Administrative Policies and Procedures: 20.29

Subject:	**Safety Systems Analysis Review**
Authority:	TCA 37-1-401 et seq; 37-1-601et seq; 37-1-607; 37-5-105 (3); 37-5-106; 37-5-107; 37-5-124; 68-142-101(c); Child Abuse Prevention and Treatment Act (CAPTA)
Standards:	**COA:** AM 6, 7
Application:	To All Department of Children's Services employees

Policy Statement:

The Department of Children's Services (DCS) conducts Safety Systems Analysis on child death/near death cases referred by the Central Office Child Death Review Team (CO CDRT) and other identified cases, as referred by the Commissioner or Deputy Commissioners.

Purpose:

To provide the rules and guidelines for conducting a Safety Systems Analysis Review to address how cases meet criteria for a review, how reviews are conducted and how information is tracked and trended following their completion.

Procedures:

A. Safety Systems Analysis Review Case Assignment Process	Referrals are provided by the Central Office Child Death Review Team (CO CDRT) or are referred at the request of the DCS Commissioner or Deputy Commissioners (see DCS Policy ***20.28, Child Death/Near Death Review***).
B. Safety Systems Analysis Procedures and Goals	1. Prior to Safety System Analysis review, Regional Leadership (i.e., administrators and/or directors) is notified via email of the case set for review and any of their assigned staff who are requested for debriefing. 2. During Safety Systems Analysis, the following tasks will occur: a) TFACTS review of all DCS history (with an emphasis on history occurring within the past 3 years); b) Hard copy case file review; c) Review of applicable facility records (e.g. communication logs, progress notes, video recordings, etc.); d) Review of applicable DCS Policies and Work Aids; e) Individual debriefings with internal (e.g. Investigator, Family Service Worker, Team Leader, etc.) and/or external (e.g. Mental Health

Professional, Medical Professional, Law Enforcement) personnel assigned to the family.

- For cases that are concurrently being investigated by SIU, the Safety Analyst waits a minimum of ten (10) business days from the date of SIU referral before requesting debriefing with any internal or external person formally identified in a SIU investigation. After this waiting period, the Safety Analyst communicates with the SIU Investigator and/or Lead Investigator prior to proceeding with requests for debriefing, to allow SIU an opportunity to report any potential concerns.
- Any staff requested for debriefing has engaged in current or historical work with the family. The specific case identification numbers under review are provided to staff prior to debriefing.
- The Safety Analyst provides a list of ***Information for Case Members prior to Debriefing***, via email or in-person, regarding the debriefing process to best ensure a supportive environment for staff to feel safe in discussing systemic issues that exist in the case.
- Any staff requested to debrief with the Safety Analyst may voluntarily consent or decline the entire debriefing process or individual questions asked during debriefing.
- During debriefing, the Safety Analyst leads staff through case timeline(s), examining the circumstances surrounding a particular event (e.g. child runaway, child near death, child death) and seeks to understand salient issues and systemic influences to case work (*e.g.*, understanding why and/or how decisions were made, identifying environmental cues and cognitive factors, *etc*.).
- The Safety Analyst provides information on accessing the Employee Assistance Program (EAP) to any DCS staff who participates in debriefing.

3. The Safety Analyst is responsible for the completion of the Safety Systems Analysis Report (SSAR), which contains the following information:
   a) A chronological summary of TFACTS history and current case information;
   b) Family case file information (e.g. Law Enforcement, Medical, Mental Health records, etc.);
   c) Summary of information collected through individual debriefings;
   d) Copies of relevant materials (e.g. Law Enforcement reports, Autopsy, Death Certificate, Serious Incident Reports, etc.) are provided as deemed useful by the Safety Analyst;
   e) Medical information is included in the SSAR by the Safety Nurse (when applicable);
   f) Key Observations and accompanying narrative describing systemic issues believed or evidenced to bear influence to the Key Observation;

	g) Considerations for changes of policy, procedures, service array, training or other improvements. 4. At the conclusion of the review, the Safety Analyst assesses the case using the ***Protocol for Safety Systems Analysis Instrument.*** 5. All SSARs are securely created and stored in Vanderbilt's secure, web-based system, REDCap. 6. For recommendations and reporting procedures, see DCS Policy ***20.28, Child Death/Near Death Review.*** 7. All SSARs are completed within 90 days of the CO CDRT's recommendation or sooner at the Commissioner and/or Deputy Commissioner's request.
C. Grand Regional Systems Analysis Teams	1. Grand Regional Systems Analysis Teams (GRSAT) convene to review the aggregate, grand regional themes and Key Observations derived from Safety Systems Analysis Reviews. GRSATs may also review case-specific SSARs. The GRSAT's purpose is to review themes and Key Observations, discuss systemic influences, promote region-level organizational learning and quality improvement, and develop considerations for regional and statewide quality improvement. 2. At least one (1) GRSAT exists in each Grand Regional grouping. These groupings are as follows: a) Group 1: Shelby, Northwest, Southwest b) Group 2: Mid-Cumberland, Davidson, South Central c) Group 3: Upper Cumberland, Tennessee Valley, East d) Group 4: Smoky Mountain, Knox, Northeast 3. Each team is scheduled to meet at least once per quarter. 4. All GRSAT members will be required to sign form ***CS-0993, Child Death/Systems Analysis Review: Attendance and Confidentiality Agreement***. 5. Each team is comprised of the following representatives or their assigned designees: a) Safety Analyst b) Safety Nurse c) Regional Administrator d) Child Protective Services Assessment Case Manager e) Child Protective Services Assessment Team Leader or Team Coordinator f) Office of Child Safety Investigator g) Office of Child Safety Lead Investigator or Investigative Coordinator h) At least one (1) interested community partner, which may include

	representatives from: law enforcement, an independent physician, Child Advocacy Center, Department of Health, domestic violence specialist, child abuse prevention specialist, substance abuse specialist, disability specialist, foster parent or other as deemed useful; i) Other internal DCS personnel (e.g. Attorney, Family Service Worker, CANS Consultants, etc.) will be utilized as ad hoc members, based on the DCS offices (Child Programs, Child Safety, etc.) involved in the case(s) under review. 6. At a minimum, the following representations (or their designees) must be present for a GRSAT meeting to be held: a) Safety Analyst, b) Safety Nurse, and c) At least two (2) people from the remaining representations listed under number 4(c-i) above. 7. Any frontline case manager, direct supervisor (i.e. Team Leader or Lead Investigator) or foster parent present at the GRSAT meeting must not have been directly involved in a case-specific SSAR set for review. They may be involved in the review of aggregate themes and Key Observations derived from the review of several cases. 8. Meeting minutes are maintained for all GRSAT meetings.
Forms:	***CS-0993, Child Death/Systems Analysis Review: Attendance and Confidentiality Agreement***
Collateral documents:	**DCS Policy *20.28 Child Death/Near Death Review*** ***Information for Case Members prior to Debriefing*** ***Protocol for Safety Systems Analysis Instrument***

Glossary:	
Term:	**Definition:**
Systems Analysis Tool:	A multi-purpose information integration tool whose purpose is to support a culture of safety, improvement, and resilience. Completion of the instrument is accomplished in order to allow for the effective communication of influencing factors on a case at all levels of the system.