



STRATEGY BRIEF

HEALTHY ORGANIZATIONS

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

Child protection agencies operate under tremendous social and political pressure. Too often, a tragic outcome (such as a child death or serious injury) leads to a cycle of intense media scrutiny, blaming and firing of individuals determined to be responsible, and an increased agency-wide focus on compliance and heightened practice monitoring. Such responses, driven by emotion, often contribute to organizational cultures of anxiety and defensiveness while doing little to improve safety.¹

Child protection agencies can learn much from other safety-critical industries — such as aviation, health care, and nuclear power — that have applied the principles of safety science to change organizational culture, improve practice, and reduce the incidence of tragic outcomes. Public safety in these areas also has increased as a result.

As child welfare leaders have sought to implement these principles, they are discovering that race equity is a critical lens in the development of a safety culture within child protection agencies. Safety is a prerequisite for the honest conversations necessary to address racial disparities. Likewise, no organizational culture can claim to be truly safe until it is equally safe and just for all.



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Safety science vs. Safety culture

Safety science involves applying scientific methods, research, and tools to understand, assess, and manage safety.² 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 we employ safety science, we identify and apply lessons learned based on the best available research and evidence.

Experts in the field of safety science seem to agree that organizational culture is an important piece of the puzzle. Other safety critical industries have recognized that a culture of fear and blame does not promote learning from error, and it can result in decreased organizational effectiveness and compromised safety. Today, research is increasingly available to guide child protection agencies in creating a **safety culture** that is more effective in protecting children from harm. This includes balancing individual and system accountability by examining system factors.

Creating a safety culture

Studies of hospital nurses have found “a positive association between organizational cultures characterized by reluctance to report errors and acknowledge mistakes and the frequency with which medical errors occur.”³ Certainly, the cycle of blame in child protection agencies has not been shown to measurably or sustainably reduce the incidence of tragic events.

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 and take effective action to promote child safety. Some of these are directly related to the individual (training, experience, and critical thinking skills), but many are not (agency policy, agency or office climate, and caseload or workload). Agency leaders therefore play a critical role in creating an organization-wide culture to support effective casework.

The journal article “Applying Principles from Safety Science to Improve Child Protection”⁴ 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:

- **Leadership 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

There will not be anything we do in this organization that will not be girded in ... a safety culture and culture of equity. We recognize that we have significant challenges around racial bias. As a result we have created the Office of Equity that sits at the executive level of the organization. Everything we do — every policy we make, practice, hiring, must all be viewed through a lens of safety culture and a culture of equity.”

— VIRGINIA PRYOR,
CHIEF DEPUTY DIRECTOR, LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES

to safety and how to effectively address them. For example, in 2013, Tennessee conducted an anonymous, cross-sectional survey of staff to measure various aspects of safety culture: safety climate; psychological safety; stress recognition; safety organizing; and workers' emotional exhaustion.⁵ The [intent behind the survey](#) was to create a common language to drive culture change, raise staff awareness about safety, identify opportunities, and allow the state to track changes over time. Other strategies employed by the state include improving communication, teamwork, and supervision, as well as anonymous reporting of concerns and safety incidents.

- **Developing and enforcing a non-punitive approach to event reporting and analysis.** Some child welfare agencies are beginning to explore the practice, currently more common in other industries such as aviation, of creating a system for confidential reporting of practice errors and “near misses.” This approach helps to promote organizational learning and a better balance between individual and system accountability for safety.
- **Committing to becoming a learning organization.** It is important for child protection professionals to have opportunities to learn not only from their mistakes, but also from their peers, and to continually improve their critical thinking skills. Likewise, the organization as a whole must continue to learn and evolve in response to an ever-changing world. In 2011, Tennessee hired master's level mental health professionals to conduct non-punitive analyses of child fatality cases in order to support continuous organizational learning.⁶

Responding to critical events

Maintaining a safety culture becomes even more essential when managing the organizational response to a crisis, such as a fatality or serious injury to a child. When the public, the media, policymakers and the child welfare system's response to a high-profile death results in individual blame, staff can become more risk averse and fearful, leading to increased removals of children and delayed reunifications. In addition, when policymakers react by passing new laws and the system institutes more procedures in response to critical incidents without fully considering the unintended consequences, they add to the complexity of an already overwhelmed system. The result can be increased workload and high staff turnover. Overall, these reactive responses can make the system less effective in keeping children safe.

In addition to developing a culture and expertise that supports critical thinking, the journal article “Leading for Learning in Child Protection Services Following a Child Fatality”⁷ recommends the following in response to specific 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

Safety culture means that after critical incidents we no longer ask, ‘Who is responsible for this failure?’ but instead, ‘What factors led to this outcome, and how do we need to change our systems so that we can better protect children in the future?’

— DAVID HANSELL,
COMMISSIONER, NEW YORK CITY ADMINISTRATION FOR CHILDREN'S SERVICES

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leaders. David Hansell, commissioner of the New York City Administration for Children's Services (ACS), notes: "When there are critical incidents, we are accountable to our political leadership and to oversight agencies, so we included those stakeholders in our initial orientations to safety science. It was important that they understood the cultural change we were going through, so we weren't working at cross purposes with them as we developed a new way of responding to incidents."

- **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 foster 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. Jodi Hill-Lilly, deputy commissioner of the Connecticut Department of Children and Families, points out: "You need safe and sound staff, in order to have safe and sound practice, in order to get safe and sound outcomes on behalf of kids and families. Creating an environment where staff can be honest, where we are attentive to their psychological and physical safety and grounded in anti-racist practice, is critically important to the safety of our kids and families. We ground our work in justice."

Lessons learned⁸

Leaders who have implemented the principles of safety science to promote a safety culture offer strikingly similar advice to other jurisdictions:

- **Incorporate the voice 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 other industries. The [National Partnership for Child Safety](#) is a quality improvement collaborative formed by child welfare leaders in 15 jurisdictions with a shared goal of strengthening families and promoting innovations in child protection.
- **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 implementing 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.
- **Safety culture must be modeled by leadership.** Some leaders have suggested that adaptive leadership, humility, and honest, two-way communication are core competencies for leaders in a safety culture. New York City ACS

We work hand in hand with the Office of the Child Advocate, our oversight agency, involving them in both case staffings and critical incident reviews. The more people involved in a decision, whether it is to remove a child or move a child, the more likely it is that the decision reached will be the right one. People can then do what they know is right, rather than being motivated by fear of making a critical mistake."

— TOM RAWLINGS,
DIRECTOR, GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES

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introduced safety science and safety culture at senior levels in the organization to ensure broad leadership commitment to the process. Hansell recalls: “We began with a very in-depth orientation of our senior leadership team. We then moved down through tiers of management, to be sure that everyone understood and could reinforce the messages about how we intended to work differently as a system.”

- **Engage external stakeholders.** It is essential to engage stakeholders such as political leaders, oversight boards, and union representatives in the shift to a safety culture so that they fully understand and can support the changes.

Agencies 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 care as a culture of fear becomes one of accountability and mutual support.

To learn more, visit [Questions from the field](#) at [Casey.org](#).

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8. Content for this brief derived from presentations made at two convenings of the National Partnership for Child Safety: 1) in Palm Beach, Florida on June 11-12, 2019, and 2) virtually on May 13, 2020.

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