Root Cause Analysis to Improve Jail Safety: Getting Past Blame

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What's Here?

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Introduction

This toolkit is intended to introduce, or re-introduce, the concept of root cause analysis (RCA) to help jail leaders assess both current risk management and prevention strategies. Whether faced with examining a critical incident, or being proactive in addressing emerging issues, RCA is a viable instrument. Waiting for a "spectacular" incident before examining operations is an irresponsible way of doing business. The consequences of error may be perceived as minor. For example, an inmate in court misses her medication; to tragedy, if that missed medication was a pattern that contributed to a negative medical outcome. Failure to collect, analyze and act on data itself creates or magnifies harm and safety risks.

> "[B]lame and fault have never answered the big questions, such as 'How did this [error] happen in the first place?'"
>
> (Ritter, Testing a Concept and Beyond: Can the Criminal Justice System Adopt a Nonblaming Practice?, 2015)

> "Criminal justice practitioners . . . rank and file have been taught throughout their careers that silence on the matter [of errors] is usually the safest policy."
>
> (Doyle, Learning from Error in American Criminal Justice, 2010)

"Is it possible that the current era, defined by episodic patches motivated by high-profile tragedies, will be replaced by a new period, dedicated to the sustained *practice* of learning from error?" (Doyle, Leaning from Error in American Criminal Justice, 2010). Although this sentence was written about reform associated with wrongful convictions, the sentiment applies as well to the uneven way in which jails seek to truly understand incidents and effectively implement reforms. Doyle asks when criminal justice practitioners will ". . . mobilize the experiences of medicine and aviation in blazing their own trails toward a culture of safety to illuminate what may develop from the criminal justice system's efforts to learn from error." (Doyle, Learning from Error in American Criminal Justice, 2010) Jail managers will be better served to lead from a proactive position before incidents occur rather than waiting for a crisis to lead them. "The contemporary criminal justice system lacks a routine for identifying and analyzing its unspectacular errors and a template for reporting their lessons." (Doyle, Learning from Error in American Criminal Justice, 2010)

This toolkit is intended to help jail leaders create and instill methods for assessment of current processes before, during and after incidents.

With a numbing sense of déjà vu, some jails seem to run on adrenalin; staggering from one crisis to another. Often jails don't see the early warnings of policy failure, or lapses in supervision or training – until it is too late. Prevention initiatives, review of events to discern patterns and trends and address the fixes are perceived as extravagances and/or not supportable by current politics, resources, or the internal culture. While an internal affairs investigation may be done to identify, or "blame" who was responsible for an incident, prevention and sustainable change are often not a priority. Yet, does this philosophy of jail operations keep staff and inmates safe, and/or inspire the confidence of the employees, the community and funders?

What is Root Cause Analysis (RCA)?

The objectives of RCA are to create and sustain a "culture of safety" separating symptoms from core deficiencies – including that the organization:

"(1) is informed about current knowledge of its field;

(2) promotes the reporting of errors and near misses;

(3) creates an atmosphere of trust in which people are encouraged to report safety-related information;

(4) remains flexible in adapting to changing demands (by, for example, shifting from steeply hierarchical modes into "flatter" team-oriented professional structures); and

(5) is willing and able to learn about and adjust the functioning of its safety system." (Reason, 1997)

The ultimate objectives of RCA are problem-solving, reduction of risk and prevention of future occurrences of adverse events through implementing measurable and time-driven action-plans.

RCA is a transparent, collaborative process, occurring after a sentinel event, or utilized to address an emerging operational challenge, to:

- identify the policy/procedure disconnect or the emerging challenge;
- gather data;
- thoroughly analyze the event (sometimes labeled as determining the "5 Ws – who what when, where, why);
- determine causation;
- articulate recommendations; and
- develop and implement a corrective action plan.

Principles of Root Cause Analysis (RCA)

- Focusing on corrective measures of root causes is more effective than simply treating the symptom of a problem or event.
- RCA is performed most effectively when accomplished through a systematic process with conclusions backed up by evidence.
- There is usually more than one root cause for a problem or event.
- The focus of investigation and analysis through problem identification is WHY the event occurred, not who made the error.

(Washington State, n.d.)

RCA is a tool for jails in at least two areas. First, RCA can be used to dissect an incident or event happening in the jail. "A sentinel event is a significant, unexpected negative outcome that signals possible underlying weaknesses in a system or process; is likely the result of compound errors; and may provide keys to preventing future adverse events or outcomes." (U. S. Department of Justice, National Institute of Justice). Sentinel events should serve as early warnings of pending adverse events.

Secondly, administrators can use RCA to look at emerging issues, or perceived barriers to jail operations **before** a crisis or event. For example - RCA can examine the causes for employee attrition, physical plant deficiencies, or trends in incidents among inmates. This is true risk avoidance – for the more issues that can

be identified before an event, the more likely negative outcomes can be circumvented. The process also helps identify what the jail missed as warning signs before the incident happened.

Most jails have a process by which a serious incident is reviewed. The question is whether that process results in identifying the ROOT cause(s) and whether the jail takes meaningful and significant action to prevent another occurrence. Whether the process is called a critical incident review, sentinel event review, after-action report/critique, operational audit, fact finding – the desired outcome should be the same – prevention. A secondary and separate issue is employee-related actions, and assignment of "blame" or employee responsibility.

Jail staff may have heard terms employed by the facility's health care provider that speak to self-critical review. These terms, defined herein include: continuous quality improvement (CQI); morbidity and mortality review (M & M); quality assessment (QA); and quality improvement (QI). Such terms and practices are integral components of an organization seeking self-improvement and reduction of harm.

An RCA is NOT intended to be an internal affairs investigation. The RCA looks at process, policies, procedures, training, supervision, etc., while an internal affairs investigation is often seeking to focus on employee behaviors. These are not mutually exclusive processes. The agency's policy must define the role of each and how, and if, the processes coalesce.

What Events Trigger a Root Cause Analysis?

A jail's policy will define when RCAs are conducted. An RCA looks at more than just the cause of an event. It must examine systems issues and highlight prevention actions. For example, an internal review of an escape from custody might find that a lock was defective, but a deeper look at the incident may reveal lapses in security checks, delays in repairs, budget issues, training issues, and/or supervisory issues. In this example, just fixing the lock might not prevent a recurrence of the event. Focusing on breakdowns in systems or operations is what addresses prevention,

Events requiring activation of a RCA should also be included in the jail's policy. Triggering events may include:

- In-custody death or serious self-harm
- Escapes
- Inmate disorders
- Inmate back-ups in booking, and related operational challenges
- Housing shortages for special populations

RCAs can also be used to drill down into emerging issues before these become incidents. For example, when there are documented recoveries of dangerous contraband – such as opioids - examining the issues before there is harm to an inmate or staff will be beneficial. Other emerging challenges which might trigger an RCA include, but are certainly not limited to:

- Uses of force involving inmates on the mental health caseload
- Introduction of contraband

- Compromised security systems
- Mandatory overtime
- Employee recruitment or retention
- Physical plant issues
- Staff sexual misconduct
- The impact of the community's opioid crisis on the jail

Developing a simple tracking mechanism, with monthly or quarterly reviews of these types of occurrences will likely highlight where attention is needed. It is the jail's decision as to what will trigger a RCA.

How is a Root Cause Analysis Different from an Internal Investigation?

Generally, traditional internal investigations focus on finding the persons or conditions responsible for an event. Investigating suspicious activities and acting upon alleged violations of policies by inmates or staff is the primary objective. Internal investigations are typically reactive; and while RCAs can also be reactive, the RCA goal is to achieve pro-active benefits. While internal investigations may include recommendations aimed at prevention, such as remedial/corrective training where misconduct is found, these investigations often do not drill down into whether there are larger systems issues. RCAs are intended to examine many of the same issues regarding how the incident happened, but the RCA is not intended to assign blame. The end goal of the RCA is to prevent future incidents.

Both internal investigations and RCAs have a defined role in the organization. As policies are developed, care needs to be taken in assuring that the timing of RCAs does not compromise internal investigations that might result in negative personnel actions and/or criminal prosecution. Deliberately conducting parallel reviews – internal reviews and RCAs, within predetermined policy guidelines, is an option for the jail.

Viewing samples of RCAs highlighted in the Bibliography and Resource section of this toolkit will help further define the roles of both activities.

Why Conduct Root Cause Analysis?

Introducing or updating a self-critical review process such as RCA may require education and gaining buy-in from employees, stakeholders, funders and the community. Here are some positive outcomes that can emerge from an agency's commitment to RCA.

- Establishes commitment to excellence through objective reviews of serious incidents, examination of emerging issues, and development and implementation of change strategies. As publicly funded agencies, jails have an obligation to be accountable to the community. RCA provides the vehicle to do this. Jails can't have it both ways – lamenting the community's tepid support of the jail and lack of resources, while at the same time failing to be forthcoming and transparent when a serious incident happens. (McCampbell, Organizational Accountability: The Real Breakfast of Champions, 2016)

- Establishes a culture of ". . . non-blaming, forward-thinking, all-stakeholder approach to improving criminal justice

outcomes." (Doyle, NIJ's Sentinel Events Initiative: Looking Back to Look Forward, 2014) The "blame game" is one obstacle to creating an environment for meaningful self-critical analysis, prevention and problem solving. Those operating jails work in ". . . an inherently political context" with potential negative outcomes of public scrutiny and criticism. (Ritter, Testing a Concept and Beyond: Can the Criminal Justice System Adopt a Nonblaming Practice?, 2015) Transparent review of sentinel events goes a long way in maintaining credibility with the public and in the political realm. Preventing them certainly reduces scrutiny.

- Role modeling leadership expectations. Jails leaders leave a legacy – whether positive or negative, sought or unearned. That legacy is even more apparent in emergencies and critical incidents. Employees, inmates, and the community observe how the leader manages in very difficult times. This then sets and/or redefines the future of the organization.

- Identifies system failures. (U. S. Department of Homeland Security, U. S. Fire Administration; National Fire Data Center, Federal Emergency Management Center, 2008) The goal of conducting a RCA is to find systems failures. "Systems" or processes are what jails put in place to achieve the mission. Often, we create redundant systems so that if one fails, the back-up system will flag and address the matter. Sometimes these processes are people focused; sometimes hardware focused; but quite often are a combination of both. There is frequently more than one cause of an incident, hence a failed system. Systems may fail because staff are untrained, processes not written down, supervisors are ineffective, or people just don't do their job. The RCA is to learn more about the underlying issues.

- Examining from a global perspective. Borrowing from the National Transportation Safety Board's "Go Team" investigations – aviation accidents are examined from a wide view – the history of the flight and crew immediately prior to the crash, the airframe's integrity, the craft's power plant; the aircraft's hydraulic, electrical, pneumatics and associated systems, communication from air traffic control, weather, human performance and survival factors. Just knowing that the weather was bad is insufficient to assess the accident and focus on prevention. (National Transportation Safety Board, n.d.)

- Provides a framework for review, assuring that data and steps in the process are not missed. (Washington State Department of Enterprise Services, n.d.) A jail's commitment to conducting transparent reviews of incidents requires a framework. This framework protects the process from those who may not be happy with the potential results, and provides credibility.

- Evaluates the effectiveness of policies, procedures, protocols, supervisory practices, training, and leadership. Even if a jail periodically and systemically assesses operations, and updates policies and procedures, an adverse outcome will most likely result in a more detailed review. The process of evaluating foundational provisions using a structured framework will improve the organization. Addressing the "blaming" culture noted above, the focus is on processes NOT people.

- Documents trends and patterns in operational errors. While seeing the same errors repeated too often might be the result of focusing on symptoms rather than the cause, stepping back to identify and examine patterns will help define solutions. Jails' decision-making should be data-driven. If solutions have been previously attempted, why did those not work? What are the barriers to a permanent solution? How effective is the risk management system when considering the adverse event?

- Serves as a platform for change. The first step in the change process, according to James P. Kotter, is establishing a sense of urgency. (Kotter, 1996) It is concerning that, in some organizations, change only happens after an adverse incident is aired on the six o'clock news and on social media.

- Separates symptoms from the disease. As action oriented organizations, jails are quick to react to negative outcomes, but often do not spend time figuring out the underlying issues that caused an incident. Leaders are often left wondering why the "fix" didn't work. The RCA process focuses on unpeeling the event to its core.

- Other positive outcomes:
  - Tracks issues considering adequate funding, assists with budgetary prioritization. (Zarnescu, 2017) The competition for funding in any community is intense. Local political leaders must choose between competing and compelling priorities. Delaying preventive maintenance of a jail's security systems, which may have been a contributing factor to an escape, could be an opportunity for "told you so" from the jail's leaders. More productively, it provides the framework for surfacing and addressing the entire physical plant status. The RCA process is part of that foundational work. (McCampbell, Core Competency: Comprehend, Obtain and Manage Fiscal Resources, 2016) (McCampbell, The Physical Plan and Infrastructure: The Jail Leader's Responsibilities, 2016)
  - Identifies emerging community trends and issues. The public does not view jails as part of the community's law enforcement/ public safety. Jails must be active in identifying and tracking community changes. The most

profound examples are the evolution of jails into the community's de facto mental health hospital, and the impact of the opioid crisis. RCAs provide the opportunity to engage in community research, identifying stakeholders, and community – wide problem solving. Without the community's knowledge and support, jails will struggle to solve the issue of incarceration of the mentally ill.

- Identifies positive outcomes. Jail staff feel underappreciated in the best of times. In crisis, when the community is scrutinizing the facility, accurately identifying what went well and who contributed are helpful to boost staff morale and public opinion.

Elements of a Root Cause Analysis

The jail's written directives and policies define what events TRIGGER an RCA and the necessary components. Among the first steps are: assembling a team, gathering information, brainstorming contributing factors, identifying root causes, writing and implementing a corrective action plan, and assuring the plan is effective. (California Correctional Health Care Services, April 2013)

Not meant to be an exhaustive list – here are elements of the RCA PROCESS. Each jail must evaluate the elements and incorporate them into their own internal strategies. Above all the process must be systematic and not be derailed by politics, relationships, or predetermined conclusions.

The goals of RCA are to determine:

- What happened
- How it happened
- Why it happened
- How can it be prevented and/or improved (corrective actions)?
- What warning signs were missed?

To conduct a credible root cause analysis – here are additional elements to consider:

- Develop the preliminary plan – who is to do the work, who is to assist, what is a reasonable time frame; revise the plan as needed. Be sure to keep records of meetings, attendees, and assignments. Assure documents are securely and confidentially maintained.
- Determine what happened (if there is an immediate, urgent need for action – don't wait to report).
- Establish the facts; gather the data, evidence, information, interviews, video, examine existing audits, inspections, etc., act promptly so that information does not get misplaced or disappear.
- Identify issues, conditions, and events that contributed – perhaps using techniques such as charting or mapping; drill down to assure that actual causes, not just the symptoms are identified.
- Assure contributing factors are identified.
- Compare findings to relevant policies, including training lesson plans.
- Identify the root causes, keep asking "why"; are the issues human factors, communications, training, staffing, scheduling, environment, equipment, rules, policies, procedures?

- Avoid hindsight bias. You only know what you know as an incident unfolds.
- Start with the problem not the solution. Assumptions and "fixing" can hamper through analysis of causes.
- Develop specific recommendations; brainstorm; discuss recommendations with those involved.
- Write the report; align cause and effect, be specific and factual, focus on incident.
- Develop corrective action plan(s) and/or after action report (based on jail's policy).
- Discuss individual staff accountability (leave employee discipline and commendations to others).

A challenging reality in conducting RCA are the influences, positive or negative, of forces outside the jail. For example: During the root cause review of an escape, corroded locking mechanisms are identified. The drill-down must include asking tough questions. Is the root cause due to: the absence of a jail inspections/audits; failure of supervisors to identify and/or report the problem; the jail's failure to revise operations to address the security issue; the jail's failure to appropriate available funds to fix the locks; the jail's failure to ask for funding for an identified security issue; or the funding authority's failure to appropriate funds to fix the problem? This simplistic example of drill-down does not seek to "blame" the persons who may be involved; rather it looks at the cause with an eye toward prevention.

A more likely scenario for a jail will required collaboration with the medical and/or mental health care providers, or medical examiner, for events such as self-harm, suicides and other negative medical outcomes. Knowing this is inevitable presents an opportunity for discussions and expectations **prior** to an incident, adding language to the jail's written directive and/or the provider's policies.

Five Rules of Causation

Rule 1: Clearly show the cause and effect relationship
Rule 2: Use specific and accurate descriptors for what occurred, rather than negative & vague words.
Rule 3: Identify the preceding cause(s), not human error.
Rule 4: Violations of procedures are not root causes; they must have a preceding cause.
Rule 5: Failure to act is only causal when there is a pre-existing duty to act.
(California Correctional Health Care Services)

Corrective Action Plans

Findings and recommendations flowing from an RCA are positive only if incorporated into a realistic and timely corrective action plan. There are many formats of corrective action plans. The essential ingredients are:

- Specific actions will occur in clear, objective, measurable statements.
- Identify who will carry out these actions; include others who need to be involved.
- Establish timelines or deadlines for completion of action items.
- Identify resources needed to carry out change(s)
- Explain how the process be transparent and define how it will be communicated to staff and outside entities

- Periodic monitoring reports to leadership and management with updates to the plan as necessary.
- Evaluate/determine whether the plan resulted in the desired outcome, why or why not.

SMART MODEL
In defining actions, consider:
S – Specific – Is the wording precise and unambiguous?
M – Measurable – How will achievements be measured?
A – Action-oriented -Is an action verb used to describe expected accomplishments?
R – Realistic – Is the outcome achievable with given available resources?
T – Time-sensitive – What is the time frame?
(FEMA, 2010)

There is no ideal way to conduct an RCA and there is not one preferred format for a corrective action plan. If a jail wholeheartedly and sincerely adopts this approach, there must be discussion, debate and collaboration to arrive at their unique strategy. Wholesale adoption of another agency's policies will likely not fit the facility's specific needs or organizational structure. As part of this process, the internal culture must be identified and addressed as contributors or detractors of success.

Finally, this is an EVOLVING process. It is a learning environment each time.

How to begin? Strategic Plan for Root Cause Analysis

When a jail wants to adopt RCA and critical self-assessment as part of its operational practice consider:

- Discussion and consensus among the leadership of commitment to the process, including identification of strengths, weaknesses, opportunities, challenges, and barriers;
- Consultation with legal counsel and insurance carriers;
- Communication/orientation/ education to all employees about the initiative and what it means to them, with periodic updates;
- Designation of tasks, with time lines, and review processes to update, refine and implement;
- Assessment of internal culture and plans to address changing any "blaming" culture;
- Identification of resources needed to develop and sustain the initiative and how resources will be obtained;
- Dialogue with both the jail's internal and external stakeholders (*e.g.* community, funders) about the merits of RCA and the jail's proposed strategies; and
- Plans for on-going collective, transparent oversight as the process begins.

Initiating a RCA process begins deliberately, with planning, assignments, accountability, and timelines.

"... jail risk management comes down to three key objectives: (1) protecting the safety of the community, inmates, jail personnel and visitors, (2) preventing property damage and loss, and (3) preserving inmate rights. Ultimately, the challenge is to achieve the first and second objectives without compromising the third."
(Reiss)

Jail Risk Management – Preventing Unspectacular Errors

As the jail considers how to implement (or update) RCA and corrective actions, a word about prevention. Simultaneously adopting a risk assessment approach may mitigate the need for post-incident reviews, by preventing events from occurring in the first place. Resources devoted to prevention can potentially save time, money, and improve the safety of staff, inmates and the community. (McCampbell, Core Competencies for Jail Leaders: Reduce Jail-Related Liabilities, 2019)

This approach requires collecting meaningful and accurate data about jail operations, analyzing and trending the information, and most importantly using this data to inform decision-makers on all levels. (McCampbell, Core Competencies for Jail Leaders: Organizatiional Accountability, 2016)

How can RCA be applied in **prevention**? Here are a few ideas:

- Increasing amounts of contraband discovered during inspections. What is the specific contraband, the possible sources and prevention strategies (e.g. hardening targets, training, supervision, inmate education)?
- Employee shortages and resignations. There is a continuing upward trend in employee shortages and resignations. Why? Are there recruitment deficiencies? Background procedures? Training? Supervision? Pay? What are the real issue and possible solutions?
- Inmate/inmate altercations. Incidents are increasing, along with uses of force. Where and what time is this happening? What are common elements? Is it training, supervision, classification? What is the core reason(s)? What are options?
- Grievances are up for food service. What are the underlying reasons? Has there been a change in practices, menus, suppliers, supervision, providers?
- New arrestees are backing up in booking, especially on weekend nights. What can be done to move arrestees more expeditiously?
- The state legislature is considering new legislation to require jails to hold inmates for three years, instead of transferring them to state prison after sentencing. What will be the response in your jail? What operational practices will need to be changed, what costs will be incurred?

The ideas of how to use RCA for prevention are limitless. A shift in thinking at the jail leadership level moves away from waiting for something bad to happen and reacting – to using data to examine emerging issues, paying attention to the external environment and preventing incidents. This process also role models the behaviors desired from the emerging group of jail leaders from "firefighting" to proactive problem solvers.

Measuring Success through Evaluation

After completion of the RCA, review of all information and development of an action plan, jail leaders may implement changes to the physical plant, processes or policy to prevent repetition of an event.

Incorporation of formal or informal evaluations and focus on assuring corrective action plans are completed as part of the overall RCA strategic plan will ensure implemented changes are completed as intended. Monitoring success and ensuring staff are complying with recommended changes will be necessary to ensure it is fully incorporated into day-to-day operations. Continuing data collection and review can identify if trends are impacted by changes made.

Decision Points Updating or Implementing Root Cause Analysis

This toolkit does not provide a "model" policy, but rather outlines the decision points for the jail's leadership regarding updating or creating relevant written directives. These considerations are borrowed from the fields of medicine, corrections, law enforcement, emergency management, and fire services. This toolkit provides links to policies and procedures in these fields.

A critical underlying premise of this work is that the jail identifies, collects, and analyzes data about operations, and that this data is accurate and credible.

This document is intended to spur discussion in your jail. Leadership may have additional decisions that need to be made, and unique considerations as the process moves forward. These are not arranged in priority order, and the exact process will unfold differently in each jail.

Decision Points – Revising and/or Implementing Root Cause Analysis in Jails

Issues	Consideration(s)
Is there an existing directive that addresses critical incident reviews, RCA, corrective action plans? If so, when was the last time it was updated? Does the process produce the result of improving safety and security of the jail? Do staff believe in the process? Are there tangible results? Are risk assessments and audits routinely conducted? Is the data collection system robust and accurate?	If a current process/directive is in place, does it work to improve safety? Are corrective action plans implemented and documented? If there is no guiding directive, or a complete one, what are the elements important to the organization and stakeholders? Determine how routine inspections, audits, etc. are potentially integrated into RCAs. Review of completed RCAs prepared by other jails can provide information.
What is included in the definition of a topic/subject/event that triggers an RCA? Are there definitions on which all can agree? Are they clear?	Are sentinel events, critical incidents, current pressing issues, opportunities for change, patterns, trends supported by data? Will this be proactive, reactive, or both? Have analyses of incidents in this jail been accurate and resulted in positive change (not just, for example, employee discipline)?
Who can initiate an RCA? When is the process best done by an external entity?	Are RCAs only at the command level? Is there benefit for using this as a tool throughout the organization? If so, what are the reporting requirements?
Where, organizationally, is the responsibility to initiate, delegate, research, prepare, report findings? Where is the responsibility vested for developing corrective action plans, and following through?	Is there a benefit to delegation to trained personnel? Is this an opportunity to display decentralization?
Communication – who are responsible for communicating any new or revised RCA initiative to: funding authority, community stakeholders, employees, contractors? Who crafts the message and who follows-through?	If the internal culture is negative and/or untrusting of self-critical reviews, what specifics need to be addressed? If "blaming" is the culture, what needs to be introduced to change the perceptions?
What is the position of the jail's legal counsel and insurance carriers regarding conduct of an RCA?	Education about why root cause identification is necessary (as opposed to identifying symptoms). What is common ground in terms of improving jail safety?
Resources – what resources (human and other) are now devoted to audits, reviews, inspections, etc.? Can this be integrated with, for example, PREA requirements?	Are there opportunities for consolidation of functions and relevant cost savings?
Skill Sets – are staff who will prepare, conduct, review and edit sufficiently skilled? Is there a team? Who is the team leader?	There is a cost to having unskilled or untrained staff involved, the least of which is demoralizing those involved and jeopardizing credibility.
Internal Stakeholders	Who needs to be involved as internal stakeholders? Collective bargaining units, employee organizations?
External Stakeholders. Does the jail have credibility in the community, among funders, and with its own staff in terms of being proactive and responsive to critical incidents?	An honest assessment may help plan for the implementation of RCA; noting the benefits to stakeholders, staff, etc.
After consideration of these factors, does leadership commit (or recommit) to the RCA process?	If there is not leadership commitment, perhaps set aside to another time.
Strategic plan to implement RCA. Develop a timetable. Identify resources and talent.	Consider how staff might receive orientation and/or training not only to develop but implement RCAs. Who among stakeholders and/or other public safety agencies can assist?

Issues	Consideration(s)
Who will revise or draft the directive governing the process? What is the timetable?	What help is available – from other jails? Remember that health and mental health agencies have been involved with RCA for years, and may assist.
The process – how will the RCA unfold?	See above – Elements of RCA
Who is responsible for implementing and accountability for corrective action plans?	What is the agency commitment? Is there an evaluation of how well the corrective action plan worked?
Annual review of the policy and annual risk assessments– what did the jail learn?	How can the process be improved?
Communication – in the commitment to transparency, what elements of the process are shared with employees, stakeholders, media, funding authority?	What are state statutes guiding release, and what is the input of the jail's legal counsel?
Documentation – how has this jail improved? Been made safer? Better allocated and spent fiscal resources? Gained the confidence of staff and the community?	There is direct tangible (e.g. cost saving) and intangible results (e.g. lower staff attrition rates). How can you quantify to paint the picture of the jail's improvements?

Obstacles and Overcoming Them

There are challenges to implementing and sustaining a credible RCA process. Among these are:

- Absence of authentic leadership commitment;
- Internal agency culture which does not accept critical self-assessment and is characterized by "blaming" rather than fact finding and correction;
- Fear of findings/outcomes;
- Absence of governing policies, procedures, and formats;
- Lack of training on how to accomplish;
- No follow-through on findings or action plans, thus undermining the commitment;
- Concerns of legal counsel; and
- Resources.

As part of the strategic planning process to revise or implement a RCA process, the leadership may have identified other challenges, and gain stakeholder buy-in – including legal counsel.

Strategies to address the obstacles can be developed as part of the planning process. No one knows your jail better than you and the people who work in it. Communicating ideas about this initiative may bring supporters and detractors forward. Listening to these concerns are important, but with an eye towards solving the issue, rather than allowing these to become barriers.

This monograph does not intend to minimize the concerns of the jail's legal counsel as a barrier to implementing a credible and robust RCA process. There is real inherent conflict between the jail's need to identify the causes of an incident to prevent it from happening again, and legal counsel's desire to protect such information from discovery in the event of litigation. A legal review of the concepts and litigation associated with the "self-critical analysis privilege" are beyond the scope of this work. References are included in the bibliography that direct the jail leader and legal counsel to additional information.

Can a jail credibly operate if it fails to drill down into the reasons for harm and does not take corrective action? The jail administrator must address this matter with their counsel. Rather than furthering a conflict, identify common ground and make collaborative efforts to assure future jail safety. Depending on the physical location of a jail, a state or Federal court may have already ruled on any privilege that may exist to protect bona fide reviews conducted by a jail, consistent with their internal policies and procedure. (Jones J. , 2003)

deliberately indifferent. Finding "blame" is only one part of the jail's obligation.

What are the barriers?

The NJLCA graduates who reviewed this draft document were asked to identify all the barriers they saw to conducting root cause analysis in their jail. The responses were:

- 83% - lack of internal knowledge, skills to conduct
- 50% - lack of policy and procedure
- 25% - lack of time
- 25% - not a priority
- 25% - concerns/fear of findings
- 8% - absence of support from the funding authority

No one identified lack of support from legal counsel, or lack of support from the insurance carrier as a barrier. One respondent noted that the reviews which are conducted are more "patrol-centric" and don't always reflect knowledge of critical jail issues or operations.

The balancing of the competing interest – prevention of future harm to staff and inmates, verses protection of negative RCA findings– require consensus on the future of the jail's operations. Your state's open record laws and/or administrative regulations also influence disclosure of jail records.

Failure to thoroughly review incidents, develop and implement corrective actions, places the jail at risk of being perceived as unresponsive, or worse,

What's Next?

This toolkit is intended to further discussion for jails about seeking and maintaining a safer environment through adopting a culture accepting of critical self-assessment and getting to the root of problems/incidents/emerging trends. Examining a crisis, or pending crisis, is crucial to safety, but requires a commitment to corrective action. Taken together, these steps toward total quality management are positives for the profession.

A proactive step may be a mock table-top exercise – using a real, or invented scenario, and involving the jail's risk manager and other stakeholders. This simulation can help identify training and policy needs, and communicate a clear sense of purpose in conducting the work. Use this as a learning event, and critique proposed, or actual jail policy and procedures.

The next steps are up to you!

Resources

Provided with this toolkit are:

- Definitions
- Links to policies and procedures
- Corrective Action Plan formats
- Organization of a RCA report
- Resources and Bibliography

The resources include links to root cause analyses performed in various public safety contexts, including three for jails/prisons. Not all root cause reviews need to be as extensive and/or done by an outside organization. The reader should not be discouraged by the scope of some of these reviews.

These resources, along with the works cited in the narrative, provide a jail with the tools needed to consider and implement RCA as part of total quality management.

Definitions

Accountability-Based Management

A philosophy guiding agency operations that identifies the performance expectations of the organization, collects relevant data, measures the organization's progress toward meeting those expectations, and with the existence of an internal structure (policy and procedures) holds employees and systems accountable to achieve the expectations. (Fridell, 2006)

Action planning/Action Plans (Corrective Action Plans)

An action plan is the product of an event review whether the incident's assessment is done via a RCA and/or after-action report/critique/debrief. The action plan process and format, as part of the jail's policies and procedures, must include, at a minimum:

- a precise statement of the matter to be remediated;
- clear, measurable, and specific actions that will be taken;
- identification of the product or outcome that will prove the work is accomplished;
- the name of the person(s) assigned to each work objectives;
- the due dates for each element;
- how and when the recommendations/outcome will be implemented along with any needed staff training; and
- how the impact (positive or negative) of the work will be assessed.

Action plans can also be used for non-emergent issues to address challenges the jail is experiencing - such as employee recruitment or retention, influx of inmates on Opioids, or increase in the number of inmates on the mental health caseload. As such, sometimes the term "preventive action plan" is used to describe activities. The plan may also include a discussion of "lessons learned" from this event that can be used to improve operations.

After action report/critique/debrief

An after-action review is ". . . a tool for quickly assessing what happened during an activity and whether any lessons from it would help in the future. An AAR (After Action Review) is simple, quick, and immediately responsive to the situation and the people involved." (U. S. Dept. of Agriculture, Forest Services) This is contrasted with the more in-depth reviews noted for RCA. After an event, most organizations compile a minute-by-minute description of what happened and when – and the why either comes later, or not at all. The utility of an after-action concept is to collect all the relevant information, documents, logs, videos, statements, reports, and testimony to assure these are available for post-review investigation.

A critique may also be defined as ". . . a fact-finding exercise and a chance to relate and record pieces of information that collectively form a picture of the event and how personnel responded. . ." (U. S. Fire Administration, FEMA)

Jail leadership determines via policy what events or incidents warrant what level of review. This Monograph does not suggest that all jail events warrant a RCA. What is important is that the jail delineates what event triggers a review response, and that those various response processes are

time-driven, defined – and not just left to chance.

Audit

An audit is most often discussed in terms of reviewing financial records and determining compliance with laws and professional standards. In terms of corrections, auditing most often relates to compliance with national, state or local standards, laws, or other measurable benchmarks. For example, a security audit program can be a positive approach consistent with risk management. (Eva Martony, 2013) An audit might inform a RCA and/or might be the impetus for a preventive action plan.

"Best" practices

An outcome of RCA and action planning may be the search for "best" practices from other jails that, if adopted, might prevent adverse outcomes. While reaching out to the jail community is a good idea, caution is suggested in assessing and adopting "best" practices. Unless a practice is research and "evidence-based" it may be better to consider it a promising idea, or an emerging strategy. (Elyse Clawson, 2004)

Contributing factor(s)

When conducting an incident review, the RCA should seek to identify all factors which may have influenced the event. Some of these factors will be directly causative, others not. These factors may be positive or negative. The team reviewing the factors may assign weights to the factors perhaps such as major, intermediate or minor. For example, a roof failure at a jail may be directly caused by a weather event, but an intermediate contributing factor may be the absence of a funded preventive maintenance plan, or ineffective repairs.

Critical incident

Any event defined by the jail's policies and procedures as requiring a structured analysis and, if necessary, an action plan.

Evidence-Based

"An evidence-based organization (EBO) consistently demonstrates the ability to achieve outcomes through effective problem solving and decision making. As the name implies, such an organization simultaneously uses evidence to achieve its outcomes and corroborates those outcomes through measurement and exhaustive communication. An EBO uses data to drive decisions and develop innovative approaches to delivery services." (Christine Amenn, 2010)

Fact-finding

A process that gathers and organizes basic information about the event under review, including preparation of a list of all documents, logs, videos, statements, relevant policies, etc. This activity is in *preparation* for analysis, development of findings, and creation of action plans. Fact-finding is generally an integral part of RCA, but is in and of itself not intended to be investigatory or conclusory.

Fishbone Tool (Ishikawa Diagram)

A diagram sometimes used as part of the team examination process of an adverse incident. (U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, n.d.) The tool provides a visual display of the problem

statement, the environment, the people involved, equipment/supplies, and policies and procedures. This method was developed by a Japanese engineering professor to improve quality management primarily in manufacturing. Some teams might find the visual approach helpful in RCA.

Incident Debriefing

A mechanism for communicating information to agency employees either post-incident, and/or at the completion of a RCA. The purpose of the debriefing is to uphold the transparent nature of RCA, address rumors, relieve fears created by the event, commend staff, demonstrate leadership, and point toward any changes that will be implemented.

Morbidity and mortality reviews (M&M)

A standard practice in the medical profession, the objective of an "M&M" is to ". . . analyze a case with an adverse outcome to identify contributing factors. This process allows M&M participants to learn from the case and work to prevent future harm to patients. Therefore, M&M sits at the intersection of performance improvement, medical education, and peer review activities." (Darlene Tad-y, 2013) It is essential that the jail's medical provider have procedures in place to conduct M&M reviews for incidents involving serious threats/outcomes to inmates' medical and mental health. It is likely in the conversation about RCA that an M&M review will provide critical information, possibly of a technical nature, to inform the review of the adverse event. M&M reviews examine not only the individual patient, but the systems that were part of the outcome, including, for example, protocols and responsiveness of the corrections staff.

There is often debate about whether the M&M document is shared with jail leadership, or otherwise available. This accessibility may be guided by the contracting document, or other legal decisions. In some instances, the results of the M&M may only be shared verbally. It is essential for the jail leader to assure that any action plan to address deficiencies revealed in an M&M are addressed in a timely and thorough manner.

National Incident Management System (NIMS) Incident Command System (ICS)

"NIMS is a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards – regardless of the cause, size, location or complexity – in order to reduce loss of life, property and harm to the environment." (FEMA, 2017) This Monograph will not devote time to exploring NIMS ICS and encourages readers to review the materials noted in the bibliography. It is possible that a jail might be involved in NIMS depending the scope of the incident (*e.g.* hurricane, terrorism, community-wide disaster). The websites included in the bibliography provide the link to the NIMS supporting guides and tools, reporting formats, and resources. Jails may also subscribe to the NIMS mailing list. FEMA also provides training and technical assistance.

Non-conformity

During the completion of a RCA identification of actions, environmental issues, or circumstances which do not fall within policy, procedures, and/or accepted practice. May also be referred to as non-compliant.

Quality Assessment and Quality Improvement (QA/QI)

Terms borrowed from the medical profession, QA/QI and continuous quality improvement all seek to assess and improve health care delivery. As with CQI, this is a data driven process leading to better patient outcomes and a safer jail. The objectives are to determine if there is compliance with processes and measure and analyze outcomes. There are two types of QI studies. Outcome QI Studies examine whether expected outcomes of patient care were achieved. Process QI studies examine the effectiveness of the health care delivery process. Baseline studies are a component in both (National Commission on Correctional Health Care, 2018)

Risk assessment/management

Risk assessment is the process by which an organization identifies and examines the potential harm or impact of realistically anticipated and/or unforeseen events. While it is an uncertain world for a jail, both internally and externally, a routine and consistent process to assess risk is important. These risks may be associated with, for example:

- the physical plant (secure perimeter, roof, HVAC, glazing, doors, locks, parking lots, road/walk ways, physical plant assessment); (McCampbell, 2016)
- human resources (adequacy of the number of employees, employee screening and hiring process, pre-service and in-service training, internal investigations and employee misconduct reviews, employee discipline, worker's compensation);
- inmate medical, mental health and dental care and pressing challenges such as prevalence of mental illness, and the opioid crisis;
- financial and budgeting;
- legal (laws, administrative regulations, case law, consent judgments, rules, *e.g.* PREA);
- policies, procedures, lesson plans, training; and
- inmate programming and services. (Martin, 2008)
- Severe weather events (e.g. flood, hurricane, tornado)

Risk assessment/management, routinely performed, will assist the jail to avoid adverse events – for example, identifying the need for and installing new locking mechanisms in housing units – to prevent inmate/inmate altercations. It is a separate, but integrally related matter, if the jail notifies the funding authority of such needs, but doesn't receive funding. In this case, the assessments provide the documentation of efforts.

Related to RCA, the absence of a risk assessment/management program in the jail may be a contributing factor. Often the jail itself may need to rely on the funding or political authorities' experts or insurance providers to conduct this work.

Root Cause Analysis

A transparent, collaborative process, occurring after a sentinel event, or to address an emerging operational challenge, designed to gather data, thoroughly analyze the event (sometimes labeled as determining the "5 Ws" – who what when, where, why), determine causation, articulate recommendations, with the ultimate objectives of reducing risk and preventing future occurrences of adverse events through implementing measurable and time-driven action-plans. The purpose of a RCA is to find out what happened, why it happened, and determine what changes need to be made. (U. S. Dept. of Heath and Human Services, Centers for Medicare and Medicaid Services, n.d.)

Self-critical analysis privilege

A legal concept that seeks to ". . . protect self-evaluative materials from discovery when the public interest in preserving the internal evaluations of organizations outweighs a plaintiff's right to the evidence. Courts recognize that organizations may be less likely to engage in self-policing, and in addition may compile less reliable information when doing so, if plaintiffs can access the results of these self-analyses." (Jones, 2003)

Sentinel Event Reviews (SERs)

As noted in the Introduction, a sentinel event is most often defined as ". . . a bad outcome that no one wants repeated and that signals the existence of underlying weaknesses in the system." (U. S. Department of Justice, Office of Justice Programs, National Institute of Justice, 2014) "A sentinel event is a significant, unexpected negative outcome that signals possible underlying weaknesses in a system or process; is likely the result of compound errors; and may provide keys to preventing future adverse events or outcomes." (U. S. Department of Justice, National Institute of Justice) Sentinel events should serve as early warnings of pending adverse events. Through an ongoing initiative of the U. S. Department of Justice's National Institute of Justice, the three fundamental principles of a sentinel event review are:

- "Non-blaming: Reviews must not be framed as a hunt for a bad actor. Rather, they must seek to understand why multiple, smaller errors occurred; why decisions seemed like the best decisions at the time; and how the system is structured to allow for such mistakes.
- Forward-looking: Reviews must be conducted for the purpose of learning, with an eye toward using information to improve policy and practice, and to reduce the likelihood of future harm.
- All-stakeholders: Reviews must include representatives from all aspects of the system whose actions and/or failure to act could have reasonably contributed to the error. They must be willing and able to share all relevant information across disciplines to inform a deliberative, transparent process." (U. S. Dept. of Justice, National Institute of Justice)

Total Quality Management (TQM)

Stemming from the post-World War II work of Edward Deming, TQM seeks to look at issues at an organization level and works to establish and then examine processes to accomplish, and correct

activities leading to achieve of the organization's mission and vision, inclusive of customers and stakeholders. It is customer-focused, involves all employees, is process centered, integrated, strategic and systematic, focuses on continual improvement, is data and fact driven, grounded in meaningful and timely communication. (Quality, n.d.)

In a medical environment, the purpose of TQM is "… continuous quality improvement is to improve health care by identifying problems, implementing and monitoring corrective action and studying its effectiveness." (National Commission on Correctional Health Care, 2010)

Links to Policies/Procedures

These examples are provided for the education of the reader, with NO assessment of their effectiveness, nor endorsement by the authors. These examples are available on public websites. Examples from health and behavioral health settings are also relevant. These links are operational as of this date. If they no longer work, search on the report title for more information.

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Corrective Action Formats/Templates

There are many formats and templates for corrective action plans. A review of the Internet identifies many options. Here are some ideas for your team to consider. The format can be as simplistic or as detailed as required by the jail's policy and the nature of the event/incident. The operational policy/written directive should define each element. As with all components of the RCA process, these templates should be assessed after each use and modified to adapt to the jail's needs.

Sample # 1
Issue/Event/Incident:
Date of Development:
Dates of Revision/Reporting:

Item #	Condition to be addressed (Measurable/objective)	Steps	Timelines	Who	Assistance Needed/Stakeholders	Output	Measure of Success
1.0							
1.1							
1.2							
1.3							
2.0							
2.1							
3.0							

Sample # 2
Issue/Event/Incident:
Date of Development:
Dates of Revision/Reporting:

Item #	Condition to be addressed (Measurable/objective)	
	Steps to complete	
	Timeline/by step	
	Who	
	Assistance Needed/Stakeholders	
	Output	
	Measure of Success	
Item #	Condition to be addressed (Measurable/objective)	
	Steps to complete	
	Timeline/by step	
	Who	
	Assistance Needed/Stakeholders	
	Output	
	Measure of Success	

Sample # 3
Issue/Event/Incident:
Date of Development:
Dates of Revision/Reporting:

No.	Action	Responsible Party	Priority H/M/L	Status/Not started/Stated/Completed	Planned Finish Date	Actual Finish Date	Notes
1.0							
1.1.1							
1.1.2							
1.1.3							
2.0							
2.1.1							
2.1.2							
3.0							

Sample # 4
Issue/Event/Incident:
Date of Development:
Dates of Revision/Reporting:

Goal/Objective:			
ACTION PLAN			
Status (complete or in-progress)	**Task/Activity**	**Person Responsible**	**Due Date**

Organization of RCAs Reports - Formats and Templates

There are many formats and templates to organize RCAs. A review of the Internet identifies many options. Here are some ideas for your team to consider. The format can be as simplistic or as detailed as required by the jail's policy and the nature of the event/incident. The operational policy/written directive should define each element. As with all part of the RCA process, these templates should be assessed after each use and modified to adapt to the jail's needs. There are several RCA reports referenced in this document that provide additional ideas.

Sample – Table of Contents of an RCA Report (Suggestions only, not all topics may be relevant to the matter under review)

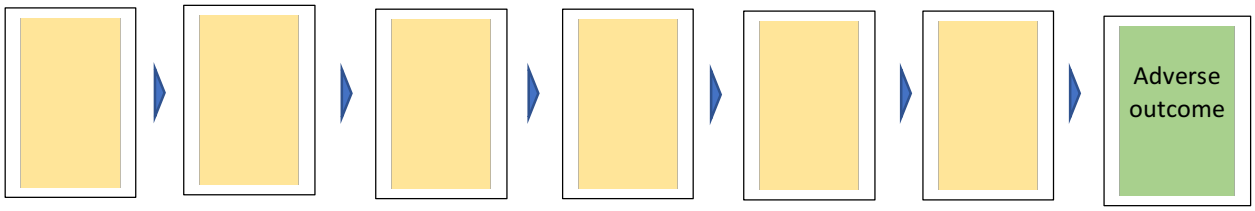
- Introduction
  - Purpose
  - Scope and Objectives
  - RCA team leader and members
- Executive Summary
- Background
- Report Methodology
  - Data collection and analysis
- Summary of Incident/Event Narrative
  - Response
- Analysis of Incident/Event
  - Chronology of events
- Findings/Root Causes (As each topic is applicable)
  - Administrative issues (e.g. budget)
  - Classification
  - Command and control
  - Communication
  - Environment
  - Equipment
  - External environment
  - Information Technology
  - Inmate matters
  - Leadership
  - Policies, procedures, written directives, and practice
    - Inmate classification
    - Audits and Inspections
    - Employee hiring and background investigations
  - Post event
  - Staffing
    - At the time of the incident/event

Fatigue and scheduling
Supervision
Training – to include retaining of staff about how RCAs work and their role
Conclusions, Lessons Learned
Recommendations
Appendices
List of documents reviewed
List of interviews
List of team members
Photographs/videos
Other items reviewed

Options for Organizing Information

Option 1 – Chronology of Events Diagram

Review the flow of events:



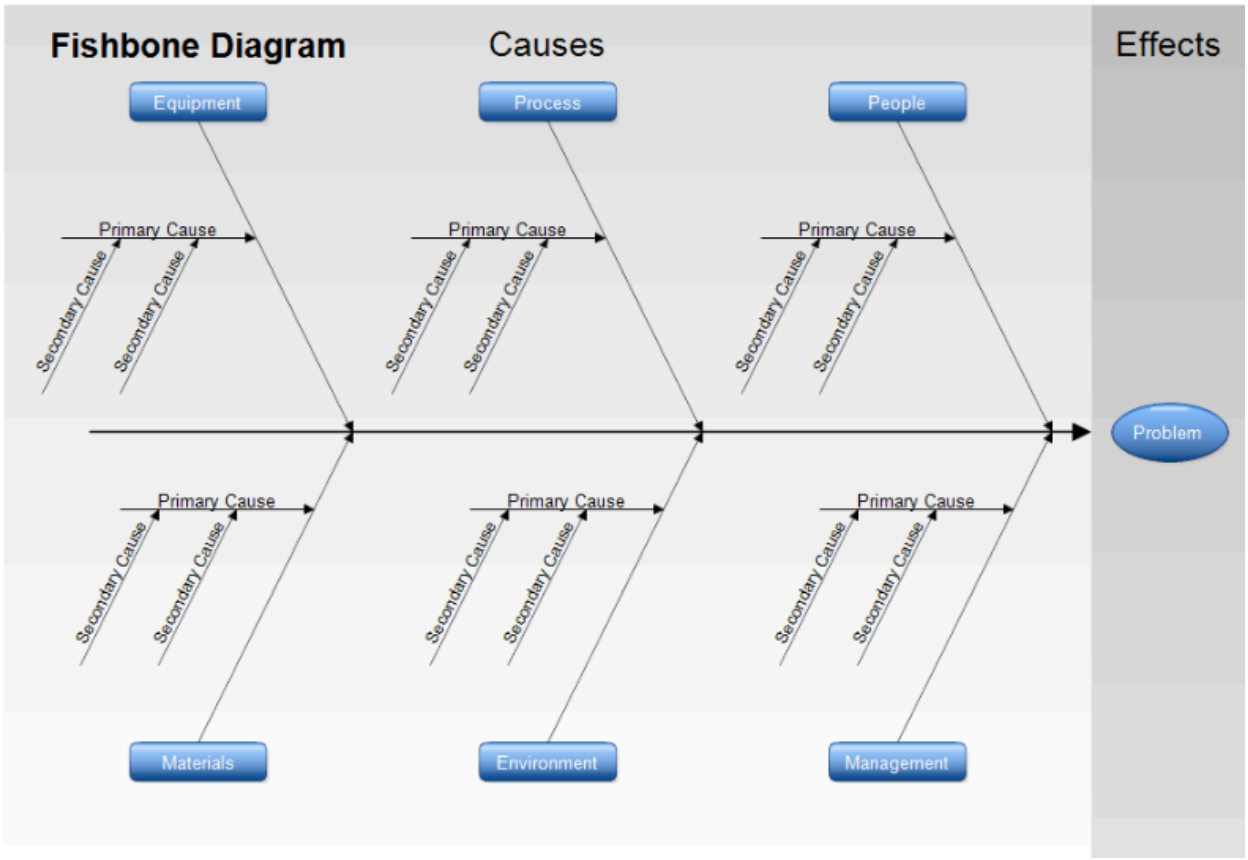
Option 2 - The Whys California Health Care

Consider the factors that resulted in the negative event (or the matter under consideration). Brainstorm the "why" of each.

Factor Being Considered:	Why is that?
1.	Why is that?
2.	Why is that?
3.	Why is that?
4.	Why is that?
5.	

Option 3 – Fishbone Diagram (Ishikawa)

This option allows the reviewers to group various causes by categories designed by the reviewers – for example, people, process, equipment, materials, environment, management, etc.) The use of this method requires assuring background is gathered, and that employees using the technique are all proceeding with the same understanding. Internet research will provide multiple vendors and resources for this strategy. The Internet provides more examples of this template.



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