Imagining Sentinel Event Reviews in the U.S. Probation and Pretrial Services System

Janette Sheil
Administrative Office of the U.S. Courts
James Doyle[1]
Of counsel to the Boston firm of
Bassil, Klovee & Budreau
Christopher T. Lowenkamp
Administrative Office of the U.S. Courts

DNA EXONERATIONS OF wrongfully convicted defendants have thrown a new light on the problem of error in American criminal justice. The fact that people sometimes make mistakes came as no surprise to active practitioners, but the growing list of highly publicized disasters gradually revealed a gap in our system's design. Our criminal system lacks a feature that medicine, aviation, and other high-risk fields see as critical: a way to account for the sources of the tragic outcomes that no one intended, to learn their lessons, and to use those lessons to reduce the risk of recurrence.

Corrections and probation professionals shudder at the nightmare of analogous headlines raising their own version of these questions: Why did we *release* the wrong man, so that he could inflict catastrophic harm? Or why did we keep the *right* man, but past his maximum sentence? How did we inherit this mentally ill prisoner, when we had no program of safe and useful treatment available? Why did our testing or tracking procedures fail to raise red flags? Why did we miss the red flags when they were raised?

In aviation and in medicine the recognition has grown that most catastrophes can't be understood simply by finding a frontline individual to blame. These are not single-cause events. More often, they are system errors: the outcome of normal people doing normal work in normal organizations (Dekker, 2007). As Dr. Lucien Leape (1994), one of the pioneers in medicine's patient safety movement, put it:

> While an operator error may be the proximate "cause" of the accident, the root causes were often present within the system for a long time. The operator has, in a real sense, been "set up" to fail by poor design, faulty maintenance, or erroneous management decisions.

Stopping at disciplining a "bad apple" or tinkering with an isolated procedure can leave the underlying causes of an error lying in wait for the next practitioner who comes along. With this in mind, medical reformers adopted the battle cry "Every defect a treasure" (Berwick, 1989). If we have paid the price for a mistake, they reasoned, we should learn the preventive lessons it can teach. They argue for a pivot from a focus on blame to a focus on cutting future risk. Error is an inevitable part of the human condition, and, as safety expert James Reason (2000) put it, "We cannot change the human condition, but we can change the conditions humans operate in."

Reason compares an organization to Swiss cheese: having layers of defense or protections against errors, with the holes in the block of cheese representing the weakness in those defenses. In most cases, the holes in the block do not line up, so if you look through one hole you will not see daylight on the other side. A small error may occur, but one of the layers of defense will catch it before it cascades through the system. However, in some instances, the holes become completely aligned, allowing an error to traverse the block. Reason argues that we should look at our poor outcomes to try to find ways to reduce the holes and find the weaknesses in our organizational systems. Once this is done, we can add layers to catch smaller errors (2000).

Sometimes errors are tough to identify on first glance. It is not uncommon for employees to develop work-arounds or best ways of performing a task or a series of tasks more efficiently. After time, these diversions from policy and procedures, sometimes called practical drift (Snook, 2002), become accepted practice in the organization, especially in response to a reduced workforce. In normal operations, drift may go unnoticed, but in a critical high-profile situation any deviation from policy will be scrutinized. Conducting system-wide reviews can help uncover practical drift at all levels of the organization.

So the question remains, can the criminal

[1] The views expressed by Mr. Doyle in this article are his own and not those of any firm or agency.

justice system develop this capacity for "forward-looking accountability" (Sharpe, 2003)? Can we accept error as an inevitable element of the human condition and study known errors in a disciplined and consistent way? Can we share the lessons learned from these studies to prevent future errors? Can we focus on future risks instead of on blame for the past?

What is a Sentinel Event (SE) Review?

The word "sentinel" refers to a watchman who stands guard, detecting the first sign of a looming threat and sounding a warning. A sentinel event is a significant, unexpected negative outcome—such as a wrongful conviction, the failed supervision of a dangerous probationer, or the avoidable death of a vulnerable inmate—that signals a possible weakness in the system or process. It is likely to have been the result of compound errors and may provide—if properly analyzed and addressed—important keys to strengthening the system and preventing future adverse events or outcomes.

The goal of the process is not to mobilize a *performance* review aimed at an individual whenever some front-page catastrophe occurs, but to develop a regular practice of conducting an all-stakeholders, all-ranks, non-blaming, *event* review whenever a learning opportunity arises. That opportunity can be found in every tragedy. It can also be found in many "near miss" or "good catch" situations where the ultimate disaster was averted, but only by good luck, special vigilance, or a uniquely talented individual.

In these Sentinel Event reviews, features of the system that genuinely shaped the frontline decision-making (but would be dismissed as "excuse-making" in a more typical disciplinary performance review) can be raised and analyzed for their explanatory power. The "accountability" these reviews provide can reach not only the frontline operator who was the last person in the chain of delivery (for example, the nurse who delivered the medication) but that operator's superiors and the diverse upstream and downstream actors whose budgets, policies, training, and procedures shaped the frontline operator's environment and limited his or her options.

This approach has generated important changes in the fields of aviation and hospital patient safety. It has led not only to improved safety records, but to the creation of overall "cultures of safety" in which everyone, in every rank and role, feels individual responsibility for the safety of the collective outcome, and—maybe just as importantly—takes pride in and satisfaction from their unique contributions.

A typical hospital SE review would include a team of 4-6 people, including process experts as well as others from all levels of the organization. Individuals who were involved in the event are not a part of the team, but are interviewed for information. Factors that are reviewed likely include communication (including supervisory oversight), training, environment/equipment, experience, and rules/policies/procedures (National Patient Safety Foundation, 2016). All of these areas can contribute to human error. Most hospitals will provide feedback to the persons involved and submit their review results and an action plan to the Joint Commission, which is a non-profit organization that accredits and certifies nearly 21,000 health-care organizations and programs in the United States. The Joint Commission provides support and expertise to the hospital during its reviews, shares "lessons learned" with the medical community, and helps raise the level of transparency in the medical profession, providing a message to the public that patient safety is critical (The Joint Commission, 2016).

The military also engages in After Action Reports as standard operating procedure to discuss unintended outcomes, enabling soldiers to discover for themselves what happened, why it happened, and how to sustain strengths and improve on weaknesses. Similarly, the National Transportation Safety Board conducts approximately 2,000 aviation accidents and incidents a year and about 500 transportation accidents (NTSB, 2016) and posts the well-organized investigation reports on the Internet.

In 2014, the National Institute of Justice (NIJ) began focusing on the applicability of the Sentinel Event process to the criminal justice system with the support of then-Attorney General Eric Holder, Jr. (NIJ, 2014), who offered the following words:

> With few exceptions, justice system professionals hold themselves to high standards of integrity and are thorough and exacting in their quest for answers. If we truly hope to get to the bottom of errors and reduce the chances of repeating them, then it is time we explore a new, system-wide, way of responding…

The NIJ recognized that it is unwise to simply assume that these changes can be imported seamlessly into the unique context of criminal justice, and it has dedicated substantial resources to conducting a rigorous investigation of how the core ideas of Sentinel Event reviews can be mobilized in differing criminal justice environments (NIJ, 2014).

To test the concept, NIJ selected three jurisdictions to participate as beta sites. One of the selected sites in Milwaukee formed a group of diverse participants and analyzed the kind of event that strikes fear into any practitioner's heart: the "wrongful release," with fatal consequences, of a youthful defendant. "This was a kid who had red flags all over him," John Chisholm, the Milwaukee County district attorney, who participated in the review, later said, "Why was he still in the community?" (Starr, 2015). The usual impulse would be to hunker down under a media storm, or to blame the judge or the frontline probation officer. But after months of meetings, the all-stakeholders event review process revealed that at almost every turn, the people who made decisions about the boy had not seen his larger pattern of violent behavior because they did not have access to his complete records, or did not see them. System reforms to communications and data-sharing followed.

Is this Process a Good Fit for Federal Probation and Pretrial Services?

The Probation and Pretrial Services Office (PPSO) within the Administrative Office of the U.S. Courts (AOUSC) has a long history of providing oversight of the work of the United States courts. This function fulfills the statutory requirement of the Director of the AOUSC, or his authorized agent, to investigate the work of the probation officers and promote the efficient administration of the probation system (18 § U.S.C. 3672). Similar authorization to investigate the work of federal pretrial services rests under U.S.C. § 3153(c)(2).[2] In order to meet its statutory responsibilities, PPSO has relied in large part on its office reviews, which are cyclical on-site, broad examinations of an office's operations. In contrast, case reviews are conducted on an

[2] U.S.C. § 3153(c)(2) states that the Director of the Administrative Office of the United States Courts is authorized to issue regulations governing the release of information made confidential by 18 U.S.C. § 3153(c)(1), enacted by the Pretrial Services Act of 1982. Within these regulations, pretrial services information shall be available to the staff of the AOUSC for reviews, technical assistance, or other research related to the administration of justice.

ad hoc basis, usually looking into the supervision of an individual defendant or offender implicated in new serious criminal conduct, such as a murder or rape (Whetzel & Sheil, 2015). The number of these reviews is limited due to resource constraints. Additionally, the probation and pretrial services offices conduct their own investigations related to new criminal conduct by persons under supervision, but the scope is generally focused on the offender and not the system as a whole. Considering that in a ten-year period, from fiscal year 2005 through fiscal year 2014, there were roughly 4,000 homicides, sexual assaults, robberies, and felonious assaults committed by offenders on federal supervision,[3] the federal probation and pretrial services system could learn a considerable amount from examining more of these situations using a systematic, structured, and objective review process.

Over the last several decades evidence-based practices have taken hold in correctional systems around the country. While risk assessment has been used to identify persons on supervision who are at greater likelihood of committing an offense specifically, very little has been done to develop *systems and processes* that are keyed to reduce the risk of such an event. The Sentinel Events review process, if modeled on the same process in the medical system, promises to help us begin to understand what organizational deficiencies are occurring leading to violent offending.

As a system, we recognize that there will be mistakes, oversights, and problems despite having very capable staff; missteps by any person involved in a case are inevitable, especially in a higher-risk organization (Perrow, 1999). It takes strength of character and investment in the system to do the self-analysis required to answer the hard questions. Maybe what looked at first glance like great supervision had hidden flaws, maybe assumptions were made, or practice drift occurred? A SE review may help to draw out the systemic flaws. For example, during a post-incident case review, the review team may find out that the officer was supervising a person at a lower risk level, because the risk assessment tool was scored incorrectly. It would be easy to focus the blame on the officer's mistake. Taking a system's analysis approach would move the review beyond the officer by asking a series of "why" questions:

- If the assessment was scored wrong, why? Maybe the officer assumed he was scoring it correctly because he passed the recertification and did not feel the need to reference the scoring guide.
- Why didn't the supervisor catch it? Maybe the officer and the supervisor both were tasked with too high a caseload or too many other responsibilities.
- Did the supervisor communicate any barriers to conducting his or her work to the deputy chief? If so, did the deputy chief address the concerns?
- Was the district emphasizing the importance of risk assessment accuracy as the foundation of supervision?
- Was the national policy and training sufficient?

The potential outcome of this questioning style focuses on the agency instead of just the officer and maybe the supervisor. Officers will have the opportunity to explain—without seeming to excuse—a decision, evoking a more collaborative, "flatter," and less hierarchical approach.

The big question is how to conduct a sentinel event analysis and still hold staff accountable for performance issues. In the article *Balancing "No Blame" with Accountability in Patient Safety* (2009), the authors discuss how hand hygiene rates in the medical field barely rose past 70 percent despite aggressive efforts to change hospital practices, including policy changes, training, hand-gel dispensers in or near every patient's room, financial incentives, etc., to increase rates. The article suggests it may be easy to overlook the 30 percent as reasonable people occasionally making mistakes. However, if after system improvements are in place an individual continues to bypass the practice, negative consequences should be implemented. And of course, as James Reason acknowledges, every industry has transgressions that require discipline (1997). The idea is to create an environment where employees understand that if something happens, the leaders will look at the entire process, understanding that no one act would have been the sufficient cause of the negative outcome. Staffs also need to understand that as part of that process, they will be held accountable for their actions, especially if they have been provided with clear performance expectations or the action was egregious or deliberate. Being held accountable is understandable and acceptable if the employee knows that the agency will take ownership of system failures.

The Benefits of Sentinel Event Analysis

If our system continues to limit our examining of cases to the most egregious and/or notorious events, then our ability to identify system-wide failures will be limited. This limitation will in turn limit the number of sentinel events that can be avoided. This void can be filled by expanding the current process to include a Sentinel Event review process examining more cases, but such a change would require the assistance of each probation and pretrial services office. The local offices are in a better position to see beyond the officer, beyond the case, and beyond the supervisor. A local team could collaboratively provide constructive reflection, looking for explanations and new ideas that promote continual change, capitalizing on the talents and insights of all team members and contributors.

Even if each district did one Sentinel Event review a year and provided the resulting data to the AO, the system would benefit from a plethora of useful information about the complex network of agencies, policies and practices, and decision-making leading up to these events. Subsequent analysis could determine if the events were due to shortfalls in national policy and practice. For example, results from a series of case reviews might reveal that offenders' acute risk factors were not being assessed in an ongoing, formal, and structured way and why that is happening. Further, the application of such an assessment process will likely uncover cues that can be provided to officers to let them know when an offender's risk is rising to a potentially dangerous level.

If a sentinel event/root cause analysis were conducted in the district and involved all levels of the local hierarchy, taking advantage of the insights and knowledge of office staff in a non-blaming, forward-looking manner, officers might be more willing to talk candidly about their roles and help identify areas for improvement. Inevitably, SE reviews will identify a lot of quality work. Managers can capitalize on these insights to praise officers and develop others.

From the officer's perspective, the office's adoption of the SE process can help reduce work-related pressures associated with supervising higher-risk offenders. Since 2012, federal probation managers have been adjusting caseloads to allocate more time, attention, and resources on higher-risk offenders to

[3] This number represents 2.5 percent of the total population of federal offenders entering post-conviction supervision during that same time period.

better align with the risk, needs, and responsivity principle (Cohen, Cook, & Lowenkamp, 2016). Probation officers around the country are beginning to express increased stress levels as a result. In the article "'It's relentless': The impact of working primarily with high-risk offenders" (2016), the authors interviewed county juvenile officers about their high-risk caseloads. One officer stated:

> …you're going to be left with domestic violence cases who are manipulative, aggressive and controlling, you're going to be left with sex offenders who just, the nature of the work can just be distressing, and violent offenders who are quite possibly going to be kind of aggressive towards you. Plus underlying all that is the terrifying thought that one of them is going to go and do something really serious and you're going to have a big case review and investigation into how good or bad you are as a probation officer.
>
> Plus, just the thought of one of your cases committing a really serious offence and harming somebody is just horrible.

In the current federal probation and pretrial services review process, talented officers who have done exceptional work with a defendant or offender may feel as though they are being attacked; the process makes them feel like a "second victim" (Dekker, 2015). In an interview with an officer after an AO case review on one of his supervisees, he said the whole process felt like *he* was under investigation. Although the AO administrators explained that the process was intended to bring about improvement, he was nervous that he had missed something, even though he felt like he had really worked hard with the person from day one. He was worried that because of public and political pressure, he was going to be the scapegoat, so he was reluctant to expand upon his answers. It was a very stressful time and made him rethink why he wanted to be a probation officer.

Likewise, probation and pretrial services officers who supervise high-risk cases that have not been under the limelight are feeling the pressures of the *potential* for media attention on their performance, because they hear about situations from colleagues across the country. Chiefs are reporting that it is difficult to convince officers to apply for promotional opportunities. Making the move to a Sentinel Event process can help reduce these types of pressures. As stated, it is bad enough knowing your case could cause serious harm, without the stress of a "big case review and investigation" that feels like someone is looking for a scapegoat. Reducing the fear of misdirected consequences related to making occasional human mistakes allows the officer to focus more energy on working with the individuals under supervision. Additionally, potential applicants may be encouraged to work for an organization that is viewed as a progressive, learning organization (Senge, 2006).

Conducting SE reviews will likely build future leaders who have the desire to ask the hard questions, delving deep into the interrelated operational and administrative actions of the office that contribute to the success (or failure) of individuals involved in the justice system. Gaining these types of skills is huge for a system that struggles, along with the rest of the civilian federal government workforce, with the retirement of large numbers of experienced employees (General Accounting Office, 2014). According to the AO personnel data, in the next five years, 45 percent of chief probation and pretrial services officers, 33 percent of deputy chiefs, and 33 percent of supervisors will be retiring, leaving a significant need for opportunities to build capable leaders—leaders willing to accept feedback at all levels, providing a safe, trusting environment that encourages officers to talk about deficiencies and offer suggestions for strategic improvements that align with the agency's mission to become outcome-driven.

From a national perspective, the contributions of information from districts on just a handful of SE reviews would provide a unique view into the interworkings of probation and pretrial offices in relation to the entire system. This concept of learning from situations is not new. Researchers are acknowledging that just looking at the data points without the human element shows an incomplete story. In fact, some have begun discussing the limitations of big data and have introduced the term "thick data." Wang (2013) describes these two concepts this way:

> Big Data reveals insights with a particular range of data points, while Thick Data reveals the social context of and connections between data points. Big Data delivers numbers; thick data delivers stories. Big data relies on machine learning; thick data relies on human learning.

Or perhaps in a more familiar context, Ulmer (2012), discussing the state of the research and new directions in sentencing research, stated:

> As the discussions of recent literature and desirable new research directions show, the study of sentencing in the past decade has been highly focused on quantitative measurement and modeling. As I said earlier, this is not a problem in itself. However, if we do not match that focus on modeling with a parallel focus on the in situ decisions and activities of courtroom workgroup participants, and how these are shaped by their surrounding court community contexts, our understanding of sentencing will be truncated.

Both Wang and Ulmer are making the point that big data and quantitative studies using available datasets are limited in their ability to help us develop a true understanding of how and why events occur as they do. We would argue that Sentinel Events review would provide us with the "thick data" to supplement our big data and begin to develop a thorough and explanatory reason as to why these sentinel events occur and how to best reduce the likelihood of these events going forward.

Can We Do This?

Conceptualizing the Sentinel Event or systems analysis approach may be difficult for the U.S. probation and pretrial services system due to concerns about time pressures, legal concerns, and confidentiality, but consider the similar stakes at play in the medical, aviation, energy, and transportation industries. These industries have forged the way for the past 20-plus years to provide us with an evidence-based approach that offers a substantial opportunity to learn and help us grow as a system to better help those under our charge and the community. Since probation and pretrial services offices already conduct post-incident case reviews locally, albeit not consistently and not necessarily with a systems lens, adding a non-blaming team approach on a small cohort of Sentinel Event cases may be an acceptable time commitment. The overall value of these types of reviews may far outweigh the allocation of resources.

Before the federal probation and pretrial system embarks on the Sentinel Event analysis track, input and support has to come from the chief probation and pretrial services officers and their staffs to take advantage of this learning opportunity. If chiefs engage in the process, it has to be with interest and commitment to help protect the community and

improve our work, not just because the AO is asking. A working group is the logical venue to establish short- and long-range strategic goals for engaging in this process. The group will be charged with tasks such as exploring the research, defining a sentinel event, and making recommendations for a path forward.

Conclusion

We have a choice to work together on a shared goal to improve the U.S. probation and pretrial services system at all levels, capitalizing on less than optimal situations. By getting away from the "single-minded focus," we can draw out insights from all layers of the organization. Jeffrey Thomason, chief of the Idaho U.S. probation office, has experience with these types of review both in and outside of the federal probation arena and sums it up well.

> In the probation system, we tend to look at failure from the perspective of the failed. The high-risk individual who revokes with a new offense inside of a year on supervision is performing to type and may not raise an eyebrow. However, when that new offense causes significant damage and results in attention both from within and outside the organization, our tendency is to circle the wagons. Across our system, we have a large enough number of these cases in the aggregate that conducting a robust post-incident review has the potential to greatly improve our case management, and hopefully, prevent even one of these cases from occurring in the future.

The idea is to have a coordinated effort to learn as much as we can in the interest of improving the system, the experience for the person under supervision, and most of all, the community. With the chiefs at the helm, encouraging a synergistic, action-oriented process, the U.S. probation and pretrial services system can prepare for the future of corrections.

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