach and child welfare systems throughout the U.S. have adopted this approach for reviewing their critical incidents. DCBS has defined critical incidents as any child fatality or near fatality accepted for investigation or a death of a child on an active case.

The process focuses on understanding the complex nature of child welfare work and the factors that influence decision-making and practice in real time. It moves away from the simplistic approach, which tends to assess blame and results in the application of “quick fixes” that fail to address the underlying issues. The process recognizes that frontline workers strive to make the best decisions in their cases based on information available to them at that time and that those decisions are affected by the system

around them. This new approach emphasizes shared accountability. Frontline workers will be engaged through human factors debriefings to provide their insight on how adverse events occur and how they can be avoided. Staff at various levels of the agency and external stakeholders will be accountable to contribute to the systemic analysis. Furthermore, agency leadership will be accountable for making improvements to create a more resilient and reliable system which improves its capacity to provide safe outcomes for children, families, and employees.

The intended outcome of the SSR is to learn and make meaningful systemic change. In pursuit of this goal, the process will create a safe environment for staff to communicate the influences in their decision making and other system barriers without fear of punitive actions. The Culture of Safety environment will lead to staff being able to provide enhanced and more effective services to families.

Process Overview

The Division of Protection and Permanency (DPP) is responsible for completing the SSR. The process will be conducted by the SSR team made up of system safety analysts, with oversight by an assistant director within DPP.

Cases requiring review include:

- Any death of a child on an active case.
- Any child fatality or near fatality with prior DCBS involvement.

The system safety analyst will complete an initial case review, which will include a review of the circumstances of the fatal/near fatal incident, allegations and details of prior investigations, and the provision of ongoing

services. The goal of this initial review is to identify features that may be recommended for a more in-depth analysis. Particular attention will be given to history occurring within the twenty-four (24) months prior to the fatal/near fatal incident. The system safety analyst will present the cases to the multi-disciplinary team (MDT) to determine if a further analysis is needed to identify systemic themes or trends.

Upon selection for further analysis, the system safety analyst will identify DCBS personnel and others who may have been involved in the decision making of the agency's previous involvement, to participate in human factors debriefings. Human factors debriefings provide staff with the opportunity to share their experiences related to the critical incident and/or historical cases. At this time, the system safety analyst will explore the decisions and interactions with the child and family. The system safety analyst compiles the information gathered, with the findings from the initial case review, and provides this information to the regional mapping team for analysis of systemic influences that may affect decision making. The system safety analyst will evaluate the information gathered from the regional mapping team using the System Safety Scoring Tool. Data from this tool will be collected and used to identify underlying systemic themes. Aggregate data will be presented during the MDT data review to develop the components that will be presented to the safety action group (SAG).

Procedure

I. Notification

Within forty-eight (48) business hours of the receipt of a report accepted as a fatality or near fatality investigation or any death of a child in an active case, the service region (SRA or designee) notifies the system safety review team by completing sections I and II of the System Analysis Report (SAR). The case will be assigned to a system safety analyst and entered into a tracking database accordingly. The system safety analysts' case assignments will be according to regions, however, they may receive assignments in other regions as needed.

II. Initial System Safety Review

The system safety analyst assigned will complete an initial case review within thirty (30) days of notification, identifying potential features for further consideration. The system safety analyst may request relevant medical records, police reports, and hard copy records, as needed. The analyst will provide a summary report to the MDT one week prior to the meeting.

Within thirty (30) days of notification, the region will provide the system safety analyst with a status update for the fatality/near fatality investigation, which may include additional information regarding the cause of death or mechanism of injuries as determined by the autopsy or pediatric forensic medical consult.

III. Multi-Disciplinary Team Meeting

The MDT is a standing monthly team meeting. Cases received in the previous forty-five (45) days will be reviewed. One week prior to the scheduled meeting, the system safety review team will provide an agenda

for the meeting and case summaries. The decisions made by the MDT will be recorded in meeting minutes and distributed back to the team within one (1) week.

MDT members include, but are not be limited to:

- Central office staff from the SSR team;
- Child Safety Branch manager or designee;
- Division of Service Regions (DSR) staff (director, assistant director, and/or branch managers);
- Training Branch staff;
- Clinical Services Branch staff (including staff from the Medical Support Section);
- Department for Public Health staff;
- Office of Legal Services staff; and
- Other central office staff (invited by the SSR team who may have programmatic knowledge of specific cases scheduled for presentation).

All members will be required to sign the SSR Confidentiality and Attendance sheet and will be required to leave any notes written during the meeting at its conclusion.

Each system safety analyst will present their case review findings to the MDT. The primary goal of this function of the MDT is to identify cases where further analysis is recommended. The MDT findings for cases not selected for further analysis will be documented in section IV of the SAR. The number of cases selected for further analysis will be limited to two (2) cases per system safety analyst, per MDT meeting.

IV. Human Factors Debriefing

The human factors debriefing process is designed to gather additional information about the case and circumstances under which the decisions were made. This includes an understanding of the interactions between DCBS and the family. This approach seeks to learn from this interaction and is not intended to promote punitive actions. The intention is to develop the "second story", which is the description of the frontline worker's and other's decision making process and of the systemic influences in their decisions.

a) All debriefings are voluntary. Staff who are requested to participate may decline the entire debriefing process, or if they agree to debrief, may decline to answer specific questions asked during the process.
b) Staff will receive an invitation to debrief via email and be provided with specific case identifying information and the Human Factors Debriefing Participant Guide that explains the process prior to accepting or declining participation.
c) During the debriefing, the system safety analyst will guide the participant through the timeline of the case while seeking to understand the relevant factors and systemic influences that led to the decisions made at the time of involvement.
d) The system safety analyst will provide information about how to access the Kentucky Employee Assistance Program (KEAP).
e) After the debriefing, a System Safety Review Survey will be distributed to all participants to collect feedback and gather data on perceptions of participants' experiences. This is also a voluntary process.

The system safety analyst will complete a second, more in-depth review of those cases selected for further analysis to determine individuals who will be invited to participate in the human factors debriefing. Human factors debriefings will be conducted in private and will occur in a location convenient for the participant (most likely in the local DCBS office).

Individuals identified for debriefing may include, but are not limited to:

a) Investigative worker of the fatality/near fatality investigation;
b) Investigative worker for the prior investigations within twenty-four (24) months of the fatality or near fatality;
c) Investigative supervisors;
d) Ongoing workers (if applicable);
e) Regional management personnel;
f) Law enforcement;
g) Health care providers; and
h) Other community partners involved with the family, when deemed appropriate.

The SRA will receive notification that a case from their region has been selected for further analysis, however, will not receive notification of the individuals invited to participate in the debriefing process.

Upon completion of the debriefing process, the system safety analyst will complete section V of the SAR and forward the case to the regional mapping team.

V. Mapping

The system mapping process is intended to analyze the human factors data collected during the debriefing to develop a clear picture of systemic influences. It uses the System Safety Mapping Tool that encourages analysis across multiple levels rather than traditional horizontal or linear generalizations.

The team approach is used to assure adequate representation of knowledge and perspectives when defining the influences being studied. The system safety analyst acts as the facilitator for this process guiding the discussion from identified findings to exploration of relevant influences at each level.

The system safety analyst combines the information gathered during the mapping into a written narrative describing the influences affecting each learning point.

Mapping tool levels include:

- Level 1: Conditions, process, and actor activities, which can include use of technology, critical decisions, services, and supports.
- Level 2: DCBS regional operations, which can include regional culture, management expectations, geography, and demographics.
- Level 3: DCBS central office operations, which can include executive decision making, policies, and fiscal operations.
- Level 4: Entities external to DCBS, such as law enforcement, healthcare providers, and social service providers.
- Level 5: Government and regulatory bodies comprised of state and federal legislation, resource allocation, and mandates, or regulatory bodies such as accreditation agencies.

The mapping teams will be standing teams that meet monthly. The team will consist of regional staff.

Members of the regional mapping team will include, but not be limited to:

a) System safety analyst(s);
b) Four (4) rotating staff in a case manager position (social service worker (SSW) or social service clinician (SSC)-two (2) investigative workers/two (2) ongoing workers;
c) Four (4) rotating family services office supervisors (FSOS)-two (2) investigative/two (2) ongoing;
d) One (1) service region clinical associate (SRCA) or service region administrator associate (SRAA);
e) One (1) SRA;
f) Assistant director or director of DSR;
g) A centralized intake representative from the regional team;
h) Regional social service specialist – child fatality liaison;
i) A specialized SSW, SSC, or FSOS (from a recruitment and certification (R&C) team, permanency team, or APS team) (optional/as needed);
j) Regional Office of Legal Services attorney;
k) CQI specialist – preferably one from each region;
l) Community partner – law enforcement, court personnel, PCC/PCP staff, prevention provider, etc.; and
m) Any member of the SSR team.

Members present at the regional mapping review must not have been directly involved in a case scheduled for review.

Standing regional mapping teams will be established as follows:

- Jefferson Service Region (JSR);
- The Cumberland Service Region (CSR);
- Salt River Trail Service Region (SRTSR);
- Eastern Mountain Service Region (CSR);
- Southern Bluegrass Service Region (SBSR);
- Northern Bluegrass Service Region (NBSR);
- Northeastern Service Region (NESR);
- Two Rivers Service Region (TRSR);
- The Lakes Service Region (TLSR); and
- Centralized intake (CI).

At least one SRA and SRCA/SRAA should attend all regional mapping team sessions. The regional CQI specialist and child fatality specialist should always be in attendance.

In instances where the case history involves multiple regions, the location of the mapping will be determined on a case-by-case basis by the SSR team. The information derived from the mapping process will be cultivated into a written record or narrative by the system safety analyst and be recorded in section VI of the SAR indicating the conclusions drawn for each level.

System Safety Mapping Tool

System Safety Map	
Case No.	
Government and regulatory bodies	

External factors	
Organizational factors (central)	
Organizational factors (regional)	
Conditions, processes, and actor activities	
Outcome	

VI. Scoring

Influences revealed through the mapping process and narrative creation will be scored using the System Safety Scoring Tool. The tool is designed to explain the inherently complex nature of the work and the many factors influencing practice. First, systemic themes are identified and then the level of influence that the theme had on the caseworker's ability to perform their duties, relative to the study case, are captured. The scoring process assists in the identification and aggregation of systemic influences and

allow for guidance on developing recommendations for systemic change and trending of intervention progress and success.

Every case that is tracked by the SRR team (all investigations accepted with a fatality/near fatality designation and cases where a child fatality occurs in an active case) will be scored using section VII of the SAR.

Section VII of the SAR is completed by the system safety analyst:

- When the system safety analyst receives a finalized update on an investigation with a fatality/near fatality designation (this will be for cases that are not selected by the MDT for the further analysis AND are not referred to the regional mapping team).
- At the conclusion of the MDT meeting, (this will include cases that are NOT selected for the further analysis).
- At the conclusion of the of the comprehensive analysis process (this includes cases where the debriefings and/or mapping process is conducted and after the narrative is developed).

Systems Analysis Scoring Tool

Case No.					
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	
Demand-Resource Mismatch	0	1	2	3	
Documentation	0	1	2	3	
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	
Service Availability	0	1	2	3	
Supervisory Support	0	1	2	3	
Procedural Drift	0	1	2	3	

VII. Multi-Disciplinary Team – Data Action Review

The MDT meeting will be extended at certain points in the year when the SSR team has determined that enough data exists to be presented. During the extended meetings (data action group meeting), the team will review data compiled from the cases previously selected for human factors debriefings and mapping. The MDT will evaluate the presenting themes and develop areas for potential improvement. The conclusions reached will be forwarded to the central office SAG.

VIII. Safety Action Group (SAG)

The SAG meets once per calendar year or more frequently as requested or necessary. The purpose of the SAG is to review the data and recommendations of the data action group and monitor improvements to respond to factors found to be influencing practice. This may include DCBS policy, practice, statute, regulation, budget allocation, or initiatives. The factor could be an internal issue or an issue involving an outside agency or entity.

Members of the SAG will include:

- The DCBS commissioner;
- The DCBS deputy commissioner;
- The DPP director;
- The DSR director;
- Executive director of the Training Resource Center;
- General counsel;
- The DSR Field Quality Branch manager; and
- Any staff as requested by the DCBS commissioner's office.

IX. Annual Fatality Report

Data and actions taken in response to the findings of the SSR process will be incorporated in to the Annual Fatality Report provided to the governor, the General Assembly, and the state child fatality review team each year.