The National Partnership for Child Safety: A Multi-State Learning Collaborative's Impact on Prevention

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NATIONAL PARTNERSHIP FOR CHILD SAFETY

The NPCS mission is to **improve child safety and prevent child maltreatment-related fatalities by strengthening families and promoting innovations in child protection**.

Central to this work is the introduction of principles from the sciences of **safety, improvement, and implementation**.

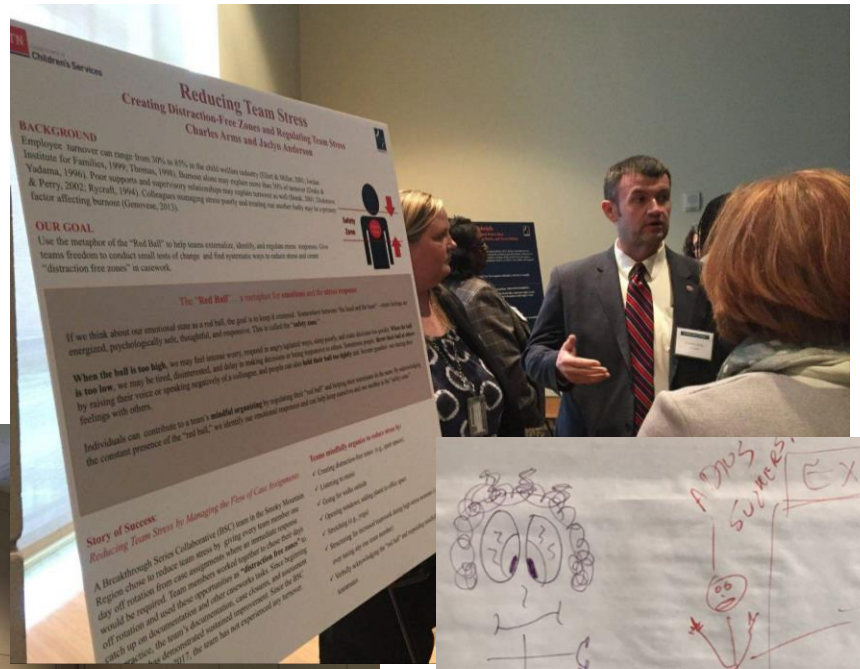
casey family programs

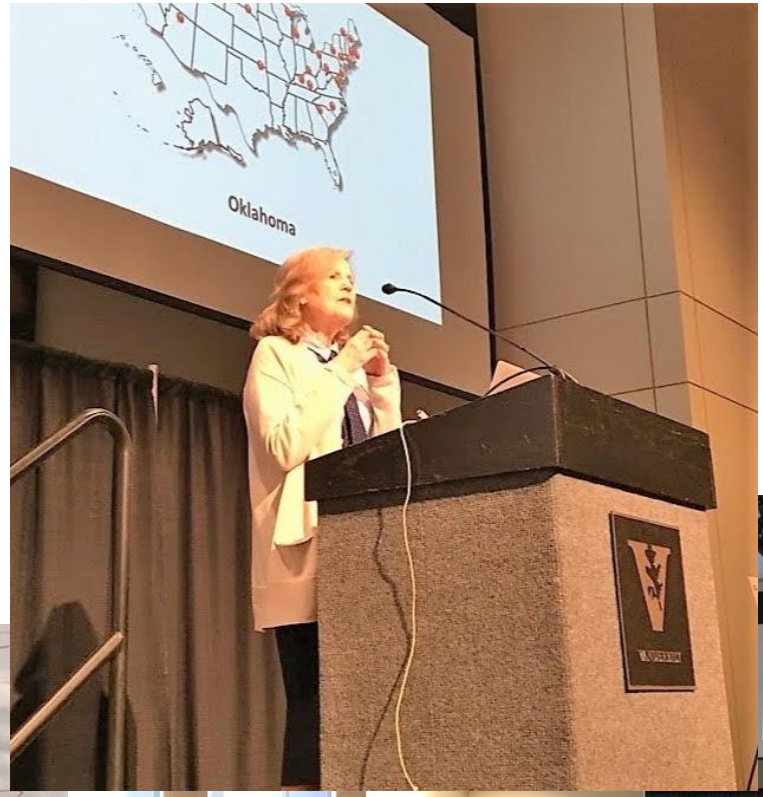
NATIONAL CFRP Center for Fatality Review & Prevention

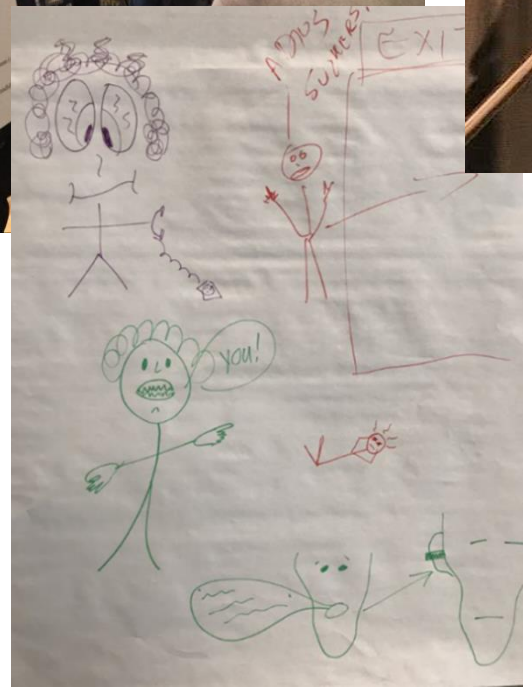
Center for the Helping Professions

Vanderbilt Safety Science Summit

2018







Tennessee: Pioneers in Safety Science

The Tennessee Department of Children's Services is implementing some of the elements of safety science through three primary efforts: a systemic approach to Critical Incident Reviews, legislatively protected confidential reporting, and an ag
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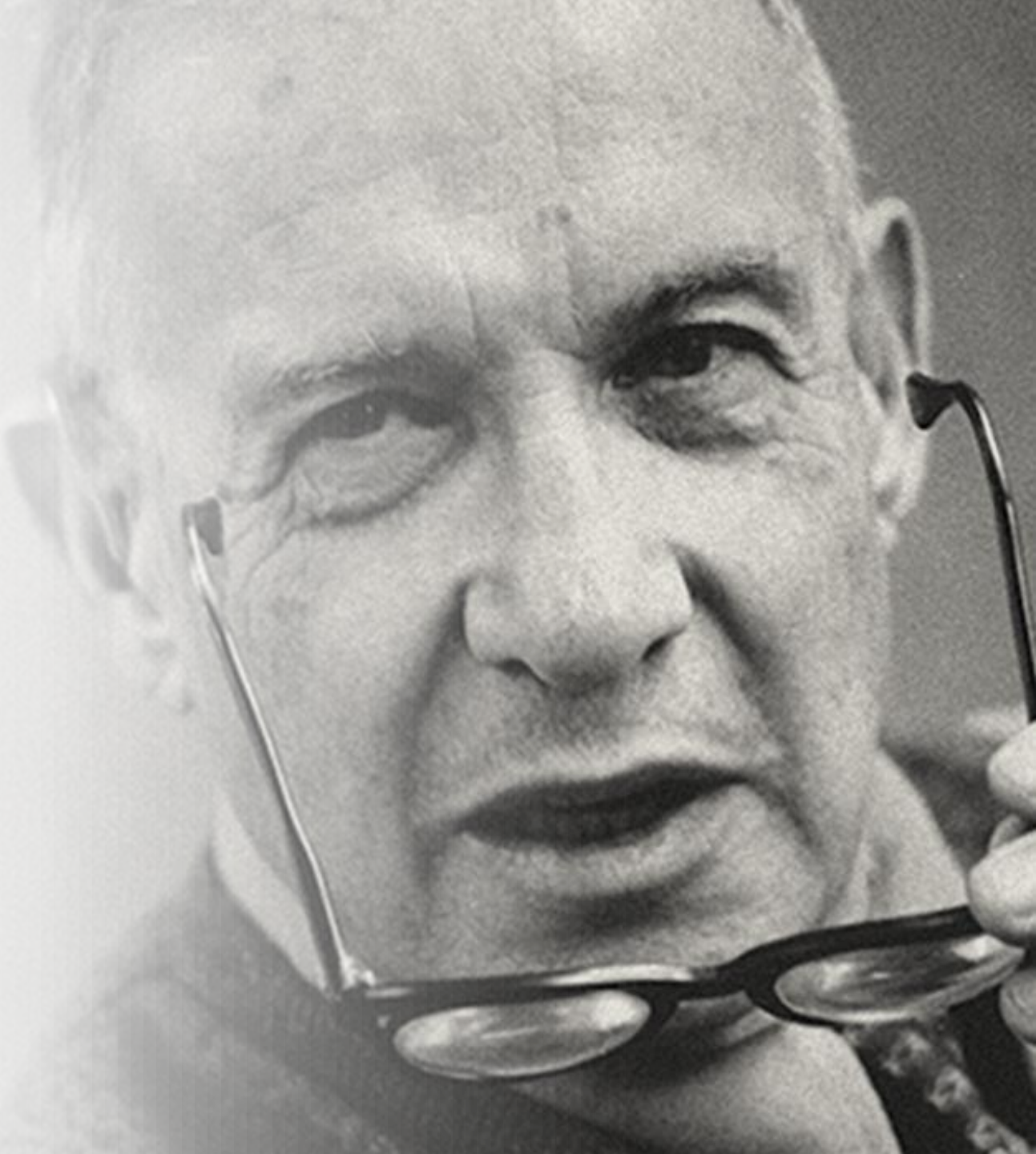
tions and to reduce the effects of hindsight and confirmation bias. The strategy entails building a broad category of staff with skills in safety science. With support from a national foundation, Tennessee staff are providing support to three states that have expressed interest in this work.

"Fund pilot programs to test the effectiveness of applying principles of safety science to improve CPS practice".

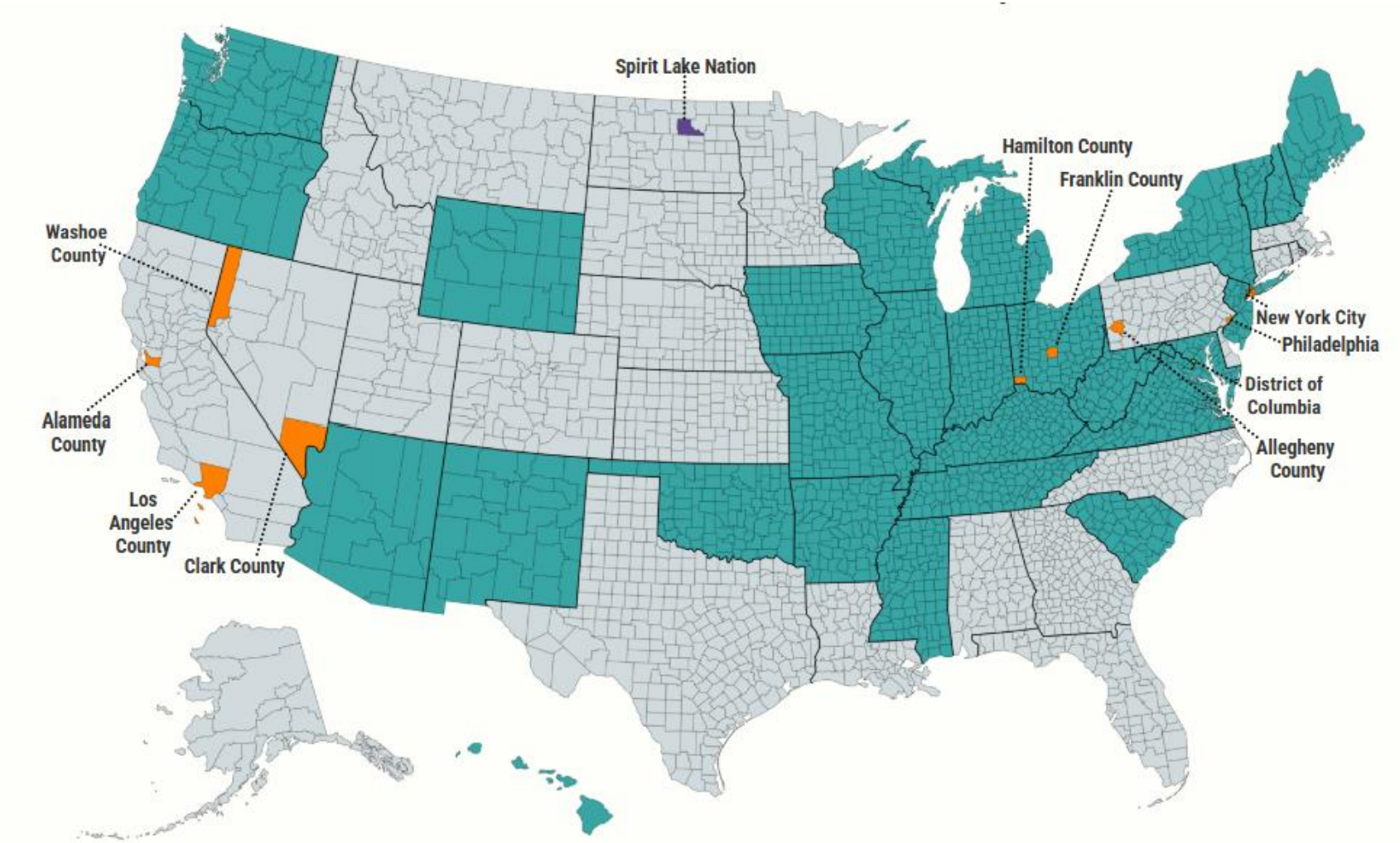
Learning From Other Industries

Culture Eats Strategy For Breakfast

Peter Drucker



NATIONAL PARTNERSHIP FOR CHILD SAFETY



As of February 2025, we have 39 partner jurisdictions in NPCS:

State Partners (28)

Arizona
Arkansas
Connecticut
Hawaii*
Kentucky
Illinois
Indiana
Iowa
Maine
Maryland
Michigan
Mississippi
Missouri
New Hampshire
New Jersey
New Mexico
New York
Ohio
Oklahoma
Oregon
South Carolina
Tennessee
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Tribal Partners (1)

Spirit Lake Nation

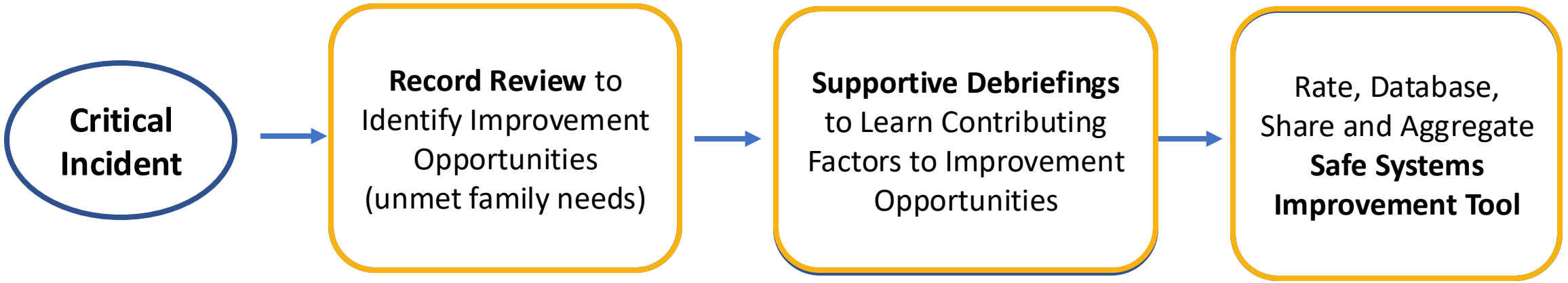
City, County & District Partners (10)

Alameda County, California
Allegheny County, Pennsylvania
Clark County, Nevada
Franklin County, Ohio
Hamilton County, Ohio
Los Angeles County, California
New York City, New York
Philadelphia County, Pennsylvania
Washington D.C.
Washoe County, Nevada

For more information about NPCS: https://nationalpartnershipchildsafety.org/

**** New 2025 Members***

Guided, Multifactorial Root Cause Analysis: A National Best Practice of Applied Safety Science



Psychological Safety

What it is:

- A **shared belief** that comes from **shared experiences.**
- A state of feeling accepted, supported, respected, and free to take **interpersonal risks**.
- A place where **mistakes** are treated as **opportunities to learn –** not a time to blame and punish.

What it is NOT:

- Free from **accountability.**
- A place where people always feel **comfortable.**

Safe Systems Improvement Tool:

National Partnership for Child Safety Version (SSIT-NPCS)

Child/Family Domain		
Family Conflict	Caregiver Substance Use	Child Medical/Physical
Economic Stability	Caregiver Developmental	Child Developmental/Intellectual
Parenting Behavior	Caregiver Mental Heath	Child Mental Heath
Cultural Stress		Child Substance Use
Professional Domain	**Team Domain**	**Environment Domain**
Cognitive Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Practice Drift
Knowledge Base	Production Pressure	Policies/Rules/Statutes
Documentation		Training
Information Integration		Public Service Array
		Private Service Array

SSIT RATING SHEET

CASE ID:					
Improvement Opportunities (IOs)					
* An unmet family need, usually with a corresponding agency-level action or inaction. IOs are essentially clear, well-described problem statements; the Family Domain may help identify potential IOs. IOs are the starting point for the systems exploration that is guided by the Professional, Team and Environment Domains.					
1					
2					
3					
4					
5					

Abbreviated Rating Summary for Family Domain

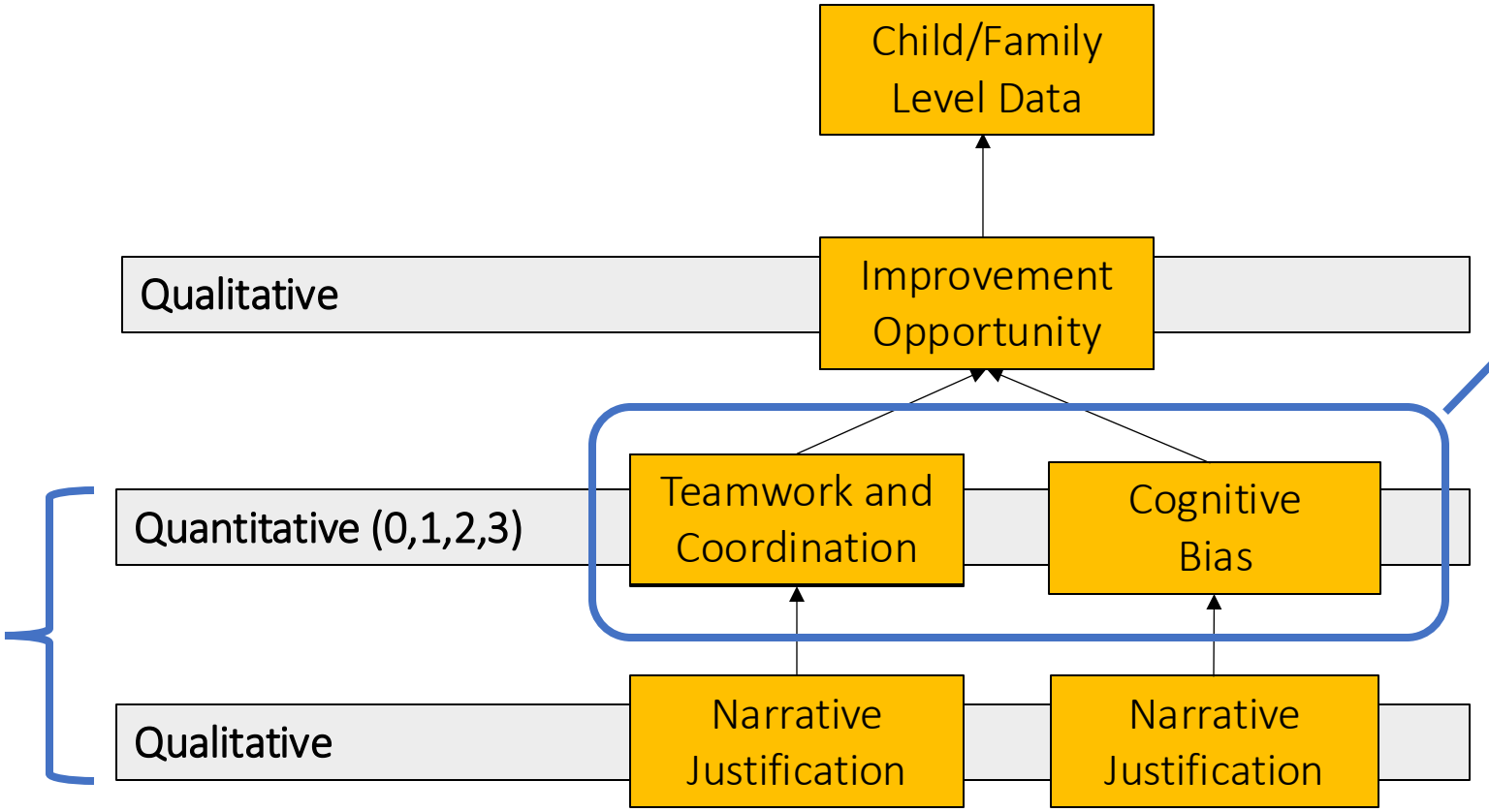
0=No Evidence | 1=Minimal Problem or History | 2=Problem affected Functioning | 3=Severely Disabling or Dangerous Problem

Abbreviated Rating Summary for Professional, Team, and Environment Domains

0=No Evidence of Influence | 1=Latent Factor | 2=Evidence of Influence | 3=Evidence of Proximity to Poor Outcomes

Family Domain	Influence 0	1	2	3	Narrative *Required if rating is 2 or 3*
1. Family Conflict (Family)	○	○	○	○	
2. Developmental (Caregiver)	○	○	○	○	
3. Mental Health (Caregiver)	○	○	○	○	
4. Substance Use (Caregiver)	○	○	○	○	
5. Cultural Stress (Family)	○	○	○	○	
6. Economic Stability (Caregiver)	○	○	○	○	
7. Parenting Behaviors (Caregiver)	○	○	○	○	
8. Medical/Physical (Child)	○	○	○	○	
9. Developmental/Intellectual (Child)	○	○	○	○	
10. Mental Health of (Child)	○	○	○	○	
Professional Domain	**0**	**1**	**2**	**3**	*Required if rating is 2 or 3*
11. Cognitive Bias	○	○	○	○	
12. Stress	○	○	○	○	
13. Fatigue	○	○	○	○	
14. Knowledge Base	○	○	○	○	
15. Documentation	○	○	○	○	
16. Information Integration	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	*Required if rating is 2 or 3*
17. Teamwork/Coordination	○	○	○	○	
18. Supervisory Support	○	○	○	○	
19. Supervisory Knowledge Transfer	○	○	○	○	
20. Production Pressure	○	○	○	○	
Environment Domain	**0**	**1**	**2**	**3**	*Required if rating is 2 or 3*
21. Demand-Resource Mismatch	○	○	○	○	
22. Practice Drift	○	○	○	○	
23. Equipment/Technology/Tools	○	○	○	○	
24. Policies/Rules/Statutes	○	○	○	○	
25. Training	○	○	○	○	
26. Public Service Array	○	○	○	○	
27. Private Service Array	○	○	○	○	

Data Structure: Linking Qualitative and Quantitative



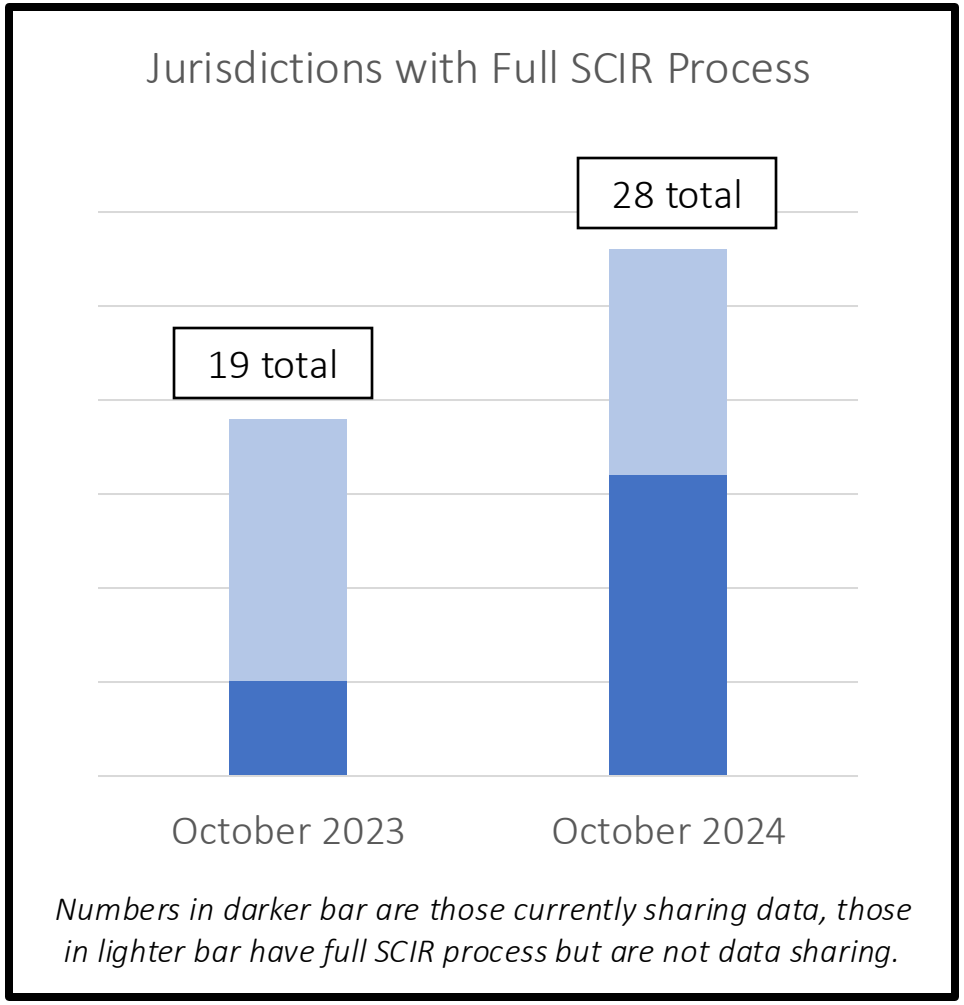
SSIT has items to support detection of systems factors that may be otherwise unexplored or feel inaccessible

Systems analysis of contributing factors

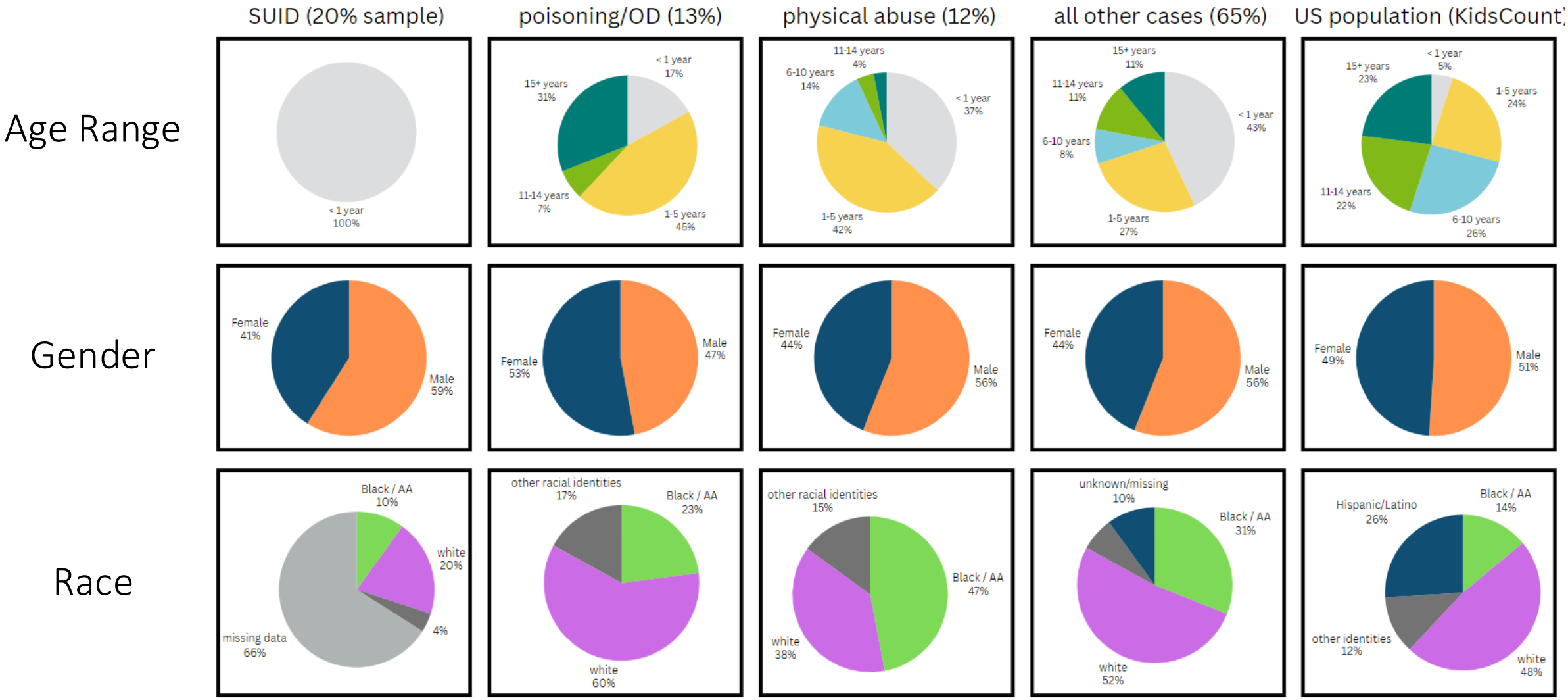
Standardizing and organizing themes within reviews allows for easier aggregated learning across reviews

Systems-Focused Critical Incident Reviews (SCIR): In Aggregate, Low Base Rate Events Become Easier to Learn From

- The NPCS approach to critical incident review has become the national best practice to fatality review in public child welfare. **It is the *only* standardized dataset of systemic contributors to adverse child/family experiences.**
- March 2023 - October 2024:
  - **711 reviews with systems findings**
  - 1841 improvement opportunities
  - 28 jurisdictions have SCIRs in place, **16 jurisdictions sharing reviews into the MPHI dataset**
- Top 3 Causes of Critical Incident:
  1. Sudden Unexpected Infant Death (SUID): 94 reviews (20%)
  2. Poisoning/Overdose: 60 reviews (13%)
  3. Physical Abuse: 57 reviews (12%)

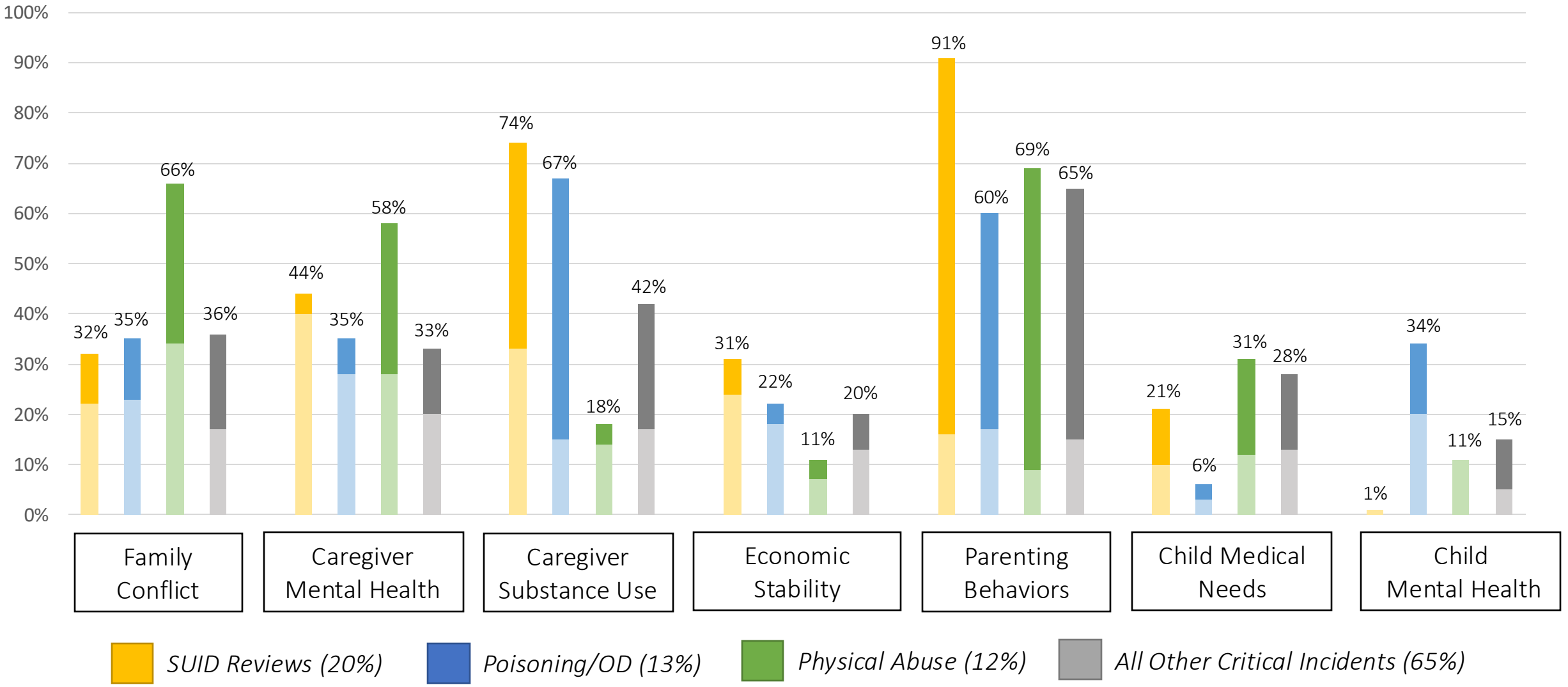


NPCS Critical Incident Dataset: Demographics

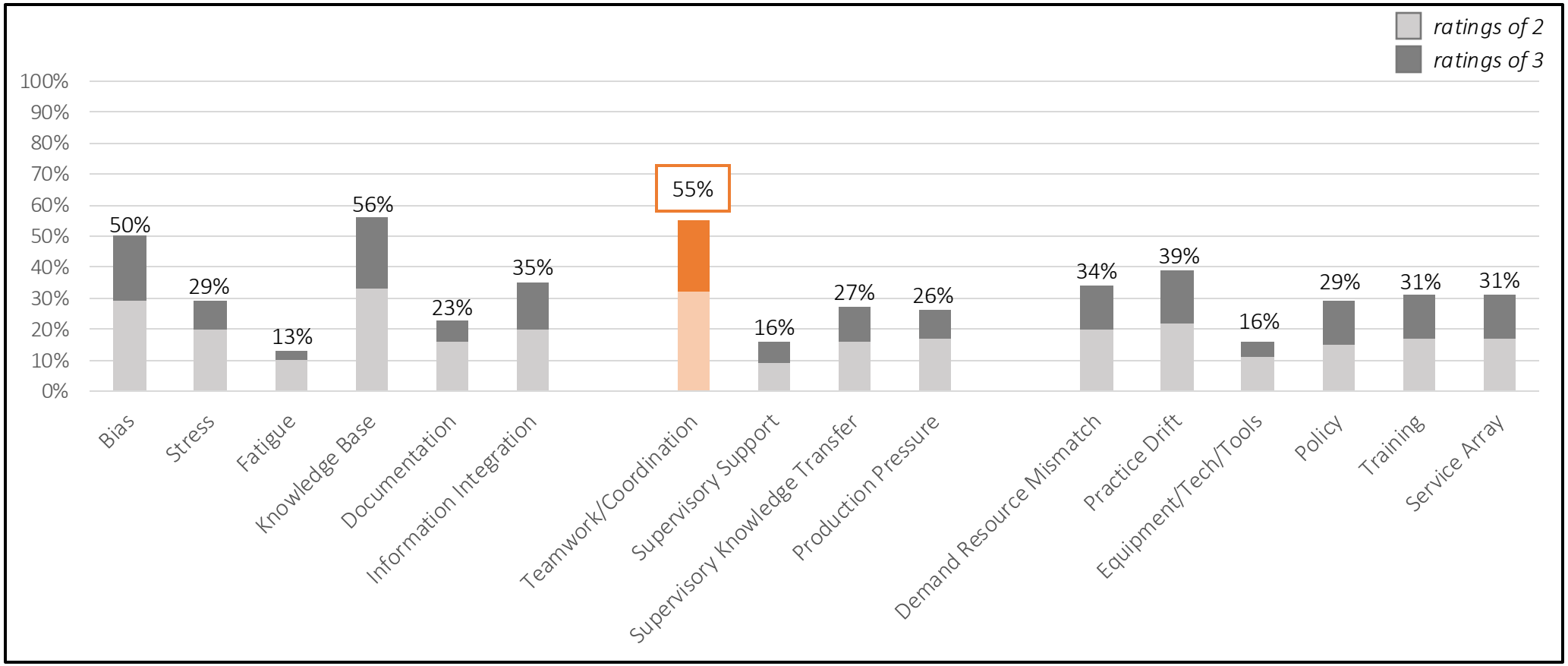


demographic information for SUID reviews, poisoning/overdose reviews, physical abuse, all other reviews in dataset with a stated cause of critical incident, and data on whole child population from KidsCount (2023 data)

Family Domain Items: Frequency of Rating 2 (light) or 3 (dark)



Systems Domain Items: Frequency Ratings



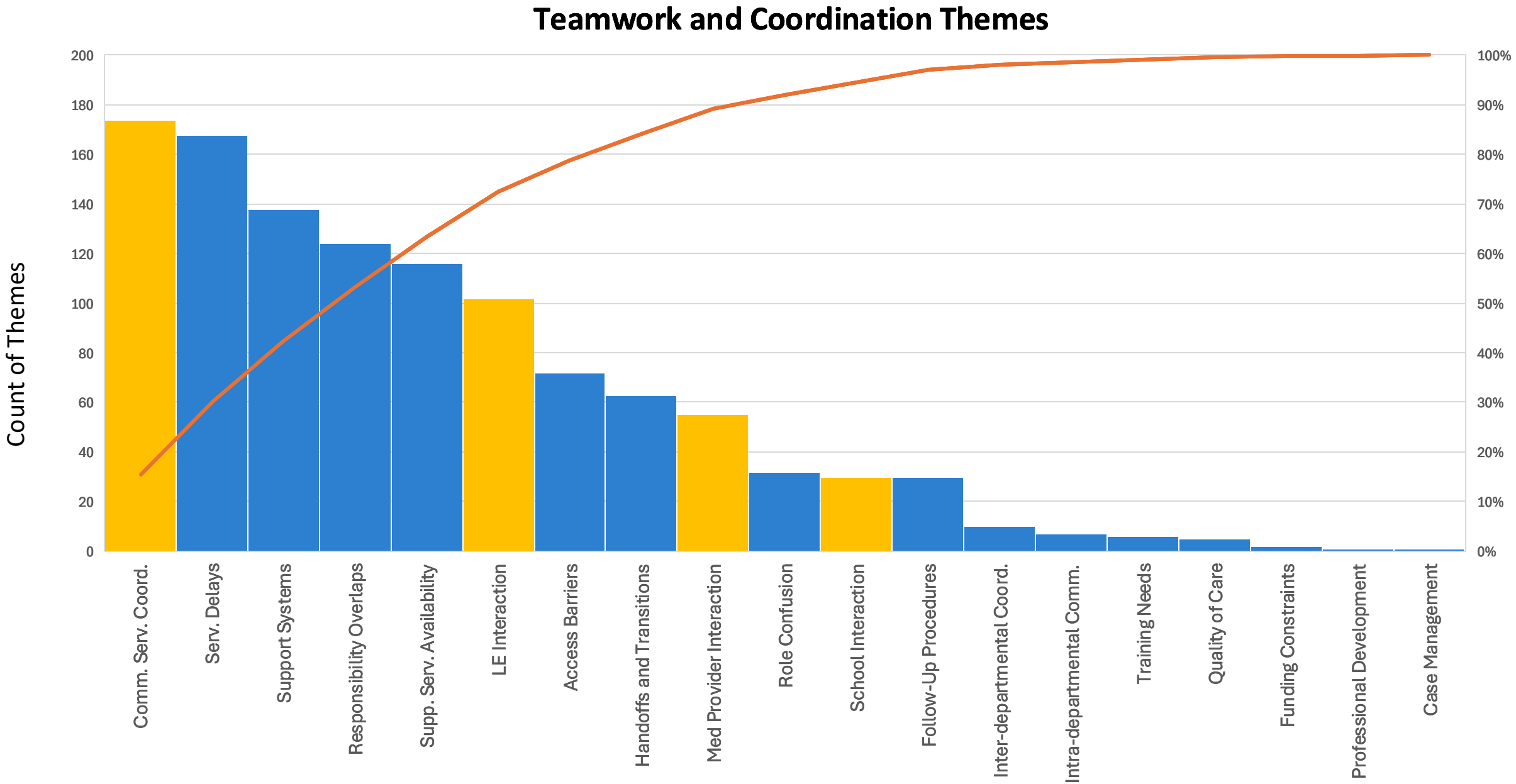
Teamwork and Coordination: ineffective collaboration between two or more internal and/or external entities

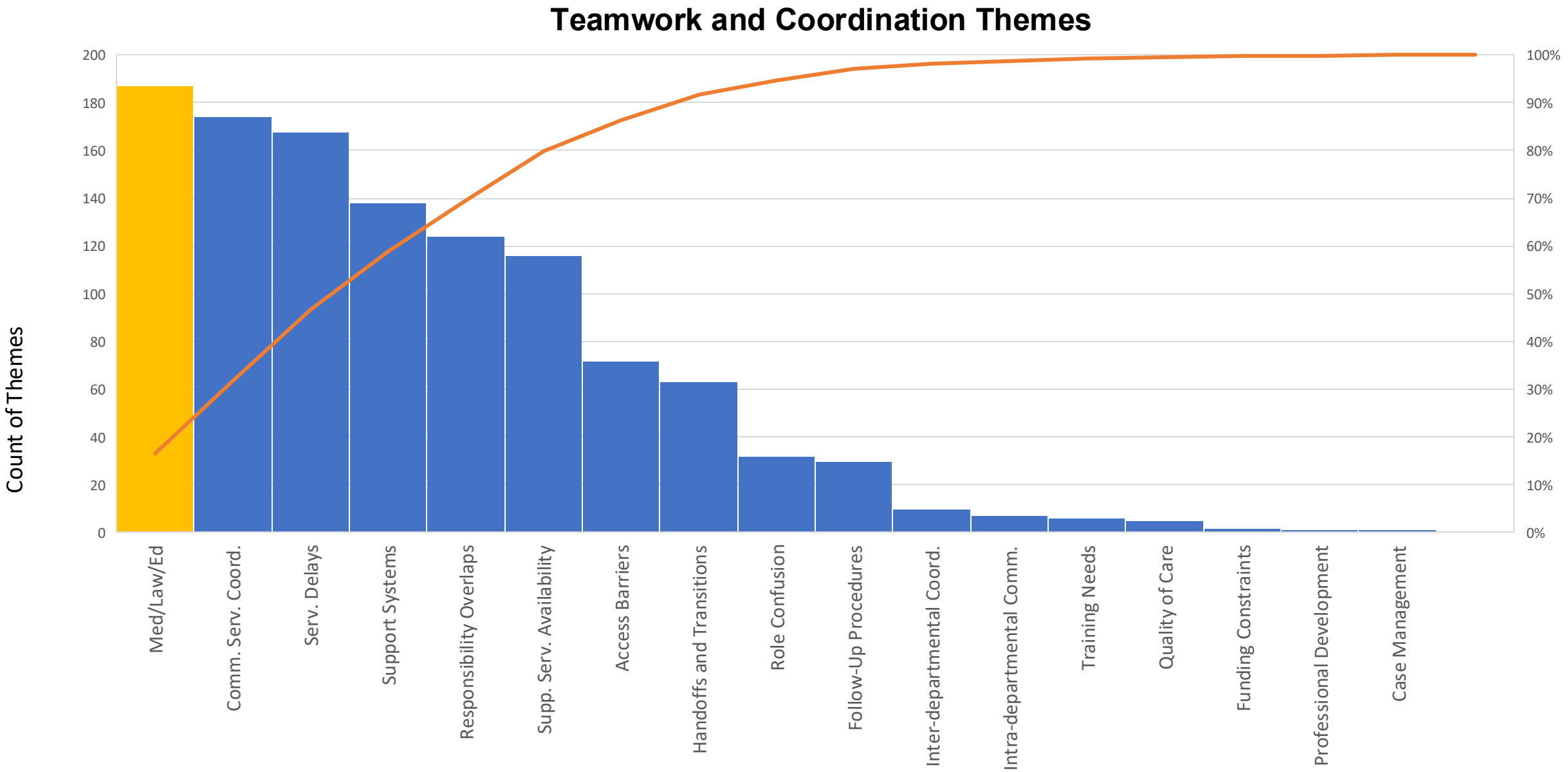
- Qualitative data analysis indicates most teamwork/coordination barriers related to **external partners**
- Top three external partners described in data: law enforcement, medical system, courts/legal system

Artificial Intelligence and Large Language Model Analysis

- Richness of NPCS dataset is in **qualitative data**, but scale of data is insurmountable to code by hand
  - Total in dataset: **1,041,229** words

- Northwestern colleagues built a model is able to pull themes from that **data in seconds**
  - The NLP replicated our coding structure with a high degree of fidelity, but there is still refinement
  - The model coding will always be human-supervised


Teamwork and Coordination Themes
Count of Themes
200
180
160
140
120
100
80
60
40
20
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Comm. Serv. Coord.
Serv. Delays
Support Systems
Responsibility Overlaps
Supp. Serv. Availability
LE Interaction
Access Barriers
Handoffs and Transitions
Med Provider Interaction
Role Confusion
School Interaction
Follow-Up Procedures
Inter-departmental Coord.
Intra-departmental Comm.
Training Needs
Quality of Care
Funding Constraints
Professional Development
Case Management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10%
0%
Med/Law/Ed
Comm. Serv. Coord.
Serv. Delays
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Supp. Serv. Availability
Access Barriers
Handoffs and Transitions
Role Confusion
Follow-Up Procedures
Inter-departmental Coord.
Intra-departmental Comm.
Training Needs
Quality of Care
Funding Constraints
Professional Development
Case Management

External Communication and Collaboration (n=361)

Community Service Coordination (n=174) Problems coordinating with community service providers, leading to gaps in service delivery.

Law Enforcement Interaction (n=102) Difficulties in communication and coordination with police and other law enforcement agencies, affecting case investigations.

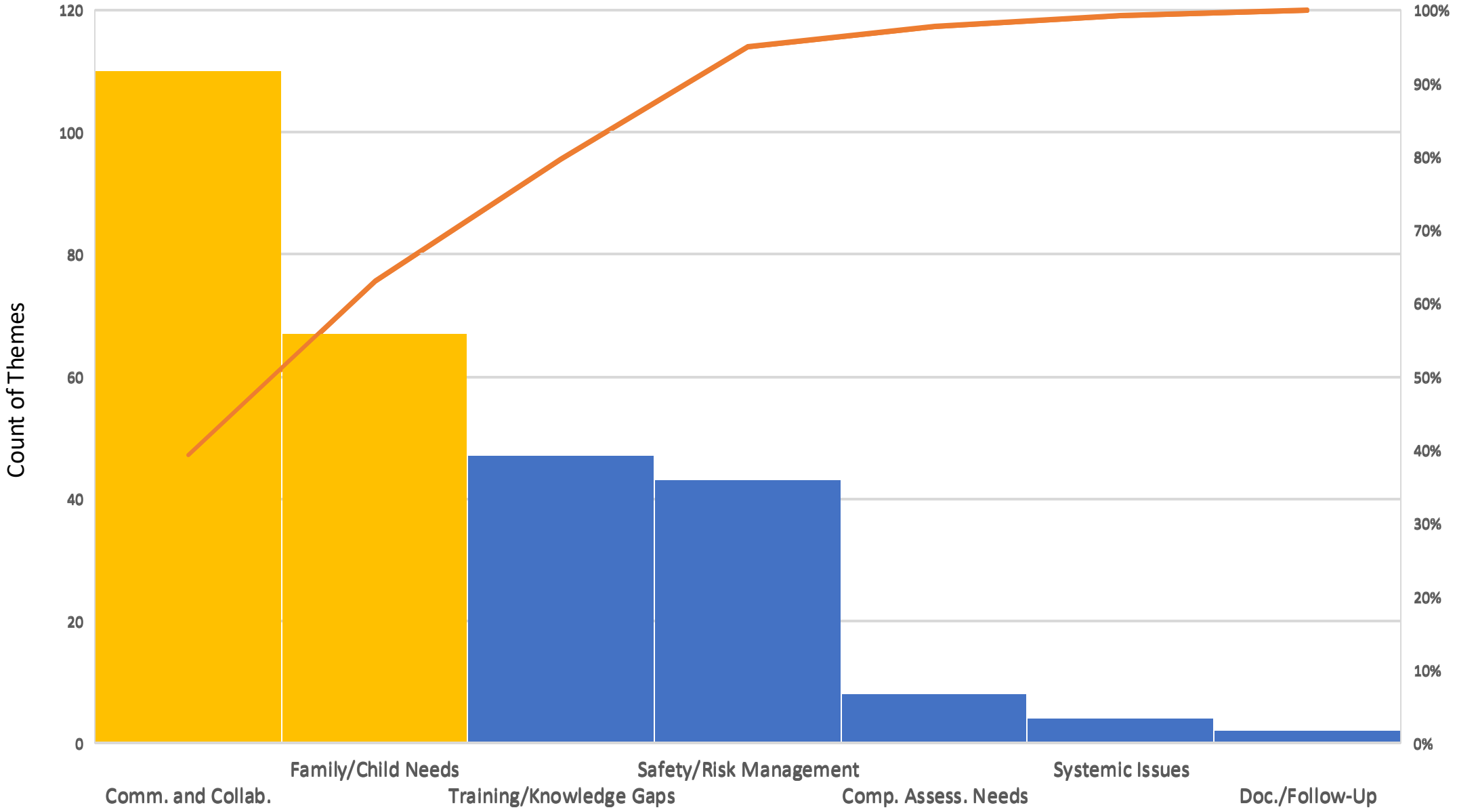
Medical Provider Interaction (n=55) Issues in exchanging information with healthcare professionals, impacting client care.

School Interaction (n=30) Challenges in interacting with educational institutions, such as gaining access to students and sharing information.

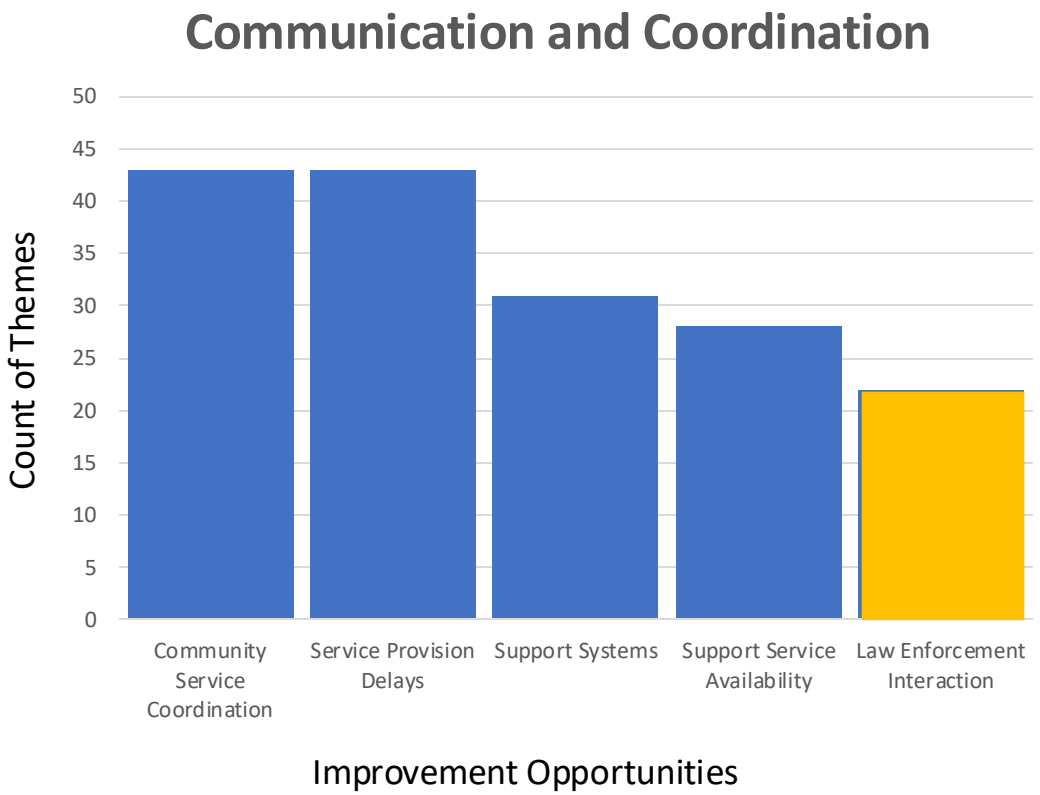
Law Enforcement Interaction

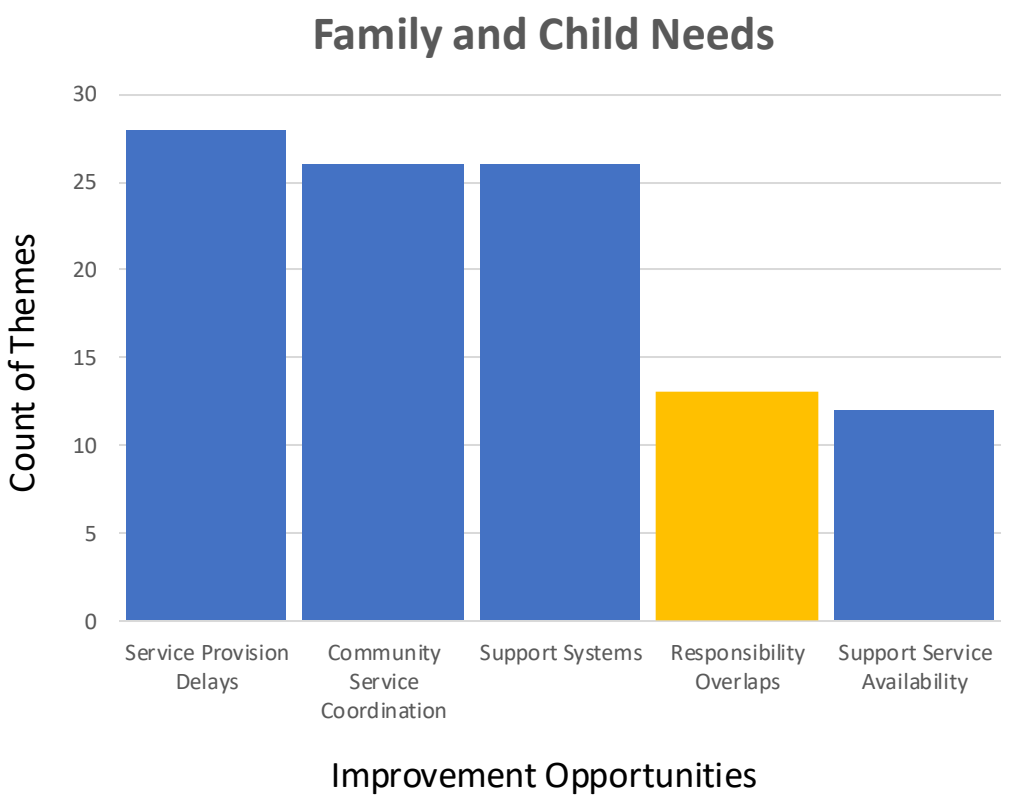
"**Inconsistency** with law enforcement agencies being **willing to provide support** to case managers."

Teamwork and Coordination Linked to Improvement Opportunities



Linking Item Themes and IOs: Teamwork and Coordination





Teamwork Coordination IOs (n=177)

Communication and Collaboration (n=110) Poor communication and limited engagement with external supports and informal networks hindered effective case management.

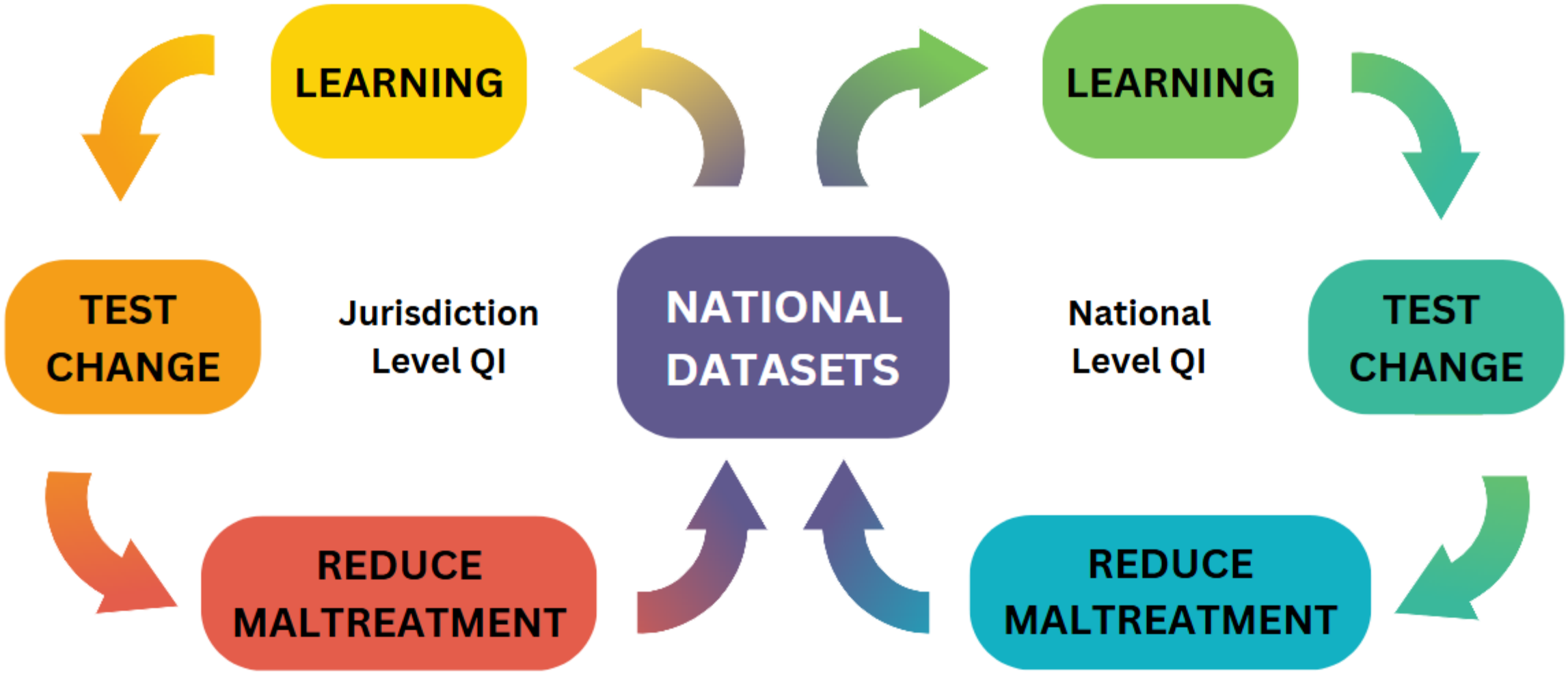
Family and Child Needs (67) Families had multiple risk factors, including mental health issues, substance abuse, and domestic violence, requiring specialized care and consistent medical treatment.

Communication and Collaboration

"When staff are responding to a child fatality, Law Enforcement rushes staff during initial contact and makes **staff feel they have to rush to complete initial contact**".

Family and Child Needs

"Participants reported that the **assessment and permanency teams are divided** and are **unwilling to work as a team**. Both sides are becoming unprofessional with each other and there appears to be a lack of trust with decision making with families".


LEARNING
LEARNING
TEST CHANGE
Jurisdiction Level QI
NATIONAL DATASETS
National Level QI
TEST CHANGE
REDUCE MALTREATMENT
REDUCE MALTREATMENT

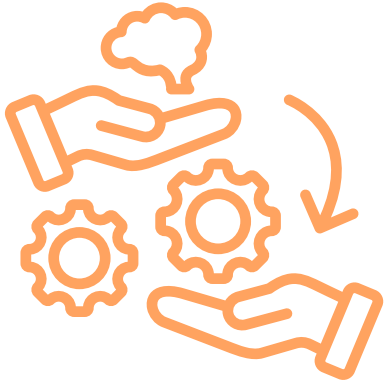
NPCS Affinity Groups and Applied Practice Communities

Affinity Groups:

1) Safety Science and the Workforce
2) Safety Science and Child Welfare Attorneys
3) Identity, Intersectionality and Safety Culture
4) State Oversight Agencies Peer-to-Peer

Practitioner Community:

Critical Incident Review (CIR) Program Leader Calls
CIR All Practitioner Calls



Applied Practice Communities:

1) Safely to Their 1st Birthday
2) Safely to Their 5th Birthday
3) Integrating Child Welfare Attorneys into Quality Improvement Work
4) Co-Designing with Lived Expertise in Quality Improvement Work

Panel Discussion

1. Piggybacking off Mary Beth, how do we in Tennessee implement psychological safety and improvement opportunities from this tool?
2. Improvement opportunities are often talked about at the point that they are already accepted, how do we talk about improvement opportunities becoming accepted, sorted, and/or prioritized?
3. What is the benefit of the NPCS partnership that you have been able to see and take advantage of?
4. For me when we know better, we do better is very important. If we don't take the time to learn from missed opportunities then we will never improve. Safety systems takes the emotions and personal opinions out, giving a better way to use data to improve practice.
5. Working these cases can take an emotional toll on people and having the safe space to say it without fear of judgment is key. When an employee says I don't think I can work this type of case, as leaders we must recognize there's a valid reason and process the situations and let people be human and know what is best for themselves when it comes to hard decisions and secondary trauma.