NIJ's Sentinel Events Initiative: Reducing Errors in the Criminal Justice System

By James M. Doyle

***Author's Note**: Findings and conclusions reported in this article are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

DNA exonerations of wrongfully convicted defendants have shone a new light on an error in American criminal justice and revealed a gap in our system's design. As discussed in the National Institute of Justice (NIJ) Special Report *Mending Justice: Sentinel Event Reviews*, published in September 2014, some believe the criminal justice system lacks a feature that medicine, aviation and other high-risk enterprises see as critical: a way to account for tragic outcomes and using those lessons to reduce risk of recurrence.[1] Can the criminal justice system develop this capacity for "forward-looking accountability"?[2] 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?

To explore these questions, NIJ launched a sentinel events initiative that corrections professionals might want to watch with interest. A sentinel event is a significant, unexpected negative outcome — for example, a wrongful conviction, the failed supervision of a dangerous parolee or the avoidable death of a vulnerable inmate — that signals a possible weakness in the system or process. It is likely the result of compound errors and may provide, if properly analyzed and addressed, important keys to strengthening the system and preventing future adverse outcomes.

Wrong Patient, Wrong Man, Wrong Date

One way to see the learning opportunities presented by criminal justice sentinel events, such as wrongful convictions, wrongful releases or custodial fatalities, is to examine contemporary medicine's encounter with its own version of the problem: "iatrogenic" injuries to patients — harm caused by medical treatment itself. The criminal justice system is haunted by the fact that it sometimes releases the wrong person, and the medical field is haunted by the fact that it sometimes operates on the wrong patient. When modern medical researchers began to look carefully at wrong-patient events, they uncovered surprising insights.

For example, one intensive examination of a wrong-patient surgery discovered at least 17 errors, including the patient's face being draped so the physicians could not see it. A resident left the lab assuming the attending physician had ordered the invasive surgery without telling him. Conflicting charts were overlooked, and contradictory patient stickers were ignored. But the crucial point for the researchers was that not a single one of the 17 errors they catalogued could have caused the wrong-patient surgery by itself.[3] Their analysis showed not only mistakes by individual doctors and nurses, but also latent systemic problems. Communication between staff was terrible, and computer systems did not share information. When teams failed to function, no one was alarmed because of a culture of low expectations that "led [staff] to conclude that these red flags signified not unusual, worrisome harbingers, but rather mundane repetitions of the poor communication to which they had become inured."[4] Deviations from good practice had become normal, and tragedy resulted.

The wrong-patient surgery was an "organizational accident." No single error can cause an organizational accident; the errors of many individuals ("active errors")

converge and interact with system weaknesses ("latent conditions"), increasing the likelihood these individual errors will do harm. These insights can apply to the "wrong man" or "wrong date" releases that worry all levels of corrections personnel. Many things have to go wrong before the wrong man is released and commits another crime. Yes, the parole board made a decision, but why did that decision look like a good idea? Was criminal or psychological history overlooked or, even if properly collected, ignored in designing community supervision? Were technological monitoring aids unavailable? If so, why? Was the original sentence inadequate? Did poorly funded or untrained prosecutors fail to investigate? Did caseload pressures overwhelm the sharp-end practitioners? Usually, these errors combined and cascaded — then, there was tragedy.

The right answer to the question, "Who is responsible for this mistaken release?" is almost invariably, "Everyone involved, to one degree or another," either by making a contributing mistake or failing to catch one. And "everyone" includes not only probation officers, parole boards and institutional administrators at the sharp end of the system, but also legislators, policymakers, funders and appellate judges far removed from the scene of the event, who helped design the system and who dictated the conditions under which the sharp-end operators worked. The range of criminal justice sentinel events encompasses "near miss" and "good catch" cases where a warrant or detainer was discovered by luck at the last minute. It even includes situations where catastrophic cost constitutes the harm, such as incarcerating a harmless geriatric inmate long past the point at which the term of imprisonment serves any purpose. In fact, anything stakeholders can agree should not happen again could be treated as a sentinel event.

From Blame to Comprehension

The criminal justice system traditionally takes a single-cause approach to error that assumes those responsible are "bad apples." The impulse is to find and discipline that person: charge him, sue him, fire him, etc. This is what people typically mean when they call for "accountability" in the aftermath of an inmate death or premature release. But by focusing exclusively on finding the culprit, we drive valuable reports of errors underground and leave latent system weaknesses unaddressed. This can affect agencies, as well as individuals. In a blame-oriented environment, when sentinel events cannot be buried, the pressure intensifies to keep them in house or to try to shift the blame to someone else's "house."

To attack the chronic risk of their organizational accidents, medicine and aviation bring all stakeholders together to examine, in a nonblaming manner, sentinel events; they then share the lessons uncovered. Can — and should — criminal justice develop a commitment to regular, routine, risk-oriented review of known errors and near misses, conducted by experienced practitioners and other stakeholders, such as victims? NIJ's sentinel event initiative is posing that question to the criminal justice field.

In May 2013, NIJ convened a roundtable of experts to discuss the applicability of such an approach to improving criminal justice outcomes The high-level round-table, which included nationally recognized experts from law enforcement, prosecution, defense, courts, crime labs, the victims' community, risk management and the research community, was the first step in assessing the concept of a sentinel-events review in criminal justice. The group foresaw many challenges to a sentinel-events approach, but most of the roundtable participants came away convinced there is room for taking a step forward and testing the prospects.[5] Exploratory "beta" versions of reviews testing this conclusion are now underway in three cities, and NIJ's sentinel events initiative is determined that any such effort be subjected to evaluation from the start. *Mending Justice: Sentinel Event Reviews* marshals the commentary of 17 diverse criminal justice stakeholders and presents a comprehensive survey from multiple perspectives of future prospects.

ENDNOTES

[1] Doyle, J.M. 2014. Learning from error in the criminal justice system. In *Mending justice: Sentinel event reviews.* Retrieved from www.nij.gov/topics/justice-system/pages/mending-justice.aspx.

[2] Sharpe, V.A. 2003. Promoting patient safety: An ethical basis for policy deliberation. *Hastings Center Report Special Supplement*, 33(5):S1-S20.

[3] Chassin, M.R. and E.C. Becher. 2002. The wrong patient. *Annals of Internal Medicine*, 36(1):826-833.

[4] Ibid, pp. 829-830.

[5] National Institute of Justice. 2014. The sentinel event initiative: Proceedings from an expert roundtable. Retrieved from an expert roundtable. Retrieved from www.nij.gov/topics/justice-system/Pages/sentinel-event-roundtable.aspx.

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