Accountability

Accountability Discussion

Importance of Accountability

- Movement across industry
- Moving Beyond Cycle of Blame
  - Healthcare
  - Child Welfare
  - Aviation

"Today we are going to decide who to blame."

Importance of Accountability

- Historical importance to account
- Need to explain:
  - History:
    - » Early civilizations
    - » Enlightenment

Importance of Accountability

– When bad things happen, there is a public call to account for what went wrong
  – Mid Staffs
  – High Risk Industries
    » Aviation
    » Healthcare
    » Child welfare

Importance of Accountability

• How we call on to account
  – Artifact of how we think humans contribute to failure in complex organizations
    » Old View
    » New View

Human Error in Old View

- Human Error
  - Humans are the cause
  - Safety interventions target human
  - Human is shaped to environment
  - Humans selected by psychological traits
  - Control safety by controlling the human

Human Error in New View

- Human Error
  - Human is recipient of trouble
  - Reviews start with human error
  - Psychology helps understand decision making and perception
  - Technology can be fixed to support human interaction
  - Control the environment not the human
  - Responsibility down instead of accountability up
- Florence

Importance of Accountability

- Connection to Performance
  - Influences decisions and their quality
  - Free flowing accounts increases learning
  - Robust learning leads to improvement

Current State of Accountability

Child Welfare Across the U.S.

Current State

- Criminal Prosecution
  - Rare but still happens
  - Effect of prosecution
    - » Negative effects
      - Decreased sharing of information
- Negligence*

Current State

Negligence is conduct that falls below the standard required as normal in the community. It applies to a person who fails to use the reasonable level of skill expected of a person engaged in that particular activity, whether by omitting to do something that a prudent and reasonable person would do in the circumstances or by doing something that no prudent or reasonable person would have done in the circumstances. To raise a question of negligence, there needs to be a duty of care on the person, and harm must be caused by the negligent action. In other words, where there is a duty to exercise care, reasonable care must be taken to avoid acts or omissions which can reasonably be foreseen to be likely to cause harm to persons or property. If, as a result of a failure to act in this reasonably skillful way, harm/injury/damage is caused to a person or property, the person whose action caused the harm is negligent.[4]

Current State

- Negligence
  - Does not provide answers or a useful definition
  - Creates a new set of judgements
  - Brings a legal standard to human performance

Thesis Findings

- Moving Towards a Forward Looking Accountability in Child Welfare
- Focus Groups
  - Throughout Hierarchal Strata
- Focused on perceptions on accountability
- FLA Description

Thesis Findings

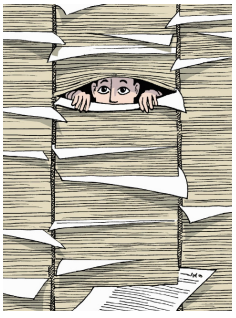
- FLA Description
  - Just Culture
  - Second Stories
  - Second Victim

Thesis Findings

- Results
  - Bureaucratic Demands
  - Backward Looking
  - Inconsistent

Thesis Findings

- Bureaucratic demands
  - Typically spoke to bureaucratic structures
    - » Didn't meet metrics
    - » Or talked about the bureaucracy of holding people accountable



Thesis Findings

- Backward looking
  - Typically focuses on punishment
    - » Firing
    - » Performance improvement

Thesis Findings

- Inconsistency
  - Similar to negligence
  - Depends on who the person is
    - » Good or bad performer
  - Media Attention
  - High Profile

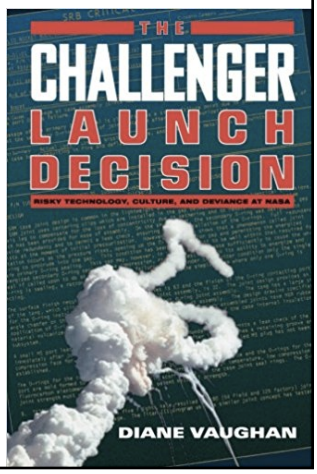
Bureaucratic vs Professional Accountability

Bureaucratic vs. Professional Accountability

- Professional Accountability
  - Apollo example
  - Different areas had autonomy
  - Central control for system initiatives
  - Otherwise deference to expertise
  - Work stays within experience of worker

Bureaucratic vs. Professional Accountability

- Bureaucratic Accountability
  - Challenger example
  - Shift towards:
    - » Metrics
    - » Paperwork
    - » Travel
    - » Supervisory roles (hierarchy)



Bureaucratic vs. Professional Accountability

- Bureaucratic Accountability
  - Burdened with Procedural and paperwork demands
  - Less Hands-on work
  - Less emphasis on line workers' expertise
  - More towards bureaucratic needs
    - » Budget
    - » Metrics

Safety as a Bureaucracy

- Currently significant
- Compliance based
- Use in industrial safety
  - Lost Time Injuries
  - 0 Vision
    - » 0 Accidents
    - » 0 Injuries
    - » 0 Errors/Mistakes
  - Current Realities
    - » System workarounds
      - Examples
        - » **ACE**
        - » **Logging**

Safety as a Bureaucracy

- Accountability up instead of responsibility down
  - Efficiency quotas
  - Documentation

Safety as a Bureaucracy

- Effect on operational accountability
  - Work is shifted towards:
    - » Paperwork/tools
    - » Documentation
    - » Meeting quotas
  - Loss of operational expertise
    - » Less time to spend in practice
    - » Less time supervising

Backward Looking vs. Forward Looking Accountability

Backward Looking vs. Forward Looking

- Backward Looking Accountability
  - Features
    - » Focus on blame
      - Typically, on frontline worker
    - » Looks for antecedents correlated to event
      - Like retributive justice
    - » Leads to Lawsuits and criminal prosecutions
      - Dekker examples

Backward Looking vs. Forward Looking

- Backward Looking Accountability
  - Contributions to Learning
    - » Focus is on outcomes
      - What happens because of broken component
    - » Typically inhibits learning
    - » Why?

Backward Looking vs. Forward Looking

- Backward looking Accountability
  - Focus is on the human
    - » We know that all parts jointly sufficient through emergence
      - Success and failure in complex systems emerges
    - » This is a mechanistic reasoning
      - Component failure (human)
    - » Focus leads to ending investigation with human error
    - » Implications for learning
      - Cycle of quick fixes and not addressing real issues

Backward Looking vs. Forward Looking

- Backward Looking Accountability
  - Responsibility Authority Double Bind*

Responsibility Authority Double Bind

- Workers feel are held responsible for the outcomes of their work
  - High Risk Industries
- Frontline workers also experience a lack of authority to achieve the outcomes they want to provide

Responsibility Authority Double Bind

- This conflict between responsibility and authority create a conflict
- Typically influences two responses
  - Learned helplessness
  - Covert operations

Responsibility Authority Double Bind

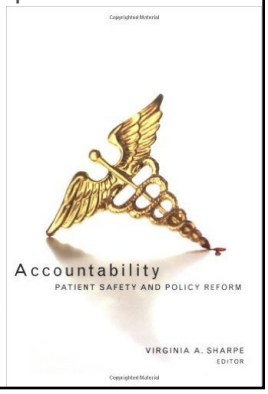
- Learned helplessness
  - Least likely to occur
  - Feel they have no ability to have success
  - Lose the feeling of responsibility
  - Become passive bystander to bad outcomes

Responsibility Authority Double Bind

- Covert operations
  - Most likely to occur
  - Cut corners and work outside of written procedure to complete job
  - Do not feel safe to talk about the risks they have to take
  - Fluency Law

Backward Looking vs. Forward Looking

- Forward Looking Accountability
  - Features of FLA
    - » Focus on setting and meeting goals of improvement
    - » Has a systemic lens
      - All parts jointly sufficient
      - People create safety at all levels

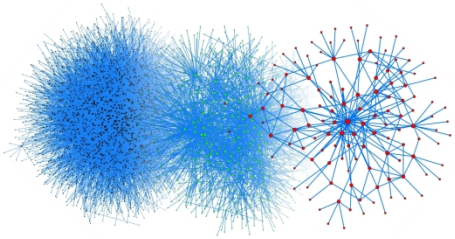


Backward Looking vs. Forward Looking

- Forward Looking Accountability
  - Looks to distribute accountability
  - Looks ahead towards improvement

Backward Looking vs. Forward Looking

- Forward Looking Accountability
  - Contributions to Learning
    - » Shifts to systemic focus
    - » Distributes accountability
    - » Gives credit to complexity



Backward Looking vs. Forward Looking

- Forward Looking Accountability
  - Brings info about learning up to those who can make change
    - » Safety Action Group in TN

Backward Looking vs. Forward Looking

- Forward Looking Accountability
  - Tries to bring:
    - » Transparency
    - » Analytical thought
    - » Systemic Improvement
  - Use of Language

Use of Language

- Removes
  - Cause
  - Error/Mistake
  - Failure
  - Blame
  - Counterfactuals (Should/could/would)
  - What else?

Contrasting Reviews

Expert Findings

- The length of B737 type training at THY, as well as procedural compliance at THY, appear to at least match industry standard.
- The Captain had close to 11,000 hours on the Boeing 737 alone. This combination of training standards and experience is apparently not enough to protect crews from the subtle effects of automation failures during automated, human-monitored flight.
- The documentation and training available for flight crews of the Boeing 737NG leaves important gaps in the mental model that a crew may build up about which systems and sensor inputs are responsible for what during an automatically flown approach.

(Dekker, 2009)

Expert Findings

- It is indisputable that OKDHS was well aware of the hazard associated with the pool.
- The home should *never* have been approved without a specific and shared understanding between OKDHS and the foster parents about the pool.
- The pool should have been removed or a suitably protective fence should have been placed around it.
- No children should *ever* have been placed in the home before one of these things happened.
- By failing to ensure that this hazard was either removed or mitigated, OKDHS violated CWLA and COA standards and its own policy.

Goad, 2011

Director Responses

Agency Response Example

Case: Social workers charged with child abuse in case involving torture and killing of an 8-year-old boy

- Four County social workers have been charged with felony child abuse in connection with the 2012 death of the 8-year-old, who was tortured and killed even though authorities had numerous warnings of abuse in his home.
- County prosecutors allege that county Department of Children and Family Services employees allowed a vulnerable boy to remain at home and continue to be abused.

Agency Response Example

Agency Response:

- Director Statement: “In our rigorous reconstruction of the events surrounding the boys death, we found that four of our social workers had failed to perform their jobs. I directed that all of them be discharged. I want to make it unambiguously clear that the defendants do not represent the daily work, standards or commitment of our dedicated social workers, who, like me, will not tolerate conduct that jeopardizes the well-being of children.

Agency Response Example

Case: Three male children — ages 2 months old and 5 and 8 years old were found in a closet full of miscellaneous items.

- The youngest boy's body was in a suitcase.
- The children appeared to have been stabbed to death and parts of their bodies dismembered.
- DCS agency had multiple contacts with the family of the 3 slain boys

Agency Response Example

Agency Response:

- Director Statement: "It is a sad day as we reflect on the gruesome nature of what occurred. We grieve as a community, trying to understand why three innocent souls have been taken. We grieve as an organization, suffering the loss of children whom we knew. When a child is murdered, it's common to ask if something could have been done to prevent such a tragedy. At DCS, we ask ourselves those questions because we take the responsibility of protecting children very seriously. But our powers are limited; we cannot predict the future; and people, can at times, do awful things. We offer our deepest sympathies to the family and pray for the peace of the departed. I ask all of us to respect, support, and commend the dedicated men and women of DCS and Law Enforcement who do the unimaginable. Who do, when no one else can or will. Who comfort the afflicted, protect the weak, and wipe the tears; who then go find a private place to shed their own."

THE TENNESSEAN
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TN examines child deaths with more care

Tony Gonzalez, tgonzalez@tennessean.com 11:57 p.m. CDT May 7, 2014

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(Photo: Samuel M. Simpkins / File / The Tennessean)

STORY HIGHLIGHTS

- High caseloads make work tough for TN child abuse investigators.
- After problems, the state has a new way of reviewing child fatalities.
- So far in 2014, DCS has opened 69 child death investigations.

Tennessee's child abuse investigators, who confront life-or-death decisions about whether kids are safe in their homes, haven't always been willing to talk when things go wrong — when children die or suffer severe injuries.

And for at least a couple of years, caseworkers didn't have to say much of anything.

The Department of Children's Services fell behind on internal reviews of child deaths. When they did look back, the reviews did little to explain what led to each incident, or what might save other children.

That's changing.

The department recently completed its first year of new, more immediate and more exacting death reviews as required by a federal judge. A court order requiring changes followed a Tennessean investigation and outcry from a watchdog group. DCS now must learn as much as possible about every death and near-death incident involving families who had contact with state caseworkers.

Blame and Accountability

Blame and Accountability

- Pronovost Wachter article
- No Blame vs Accountability
  - Assumptions
    - » No blame means no accountability
      - – False
    - » Blame decreases accountability

Blame and Accountability

- When we blame we inhibit learning and improvement
  - Backward Looking
- Accountability seeks to improve
  - Forward Looking

Making Change

Making Change

- Practical Elements
  - Just Culture
  - Second Stories
  - Second Victim
  - Org. Response

Making Change

- How else can we see this in practice?
  - Woods Questions
    - » Do changes enhance the flow of communication?
    - » Do they help connect and share responsibility across systems of care?
    - » Do enhancements help people see how multiple factors (including organizational) combine to create conditions for adverse events?
    - » Do they reduce double binds?
    - » Do they degrade coordinating activity?

Discussion