



The National Partnership for Child Safety charter

Applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities

Acknowledgments

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The National Partnership for Child Safety would not have been possible without the remarkable leaders from the 15 jurisdictions who formed this Collaborative. Current member states/jurisdictions are:

- | | |
|-----------------------------------|---------------------------|
| 1. Los Angeles County, California | 9. Franklin County, Ohio |
| 2. Santa Clara County, California | 10. Hamilton County, Ohio |
| 3. Connecticut | 11. Oregon |
| 4. Georgia | 12. South Carolina |
| 5. Indiana | 13. Tennessee |
| 6. New Hampshire | 14. Vermont |
| 7. New Jersey | 15. Wisconsin |
| 8. New York City | |

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Mission statement

The National Partnership for Child Safety mission is to improve child safety and prevent child maltreatment fatalities by strengthening families and promoting innovations in child protection.

Introduction

In an effort to improve child safety and prevent the estimated 1,500 deaths due to child abuse and neglect that occur every year in America, child welfare leaders representing 15 jurisdictions and states have formed The National Partnership for Child Safety (NPCS), a quality improvement collaborative.

The collaborative was formed in partnership with Casey Family Programs, a national operating foundation focused on safely reducing the need for foster care and building Communities of Hope. Casey Family Programs hosted several safety convenings since 2011 aimed at improving safety and preventing child maltreatment fatalities and has supported efforts to implement safety science principles in child welfare in several jurisdictions through peer visits and technical assistance from consultants with expertise in the safety science field. In January 2018, child welfare agencies from 20 jurisdictions participated in the Tennessee Safety Culture Summit in partnership with Casey Family Programs and the Tennessee Department of Children's Services at Vanderbilt University. The summit was focused on applying safety science in child welfare to improve safety and prevent child maltreatment fatalities and served as a launching point for ongoing collaborative work among interested jurisdictions.

The federal [Commission to Eliminate Child Abuse and Neglect Fatalities](#) recommended in its final report that safety science be explored as an approach to better understand and prevent fatalities: "Child protection is perhaps the only field where some child deaths are assumed to be inevitable no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable."¹

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. The approach that systems take to responding to and learning from critical incidents can have a crucial impact on quality improvement and services reliability. Safety cultures strive to balance individual accountability with system accountability and value open communication, feedback, and continuous learning and improvement.² For example, when the public, the media, policymakers and the child welfare system's response to a high-profile death results in 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.

Although progress has been made by implementing various strategies in child welfare such as evidence-based interventions, their effectiveness is limited by their application to systems with pervasive workforce instability and the related absence of effective learning systems. In addition, current quality improvement reviews are primarily retrospective after incidents occur. New strategies and tactics informed by safety science, such as prospective instead of retrospective quality improvement processes similar to other safety critical industries, are needed to improve outcomes in the complex, interdependent work of child welfare.³

Background

This charter describes the structure for the National Partnership for Child Safety and how the work will be developed and applied. The charter will be reviewed and approved annually and when major changes to the group's structure or function occur to ensure its relevance and appropriateness to the work.

Values and guiding principles

The NPCS members firmly believe in:

- A collective responsibility for improving child safety and preventing maltreatment fatalities.
- The rigorous scrutiny of ideas and practices to promote innovation in child protection.
- A commitment to improving practice while working within frameworks for family inclusion.
- Sharing between agencies and individuals to build internal and external support for agencies and jurisdictions.
- The collection, sharing and analysis of data to inform decisions for practice improvements.
- Respecting each other as colleagues by honoring the work and diverse perspectives of all member contributions.
- Creating a resource for jurisdictions structured around the sciences of safety, reliability and improvement.
- A focus on team culture to advance learning and spread tools in the interest of improving child welfare safety outcomes.



NPCS goals

Long-term goals

We will develop a learning system:

- That promotes a system shift toward prevention policies and practices to address risk to vulnerable children.
- Aimed at improving child safety through the development of best practices, including development of standardized definitions for reviewing critical incidents (child maltreatment fatalities and near fatalities) by applying safety science, data analytics and research evidence in child welfare and child- and family-serving systems.
- To foster a national prospective quality improvement approach that balances individual and system accountability to prevent critical incidents, including child maltreatment fatalities and serious injuries.
- To increase psychological safety and create a resilient workforce, whereby increasing staff retention and ultimately improving child safety outcomes.
- That models technical excellence in child welfare, ultimately broadened to include other child- and family-serving agencies, to improve child safety and prevent child maltreatment fatalities.

Short-term goals

- Develop standard definitions, share data among member jurisdictions and establish a national repository of critical incident data, including child welfare fatalities and near fatalities.
- Lend support and guidance to leadership in child welfare systems when a critical incident or child maltreatment fatality occurs.



Outcomes

The collaborative aims to improve safety as measured by:

- Reduced numbers of child fatalities and near fatalities
- Decreased repeat maltreatment
- Improved ratio of entries to exits
- Creation of a culture of safety that promotes workforce retention and proactive, highly reliable child welfare organizations

Infrastructure

Membership

This is a membership model, similar to quality improvement programs in other safety critical industries. Membership is composed of state/ jurisdiction teams representing child welfare systems. State/jurisdiction teams, at minimum, must include child welfare leaders and executive team members.

Responsibilities and expectations

Members are expected to:

- Bring their expertise, influence, knowledge and other contextual factors to bear in advancing the work of the collaborative.
- Regularly attend and/or have their state/ jurisdiction represented at all meetings and participate on workgroups and teams as needed to advance the work of the collaborative.
- Employ active and timely communication and feedback loops across the collaborative.
- Demonstrate good-faith effort in completion of core activities of the collaborative.
- Commit to gathering and providing the core data set identified for the collaborative for stability of reporting to support data analysis and achievement of the goals set forth by the collaborative.
- Serve on the Executive Committee and rotate off with highest level of leadership.

This collaborative can expand over time to include other interested jurisdictions. Other entities may participate as determined by the collaborative, i.e., organizations providing support, developers of tools and best practices with an interest in collaboration for the pursuit of balanced implementation, along with researchers interested in studying safety, reliability and improvement in social services organizations.





Dissolution

No dissolution is planned. The intention is for the group to continue as an autonomous member-based organization.

Governance structure

Executive Committee membership will be open to leadership representatives from all member jurisdictions of the collaborative. Executive Committee members are expected to demonstrate their commitment to the work through consistent attendance and participation in monthly Executive Committee meetings and other activities, except when prevented by unforeseeable events. Executive Committee meeting attendance will be recorded and monitored.

The Executive Committee will be responsible for:

- Monitoring and tracking progress toward meeting the identified short- and long-term goals of the collaborative.
- Identifying when it may be necessary to form subcommittees and ad hoc workgroups to address specific goals and tasks and obtain the assistance of technical advisors to advance the work of the collaborative.
- Reviewing recommendations proposed by subcommittees and workgroups and providing feedback and guidance as needed.
- Deciding which recommendations are adopted to advance and support progress toward outcomes of the collaborative.

The Executive Committee will move through a consensus decision-making process. If a consensus cannot be reached, then two-thirds of the Executive Committee must be in agreement in order to move a decision forward. This will help to ensure that representation, equality and accountability are upheld in the Executive Committee's processes.

Once a decision-making process is complete and consensus or a two-thirds majority vote has been reached, Executive Committee members may be asked to share updates with outside individuals and groups.

The composition of the Executive Committee will be inclusive of the range of participating jurisdictions (e.g., counties, states, large, small). Executive Committee members are free to participate in any and all activities and events of the collaborative.

Executive Committee members will serve a one-year term. When an Executive Committee member leaves the Executive Committee or the organization, a new member may be appointed from among volunteers. Member jurisdictions may nominate potential Executive Committee members. All new members start their own term clock, even those replacing an outgoing member with remaining term time.

The Executive Committee will be led by two co-chairs. Any member of the Executive Committee is eligible to be a co-chair. Co-chairs may hold their positions for a maximum of two consecutive years. Co-chairs will develop the agenda in concert with technical advisors, co-lead Executive Committee

meetings and regularly review meeting attendance. Co-chairs will communicate Executive Committee decisions to all collaborative members.

Technical advisors will provide resources, guidance and support to the collaborative as a whole and will work closely with the Executive Committee. Technical advisors shall be entitled to receive all written notices and information that are provided to the Executive Committee, attend and participate in all Executive Committee and collaborative meetings, participate in subcommittees and participate in all activities and events of the collaborative. Technical advisors will not hold office or vote at Executive Committee meetings.

The Executive Committee will have the freedom to pursue and select technical advisors and backbone organization(s) to implement and sustain the work of the collaborative.

A project coordinator will be assigned to coordinate Executive Committee meetings, help prepare meeting agendas, take minutes during scheduled meetings and ensure dissemination to collaborative members. The project coordinator will streamline and manage all communication and feedback loops.





Expected activities

NPCS members will share practices, tools and policies with a willingness to candidly offer both successes and “lessons learned.” In addition, training, “spread” and organizational culture-change strategies will be part of the learning and peer advising focus. The other aspect of the NPCS involves sharing mutually agreed upon data to inform our continuous learning and practice improvements. In so doing, the NPCS strives to improve safety, permanency and well-being outcomes for children as it expands and joins with other networks to promote effective child welfare practice.

The members of this collaborative will participate in safety science-derived quality improvement activities, sharing data and applying a set of strategies including:

1. Applying a standardized platform for critical incident review and reporting of data, such as the Safe System Improvement Tool (SSIT) to support a systems focused, non-punitive, critical incident review process and submit standardized critical incident data to a shared database;
2. Collecting and sharing comparative critical incident and team culture data by participating in an annual safety culture assessment and using the results for improvement
3. Providing access to a library of Spaced Ed curricula
4. Sharing cross-jurisdictional Safety Notices
5. Partnering in developing Quality Improvement Priorities such as children O-3 Care Bundle

Status of expected activities is captured in Appendix 1.1 Work Plan.

Data

NPCS will collect and share data within the parameters of the NPCS goals. It is recognized that member states/jurisdictions will have varying levels of internal parameters that will impact the level/amount of detail that can be provided and may have restrictions/limitations on data sharing.

An encrypted and protected cloud-based sharing platform will be identified to maintain data. Member states/jurisdictions retain ownership over their data, even while these data reside on the cloud. Data analytics will be governed by data-sharing agreements and business rules.

Additional information regarding data sharing, data analytics, evaluation and research will be outlined in Appendix 2.1 Data Sharing.



1 Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office. Accessed at <http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report>.

2 Chassin, M. R., & Loeb, J. M. (2011). The ongoing quality improvement journey: next stop, high reliability. *Health Affairs*, 30(4), 559–568.

3 For example, New York City is implementing a just-in-time proactive quality review system for CPS.

