

# Creating a Culture of Safety

Sentinel Event Reviews for Suicide and Self-Harm in  
Correctional Facilities

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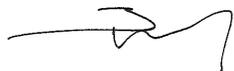
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# From the Director

People enter prison and jail at a low point in their lives and are particularly vulnerable to violence of all kinds—including self-harm and suicide. Although the rate of suicide in jails has decreased by 50 percent since the 1980s, it continues to be the leading cause of death, far outpacing rates seen in the community. While it is important to acknowledge the progress that has been made in addressing suicides in custody, there is still much room for improvement. With recent years having seen increases in the rate of suicides (since the lowest point in 2008), there is an urgent need for action.

The corrections community has much to learn from medicine. When a death or other serious negative outcome occurs in a hospital or other community health setting, it is seen as a “sentinel event,” signaling a breakdown in systems of care. The sentinel event framework acknowledges that, to prevent similar incidents in the future, it is insufficient to assign blame to a person or people. Rather, it is necessary to collaboratively develop and implement systems-level solutions to prevent similar tragedies from happening in the future.

Framing suicide and self-harm in correctional facilities as sentinel events and targeting them for collaborative, forward-thinking reviews is an important step towards ensuring the safety of people held in corrections. This report is designed to provide practical guidance on how correctional agencies can learn from other fields to better protect the people entrusted to their care.



**Jim Parsons**

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# Introduction

Since 2011, the National Institute of Justice (NIJ), through its Sentinel Events Initiative, has been investigating the feasibility of using a sentinel events approach to review and learn from errors in the criminal justice system such as wrongful convictions, eyewitness misidentifications, or incidents of suicide and self-harm in custody.<sup>1</sup> Recognizing that adverse situations are rarely caused by a single event or the actions of an individual person, NIJ defines a sentinel event as a significant negative outcome that: 1) signals underlying weaknesses in a system or process; 2) is likely the result of compound errors; and 3) may provide, if properly analyzed and addressed, important keys to strengthening the system and preventing future adverse events or outcomes.<sup>2</sup>

The fields of aviation and medicine have long used sentinel event reviews as a way to account for significant, unexpected negative outcomes, and to leverage the knowledge gleaned from the review process to reduce future errors (see section on “Sentinel event reviews in aviation and medicine.”)<sup>3</sup> These reviews are intended to be non-blaming, systemwide, and forward-looking—to prevent future errors by creating an ethic of shared responsibility and a culture of safety.<sup>4</sup> Taking the examples set in these fields, leaders in criminal justice also have come to recognize that system errors might be better conceived as sentinel events that speak to larger systemic problems.

Indeed, there is a growing body of literature and there are increasing examples from the field to suggest the utility of a systems approach in reducing errors in the criminal justice system. Several jurisdictions have recently used the process of root cause analysis (RCA)—a methodology that can be used to carry out sentinel event reviews—to examine why an adverse event occurred. For example, the New York State Justice Task Force formed a root cause analysis subcommittee in December 2014, which led to the recommendation that RCAs be used to respond to adverse events across the state’s criminal justice system. And in Montgomery County, Pennsylvania, the office of the district attorney’s use of RCA revealed that a lab report had been misread, which led to the dismissal of an indictment.<sup>5</sup>

NIJ’s Sentinel Events Initiative has undertaken a broader and more robust effort to understand whether actors across various parts of the criminal justice system can adopt sentinel event reviews as a means for creating a “culture of safety” that leads to greater system reliability and enhanced public confidence in the system’s integrity.<sup>6</sup> The initiative has included a research fellowship to gather feedback from criminal justice practitioners and researchers in the field; beta projects in Baltimore, Milwaukee, and Philadelphia that provided empirical evidence for the feasibility of such reviews in the justice system (sites designed and conducted their own review of a justice error that had occurred in their jurisdiction); and ongoing research projects on topics ranging from wrongful convictions to gun homicide and non-fatal shootings.

With funding from NIJ, the Vera Institute of Justice (Vera) has been examining the applicability and appropriateness of using sentinel event reviews for incidents of suicide and serious self-harm in detention.<sup>7</sup> Suicide is the leading cause of death in jails and 85 percent of U.S. prison systems report that self-injurious behavior occurs at least once a week.<sup>8</sup> This report focuses on these incidents as prime opportunities to implement sentinel event reviews in the criminal justice context. It takes significant direction from the health care field since suicide and self-harm are health-related issues and health care facilities must frequently face and respond to such incidents (see section on “Sentinel event reviews in aviation and medicine”). The aim of this report is threefold: to provide an overview of the problem of suicide and self-harm in correctional facilities and describe the insufficiency of current responses; to outline the current evidence for the feasibility of sentinel event reviews in the criminal justice system and highlight potential implementation challenges; and to offer guidelines for conducting a sentinel event review in response to an incident of suicide or serious self-harm in a correctional facility. In so doing, this report contributes to the momentum for adopting a more institutionalized process of diagnosing and addressing errors in the criminal justice system.

## Sentinel event reviews in aviation and medicine

In the mid-1970s, the Federal Aviation Administration created the Aviation Safety Reporting System for mandatory and confidential reporting of errors and “near-misses.” The National Transportation Safety Board compiles and publishes reports on all significant events.<sup>a</sup>

The medical field also has a long tradition of conducting multidisciplinary reviews of medical errors and adverse outcomes. The Morbidity and Mortality Conference—a regularly occurring meeting that provides clinicians with the opportunity to review adverse events—has been a standard forum for medical resident and continuing education since the early 20th century.<sup>b</sup> Beginning in the 1990s, however, academics and practitioners increased their attention to the problem of medical error and to making good on the system’s promise to “first, do no harm.” Reports by both the Institute of Medicine and Lucian Leape, a leader in the field of medical error, encouraged the field to move away from a view of error as solely the product of individual negligence and to adopt instead an institutionalized approach that identifies root causes and underlying system failures.<sup>c</sup>

The Joint Commission—a major independent accreditation body for U.S. health care organizations and programs—has had a Sentinel Event Policy in place since 1996 to review patient safety events that are not primarily related to the natural progression of the patient’s illness or underlying condition, and that result in death, permanent harm, or severe temporary harm.<sup>d</sup> The Joint Commission’s policy requires a “comprehensive systematic analysis for identifying the causal and contributory factors” as well as “strong

corrective actions that provide effective and sustained system improvement.”<sup>e</sup> All sentinel events that occur in accredited health care facilities, which include some correctional facilities, must be reviewed by the organization and are subject to review by The Joint Commission.<sup>f</sup> Because health care facilities such as psychiatric units also face the issue of suicide and self-harm among their patient populations, applying sentinel events reviews from the medical field to a correctional setting is particularly promising.

## Overview of the problem: Suicide and self-harm in correctional facilities

Suicide is the leading cause of death in local jails, accounting for over one-third of jail deaths in 2013; it is less frequent in prison settings but still accounted for nearly 6 percent of the deaths of people in state custody in 2013.<sup>9</sup> Although suicide rates in jail declined steadily from 129 deaths per 100,000 people in 1983 to 47 deaths per 100,000 in 2002, the rate of suicide increased by 12 percent between 2008 and 2013 and the suicide mortality rate is three times higher in jail populations than in either prison populations or in the community.<sup>10</sup> There are also clear demographic trends in jail suicides: men incarcerated in jail are 50 percent more likely to commit suicide than women and incarcerated people who are white are far more likely to commit suicide than those who are black or Latino (six and three times more likely, respectively).<sup>11</sup>

Self-harm in correctional settings is a less well-understood phenomenon but nonetheless a serious health concern. Historically, research on its occurrence has been hindered by a lack of consistent terminology as well as ambiguity in defining what constitutes self-harm or self-injury. (See “Defining suicide and self-harm.”) No comprehensive national data exist on self-harm in correctional facilities, but recent research indicates that up to 15 percent of adults and up to 24 percent of young people engage in non-suicidal self-injury while in custody (defined as “deliberate, self-inflicted tissue damage without intent to die”); rates are even higher when the person has a mental health disorder (up to 61 percent).<sup>12</sup> Surveillance data from the New York City jail system are also revealing; there were 2,514 acts of self-injury from 2007 to 2011, with the annual rate of self-injury increasing significantly during this time period.<sup>13</sup>

## Defining suicide and self-harm

Although the definition of suicide is generally considered straightforward (defined by the Centers for Disease Control and Prevention as “death caused by self-directed injurious behavior with an intent to die as a result of the behavior”), appropriate definitions for various acts of self-harm are debated.<sup>a</sup> The term “self-harm” is commonly used to define a wide range of behaviors in which people deliberately inflict physical harm on themselves. Terminology for this behavior varies and may include terms such as “attempted suicide,” “deliberate self-harm,” “parasuicide,” “self-injury,” and “self-mutilation.”<sup>b</sup>

One particularly difficult question to resolve is whether and how to include a person’s motivation or “intent” in definitions of self-harm. While some believe that definitions of self-harm should include those acts where someone has intent to kill oneself, others argue that the definition should only include acts undertaken without the intent to die.<sup>c</sup> Still others argue that self-harm can be defined without reference to the presence or absence of intent since intent itself is so difficult to assess and since intention may not be relevant to the physical damage that occurs.<sup>d</sup> For this report, Vera employs a broad definition of self-harm that includes all acts leading to direct and deliberate harm to oneself with or without intent to die. The terms self-harm and self-injury are used interchangeably and the inclusion or exclusion of intent is noted where appropriate.

A full review of how suicide and self-harm may differ in terms of intent, function, and prevalence is beyond the scope of this report; however, recent literature suggests there are important differences in the people who engage in self-harm versus those who attempt or complete suicide while in custody. For example, rates of suicide and self-harm vary by gender, with men more likely to commit suicide in jail but with documented rates of self-harm significantly higher among women.<sup>e</sup> Other research suggests that whereas most people who engage in suicide are engaging in an act that is intended to be life-ending, some people who engage in self-harm are employing the behavior as a coping mechanism to relieve psychological distress and are not intending to end their lives.<sup>f</sup> A better understanding of the differences between suicide and self-harm is thus important for practitioners, both because self-harm can be a risk factor for suicide and because these distinctions affect how a person should be assessed and treated.

The reasons for elevated rates of suicide and self-harm in correctional facilities are myriad, ranging from the characteristics of the population, to the experience of incarceration, to the common features of the environment. Many people enter the correctional system with multiple risk factors for engaging in suicide or self-harming behavior, including having a

serious mental illness and/or substance use problems, a history of trauma, and a history of self-harm, suicide attempts, and recent suicidal ideation.<sup>14</sup> These individual risk factors, combined with environmental risk factors, such as the stress of the correctional environment and the trauma of arrest, place detained people at a particularly high risk for suicide and self-harm.

In addition to the direct harm caused by these behaviors, staff, or other people who witness suicidal or self-harming acts, are at serious risk for experiencing psychological repercussions, such as post-traumatic stress disorder.<sup>15</sup> They are also likely to experience burnout and apathy over time.<sup>16</sup> Even having relatively small numbers of people who self-harm can present substantial challenges to institutions and the people who both work and are detained there, since self-injurious behaviors consume significant institutional resources through disrupted routines, higher staffing levels, and security risks.<sup>17</sup>

## Traditional responses to suicide and self-harm in correctional facilities

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Best practices for suicide prevention and response for correctional systems do exist and a growing body of research establishes the essential components of a reasonable suicide prevention program in jails and prisons.<sup>18</sup> These include initial and annual staff trainings, intake and on-going assessment, communication procedures, and housing that includes architectural and environmental safeguards—for example, buildings free of protrusions and designed to ensure the incarcerated person is maximally visible in any location, procedures for emergency response, appropriate mental health care, and multidisciplinary mortality reviews.<sup>19</sup> Even so, prevention and review processes for incidents of suicide and self-harm in many correctional facilities lag in three specific ways, detailed below.

### Lack of review processes

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When a death in custody occurs, the National Commission on Correctional Health Care (NCCHC) has standards that stipulate a three-pronged review:

- an administrative review (an assessment of the correctional and emergency response actions);
- a clinical mortality review (an assessment of the clinical care provided and the circumstances leading up to a death); and
- a psychological autopsy if the death is by suicide (a written reconstruction of the person's life emphasizing factors that may have contributed to his or her death).

The goal of such a review is “to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.”<sup>20</sup> These mortality reviews share many features of sentinel event reviews but are limited in scope to incidents of death; a sentinel events framework calls for a broader scope of review for negative outcomes and could include serious, non-fatal incidents.

However, even with standards for review in place, it is clear that many correctional facilities do not follow them. A national survey of jail suicide, conducted in 2005 and 2006 by the National Institute of Correction (NIC), found that the majority (63 percent) of jails did not conduct a mortality review following a jail suicide.<sup>21</sup> Although no comparable research exists on the prevalence of reviews for incidents of self-harm, it is reasonable to assume that the majority of correctional facilities also do not regularly conduct formal reviews when such incidents occur. The lack of a system-wide, institutionalized response to these events inhibits an honest assessment of the “error” that, in turn, forecloses opportunities for staff and correctional leaders to learn from mistakes and prevent future incidents of suicide and self-harm.

## Emphasis on individual versus system responsibility

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The criminal justice system has traditionally employed a “retrospective, adversarial inspection model of quality control” characterized by assigning individual responsibility for errors.<sup>22</sup> Such an approach may prove effective at providing isolated fixes to specific problems (i.e., eliminating “bad apples”), but it fails to account for the sometimes multiple and complex root causes of error that are related to underlying system problems and it is divorced from an ideal of continuous quality improvement—the idea that process-based and data-driven approaches can improve the quality of a process or service. A robust response to reducing the problem of suicide and self-harm in correctional facilities thus requires a bolder approach—one that encourages the reporting of incidents, prioritizes the identification of systemic causal factors, and looks to develop the capacity for forward-looking and shared accountability.

## Inadequate staff training

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Most correctional facilities have fairly minimal staff training on suicide and self-harm prevention. The NIC survey found that 62 percent of jails provide suicide prevention training to at least 90 percent of their correctional staff. However, the majority of these trainings were two hours or less and only 75 percent of those who held trainings did so annually.<sup>23</sup> Furthermore, it is not clear whether correctional facilities have training on non-lethal self-harm, which is essential if correctional administrators are to address the important differences in the underlying mechanisms and motivations for suicide and self-harm (for example, the differences in the issue of “intent” described in “Defining suicide and self-harm” above).<sup>24</sup> One study found that many prisons use suicide protocols to respond to acts of self-injury, a response that may be inappropriate if the differences in the motivations and risk factors for suicide and self-harm are not addressed in these protocols.<sup>25</sup>

## Using sentinel event reviews to address suicide and self-harm

The prevalence of incidents of suicide and self-harm in correctional facilities—and the fact that current responses are often fragmented and fail to account for the multiple systems and actors (such as health providers and correctional officers) involved in the operations of a correctional facility—suggest that these events are particularly ripe for a sentinel event review process.

Although there are various methods for carrying out sentinel event reviews, the RCA methodology is used most commonly and has the most available evidence for its effectiveness.<sup>26</sup> For example, individual criminal justice systems—such as New York City and State and Montgomery County, Pennsylvania, which were mentioned in previous examples—have successfully incorporated the use of RCA methodology into their practices.<sup>27</sup> In addition, The Joint Commission encourages the use of RCAs and the Veterans Health Administration requires that an RCA is conducted for certain adverse events.

In health care settings, a small but growing body of work has shown that the use of RCA can improve safety and is associated with decreased mortality during hip surgery, increased survival rates for liver transplants, and fewer adverse drug events.<sup>28</sup> There is also

research demonstrating that RCAs can improve collaboration and enhance shared decision-making in response to errors. For instance, one survey of health professionals who conducted RCAs found that more than 80 percent of respondents believed RCAs improved work practices, facilitated teamwork, and improved communication about patients. Another study found that over 75 percent of respondents who had attended RCA training felt that it enabled them to improve work processes for the provision of a safer clinical culture.<sup>29</sup> Indeed, when an event occurs that results in an undesirable outcome, RCA has been widely adopted as a powerful method to examine an organization's processes and systems and determine what happened, why it happened, and what can be done to prevent it from happening again.<sup>30</sup>

Certainly, more evaluative work of RCAs—and of sentinel event reviews more broadly—is warranted. This is particularly true in the criminal justice system, where the feasibility of conducting sentinel event reviews is just beginning to be established and where research is needed that examines how sentinel event reviews can improve system functioning and avoid future errors.<sup>31</sup> Even so, the fact that RCAs have been used successfully in a growing number of criminal justice systems and has long been recommended as standard practice in health care and other fields suggests the criminal justice field may find great utility in this methodology.

## **Steps for conducting a root cause analysis (RCA)**

Outlined below is a sequence of steps for conducting an RCA in response to an incident of suicide or serious self-harm in correctional facilities. These steps draw on examples from criminal justice systems that have used RCAs to respond to adverse events, as well as on guidance documents produced by the Center for Medicare & Medicaid Services (CMS), the Joint Commission, and the Veterans Health Administration (VHA) National Patient Safety Improvement Handbook.<sup>32</sup> However, the suggested steps are meant to be illustrative rather than prescriptive. The goal is to demonstrate how conducting an RCA in a correctional setting could result in a set of recommendations and reforms aimed at reducing the frequency of suicide and self-harm. The procedure outlined below can be modified to fit the needs of individual correctional facilities.

## 1. Identify the sentinel event

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The first step in any sentinel event review, including ones that use RCA, is defining what constitutes a sentinel event for the particular organization. In its policy, the Joint Commission requires that accredited organizations review patient safety events that fall under their basic definition of a sentinel event (resulting in death, permanent harm, or serious temporary harm) or that fall within a list of additional events (such as suicide, unanticipated death of a full-term infant, and discharge of an infant to the wrong family). However, it also specifies that organizations are expected to decide how to respond to patient safety events that do not meet the definition of a sentinel event but may nonetheless be worthy of review—for example a “near-miss” case.<sup>33</sup> Applied to correctional settings, agencies thus have the responsibility for deciding what constitutes a sentinel event within a facility and what criteria they will use to identify reviewable events.

While identifying a suicide within a correctional facility as a reviewable sentinel event may be relatively straightforward since the seriousness of death is so obvious, an important step for leadership in correctional settings will be to evaluate what incidents of self-harm should trigger an interdisciplinary review. Correctional settings might focus on incidents which were nearly lethal or which required significant medical intervention to save the life of a person in custody. Or they might decide that frequency of self-harm is an appropriate trigger. Reviewed events need not be the biggest or most notorious; sometimes, smaller events or “near-misses” yield the most informative accounts because they have less acute liability concerns. (For more information on liability concerns, see “Concerns about Legal Liability,” located under “Potential challenges for implementation in correctional facilities.”) Stakeholders may also consider “near-misses” successful, because they can cast it as a potential error that was ultimately avoided.<sup>34</sup>

## 2. Gather a multidisciplinary team

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Once a review process has been triggered for a sentinel event, the next step is to select the team members who will be responsible for conducting the RCA. The team generally consists of a leader who has knowledge of the event and authority in the organization, a facilitator, and team members (normally a maximum of six).<sup>35</sup> The facilitator, once properly trained in how to conduct a review, assembles and manages the team, guides the analysis, documents findings, and reports findings to internal stakeholders such as leadership or units that might wish to apply lessons from the work.<sup>36</sup>

It is important that review teams are multidisciplinary, with staff from all relevant

departments (including health and corrections), and involve those in leadership who have decision-making authority as well as staff members with knowledge about the processes and systems of the organization. Some guidelines suggest including, on a case-by-case basis, individuals who have been directly involved with the incident in the review process, because they have detailed information of the event, but excluding people who cannot be unbiased because they are experiencing difficult emotions related to the event.<sup>37</sup> Indeed, VHA guidelines indicate that including any of the people affected by the incident in the RCA is contraindicated, because their ability to be objective may be compromised, thus inhibiting the RCA's credibility. However, VHA guidelines go on to indicate that individuals who are directly involved should be interviewed during the RCA process, so that their knowledge and suggestions for the future are included.<sup>38</sup>

There is, of course, a careful balance to be constructed in making decisions about who to include in the process. For example, the presence of leadership is necessary for bringing people together and facilitating buy-in, but the inclusion of multiple managers or supervisory staff may discourage open and honest sharing by lower-level staff. On the other hand, in correctional facilities that have a strong sense of hierarchy and protocol, lower-level staff such as correctional officers may be unwilling to share without the explicit permission or inclusion of leadership. In addition, for organizational and administrative purposes, it may be helpful to have a staff member who does not participate in the review but acts as a note-taker, recording minutes, compiling documentation, and tracking "homework" assigned to team members as well as recommendations made by the team.<sup>39</sup> In any case, the people who make up the RCA team need to have the time to commit to the process, the desire to make improvements, the ability to cooperate, listen, and communicate, and the authority to ensure that recommendations are implemented.

### 3. Describe the event/create a timeline

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The first task of the assembled review team is to gather information about the incident and craft a detailed description and timeline of the event. Information gathering should begin as soon as feasible after the sentinel event to ensure that witnesses recall the event accurately and that the results of the review are relevant.<sup>40</sup> Review team members can gather information by interviewing staff members involved in the event, reviewing written documents such as medical records or policy and procedure manuals, and collecting other available data, such as physical evidence and video recordings. It is important during this stage that leadership guarantee to staff that the RCA is confidential and will not be used for disciplinary purposes.<sup>41</sup>

The information the team gathers will be used to create a preliminary timeline of the event. The timeline is a linear display of the steps that led up to the adverse event and

accurately conveys the “story” of the event. Every step leading to the event is pertinent. Team members should agree on the accuracy of the timeline and ensure that any missing information or inconsistencies have been addressed. Guidance from the field emphasizes that team members should focus on the facts at this stage and not try to skip ahead to identifying root causes. According to the Center for Medicare & Medicaid Services, “Jumping to conclusions about root causes increases the likelihood the team will end up with ‘quick-fix’ solutions that do not address the underlying systems gaps, or contributing factors, and fail to prevent similar events in the future.”<sup>42</sup>

## 4. Identify contributing factors

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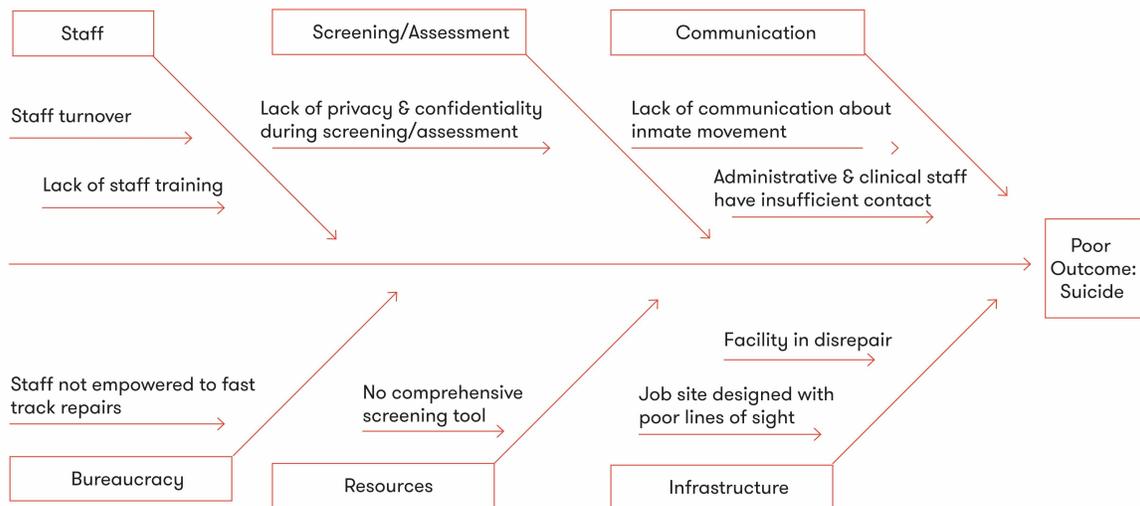
With a complete description of the adverse event, the review team can move forward with identifying the range of contributing factors. This step is “an inherently creative type of task” since it involves “generating as extensive a list as possible of potential causes that could have led to, or contributed to, the occurrence of the event.”<sup>43</sup> The idea here is not to initially zero in on the root cause specifically but to brainstorm with the goal of ensuring the team comes away with a broad overview of possible contributing factors. Thus, it is important that everyone on the team is heard during this phase and that no sorting or screening of contributing factors takes place.

A list of contributing factors is included below along with examples relevant to criminal justice settings where appropriate:

- Human: Individual limitations and capabilities, such as fatigue or distraction, and sufficiency of staffing.
- Patient assessment: Timeliness, accuracy, documentation, and communication.
- Equipment: Availability, function, and condition.
- Environment: Lighting, accessibility, safety of cell, and observation/surveillance capacity.
- Information: Accessibility, accuracy, and completeness.
- Communication: Technology, documentation, timing, and hand-off.
- Training/competency: Education, scope of practice, competency assessment, qualifications, effectiveness, and frequency of training.
- Procedural compliance: Compliance, availability of procedures and policies, and barriers.
- Care planning: Individualization and effectiveness.
- Organizational culture: Response to risk and safety issues, communication of safety priorities, and prevention of adverse outcomes.<sup>44</sup>

Organizations may choose to use different processes for identifying the range of possible factors that contributed to the adverse event. One possibility is to describe the event as well as the social and environmental context within which it occurred, and then brainstorm with the aid of a fishbone diagram. A fishbone diagram is a tool used to understand the cause and effect relationship between an event and its antecedents. The event is placed at the right end of a large arrow and the team then writes main categories of causes on branches that lead off from the arrow. All possible causes in each category are then listed at relevant branches, with the understanding that not all of these causes will ultimately be identified as root causes or be deemed worthy of further attention. Figure 1 below shows a hypothetical example of a fishbone diagram noting contributing factors for a suicide in a correctional facility. The goal of completing this exercise is for the team to walk away feeling confident they have identified all possible contributing factors to the event and are ready to proceed with looking for the root cause.

**Figure 1**  
**Example of fishbone diagram for suicide in a correctional facility**



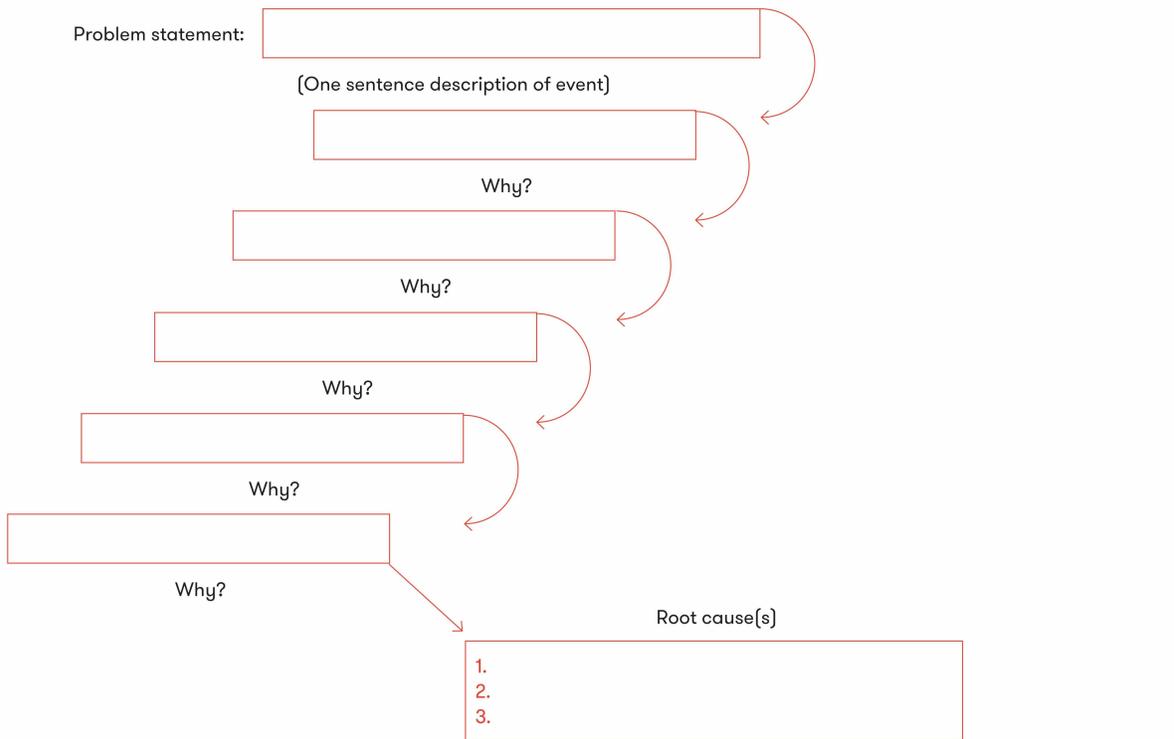
## 5. Identify the root cause(s)

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Having identified the contributing factors to an event, the next stage is for the team to drill down until they find the root cause or the most fundamental causal factor of the event. There may be more than one root cause for an event. There are multiple tools available to facilitate

this process for teams but the “Five Whys” is widely available and relatively easy to use.<sup>45</sup> As shown in Figure 2, the structured process involves asking a cascading series of “why” questions to discover organizational, systemic, and individual-level factors that explain why an incident occurred. The team starts by identifying the adverse event and asking the question, “Why did this happen?” They then continue asking “why” until no new answers have been found.

Figure 2  
**Five Whys tool**



Figures 3 and 4 below provide two hypothetical examples of how this might occur—the first in the case of a suicide related to inadequate screening at intake and the second in the case of an incarcerated person who is hospitalized due to poisoning.

Figure 3

### Five Whys - Screening Assessment

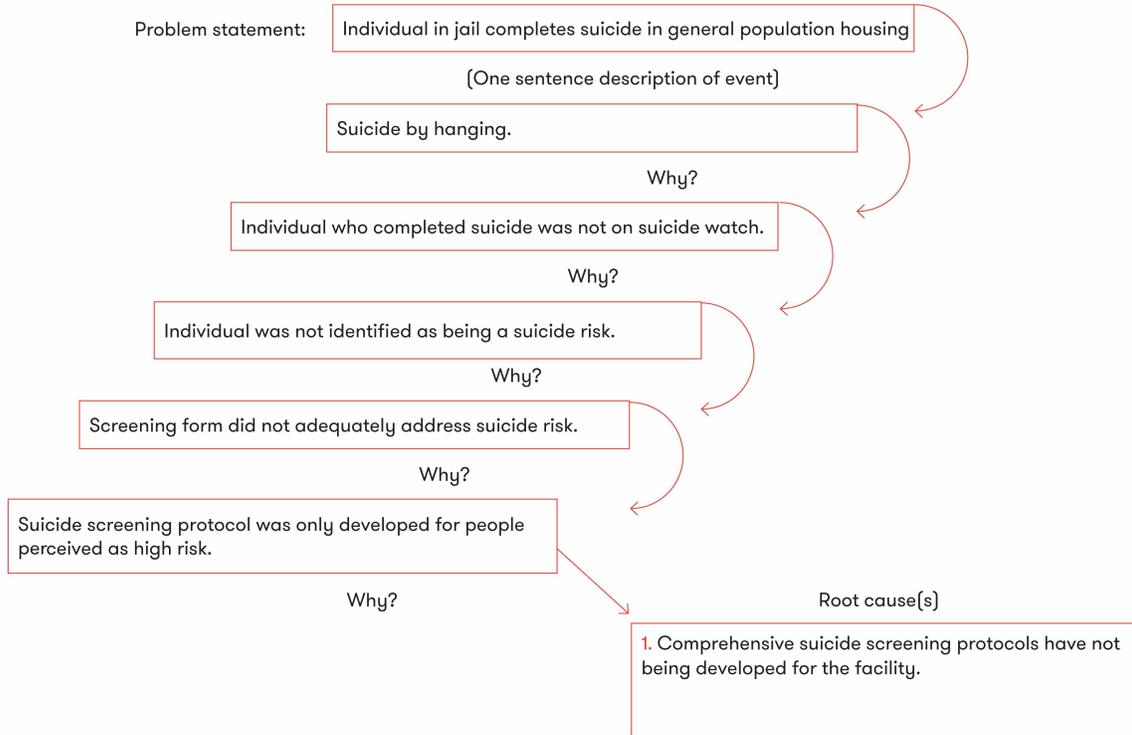
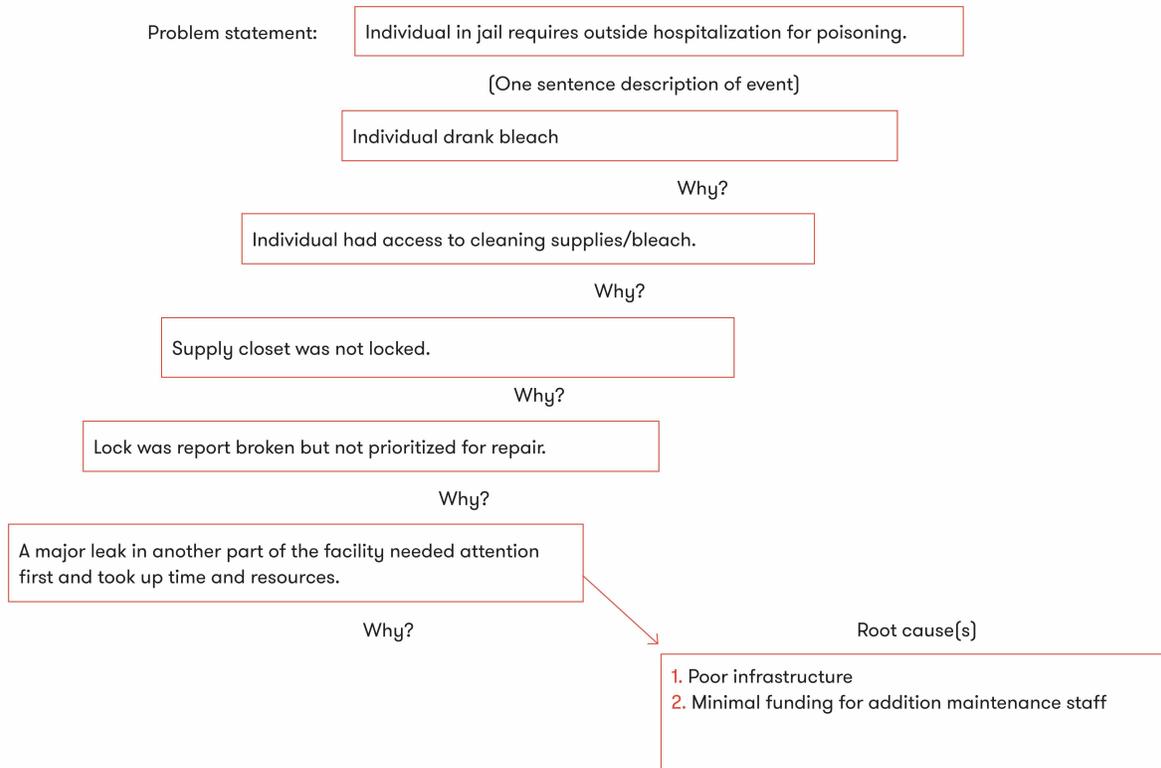


Figure 4

### Five Whys – Access to Cleaning Supplies



As the examples above suggest, teams must push themselves to continue asking “why” in order to ensure that they do not stop the exercise prematurely and fail to uncover the root cause. The Joint Commission suggests that a team has identified the root cause of the event when they can answer “No” to all of the following questions: 1) “Is it likely that the problem would have occurred if the cause had not been present?” 2) “Is the problem likely to recur due to the same causal factor if the cause is corrected?” and 3) “Is it likely that a similar condition will recur if the cause is corrected or eliminated?”<sup>46</sup>

Once the root cause has been identified, the team constructs a succinct root cause statement. The VA National Center for Patient Safety (VA NCPS) and the Joint Commission recommend that organizations consider a series of guidelines when developing their root cause statement in order to avoid focusing on individuals and instead seek out system-level causations:

- Clearly show the cause-and-effect relationship;
- Use specific and accurate descriptors for what occurred, rather than negative and vague words;
- Every human error has a preceding cause;
- Violations of procedure are not root causes, but must have a preceding cause; and
- Failure to act is only causal if there is a preexisting duty to act.<sup>47</sup>

As an example, the root cause statement in the example in Figure 4 might read, “Because the infrastructure in Facility C has not been adequately maintained in recent years, and there are a large number of emergency repairs that occupy the time of existing maintenance staff, maintenance staff were unable to respond to a non-emergency repair request in a timely fashion.”

## 6. Develop an action plan

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After the root cause(s) have been identified, the team must formulate an action plan for each root cause.<sup>48</sup> The goal of the action plan is to ensure that the same adverse event does not re-occur in the future. Actions should be concrete and easily understood. Reviewers assign responsibility for implementing each action, develop a timeline for implementation, and outline metrics for evaluating their effectiveness. Teams may consider pilot testing actions so that necessary modifications can be made.<sup>49</sup>

The VA NCPS has identified a “root cause analysis hierarchy of actions” in which actions are ranked as stronger or weaker based on their likelihood for reducing vulnerability. Stronger actions offer systemic fixes through, for example, changes to the physical environment or the standardization of a procedure; intermediate actions use systemic fixes but also rely on individual action (such as checklists or increased staffing); and weaker actions rely on changes in policies and additional training.<sup>50</sup> Teams should aim for corrective actions with stronger or intermediate ratings. Importantly, the team must consider issues related to costs, resources, long-term sustainability, and barriers to implementation.<sup>51</sup> This is one reason why it is essential for management to be involved in the development of corrective action plans.

## 7. Share lessons learned

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Once the review is complete, the team prepares a summary report that includes a brief description of the event, the analysis, the root cause, contributing factors, and the action plan.<sup>52</sup> The report identifies what was learned, who needs to know the information, and how they will be made aware of it. Such transparency is important for building the culture of safety and for demonstrating to staff that RCAs are not meant to result in punitive action. Over time, reports can be compiled in a database that tracks the types of sentinel events that occur, the root causes, and the action plans that were implemented. This database would allow a correctional facility to look for trends over time and further refine its safety procedures.

## 8. Measure the success of corrective actions

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Concurrent with the implementation of an action plan, the final step is to ensure there are mechanisms in place to measure the effectiveness of the actions. The sentinel events review team will want to monitor whether the corrective actions were put in place, whether people complied with the recommendations, and whether the changes have made a difference.<sup>53</sup> For correctional facilities that have standing Suicide Prevention Committees or Quality Assurance Programs, this might be an appropriate time for the sentinel event review team to hand off its work and allow the standing committees to provide long-term oversight and monitoring.

# Potential challenges for implementation in correctional facilities

The adversarial nature of the criminal justice system and the sensitive topics of suicide and self-harm will likely mean that there is at least initial resistance to the idea of an additional review process—particularly one that encourages a deep dive into an adverse event. Indeed, even as sentinel event reviews are supposed to be non-blaming and forward-looking, it is inevitable that concerns will be raised about the process and its outcomes. Three areas of

concern are most relevant here: logistical, interactional, and structural challenges; confidentiality; and liability.

## Logistical, interactional, and structural challenges

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The presence of logistical, interactional, and structural challenges means the quality of reviews can vary widely, that many RCAs will be performed incorrectly or incompletely (and thus will not produce usable results), and that formulating corrective action plans can be difficult.<sup>54</sup> According to research and reports from NIJ beta sites, there are several examples for these challenges:

- *Logistical*: finding enough time to commit to the review process; ensuring the right people are at the table;
- *Interactional*: getting consistent buy-in and ongoing cooperation from the team; lack of honesty among participants; and
- *Structural*: overcoming adversarial stances between agencies; getting all the information to the table from various stakeholders; facing legal barriers to data confidentiality (described further below).<sup>55</sup>

To ensure RCAs and sentinel event reviews are valuable and sustainable tools for promoting safety, such challenges should be considered and addressed. It is also important for correctional facilities undertaking a sentinel event review to have realistic expectations about the process, to develop clear goals, and to maintain confidence in the investment of time and resources.

## Confidentiality concerns

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Concerns about confidentiality may arise with respect to data sharing and the disclosure of confidential information. Review teams should therefore consider privacy and confidentiality implications of the sentinel event review process and consult relevant federal, state, and local laws as necessary. Questions that might be asked, for example, include:

- *Data sharing:* Will all team members have access to all documents? Can a thorough and credible review be completed if not? Is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) a consideration here?
- *Disclosure of confidential information:* Can the review team's documents be subpoenaed or discovered in a legal proceeding brought by a third party?

Although a detailed legal analysis of the federal and state laws governing privacy and confidentiality is beyond the scope of this report, our broad analysis suggests that common concerns about the limitations imposed by HIPAA on information-sharing in the case of suicide and self-harm incidents are likely overstated. HIPAA gives fairly broad latitude for “covered entities”—health plans, health plan clearing houses, and health care providers who transmit health information in electronic form—to share information with correctional institutions if it is a) necessary for the health and safety of the individual or other people incarcerated in a facility or b) for the maintenance of safety, security, and good order of a facility.<sup>56</sup> Even so, correctional facilities may very well need to establish their own forms and practices to ensure team members understand the importance of protecting confidential information and team deliberations.<sup>57</sup>

Separate issues may arise with respect to voluntary or involuntary disclosure of confidential information: for example, documents produced in a sentinel event review may be available through a public records request or be discoverable in court action against a correctional facility or its employees. There are exemptions in most such public records request laws as well as certain protections against disclosure during discovery. However, the analysis of whether and how records can be disclosed will depend on the laws in force in a given jurisdiction, which are too varied to survey here. Agencies should understand their exposure on these fronts before beginning and include the likelihood of public disclosure as a risk of a sentinel event review. They should also, however, weigh this risk appropriately and consider whether the review poses disclosure risks beyond those the facility already faces in events of suicide and self-harm. Medical records, for example, are generally discoverable in the event of a lawsuit. For another example, in New York City and State, reviews mandated by independent oversight committees such as the State Commission of Corrections and the City Board of Corrections following a death in custody are also discoverable in legal proceedings related to the death.<sup>58</sup> Therefore, documents created during a sentinel event review are unlikely to lead to any additional exposure for a correctional facility and the cost of engaging in sentinel event review may be marginal.

## Concerns about legal liability

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Finally, correctional facilities will have to consider their legal liability not just for possible exposure of confidential information, but also for the actual event described in a sentinel

event review. Does a sentinel event review, in and of itself, establish liability against a correctional facility or individual employees? Here again, it is important to use the liability inherent in incidents of suicide and self-harm as the scale against which the liability of the review is measured. Incidents of suicide and self-harm already draw scrutiny, because some legal precedents have established liability in certain cases. For example, New York's highest court ruled that the state has a duty to take "reasonable steps" to prevent reasonably foreseeable harms to residents of correctional facilities, such as acts of violence by others held in detention.<sup>59</sup> In New York, jails and other custodial facilities have that same duty of care in the context of suicide.<sup>60</sup> Further, that duty is sustained where an institution or mental health professional with sufficient expertise to detect suicidal tendencies, and with "control necessary to care for the person's well-being," fails to take such steps.<sup>61</sup> Although the boundaries of this duty of care is New York-specific, the special responsibilities inherent in custody (for correctional or mental health purposes) are likely to bring a similar duty to bear in other states, and possibly in federal courts as well. In *Estelle v. Gamble*, the U.S. Supreme Court set the duty's minimum standard: that is, the "deliberate indifference by prison personnel to a prisoner's serious illness or injury" constitutes cruel and unusual punishment contravening the Eighth Amendment and creates liability under 42 U.S.C. § 1983, the federal statute barring deprivations of constitutional rights by state actors.<sup>62</sup>

According to one author, "No one in local criminal justice leadership would willingly expose his or her agency and its staff to aggravated financial liability or gratuitous public humiliation." However, he also warns that liability concerns should not be overstated. He writes, "Criminal justice stakeholders who participated in the NIJ's 2013 roundtable discussion and in other focus groups and forums seemed to agree that if you are going to be sued, then you are going to be sued, with or without a sentinel event review process."<sup>63</sup> As with concerns about confidentiality, the risks attendant on a sentinel event review should be taken seriously, but kept in proportion—both to the risks inherent in managing a correctional facility under any circumstance and to the risks that come with leaving problems undiscovered and unaddressed. If the core legal obligations set forth in an agency's jurisdiction are to prevent reasonably foreseeable harms, broad practice of sentinel event reviews can be a double-edged sword: improving the agencies' ability to prevent harm, while also potentially increasing the number of events agencies can reasonably foresee.<sup>64</sup>

Both edges of that sword, however, are not equally sharp; even in New York's test, an agency that foresees harm is not liable if it takes reasonable steps to prevent the harm from coming to pass. This gets to the heart of any liability analysis done in anticipation of a review: it has to be considered in the context of the harm it studies and aims to prevent from recurring. In addition to their human toll, suicide and self-harm raise the specter of liability. Integrating and maintaining thoughtful reviews as part of regular agency practice shows, in itself, a lack of the "deliberate indifference" to harm cited by the Supreme Court. While liability is rarely the chief concern of a sentinel events review, the reality is that a sustained, conscientious review process may prevent harm from arising in the first place—and avoiding harm is the most surefire liability containment strategy of them all.

# Conclusion

The idea of an all-stakeholder, non-blaming, forward-looking error review process has significant promise for addressing the problems of suicide and self-harm in correctional facilities. Rather than pointing to individual error as the cause of these incidents or painting them as isolated cases, a sentinel events approach encourages an ethic of shared responsibility where all parties work together to understand what happened when someone dies from suicide or is injured by self-harm and to prevent similar events from happening in the future. The goal is to create a “culture of safety” that is characterized by an atmosphere of trust, flexibility, and a willingness to learn about and adjust systems.<sup>65</sup> Correctional facilities that adopt sentinel event reviews will not only demonstrate leadership in the field and contribute to the development of a new approach, but will also help to instill a new culture within their facilities that better ensures the safety and well-being of those under their custody.

Although correctional facilities may have to adapt the sentinel event review process described here to account for jurisdiction-specific issues, these materials identify a way forward for systems looking to implement a more routine and transparent response to suicide and self-harm. Instilling an ethic of transparency and accountability in correctional settings is challenging within a system that is historically adversarial. With leadership and commitment, however, a sentinel events approach can help correctional systems find partners and solutions, rather than critics and blame.

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# Endnotes

1. Criminal justice “errors” might also be called “adverse events,” “mistakes,” “omissions,” or “non-conformities.”
2. National Institute of Justice, “NIJ’s Sentinel Events Initiative,” June 17, 2016, <https://perma.cc/DL85-RMMA>.
3. James M. Doyle, “Learning from Error in the Criminal Justice System: Sentinel Event Reviews,” in *Mending Justice: Sentinel Event Reviews* (Washington, DC: U.S. Department of Justice, National Institute of Justice, 2014, NCJ 24714); James M. Doyle, “NIJ’s Sentinel Events Initiative: Looking Back to Look Forward,” *National Institute of Justice Journal* 273 (2014):10-14.
4. Ibid, Doyle, “Learning from Error,” (2014). A culture of safety includes the following features as conceptualized by the Agency for Healthcare Research and Quality (AHRQ): “1) acknowledgment of the high-risk nature of an organization’s activities and the determination to achieve consistently safe operations, 2) a blame-free environment where individuals are able to report errors or near-misses without fear of reprimand or punishment, 3) encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems, and 4) organizational commitment of resources to address safety concerns.” See Agency for Healthcare Research and Quality Patient Safety Network, Patient Safety Primer: Safety Culture, July 2016, <https://perma.cc/3RX4-FE33>.
5. New York State Justice Task Force, Recommendations Regarding Root Cause Analysis, June 2015, <https://perma.cc/6C74-K698>; The Quattrone Center, Using Root Cause Analysis to Instill a Culture of Self-Improvement: Program Replication Materials, April 20, 2015, <https://perma.cc/M7TA-DCR9>. See also Josh Hollway, “A Systems Approach to Error Reduction in Criminal Justice,” Public Law and Legal Theory Research Paper Series, 14-6 (2014).
6. Nancy Ritter, “Testing a Concept and Beyond: Can the Criminal Justice System Adopt a Nonblaming Practice?” *National Institute of Justice Journal* 276 (2015): 38-45.
7. NIJ is funding Vera’s work on A Sentinel Events Approach to Addressing Suicide and Self-Harm in Jail (Grant # 2014-IJ-CX-0030); a wide range of definitions exist for “self-harm.”

This report provides broad data on the problem of self-harm in correctional facilities but suggests that sentinel event reviews be reserved for those events that are particularly serious—whether because of their potential for lethality or the frequency with which they occur. See "Identify the sentinel event" under the section "Steps for conducting a root cause analysis (RCA)" for further discussion of this point.

8. Bureau of Justice Statistics, *Mortality in Local Jails and State Prisons 2000-2013—Statistical Tables* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2015, NCJ 248756); Kenneth L. Applebaum, Judith A. Savageau, Robert L. Trestman, Jeffrey L. Metzner, and Jacques Baillargeon, "A National Survey of Self-Injurious Behavior in American Prisons," *Psychiatric Service* 62, no.3 (2011): 285-290.
9. *ibid*, Bureau of Justice Statistics, 2015.
10. Christopher J. Mumola, *Suicide and Homicide in State Prisons and Local Jails* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2005, NCJ 210036); *ibid*, Bureau of Justice Statistics, 2015; and Centers for Disease Control and Prevention, "2014, United States Suicide Injury Deaths and Rates per 100,000," *Fatal Injury Reports, National and Regional, 1999-2014*, June 24, 2015, <https://perma.cc/S8BJ-6Y93>.
11. *Ibid*, Centers for Disease Control and Prevention, 2015. The same demographic trends can be found in suicides in the community, although the rate of suicide among men in the community is four times greater than the rate of suicide among women.
12. Katherine Dixon-Gordon, Natalie Harrison, and Ronald Roesch, "Non Suicidal Self-Injury within Offender Populations: A Systematic Review," *International Journal of Forensic Mental Health* 11 (2012): 34.
13. The total number of acts of self-injury increased by 24 percent between 2007 and 2011. When the decline in the average daily population during this time is accounted for, this increase is 38 percent. See Daniel Selling, Angela Solimo, David Lee, Kerry Horne, Elena Panove, and Homer Venters, "Surveillance of Suicidal and Nonsuicidal Self-Injury in the New York City Jail System," *Journal of Correctional Health Care* 20, no.2 (2013): 163-167.
14. Laura Frank and Regina T.P. Aguirre, "Suicide Within United States Jails: A Qualitative Interpretive Meta-Synthesis," *Journal of Sociology and Social Welfare* XL, no.3 (2013): 31-52; Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2006, NCJ 213600); Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60,

no.6 (2009): 761-765.

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16. Thomas J. Fagan, Judith Cox, Steven J. Helfand, and Dean Aufderheide, "Self-Injurious Behavior in Correctional Settings," *Journal of Correctional Health Care* 16, no.1 (2010): 48-66.
17. Hayden P. Smith and Robert J. Kaminski, "Self-Injurious Behaviors in State Prisons: Findings from a National Survey," *Criminal Justice and Behavior* 38, no.1 (2011): 26-41; and Dana D. DeHart, Hayden P. Smith, and Robert J. Kaminski, "Institutional Responses to Self-Injurious Behaviors Among Inmates," *Journal of Correctional Health Care* 15 (2009): 129-141.
18. Lindsay M. Hayes, "Reducing Inmate Suicides Through the Mortality Review Process," *Public Health Behind Bars: From Prisons to Communities* (New York: Springer Science and Business Media, 2007); Lindsay M. Hayes, *National Study of Jail Suicide: 20 Years Later* (Washington, DC: U.S. Department of Justice, National Institute of Corrections, 2010); Lindsay M. Hayes, "National Study of Jail Suicide: 20 Years Later," *Journal of Correctional Health Care* 18, no.3 (2012): 233-245; Lindsay M. Hayes, "Suicide Prevention in Correctional Facilities: Reflections and Next Steps," *International Journal of Law and Psychiatry* 36 (2013):188-194; and Jeffrey L. Metzner and Lindsay M. Hayes, "Suicide Prevention in Jails and Prisons," in *Textbook of Suicide Assessment and Management* (Washington, DC: American Psychiatric Association, 2012).
19. Ibid, Hayes, 2013; and Ibid, Metzner and Hayes, 2012.
20. National Commission on Correctional Health Care, *Standards for Health Services in Jails* (Chicago: National Commission on Correctional Health Care, 2014).
21. Hayes, 2010.
22. James M. Doyle, "Learning from Error in American Criminal Justice," *The Journal of Criminal Law & Criminology* 100, no.1 (2010): 109-147. (The quote is from page 118 of the report).

23. Hayes, 2012.
24. For additional guidance on differentiating self-injurious behavior and suicide attempts, see Barent W. Walsh, *Treating Self-Injury: A Practical Guide, 2nd edition* (New York: Guilford Press, 2012).
25. Smith and Kaminski, 2011.
26. Other methods that might be considered include, for example, common cause analysis or human factors analysis. For The Joint Commission's discussion of possible methods for conducting a comprehensive systematic analysis, see The Joint Commission, *Root Cause Analysis in Health Care: Tools and Techniques, 5th edition* (Oakbrook, IL: The Joint Commission, 2015).
27. New York State Justice Task Force, 2015; The Quattrone Center, 2015.
28. Katherine B. Percarpio, B. Vince Watts, and William B. Weeks, "The Effectiveness of Root Cause Analysis: What Does the Literature Tells Us," *The Joint Commission Journal on Quality and Patient Safety* 34, no. 7 (2008): 391-398.
29. Ibid, Percarpio, Watts, and Weeks, 2008.
30. Surveys of health care professionals have found that a large majority of people who have conducted RCAs or participated in RCA trainings feel that RCAs improve work practices, facilitate teamwork, improve communication about patients, and result in a safer clinical culture. See Jeffrey Braithwaite, Mary Westbrook, Nadine A. Mallock, Joanne F. Travaglia, and Rick A. Iedema, "Experiences of Health Professionals Who Conducted Root Cause Analyses After Undergoing a Safety Improvement Programme," *BMJ Quality & Safety* 15 (2006): 393-399; Paul Bowie, Joe Skinner, and Carl de Wet, "Training Health Care Professionals in Root Cause Analysis: A Cross-Sectional Study of Post-Training Experiences, Benefits and Attitudes," *BMC Health Services Research* 13 (2013): 50.
31. Jurisdictions involved in beta testing sentinel event reviews for NIJ suggested the following metrics as a start: 1) Were recommendations for changes in policies or procedures made? 2) Were the recommendations presented to decision-makers? 3) Did team participants value the process? 4) Were similar "potential" sentinel events averted? See National Institute of Justice, *Paving the Way: Lessons Learned in Sentinel Event Reviews* (Washington, DC: U.S. Department of Justice, National Institute of Justice, 2015, NCJ 249097).

32. This section draws extensively on literature for conducting RCAs in medical settings (and, where possible, in response to incidents of suicide specifically), because the examples provided are most relevant to understanding how such a process might be carried out in response to an incident of suicide or serious self-harm in a criminal justice setting; Center for Medicare & Medicaid Services, "Guidance for Conducting Root Cause Analysis (RCA) with Performance Improvement Projects (PIP)," <https://perma.cc/J8XF-9G5U> ; Center for Medicare & Medicaid Services, "How to Use the Fishbone Tool for Root Cause Analysis," <https://perma.cc/2WHB-QX6H> ; The Joint Commission, 2016; Veterans Health Administration, National Patient Safety Improvement Handbook, 2011, <https://perma.cc/8PW8-HNX6> ; Bjørn Andersen, Tom Fagerhaug, and Marti Beltz, *Root Cause Analysis and improvement in the Healthcare Sector: A Step-by-step Guide* (Milwaukee, WI: ASQ Quality Press, 2009); Brenda M. Ewen and Gale Bucher, "Root Cause Analysis: Responding to a Sentinel Event," *Home Healthcare Nurse* 31, no. 8 (2013): 435-443; and Charles Vincent, "Understanding and Responding to Adverse Events," *The New England Journal of Medicine* 348, no. 11 (2003): 1051-1056.
33. This is a case in which an unplanned event almost, but ultimately did not, result in a serious error.
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35. Andersen, Fagerhaug, and Beltz, 2009.
36. Center for Medicare & Medicaid Services, "Guidance for Conducting Root Cause Analysis (RCA) with Performance Improvement Projects (PIP)," <https://perma.cc/ZYH2-M3B5>
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38. Veterans Health Administration, 2011.
39. National Institute of Justice, *Paving the Way: Lessons Learned in Sentinel Event Reviews* (Washington, DC: U.S. Department of Justice, National Institute of Justice, 2015, NCJ 249097).
40. Ewen and Bucher, 2013.
41. The question of discipline is a complex one and, to date, there may not be enough research

on how to manage a potential disciplinary process in relation to the goals of a sentinel event review. However, as one participant in NIJ's Sentinel Events Initiative Expert Roundtable noted, there are avenues outside a sentinel event review by which staff can be disciplined if necessary. See National Institute of Justice, *The Sentinel Events Initiative: Proceedings from an Expert Roundtable* (Washington, DC: U.S. Department of Justice, National Institute of Justice, 2013, NCJ 243586).

42. Center for Medicare & Medicaid Services, "Guidance for Conducting Root Cause Analysis (RCA) with Performance Improvement Projects (PIP)," 4, <https://perma.cc/ZYH2-M3B5>.
43. Andersen, Fagerhaug, and Beltz, 2009, 38.
44. Ewen and Bucher, 2013, 437.
45. Bjorn Andersen and Tom Natland Fagerhaug, *ASQ Pocket Guide to Root Cause Analysis* (Milwaukee, WI: ASQ Quality Press, 2006); Ibid, Ewen and Bucher, 2013, 438.
46. Ibid, Ewen and Bucher, 2013, 438.
47. The Joint Commission, "Sentinel Events," 10.
48. Center for Medicare & Medicaid Services, "Guidance for Conducting Root Cause Analysis (RCA) with Performance Improvement Projects (PIP)," <https://perma.cc/ZYH2-M3B5>; Ewen and Bucher, 2013; and Veterans Health Administration, 2011.
49. Ibid, Ewen and Bucher, 2013.
50. Dea Hughes, "Root Cause Analysis: Bridging the Gap Between Ideas and Execution," VA National Center for Patient Safety, *Topics in Patient Safety* 6, no.5 (2006):1-4.
51. Ewen and Bucher, 2013.
52. Ibid.
53. Center for Medicare & Medicaid Services, "Guidance for Conducting Root Cause Analysis (RCA) with Performance Improvement Projects (PIP)," <https://perma.cc/ZYH2-M3B5>
54. Albert W. Wu, Angela K.M. Lipshutz, and Peter J. Pronovost, "Effectiveness and Efficiency

of Root Cause Analysis in Medicine," *Journal of the American Medical Association* 299, no. 6 (2008).

55. National Institute of Justice, 2015, 12-13; Bowie, Skinner, and de Wet, 2013; Braithwait et al., 2006; and Wu, Lipshutz, and Pronovost, 2008, 685-687.
56. See 45 CFR §164.512 and 45 CFR §164.104.
57. The Office for Victims of Crime in the U.S. Department of Justice has examined the question of confidentiality and has looked at demonstration projects that address and resolve confidentiality questions in its work on elder abuse review teams. See Lori A. Stiegel, *Elder Abuse Fatality Review Teams: A Replication Manual* (Washington, DC: American Bar Association, 2005).
58. N.Y. Correct. Law § 47 (McKinney); 40 RCNY § 3-10.
59. Sanchez v. State of New York, 99 N.Y.2d 247, 258 (N.Y. 2002).
60. See Cygan v. City of New York, 165 A.D.2d 58, 67 (1st Dept. 1991). The case held that an officer's widow could not allege that her husband's municipal employer was negligent in the instance that he turned his gun on himself while off-duty, since the suicide was not foreseeable. The record contains no evidence that the deceased was suicidal or that his employer should have anticipated that he was such that he should not have been allowed to carry a weapon.
61. Ibid.
62. Estelle v. Gamble, 429 U.S. 97 (1976).
63. Doyle, "Learning from Error," (2014), 13.
64. Vera has not undertaken a multi-state survey of the liability standards, and each agency should consult its own counsel in considering what its obligations are and how best to meet them.
65. Doyle, "Learning from Error," (2014).

## "Sentinel event reviews in aviation and medication" text box

- a. National Transportation Safety Board, *Aviation Accident Reports*, <https://perma.cc/9MQQ-39LC>.
- b. Jamie N. Deis, Keegan M. Smith, Michael D. Warren, Patricia G. Throop, Gerald B. Hickson, Barbara J. Joers, and Jayant K. Deshpande, "Transforming the Morbidity and Mortality Conference into an Instrument for Systemwide Improvement," *Advances in Patient Safety: New Directions and Alternative Approaches, Vol. 2: Culture and Redesign* (Rockville, MD: Agency for Healthcare Research and Quality, 2008).
- c. Lucian L. Leape, "Error in Medicine," *Journal of the American Medical Association* 272, no. 23 (1994): 1851-1857; Institute of Medicine, *To Err is Human: Building a Safer Health System*, edited by Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington, DC: Institute of Medicine, 1999).
- d. The Joint Commission, *Sentinel Event Policy and Procedures*, January 16, 2016, <https://perma.cc/AZY2-TJCG>. The Joint Commission requires that accredited organizations define a "patient safety event" for its own purposes. The definition must encompass events defined by The Joint Commission but can also include incidents in which no harm or only minor harm occurs. Theoretically, in a correctional setting, this could mean that "patient safety event" is broadly defined to include incidents of serious self-harm as well as suicides. See The Joint Commission, "Sentinel Events," *Comprehensive Accreditation Manual for Behavioral Healthcare*, 2016, <https://perma.cc/9P7K-WXCB>.
- e. The Joint Commission, "Sentinel Events," 3.
- f. Health services departments at all eligible Bureau of Prisons institutions are accredited by The Joint Commission, for example. (Care Level 1 facilities are not eligible, because they serve healthy inmates.) Correctional facilities may opt for health care accreditation by the American Correctional Association or the National Commission on Correctional Health Care. All of these accreditation processes are voluntary.

## "Defining suicide and self-harm" text box

- a. Centers for Disease Control and Prevention, *Definitions: Self-directed violence*, August 15, 2016, <https://perma.cc/SR5R-6VR3>.
- b. Keren Skegg, "Self-harm," *The Lancet* 366 (2005): 1471-1483.
- c. Dixon-Gordon, Harrison, and Roesch, 2012, 33-50; Jacqueline Mangnall and Eleanor Yurkovich, "A Literature Review of Deliberate Self-Harm," *Perspectives in Psychiatric Care* 44,

no.3 (2008): 175-184.

d. World Health Organization, *Preventing Suicide: A Resource for Non-Fatal Suicidal Behavior Case Registration* (Geneva, Switzerland: World Health Organization, 2014).

e. Mumola, 2005; and Keith Hawton, Louise Linsel, Tunde Adeniji, Amir Sariaslan, and Seena Fazel, "Self-Harm in Prisons in England and Wales: An Epidemiological Study of Prevalence, Risk Factors, Clustering, and Subsequent Suicide," *The Lancet* 383, no. 9923 (2014): 1147-1154.

f. Barent W. Walsh, *Treating Self-Injury: A Practical Guide, 2nd Edition* (New York: Guilford Press, 2012).