STRATEGY BRIEF

SAFESTRONGSUPPORTIVE

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How can child protection agencies use safety science to promote a safety culture?

Safety is the paramount goal for child protection agencies, so when a child tragedy such as a fatality or serious injury occurs, a cycle of intense public discourse and scrutiny often follows. What usually happens next is a series of corrective actions that may include the blaming and possible firing of individuals deemed responsible, and an increased agencywide focus on compliance.

Such hasty responses, however, do not necessarily increase child safety or organizational effectiveness. Rather, they can contribute to unhealthy agency cultures characterized by anxiety, defensiveness, and self-preservation.

Child protection agencies can learn much from other safety-critical systems and industries — such as health care, aviation, and nuclear power — that have applied the principles of safety science to change organizational culture, improve practice, and reduce tragic incidents. Safety in these arenas tends to improve as a result of the embrace of safety science, and the child welfare system can experience similar positive outcomes.

Safety science vs. safety culture

Safety science involves applying scientific methods, research, and tools to understand, assess, and manage safety.[1] In the context of child protection, this means using an evidence-based approach to inform preventive and responsive actions, rather than basing policy and practice decisions on emotion or assumption. When a safety science framework is employed, the best available research and evidence are used to identify and apply the lessons learned from a tragic incident or critical event.

Experts in the field of safety science tend to agree that organizational culture is an important component when applying and implementing safety science. Safety-critical industries have recognized that a culture of fear and blame does not promote learning and can result in decreased organizational effectiveness and

compromised safety. Research is increasingly available to guide child protection agencies in creating a **safety culture** that is more effective in protecting children from harm. To implement a safety culture successfully, an agency must examine a variety of systemic factors and balance individual and system accountability for safety.

As child protection agency leaders have sought to implement safety science and safety culture principles, they are discovering that equity is critical. Safety is a prerequisite for the honest conversations necessary to address the various demographic disparities that often are present in child welfare outcomes. Likewise, no organizational culture can claim to be truly safe until it is equally safe and just for all.

In **Los Angeles County**, as in any child welfare jurisdiction, social workers constantly have to make difficult judgment calls related to child safety. In addition to providing training and real-time supervisor support, the Department of Children and Family Services continuously examines "practice, protocols, and technologies to identify areas ripe for innovation, improvement, or change," said Brandon T. Nichols, agency director. "As we all know, this work is extremely complex with human-centered issues that are beyond our control. We take every opportunity to learn and gain insights to improve our practice."

In **Connecticut**, the Department of Children and Families strives to create a Safe and Sound culture that promotes inclusion, respect, diversity of viewpoints, permission to challenge biases, and opportunities for positive change. As part of the Safe and Sound culture, the agency has embedded a Racial Justice and Equity Assessment tool and process, with the goal to eliminate racial disparities and inequitable barriers, and increase positive outcomes for all children, beginning with child safety.

> "We embrace a culture of psychological safety that allows us to engage our workforce in direct and honest conversations without being punitive. This helps us quickly identify problems and make adjustments as needed without assigning blame."
>
> —Brandon T. Nichols, Director, Los Angeles County Department of Children and Family Services

Creating a safety culture

Research and theory in the application of safety science focus on the complex environments in which individual errors occur. Many factors affect an individual's ability to accurately assess child safety and take actions to promote it. Some factors are directly related to the individual (training, experience, and critical thinking skills), but many are not (organizational policy, agency or office climate, and caseload or workload). Leaders of organizations therefore play a critical role in creating a safety culture that supports effective casework.

Studies of hospital nurses have found a disturbing "association between organizational cultures characterized by reluctance to report errors and acknowledge mistakes, and the frequency with which medical errors occur."[2] Applying that conclusion to child protection agencies, cycles of blaming never have been shown to measurably reduce tragic incidents involving child safety.

Michael Cull, who leads the technical assistance team for the National Partnership for Child Safety, describes a safety culture as "one in which values, attitudes, and behaviors support a safe, engaged workforce and reliable, error-free operations," and cites four key principles:[3]

- **Leadership's commitment to safety.** Effective leaders keep the potential for tragic outcomes top of mind and maintain vigilance for potential organizational weaknesses, while communicating their support for staff.
- **Prioritizing teamwork and open communication based on trust.** Difficulties in practice must be discussed candidly in order for improvements to occur. Quality reviews should focus on productive, two-way communication between frontline staff and leadership, rather than individual compliance

and fault-finding. This approach can help leaders better understand systemic barriers to safety and how to effectively address them. In **Vermont**, teams have embedded safety culture into the child welfare system's response to high-stakes events — in particular, the emergency removal of children from their homes — by institutionalizing the use of "huddles." Huddles immediately bring together professionals across disciplines whenever a child enters foster care. The goals are to collaboratively assess the child and family's needs, identify the most suitable temporary caregiver, and reduce unnecessary and traumatic placement disruptions.

- **Developing and enforcing a non-punitive approach to event reporting and analysis**. Some child welfare agencies are exploring the practice of creating a system for confidential reporting of practice errors and "near misses." This approach, currently more common in other industries such as aviation, helps to promote organizational learning and a better balance between individual and system accountability for safety. The **Oregon** Child Fatality Prevention and Review Program has restructured its Critical Incident Review Team process to center on system accountability rather than individual blame. Psychological safety is now embedded at every step of a review, allowing staff to engage openly without fear of retribution. The program's coordinator is charged with leading debriefings in a judgment-free environment in an effort to foster trust and candid participation. Leaders of Oregon's child protection agency have hailed these efforts as instrumental in spreading awareness of safety science and cultivating a supportive safety culture within the agency.
- **Committing to becoming a learning organization.** Child welfare professionals need opportunities to learn from their peers and continually improve their critical thinking skills. Likewise, the organization as a whole must continue to learn and evolve. In **Ohio**, the Public Children Services Association facilitated a 15-county Safety Culture Learning Community in 2022 and 2023 with an emphasis on using safety science principles to measure and improve team functioning. From this work, PCSAO gained a deeper understanding and appreciation of the interconnected nature of culture and practice. As a result, PCSAO made the strategic decision to embed the Safety Culture Learning Community work within the implementation of PACT, Ohio's new child welfare practice model that is based on the belief that the strength of the working relationship between families and staff is the single leading indicator of safety and permanency outcomes. Using the guiding principle of "Practice is culture, and culture needs structure," some child protection agencies in Ohio counties have begun to implement practice changes using strategies focused on habits and routines informed by safety science.

Responding to critical incidents

Maintaining a safety culture becomes even more essential when managing the organizational response to a crisis, such as a child fatality. When the child welfare system's response to a child death results in individual blame, staff can become more risk-averse and fearful, which can lead to unwarranted removals of children and needlessly delayed family reunifications. Procedural or statutory changes implemented in response to child safety crises need to be well-thought-out to ensure they are not counter-productive in practice, which can make the system less effective in keeping children safe.

Researchers recommend the following when responding to crises:

- **Avoid "hindsight error" and rushing to blame.** Hindsight error is the tendency to see risk as predictable after an incident occurs, rather than recognizing that risk assessment in foresight is complex.
- **Manage political and public reactions.** This requires agency leaders to communicate a consistent message of the boundaries of agency intervention as well as close cooperation between agency and political leaders.

- **Support families.** Agencies must not lose sight of their primary responsibility to keep all of the children in the family safe, including siblings, and provide practical and emotional support to birth and resource families as needed.
- **Support staff.** A critical incident raises the anxiety of all agency staff, not just those involved with the case. All staff need to know that if they have done their best, the agency — from their peers and supervisor to the director — will stand by them.

> "In order to consistently get it right for children and families, child welfare systems must support a continuous learning and improvement culture. Building a culture of safety means that different perspectives are welcome and decisions are made based on what's right for each child and family rather than fear of blame."
>
> —Jess Dannhauser, Commissioner, New York City Administration for Children's Services.

Lessons learned

Leaders who have implemented the principles of safety science and a safety culture within their organization offer strikingly similar advice:

- **Incorporate the voices of people with lived experience.** Youth and families must help drive the narrative and be part of designing solutions.
- **Do not undertake this alone.** Take every opportunity to learn from those who are already doing it well, both within child welfare and in industries. For example, the National Partnership for Child Safety, a collaborative of child welfare leaders in 38 jurisdictions, offers a number of resources to support jurisdictional efforts to integrate safety science into their child welfare systems.
- **This is not a step to be undertaken lightly.** Changing the culture of any organization or system requires time and sustained commitment, as trust is built slowly among staff.
- **Do not allow the culture shift to be derailed by crises.** Leaders who implemented a safety culture during the COVID-19 pandemic noted that the crisis was not a reason to slow their efforts, but rather provided an opportunity to become even more adaptive and accelerate the pace of change.
- **Leadership must model a safety culture.** Humility and honest two-way communication are critical for leaders implementing a safety culture in their agencies or organizations.
- **Engage external stakeholders.** Political leaders, oversight boards, and union representatives need to be engaged in the shift to a safety culture so that they fully understand and can support the changes. Vermont proposed legislation to protect the confidentiality of critical incident review participants as part of advancing a safety culture. By supporting protections for frontline staff while maintaining transparency, the bill reflects how partnership with policymakers can help institutionalize reforms that prioritize learning over blame.[4]

Child protection agencies in **Tennessee** that have implemented these changes are beginning to see benefits, including lower caseworker turnover rates, increased community trust, and even fewer children being brought into foster care as a culture of fear becomes one of accountability and mutual support.[5]

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[1] Aven, T. (2014). What is safety science? *Safety Science, 67,* 15–20.
[2] Cull, M,J., Rzepnicki, T.L., O'Day, K., & Epstein, R.A. (2013). Applying principles from safety science to improve child protection. *Child Welfare, 92*(2), 179-95.

[3] Cull, M,J., Rzepnicki, T.L., O'Day, K., & Epstein, R.A. (2013).
[4] Derived from presentation made at the National Partnership for Child Safety convening held in Chicago, IL on October 29-30.
[5] Vogus, T. J., Cull, M. J., Hengelbrok, N. E., Modell, S. J., & Epstein, R.A. (2016). Assessing safety culture in child welfare: Evidence from Tennessee. *Children and Youth Services Review, 65*, 94– 103.

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