

BEYOND BAD APPLES: ADOPTING SENTINEL EVENT REVIEWS IN NEVADA’S CRIMINAL JUSTICE SYSTEM

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INTRODUCTION

On April 24, 2016, thirty-eight-year-old Terrill Thomas died of thirst inside his Milwaukee County cell, a mere nine days after being arrested.¹ Corrections officers moved Thomas, who suffered from bipolar disorder, to solitary confinement after he flooded his previous cell and was behaving erratically.² Neighboring cellmates stated that correctional officers had shut off the water to his cell.³ Cellmates also heard Thomas begging for water in the days leading up to his death.⁴ The medical examiner ruled his death a homicide by dehydration.⁵

A year earlier and hundreds of miles away in Virginia, authorities discovered twenty-four-year-old Jamycheal Mitchell, who had a long history of battling psychosis, had starved to death alone in solitary confinement.⁶ In April 2015, Virginia police officers arrested Mitchell for stealing five dollars-worth of snacks from a convenience store.⁷ In the four months of his detention, Mitchell had lost forty pounds.⁸ A medical examiner stated that Mitchell was “nearly cachectic,” or severely malnourished, at his time of death.⁹ Mitchell’s fellow inmates reported that jail staff had deprived Mitchell of meals, cut off water to his cell, and deprived him of clothes, bedding, and shoes.¹⁰

In Alabama prisons, the Southern Poverty Law Center (SPLC) has documented cases of jail staff misleading blind inmates and coercing them to sign “do not resuscitate” orders; diabetic inmates who have lost ligaments because they could not get their necessary medication; and officials who deprive, or change, anti-psychotic and anti-depressant medication for inmates with mental illnesses, which sometimes results in the inmates committing suicide.¹¹ SPLC

¹ Eric M. Johnson, *Black Wisconsin Inmate’s Death by Dehydration Ruled a Homicide*, REUTERS (Sept. 15, 2016), <http://www.reuters.com/article/us-wisconsin-prison-death-idUSKCN11M009> [https://perma.cc/E48L-J65U].

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ Elliott C. McLaughlin, *Jail Let Mentally Disabled Man Starve to Death, Lawsuit Says*, CNN (May 17, 2016), <http://www.cnn.com/2016/05/16/us/jamycheal-mitchell-hampton-roads-virginia-jail-lawsuit/> [https://perma.cc/44WJ-HJ5E].

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ S. POVERTY LAW CTR. & ALA. DISABILITY ADVOCACY PROGRAM, *CRUEL CONFINEMENT: ABUSE, DISCRIMINATION AND DEATH WITHIN ALABAMA’S PRISONS* 6, 14 (2014), https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/cruel_confinement.pdf [https://perma.cc/343H-EZEY].

sued the Alabama Department of Corrections (ADOC) in 2014 after an investigation.¹² In 2017, a federal court granted SPLC's motion for an emergency injunction requesting that ADOC "secure a measure of basic compliance with [inmate's] constitutional rights" that would "protect against immediate threat to human life," after an inmate who testified in the case committed suicide just ten days after taking the stand.¹³

Cases highlighting institutional failures of the criminal justice system have become more common as advocates call for government accountability, improved conditions for inmates, and criminal justice reform. Criminal justice reform advocates, the public, and government officials have been looking for ways to prevent human rights abuses in the criminal justice system. The National Institute of Justice (NIJ) offers a solution: the criminal justice system should adopt the sentinel event review systems used by the medical, military, and aviation sectors to review negative events and implement proactive changes to prevent future negative events from happening. Like the medical, military, and aviation sectors, the criminal justice *system*, is "comprised of many working parts."¹⁴ When a negative event happens in the criminal justice system, it is unlikely the result of a single actor. Multiple factors, or decision points, result in the negative event. Therefore, negative events may reveal underlying weaknesses in the criminal justice system. And, when the criminal justice system fails in its "most critical function[s] . . . the government should step in to determine the causes of the failure and identify appropriate reforms."¹⁵

State governments should learn from the medical and aviation sectors and adopt sentinel event review to improve their criminal justice system. Based on this premise, this Article proceeds in four Parts. Part I illustrates negative events in the criminal justice system that give rise to criminal justice reforms. Part II defines sentinel event review systems and how the criminal justice system could incorporate the model to address system failures. Part III discusses the U.S. Department of Justice's Office of Justice Programs and the National

¹² *SPLC Files Federal Lawsuit over Inadequate Medical, Mental Health Care in Alabama Prisons*, SOUTHERN POVERTY L. CTR. (June 16, 2014), <https://www.splcenter.org/news/2014/06/17/splc-files-federal-lawsuit-over-inadequate-medical-mental-health-care-alabama-prisons> [<https://perma.cc/GR4Y-Y3C2>].

¹³ Plaintiff's Emergency Motion for a Temporary Restraining Order or Preliminary Injunction Regarding Suicidal Prisoners at 1–2, *Braggs v. Dunn*, No. 2:14-cv-00601 (M.D. Ala. Dec. 22, 2016); see also *Judge Orders Alabama to Protect Suicidal Prisoners After SPLC Action*, SOUTHERN POVERTY L. CTR. (Jan. 13, 2017), <https://www.splcenter.org/news/2017/01/13/judge-orders-alabama-protect-suicidal-prisoners-after-splc-action> [<https://perma.cc/9WH6-PPZZ>]; *SPLC Demands Alabama Protect Prisoners After Client Commits Suicide*, SOUTHERN POVERTY L. CTR. (Dec. 22, 2016), <https://www.splcenter.org/news/2016/12/22/splc-demands-alabama-protect-prisoners-after-client-commits-suicide> [<https://perma.cc/3Z7L-ZK8S>].

¹⁴ Patrick Cleary, *Wrongful Convictions as a Sentinel Event*, CONST. PROJECT (Sept. 12, 2014), <http://www.constitutionproject.org/documents/wrongful-convictions-as-a-sentinel-event/> [<https://perma.cc/Q84Y-6E3Y>].

¹⁵ *Id.*

Institute of Justice's sentinel event review system implementation efforts across the country. Part IV discusses sentinel events specifically in Nevada's criminal justice system and what Nevada is currently doing to address problems within its criminal justice system. Lastly, Part V, this Note's conclusion, discusses why states, like Nevada, should adopt sentinel event review as a permanent front-end and back-end review process.

I. CURRENT FAILURES IN THE CRIMINAL JUSTICE SYSTEM CALL FOR SYSTEMIC REVIEW

Addressing criminal justice errors is an essential part of criminal justice reform. Cases like Terrill Thomas's and Jamychoel Mitchell's do not occur in a vacuum; there is unlikely a single individual to be blamed. Instead, these tragedies are often the result of multiple actors, policies, and external factors. They signal larger, systemic failures in the justice system that only come to light after a "sentinel event."

Sentinel events in the criminal justice system can occur before and after convictions, in policing contacts,¹⁶ pre-trial detention, and post-conviction detention. Sentinel events in the criminal justice system may include: "[a] police-citizen encounter that unexpectedly turns violent"; "[t]he release from prison of a person who quickly reoffends"; "[i]n-custody deaths or injuries, including self-harm and suicide in prisons"; "[t]he wrongful arrest or conviction of an innocent person"; "[v]iolations of an individual's right to a speedy trial"; "[i]neffective assistance of counsel or lack of access to sufficient legal assistance"; and "[u]nreasonable delays in forensic evidence processing."¹⁷ Cases of inmates dying because of inadequate medical attention have pervaded the news-sphere and call for an increased accountability on abusive policing and detention practices.¹⁸ So, too, have cases of wrongful convictions called for scrutiny after developments in DNA testing.¹⁹ Improved DNA testing has un-

¹⁶ See, e.g., Carma Hassan et al., *Sandra Bland's Family Settles for \$1.9M in Wrongful Death Suit*, CNN (Sept. 15, 2016), <http://www.cnn.com/2016/09/15/us/Sandra-bland-wrongful-death-settlement/> [<https://perma.cc/PJ2Z-NRSR>]. Sandra Bland's story is an example of a police interaction that escalated and resulted with the death of a pre-trial detainee. As demonstrated by the stories in Part I, *infra*, sentinel events can occur at any point in the justice system continuum. Accordingly, sentinel event review will vary depending on the case at hand.

¹⁷ NAT'L INST. OF JUSTICE, NIJ STRATEGIC RESEARCH AND IMPLEMENTATION PLAN: SENTINEL EVENTS INITIATIVE 2017–21 (2017), <https://www.ncjrs.gov/pdffiles1/nij/250472.pdf> [<https://perma.cc/4SY7-63CT>].

¹⁸ See *supra* INTRODUCTION.

¹⁹ See EDWARD CONNORS ET AL., NAT'L INST. OF JUSTICE, CONVICTED BY JURIES, EXONERATED BY SCIENCE: CASE STUDIES IN THE USE OF DNA EVIDENCE TO ESTABLISH INNOCENCE AFTER TRIAL (1996), <https://www.ncjrs.gov/pdffiles/dnaevid.pdf> [<https://perma.cc/FWY9-6M6S>]; Gerald M. LaPorte, *Wrongful Convictions and DNA Exonerations: Understanding the Role of Forensic Science*, NAT'L INST. JUST. (Sept. 8, 2017), <https://nij.gov/journals/279/Pages/wrongful-convictions-and-dna-exonerations.aspx> [<https://perma.cc/UQH8GHMW>].

covered cases where law enforcements tampered with evidence.²⁰ For example, in 2017, Kansas officials exonerated a man after he served twenty-three years in jail.²¹ That same year, after a police informant admitted to fabricating his story during an investigation, New York Governor Andrew Cuomo commuted an inmate who had served twenty-six years in prison for a murder he did not commit.²² These are just two instances of criminal justice systems failing to account for error regarding wrongful convictions.

Sentinel event review may be particularly instructive in assessing pre-trial detention programs. In Chicago, for example, 95 percent of the more than 8,000 inmates in 2016 were pre-trial detainees.²³ Pre-trial detainees languish in jail simply because they cannot afford to post bail.²⁴ This wait “permanently set[s] their lives off-course, causing them to lose jobs, custody of their children, their housing, and even their lives.”²⁵

Notwithstanding the collateral consequences of detention, pre-trial detainees’ mental health may deteriorate behind bars. Pre-trial detainees are more likely to commit suicide. In fact, according to the United States Bureau of Justice Statistics (BJS), 40 percent of inmate suicides in county jails occur in the first seven days of detention due to “shock of confinement.”²⁶ In 2015, the BJS revealed suicide as the leading cause of death in state and county jails.²⁷ Addi-

²⁰ See, e.g., Grant Rodgers, *Iowan Exonerated in Des Moines Evidence-Planting Case*, DES MOINES REG. (Jan. 23, 2017, 2:38 PM), <http://www.desmoinesregister.com/story/news/crime-and-courts/2017/01/23/iowan-exonerated-des-moines-evidence-planting-case-joshua-judge-tyson-teut-kyle-jacob-weldon/96954048/> [<https://perma.cc/7RHX-KQXJ>].

²¹ Jessica Schladebeck, *Kansas Man Freed After He Was Wrongly Jailed for 23 Years Gets \$0*, N.Y. DAILY NEWS (Oct. 17, 2017), <http://www.nydailynews.com/news/national/man-freed-spending-23-years-jail-owed-no-compensation-article-1.3568539> [<https://perma.cc/V3KP-4XEX>].

²² *Felipe Rodriguez Released After 26 Years*, INNOCENCE PROJECT (Jan. 26, 2017), <http://www.innocenceproject.org/felipe-rodriguez-released/> [<https://perma.cc/GF86-5FGR>].

²³ Sarah Lazare, *Hundreds of Thousands Are Languishing in Jails Because They Can't Afford Bail Bonds: A National Movement Is Building to End This*, JUST. POL'Y INST. (Dec. 22, 2016), <http://www.justicepolicy.org/news/11103> [<https://perma.cc/DR7M-2DRL>].

²⁴ *Id.*; Neil L. Sobol, *Charging the Poor: Criminal Justice Debt & Modern-Day Debtors' Prisons*, 75 MD. L. REV. 486 (2016); see, e.g., CONFERENCE OF CHIEF JUSTICES, RESOLUTION 3: ENDORSING THE CONFERENCE OF STATE COURT ADMINISTRATORS POLICY PAPER ON EVIDENCE BASED PRETRIAL RELEASE (2013); Letter from Karol V. Mason et al., U.S. Dep't of Justice, Civil Rights Div., to Colleagues (Mar. 14, 2016), <https://www.justice.gov/opa/file/832541/download> [<https://perma.cc/V2LT-NHG4>].

²⁵ Lazare, *supra* note 22.

²⁶ MARGARET NOONAN ET AL., BUREAU OF JUST. STATISTICS, MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013 - STATISTICAL TABLES 10 (2015), <https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf> [<https://perma.cc/KX8L-BD7D>]; see also Martin Kaste, *The 'Shock of Confinement': The Grim Reality of Suicide in Jail*, NPR (July 27, 2015), <http://www.npr.org/2015/07/27/426742309/the-shock-of-confinement-the-grim-reality-of-suicide-in-jail> [<https://perma.cc/GX7E-BWS2>].

²⁷ NOONAN ET AL., *supra* note 25, at 10; Kaste, *supra* note 25.

tionally, pre-trial detainees in county jails had a significantly higher suicide rate than those in federal prisons.²⁸

The shock of confinement has become a national topic of debate following the contentious death of Sandra Bland in Waller County, Texas in 2015.²⁹ Sandra Bland's story sparked national media attention after a "dash-cam" video showed a Texas police officer using excessive force to take Bland out of her car after she failed to use a turn signal.³⁰ The officer arrested Bland and—just three days later—officials found her body hanging in her jail cell.³¹ Sandra Bland's, Terrill Thomas's, and Jamycheal Mitchell's deaths are not isolated incidents. Rather, they illustrate how the criminal justice system has failed—and continues to fail—those in custody. They also call for government officials to hold individual officers accountable while simultaneously reforming the criminal justice system.

II. SENTINEL EVENT REVIEW AS A CRIMINAL JUSTICE REFORM INITIATIVE: PREVENTING "ACCIDENTS WAITING TO HAPPEN"³²

The criminal justice system is vulnerable to organizational error because it relies on human actors, their judgment, and ultimate decision-making authority.³³ This discretion induces errors.³⁴ As an inherently complex process, it "relies on the contributions of hosts of legal actors, including witnesses, investigators, lawyers, jurors, and judges."³⁵ In turn, these actors rely on their "memories, inferences, judgments and decisions, and the ensuing verdicts are unlikely to be any better than their constitutive ingredients."³⁶ Each decision point can lead to errors out of mere negligence or institutional errors. These decision points and errors present an opportunity for justice system professionals to respond, change course, and improve outcomes.

Mass incarceration is an example of organizational error. Mass incarceration has created an environment that is both unsustainable and particularly harmful to low-income individuals in the United States. In a Harvard Law Review article, President Barack Obama wrote that "[t]here is a growing consensus across the U.S. political spectrum that the extent of incarceration in the

²⁸ Kaste, *supra* note 25.

²⁹ Hassan et. al., *supra* note 16.

³⁰ *Id.*

³¹ *Id.*

³² Josh Cutino, *Continuous Quality Improvement: Increasing Criminal Prosecution Reliability Through Statewide Systematic Improvement Procedures*, 20 LEWIS & CLARK L. REV. 1065, 1079 (2016).

³³ Dan Simon, *Front-end and Back-end Solutions*, in NAT'L INST. OF JUSTICE, MENDING JUSTICE: SENTINEL EVENT REVIEWS 28 (2014), <https://ncjrs.gov/pdffiles1/nij/247141.pdf> [<https://perma.cc/E4YY-C63C>].

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

United States is not just unnecessary but also unsustainable.”³⁷ Communities of color are disproportionately affected by the criminal justice system’s failings.³⁸ Prisons and jails have become warehouses for the poor—taxing them to enter and taxing them leave.³⁹ These “debtors prisons” perpetuate a cycle of mass incarceration that permanently scars individuals and sentences them to be subclass citizens who are barred from working, voting, and housing because their criminal background strips what remaining civil rights they had, essentially sentencing them to “civil death.”⁴⁰ The United States spends \$80 billion annually to incarcerate 2.2 million men and women and this system is undermined by system errors in community policing, skewed sentencing, and wrongful convictions.⁴¹ As President Obama put it,

[W]e simply cannot afford to spend \$80 billion [just to] to write off the seventy million Americans—that’s almost one in three adults—with some form of criminal record, to release 600,000 inmates each year without a better program to reintegrate them into society, or to ignore the humanity of 2.2 million men and women currently in U.S. jails and prisons and over 11 million men and women moving in and out of U.S. jails every year.⁴²

Thus, the effectiveness and legitimacy of the justice system depend on how it carries out its core functions, the public’s trust in it, and the understanding that the system is not perfect, but trusting government officials to correct the criminal justice system where necessary.⁴³

After decades of political opposition to mass incarceration reforms, stakeholders have come to realize that the “stern discipline approach” is no longer

³⁷ Barack Obama, *The President’s Role in Advancing Criminal Justice Reform*, 130 HARV. L. REV. 811, 817 (2017).

³⁸ *Id.* at 820.

³⁹ See Christopher D. Hampson, Note, *State Bans on Debtors’ Prisons and Criminal Justice Debt*, 129 HARV. L. REV. 1024 (2016); Alicia Bannon et al., *Criminal Justice Debt: A Barrier to Reentry*, BRENNAN CTR. FOR JUST. 1–2 (2010), <http://www.brennancenter.org/publication/criminal-justice-debt-barrier-reentry> [https://perma.cc/6EGE-EHQ6]; Lauren-Brooke Eisen, *Charging Inmates Perpetuates Mass Incarceration*, BRENNAN CTR. FOR JUST. 1 (2015), <https://www.brennancenter.org/publication/charging-inmates-perpetuates-mass-incarceration> [https://perma.cc/JN6G-85YA]; *Ending the American Money Bail System*, EQUAL JUST. UNDER L., <http://equaljusticeunderlaw.org/wp/current-cases/ending-the-american-money-bail-system/> [https://perma.cc/73C2-WQN2] (last visited Apr. 27, 2018); *Shutting Down Debtors’ Prisons*, EQUAL JUST. UNDER L., <http://equaljusticeunderlaw.org/wp/current-cases/ending-debtors-prisons/> [https://perma.cc/TK3F-PZHG] (last visited Apr. 27, 2018); *Ending the American Money Bail System*, EQUAL JUST. UNDER L., <http://equaljusticeunderlaw.org/wp/current-cases/ending-the-american-money-bail-system/> [https://perma.cc/73C2-WQN2] (last visited Apr. 27, 2018); Sobol, *supra* note 24.

⁴⁰ See, e.g., Gabriel J. Chin, *The New Civil Death: Rethinking Punishment in the Era of Mass Conviction*, 160 U. PA. L. REV. 1789, 1790 (2012).

⁴¹ Obama, *supra* note 36, at 815, 835–60.

⁴² *Id.* at 815.

⁴³ NAT’L INST. OF JUSTICE, *MENDING JUSTICE: SENTINEL EVENT REVIEWS 1* (2014), <https://ncjrs.gov/pdffiles1/nij/247141.pdf> [https://perma.cc/E4YY-C63C].

effective or sustainable.⁴⁴ Criminal justice reform must start at the state and local level because state and local governments have the policing powers and house 90 percent of the prison population.⁴⁵ The federal government's role has recently been to identify and evaluate evidence-based programs in the federal system, then provide grant funding and technical assistance to states to implement the model.⁴⁶ Enter, sentinel event review.

A. *What are Sentinel Events and Sentinel Event Reviews?*

“Sentinel events” is a term of art used in high-risk environments, like the medical and aviation sectors, to classify negative events or errors: something that should not have happened, but did, and caused harm.⁴⁷ A sentinel event is “a bad outcome that no one wants repeated and that signals the existence of underlying weaknesses in the system.”⁴⁸ They signal a systemic failure, an inadequacy in the system's structure and component parts.⁴⁹ Rather than looking for a single bad decision, sentinel event review acknowledges that system errors are the result of compounded factors: bad decisions, policies, and/or actors.⁵⁰ System errors can be graded on a scale based on the risk of harm each presents: near misses, being the least harmful; adverse events, causing a small degree of harm; or sentinel events, resulting in actual harm to a person.⁵¹ Put differently, they are “‘organizational accidents’ in which complex events comprising small mistakes combined with each other and with latent conditions hidden in the system to produce unexpected tragedies.”⁵²

Sentinel event review is a dynamic process for identifying negative events, responding to these events, and implementing changes to prevent similar negative events from occurring in the future. A sentinel event triggers an immediate root-cause analysis. A sentinel event review gathers a team of stakeholders to identify missed red flags, brainstorm, and implement a variety of changes to prevent the negative event from happening again. The strength of sentinel event

⁴⁴ Obama, *supra* note 36, at 820.

⁴⁵ *Id.* at 838.

⁴⁶ *See id.* at 838–39.

⁴⁷ MENDING JUSTICE, *supra* note 43, at 1.

⁴⁸ *Id.* A sentinel event can also be a “significant, unexpected negative outcome that signals a weakness in the system or process. Sentinel events are the result of compounded errors and —if properly analyzed and addressed— may provide important keys to strengthening the system and preventing future adverse events or outcomes.” James M. Doyle, *Learning from Error in the Criminal Justice System: Sentinel Event Reviews*, in NAT'L INST. OF JUSTICE, MENDING JUSTICE: SENTINEL EVENT REVIEWS 3 (2014), <https://ncjrs.gov/pdffiles1/nij/247141.pdf> [<https://perma.cc/E4YY-C63C>].

⁴⁹ *Id.* at 6.

⁵⁰ Jim Bueermann, *High Expectations, Good Intentions and Normalized Policy Deviation: A Sentinel Event*, in NAT'L INST. OF JUSTICE, MENDING JUSTICE: SENTINEL EVENT REVIEWS 40–41 (2014), <https://ncjrs.gov/pdffiles1/nij/247141.pdf> [<https://perma.cc/E4YY-C63C>].

⁵¹ Doyle, *supra* note 48, at 2–3, 14.

⁵² *Id.* at 16.

review is that it rejects a culture of blame, embracing instead a culture of safety and professionalism. Sentinel event review does not, however, replace liability. It is a proactive approach to understanding that a system run by humans is prone to mistakes. Therefore, sentinel event review provides a continuous, forward-thinking, and collaborative approach to improve system functions.

1. *Sentinel Event Review in the Medical Field*

The regulatory and accrediting body for hospitals in the United States, the Joint Commission, adopted the Sentinel Event Policy in 1996 to assist hospitals to prevent adverse, or “sentinel,” events unrelated to a patient’s underlying condition, and to implement corrective actions through a systematic evaluation process.⁵³

The Joint Commission defines a sentinel event as one that “reaches a patient and results in any of the following: [d]eath, [p]ermanent harm, [or] [s]evere temporary harm and intervention required to sustain life.”⁵⁴ The Joint Commission adopted the Institute of Medicine’s definition of “quality” as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”⁵⁵ Healthcare organizations achieve patient safety by preventing “errors and adverse effects to patients that are associated with health care.”⁵⁶

By categorizing sentinel events as organizational accidents instead of individual errors, sentinel event review focuses on results—preventive institutional policy change.⁵⁷ Sentinel event review is a “way to account for unintended tragic outcomes, to learn lessons from our errors, and to use these lessons to reduce future risks.”⁵⁸ Sentinel event reviews address concerns by encompassing all stakeholders, anticipating future emergencies, and critically assessing mistakes. Those deemed “stakeholders” may vary from setting to setting but can include front-line workers, management, administrators, policymakers, and representatives from civil society. Sentinel event reviews are also “means for mobilizing and sharing the lessons of sentinel events in an ongoing conversation among practitioners, researchers, and policymakers.”⁵⁹

⁵³ *Sentinel Event Policy and Procedures*, JOINT COMM’N (June 29, 2017), https://www.jointcommission.org/sentinel_event_policy_and_procedures/ [https://perma.cc/7KQ9-KYEG].

⁵⁴ *Id.*

⁵⁵ *Comprehensive Accreditation Manual for Hospitals: Patient Safety Systems*, JOINT COMM’N (Jan. 2018), https://www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program/ [https://perma.cc/XW2C-G8TE].

⁵⁶ *Id.*

⁵⁷ *See id.*

⁵⁸ Doyle, *supra* note 48, at 3.

⁵⁹ *Id.*

For example, in the medical sector, one medical sentinel event review team discovered seventeen common errors that led to sentinel events. This included: a patient prematurely leaving the hospital after staff overlooked conflicting patient charts, a doctor operating on the wrong patient because staff had inadvertently draped the patient's face, and medication errors causing unexpected patient deaths because staff overlooked contra-indicatory stickers.⁶⁰

2. *Sentinel Event Review in Other Systems*

The United States military also uses sentinel event review to prevent harm and organizational error. Military “after-action reviews” are used to improve system performance and give leaders the opportunity to learn from their mistakes without repercussions.⁶¹ In an after-action review, the Army convenes “all the system actors to discuss their role and performance.”⁶² The Army recognizes that “most missions involve multiple organizations, often with diverse responsibilities and priorities.”⁶³ As such, the after-action review process does “not seek blame; it s[eeks] clarity and elevate[s] even small support players to coequal status in the discussion.”⁶⁴ Using after-action reviews, the Army learned that it was usually the “most undervalued part of the operation [that] was the primary cause of failure.”⁶⁵

B. *Sentinel Event Review in the Federal Justice System*

In recent years, policymakers have considered how the criminal justice system could benefit from adopting sentinel event review. In 2014, the United States Department of Justice Office of Justice Programs (OJP) and National Institute of Justice (NIJ) released their report, “Mending Justice,” on sentinel event review as a criminal justice tool.⁶⁶ James Doyle, a visiting fellow with the NIJ, discusses how the criminal justice system could learn from the medical sector by adopting the “sentinel event review system” to prevent error. Error, in the criminal justice system, can be a: “wrongful arrest, the wrongful release from prison of a dangerous offender who harms another victim, the conviction of an innocent person, [or] a wrongful police shooting”⁶⁷

In the criminal justice system, “[e]rrors often go undetected and, when they are detected, the detection frequently seems to be the result of extraordinary

⁶⁰ *Id.*

⁶¹ MENDING JUSTICE, *supra* note 43, at 2.

⁶² John Chisholm, *Moving Beyond a Culture of Defensiveness and Isolation*, in NAT'L INST. OF JUSTICE, MENDING JUSTICE: SENTINEL EVENT REVIEWS 20 (2014), <https://ncjrs.gov/pdffiles1/nij/247141.pdf> [<https://perma.cc/E4YY-C63C>].

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ MENDING JUSTICE, *supra* note 43, at 1.

⁶⁷ *Id.*

luck or perseverance after many years.”⁶⁸ Doyle argues that errors in the criminal justice system are a result of organizational error—a combination of cascade errors and not the result of a single actor.⁶⁹ Yet, most criminal justice systems fail to fully assess errors by using narrow system-review methods.

There are two types of error-review approaches: (1) “bad apples,” and (2) “Swiss-cheese models.”⁷⁰ The bad-apple approach blames a single person and the inquiry ends.⁷¹ For example, a law enforcement agency could identify a single officer who tampered with evidence that ultimately resulted in a wrongful conviction. The law enforcement agency could reprimand the officer and believe it had sufficiently addressed the issue. The bad-apple approach rectifies harm on a case-by-case basis. Whether a single officer is reprimanded or not does not affect the next wrongful conviction. By curtailing the review process and looking for a single wrongdoer, the bad-apple approach prevents meaningful institutional change.

On the other hand, jurisdictions that use a Swiss-cheese approach employ multiple task-forces and stakeholder groups across the state that work independently on a narrow aspect of a criminal justice initiative.⁷² Each organization works in a silo to review internal errors and implement changes within its specific organization.⁷³ With the Swiss-cheese approach, organizations miss an opportunity to learn from, and coordinate with, other similarly situated organizations.⁷⁴ The Swiss-cheese approach breaks off interdependent aspects of the criminal justice system and treats them as stand-alone components. Therefore, the Swiss-cheese approach prevents coordination and continuity across a jurisdiction.

The criminal justice system is not a structural “system.” It cannot be fixed by tightening gears or switching out parts.⁷⁵ Instead, it functions as an ecosystem, “like a pond or a swamp in which something (funding, for example) dumped on the near coast has mysterious and unanticipated effects on the far shore.”⁷⁶ As such, the “system” cannot be fixed solely with a structural ap-

⁶⁸ *Id.*

⁶⁹ Doyle, *supra* note 48, at 8.

⁷⁰ *Id.* at 5.

⁷¹ *Id.* at 5–6.

⁷² With “Swiss cheese” models, “error moves in a straight line from its origin to its tragic result unless it is blocked somewhere by one of a succession of barriers: a sequence of increasingly fine screens, each ‘inspecting’ the output of the preceding screen.” *Id.* at 6. For example, in the criminal justice system, “an erroneous ‘wrong man’ prosecution must pass through a police supervisory screen, a crime lab screen, a prosecutorial screen, a grand jury screen, an adversary trial screen and an appellate review screen, among others, before it can take effect.” *Id.*

⁷³ *See id.*

⁷⁴ *See id.*

⁷⁵ *Id.* at 7.

⁷⁶ *Id.* at 7.

proach; it requires a cultural approach.⁷⁷ While introducing the NIJ's report, former Attorney General Eric Holder stated that prosecutors "have an obligation to learn from the mistakes of the past and to work diligently to minimize the risk of future wrongful convictions" because avoiding errors was a "matter of professionalism, not social policy."⁷⁸ He went on to say:

If we truly hope to get to the bottom of errors and reduce the chances of repeating them, then it is time we explore a new, system wide, way of responding, not by pointing fingers, but by forthrightly assessing our processes, looking for weaknesses in our methods, and redesigning our approach so that the truth will be more attainable.⁷⁹

Sentinel event reviews provide the remedy that Attorney General Holder was looking for. Sentinel event reviews generally have four elements: (1) the review must be a system-wide response with the appropriate stakeholders at the table; (2) it must not assign blame where a system error led to the sentinel event; (3) it must utilize a root-cause analysis to identify the weaknesses in policy or procedure; and (4) it must be both proactive and reactive, giving stakeholders the opportunity to implement change as needed.⁸⁰

Non-blaming is an essential element of sentinel event review.⁸¹ If a system reviews negative events by ascribing blame, it "drive[s] many valuable reports of errors underground and leave[s] latent system weaknesses unaddressed."⁸² A blame-focused review system discourages reporting because no one wants to be blamed.⁸³ Likewise, a blame-focused review system reinforces agencies to address errors in-house, therefore curtailing meaningful cross-system change.⁸⁴

A blame-focused review is antithetical to system change. A sentinel event is the aggregate of multiple interacting errors, and when it occurs it signals an underlying weakness in the system—not the mistake of an individual.⁸⁵ For example, a wrongful conviction is "not the result of a single error," there are multiple people and processes that impact the result.⁸⁶ In cumulative error claims, often filed after a wrongful conviction, a court will find that a "petitioner's due process right to a fundamentally fair trial was violated because of the aggregate effect of multiple errors."⁸⁷ Sentinel events in the justice system shed light on

⁷⁷ *Id.*

⁷⁸ Cutino, *supra* note 31, at 1070.

⁷⁹ *Id.* at 1071.

⁸⁰ See generally MENDING JUSTICE, *supra* note 43.

⁸¹ MENDING JUSTICE, *supra* note 43, at 2.

⁸² Doyle, *supra* note 48, at 5.

⁸³ *Id.*

⁸⁴ *Id.* at 5–6.

⁸⁵ *Id.* at 4.

⁸⁶ *Id.*

⁸⁷ Ryan A. Semerad, *What's the Matter with Cumulative Error: Killing a Federal Claim in Order to Save It*, 76 OHIO ST. L.J. 965 (2015).

wide systemic issues that implicate the decisions, or errors, of legislators, policymakers, and judges.⁸⁸

Like sentinel events in the medical field, sentinel events in the criminal justice context are not single-cause events. Sentinel events in the criminal justice context include “wrongful arrest[s], [a] wrongful release from prison of a dangerous offender who later harms another victim, the conviction of an innocent person, [or] a wrongful police shooting.”⁸⁹ These errors go largely undetected, if at all, and when they are detected, it is usually after the victim invests years in investigating the error.⁹⁰

The goal is preventing organizational error, but the criminal justice system presently “lacks what . . . other high-risk enterprises have found essential” in preventing organizational error.⁹¹ The criminal justice system lacks “a non-blaming, all-stakeholder, *forward-leaning* mechanism” to take lessons learned from sentinel events and implement changes through a system wide mechanism that goes beyond merely “disciplining rulebreakers and render[ing] similar errors less *likely* in the future.”⁹² Current blame-centered review mechanisms tend to assign blame to a single officer who will often be fired, which incentivizes other officers not to report errors.⁹³ Adopting sentinel event review’s non-blaming culture would still hold individuals accountable. This is so because the agency takes ownership of its system failures that did not anticipate and prevent the individual’s action that caused the negative event in the first place.⁹⁴

1. *Current Initiatives: Back-end, Front-end, and Ongoing Review*

The goal of the sentinel event review “is not to mobilize a *performance* review aimed at an individual whenever some front-page catastrophe occurs, but to develop a regular practice of conducting an all-stakeholders, all-ranks, non-blaming, *event* review whenever a learning opportunity arises.”⁹⁵ That opportunity arises in tragedy, “near miss,” or “good catch” situations alike.⁹⁶ A back-end review system is insufficient because the back-end system responds only after the error has occurred. Similarly, front-end reviews of “near-misses” alone are insufficient because they also disregard the important information that

⁸⁸ Doyle, *supra* note 48, at 4–5.

⁸⁹ MENDING JUSTICE, *supra* note 43, at 1.

⁹⁰ *Id.* at 2.

⁹¹ *Id.* at 1.

⁹² *Id.* (emphasis added).

⁹³ *Id.*

⁹⁴ Janette Sheil et al., *Imagining Sentinel Event Reviews in the U.S. Probation and Pretrial Services System*, FED. PROB., Sept. 2016, at 34.

⁹⁵ *Id.*

⁹⁶ *Id.*

could result from an ongoing, multi-point system review.⁹⁷ If we have “paid the price” for one mistake, we should learn from it to prevent future harm.⁹⁸

Front-end reviews are an opportunity to anticipate future negative events and change course. Front-end reviews result in creating and adopting evidenced-based best practices, may call for new legislation, and improved data collection.⁹⁹ In corrections, agencies have adopted pre-trial risk assessments “to identify persons on supervision who are at greater likelihood of committing an offense specifically” to reduce the prison population.¹⁰⁰ However, “very little has been done to develop *systems and processes* that are keyed to reduce the risk of such an event” in the first place.¹⁰¹ Sentinel event review allows a clearer understanding of how to prevent such a risk.¹⁰²

2. *Testing Sentinel Event Reviews in Pilot Sites*

In 2014, after the NIJ released “Mending Justice,” they began testing the feasibility of sentinel event review in three “beta sites” comprised of Milwaukee, Philadelphia, and Baltimore.¹⁰³ The beta sites received no funding from NIJ and little logistical support.¹⁰⁴ The beta sites selected a past sentinel event and worked through the challenges of implementing sentinel event review in their jurisdictions. The beta testing aimed to answer questions, like whether sentinel event review is feasible in a criminal justice system, what types of events should qualify, who should be on the team and who should lead it, and how to achieve a non-blaming focused process, along with assessing benefits and challenges.¹⁰⁵ Some key takeaways from the beta testing include: (1) cases selected for review should be final, meaning there are no pending civil or criminal appeals that would adversely affect the review process;¹⁰⁶ (2) stakeholders on the review team should a mixture include “boots-on-the-ground” staff, leadership, and representatives from other systems, such as public or mental health officials that interface with the justice system;¹⁰⁷ (3) the facilitator may be an employee, government representative, or senior-staff member—what is important is that the facilitator is well-versed on sentinel event review methodolo-

⁹⁷ Cutino, *supra* note 32, at 1065.

⁹⁸ Sheil et al., *supra* note 93, at 33.

⁹⁹ Simon, *supra* note 33, at 28; *see also* NAT’L INST. OF JUSTICE, PAVING THE WAY: LESSONS LEARNED IN SENTINEL EVENT REVIEWS 13 (2015), <https://www.ncjrs.gov/pdffiles1/nij/249097.pdf> [<https://perma.cc/KD2N-8NPF>].

¹⁰⁰ Sheil et al., *supra* note 93, at 35.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ NAT’L INST. OF JUSTICE, *supra* note 99, at 2.

¹⁰⁴ *Id.*

¹⁰⁵ *Title: Paving the Way Lessons Learned in Sentinel Event Reviews*, NAT’L INST. JUST. (Nov. 1, 2017) <https://www.nij.gov/publications/pages/publication-detail.aspx?ncjnumber=249097> [<https://perma.cc/C8SS-Y8M2>].

¹⁰⁶ NAT’L INST. OF JUSTICE, *supra* note 99, at 4.

¹⁰⁷ *Id.* at 5.

gy, has rapport with the members and is intellectually curious;¹⁰⁸ (4) the team should adopt a non-blaming and continual self-improvement focus;¹⁰⁹ and (5) the team should have ground rules and defined inputs and outputs.¹¹⁰ The beta testing also brought uncovered a series of challenges, namely, cross-agency data-sharing and collection and buy-in.¹¹¹

The NIJ has since awarded grants to four jurisdictions to implement further research some of the challenges identified in the beta sites' sentinel event reviews and has compiled their findings in a Strategic Research and Implementation Plan to assist states that want to implement sentinel event review systems in their jurisdictions.¹¹² The entities awarded and the purpose for which the grants would be used include: (1) "Texas State University will use concept mapping and social network analysis to examine criminal investigative failures in wrongful convictions and unsolved cases"; (2) "Vera Institute of Justice will develop, implement and evaluate a Self-Harm Analysis and Review Protocol (SHARP) for responding to cases of serious self-harm in the New York City jail with the aim of designing a nationally replicable sentinel event review model"; (3) "Researchers from Michigan State University, . . . Indiana University and . . . the Milwaukee Homicide Review Commission [to conduct a] gun homicide and non-fatal shooting review . . . to study issues such as privacy, resources needed, and the role of the facilitator"; and "(4) Researchers at the University of Pennsylvania's Quattrone Center for the Administration of Fair Justice—in collaboration with the Philadelphia Police Department, District Attorney's Office, Defender Association, and Court of Common Pleas—are evaluating the effectiveness of multidisciplinary review teams and includes creation of a database of errors and near-misses . . . to help prioritize negative outcomes for sentinel event review."¹¹³

The NIJ's upcoming Sentinel Events Initiative Demonstration Project will test sentinel event review in twenty to twenty-five sites across the country.¹¹⁴ Through the Sentinel Events Initiative Demonstration Project, NIJ will provide technical assistance to guide states using sentinel event review with current cases and addressing perceived challenges such as dealing with media, liability, and confidentiality.¹¹⁵ NIJ is also exploring how states can use sentinel event

¹⁰⁸ *Id.* at 7.

¹⁰⁹ *Id.* at 10.

¹¹⁰ *Id.* at 9–11.

¹¹¹ *Id.* at 10–11.

¹¹² *NIJ's Sentinel Events Initiative*, NAT'L INST. JUST. (Nov. 1, 2017), <https://www.nij.gov/topics/justice-system/Pages/sentinel-events.aspx> [<https://perma.cc/G5V5-WWA3>]; see generally NAT'L INST. OF JUSTICE, *supra* note 17.

¹¹³ *Id.*

¹¹⁴ U.S. DEP'T OF JUSTICE, FY 2017 BJA SENTINEL EVENTS INITIATIVE DEMONSTRATION PROJECT: TECHNICAL ASSISTANCE PROVIDER 4–5 (2017), <https://www.bja.gov/Funding/SEI17.pdf> [<https://perma.cc/YCR5-4CKF>].

¹¹⁵ *Id.*; see also NAT'L INST. OF JUSTICE, *supra* note 99 at 9–12.

review to repair community rifts after police shootings, thereby expanding sentinel event review beyond courts and correctional facilities.¹¹⁶

3. *Sentinel Event Review and Litigation*

While sentinel event review is primarily a root-cause analysis method, governments may not wish to participate without immunity or without some mechanism to ensure that sentinel event review reports are undiscoverable in litigation. Whether the report is admissible will depend on a state's "peer-review privileges, open-meeting laws, attorney work-product privileges, and public-record laws."¹¹⁷ In the medical context, opponents of sentinel event review call it a "lawsuit kit for plaintiffs' attorneys."¹¹⁸ For example, a Pennsylvania trial court held that a sentinel event report regarding a psychiatric malpractice case, submitted by a hospital to the Joint Commission, was privileged and undiscoverable.¹¹⁹ The ruling came after the defendant-hospital asked the court to reconsider its order previously finding the report admissible.¹²⁰ Some states, including Pennsylvania, have enacted peer-review protection legislation for root-cause analysis reports that provide reviewers with limited immunity and makes reports not discoverable.¹²¹

III. NEVADA AND CRIMINAL JUSTICE REFORM

While Nevada is not a pilot site for NIJ's National Demonstration Project, the state would benefit from adopting sentinel event review in its existing criminal justice reform efforts. Specifically, Nevada could benefit from sentinel event review to decrease wrongful convictions and improve inmate safety.

With regard to wrongful convictions, in 2016, the Innocence Project reported prosecutorial misconduct in 47 percent of Clark County District Attorneys' capital punishment case in its 2016 report, *Too Broken to Fix: Part I, An In-depth Look at America's Outlier Death Penalty Counties*.¹²² In fact, Nevada judges have overturned thirteen wrongful convictions in the last twenty years,

¹¹⁶ *Empowering Local Communities to Advance Justice: NIJ and BJA Launch Sentinel Events Initiative National Demonstration Collaborations*, NAT'L INST. JUST. (Sept. 29, 2017), <https://www.nij.gov/topics/justice-system/Pages/sentinel-events-technical-assistance-provider.aspx> [<https://perma.cc/3E5W-PGEL>].

¹¹⁷ Doyle, *supra* note 48, at 13.

¹¹⁸ *Sentinel Event Policy Changed, but It's Still a 'Lawsuit Kit' for Attorneys*, ACH MEDIA (Apr. 1, 1998), <https://www.ahcmedia.com/articles/48089-sentinel-event-policy-changed-but-it-s-still-a-lawsuit-kit-for-attorneys> [<https://perma.cc/TW4L-DH3N>].

¹¹⁹ *Brink v. Mallik*, No. 2013-CV-1314, 2015 WL 1387936 (C.P. Pa. March 27, 2015).

¹²⁰ *Brink*, No. 2015 WL 1387936, at *2; see also Wendy R.S. O'Connor, *The Peer Review Protection Act ("PRPA"): Looking Back, Looking Ahead*, PA. B. ASS'N Q., Apr. 2016, at 7.

¹²¹ O'Connor, *supra* note 120, at 2.

¹²² *New Report: Death Penalty in Decline, but Where Legal, Injustice Pervades Capital Cases*, INNOCENCE PROJECT (Aug. 30, 2016), <http://www.innocenceproject.org/new-report-death-penalty-decline-legal-injustice-pervades-capital-cases/> [<https://perma.cc/USL2-N27V>].

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three of which occurred in 2017.¹²³ As discussed above, sentinel event reviews provide a systematic, root-cause-analysis methodology to identify what led to past wrongful convictions to prevent them from happening in the future.

Additionally, the state could benefit from sentinel event reviews to resolve issues with false confessions. In recent years, there has been an uptick in false confessions and national attention on resulting exonerations.¹²⁴ The following Nevada story illustrates this point and concerns the tragic death of a nursing student and a woman with mental illness.

In 1979, police in Shreveport, Louisiana contacted the Reno Police Department to inform them that Anita Porter, alias Cathy Woods, who suffered from schizophrenia and was an in-patient at a mental hospital, had confessed to murdering Michelle Mitchell.¹²⁵ Mitchell was a nineteen-year-old nursing student at the University of Nevada, Reno whose body police found three years earlier in a residential garage with her hands tied behind her back and throat slashed open.¹²⁶ Police officers questioned Woods, and in her admission, all that she told the officers about the murder was a recitation of what she had learned from the news.¹²⁷ Woods also informed the officers of her mental illness, adding that she worked for the Federal Bureau of Investigations and that her mother attempted to poison her.¹²⁸ Without questioning the veracity of the admission—given her mental illness—the officers deemed it to be a confession and they arrested Woods.¹²⁹

The prosecution relied almost exclusively on Woods's confession even though the defense had a witness, inmate Kathy Murnighan, who was willing to testify that her cellmate's boyfriend had killed Mitchell.¹³⁰ The court called the boyfriend as a witness outside the jury's presence where he denied the murder.¹³¹ Wood also refused to talk unless the court granted her immunity.¹³² Ul-

¹²³ *Exonerations by State, Nevada*, NAT'L REGISTRY EXONERATIONS, <https://www.law.umich.edu/special/exoneration/Pages/Exonerations-in-the-United-StatesMap.aspx> (select the Nevada image on the "Exonerations by State" map) [<https://perma.cc/2K9T-LXL4>] (last visited Apr. 23, 2018).

¹²⁴ See, e.g., Brandon L. Garrett, *Contaminated Confessions Revisited*, 101 VA. L. REV. 395 (2015).

¹²⁵ *Cathy Woods*, NAT'L REGISTRY EXONERATIONS, <http://www.law.umich.edu/special/exoneration/Pages/casedetail.aspx?caseid=4656> [<https://perma.cc/8R5X-ZGHC>] (last updated Aug. 23, 2016); see also *DNA Clears Nevada Woman Imprisoned 35 Years for Murder, Implicates Former Oregon Inmate*, OR. LIVE (Mar. 7, 2015, 5:48 PM), http://www.oregonlive.com/today/index.ssf/2015/03/dna_clears_nevada_woman_impris.html [<https://perma.cc/X2WU-PR8N>].

¹²⁶ See sources cited *supra* note 125.

¹²⁷ *Cathy Woods*, *supra* note 125.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

timately, the court declined to allow Murningham to testify because it believed she was not trustworthy.¹³³

Woods was convicted of first-degree murder in 1980 and the court imposed a life sentence.¹³⁴ Five years later, the Nevada Supreme Court reversed the conviction and found that the lower court should have allowed Murnighan to testify.¹³⁵ After a second trial that same year, Woods received a life sentence, again.¹³⁶

Three decades passed before Woods was exonerated. With the assistance of the Rocky Mountain Innocence Center, Woods was appointed an attorney who requested DNA testing of a cigarette butt found near Mitchell's body.¹³⁷ The DNA matched a male serial killer who was serving a life sentence in Oregon.¹³⁸ The court vacated Woods's conviction in 2014, and the state dismissed its charges against Woods the following year.¹³⁹ Woods had served thirty-five years in prison for a crime she did not commit and had falsely admitted to because of her mental illness.

If the Nevada criminal justice system used sentinel event review, Woods's wrongful convictions would have triggered a system-wide review where state officials, the judiciary, and other stakeholders could have assessed the missed red flags that resulted in her wrongful convictions. In Woods's case, she could have avoided a wrongful conviction not once, but twice. While the DNA science that would ultimately exonerate her was not available during Woods's trial, a review of the interrogation, confession, and lack of real evidence in her case presents a learning opportunity for Nevada prosecutors to implement safety precautions to prevent future wrongful convictions.

Similarly, by adopting sentinel event review, Nevada could improve inmate health and safety across the state. The Nevada Attorney General's office charged a correctional officer with involuntary manslaughter for shooting an inmate in 2014.¹⁴⁰ The inmate, twenty-eight-year-old Carlos Perez, was fighting with another inmate when corrections officers arrived.¹⁴¹ After both inmates were restrained, one of the officers fired at Perez with multiple live rounds of birdshot—he died with 60 pellets in his face and neck and 200 in his face and

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ See sources cited *supra* note 125.

¹³⁸ See sources cited *supra* note 125.

¹³⁹ *Cathy Woods*, *supra* note 125.

¹⁴⁰ Dana Liebelson, *Nevada Charges Ex-Prison Guard with Manslaughter for Shooting and Killing Handcuffed Inmate*, HUFFINGTON POST (Apr. 18, 2016, 3:29 PM), http://www.huffingtonpost.com/entry/nevada-charges-guard-manslaughter-shooting-death-handcuffedinmate_us_5715058be4b06f35cb701612 [https://perma.cc/779X-W4DF].

¹⁴¹ *Id.*

arms.¹⁴² Perez died just four months before his release date.¹⁴³

Nevada's inmate mortality rate is striking. A Nevada public radio study of detention facilities found that between 2001 and 2012, "80 percent of 379 prison deaths were due to medical problems."¹⁴⁴ On average, an inmate in Washoe County is five times more likely to die than anywhere else in the United States.¹⁴⁵ An eleven-month-long investigation of the Washoe County Jail by the Reno Gazette Journal revealed that the high mortality rate—a 600 percent increase from 2015 to 2017—occurred as result of officer-inmate altercations and inadequate mental health treatment for inmates who demonstrated suicidal ideation, were detoxing upon arriving, or were decompensated while detained.¹⁴⁶

Regardless, the government is obligated by the Eighth Amendment to care for inmate safety.¹⁴⁷ This includes protection from inmates, officers, and staff, as well as adequate medical and mental health services.¹⁴⁸ It necessarily follows, then, that the local government must respond and correct its jail conditions within constitutional parameters.

Other inmate safety concerns, such as inadequate medical care and unnatural inmate deaths, make clear that Perez's story is not unique. In 2008, the American Civil Liberties Union (ACLU) sued Nevada officials after reviewing thirty-five claims that the state was "failing to rectify a pervasive pattern of grossly inadequate medical care at the Ely State Prison that creates a substantial risk of serious medical harm."¹⁴⁹

As in the medical sector, sentinel event review of inmate deaths related to inadequate medical attention would identify the specific internal and external factors contributing to the inadequacy. A sentinel event review at the local jail

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Joe Schoenmann & Casey Morell, *Is Poor Medical Care Killing Nevada's Prison Inmates?*, NEV. PUB. RADIO (July 7, 2015), <https://knpr.org/knpr/2015-07/poor-medical-care-killing-nevadas-prison-inmates> [<https://perma.cc/38D2-7PX3>].

¹⁴⁵ Anjanette Damon, *Death Behind Bars: Washoe County Jail Inmates Are Dying from Suicide, Accidents and Homicide*, RENO GAZETTE J. (Apr. 5, 2017), <http://www.rgj.com/story/news/2017/04/05/washoe-county-jail-inmates-dying-suicide-accidents-and-homicide/98972810/> [<https://perma.cc/ZAW4-NJLV>].

¹⁴⁶ *Id.* Damon reports a trend of a crowd of officers who engaged in altercation with inmates resulting in the inmates' deaths.

¹⁴⁷ U.S. CONST. amend. VIII.

¹⁴⁸ See *Farmer v. Brennan*, 511 U.S. 825 (1994) (establishing "failure to protect" claims in deliberate indifference causes of action); *Hudson v. McMillian*, 503 U.S. 1 (1992) (establishing that inmates are protected from excessive force from correctional officers); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (finding rights to medical care); see also *Pa. Dep't Corrections v. Yeskey*, 524 U.S. 204 (1998) (requiring prisons to comply with the Americans with Disabilities Act).

¹⁴⁹ Press Release, Am. Civil Liberties Union, Prisoners at Risk of Pain, Injury and Premature Death (Mar. 6, 2008), <https://www.aclu.org/news/aclu-lawsuit-charges-grossly-inadequate-medical-care-state-prison-nevada> [<https://perma.cc/EM5B-VAVY>].

level may include a review of the jail's policies and procedures, contracts with vendors, staff training, budget, and staffing ratios to determine how the jail provides safety and mental health services. Additionally, a review team could collaborate with outside stakeholders to determine how intoxicated or mentally ill people arrive at the jail and whether there are detox centers or crisis stabilization centers where jails could stabilize individuals before transferring them to cells.

Sentinel event reviews of inmate deaths, unlike case-by-case reviews, reveal system-wide inefficiencies and call for system-wide solutions. The Reno Gazette Journal undertook a similar approach in reviewing the Washoe County Jail's mental health system after an inmate, who was actively detoxing, died of excited delirium—"a condition precipitated by drug use or mental illness in which an agitated person enters a 'fatal spiral' while over-exerting himself, often during a struggle against restraints."¹⁵⁰ The investigators uncovered "fundamental breakdowns in the delivery of health care at the jail, particularly with mental health service and suicide prevention."¹⁵¹ In that inmate's specific case, the corrections officers had a written policy on excited delirium, but officers either did not know or did not follow it.¹⁵² In response, the jail officials pointed to external sources: Northern Nevada's high suicide rate and lack of access to mental health services.¹⁵³ Officials went on to state that inmates arrive "a mess" and the jail is not equipped to handle such "critical incident[s]."¹⁵⁴ In that regard, the inmate suicide rate cannot be remedied by an internal jail policy alone. Rather, this system or statewide problem requires a statewide response.

A. Nevada's Current Efforts in Criminal Justice Reform

The Nevada judiciary has taken several steps to reform the criminal justice system. At the state level, the Nevada Supreme Court has taken the lead in criminal justice reform efforts. The Court created several commissions tasked with reviewing and improving different areas of the law, among them: the Access to Justice Commission, the Blue Ribbon for Kids Commission, the Commission to Study the Administration of Guardianships, the Indigent Defense Commission, the Judicial Council Judicial Selection Commission, the Juvenile Justice Reform Commission, the Records Commission, the Statewide Rules of Criminal Procedure Commission, and the Commission to Study on Evidence-Based Pretrial Release.¹⁵⁵

¹⁵⁰ Damon, *supra* note 145 (internal quotation marks omitted).

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Commissions and Committees Overview*, SUP. CT. NEV.: ADMIN. OFF. CTS., https://nvcourts.gov/AOC/Committees_and_Commissions/Overview/ [<https://perma.cc/9NW9-68JF>] (last visited Apr. 27, 2018).

At the local level, two issues have prompted courts to reform the criminal justice system. First, local jails are egregiously overcrowded. In the summer of 2016, Eighth Judicial District Chief Judge David Barker issued a “depopulation order” for Clark County Detention Center (CCDC) to release low-level offenders to alleviate the overcrowding.¹⁵⁶ CCDC had a bed shortage because the inmate population had increased by 20 percent from January to June of 2016.¹⁵⁷ At one point, there were over 4,455 inmates in Las Vegas’s two jails, which had only 3,706 beds between them.¹⁵⁸ The detention facilities had been previously ordered to depopulate, but the courts had failed to renew a previous order.¹⁵⁹ This demonstrated that absent a court order, the jails were not prioritizing bed space for the most dangerous offenders.¹⁶⁰ In fact, a 2015 report from CCDC showed that 73 percent of the inmate population consisted of pre-trial detainees.¹⁶¹ Studies show that jails do not need to detain every person awaiting trial because pre-trial detention contributes to a slew of adverse consequences.¹⁶² Clark County Commissioner Steve Sisolak described this cycle as a “ripple effect . . . [because] people unnecessarily incarcerated lose their jobs and homes.”¹⁶³ Accordingly, CCDC’s large pre-trial population was comprised of inmates jailed simply because they could not afford bail, and inmates waiting for the Division of Parole and Probation to interview them to compile a presentence investigation of the inmate for the judge—a process that takes an average of fifty days.¹⁶⁴

The second issue, which is related to overcrowding, is the lack of a timely process to assess a defendant’s risk of harm to the community. For example, in 2016, Las Vegas Justice of the Peace Melanie Tobiasson, denied a prosecutor’s motion to revoke or increase a defendant’s bail, because the defendant had already posted the minimum fifteen thousand dollars and the judge had no evidence that he posed to a risk to the community.¹⁶⁵ The defendant proceeded to

¹⁵⁶ Jackie Valley, *County Jail Population Soars, Triggering Depopulation Order*, L.V. SUN (June 22, 2016, 2:00 AM), <https://lasvegassun.com/news/2016/jun/22/county-jail-population-soars-triggering-depopulati/> [<https://perma.cc/5A42-B39R>].

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ CLARK CTY. DET. CTR. & L.V. METRO. DEP’T, CLARK COUNTY DETENTION CENTER 2015 ANNUAL REPORT 32 (2016), https://www.lvmpd.com/en-us/Documents/CCDC-Annual-Report-2015_FINAL.pdf [<https://perma.cc/JP9U-Q84M>].

¹⁶² CONFERENCE OF CHIEF JUSTICES, *supra* note 24; NOONAN ET AL., *supra* note 26, at 10; Martine Kaste, *The ‘Shock Of Confinement’: The Grim Reality of Suicide in Jail*, NEV. PUB. RADIO (July 27, 2015, 5:59 PM), <http://www.npr.org/2015/07/27/426742309/the-shock-of-confinement-the-grim-reality-of-suicide-in-jail> [<https://perma.cc/V47Y-B4AW>].

¹⁶³ Valley, *supra* note 156.

¹⁶⁴ *Id.*

¹⁶⁵ David Ferrara & Kimber Laux, *Judge Who Refused to Revoke Bail Says There Was ‘No Indication’ of Threat Before Day Care Slaying*, L.V. REV.-J. (May 9, 2016, 9:09 PM),

shoot his girlfriend, injure their child, and then shoot himself outside of a day-care center just two days later.¹⁶⁶ Judge Tobiasson later explained, in an interview, that “[t]here was no indication . . . at the time of th[e] preliminary hearing that he had threatened [his girlfriend], or that he had been a threat to her.”¹⁶⁷ Further, she might have ruled differently “if indications were made . . . that he had been a threat to her.”¹⁶⁸ Events like this call for the Nevada Supreme Court, the Clark County District Attorney’s Office, and other leaders to review Nevada’s criminal justice system and implement changes to avoid error, work efficiently and effectively, and promote public safety.

Nevada also has a variety of ad hoc committees through its state and local government offices. Two examples, the Domestic Violence Fatality Review Team (DVFRT)¹⁶⁹ and the Child Fatality Review Team, gather domestic violence advocates, prosecutors, defense counsel, and law enforcement officials after a domestic violence incident or child death occurs. The DVFRT reviews selected cases to “identify red flags that may have indicated escalating levels of violence and develop recommendations to improve systems designed to protect victims of domestic violence.”¹⁷⁰ The DVFRT exists at the state level, through the Office of the Nevada Attorney General, and at the local levels through Washoe and Clark counties.¹⁷¹ The DVFRTs were created by statute and its results are not admissible in civil actions.¹⁷² Examples of its findings include: ensuring that a language line or interpretation services are available for 911 operators and law enforcement responding to domestic violence emergency calls,¹⁷³ and proposing an amendment so that persons convicted of “a misdemeanor offense of battery constituting domestic violence are included in the list of persons prohibited from owning or possessing a firearm.”¹⁷⁴

<http://www.reviewjournal.com/crime/homicides/judge-who-refused-revoke-bail-says-there-was-no-indication-threat-day-care-slaying> [<https://perma.cc/C4VY-W9JT>].

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ The AG’s DVFRT was consolidated into a “supercommittee now known as the Nevada Committee on Domestic Violence” during the 79th Nevada Legislative Session through Senate Bill 25. *Nevada Committee on Domestic Violence-NCDV*, OFF. NEV. ATT’Y GEN., http://ag.nv.gov/Hot_Topics/Victims/Committee_on_Domestic_Violence_-_CDV/ [<https://perma.cc/7VS5-4RU3>] (last visited Apr. 27, 2018). This committee consolidated the statewide DVFRT with the Nevada Council for the Prevention of Domestic Violence, Committee on Domestic Violence–Batterer’s Intervention Program Certification, and Victim Information Notification Everyday Subcommittee. *See id.*

¹⁷⁰ TARA PHEBUS, STATE OF NEV. ATTORNEY GEN. OFFICE, DOMESTIC VIOLENCE FATALITY REVIEW IN NEVADA 3 (2014), http://ag.nv.gov/uploadedFiles/agnv.gov/Content/News/PR/PR_Docs/2014/2014-12-19_2014_DVFR_Annual_Report_-_Final.pdf [<https://perma.cc/387ZXC2Z>].

¹⁷¹ *Id.*

¹⁷² NEV. REV. STAT. § 217.475 (2015).

¹⁷³ PHEBUS, *supra* note 170, at 9.

¹⁷⁴ *Id.* at 10.

The Child Death Review Teams at the state and local levels are also statutorily created.¹⁷⁵ The teams are tasked with analyzing cases involving the death of any child under eighteen years of age across the state.¹⁷⁶ The Clark County Child Death Review Team last issued a report in 2012.¹⁷⁷ It reviews cases of natural deaths, such as Sudden Infant Death Syndrome; accidental deaths, such as drownings; suicides; and homicide deaths, such as weapon-involved, suffocation, and strangulation.¹⁷⁸ Some of its recommendations include creating or supporting baby-safe-sleeping educational campaigns and drowning awareness campaigns. Both the DVFRs and the Child Death Fatality Review teams demonstrate examples of sentinel event review.

1. *The Clark County District Attorney's Office Conviction Integrity Unit*

Examples of localized sentinel event review can be found at the Clark County District Attorney's Office, which has attempted to remediate wrongful convictions by creating the Clark County District Attorneys' Conviction Integrity Unit (CIU).¹⁷⁹ With this new unit, District Attorney Steve Wolfson planned to bring Nevada "in line with other major jurisdictions" throughout the country by taking an internal, proactive approach to identify and rectifying wrongful convictions.¹⁸⁰ The new unit is tasked with re-examining "convictions where new evidence suggesting actual innocence has surfaced, and to guard against future error by adopting and implementing prosecution best practices."¹⁸¹ District Attorney Wolfson added, "[i]t is essential to have a formal mechanism in place to allow cases to be reviewed when evidence of innocence surfaces."¹⁸²

In creating the CIU, Wolfson acknowledged that a wrongful conviction can result from organizational error and that reviewing convictions is an opportunity to learn from the past to prevent future harm. In this way, the Clark County District Attorney's Office, through the CIU, has adopted a root-cause analysis and non-blaming approach to identify errors within its system, then correct the errors by implementing changes in policy or procedure.¹⁸³ Because the Clark County District Attorney's office is already conducting sentinel event review

¹⁷⁵ NEV. REV. STAT. §§ 432B.403–432B.4095 (2015).

¹⁷⁶ NEV. REV. STAT. § 432B.403 (2015).

¹⁷⁷ *Summary of Findings from the 2012 Child Death Review Annual Report*, NEV. INST. FOR CHILDREN'S RES. & POL'Y, <http://nic.unlv.edu/files/2012%20CDR%20Summary.pdf> [https://perma.cc/7VQK-GRTE] (last visited Apr. 27, 2018).

¹⁷⁸ *Id.*

¹⁷⁹ Press Release, Clark Cty. Dist. Attorney, Creation of the District Attorney Conviction Integrity Unit Moving Forward (May 19, 2016), <http://www.clarkcountynv.gov/district-attorney/announcements/Pages/Creation-of-the-District-Attorney-Conviction-Integrity-Unit-Moving-Forward.aspx> [https://perma.cc/NC67-CYFT].

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ *Id.*

with the CIU, the office could expand its efforts and participate in statewide multi-stakeholder sentinel event review systems.

What remains unclear is whether the CIU program—as an internal, overt operation—prevents wrongful convictions independent from collaboration with the defense bar, law enforcement, the bench, and other stakeholders. Without a multidisciplinary, stakeholder-inclusive approach, the CIU program is akin to the Swiss-cheese model that may limit its effectiveness and ability to provide meaningful system-wide change.

2. *Advisory Commission on the Administration of Justice*

Other criminal justice reform efforts involve out-of-state organizations. The Nevada Supreme Court's Advisory Commission on the Administration of Justice (ACAJ) partnered with the Rocky Mountain Innocence Center (RMIC), an affiliate of the national Innocence Project, to work on a variety of statewide eyewitness identification reform efforts.¹⁸⁴ In RMIC's report to the ACAJ, the RMIC noted success in working with the Clark County and Washoe County District Attorneys' offices in implementing the RMIC's proposed best practices for eyewitness identification reforms.¹⁸⁵ These include:

- 1) blind or blinded administration of a lineup (e.g. the officer conducting the lineup is unaware of the suspect's identity or is prevented from seeing which lineup member is being viewed by the witness), [sic] 2) witness instructions that the perpetrator may or may not be present, [sic] 3) proper use of non-suspect fillers that do not make the suspect stand out, [sic] and 4) eliciting witness confidence statements at the time of the identification.¹⁸⁶

The RMIC, which reviewed Cathy Woods's case and three other Nevada wrongful convictions based on false confessions, urged the state of Nevada, through the ACAJ, to adopt legislation mandating electronic recording of confessions.¹⁸⁷ The RMIC's survey of public defender offices statewide revealed that law enforcement agencies in the state's most populous cities already had recording equipment available to them, but police officers had the discretion to use it or not.¹⁸⁸ With no consistent statewide policies, judges lack information

¹⁸⁴ THE ROCKY MOUNTAIN INNOCENCE CTR. INNOCENCE PROJECT, INNOCENCE PROTECTIONS PROPOSAL PRESENTED TO THE NEVADA STATE ADVISORY COMMISSION ON THE ADMINISTRATION OF JUSTICE (2016), <https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/4361> [<https://perma.cc/W7Q4-BGMJ>].

¹⁸⁵ *Id.* (also noting that approximately 80 percent of the Nevada population resides in either Clark or Washoe Counties).

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 3–4.

¹⁸⁸ *Id.* Other Nevada law enforcement agencies recording confessions in some form: Boulder City PD, Carlin PD, Douglas County Sheriff, Elko PD, Elko County Sheriff, Henderson Police Department, Lander County Sheriff, Las Vegas Metro Police Department, Nevada Department of Public Safety, North Las Vegas PD, Reno PD, Sparks, Washoe County Sheriff, Wells PD, Yerington PD. *See also Preventing Wrongful Convictions: Regulating Suspect & Informant Evidence*, NEV. LEGISLATURE, <https://www.leg.state.nv.us/App/InterimComm>

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to determine the voluntariness of a confession, whether the confession is reliable based on an underlying mental illness, or whether an officer should be protected from frivolous claims of coercion.¹⁸⁹

Aside from confession recordings, the RMIC recommended that the ACAJ and State of Nevada adopt the following policies:

- Statutorily requiring prosecution offices to maintain an internal system to track informants for impeachment purposes;
- Pre-trial reliability hearings;
- Pre-trial discovery for informant testimony; and
- Jury instructions for in-custody informant testimony.¹⁹⁰

In reviewing the state's wrongful convictions, the RMIC has identified sentinel events, reviewed organizational errors that led to the sentinel events, and made recommendations to the state to prevent future wrongful convictions. However, RMIC's work is distinguished from typical sentinel event reviews systems because RMIC is an outside organization tasked with a specific goal-oriented project. Outside organizations, like RMIC, leave the state after delivering their report and recommendations. However, given the nature of the post-conviction appeal process, the sentinel event does not occur until after the court determines the defendant is wrongfully convicted. Thus, sentinel event review for wrongful convictions likely would not result in retributive justice. Sentinel event review could, however, prevent future wrongful convictions by generating a checklist for each case that would flag risks for error to prevent wrongful convictions or identify cases with potential for wrongful convictions.

Additionally, sentinel event review calls for a permanent and ongoing organization that is "activated" when a sentinel event occurs. Sentinel event review's deliverable is an ongoing response and review; its implementations cannot be conditioned on a single grant-funded project. While organizations like RMIC provide much-needed assessment and support, for sentinel event review to succeed, it must be permanent and self-sustaining.

3. *Nevada Supreme Court's Committee to Study Evidence-Based Pretrial Release*

One of the Nevada Supreme Court's commissions, the Committee to Study Evidence-Based Pretrial Release, conducted an in-depth review of the state's pretrial release practices. The Court created this committee after securing a grant from the United States Department of Justice Office of Justice Programs and the National Institute of Corrections (NIC) to establish a pilot program to

ittee/REL/Document/4352 [https://perma.cc/77C7-9NX7] (last visited Apr. 27, 2018).

¹⁸⁹ *Preventing Wrongful Convictions: Regulating Suspect & Informant Evidence*, *supra* note 188.

¹⁹⁰ *Id.*; see also *Nevada: Eyewitness Identification Reform*, INNOCENCE PROJECT, <http://www.innocenceproject.org/policy/nevada/> [https://perma.cc/97N7-UEG8] (last visited Apr. 27, 2018).

create and implement an evidence-based statewide pre-trial risk assessment tool.¹⁹¹ NIC finished the tool in February of 2016 and tested it in four jurisdictions in Clark and Washoe Counties.¹⁹² The state has since implemented the tool statewide and the NIC continues to provide technical assistance to staff who will be using the instrument to score pre-trial defendants and court officials who will be using the results to make pre-trial release decisions.¹⁹³ While judges across the state are not required to use the pre-trial risk assessment tool, it is available to all Nevada judges and assists judges by providing information about a defendant's "pending cases . . . , age at first arrest, whether he has a history of violent arrests, prior failures to appear and substance abuse history."¹⁹⁴

Nevada Supreme Court Justice James W. Hardesty explained that the program had been more successful than anticipated in its trial phase and "sped up the entire process, allowing defendants to work with their lawyers and resolve cases more rapidly" in rural counties.¹⁹⁵ Justice Hardesty said the risk assessments provide the judge more information to use in deciding who should be released from jail, "not simply relying on cash bail or bonds that many defendants can't afford to pay."¹⁹⁶ Another feature of the tool is that it provides defendants with a courtesy reminder call the day before their scheduled hearing.¹⁹⁷ In one instance, a mother was on her way to have an emergency cesarean section birth and, but for the reminder call, would have had an arrest warrant waiting for her after she gave birth.¹⁹⁸

The Nevada Supreme Court's Committee to Study Evidence-Based Pretrial Release is an example of the coordinated action that could result from a statewide Sentinel event review team. A triggering event, like the man who shot and killed his girlfriend at the daycare, would trigger a sentinel event review.¹⁹⁹ In that case, Judge Tobiasson could have used a pre-trial risk assessment to inform her decision to determine whether to revoke the defendant's bail. Specifically, the defendant showed behavior typical of domestic violence offenders. For example, the defendant had forged his partner's signature on a

¹⁹¹ JAMES AUSTIN & ROBIN ALLEN, DEVELOPMENT OF THE NEVADA PRETRIAL RISK ASSESSMENT SYSTEM: FINAL REPORT 1 (2016) <http://www.ncsc.org/~media/Microsites/Files/PJCC/NV%20Pretrial%20report%202016.ashx> [<https://perma.cc/4NGB-4HFX>].

¹⁹² *Id.* at 2.

¹⁹³ *Id.* at 6; *see also* SUPREME COURT OF NEV., ANNUAL REPORT OF THE NEVADA JUDICIARY: FISCAL YEAR 2017, at 15 (2017), <https://www.nvbar.org/wp-content/uploads/AR2017.pdf> [<https://perma.cc/S8CT-DVZB>].

¹⁹⁴ Geoff Dornan, *Pre-Trial Release Program is More Successful than Expected*, NEV. APPEAL (Dec. 4, 2016), <http://www.nevadaappeal.com/news/government/pre-trial-release-program-is-more-successful-than-expected/> [<https://perma.cc/ULJ7-6Q2M>].

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ Ferrara & Laux, *supra* note 165.

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subpoena compelling her to testify against him.²⁰⁰ This behavior showed his unwillingness to cooperate with the court and comply with the temporary protection order ordering him to stay away from his partner.²⁰¹ The signs were there, but the criminal justice system lacked the protocol to bring those red flags to light.

4. *Statewide Juvenile Justice Improvement Initiative (SJIII)*

In 2016, the State of Nevada secured a grant from the United States Department of Justice Office of Juvenile Justice Delinquency and Prevention to undertake a comprehensive review of the state's juvenile justice system.²⁰² Nevada Governor Brian Sandoval, by executive order, created the Statewide Juvenile Justice Improvement Initiative Task Force (SJII), a committee led by First Lady Kathleen Sandoval and comprised of legislators, judges, state and local juvenile justice leaders, and other stakeholders.²⁰³ The SJII will work with the Council of State Governments Justice Center (CSG), a national non-profit bipartisan group, to review the state's juvenile justice system and assess the services available to youth who enter into both the juvenile justice and child welfare system.²⁰⁴ The SJII and CSG's priority will be to "conduct an extensive data analysis of Nevada's juvenile justice policies, practices, and resource allocation, from diversion through reentry" to determine whether the \$89 million the State spends on juvenile justice statewide is working effectively to ensure juveniles do not recidivate.²⁰⁵ This will be carried out by implementing data collection protocols.²⁰⁶

CSG acknowledged that Nevada has previously made significant efforts to reduce the census in youth-detention facilities, noting that the number of youths detained was at a ten-year low.²⁰⁷ In fact, between 2006 and 2014, juvenile arrests decreased by 47 percent and arrests for violent and weapons offenses de-

²⁰⁰ *See id.*

²⁰¹ *See id.*

²⁰² Sandra Chereb, *Task Force Begins Weighing Overhaul of Nevada's Juvenile Justice System*, L.V. REV.-J. (Nov. 29, 2016, 8:10 PM), <http://www.reviewjournal.com/crime/courts/task-force-begins-weighing-overhaul-nevada-s-juvenile-justice-system> [<https://perma.cc/G5RD-ZLKM>].

²⁰³ *The Statewide Juvenile Justice Improvement Initiative: Improving Outcomes for Youth under the Supervision of Nevada's Juvenile Justice System*, COUNCIL ST. GOV'TS JUST. CTR. (July 2016), <https://csgjusticecenter.org/wp-content/uploads/2016/07/Statewide-Juvenile-Justice-Improvement-Initiative.pdf> [<https://perma.cc/6HGB-T73G>] [hereinafter *Statewide Juvenile Justice*].

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Gov. Sandoval Launches Review of Nevada's Juvenile Justice System*, COUNCIL ST. GOV'TS JUST. CTR. (July 12, 2016), <https://csgjusticecenter.org/youth/posts/launch-of-comprehensive-review-of-juvenile-justice-system/> [<https://perma.cc/GSF8-6RLD>].

²⁰⁷ *Id.*

creased 70 percent.²⁰⁸ Commitments to the Division of Child and Family Services for delinquent offenses also decreased by 54 percent over that same period.²⁰⁹ The group will present a report of its recommendations to the Nevada legislature in 2017.²¹⁰

The CSG's approach will consist of: (1) analyzing quantitative data, (2) reviewing policy and practice procedures, and (3) presenting system-improvements recommendations and adopting new policies.²¹¹ In order to get a "comprehensive picture of statewide juvenile justice trends," the task force will gather data from multiple juvenile justice jurisdictions and service providers, including, "referral, intake, diversion, detention, disposition, county probation, youth camps, DCFS commitments, Youth Parole Bureau (YPB) releases, as well as programs, services, recidivism, and other outcome data."²¹² The task force will then facilitate focus groups and meetings with "key constituents across the state to garner their perspective and recommendations on system challenges and strategies for improvement."²¹³ The interviewees will include front-line staff, prosecutors, defense attorneys, judges, probation and parole officers, and representatives from child welfare.²¹⁴ The taskforce will also review current policies and procedures to determine if they align with evidence-based practices and desired outcomes.²¹⁵ The results of the interviews and policy review will inform recommendations that the taskforce will present to state leaders.²¹⁶ Finally, the CSG will assist Nevada in enacting these changes through legislation or policy reforms.²¹⁷

The SJII's partnership with CSG and OJJDP mirrors the objective of sentinel event review systems. Together, these entities share a predetermined triggering sentinel event: juvenile recidivism. The SJII also has a collaborative interdisciplinary team of stakeholders coming together to review the sentinel event, policies and procedures that influenced whether the event occurred, and, finally, a reactive and preventive modality to enact change to remediate the harm.

However, the SJII differs from sentinel event review systems in one aspect: the lack of an ongoing review process. The SJII, like other state initiatives, is grant-focused. The group will write a report, present it to legislators, and hope to pass a bill. Once the grant money is gone, the review ends. The difference between review initiatives and the sentinel event review system is that stake-

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Statewide Juvenile Justice*, *supra* note 203.

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

holders permanently adopt sentinel event review so that the reviews occur on an ongoing basis. Under sentinel event review, a triggering event would occur every time a child recidivates. Then, a team would come together to identify gaps in services that could have prevented the child from entering the juvenile system again. With the sentinel event review system in place, the SJJII, and the state as a whole could meet its goal of having an “outcome driven, and . . . individual child” driven juvenile justice system.²¹⁸

IV. RECOMMENDATIONS

The criminal justice system reform efforts mentioned above show that Nevada currently uses a “Swiss-cheese” approach in addressing its criminal justice system issues.²¹⁹ Nevada’s blue-ribbon panels, ad-hoc committees, and review teams do not provide an opportunity for intersectional review of sentinel events. These committees have a short-term focus, leaving unaddressed gaps in its review systems and opportunities for negative events to persist. Swiss-cheese models hurt the criminal justice system because they have “tunnel vision” and blame single entities for widespread failure.²²⁰ In-house and blue-ribbon commissions fail to question whether the system is reliable because there is no transparency in data or defendant access to the review commissions.²²¹ The commissions do not communicate, track or share data, or coordinate policy implementation. Therefore, they are unlikely to result in long-term and meaningful change.

A. *Who Should Be on a Sentinel Event Review Team in Nevada*

It is important that states, like Nevada, implement sentinel event review at the state level. The Governor could use an executive order, like the SJJII, to create a comprehensive, state-wide sentinel event review team. State-level coordination will foster collaboration with stakeholders. In turn, stakeholders will be able to adopt evidence-based practices, collect uniform data, and communicate to provide uniformity across the state.

Nevada would also have to find a home for the sentinel event review. Nevada could implement a sentinel event review team through one of the Supreme Court’s initiatives, the Governor’s office, or a standing legislative task force committee. Another option is for the Nevada Attorney General’s office to house the sentinel event review team. The Attorney General’s office is a good

²¹⁸ Amanda Ketchledge, *Nevada Task Force Analyzes How to Improve Juvenile Justice System*, COUNCIL ST. GOV’TS JUST. CTR. (Oct. 19, 2016), <http://csgjusticecenter.org/youth/media-clips/nevada-task-force-analyzes-how-to-improve-juvenile-justice-system/> [https://perma.cc/65L4-D7RR] (quoting Kathleen Sandoval, the co-chair of the SJJII Task Force and First Lady of the State of Nevada).

²¹⁹ Doyle, *supra* note 48, at 5.

²²⁰ *Id.* at 4.

²²¹ *Id.* at 6.

option as it is a statewide agency that represents many of the stakeholders: the prisons, the health and human services department, and the state parole and probation office.

The sentinel event review team should include prosecutors, judges, defense counsel, advocates, members from civil society, former inmate representatives, academics, mental health professionals, lawmakers, and other social services entities. Importantly, this multi-disciplinary team would not replace the adversarial system. Rather, it would allow prosecutors and defense attorneys to zealously advocate for policies that will make the criminal justice system stronger and avoid future harm, thus progressing towards fundamental notions of impartiality, representativeness, and trust in the justice system.

B. Potential Obstacles in Implementing Sentinel Event Review

Implementing a sentinel event review team will take time and resources—a common obstacle for states already fighting for funding from limited resources, as is the case in Nevada. Other potential barriers include communication and privacy issues between the different organizations present at the table. Confidentiality is a major concern for hospitals, for example, because “[e]ven just the worry of litigation is enough to keep providers from engaging fully in the incident reporting process.”²²² Confidentiality is key to meaningful review; without it, “reports will lack any useful mental impressions or thorough analysis” and the review will be a missed “opportunity to learn any lasting, meaningful lesson about the error—why it happened, and how another can be prevented” at a different facility.²²³ These concerns can be alleviated with a memorandum of understanding and confidentiality agreement between the stakeholders on the team.

Another potential barrier is time. The initial sentinel event review team must spend a considerable amount of time defining what events will be “sentinel,” if they will include adverse or near-miss events, and how the team will respond to events and investigate and implement change. The sentinel event review team will also have to spend a considerable amount of time talking about data collection and reporting.

A final potential obstacle is stakeholder buy-in and adopting a culture of non-blaming. Unlike sentinel events in the medical sector, mass incarceration cannot be traced to a single decision point. Instead, mass incarceration and jail overcrowding have been the result of years of individual sentencing and bail revocation hearings. Likewise, adopting a non-blaming culture is especially important for judges because, even though judges may have contributed to wrongful convictions, they will need to approve the sentinel event reviews going forward.

²²² Katherine Mikk, *Making the Plaintiff's Bar Earn Its Keep: Rethinking the Hospital Incident Report*, 53 N.Y. L. SCH. L. REV. 133, 156 (2009).

²²³ *Id.* at 157.

CONCLUSION

Nevada would benefit from implementing a statewide sentinel event review system to improve its criminal justice system. Sentinel event reviews help prevent wrongful convictions, jail overcrowding, re-reentry work, reduce pre-trial detention, and ensure inmate safety by having a statewide taskforce identify, investigate, and implement systemic policy changes to prevent sentinel events. Sentinel event reviews provide an opportunity to make an impactful change at the beginning, throughout, and at the end of the criminal justice pipeline. Nevada is already addressing multiple issues with its current criminal justice system through the Nevada Supreme Court and gubernatorial taskforces.²²⁴ However, Nevada would benefit by adopting a permanent methodology to provide ongoing review as opposed to short-term or report-oriented initiatives that attempt to resolve an issue at a fixed point in time.

“How we treat those who have made mistakes speaks to . . . our dedication to fairness, equality, and justice.”²²⁵ Sentinel event review systems recognize that humans, law enforcement, judges, attorneys, correctional officers, and criminals all make mistakes. However, these mistakes rely on a system’s status quo, and that system should not be immune from review. Adopting a sentinel event review system would hold justice professionals and the justice system accountable. Just as the medical sector no longer waits until a doctor operates on the wrong person before implementing a safe identification process, neither should the criminal justice system wait until more inmates commit suicide to provide adequate mental health services for the remaining population. Too many inmates have committed suicide, too many judges have wrongfully convicted the innocent and now that these events have gotten our attention, it is our duty, as professionals,²²⁶ to ensure to that we have a just, efficient, and effective criminal justice system. The way to achieve that is by adopting sentinel event review.

²²⁴ See *supra* Part III.

²²⁵ Obama, *supra* note 37, at 865–66.

²²⁶ See Cutino, *supra* note 32, at 1070.

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