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October 20, 2021

Todd Landry, EdD

Director Office of Child and Family Services

Maine Department of Health and Human Services

2 Anthony Avenue. Augusta, ME 04333

Dear Dr. Landry:

This past July, you requested Casey Family Programs' assistance in investigating several recent child fatalities, to evaluate existing child safety policies in the context of the deaths, and to offer interim policy recommendations that could be implemented by the State of Maine to support child and family safety.

As you know, as part of our ongoing collaboration, we had previously discussed Casey Family Programs' work to support the application of safety science principles to critical incident reviews and how that work might be brought to OCFS. Collaborative Safety is an organization that has demonstrated expertise in this area and has developed a safety science-based model for conducting critical incident reviews. Casey Family Programs has partnered with Collaborative Safety in working with several jurisdictions to build internal capacity to implement this model. Therefore, in order to carry out this request we engaged Collaborative Safety to conduct critical incident reviews of these fatalities using their safety science-based model. Casey Family Programs joined in this process and the analysis that led to the recommendations offered in the accompanying report.

As outlined in the accompanying report, prepared by Collaborative Safety, the review process included the participation of OCFS staff at all levels, as well as external stakeholders, including partner agency staff, law enforcement, the Maine Child Welfare Ombudsman and a member of the Office for Program Evaluation and Government Accountability (OPEGA). The inclusion of the expertise and perspectives from these multiple stakeholders in the systemic analysis made for a strong process that identified several useful learning points. These learning points were mapped by the multi-stakeholder team, resulting in the findings and recommendations outlined in the report. We commend OCFS for its openness and commitment to learning, by making it possible for so many staff members to participate and by inviting external stakeholders to join in this process.

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As stated in the report, it will be important for OCFS to continue engaging input from stakeholders, including staff at all levels, system partners and those with expertise from lived experience of the child welfare system, as system improvements are considered, planned and implemented. Indeed, the review process illuminated and reinforced the fact that the child welfare system is much broader than OCFS. Efforts to improve or transform that system to ensure optimal performance require an approach of inclusion and shared responsibility. OCFS recently led such a process, with the development of Maine's Family First Prevention Services Act (FFPSA) plan and can build on that approach as it considers implementing the recommendations in this report.

Beyond our assistance in this recently completed investigation and review, Casey Family Programs can play an ongoing role in supporting OCFS and its stakeholders in the consideration, planning and implementation of the recommendations. This support can range from the examination of national best practices to facilitation of group processes with system partners and stakeholders.

We appreciate the opportunity to assist with this process and look forward to an ongoing role in supporting the State of Maine in its efforts to improve child safety and develop a child and family well-being system that achieves optimal outcomes for those it serves.

Sincerely,

Dan Despard

Senior Director, Strategic Consulting Team 3

Systems Improvement, Casey Family Programs

Fred Simmens

Interim Managing Director, Strategic Consulting Team 3

Systems Improvement, Casey Family Programs

TRANSFORMING CULTURE | TOGETHER

Collaborative Safety Review
Maine Office of Child and Family Services
Summary and Recommendations

Collaborative Safety, LLC
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Summary

In July of 2021, Collaborative Safety (CS) was engaged by Casey Family Programs (CFP) to partner in conducting an independent systemic analysis of the Maine Office of Child and Family Services (OCFS), in the context of five child fatalities that occurred in June of 2021. At the time of this request, CFP and CS were in planning discussions with OCFS about integrating safety science into its critical incident review process. CFP has been a partner with CS to support the successful integration of safety science into child welfare systems throughout the United States. For this report, CFP partnered with CS in the review process as well as the recommendation development.

The request for this review was done so with the expectation that the report be completed to provide systemic learning and improvement, as opposed to an allocation of blame. Consistent with the approaches of Collaborative Safety and the field of Safety Science, the methods and outcomes of this report are consistent with those expectations.

To understand how a complex system operates, it must be understood from the perspective of those who operate within the system. As such, this review is the product of multiple and differing perspectives, each having a valuable contribution to the product of this report. Throughout this review, voices, and experiences from staff at all levels of the system were engaged. This included over 10 hours of discussion with multiple staff that had worked directly with the cases within the scope of the review. Additionally, the systemic analysis included the contributions of many staff throughout OCFS, from frontline staff to executive leadership across a 3-day period. This also included the participation of external stakeholders including partner agencies, Law Enforcement, the Maine Children's Ombudsman, and the Office of Program Evaluation and Government Accountability.

Through the course of this systemic analysis, Key Findings were produced that provided insight across multiple programmatic areas within OCFS and within the broader Child Welfare System. These Key Findings were comprised of the following:

- The Impact of the Covid-19 Pandemic,
- The Contribution of Turnover,
- The Constraints of Timeframes,
- Standby Staffing Patterns,
- Communication and Coordination with Providers,
- Difficulty Engaging Caregivers,
- Family Team Meeting Coordination, and
- Communication between Partners: Law Enforcement & Hospitals.

From the Key Findings, recommendations were developed to support systemic improvement. It is understood that there are no quick fixes within the child welfare system and careful thought and planning must be considered prior to their implementation. When considering the implementation of these recommendations, it is important that the changes made include the voice and input from staff at all levels that are affected. Furthermore, it is important that this document be considered more than a means for recommendations but rather as a source of learning. The following recommendations are listed in no particular order:

1. It is recommended that OCFS work with a coalition of providers to support effective coordination with child welfare staff (e.g., supporting families, court and Family Team Meeting participation, sharing information, etc.) and address any identified barriers.
2. It is recommended that OCFS establish joint protocol agreements between Law Enforcement, Hospitals and Child Welfare staff when there is suspected abuse or neglect to support communication and coordination.
3. It is recommended that OCFS explore ways to support consistent practices, including role clarity and ongoing support for Family Team Meetings.
4. It is recommended that OCFS explore ways to support engagement between parents and the child welfare system, such as parent partner/parent mentor programs.

5. It is recommended that OCFS continue to examine national best practices regarding standby and after-hours practices.
6. It is recommended that OCFS examine national best practices for assessment timeframes and ensure that whatever timeframe is selected, it is compatible with the expected workload.
7. It is recommended that OCFS conduct an analysis of current work tasks required in an assessment and remove any unnecessary and/or redundant tasks.

Collaborative Safety would like to specifically mention Casey Family Programs as being a significant catalyst for the integration of Safety Science into the Nation's Child Welfare Systems. Additionally, we would like to commend the openness and dedication to learning displayed by the leadership of the Maine Office of Child and Family Services and their staff who were engaged throughout this systemic analysis. This openness and dedication to learning were critical for the success of this systemic analysis.

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Review Approach

This review was conducted using methods and techniques consistent with contemporary safety science, which incorporates contributions from multiple fields of academia, such as psychology, engineering, sociology and organizational theory and management. Outdated methods of system analysis traditionally deconstruct organizational programmatic areas and individuals into separately existing entities requiring isolated analysis or scrutiny (Svedung, & Rasmussen, 2002). Contemporary safety science uses systemic analysis to understand how actions and decisions of workers within an agency are tied to their existing tools, tasks, and operating environment (Dekker, 2006). Furthermore, this approach seeks to understand how decisions, initiatives, resource allocations deeper within an organization and outside of it can surface in the work and outcomes experienced in everyday work (Svedung, & Rasmussen, 2002). Essentially, the systemic focus is less interested in component parts in isolation and more concerned with component interactions and connections between organizational and external structures.

These principles are structurally embedded into this review's approach. Guiding this review is the goal to learn about system interaction and function and ultimately make effective improvements. The goal is not to attribute cause or blame to any individual, organization, or programmatic area. The approach does not see "human error" or non-compliance as a suitable ending or conclusion for a review. Rather, "human error" is used as the beginning of further analysis and is seen as a surfacing representation of systemic conflict. Furthermore, this review is dependent on the contribution of individuals who operate the system of study. This includes engagement of individuals involved directly with the event of study. Additionally, it relies on representative voices throughout the organizational hierarchy and programmatic areas to most reliably capture and account for the complexity of the system of study.

To create context in which this case was analyzed, it is essential to expand on how the word system is conceptualized. System is not used as a reference to isolated organizational structures, such as policy units, clinical programs, or

training units. Further, it does not refer to an existing mechanical or technical system either. The system, as used in this review will consist of the different contributors (internal and external) to outcomes in work and the nature of their involvement or systemic contribution to an event. For instance, policy units, training units, and technical systems are considered to be components within a larger system that contribute to emergent outcomes. These system components do not exist in isolation and are all jointly sufficient for outcomes to occur (Hollnagel, Woods, & Leveson, 2006).

Hindsight and Outcome Bias

In the wake of tragic events, such as child fatalities, which will be further studied within this review, it is important to maintain awareness of hindsight and outcome bias. Hindsight Bias is the tendency to oversimplify events leading up to an adverse event when there is knowledge of outcome, access to all information and the ability to process that information outside of time constraints experienced during the event occurrence. Hindsight Bias simplifies the dilemmas, constraints and complexities faced by organizations and individuals and can lead to countermeasures that have counterproductive effects (Hugh, & Dekker, 2009; Woods, 2002). This understanding and management of this bias is necessary for learning to take place (Woods, 2002).

Hindsight Bias, when unaccounted for can leave reviewers and readers with the impression that worker decisions and actions can be reduced to the presentation of two choices: good or bad. It can lead towards giving little credit to the complexities and constraints faced by workers in context and can result in counterfactual reasoning. Counterfactual reasoning is when outcomes are explained by what did not happen as opposed to what did happen. It typically incorporates vocabulary such as “should have,” “could have” and “if only,” as if better options presented themselves and were subsequently ignored. Decisions in context are made because they are viewed to be the most rational given knowledge, tools, supports, assessments, and expectations. Any decision is assumed to be correct at the time it is made, otherwise it would not have occurred.

Outcome Bias refers to the influence of outcome knowledge onto the understanding of decision or service quality (Hugh, & Dekker, 2009). Specifically seen is the increased likelihood for post hoc reviewers to make judgements on decisions and actions. In addition, Outcome Bias also influences those judgments to be harsher (Hughes, & Dekker, 2009). As reflected with Hindsight Bias, in order for learning take place, the outcome bias must be accounted for.

Outcome Bias can lead reviewers and readers to applying heavy scrutiny and judgement to worker decisions and actions associated with adverse outcomes. The outcome bias may create an inaccurate proportional congruence between cause and effect. Essentially, if a decision preceded an egregious event, the decision will be viewed in equal magnitude to the egregiousness of the outcome (i.e., bad outcome = bad decision). Conversely, if a decision or action preceded a benign or good outcome, although it may be the same decision, it will be viewed as being less egregious and more acceptable.

Review Method

The approach used in this systemic review can be represented by three critical components: technical data collection, human factors analysis and system analysis. The technical data collection is characterized by an in-depth exploration of available data comprised of recent and historical information specific to the subject children and their families. This information includes case records, provider documents, police reports, medical records, and first-hand accounts from workers involved with casework. The human factors analysis is represented by a collection of accounts provided by workers involved with casework. Where this departs from typical interview responses is the focus of questioning and inquiry. The human factors analysis is designed to understand decision making in context, capturing focus of attention, key knowledge supports and guiding goals and/or strategies. Lastly, the systemic analysis seeks to make the connection between key areas of study supplemented by human factors data and the system in which they exist. This analysis incorporates perspectives across the system hierarchy to most reliably reflect the complexity of the system of study.

Technical Data Collection

Technical data is documented evidence that is discovered in available records, such as, case records, medical records, note entries, clinical reports, etc. While gathering the technical data that is available specific to an event, it is important to note that one may never uncover the whole truth of an event and the past is never completely knowable, especially when interpretations are always subjective and alternative views will inevitably exist (Reason, 2008). A guiding principle used in this report is to gather all factual data relevant to the situation in question (Dekker, 2006).

Within any system, there is an abundant amount of data sources to start; a few examples for this review include:

- Policies
- Case Records
- Child Abuse or Neglect Reports
- Medical Records
- Police Reports

The collection of data typically reveals a sequence of activities which includes human observations, actions, assessments, decisions and any changes in the processes or system (Dekker, 2002), all of which provide an opportunity to understand the environment influencing the subject child and the care provided. This collection provides a starting point to look further into the data to identify key areas of study called learning points. Learning points are determined from the data review. The determination of learning points is guided by, but not limited to:

- Work conducted outside of policy and/or written guidance
- Work conducted outside of expectations and norms
- Other areas of work that would benefit from further analysis

Human Factors Data Collection

The field of human factors studies how individuals operate in sociotechnical systems. Human factors data is needed because people do not operate within a vacuum; they operate while constantly interacting with the system around them (Dekker, 2006). For this very reason, the hard, factual information may serve little purpose in trying to understand why systems encounter

difficulties, if it is not understood from the perspective of frontline workers. To achieve this enhanced knowledge, debriefings provide insight into the unfolding mindset of the individuals within the system (Dekker, 2006), closest to children to which care is provided.

Debriefings are conducted to help reconstruct the situation that surrounded frontline workers (Dekker, 2006). Gary Klein developed a method of debriefing (as cited in Dekker, 2006, pp.94-95), which outlines a useful order and strategy:

1. Have the participant tell the story from their point of view, without presenting any additional information that may distort their memory.
2. Tell the story back to the participant as the investigator, in an attempt to gain common ground.
3. Identify critical junctures in the sequence of events (this includes issues identified from hard data) if anything additional is detected.
4. Progressively probe critical junctures to show how the situation was understood from the perspective of the participant, additionally it may be appropriate to provide any necessary data to the participant.

Table 1: Debriefing Example

At each critical juncture one will want to know	**Examples**
1. What cues may have prompted decisions or actions from the participant's perspective.	Environmental features, perceptions of tasks, etc.
2.What knowledge was utilized to inform these decisions or actions.	Trainings, policies, education, experiences, etc.
3.What goals were being pursued.	Being efficient, thorough, etc.
4.What other influences or constraints may have influenced their perception of a situation and subsequent actions.	Biases, system difficulties (e.g., fiscal processes, workload demands), etc.

Systems Analysis

After the technical data has been combined with the human factors data, this information is compiled and arranged for the Systemic Analysis. The overall goal is to place the collected data in a useful format that will provide a clear and relevant picture of the event within context, which will allow for the exploration of any issues from a systems perspective. The systems analysis is a collaborative process and begins with the selection of the Mapping Team.

Mapping Team Selection

The primary purpose of having a team analyze events from a systems perspective is because one person does not have adequate knowledge of an entire system. Rather, richness is provided from a collaboration of different disciplines and perspectives, each further shaping useful explanations and interpretations which can promote learning from adverse events, such as deaths. Thus, teams should be dynamic and comprised of individuals who can provide insight into the components of the system being reviewed, which will typically include:

- Frontline staff
- Frontline supervisors
- Regional Management
- Central Office Leadership
- System Partners

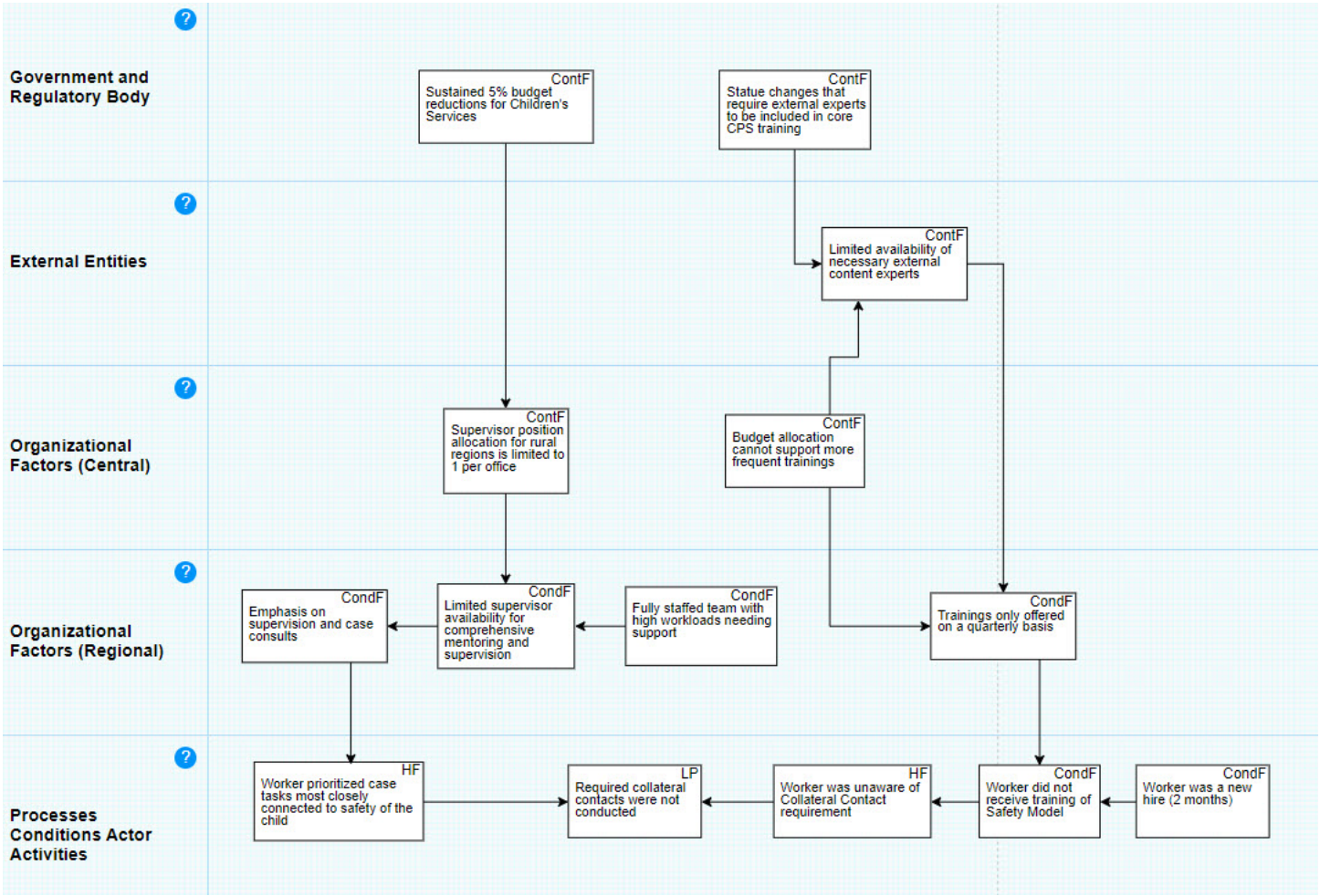
Methods for Mapping

For the purpose of review, a model is needed to guide the discussion of the Mapping Team away from perceived proximal causes and instead use them as a starting point for further exploration (Woods, Dekker, Cook, Johannesen, & Sarter, 2010). AcciMap is an accident model that is based on a vertical analysis across system levels and breaks away from traditional horizontal generalizations of events proximal to an adverse event (Svedung & Rasmussen, 2002). Specifically, the goal of the AcciMap is to design improved systems and to avoid traditional methods of assigning blame (Svedung & Rasmussen, 2002). The belief is that influences at higher levels of a system travel down to the bottom, which is most proximal to families (Salmon, Cornelissen, & Trotter, 2012). Figure 1 represents the map used for this analysis. Figure 2 represents an example of a complete map, not specific to this review.

Figure 1: Systems Map

Government and Regulatory Body	
External Entities	
Organizational Factors (Central)	
Organizational Factors (Regional)	
Processes Conditions Actor Activities	

Figure 2: Example Systems Map Completed



The adapted AcciMap focuses on issues spread across 5 different levels: conditions, processes and actor activities; regional operations; central operations; entities external to the child welfare system; and government and regulatory bodies. The bottom of the tool represents the local influences specific to the incident in question. Higher levels of the AcciMap are representative of processes and decision makers which ultimately influence local outcomes (Svedung & Rasmussen, 2002).

For the purpose of the review, the process is guided by the analysis facilitator. Starting with the pre-identified issues, the facilitator guides discussion up and out from the key areas of study in order to explore all relevant influences throughout the system at each level. The process does not identify broken components or propose fixes when exploring different levels of the system; rather, the analysis identifies "normal" influences which may have participated in the promulgation of the subject at hand.

As a final step in analyzing the information from the technical data, human factors data and systems mapping process, the information should be brought up to a conceptual level. At this time, the objective is to build an account of what happened in a way that does not utilize domain specific terms; rather, the language is of human factors (Dekker, 2002). This account includes the language of production pressures, goal conflicts, tradeoffs, resource constraints, knowledge gaps and procedural adaptions, to name a few. This allows findings to be set in a language that can be communicated to other domains and allow for the identification of common conditions across cases (Dekker, 2002).

Key Findings

The Impact of the Covid-19 Pandemic

There are intuitive expectations that one can have regarding the impact of the Covid-19 pandemic on the operations of a large state system. The impact of Covid protocols surfaced during the review. Covid protocols were identified to be a stressor onto already difficult staffing situations. As frontline staff and supervisors follow guidelines to isolate and quarantine, their workload is shifted to others within the system. This can result in frontline staff taking additional cases or supervisors taking additional cases and oversight as well. Supervisors are expected to cover for their peers in the event that they are on leave. Staffing and workload are consistent pressures across the nation's child welfare systems, and this places additional pressure onto an already scarce resource. More on how staffing levels affect supervisor support and frontline staff work will be further discussed in "The Contribution of Turnover" section.

In another instance, the pandemic was recognized to be contributing to staff availability within the Alternative Response Program. While staff across programmatic areas are working hard to manage Covid responses within their respective work context, they are also managing the effects in their personal life. Staff availability can be affected by quarantine and/or isolation measures. They are also impacted from family members, for instance varying expectations on whether their children will be in class or learning virtually. These variables take staff away from their primary work focus and can create workload and availability pressures.

These pressures contribute to important expectations not being met, such as contacts with children and families. As workload expectations stay consistent or are increasing and there is lost time due to Covid restrictions, staff will allocate their attention to more high-risk or manageable cases. In a case where there are barriers to completing the work because of difficulty engaging family members, staff may forego completing activities on those cases at the expense of cases where they will see better engagement.

The Contribution of Turnover

Staffing, and specifically turnover, surfaced as having impact on the completion and quality of tasks. The effects of turnover have been understood to place strain on the child welfare system leading to inconsistencies in services to children and families (Strolin, et al., 2008). Consistently noted across cases was the mismatch between the demand of high workload and the human resources to meet that demand.

Turnover was specifically a concern in the area of permanency, which is likely impacted by the cases and learning points explored during the review. Ultimately, the turnover was shown to be a stressor on staff workload contributing to case expectations not being completed. This had impact on both front-line permanency staff and their supervisors. For frontline staff, this surfaced as case expectations not being met. Supervisors were faced with not being able to provide expected supervision and support for their staff.

Turnover is influenced by both individual and organizational factors (Strolin, et al., 2008). Individual factors such as feelings of being ineffective with families, facing hostility from community partners or exhaustion were noted to have impact. A unique attribute to the permanency unit that was discussed, was the span of time that staff can spend working with a particular case. This contributed to feelings of ineffectiveness or helplessness. As staff are connected with a particular family over time and they do not see progress, they may feel that their efforts are not effective and there is little hope for a positive outcome.

A reciprocal effect between turnover and workload also evidenced itself. Organizational factors such as workload and variance in cases that are experienced in the permanency unit contribute to exhaustion and burnout of workers which ultimately increases turnover rates. These turnover rates then further perpetuate workload pressures.

The Constraints of Timeframes

A constraint that surfaced was the 35-day time frame that assessment cases need to be completed. These timeframes were noted to have a negative influence on the ability of staff to complete case tasks and maintain standards or expectations. In this child welfare agency, and across the nation,

there is ongoing monitoring of compliance with these metrics and there can be considerable pressure that staff face. While performance monitoring systems are effectively trying to manage resources, the way these systems are conceptualized and implemented may have substantial impact on quality (Tilbury, 2004).

These 35-day timeframes were developed following careful examinations of national standards and with the important goal of not staying involved in family lives more than necessary. Additionally, there is a workload component to consider; when cases stay open too long, the required activities create workload "bottlenecks." It was noted that when the 35-day timeframe was first implemented in 2005, it was widely recognized as successful. However, as time has progressed, there has been an asynchronous development between the additional case activities and the timeframes.

Essentially, the amount of work that is expected to be completed in cases has gradually increased over time without adjustments to the timeframe in which they need to be completed. Staff then feel they do not have the time they need to complete all tasks or have meaningful impact with the families they support. Additionally, with limited time to collect the information they may need, staff are placed in a position where they are more likely to make hurried decisions on how to proceed with a family with limited knowledge.

This also impacts quality of supervision. As initially designed, 30 days were allocated for the assessment staff to complete the assessment and the remaining 5 days were for supervisors to provide guidance and oversee quality. Because of the difficulty of completing tasks, staff are completing cases beyond the 30-day expectation, leaving supervisors with limited time to provide supervision. This results in supervisors not being able to allocate the necessary time for supervision on a particular case, further increasing the likelihood that case expectations may not be met or gaps in casework may not be recognized.

Standby Staffing Patterns

After hours staffing procedures surfaced as having a significant impact on the ability of staff to effectively complete their work. This was shown to have impact not only on frontline staff, but their supervisors and district managers. The current approach to afterhours staffing is to assign staff standby shifts which are based off seniority. The choice of shifts being based off seniority is consistent with expectations that were set by worker unions. While clearly well intentioned, there are noticeable unintended consequences.

From the perspective of frontline workers, these standby assignments can create difficulties. When staff are signed up for standby shifts, they are often assigned assessment cases. These cases are inherently difficult, given the severity that some cases may have and the numerous tasks that are required to be completed within a 35-day timeframe. However, the staff that are required to work these cases may not be assessment staff but rather permanency staff. While they may have gone through the same basic Foundations training course, the experience levels may vary greatly. For instance, in one reviewed case, the standby staff assigned to an assessment case was not only new to being a permanency worker, but they had also never worked an assessment case before.

The standby staffing structure has an impact on the quality of work, the completion of expected tasks and the comfort of the staff. When staff are unfamiliar with the required tasks and have less experience carrying out required activities, the likelihood that those tasks are not completed increases. This is compounded with the fact that staff are already carrying full caseloads prior to the cases acquired on standby, which are kept until closure.

Furthermore, the ongoing monitoring of the case work of the staff is conducted by their supervisor for their unit. This can put supervisors in a position of having to support workers when their own experience may be limited in assessment cases. This is also compounded by the fact that both frontline workers and supervisors are already managing their own cases that are competing for their time and attention. Given that the standby workers'

primary knowledge and experience is within permanency, it is understood that their attention would be dedicated to those cases.

Another contribution from the current standby process, involves staff having minimal experience working together. During the standby shift, staff initially may work with supervisors and managers for the first time. This can create a host of difficulties for joint activity. Common ground, or the state of working with mutual understanding of each other's skillsets is compromised (Klein, et al., 2004). Teams working together for the first time do so without understandings of level of skill and experience of staff. This can create situations where supervisors and managers may not know what a staff needs support on or have any familiarity with how they communicate information. This contributes to decisions being made with good faith that frontline staff are completing tasks to expected standards. Furthermore, supervisors and managers are put in a position where they may not know how to best support staff they are paired with.

Communication and Coordination with Providers

Contributing to the ability of staff to support children and families is the breakdown in communication and coordination with provider agencies. For many families, including those that were involved within this report, there may be needs of parents, which include mental health support, substance use counseling, etc., that are being addressed by these providers. From the perspective of a systems approach, the goal of this system would be to coordinate between child welfare staff and the providers that they refer family members to see for support (Klein, et al., 2004). This would allow for a holistic approach to supporting the family unit as a whole. However, providers may be less likely to want to coordinate with child welfare staff. When providers become engaged with parents, they can see the parent as their primary patient and customer. So, this contributes to providers being primarily focused on supporting the needs of the parent without considering the needs of the family unit as a whole. This can also create situations where providers may try and protect parents from the child welfare agency as they come to see the child welfare agency as being a stressor or threat to the family itself.

Further contributing to this difficulty in coordination, are barriers that providers can face when trying to meet the expectations of the child welfare system. Perceptions on confidentiality can put providers in a situation where they do not feel comfortable sharing information with the child welfare agency. Additionally, as part of the requirements of the child welfare system, there may be expectations for providers to show up to court dates or family team meetings. Providers are reluctant to participate in these expected activities as they may see them as being harmful to their primary client, the parent. Further, this could be seen as a loss of revenue for the provider as they typically are not compensated for participating in these activities required by the child welfare system. Collectively, these factors decrease the likelihood that providers want to share information and engage with staff from the child welfare system to support the child and family as a whole. In some instances, providers may completely decline to work with the state in this capacity.

Difficulty Engaging Caregivers

Difficulty engaging caregivers surfaced as strongly affecting the ability of the child welfare system to support the child and the family. Families in general may be reluctant to want to engage with the child welfare system, however it is widely understood that engagement is critical for effective interventions (Toros, et al., 2018).

As families that have frequent interaction with the child welfare system gain knowledge about how it functions, their understanding of what they are or are not required to participate in becomes more robust. Therefore, parents know what they are required to comply with and what they do not have to comply with. This can put staff into a difficult situation where they know that there are needs of the child and or family, but they feel there is little to do in way of addressing those needs. Outside of a court order, a family's engagement with the child welfare agency is voluntary. As such, unless a court order is obtained (e.g., establishing jeopardy), frontline staff are placed in a position of having to rely on the engagement of the family for them to provide supports. So, if the parent or family does not want to engage, they feel there may be little they can do beyond continuously asking for the parents to meet with them with little or no success and eventually closing the case.

This was also noted to impact how cases are passed from one staff to another. For instance, how information is passed to a new worker from another that has been previously involved with the same child or family. If it is well known among staff that a particular family member is evasive and will not comply with requests for contacts, then that message will be passed to the new worker. This may promote a discouraged attitude for staff who take on this new case and set a mental model that no matter their efforts the parent or family will not want to engage with them. As a result, this may decrease the effort that staff place towards making that engagement or that contact.

The lack of engagement with a parent and family can also contribute to staff feeling a sense of helplessness. Because of the ongoing experience of not having success engaging with the parent or family, their perceptions of future success with that family become compromised. This can decrease motivation to keep cases open for continued monitoring or going to extra efforts (e.g., unannounced home visit) to make contact with the family.

Family Team Meeting Coordination

Difficulties in engagement and coordination surfaced within Family Team Meetings (FTM). As Kemp et al. states, families that are sometimes in most need may be least likely to engage, and it is connected to the myriad challenges these families face (2009). Difficulties experienced during FTMs can contribute to the engagement of parents and families. For instance, the ability to communicate intent to parents can sometimes be negatively affected as these meetings are carried out.

FTMs are typically acutely focused on the most recent incident that has occurred and place less emphasis on a child or family's historical cases or needs. This is first impacted by lack of role clarity that exists during the FTM. It is expected that the investigator would be the lead on these meetings, however it is common for that not to be the case. Additionally, investigators may have limited knowledge and experience to lead or conduct an FTM.

Expectations of staff within the FTM were noted to be unclear. Contributors to this are varying practice, training, and expectations across districts. A central

office memo was distributed to districts to help clarify the role of staff during FTMs, however this did not shift the varying practices across districts. This could be impacted by the relevance districts place on policy that is communicated by memo and the acute point in time nature of the memo release. As staff turnover occurs or staff take on new positions, there may be limited institutional knowledge of what was in the memo. The makeup of the FTM also contributes to a narrow scope of information discussed.

Parents and their attorneys may defensively only share information that primarily highlights positive achievements of the parent at the expense of important needs. For instance, the dialogue of the group will be directed toward the achievements of the parent, which is beneficial information. However, parents and attorneys can be reluctant to discuss and reveal information that may represent the needs of the parents, family, or children. Furthermore, it may be less likely that historical concerns about the family are discussed. This impacts transfer of knowledge to ongoing workers, but also does not allow for the opportunity to engage in dialogue about important needs. This is likely further used as a defense mechanism against a child welfare system that they may viewed as authority based and harmful.

<u>Communication between Partners: Law Enforcement & Hospitals</u>
An interesting influence that surfaced outside of the child welfare agency itself but was relevant to the child welfare system, was the interaction between law enforcement (LE) and hospital staff. The communication of these two entities is important to note since staff interact with these community partners often with cases. Child welfare staff generally will defer to LE and this is independent of experience and knowledge when gathering information.

Often, LE receives information from hospitals and then provides that information to case workers in support of their investigations. However, LE faces difficulty collecting information from hospitals. Essentially, hospitals are less likely to share information with LE due to fear of HIPAA violations. LE is then left with limited or purposefully vague knowledge about the child in the hospital (e.g., severity of injuries, origin of injuries, etc.) but provides this information to the caseworker. Caseworkers will then use this information

from LE to make decisions on child safety and this reliance becomes heightened in emergency responses when there is little time to conduct in depth fact finding. The caseworker subsequently takes LE information over direct information from hospital even though the information from hospitals is more robust for the social worker and at times more accurate.

Conclusion

Given the nature of the cases reviewed, it is understandable that there is frustration on the part of all those involved: families, OCFS, involved staff, community partners, community members, elected officials, and media. The next step, which is incredibly important, is how child welfare system progresses in the future. It is strongly advocated in the field of safety science that accountability be forward looking, meaning that we do not progress as a system by looking back for blame and punishment, we progress through in-depth and genuine learning. While work can be identified as going outside of expectations or norms, this cannot be constructed as the cause for the tragic outcomes that were the subject of this review.

Through this review, we are confronted with the terrible realities that many child welfare systems encounter. A child with connection to the child welfare system tragically loses their life and many influencing variables were outside of the control of the child welfare agency. Child welfare agencies are not all knowing, not unlimited in intervention, and cannot predict the future. With that said, there are lessons that can be learned by the child welfare agency as it moves forward from these tragic events and supports children and families in the future.

- Throughout the presented findings, the notion of drift stands out. As Woods states, complex systems are subject to pressures of faster, better cheaper (2019). Complex systems such as child welfare pursue success in an environment that faces pressures for efficiency, expectations for higher quality, and responsibilities to be fiscally responsible. These pressures force adaptions at all levels of the system, however adjustments are made locally to component parts without the corresponding adjustment for interdependent system components and functions (Dekker, 2011).
  Connecting back to this review, this phenomenon is seen through the finding of The Constraints of Timelines. Supporting efficiency, a decision is made to set timeframes for work to be completed and as time progresses local adjustments to support quality are made (e.g., new forms, new tasks, new compliance). While the impact of these adjustments is not noticed immediately, they begin to slowly push

performance to the boundary of what is feasible given that timeframe. The lesson here is not one of improper or problematic timelines, it is that locally rational changes can have global impact and systems must evolve to pressures over time. This places great importance on the child welfare agency to anticipate how changes may have systemic effect and monitor when work goes outside of acceptable performance so that appropriate adjustments can be made.

- Another prominent concept that emerged is regarding joint activity and team coordination as a system. This is inherently connected to and a precondition for interacting as a team within the child welfare system (Klein, et al., 2004). Essentially, to effectively work together as a system or as a team, certain criteria need to be met. A first consideration would be understanding who comprises the team. In a child welfare system this includes community partners, families, providers, and various programmatic areas. Another consideration is that having common ground with team members is essential. This can refer to effective communication and mutual understandings of expectations, roles, intent, and/or goals.

  The difficulties of this joint activity and team coordination were noticed in numerous findings. It was noted that community partners such as Law Enforcement and Hospitals face difficulty in trusting what information can and cannot be shared between the two. In another example, the goal conflicts between the child welfare agency and the provider community create dilemmas in being able to effectively work together to support families. At the local level, it was noticed that standby staff coming together for the first time to coordinate activities on a case can face difficulties from not having common ground or mutual understandings of each other's needs and skillsets. This also connects to the adversarial relationship between the child welfare agency and the families they support. The lesson here is that there is importance for members of the system to realize that they are trying to pursue a mutually beneficial goal, the health and safety of children. Ultimately, the better these members of a system can work together, the better the outcomes will be.

- There is significant value in creating a system that can retain its workforce. The strain that turnover places on the child welfare system is widely understood and can have significant impact on the effectiveness of the child welfare system (Strolin, et al., 2008). Adding to the complexity of this widely experienced matter is that the influences are numerous. They encompass the personal experiences of staff that work within the child welfare system and the organizational context in which work is conducted.

  Validated across reviews was the point that turnover has cascading impact throughout the system. It was shown to have contributions to workload for staff and supervisors, the support supervisors can provide their staff, and the quality of supports provided to children and families. The features of how turnover was produced in the system were focused on caseload and workload stressors, feelings of being ineffective, and burnout. The lesson here is that agencies must consider the notion of accountability up vs. responsibility down. Often, agencies are effective in creating accountabilities that staff are held responsible for (e.g., metrics, timelines, compliance). However, agencies also must focus on having an important responsibility to provide the supports for staff to be successful in the workplace. This includes engaging staff, listening to needs and allowing them to have an impact on their organization.

- Lastly, it is important to highlight the effect that high profile events can have on a child welfare system. Given the nature of tragedies that occur in child welfare systems across the country and internationally, there is often public outrage that ensues. This can be noticed in the media through language of blame on the organization and the individuals who do the work every day. This retributive response has numerous unintended consequences ranging from unnecessary removals of children, staff turnover, decreased timeliness to permanency, and impact on the mental health of caseworkers.

  While accountability is important following these events, it cannot be isolated to the retributive responses currently being experienced. Child

welfare is an incredibly complex system that interfaces with high-risk situations and can rarely, if ever, be reduced to the failings of a person or component of that system. The narratives we provide need to reflect the inherent complexity of the child welfare system. When this is accomplished, our system can better learn and improve so that progress is made towards better supporting children and families.

Recommendations

From the Key Findings, recommendations were developed to support systemic improvement. It is understood that there are no quick fixes within the child welfare system and careful thought and planning must be considered prior to their implementation. When considering the implementation of these recommendations, it is important that the changes made include the voice and input from staff at all levels that are affected. Furthermore, it is important that this document be considered more than a means for recommendations but rather as a source of learning. The following recommendations are listed in no particular order:

1. It is recommended that OCFS work with a coalition of providers to support effective coordination with child welfare staff (e.g., supporting families, court and FTM participation, sharing information, etc.) and address any identified barriers.
2. It is recommended that OCFS establish joint protocol agreements between Law Enforcement, Hospitals and Child Welfare staff when there is suspected abuse or neglect to support communication and coordination.
3. It is recommended that OCFS explore ways to support consistent practices, including role clarity and ongoing support for Family Team Meetings.
4. It is recommended that OCFS explore ways to support engagement between parents and the child welfare system, such as parent partner/parent mentor programs.
5. It is recommended that OCFS continue to examine national best practices regarding standby and after-hours practices.
6. It is recommended that OCFS examine national best practices for assessment timeframes and ensure that whatever timeframe is selected, it is compatible with the expected workload.
7. It is recommended that OCFS conduct an analysis of current work tasks required in an assessment and remove any unnecessary and/or redundant tasks.

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