



Team Health is Contagious: Strategies for Fatality Review Teams

National Center Guidance Report

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The National Partnership for Child Safety is a national leader in creating safety culture within child welfare agencies. NPSC has contributed significant leadership, resources, and content to this guidance. NPSC has a wide variety of resources available at the National Partnership for Child Safety website (**URL:** <https://bit.ly/3QJQml4>).

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Introduction

The death of a child is a tragedy that ripples through the entire community. Even professionals and community members without direct knowledge of the child or family may experience negative emotions and outcomes. Fatality review team members may experience significant distress due to reviewing fatalities. Because the health of individual team members may impact the entire team, it is important for all team members to practice self-care strategies. However, it is equally important that the team creates a culture where safety is prioritized, because team health is contagious.

This guidance will provide fatality review teams with an understanding of:

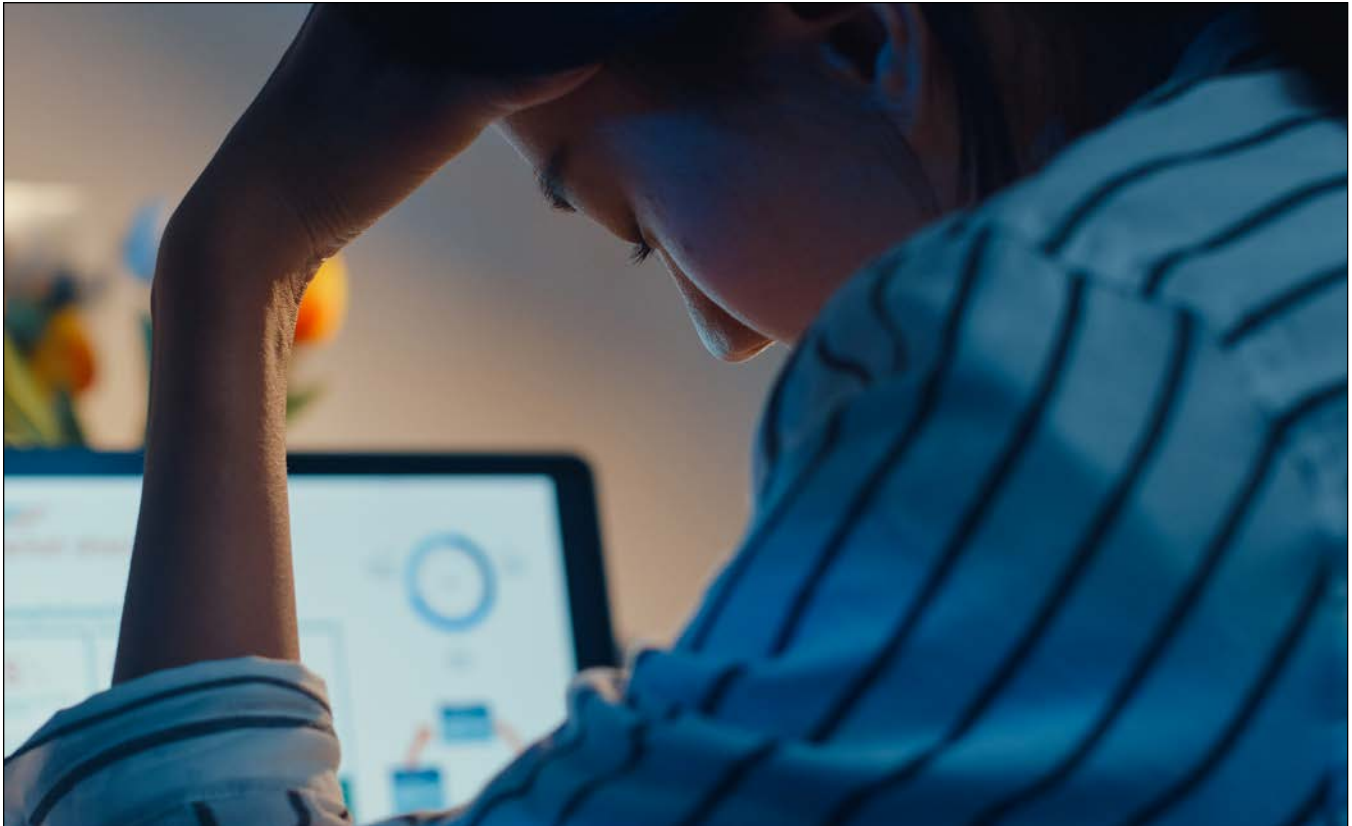
- The impact of burnout and secondary traumatic stress.
- The role team culture plays in fatality review team health and well-being.
- The importance of habits in promoting healthy cultures.
- Strategies teams can implement to build a safety culture.

Cause for Concern

Professional burnout and new stressors to nearly every domain of life has increased since the COVID-19 pandemic. Anyone exposed to chronically stressful conditions can experience burnout, but fatality review team members, such as public health workers, human services professionals, healthcare workers, first responders, and school personnel, are at an even higher risk. Burnout results from chronic workplace stress that has not been successfully managed; and is characterized by feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism; and reduced professional efficacy¹.

Another challenge for fatality review team members is Secondary Traumatic Stress (STS). STS is trauma resulting from hearing about the trauma experiences of another. The desire to help the traumatized person causes stress in the helper². STS is characterized by hypervigilance or avoiding similar situations, feelings of anger, guilt, exhaustion, or problems sleeping. STS can also impact the immune system resulting in illness³.

Key methods for reducing team member burnout rely on a supportive and innovative team culture. Previously held theoretical frameworks have assumed that burnout and STS may co-occur, but there was no research to suggest if burnout or STS came first⁴. However, more recent research demonstrates the "relationship between burnout and STS seems to be unidirectional, with job burnout being a potential 'gateway' outcome, enhancing the risk of developing STS⁵." More research is needed to further define the relationship between STS and burnout.



Team Culture

Many public health functions are carried out in a team setting or through teamwork. While there are many definitions of teamwork, Salas et al. (2005) defined teamwork as a “set of interrelated behaviors, actions, cognitions, and attitudes that facilitate the required task work that must be completed. For teams to be effective, there must be shared beliefs about norms, culture, risk taking, and mutual trust. These shared beliefs are defined as culture. Team culture shapes how members understand and participate in their work⁶.”

Members of successful fatality review teams promote a culture of safety, or safety culture, around beliefs, attitudes, and values. These cultures seek input from each other, promote accountability for mistakes, operate as parts of a whole instead of as individuals, and identify innovative solutions to problems⁷. The traits of a successful team are encompassed in the concept of a safety culture.



For teams to be effective, there must be shared beliefs about norms, culture, risk taking, and mutual trust.



Teamwork and Culture

Team culture shapes how members understand and participate in their work⁶. The culture of a team governs, formally or informally, the values, beliefs, and behaviors of the team members. Creating a safety culture is a strategy used in high-stress, high-consequence professions to improve shared decision-making, engage in continuous learning, and make change.

Teams with a safety culture allow for learning and improvement, especially following a mistake. This culture of empowerment allows teams to operate more efficiently and effectively and focus on addressing systems-level problems⁸. By understanding the current culture, changes can be identified and implemented to improve outcomes⁹. In a safety culture, those qualities orient the work toward safety as the prevailing priority for members, and there is a focus on team-based solutions that simultaneously improve decision-making and address workforce development^{10,11}.

A system's level problem is a challenge that may be difficult to understand and resolve. These complex problems frequently change and benefit from a multifaceted approach with a broad group of dedicated partners. Common systems problems are obesity, youth violence, or teen pregnancy¹².

Psychological Safety

Psychological safety is the belief that someone won't be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes¹³. Mutual respect and trust are necessary for teams to achieve psychological safety.

Group norms are a core part of psychological safety. Group norms minimize interpersonal conflict, which allows for teams to focus on their work. Group norms include traditions, behaviors, written and unwritten communication, and processes for decision making. In general, when group norms support treating colleagues with fairness, empathy, and compassion, the team is more successful. Group norms that promote belonging, respect, and fairness are commonly found on highly successful, psychologically safe teams.

Building psychological safety is challenging and rarely follows a clear path¹⁴. Psychological safety is cultivated through shared experiences and a focus on teams learning together¹⁵. The more frequently a team experiences positive interaction, and group norms are upheld, the more psychological safety is produced.

Concrete Steps for Building Psychological Safety: The 4 Stages of Psychological Safety¹⁶

Building and enhancing psychological safety is the foundation for a strong culture of safety. Building on the work of Edmondson, Timothy Clark (2020), expands the definition of psychological safety to “a condition in which you feel (1) included, (2) safe to learn, (3) safe to contribute, and (4) safe to challenge the status quo—all without fear of being embarrassed, marginalized, or punished in some way¹⁷.”

The four components of Clark's definition of psychological safety mean individuals are invited to learn new tasks, share ideas, and make mistakes. Belonging in a team is being accepted without fear or rejection. The path toward psychological safety begins with belonging. A team member who is experiencing rejection may feel unnoticed. If a team member is ignored, they may seek attention as a method of "fitting in." Barriers to belonging and engagement need to be addressed with the understanding that each person has different circumstances and different participation needs¹⁸. Addressing barriers to belonging is only possible if we know that those barriers are for each individual and for the group as a collective.



Belonging is being accepted without fear or rejection.

Belonging is both formal—for example, when someone is hired—and informal, such as when someone is invited into a casual conversation. Belonging is achieved when team members are invited into the team in an intentional and meaningful way, and all team members feel they are afforded the opportunity to participate and influence the outcome of the team¹⁹. Belonging is required to develop psychological safety²⁰.

Mindful Organizing

An integral part of creating a culture of safety and resilience within the team can be learned from the perspective of mindful organizing. Mindful organizing enables a team to rapidly and effectively identify and respond to unexpected events²¹.

Organizations that can predict and prepare for failure are called high-reliability organizations (HRO). HROs are successful at achieving a culture of safety because they have moved from a reactive model of managing hazards to a proactive model in which staff can anticipate and prevent problems before they occur. HROs are successful at addressing problems proactively because leadership has taken charge of the culture, promoted a culture of psychological safety where staff are empowered to speak up, and embedded continuous opportunities for learning and quality improvement.

Fatality review teams, like HROs, can promote safety and resilience by adopting an environment of “collective mindfulness” where all team members consistently look for smaller issues and address them before they become larger issues and are harder to fix²².

Cognitive Bias

Everyone has biases. These biases can be implicit or explicit and exist at the individual and systems levels. Cognitive biases are intertwined with an individual's understanding of their surroundings, including other people. They are automatic and impact all aspects of work. The level of awareness of cognitive biases, what is done about it, or how they are addressed can impact team culture and psychological safety.

Individuals within high-risk, high-consequence professions must make complex decisions quickly. Cognitive biases create simplified decision-making paths that allow decision making to focus on new information. While there is a research gap evaluating cognitive bias within CDR teams, research within other professions such as child welfare demonstrate clear biases²³.

Cognitive bias is impacted by individual and system factors. Individual factors that increase the likelihood of cognitive bias include fatigue, feelings, and cognitive load, or the amount of memory and brain processing necessary to complete a task. Together, these three traits result in the brain relying on the decision-making shortcuts that result in bias²⁴. At the systems level, workflow design, inadequate processes or environments, and toxic culture can result in bias.

Cognitive biases can be reduced through raising awareness, promoting critical thinking, and enhancing work systems. All three of these steps can be taken at the individual and systems levels. Enhancing the mindful organizing and psychological safety of teams may help to protect against team-based bias in decision-making and help ensure a culture of safety²⁵.



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Habits that Build Team Culture

An effective team uses habits to help establish and sustain a healthy culture. These habits become the predictable foundation for how teams interact within and between teams. An effective team has the following five habits:

- Plan forward
- Reflect back
- Communicate effectively
- Test change
- Promote professionalism

Relational Pauses

Humans crave connection. Being disconnected is a risk factor for potentially unhealthy behaviors such as excessive alcohol consumption, smoking, or lack of exercise. By framing challenges as belonging to the group, instead of individuals, team functions can improve. Struggling through a challenge together is called struggling well together.

Overcoming collective challenges can foster empathy, trust, improved communication, and ownership of work. Connections that improve problem solving and resource utilization are enhanced. Individuals on teams who struggle well are less likely to experience isolation, communication gaps, and errors.

Developing a resilient team culture requires a time investment to develop shared experiences, ideas, and opportunities to resolve conflict. One of the ways teams can build this group resilience is by incorporating relational pauses as part of the shared team culture. A relational pause is a reflective process or way to measure or assess how the team culture is affecting team members²⁶. The following two strategies—plan forward and reflect back—are relational pauses that give teams opportunities to have purposeful, supportive interaction, and foster a resilient group dynamic.



Plan Forward

Implementing consistent opportunities to plan for the future creates connection. One strategy for planning forward is team huddles. These intentional gatherings provide measured, consistent, and predictable opportunities for the team to connect. Not only does this strategy create connections between team members with the work, but it also creates an opportunity for team members to support each other. A strategy for effective huddles is to PREP (Prepare, Review and Anticipate, Enact, and Promote).

Prepare

- Each team member has what they need to be successful.
- Materials are organized to meet those needs.

Review and Anticipate

- Remind team members the purpose is to update and identify potential challenges.
- Provide individual and team updates.
- Anticipate future needs by asking “What are you concerned about?”

Enact

- Use resources to lessen or remove barriers.
- Challenges are a part of daily life that everyone experiences. Building individual and team resilience by closing communication loops can help reduce challenges.

Promote Resilience

- End the team huddle with a shared statement that reinforces the positive team culture.

Another strategy for planning forward is to use checklists. A checklist can be used during infrequently conducted activities, such as a fatality review meeting. The checklist should be concise, relevant, and easy to use. A checklist creates shared understanding of how a task should be completed.

Fatality Review Application

Using a checklist for conducting a case review can ensure that a systematic discussion happens for each death. Using checklists can also reduce bias in the fatality review process by improving consistency between case reviews. A checklist for fatality review teams should include:

- Order of information sharing listed by discipline or time to read a case abstraction
- Discussion questions
- Positive and constructive findings from review discussion
- Data elements still needed
- Action items

Reflect Back

Risk taking and failure are a normal part of work. How individuals and agencies reflect back on previous actions and respond to risk taking and failure is vital. The opportunity to reflect on challenging times through debriefings is a strategy to understand failure to mitigate its effects or prevent it from happening again. Creating space for intentional debriefing as part of the team dynamic, shifts framing risk and failure as an individual problem or issue, and normalizes failure as a collective concern. Briefings should be scheduled after major events and answer the following questions:

- What went well?
- What could have been better?
- What will we do differently next time?

Restorative Accountability

Missteps happen, rules are broken, and goals are not met. Using a restorative approach to accountability, the stories of individuals are heard with the key purpose of learning. A restorative approach asks three key questions:

- Who was harmed?
- What do they need now?
- Whose responsibility is it to help?

A facilitated discussion centered on these questions can foster trust and belonging among team members.

Fatality Review Application

Fatality review teams can use reflect back rationale pauses to evaluate the effectiveness of their process. At regular intervals, the team can discuss needed modifications to the team membership, process, or outcomes. By holding discussions at predetermined intervals, team members gain comfort with providing feedback. Additionally, regular discussions allow the team to pivot and change processes before there is a major issue.

Communicate Effectively

Effective communication is a foundational element of teamwork. Communication is both verbal and nonverbal. In the age of digital communication and virtual meetings, it is very challenging to communicate effectively due to the lack of nonverbal cues.

Communication can be enhanced by setting community agreements. These consensus-driven agreements often speak to process as well as interpersonal interactions. Community agreements, when followed, provide a framework for testing change, managing conflict, and celebrating success. Common community agreements, include:

Make space, take space

- Let one person share at a time
- Take at least one full breath before you speak
- Ask yourself Why Am I Talking (WAIT) or Why Am I Not Talking (WAIN)
- Ask yourself if it's already been said

Encourage healthy conflict/tension

- Address problems, not people
- Share your experience or feelings
- Let go of defensiveness

Listen to understand vs respond

- Ask questions of clarity

Reflect back

- "What I hear you saying is..."

We are all learning and we are all wise

- Share your experience and expertise
- Make space for the expertise of others

Both/and thinking

- Use "yes, and..."
- "I understand you **and**"

Take accountability

- Use "I" statements
- Tend to the impact vs the intent
- Call one other in vs out

In addition to community agreements, the following strategies can improve communication.

- Learn about preferred communication styles.
- Use structured communication tools such as Situation-Background-Assessment-Recommendation (SBAR).
- Practice empathy and vulnerability.
- Examine subconscious or unconscious narratives or biases that might be driving communication.

Fatality Review Application

Fatality review teams should set community agreements and revisit them at regular intervals. Community agreements can be revisited at the beginning of each meeting. Display community agreements during review meetings. These should be displayed where all team members can see them. For in-person meetings, they can be printed on the back of name tents or the bottom of the agenda. For virtual meetings, they can be placed in the chat, pinned on the screen, or read at the beginning of the meeting.

Test Change

Change can be scary. High functioning teams embrace change but implement structured processes for evaluating the impact of change. Common methods for testing change include:

- [Plan-Do-Study-Act \(PDSA\)](https://bit.ly/4kokBeD) (URL: <https://bit.ly/4kokBeD>)
- [Driver Diagrams](https://bit.ly/3Dbl1o9) (URL: <https://bit.ly/3Dbl1o9>)
- [LEAN Management](https://bit.ly/3XrG9NE) (URL: <https://bit.ly/3XrG9NE>)
- [Six Sigma](https://bit.ly/4h7MLlj) (URL: <https://bit.ly/4h7MLlj>)

Testing a PDSA

Planning a PDSA cycle will require focused discussions to break down a task into steps that can be evaluated. The PDSA cycle framework can be used repeatedly until all components of a task have been evaluated through at least one PDSA cycle.

- **Plan:** Identify the area in which you want to test change. Be careful not to think broadly. It may take several PDSA cycles to fully test changes.
- **Do:** Take the action you've planned. It could be for one team meeting, with one team member, or during one fatality. Complete the action exactly as planned but do not over think it.
- **Study:** Reflect on the actions you took. Pay special attention to what went well, what was challenging, and what surprised you. Solicit feedback from the person or group that participated in the PDSA cycle.
- **Act:** Using what you experienced, observed, reflected on, and the feedback from the person who participated in the PDSA cycle begin to adjust the original to make it more effective. This leads to the next PDSA cycle.

An important component of testing change is ensuring that changes are tested quickly. Failure is bound to happen. Failing quickly can help support psychological safety.

Fatality Review Application

A common goal of fatality review teams is to improve the quality of their data. This important goal is multifaceted and complex. Using PDSA cycles is a great way to divide the goal into actionable steps. Examples of common starting places for testing data-related PDSA cycles are:

- Improving data quality for one specific variable (e.g., child's health insurance status) by trying a new data source.
- Improving data quality for information collected from one specific discipline (e.g., Doe City Police Department not all law enforcement agencies).
- Utilizing different ways to share information between agencies to improve data completeness by focusing on one agency (e.g., Saint Joes Hospital not all medical providers).
- Identifying methods to improve data timeliness with one data source.

Promote Professionalism

Effective teams have candid and challenging conversations. The ability to challenge ideas is a sign of a psychologically safe work environment. Respect, trust, and belonging are prerequisites for candid conversations. Speaking up behaviors can be cultivated using signal words or phrases. When used, a signal word lets colleagues know that there is a concern present that needs everyone's full attention. A common signal phrase uses the acronym CUS (check-in, understand, and stop). Using CUS allows team members the opportunity to slow down, ask questions about safety and critical decisions, and resolve the concern as a group.

- Can we **check-in**?
- Help me **understand**?
- Let's **stop** for a minute.

Signal words can be agreed upon while setting community agreements.



Providing Feedback

Giving and receiving feedback is vital to a healthy team culture. Healthy feedback is timely, respectful, specific, considerate, and framed as an opportunity. To maximize the effectiveness of feedback, communication between colleagues should be candid and direct. One strategy for structured conversations and feedback is OSSCR (Open, Share, Suggest, Close, and Reflect).

- **Open** with specific examples of behavior or situations that need to be discussed. Using concrete information as much as possible.
- **Share** your concerns, observations, and feelings.
- **Suggest** alternatives and reach agreement.
- **Close** the discussion to avoid repeating previous discussions and furthering conflict.
- **Reflect** on the discussion, your actions and words, and begin to move forward.

Fatality Review Application

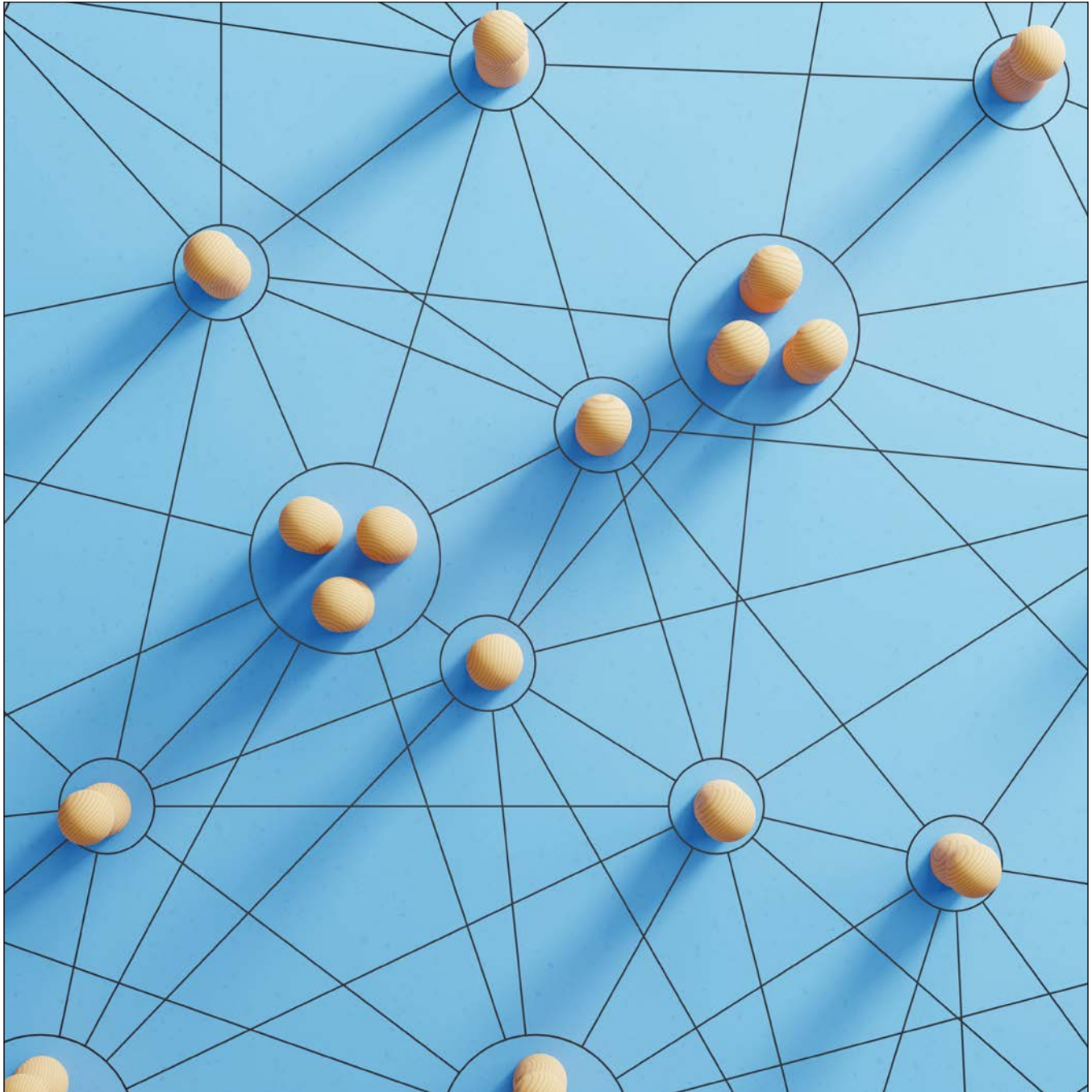
Signal words can be used by fatality review teams for a variety of reasons. Key opportunities to use signal words are to:

- Discuss culturally appropriate terms instead of biased or derogatory terms.
- Refocus a discussion on systems gaps instead of blaming individuals.
- Expand on the specific obligations or limitations of an agency.
- Identify positive or constructive findings from the review process.



Conclusion

Fatality review teams provide a unique view of how systems interact within a community function. This view provides a set of information that is vital for understanding the shared risk and protective factors impacting community health and safety. The high-consequence work of fatality review teams can result in burnout and secondary traumatic stress for professionals engaged in the process. By building a safe, resilient culture that supports individuals, fatality review teams can lessen the negative impact and improve outcomes to be successful and adaptive.



Endnotes

- 1 World Health Organization, Burn-out an “occupational phenomenon”: International Classification of Diseases, 2019, <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases>.
- 2 Figley CR. Compassion fatigue as secondary traumatic stress disorder: An overview. In: Figley CR, editor. Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner-Routledge; New York: 1995. pp. 1–20.
- 3 Marsac, M. L., & Ragsdale, L. B. (n.d.). Tips for Recognizing, Managing Secondary Traumatic Stress in Yourself. <https://publications.aap.org/aapnews/news/14395/Tips-for-recognizing-managing-secondary-traumatic?autologincheck=redirected>.
- 4 Shoji K, Lesniewska M, Smoktunowicz E, Bock J, Luszczynska A, Benight CC, Cieslak R. What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland. PLoS One. 2015 Aug 25;10(8):e0136730. doi: 10.1371/journal.pone.0136730. PMID: 26305222; PMCID: PMC4549333.
- 5 Shoji K, Lesniewska M, Smoktunowicz E, Bock J, Luszczynska A, Benight CC, Cieslak R. What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland. PLoS One. 2015 Aug 25;10(8):e0136730. doi: 10.1371/journal.pone.0136730. PMID: 26305222; PMCID: PMC4549333.
- 6 Schein, E. H. (2010). Organizational Culture and Leadership (4th ed.). San Francisco, CA: Jossey-Bass.
- 7 Edmondson A, The Role of Psychological Safety, Maximizing Employee Input and Commitment, Leader to Leader, Volume 2019, Issue 92, Pages 13-19.
- 8 Julianne M. Morath, RN, MS, Joanne E. Turnbull, PHD. John Wiley & Sons, May 6, 2005.
- 9 Commission to Eliminate Child Abuse and Neglect Fatalities, (2016).
- 10 Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). With in our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office.
- 11 Cull MJ, Rzepnicki TL, O’Day K, Epstein RA. Applying principles from safety science to improve child protection. Child Welfare. 2013;92(2):179-95. PMID: 24199329.
- 12 Centers for Disease Control and Prevention, How Do you Identify a Systems Problem, https://www.cdc.gov/polaris/php/thinking-in-systems/identifying-systems-problems.html?CDC_AAref_Val=https://www.cdc.gov/policy/polaris/tis/systems-problems/index.html, March 2021.

- 13 Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), 350–383. <https://doi.org/10.2307/2666999>.
- 14 Edmondson A, The Role of Psychological Safety, Maximizing Employee Input and Commitment, *Leader to Leader*, Volume 2019, Issue 92, Pages 13-19.
- 15 Edmondson A, The Role of Psychological Safety, Maximizing Employee Input and Commitment, *Leader to Leader*, Volume 2019, Issue 92, Pages 13-19.
- 16 Clark, T. (2020). *The 4 Stages of Psychological Safety*. Oakland: Berret-Koehler Publishers, Inc.
- 17 Clark, T. (2020). *The 4 Stages of Psychological Safety*. Oakland: Berret-Koehler Publishers, Inc.
- 18 Napier-Dunnings & Williams, Michigan Public Health Institute, *Facilitating Collaboration: A Relationship-Driven Practice Facilitation Guidebook*.
- 19 Napier-Dunnings & Williams, Michigan Public Health Institute, *Facilitating Collaboration: A Relationship-Driven Practice Facilitation Guidebook*.
- 20 Clark, T. (2020). *The 4 Stages of Psychological Safety*. Oakland: Berret-Koehler Publishers, Inc.
- 21 Casey Family Programs, Strategy Brief, *Healthy Organizations, How can mindful organizing promote a safety culture in child protection agencies?*, 2020, <https://www.casey.org/media/20.07-QFF-HO-Mindful-organizing.pdf>.
- 22 Weick KE, Sutcliffe KM. *Managing the Unexpected*. 2nd ed. San Francisco: Jossey-Bass; 2007.
- 23 Font SA, Berger LM, Slack KS. Examining Racial Disproportionality in Child Protective Services Case Decisions. *Child Youth Serv Rev*. 2012 Nov 1;34(11):2188-2200. doi: 10.1016/j.childyouth.2012.07.012. PMID: 22984321; PMCID: PMC3439815.
- 24 Le, T., Fedechko, T., Cohen, A., Allred, S., Pham, C., Lewis, S., & Barkus, E. (2019). Stress and cognitive biases in schizotypy: A two-site study of bias against disconfirmatory evidence and jumping to conclusions. *European Psychiatry*, 62, 20-27. doi:10.1016/j.eurpsy.2019.08.006.
- 25 Strategy brief healthy organizations. Casey Family Programs. (2020, April). <https://www.casey.org/media/20.07-QFF-HO-Mindful-organizing.pdf>.
- 26 Cull & Lindsay (2019). *Team First: A Field Guide for Safe, Reliable, and Effective Child Welfare Teams*.

