2nd DRAFT Behavioral Health Crisis Incident Review Protocol for Sentinel Events and Quality Assurance Audits

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I. INTRODUCTION

In the absence of a comprehensive community-based crisis system of care in Baltimore, the Baltimore Police Department (BPD) plays an outsized role in responding to behavioral health crises. In large part, these crises are preventable or would be more appropriately addressed by behavioral health professionals. For a number of reasons, including the absence of a state-level funding strategy and a rigorous, ongoing system of quality assurance/quality improvement, the behavioral health system of care in Baltimore is underdeveloped and underfunded. There is insufficient local capacity and accountability for crisis prevention and early intervention. There are also limits in response capacity from the agencies that do provide acute crisis intervention. Traditionally, law enforcement has then been left with the responsibility of intervening in these emergencies. The BPD is taking steps to improve police interactions with people who have behavioral health needs, including training officers in de-escalation, general recognition of the signs and symptoms of behavioral health disabilities, and strategies for crisis intervention. Encounters with people in behavioral health crises that began as non-criminal in nature too frequently result in a use of force or the individual's further involvement in the criminal justice system. The overarching goal is for BPD personnel to be well-trained in these areas, but to rarely call upon their services because the public behavioral health system is functioning appropriately.

Behavioral health crises that now involve BPD sometimes result in serious injuries or other adverse outcomes that are categorized as "Sentinel Events" – incidents that point to systemic errors and present learning opportunities for all stakeholders to improve service delivery. Most police encounters with people who have behavioral health needs do not entail such outcomes and may be regarded, incorrectly, as routine, or benign. In fact, these encounters with police may be traumatizing to the individual and may reinforce negative stereotypes about people with behavioral disabilities. They also represent an unnecessary draw on police resources. In either instance, these encounters do not occur in isolation; there are manifold "root causes" and precipitating factors that lead to an individual encountering law enforcement. As such, it is critical to conduct Behavioral Health Crisis Incident Reviews that include the participation of key decision-makers within the city's public behavioral health system to promptly identify where an individual was not adequately served, and how such encounters may be avoided in the future. Born of the Consent Decree agreement between the City, the BPD, and the United States Department of Justice (DOJ), which requires an analysis of Baltimore's public behavioral health system, to include a sample of police interactions with people with Behavioral Health Disabilities, Behavioral Health Crisis Incident Reviews are designed to persist beyond the duration of the Consent Decree and will serve to inform continuous improvement in the City's criminal justice, public behavioral health, and other systems.

Currently, the BPD performs a process of systematic introspection known as the Performance Review Board (PRB). The PRB is an opportunity for BPD command staff and subject matter experts within the department to evaluate a critical incident, typically an officer's use of deadly force, in order to determine whether current training, supervision, policy, equipment, and/or tactics could be improved to prevent a similar incident from occurring in the future. Where the PRB's

evaluation is limited to those areas directly under BPD's control, the Behavioral Health Crisis Incident Review Protocol is meant to apply the same level of scrutiny across stakeholders to identify key moments leading up to the interaction where improvement could be made.

III. DEFINITIONS

Behavioral Health or Intellectual or Developmental Disability – Primarily refers to any mental illness and/or substance use disorder but also may be used to describe any disabling condition that impacts a person's ability to self-regulate their thinking, mood, or behavior, including intellectual and developmental disabilities, autism spectrum disorders, and dementia. A person may be suspected of experiencing a Behavioral Health or Intellectual or Developmental Disability through multiple factors including:

- Self-Report,
- Information provided to dispatch or BPD members by witnesses or informants,
- An individual's previous interaction(s) with the BPD, or
- A member's direct observation including, but not limited to, behaviors consistent with psychiatric diagnoses, such as disorientation/confusion, unusual behavior/appearance (neglect of self-care), hearing voices/hallucinating, anxiety/excitement/agitation, depressed mood, crying, paranoia or suspicion, self-harm, and/or threatening violence towards others.

Collaborative Planning and Implementation Committee (CPIC) – A group of individuals and organizations representing a wide range of disciplines and perspectives who develop, implement, and evaluate a comprehensive Crisis response system for Baltimore City that allows for the least police-involved response for people with Behavioral Health Disabilities or experiencing Crisis consistent with community safety while improving outcomes to develop a system of care that: treats all people with dignity and respect, prevents people from having unnecessary contact with police, diverts people away from the criminal justice system into services that will meet their needs, and deescalates crisis situations with minimal or no use of force. The CPIC advises the BPD Crisis Intervention Program and the broader public behavioral health services within the City.

Crisis – An incident in which an individual experiences or displays intense feelings of personal distress (e.g., anxiety, depression, anger, fear, panic, hopelessness) that they are unable to address with their ordinary coping strategies and that may cause disruptions in thinking (e.g., visual or auditory hallucinations, delusions, cognitive impairment) or behavior. Crises can result from factors such as: mental illness, a substance use disorder, an intellectual or developmental disability, a personal crisis, homelessness, domestic disputes, harm reduction, food insecurity, the effects of drugs or alcohol, or a combination of these factors.

Sentinel Event – The National Institute of Justice (NIJ) defines a Sentinel Event as "a significant negative outcome that signals underlying weaknesses in the system or process; is likely the result

of compound errors; and may provide, if properly analyzed and addressed, important keys to strengthening the system and preventing future adverse events or outcomes.[1]

Sentinel Event Review -- Sentinel Events are encounters between individuals with behavioral health or intellectual or developmental disability and BPD personnel that provide opportunities for the CPIC to convene all stakeholders to "learn from the past to achieve better outcomes in the future, [and] focus on broader issues of policy, training, supervision… needed resources."[2] This may involve numerous agencies and systems and gaps in the behavioral health system of care. Sentinel Events include incidents involving death, injury, or excessive use of force. Because Sentinel Event Reviews are focused on the identification and amelioration of systemic factors, many of which are compound, a core principle in conducting the reviews is to avoid finger-pointing or the assigning individual or organizational blame.

Quality Assurance Audit – An audit of behavioral health or intellectual or developmental disability related incidents as identified in Computer Aided Dispatch (CAD). The purpose of the Quality Assurance Audits is to review the system as whole and identify trends and gaps in systems of care. These audits will include the participation of key decision-makers within the City's public behavioral health system as well as members of CPIC to promptly identify deficiencies and successes in service delivery, establish recommendations as a result of Quality Assurance Audits and implement change as necessary to improve crisis care experience, earliest and least restrictive resolution of behavioral health crises that minimizes need for law enforcement involvement.

III. PURPOSE

As the City of Baltimore assesses its role and the future relationship of the Baltimore Police Department (BPD) to the public behavioral health system, the prompt cross-sector evaluation of Sentinel Events and Quality Assurance Audits of Behavioral Health related incidents are invaluable tools through which key stakeholders can identify barriers or gaps that may be addressed in a coordinated manner. Sentinel Event reviews are also a critical element of the City's ongoing endeavors to improve the quality of services afforded people with behavioral health needs and to reduce the risk of crises that may culminate in police involvement and other adverse outcomes. As such, this Quality Assurance Audit and Sentinel Event review process supports the City's efforts to enable people with behavioral health disabilities to live successfully within the community, in accordance with the Americans with Disabilities Act.

[1] In criminal justice, a sentinel event might be a police shooting, the wrongful conviction of an innocent person, the release from prison of a dangerous offender, or even a 'near-miss' that could have led to a bad outcome had it not been caught."[1] Within the healthcare realm, The Joint Commission (an accrediting body), defines a Sentinel Event as "a patient safety event that results in death, permanent harm, or severe temporary harm. Sentinel events are debilitating to both patients and healthcare providers involved in the event."[1] Accordingly, this cross-system methodology aligns with practices and standards in both criminal justice and behavioral health.

[2] City of Tucson. 2020. Critical Incident Review Board (CIRB). https://www.tucsonaz.gov/police/critical-incident-review-board-cirb-0

The purpose of this Protocol is to:

- Define the scope of behavioral health and crisis-related incidents involving the Baltimore Police Department (BPD) to be reviewed as Sentinel Events, and
- Establish a routine Quality Assurance Audit of Behavioral Health calls for service to be reviewed as Quality Assurance Audits, and
- Identify the key participants for the Behavioral Health Crisis Incident Reviews,
- Provide the operational structure for Quality Assurance Audits and Sentinel Events Reviews, and
- Furnish the process for identifying root causes and patterns of factors within and across public systems that culminate in Behavioral Health Crises, particularly when those crises result in adverse outcomes or avoidable law enforcement intervention, and
- Provide recommendations as a result of Sentinel Events Reviews and Quality Assurance Audits and collaborate with involved entities responsible for quality and performance improvement,
- Outline process for reviewing recommendations provided with CPIC, receiving feedback on identified recommendations and establishing a system for reporting on progress of implementation and accountability, and
- Implement change as necessary (procedural, logistical, clinical, cross-sector collaboration) to improve consumers' crisis care experience, improve access to voluntary behavioral health services to avoid crisis, and deliver the earliest and least restrictive resolution of behavioral health crises that minimizes need for law enforcement involvement.
- Report out and monitor implementation of necessary changes.

IV. STRUCTURE

<u>Sentinel Event Behavioral Health Crisis Review Committee</u>

1. The following CPIC co-chairs (or designees) shall serve as Board of Governors:

    1.1 Behavioral Health System Baltimore (BHSB),

    1.2 BPD, and

    1.3 Mayor of Baltimore or their designee (this co-chair will run the "Board," similar to how the Executive Director of BHSB runs CPIC meetings).

The Board shall be further composed of the following permanent members (or their designees):

2.1 BPD's Crisis Intervention Team Coordinator,

2.2 Maryland Hospital Association's CPIC delegate,

2.3 Executive Director or designee, Baltimore Crisis Response, Inc. (BCRI),

2.4 President & CEO or designee, Behavioral Health System Baltimore,

2.5 Licensed clinical social worker that works in Baltimore City,

2.6 9-1-1 Director, Baltimore City Fire Department,

2.7 Chief, BPD Legal Affairs,

2.8 Representative(s) from the Office of Homeless Services,

Representative(s) from the Baltimore City Health Department,

Representative(s) from the Baltimore City Fire/EMS Service to include the following:

-EMS medical director or physician designee

-EMS clinician

Representative(s) from the Office of Equity and Civil Rights.

3. The following individuals shall be invited to attend Sentinel Event Reviews as at-large members:

3.1 BPD's Behavioral Health Reform Manager, Consent Decree Implementation Unit (CDIU),

3.2 BPD Crisis Response Team (CRT) Supervisor, and

3.3 The Board of Governors may request ad-hoc representatives from other agencies on occasion if a particular Sentinel Event Review may be better informed through an agency's participation.

<u>Quality Assurance Behavioral Health Crisis Incident Review Committee</u>

1. The following CPIC co-chairs (or designees) shall serve as the Board of Governors:

1.1 Behavioral Health System Baltimore (BHSB),

1.2 BPD, and

1.3 Mayor of Baltimore or their designee (this co-chair will run the "Board," similar to how the Executive Director of BHSB runs CPIC meetings).

The Board shall be further composed of the following permanent members (or their designees):

2.1 BPD's Crisis Intervention Team Coordinator,

2.2 Maryland Hospital Association's CPIC delegate,

2.3 Executive Director or designee, Baltimore Crisis Response, Inc. (BCRI),

2.4 President & CEO or designee, Behavioral Health Systems Baltimore,

2.5 Licensed clinical social worker that works in Baltimore City,

2.6 9-1-1 Director, Baltimore City Fire Department,

2.7 Chief, BPD Legal Affairs,

2.8 Representative(s) from the Office of Homeless Services,

Representative(s) from the Baltimore City Health Department,

Representative(s) from the Baltimore City Fire/EMS Service to include the following:

-EMS medical director or physician designee

-EMS clinician

Representative(s) from the Office of Equity and Civil Rights.

3. The following individuals shall be invited to attend Quality Assurance Behavioral Health Crisis Incident Reviews as at-large members:

3.1 The BPD's Behavioral Health Reform Manager, Consent Decree Implementation Unit (CDIU),

3.2 BPD patrol officer,

3.3 BPD Crisis Response Team (CRT) Supervisor, and

3.4 Members with lived experience, including a family member of a person with a behavioral health or developmental disability,

3.5 The Board of Governors may request ad-hoc representatives from other agencies on occasion if a particular quality assurance audit may be better informed through an agency's participation,

3.6 Members of the CPIC general body.

V. QUALITY ASSURANCE AUDITS

It is critical for Behavioral Health Quality Assurance Audits to include the participation of key decision-makers within the City's public behavioral health system as well as members from the community with lived experience to promptly identify where a citizen was not served – or not adequately served – resulting in police involvement in crisis intervention, and how such encounters may be avoided in the future. Although a random selection of computer-aided dispatch (CAD)/911 behavioral health related incidents will be used to identify specific people and specific

interactions, the purpose of the Quality Assurance Audits is to review the system as a whole and identify trends and gaps in systems of care.

Frequency and Scope of Audits:

- The Board shall meet three times per year to conduct a random audit of behavioral health CAD incidents, as well as a review of all behavioral health or crisis-related calls for service (including those calls for service later classified as behavioral health or crisis-related) that result in a level 2 use of force. (See BPD Policy 725, *Use of Force Reporting, Review, and Assessment*),
- These meetings will include (a) quality assurance case audits, (b) recommendations.
- Plan for implementation of recommendations will be produced by involved stakeholders within 30 days.

Data Availability:

- The Governing Board shall determine the minimum set of data to be reviewed and may include factors such as: number and types of other crisis incidents occurring during the prior year, whether the individual was being served by a public behavioral health provider at the time of incident, behavioral health hospitalizations occurring during the prior year.
- Select a representative sample of CAD incidents from the previous four months that are behavioral health related for each quality assurance audit
- Selected sample of behavioral health CAD incidents will be sent one month in advance of the audit to all stakeholders required to review.
- If possible, stakeholders will be asked to pull summary interactions for the past calendar year relevant to each identified CAD incident, including any critical gaps identified by case managers and/or staff

Quality Assurance Audit Review Process:

- Relevant stakeholders will present an overview of the interactions that their agency has had with the individual associated with the call

BPD Initial Review:

1. Upon receiving identified behavioral health related CAD incidents for the audit, the BPD's CIT Coordinator shall request, through official channels, the following materials:

    1.1. A copy of the Behavioral Health Report, if available,

    1.2. A copy of the 9-1-1 recordings from the incident, and 9-1-1 call taker notes, if available, unless the incident was on-view and,

1.3. Any other BPD-member generated reports pertaining to the incident (e.g. arrest or incident reports, use of force reports, any criminal charges filed by BPD members, PIB complaints, body worn camera footage)

2. BPD shall complete an initial review, which shall analyze:

2.1. The assignment and dispatch of the call for service (i.e., was a CIT officer available and assigned to the call for service),

2.2. The member's initial approach and how the member(s) sought additional information on-scene,

2.3. Evaluate disposition of the CAD incident compared to BPD Policy 712 and what the "disposition table" recommends more broadly,

2.4. If relevant, use of de-escalation techniques (e.g., time, distance, cover, calls for additional resources, and communication).

Behavioral Health Initial Review:

3. BHSB will review Public Behavioral Health System data and records for service utilization history and individual clinical information pertinent to the event under review.

3.1. How the decision was made to call 9-1-1 and whether the call was initiated by a behavioral health treatment provider, if the CAD incident was a call for service,

3.2. Whether the caller sought or utilized non-police crisis response services in Baltimore and whether they sought those services prior to calling 9-1-1,

3.3 Whether the individual or another party had sought or utilized non-police crisis intervention within 30 days of the incident, whether that intervention occurred in a timely way, and the outcome of that intervention

3.4 A description of the nature of the crisis that prompted the CAD incident as described by the person, family member, or referring entity, including the duration of the crisis; and

3.5 Whether the involved individual was actively receiving behavioral health treatment, what types and duration of services the individual was receiving, and, if so, the circumstances for seeking/obtaining crisis services (e.g., did the individual contact the treatment provider prior to police contact, what interventions were they offered, etc.).

Fire Department Initial Review:

4. Upon receiving identified behavioral health related calls for service for the audit, the Fire Department will provide any reports pertaining to this incident including but not limited to:

4.1. A copy of the Medical Report, if available;

4.2. A copy of the 9-1-1 recordings from the incident, if available;

4.3. A copy of the CAD report; and

4.4. Any other Fire Department generated reports or medical reports pertaining to the incident

5. Fire Department personnel shall complete an initial review of reports produced

Preparing the Board Presentation

6. The findings of the initial review from BPD, BCFD, and BHSB shall be compiled by the Mayor's Office to include a chronological timeline of the individual's involvement with the behavioral health and/or law enforcement system(s) prior to the event under review. The information presented to the Board shall not include names or other personal identifiers; it may identify individuals via reference numbers.

7. The Board presentation shall be distributed to all permanent members one week in advance of the Quality Assurance Audit.

Recommendations:

The City's Board Governors shall present a general overview and discussion of cases reviewed and the final list of recommendations to CPIC. Recommendations may include, but are not limited to:

1.1. System Coordination: Observations on gaps within the public behavioral health system and other systems that could be addressed through enhanced coordination and accountability.

1.2. Remediation: Issues observed from any involved individual that violated current policy/practice and contributed to negative outcomes in the Sentinel Event. Examples of remedial recommendations may include Training Bulletins, internal memos, additional training for involved members, etc.

1.3. System Enhancement: Recommendations related to procedures or resources that currently do not exist within the public behavioral health system or other systems that could have prevented the incident, including identifying legislative solutions that the City can advocate, data tracking and reporting, and routine audits.

1.4. Organizational: Issues related to the structure and function of involved entities related to supervision or overall effectiveness.

2. Each recommendation that arises from a Board presentation shall be assigned to a specific party with a proposed timeframe for implementation of the recommendation. If a Board member objects to the assignment of a recommendation, the objection shall be

noted in the final recommendations list with a proposed solution to pursuing the recommendation.

3. The final list of recommendations shall be distributed by the City's Board Governor to all members in attendance within 7 days of the Board meeting.

4. The list of recommendations shall be presented during the following CPIC monthly meeting of the general CPIC body to solicit feedback and input on implementation of recommendations. Subsequent CPIC monthly meetings shall include an update on the progress towards completion of the recommendations.

5. Each Quality Assurance Audit meeting shall include a review of the status of prior recommendations and any further measures needed for implementation.

VI. SENTINEL EVENTS: INITIAL INVESTIGATION

For purposes of this methodology, Sentinel Events shall refer to the following types of incidents that shall be reviewed by the Board of Governors:

- Behavioral health or crisis-related calls for service (including those calls for service later classified as behavioral health or crisis-related) that result in a level 3 use of force (See BPD Policy 725, *Use of Force Reporting, Review, and Assessment*),
- On-view incidents that include behavioral health or crisis components that result in a level 3 use of force,
- Whether or not involving use of force, any police encounter involving an individual in behavioral health crisis that includes the death or serious injury to the individual, and
- Any other critical incident or category of incidents, as identified by the Sentinel Event Review Board of Governors, involving a person with behavioral health needs or a person who experiences a crisis that leads to or involves police interaction.
- Patterns of referrals from entities to 9-1-1.

<u>Notification and Preliminary Review</u>

This Committee may be notified of a Sentinel Event via BPD, a City Department, BHSB, a provider of Behavioral Health Services, 9-1-1, dispatch, or the general public[3]. The responsibility of notification to the Board of Governors rests with BPD, but any member of the Board may request a Sentinel Event review. Upon an initial determination by the Board that a Sentinel Event has occurred, the Board shall oversee a root cause analysis that entails a review by BPD, a review by BHSB, and, as applicable, a review by another public service provider within two weeks of the critical incident.

[3] The City will provide instructions for how the general public can notify Board of Governors of a request for a Sentinel Event review.

BPD Initial Review:

1. Upon identifying or receiving notification of a Sentinel Event, the BPD's CIT Coordinator shall request, through official channels, the following materials:

    1.1. Body-Worn Camera footage from all involved members related to the incident,

    1.2. A copy of the 24-hour and 72-hour Report(s), as available,

    1.3. A copy of the Behavioral Health Report, if available,

    1.4. A copy of the 9-1-1 and Dispatch tapes from the incident; and

    1.5 Any other BPD-member generated reports pertaining to the incident (e.g. arrest or incident reports, use of force reports, any criminal charges filed by BPD members, PIB complaints, summary of individual's history of police encounters etc.)

2. The CIT Coordinator shall share the materials with the following BPD personnel for an initial review:

    2.1. BPD's Board governor/CPIC Co-Chair,

    2.2. The CRT Supervisor, and

    2.3. The Behavioral Health Reform Manager, CDIU.

3. The BPD's Board personnel shall complete an initial review within 7 days of the incident and submit to co-chairs, which shall analyze:

    3.1. The assignment and dispatch of the call for service (i.e., was a CIT officer available and assigned to the call for service),

    3.2. The member's initial approach and how the member(s) sought additional information on-scene,

    3.3. Attempts to contact additional resources (e.g., CRT, Mobile Crisis Response Team, the individual's caretaker or clinician, and/or FAST) for support, and

    3.4. Use of de-escalation techniques (e.g., time, distance, cover, calls for additional resources, and communication).

    3.5 Whether appropriate interventions occurred to address the physical injury to the individual

4. All co-chairs shall include follow-up questions to be distributed. Such follow-up questions are intended to enhance the reviews being conducted via BHSB and, as applicable, other entities, by highlighting gaps in information or possible root causes.

5. The initial BHSB review will also consider questions forwarded via BHSB or the Board that may further clarify the behavioral health component of the root cause analysis (e.g., LEAD involvement).

Fire Department Initial Review:

6. Upon receiving identified behavioral health related calls for service for the Sentinel Event Review, the Fire Department would provide any reports pertaining to this incident including but not limited to:

    6.1. A copy of the Medical Report, if available,

    6.2. A copy of the 9-1-1 recordings from the incident, if available,

    6.3. A copy of the CAD report,

    6.4. Any other Fire Department generated reports or medical reports pertaining to the incident

7. Fire Department personnel shall complete an initial review of reports produced.

Behavioral Health Initial Review:

8. BHSB will complete a review Public Behavioral Health System data and records for service utilization history and clinical information pertinent to the event under review.

    8.1. The individual's history of behavioral health symptoms or treatment history, as well as the last encounter between the individual and the service provider;

    8.2. During the six months preceding the Sentinel Event incident, the individual's prior history of behavioral health crises and interventions, including hospitalizations and aftercare plans, and/or;

    8.3. Where inpatient behavioral healthcare occurred, the kind of treatments/supports were provided to the consumer between hospitalization and the incident;

    8.4. How the decision was made to call 9-1-1 and whether the call was initiated by a behavioral health treatment provider;

    8.5. Whether the caller was aware of non-police crisis response services in Baltimore and whether they sought those services prior to calling 9-1-1;

    8.6. If the caller was aware of non-police crisis response services what factored into the decision to call 9-1-1;

8.7. Whether the individual or another party had sought non-police crisis intervention within 30 days of the incident, whether that intervention occurred in a timely way, and the outcome of that intervention;

8.8. A description of the nature of the crisis that prompted the call to 9-1-1 as described by the person, family member, or referring entity, including the duration of the crisis prior to the call;

8.9. Whether the involved individual was actively receiving behavioral health treatment whether the individual was active with an ACT team or other provider of intensive behavioral health services, and, if so, the circumstances for seeking/obtaining crisis services (e.g. did the individual contact the treatment provider on their own, what treatment were they offered, etc.), and

8.10. Whether the treatment provider was aware of the crisis event and BPD's involvement.

9. BPD's Board Governor shall share all materials, reports, and follow-up questions to the other Board Governors and the Governors shall schedule a date within 30 days of notification of the Sentinel Event for a Board review.

Preparing the Board Presentation

10. The findings of the initial review from BPD and BHSB shall be compiled to include a chronological timeline of the individual's involvement with the behavioral health and/or law enforcement system(s) prior to the event under review.

11. The BPD'S CIT Coordinator shall prepare a brief presentation for the Sentinel Event Review Board that includes:

11.1. Chronological description of the incident under review;

11.2. Body-Worn Camera, surveillance, and/or other video footage capturing the incident;

11.3. Audio recordings of the 9-1-1 Call and Dispatch; and

11.4. Background information related to the incident as discovered through the initial review by BHSB, BCFD, and BPD.

12. The Board presentation shall be distributed to all permanent members in advance of the Sentinel Event Review.

VI. BEHAVIORAL HEALTH CRISIS INCIDENT REVIEW BOARD PROCEDURES

Conducting a Review

1. BPD, BCFD and BHSB, in partnership, shall present the case detailing the facts and circumstances of the identified events and incidents.

2. During the presentation, the Board may ask questions of the BPD, BCFD, BHSB, and other entities conducting the initial review during the presentation to develop a more comprehensive understanding of the available facts and circumstances of the events and incidents. For each event and/or incident, BPD, BCFD and BHSB shall facilitate a discussion in order to specifically address the:

   3.1. **Initial Response**: How the police became involved in the incident, and whether 9-1-1 call intake or police emergency dispatch could have sought additional or alternative resources.

   3.2. **Police Interaction**: Whether the involved member(s) conducted themselves in accordance with BPD policy and training, consistent with the core principles that govern the BPD's crisis intervention policies, and with a special emphasis on de-escalation.

   3.3. **Health System Interaction:** Whether the involved members of the public behavioral health system (e.g., clinicians, mobile crisis team members), or the public health system in general (e.g., emergency department personnel, EMS personnel), conducted themselves in a manner that respected the consumer's dignity, civil rights, and promoted positive health outcomes for the consumer.

   3.4. **Precipitating Events**: What led to the Sentinel Event, whether it be a crisis, problems in behavioral health services, or other triggers.

   3.5. **Preventing the Crisis**: An analysis of the potential services or service improvements that could have prevented the Sentinel Event.

   3.6. **Barriers and Opportunities**: What occurred, or did not occur, that created the environment for the Sentinel Event. Similarly, what resources do not exist currently that could have contributed to a better outcome.

4. Following the discussion, the governors shall compile a list of recommendations to be acted upon by the assigned parties.

VII. RECOMMENDATIONS

1. The City's Board Governor shall present the final list of recommendations that were made during the Sentinel Event Review. Recommendations may include, but are not limited to:

   1.1. System Coordination: Observations on gaps within the public behavioral health system and other systems that could be addressed through enhanced coordination.

1.2. Remediation: Issues observed from any involved individual that violated current policy/practice and contributed to negative outcomes in the Sentinel Event. Examples of remedial recommendations may include Training Bulletins, internal memos, additional training for involved members, etc.

1.3. System Enhancement: Recommendations related to procedures or resources that currently do not exist within the public behavioral health system or other systems that could have prevented the incident, including identifying legislative solutions that the City can advocate, data tracking and reporting, and routine audits.

1.4. Organizational: Issues related to the structure and function of involved entities related to supervision or overall effectiveness.

2. Each recommendation that arises from a Board presentation shall be assigned to a specific party with a proposed timeframe for implementation of the recommendation. If a Board member objects to the assignment of a recommendation, the objection shall be noted in the final recommendations list with a proposed solution to pursuing the recommendation.

3. The final list of recommendations shall be distributed by the City's Board Governor to all members in attendance within 7 days of the Board meeting.

4. A limited review of the incident as well as the list of recommendations shall be presented during the following CPIC monthly meeting of the general CPIC body to solicit feedback and input on implementation of recommendations. Subsequent CPIC monthly meetings shall include an update on the progress towards completion of the recommendations.