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## **Sentinel Events: A Sustainable Model for System Change –**

### **Draft Final Summary Report Overview**

**2015-R2-CX-K041**

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#### **Purpose of Project**

This research project involves implementation of sentinel event review processes in three jurisdictions to study the feasibility and utility of employing sentinel reviews in criminal justice settings. The goals of the study include:

- 1) advancing knowledge about sentinel events and the sentinel review process
- 2) assessing the utility of the review process for identifying, analyzing, and addressing system failure
- 3) identifying obstacles in implementing sentinel reviews

#### **Project Design, Methods and Analysis**

The sentinel event review occurred in distinct but related processes in three Midwestern cities. Specifically, the project built upon review processes that were developed in Detroit, Indianapolis, and Milwaukee as part of violence reduction initiatives. In Detroit, weekly incident reviews of firearm crime incidents to inform a focused deterrence violence prevention effort formed the basis of the sentinel event (SE) reviews. Similarly, in Indianapolis SE reviews built upon a nonfatal shooting incident review process. In Milwaukee, SE reviews built upon the foundation provided by the Milwaukee Homicide Review Commission, including incident reviews of homicides and nonfatal shootings as well as domestic violence incidents. The overall project also built upon Milwaukee’s participation as a demonstration site in the National Institute

of Justice's (NIJ) piloting of SE reviews. As will be described, in all three cities the SE reviews built upon the existing review processes but then extended the reviews into more in-depth reviews customized to each local context. Additionally, the Principal Investigator and Co-Principal Investigators were involved in the incident review process and used this trusted researcher-practitioner relationship to develop SE reviews.

The study design followed a participant observer protocol whereby members of the research team facilitated the SE reviews through planning and consultation, problem solving, analytical support, and observation of the reviews. Toward the end of the study period, the research team conducted key informant interviews to understand practitioner perceptions of the SE reviews. The interviews focused on the understanding of SE reviews, the challenges and obstacles to implementing SE reviews, the benefits of the reviews, and the customization of the reviews to meet local needs. The participant observation and interviews resulted in qualitative data. An additional supplemental data analysis was conducted in Detroit based on issues that arose in incident review meetings and related to the development of Detroit's GUNSTAT review process (see subsequent discussion). The nature of the review meetings across the three study sites and the corresponding research methods are displayed in Figure One.

**Figure One – Data Collection Summary**

Sequencing of Various Reviews in Study Sites				Data Collection		
Detroit				Participant Observation	Key Participant Interviews	Supplemental Data Analyses
Ceasefire Incident Reviews				X	X	
	Shooting Reviews			X	X	
	Strategy & Accountability Reviews (gangs, places, individuals; after action reviews)			X	X	
		GUNSTAT Reviews		X	X	X
		CGIC Reviews		X	X	
			Public Health SE Reviews	X – planning only		
<b>Indianapolis</b>						
NFS Reviews				X	X	
	Multi-partner SE Reviews			X – planning only	X	
		Police Dept. SE Reviews (violations policy; negative consequences; near misses)		X	X	
<b>Milwaukee</b>						
MHRC Incident Reviews				X	X	
	Multi-partner SE Reviews (places, individuals, policies, overdose fatalities)			X	X	

## **Project Findings**

In this section, we begin with a descriptive overview of the findings from each of the three sites. This overview is followed by addressing each of the research questions studied in this project.

### ***Detroit***

As noted above, SE reviews built upon weekly incident reviews that were occurring as part of Detroit Ceasefire, a focused deterrence initiative intended to reduce gang- and group-related violence. At the outset of the Sentinel Event Review project, the weekly incident reviews focused on firearm crime incidents occurring in two eastside precincts. Over the course of the project, the focus expanded to first include two additional westside precincts and eventually ten precincts. The nature of the meetings also shifted from one weekly meeting to two. The first is an incident review examining every gun crime incident occurring in the prior week in the target precincts. The second meeting is a strategy and accountability meeting based on the incident review. This second meeting became the forum for a modified approach to SE reviews that sought to fill gaps that existed in the incident reviews. Examples of these gaps include:

- Potential system failures and the inability to prioritize high-risk defendants
- Gaps in knowledge about gangs and violent street groups as well as chronic shooting locations
- Lost opportunities for training and cross-team sharing about successful and less successful responses to violent crime incidents
- Use of ballistics evidence for evidentiary purposes but missing opportunities for strategic and tactical intelligence

Several different types of modified SE reviews were developed to address each of these gaps.

- Bi-weekly GUNSTAT meetings were used to assess risk and prioritize booking and prosecution
- Detailed reviews of gangs and violent street groups led by the Gang Intelligence Unit. Additionally, geographic reviews, based on the Milwaukee experience, were also conducted.

- After action reviews were conducted to examine successes, failures, and challenges related to Ceasefire responses to violent crime.
- Development of a Crime Gun Intelligence Center and enhanced NIBIN capability with bi-weekly reviews to examine connections with firearms used in multiple incidents

Additionally, the research team worked with the Detroit Health Department and Detroit Public Schools to develop an additional sentinel event review process based on shooting victims presenting at a Level One Trauma Center. This review process proved to be the most challenging of the different review meetings due to concerns about privacy and both “The Standards for Privacy of Individually Identifiable Health Information,” commonly known as the HIPAA Privacy Rule as well as “The Family Educational Rights and Privacy Act,” known as FERPA. As these hurdles were overcome, the reviews were put on delay due to the COVID-19 impact, particularly on the health department. The reviews are planned to continue during 2021 following the completion of this grant award.

### *Indianapolis*

Indianapolis launched its SE review process with the formation of an interdisciplinary sentinel event review advisory group. This advisory group was beneficial as it included a mental health professional as well as a registered nurse who had experience with SE reviews (i.e., root cause analyses) in health settings. This experience complemented the experience of law enforcement and prosecutors in the Indianapolis nonfatal shooting review process. Initially, the Indianapolis team planned a series of multi-partner sentinel event incident reviews. One example included an allegation of police misconduct related to a witness lineup. Another involved a homicide where the suspect was under correctional supervision at the time of the incident. The Indianapolis team prepared extensively to review the homicide event, but the review meeting was cancelled one week before it was supposed to happen due to a key partner’s concerns of pending litigation.

Because of the failed large-scale review and the inability to mitigate similar circumstances in the future, the SE reviews were modified to address issues internal to the police department. Police officers from any rank or position could nominate an incident for review through his or her supervisory chain of command. The reviews were coordinated through the Deputy Chief of Operations' office. Three types of reviews emerged. There were reviews focusing on:

- incidents that involved violations of policy
- incidents that did not involve a violation of policy but where negative consequences occurred
- incidents that turned out well but that involved near misses

The Indianapolis team also developed a standard incident review nomination form, a review coordinator guide, and a communication system to ensure review results are disseminated up and down the chain of command. Towards the end of the project, the agency added a fourth category of reviews: incidents that went well. These reviews were done to reinforce current policies and practices that worked as intended.

### ***Milwaukee***

As noted above, the Milwaukee team appeared to benefit through its prior participation as a demonstration site in NIJ's sentinel event review initiative and from the experience of the Milwaukee Homicide Review Commission in conducting incident reviews. As such, the first sentinel event review conducted under this research award occurred in Milwaukee. This review focused on critical incidents occurring in a specific geographic area. The review enjoyed broad and rich participation and revealed new insights into the dynamics associated with these geographic-based gun violence incidents. The initial review served as a model for the implementation of additional reviews in all three sites.

Several different types of SE reviews were conducted in Milwaukee. As noted, one type involved geographic reviews focused on specific areas or locations that generated critical incidents. Multiple sources of data and intelligence about crime and health issues in specific, small geographic areas were shared and the discussion focused on the nature of the problem as well as potential action steps to address changes to the location that could have the potential of reducing future violence.

A second type of sentinel event review focused on conducting a deeper analysis of individuals involved in specific violent crime incidents. These reviews typically looked at the life course of an individual involved in one or more cases, focusing on an extended period, such as from birth to the time of the focus incident to identify potential opportunities for change, intervention, or prevention that may have impacted later outcomes.

A third type of SE review focused on specific policies and the potential implications for health and safety. The initial focus of the policy review was on reckless driving. The SE team identified a variety of data sources (e.g., traffic accidents, stolen vehicles) and expanded partnerships to better understand issues and prepare for SE reviews involving reckless driving incidents. The principles behind the SE reviews were also applied to other areas such as the development of overdose fatality reviews.

### ***Findings Related to Research Questions***

#### ***RQ1: Can sentinel events be identified through ongoing systematic reviews of gun crime incidents?***

In all three cities, the systematic review of gun crime incidents resulted in the identification of issues for which a deeper analysis through SE reviews proved valuable. Examples include geographic reviews; reviews of gangs and groups; in-depth reviews of individuals; system gaps; and policy issues.

***RQ2: Do systematic SE reviews yield information about system or process failures?***

In all three cities, the reviews provided information and facilitated shared understanding of system and process failures. For example, in Detroit the reviews indicated that chronic violent offenders had prior weapons and violent crime arrests but often did not have prior convictions relevant to future prosecutorial decision-making. For example, one identified system failure included individuals participating in a diversion program known as the Holmes Youth Training Act (HYTA) multiple times even though police and prosecution understanding was that participation was limited to one diversionary placement. This realization resulted in follow-up policy analysis of criminal history patterns of gun-crime arrestees. In Indianapolis, reviews indicated weaknesses in information dissemination among the working rank and file during large events in the downtown district as well as the way private businesses interact with the police. They also revealed needed changes to several internal police policies, for example, allowing any officer of any rank to stop a pursuit rather than just a supervisor. In Milwaukee the reviews identified a variety of system or process challenges. For example, the need to hold exploitative or absent landlords accountable, as part of reducing neighborhood turnover, was identified as a potential system gap in part through the reviews.

***RQ3: Does the identification of system or process failures result in identifiable corrective action?***

Similarly, in all three cities examples emerged of corrective action. In Milwaukee for example, several gaps were identified related to women in the street-based sex trade and the inconsistency in enforcement efforts related to prostitution. The identification of this gap led to recommendations surrounding this particular population, including an emphasis on social services and coordination with law enforcement on prostitution sweeps, which provided additional background for a collaborative grant-funded project to implement a diversion program

focusing on the needs of this target population related to housing, substance misuse and related services. In Indianapolis, as mentioned, several internal police policies were updated. Similarly, the group worked to determine how to best disseminate large event information to street-level officers who are inundated with information all the time.

In Detroit, the identification of chronic violent offenders not being prioritized in joint federal-state prosecution reviews, resulted in a new Gunstat process. The Ceasefire and SE team reviewed similar programs in Atlanta, Baltimore, and Tampa, and decided on a process where gun crime arrestees are reviewed, and a risk assessment conducted. The risk assessment guides prosecutorial decisions and a bi-weekly review process was implemented for system accountability and sharing of information. The research team also analyzed the extent to which the risk assessment related to re-offending as well as the potential impact on prosecutorial and judicial decision-making.

In addition to identification of system gaps or failures, the reviews also provided an opportunity to share positive lessons. This sharing was evident in Detroit's modified SE reviews known as After-Action Reviews (AAR). The AAR's reviewed enforcement, outreach, and prevention actions that followed a violent crime incident. Although this did include identification of system gaps, it also identified positive action steps that could be shared with other criminal justice actors to foster sharing of best practices. The reviews also provided a unique opportunity for participants to learn more about standard practices and to challenge assumptions about how other agencies operate. These discussions can lead to a better and more nuanced understanding of why certain operational practices are in place, as well as provide the opportunity to ask questions or make suggestions that may lead to process improvement.

***RQ4: Are there characteristics of the sentinel review process that enhance or impede the sharing of information and ultimately the value of the review process?***

Although this research found many benefits associated with SE reviews, and the related reviews described above, it also demonstrated that there are a variety of barriers and challenges to effectively implementing SE reviews in a criminal justice context. Among the issues identified in this study:

- *System failure, culpability, liability in an inherently adversarial system.* Despite a repeated emphasis that sentinel events reviews were not intended to assign blame, these issues are difficult to ignore in the criminal justice context. The same prosecutor's office asked to participate in a sentinel event review may have to prosecute a police officer accused of excessive use of force. A parole agency may find itself potentially liable for releasing a parolee who commits a subsequent violent act. With potential liability issues inherent, it can be difficult to create a forum for openly sharing information among these agencies especially given the roles the sentinel event review participants may play in the adversarial process. This highlights the need to build trust and a forum for open dialogue and shared accountability about how changes can collectively lead to system and outcome improvements, so there is less concern about blame being focused on a particular agency.
- *Blame.* Related to the above issues around "blame," many criminal justice agencies and actors find themselves under scrutiny based on broad cultural trends (e.g., criticism of police use of force, mass incarceration). The sentinel event review may appear to be one more occasion for criticism of police, prosecutors, and corrections officials, which may limit the willingness of agencies to actively participate in the process and to be publicly self-critical.

- *Hierarchical Organizations.* Interviews with participants revealed that the hierarchical nature of criminal justice organizations can create obstacles to active participation in the SE review. A subordinate employee may be reluctant to identify a “mistake” or “issue” in the public SE review meeting for fear of undermining or embarrassing their superior. They may also be reluctant to speak up if they think that it is their superior’s position to share, or not share, information.
- *Privacy.* Privacy issues were a particular concern for other partnering agencies. All three cities experienced continual issues related to what criminal justice and non-criminal justice information could be shared outside of authorized actors. Specific questions included, for example, how do HIPAA regulations affect health care professional’s ability to share information?; what limits need to be placed on sharing information on an open case/investigation?; and how do FERPA regulations affect school official’s ability to share information? Similarly, non-criminal justice agencies (e.g., health, schools, treatment providers, community service agencies) may have concerns about sharing information with law enforcement and criminal justice agencies may have concerns about sharing with non-criminal justice entities, depending on who is in the room.
- *Relevancy.* Some criminal justice actors found the long-term prevention focus of SE reviews to be less relevant to the day-to-day demands for strategic and tactical intelligence, enforcement, and investigative activities. This disparity was highlighted when a police official responded to the proposed sentinel event review with the comment: “this sounds like some type of sociological analysis.”
- *Time.* To be done properly, most SE reviews cannot be set to a specific time window (e.g., one hour). The request to conduct SE reviews occurred in three cities that were already

devoting considerable time to systematic incident reviews so the additional time commitment can be challenging. “We don’t have time for one additional set of meetings” was a common refrain.

- *The right people.* The right agencies and individuals also need to be at the table for the reviews to be effective. Having the commitment from the agencies, regular attendance at and preparation for the meetings, and engaged participation across sectors can be challenging, but is critical for being able to gather detailed information, identify gaps, and develop and implement recommendations. The coordinator/facilitator role is particularly important. The tone of the review can instantly change if the facilitator is not the right person. For example, in Indianapolis, the facilitator changed depending on the incident. In some cases, the facilitator was someone who was not familiar with the SE process or perhaps did not buy-into it potentially resulting in more harm than good.

***RQ5: How do criminal justice professionals perceive the value of the sentinel review process?***

One common theme in discussions with practitioners is that the reviews are of benefit in identifying challenges and issues, developing strategies, enhancing collaboration, and sharing information. These themes were reiterated during stakeholder interviews conducted in each site. In Milwaukee, those interviewed reinforced the value of taking a “deeper dive” into a specific event, policy, or geographic area and evaluating it from a variety of perspectives through the SE reviews. They seemed to distinguish it from other types of reviews by both the content and the depth of the reviews and that it could lead to specific ideas and recommendations through discussion and collaboration, particularly if the right cases or topics are selected that have cross-agency or system implications.

At the same time, criminal justice professionals noted the challenges of time demands. In all three cities, the success of initial incident review meetings resulted in additional types of review meetings. These additional meetings created challenges in terms of time management and a sense of “meeting fatigue.” In Milwaukee and Detroit, this tied into the concept that the value of the meetings was impacted by who was in attendance and how well-prepared participants were for the discussion. In addition, there was a desire for additional action between meetings and clear communication on recommendations and implementation to keep the process moving forward. In Indianapolis, leaders felt it was important to schedule the SE review as soon as possible after the event however it proved challenging due to schedules as well as other internal review processes and external pressures from the police union.

***RQ6: Can schematic models be developed for the implementation and assessment of sentinel reviews to assist sustainability and transferability to other jurisdictions and types of criminal justice issues (e.g., wrongful conviction)?***

The research team is working with a group of researchers and practitioners convened by NIJ and BJA to develop a sentinel event review implementation guide. This guide will support the transferability goal.

***RQ7: How do reporting formats influence the perceived value of sentinel review reports?***

The key lesson learned across all three study sites is that criminal justice professionals need short and concise reports that highlight findings and actionable implications. Additional information and documentation should be included as attachments or appendices. Follow-up reporting and communication, particularly on the development and implementation of recommendations coming out of the reviews, are important to developing buy-in for the process and the potential impact.

### *Implications for Criminal Justice Practitioners*

The experience in these three study sites suggests that SE reviews hold promise for addressing complex issues that confront criminal justice professionals. The ability to address in depth issues such as policy changes, chronic micro-place hotspots, or near misses that could have had tragic consequences was evident in all three sites. There was, also, a degree of receptivity among criminal justice professionals who were familiar with similar review processes through systematic incident and after-action reviews.

Having said this, challenges did emerge in all three sites. These ranged from time pressures, to concerns about liability, to privacy issues arising particularly when non-criminal justice partner agencies become involved. Further, although the familiarity with incident reviews seemed to create an openness to considering SE reviews, it also created challenges in terms of differentiating SE reviews from existing review processes that either did not include external partners (e.g., Indianapolis) or that did not involve the breadth and depth of analysis intended for a sentinel event review (e.g., Detroit, Milwaukee). Providing further guidance on the nature of SE reviews and how they differ from other types of incident reviews, developing processes for routinely reporting back on recommendations and their implementation, and for addressing the challenges that will inevitably arise, will be important for gaining support among criminal justice professionals.

## **Scholarly Products Produced or in Process**

McGarrell, E., Hipple, N.K., & Kostelac, C. In process. The Utility of Sentinel Event and Systematic Incident Reviews: Lessons from the Field (article under development for submission to peer reviewed journal)

Oliphant, S.N, G. Circo, E.F. McGarrell, J.M. Krupa, & J. Liebler. 2020. Detroit GUNSTAT: Criminal History Analysis. East Lansing, MI: Michigan Justice Statistics Center, School of Criminal Justice, Michigan State University.

O'Brien, M., Hipple, N.K., & McGarrell, E. Shooting Incident Reviews and Sentinel Event Reviews. Symposium hosted by Milwaukee Homicide Review Commission and COPS Office. Washington, DC (presentations, September 2017).

O'Brien, M. Paving the Way: Lessons Learned from Early Explorations into Sentinel Event Reviews in Criminal Justice. NIJ Sentinel Events Initiative All-Stakeholder Symposium. Washington, DC (panelist, June 2017).

Hipple, N.K. & O'Brien, M. Mock Sentinel Event Reviews. NIJ Sentinel Events Initiative All-Stakeholder Symposium. Washington, DC (facilitators, June 2017).

Background on the Three-City Sentinel Event Review Project. Sentinel Event Initiative Meeting, National Institute of Justice. Washington, DC (presentation, March 2016).

### **Two technical reports are in development in cooperation with NIJ and BJA:**

Historical Development of Sentinel Event Research Projects & Lessons Learned (in process).

How to Make Sentinel Event Review Processes Work (in process)