Innocence and Prevention: Could We Build Justice Safety Centers?

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Some contemporary writers argue that wrongful convictions represent system failures in a complex criminal justice system. Currently explorations are underway into whether pursuit of non-blaming, all-stakeholders, forward-looking "sentinel event" reviews focused on lowering risk rather than laying blame can improve safety from wrongful convictions. This article reviews the underlying theory of safety-based practices and sketches one model of how work on preventing wrongful convictions might be institutionalized: made a part of a new culture of continuous improvement that lowers the risk of future wrongful convictions and offers a degree of restorative justice to the victims of errors.

Innocence work naturally prioritizes a tight, reactive focus—a concentration on apprehending errors and rescuing individual clients.

But the people closest to the suffering of the justice system's victims are also best placed to appreciate the restorative value of honoring their exonerated clients' perspectives, recognizing the harms done to the original crime's victims, and preventing new tragedies. Like it or not, innocence workers and exonerated men and women inherit a unique guardianship relation with future defendants, their families, and communities.

What if we focused on learning the lessons of the last wrongful conviction in order to prevent the next one? Can we find a way to make continuous learning available? Offer exonerated men and women and the original crime's survivors roles in a restorative process? Develop the capacity for a "forward-looking accountability"[1] that prevents future tragedies?

[1] Virginia A Sharpe, "Promoting Patient Safety: An Ethical Basis for Policy Deliberation" (2003) 33 Hastings Ctr Rep S2 at S8, S10.

This piece concludes with a sketch of one potential vehicle for accomplishing these things. Others have been discussed previously.[2] But weighing the potential (if any) of such efforts requires adjusting the perspective that we naturally employ when litigating claims and sharing histories.

I Using Safety's Wider Lens

Barry Scheck recently observed that every exoneration or "near miss" raises the "[Q]uestion the 'innocence movement' has asked from the beginning: What went wrong and how do we fix it so it doesn't happen again?"[3] Addressing that question, as Scheck points out, is not so easy: "By its very nature this is a 'system' question involving multiple stakeholders that intersects with complex ethical, legal, and scientific issues."[4]

The work of exposing a wrongful conviction and winning exoneration is channeled within a traditional process. Except in cases where a DNA comparison offers a compelling independent lever, investigators and lawyers litigating a wrongful conviction must generally find a mistake or a rule violation, and then prove that it was harmful.[5]

In this vision the criminal justice system is a Newtonian arrangement of components: linear and sequential. Effects follow inevitably from causes. This view, which is characteristic of media accounts of wrongful convictions as well as of legal proceedings, foregrounds the broken component— "the eureka part"—and then offers it as the cause of a miscarriage of justice. Sometimes, the broken component is human: a dishonest police officer, a "dry-labbing" forensic worker, or a prosecutor who buries exculpatory evidence. Sometimes the broken element is technical—a faulty interrogation method or identification technique, or an unscientific forensic comparison.

As a result, corrective efforts focus on repairing or replacing the broken individual components. For example, we can work to modernize identification practices by developing and instituting science-supported best practices such as "double-blind" photo displays and immediate post-identification confidence reports in eyewitness cases.[6] We can require video recording of all interrogations, or ban Reid method interrogations of young or developmentally disabled people.[7]

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[2] See e.g., Keith Findley, "Learning From Our Mistakes: A Criminal Justice Commission to Study Wrongful Convictions" (2002) 38 Cal W L Rev 333; Kent Roach, "The Role of Innocence Commissions: Error Discovery, Systemic Reform, or Both?" (2010) 85 Chicago-Kent L Rev 89.

[3] Barry Scheck, "The Integrity of Our Convictions: Holding Stakeholders Accountable in an Era of Criminal Justice Reform" (2019) Geo LJ Ann Rev Crim Proc iii [*Scheck*].

[4] *Ibid*.

[5] Brandon Garrett, "Innocence, Harmless Error, and Federal Wrongful Conviction Law" (2005) 2005 Minn L Rev 36.

[6] See e.g., John Turtle, RCL Lindsay & Gary Wells, "Best Practice Recommendations for Eyewitness Procedure: New Ideas for the Oldest Way to Solve a Case" (2003) 1 Can J Pol & Sec Serv 1.

[7] See generally, Kyle C Scherr, et al, "Cumulative Disadvantage: A Psychological Framework for Understanding How Innocence Can Lead to False Confession, Wrongful Conviction, and Beyond" (2020) 15(2) Perspect Psychol Sci 353.

The revelation of wrongful conviction cases has played an important role in generating improvement in routine investigative practices.[8]

When the failed component is human, we can isolate and discipline the human actor. Anyone who has been a direct witness to the devastating personal consequences of planting evidence, suborning the perjured testimony of jailhouse informants, or hiding exculpatory evidence naturally feels a heightened desire to see appropriate punishment imposed. By now, the startling impunity with which "bad apple" cops, prosecutors, and ineffective defenders have populated the wrongful convictions list has created a reservoir of rage that intensifies the focus.[9] For many people the first order of business in the aftermath of a wrongful conviction is to seek the discipline and punishment of the culpable actors. The punishment of insider wrongdoing is an important factor in producing system legitimacy and public faith in the law. No system can function without disciplining its conscious rule-breakers, and, making the sanctioning of misconduct a reality is a perfectly reasonable place to start.[10]

Still, if preventing future wrongful convictions is one of our goals, the punishment—however draconian—of a lone unethical practitioner, or the reform of a single forensic practice is a bad place to stop. There is much more to learn from a wrongful conviction than that some techniques are faulty, some cops and prosecutors are dishonest, some defenders are lazy.

We have to make room somehow for a complementary process that focuses not on blame but on prevention. A developing body of insights from researchers who study safety in aviation, medicine, and other high-risk fields indicates that uncovering a wrongful conviction can illuminate a very broad array of critical system weaknesses.[11]

The phrase "criminal justice system" is everywhere, but what sort of system do we mean? Sometimes "system" seems to refer to an enigmatic eco-system—a pond or a swamp where local actions produce mysterious impacts on the far shore. Sometimes "system" denotes a mechanical construction of gears and switches—a linear, sequential, Newtonian arrangement of discrete causes that generate automatic effects. It can be easily captured in a timeline, flow chart, or "fish bone" diagram. One domino falls; it knocks over the next.

Over the past decade an alternative explanatory paradigm has begun to gain traction. It understands the criminal justice system not as a chaotic wetland and not as a "complicated" machine with many parts, like a jet airliner at rest. In this conception, criminal justice, like a jet airliner *in operation*, is a complex adaptive system in which the frontline operators are engaged in "sense-making" in a dynamic environment.[12]

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[8] James M Doyle, *True Witness: Cops, Courts, Science, and the Battle Against Misidentification* (New York, Palgrave MacMillan, 2005) at 131-140 (On reform impact of first DNA exonerations) [*Doyle*].

[9] For an example of the frustration bred by this impunity, see Kate Levine & Joanna Schwartz, "Hold Prosecutors Accountable Too" *Boston Review* (22 June 2020), online: http://bostonreview.net/law-justice/kate-levine-joanna-schwartz-hold-prosecutors-accountable-too.

[10] For a number of astute proposals for clarifying and enhancing that process, see Scheck, *supra* note 3.

[11] See authorities collected in James M Doyle, Essay: "A "Safety Model" Perspective Can Aid Diagnosis, Prevention, and Restoration After Criminal Justice Harms" (2019) 59 Santa Clara L Rev 107.

[12] Sidney Dekker, *Safety Differently: Human Factors for a New Era*, 4th ed (Boca Raton, CRC Press: Taylor & Francis Group, 2015); Stanley Dekker, Paul Cilliers & Jan-Hendrik Hofmeyr, "The Complexity of Failure: Implications of

Wrongful convictions can be understood as system errors arising in a complex socio-technological system.[13] It is generally impossible to discover a single broken component or incompetent operator that fully explains the event. Even in situations where it appears that an individual's misconduct is responsible for the harm, someone hired that "bad apple"; someone supervised him; someone failed to prevent or intercept his missteps; someone (or many "someones") created the environment in which he decided he would zig when he should have zagged. The shifting, overlapping (and often conflicting) goals, conditions, and influences that buffet sharp end actors and produce mistakes are not determinative, as failed switches or frozen gears would be; their impacts are probabilistic. The effects are not linear and sequential; everyone's actions are affecting everyone else's actions simultaneously. While it is true that "upstream" police are affecting the "downstream" prosecutors, the police decisions are affected by their understandings of the prosecutors' downstream requirements,[14] and both groups are affected by what they anticipate in the courtroom. All the actors are responding to pressures from caseloads, budgets, politics, and media. A "bad apple" explanation is not sufficient. Even identifying a free-standing "rotten barrel" (for example, a police department or crime lab) will almost never provide either an adequate diagnosis or a fully effective treatment. Safety cannot be found in a single component or silo any more than wetness can be found in single molecule of H_2O. Complexity requires an understanding not simply of components, but also of their interactions.

Even the paradigmatic misconduct case of a prosecutor hiding exculpatory evidence is an "organizational accident". The dishonest prosecutor did not contrive the wrongful conviction on his or her own.[15] The police had to arrest the wrong person[16] and "shape" the evidence for the prosecutor.[17] Their mistake might have been influenced by frailties in local forensic science systems. The prosecutors' office culture may have exacerbated cognitive biases,[18] incentivized shortcuts and "workarounds," and created pressure to produce convictions. Information systems may have created pockets of "structural secrecy."[19] A "see-no-evil" tradition of trial court oversight may have warped judges' conduct. The jury failed to intervene. Enormous caseloads and grudging funding may have gutted the defense function and made the detection of the prosecutor's suppression or independent identification of the exculpatory evidence nearly

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Complexity Theory for Accident Review" (2011) 49 Safety Sci 939; Ivan Pupilidy & Crista Vessel, "The Learning Review: Adding to the Accident Investigation Toolbox" in *EU Commission Joint Research Centre* (Ispra, Italy, Nov 2017) [*Pupilidy*].

[13] See generally, Boaz Sangero, *Safety from False Convictions* (Scotts Valley, CA, CreateSpace Independent Publishing Platform, 2016) [*Sangero*]; James M Doyle, "Learning from Error in American Criminal Justice" (2010) 100 J Crim L & Criminol 109.

[14] Somli Trivedi & Nicole Gonsalez-VanCleve, "To Serve and Protect Each Other: How Prosecutor-Police Codependence Enables Police Misconduct" (2020) 100 BU L Rev 895 [*Trevidi*]; Kim Rossmo & Jocelyn Pollack, "Confirmation Bias and other Systemic Causes of Wrongful Convictions: A Sentinel Events Approach" (2019) 11 Ne L Rev 791 [*Rossmo*].

[15] James Doyle, "Orwell's Elephant and the Etiology of Wrongful Convictions" (2015/2016) 79 Alb L Rev 895.

[16] Rossmo, *supra*, note 14.

[17] Trevidi, *supra*, note 14.

[18] See Barbara O'Brien, "A Recipe for Bias: An Empirical Look at the Interplay Between Institutional Incentives and Bounded Rationality in Prosecutorial Decision Making" (2009) 74 Mo L Rev 999 at 1022, 1032.

[19] Andrew Guthrie Ferguson, "Big Data Prosecution and Brady" (2020) 67 UCLA L Rev 180 [*Ferguson*].

impossible. The distant appellate courts that developed a legal architecture resting on a framework of "materiality" may have encouraged the prosecutor to gamble on deviating (just a little further) from the requirements of due process. [20]

All of the individuals involved had reasons for their decisions; all were trying to make sense of a swirling cloud of overlapping and often clashing influences as they chose their courses of action. The possibility (or unlikelihood) of exposure and punishment for misconduct may well be one of the influences, but when it is it will be one influence among many.[21] Everyone's work affected everyone else's work. Typically, numerous information gaps and misunderstandings, actions, and omissions---no one of which is independently sufficient to cause the event---combine with each other and with latent system weaknesses, and only then produce (or nearly produce) the disaster.

Safety researchers such as Charles Perrow argue that Murphy's Law is wrong—that everything that can go wrong usually *doesn't,* and then we draw the wrong conclusion.[22] The absence of known accidents is not proof of safety. The absence of exonerations is not proof that the system has not generated wrongful convictions and will not generate more. In this view the absence of a disaster proves only that the probabilities inherent in various unsafe conditions and acts have not coalesced today; it does not prove that they are not present, or that they will not coalesce tomorrow.[23] If these conditions are not identified and addressed there will be no guarantee that the same dismal narrative will not be repeated with another practitioner—who may not be a "bad" actor, but may not be an exemplary actor either—when his turn comes.

II Reviewing the Event, Not the Performance

The submerged nature of the criminal system's dangers is unsettling, but a useful converse of the Perrow maxim is that when an exoneration *does* make a dangerous condition visible that event can be, as patient safety pioneer Dr. Donald Berwick argued, "A treasure."[24] Careful examination of an exoneration through a safety lens will reveal not only a defective component (e.g., hair comparison or coercive interrogation) or isolated dishonest human (e.g., a prosecutor who hides Brady material) but an extensive "influence map" of overlapping and interactive

[20] Riley E Clafton, "Note—A Material Change to Brady: Rethinking Brady v Maryland, Materiality, and Criminal Discovery" (2020) 110 J Crim L & Criminol 307.

[21] The steps recommended by Scheck, *supra,* note 3, (at least as I understand them) are aimed to bolster this influence by thoughtfully increasing the clarity of the choices and actionable nature of ethical and procedural contexts rather than by simply ratcheting up the frequency and ferocity of threatened penalties. They recognize the complexity of the pathway between knowing ethical precepts and applying them. See generally, Max H Brazerman & Francesca Gino, "Behavioral Ethics: Toward a Deeper Understanding of Moral Judgment and Dishonesty" (2012) 8 Ann L Soc Sci 85.

[22] William Langewieshce, *Inside the Sky: A Meditation on Flight* (New York, Vintage, 1998) at 196 (referencing Charles Perrow); Charles Parrow, *Normal Accidents* (Princeton, Princeton U Press, 1984).

[23] Professor Boaz Sangero has argued there is a "Hidden Accidents" principle at work in criminal justice that makes mistakes hard to see and often impossible to prove: Sangero, *supra*, note 13.

[24] Donald Berwick, "Continuous Improvement as an Ideal in Healthcare" (1989) 320 New Eng J Med 53 at 54.

dangers and weaknesses that can be addressed and mitigated before the next practitioners confront them.[25]

A fully contextualized *event* review can contribute to system resilience in a way that a *performance* review aimed at misconduct cannot.[26] The logic of complexity[27] dictates that no criminal justice "silo," no matter how dedicated and well-meaning its representatives, can address all of these conditions on its own. It also underlines the importance of reviewing a wrongful conviction from an "all-ranks" perspective. An event review is free to act on both of these precepts.

Because criminal justice is a system under pressure "workarounds," triage, and "covert work rules" multiply. The "work-as-imagined" by rule-makers and Best Practice authors and the "work-as-done" by the people on the frontlines diverge. This doesn't usually occur through explicit rebellion and repudiation; it proceeds by a process of practical drift.[28] As safety expert Sidney Dekker explains:

> …[D]ecisions that are seen as "bad decisions" after the accident (even though they seemed like perfectly acceptable ideas at the time) are seldom big, risky steps. Rather, there is a long and steady progression of small incremental steps that unwittingly take an organization toward its boundaries. Each step away from the original norm that meets with empirical success (and no obvious sacrifice of safety) is used as the next basis to depart just that little bit more. It is this incrementalism that makes distinguishing the abnormal from the normal so difficult. If the difference between what "should be done" (or was done successfully yesterday) and what is done successfully today is minute, then this slight departure from an earlier established norm is not worth remarking or reporting on.

Disciplinary processes (when they occur[29]) generate information in a story-like format, but, as Susan Bandes has pointed out, their tendency is to present atomized anecdotes, blinded to system implications:

> The conventional story of blame and purposeful misconduct dangerously misdescribes the way governmental misconduct works, by disaggregating it into a series of individual, anecdotal acts. Government causes harm not through the misdeeds of a single malevolent person who wants to harm a specific individual, but through the collective decision-making of numerous people many of whom are acting in good faith. Few have affirmatively to act in bad faith, because all of the incentives are skewed in favor of simply not acting at all. [30]

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[25] See, Pupilidy, *supra*, note 12.

[26] Sidney Dekker, *The Second Victim: Error, Guilt, Trauma and Resilience*, 1st ed (Boca Raton, Florida, CRC Press, 2013) (quoting Ivan Pupilidy) [*Dekker*].

[27] Sidney Dekker, et al., "The Complexity of Failure: Implications of Complexity Theory for Safety Investigations" (2011) 49 Safety Sci 939.

[28] Scott A Snook, Friendly Fire: *The Accidental Shoot Down of U.S. Blackhawks over Northern Iraq* (Princeton, Princeton U Press, 2000) at 232-236.

[29] See Trevidi, *supra*, note 14.

[30] Susan Bandes, "Patterns of Injustice: Police Brutality in the Courts" (1999) 47 Buff L Rev 1275 at 1330.

In a misconduct-oriented performance review, the factors that persuaded frontline workers that their decision was evidence of informed, veteran workmanship, not a dangerous rule violation, will be overlooked altogether or brushed aside as "excuses." The desire to avoid treating influences and conditions as mitigation of misconduct reduces the appreciation of their explanatory power. When a rule violator is identified as "the cause" of a wrongful conviction, but his misconduct is not also examined as an *effect*, we can doom ourselves to an endless game of whack-a-mole when subsequent practitioners see the same deviation as a normal, pragmatic adjustment to unchanged facts of life. Reform efforts will always stay one tragedy behind.

Many acts and omissions are not accounted for in discipline-oriented reviews because they implicate no legal theory of culpability. The distant authors of an unsafe policy or technique, the architects of information systems,[31] the bureaucratic sources of daunting caseloads and inadequate budgets, the accelerators of media frenzy, all of whom contributed to the likelihood of a wrongful conviction, are not liable in a performance-oriented punitive review. It is important, of course, to learn what these influential figures did, but it is also important to learn *why* they did it. In many cases they will not recognize their own contributions to the wrongful conviction.

Fault-based proceedings in the aftermath of a wrongful conviction (e.g., criminal prosecutions, departmental disciplinary hearings, professional ethics reviews, or civil tort suits) are built on adversarial structures heavily weighted with due process protections for the person accused. These concerns constrict participation. In contrast, an all-stakeholders event review could offer restorative capability by mobilizing the perspectives of numerous persons harmed.

No one questions, for example, that the original crime's victims were wounded by the wrongful conviction,[32] or that the actual perpetrator's subsequent victims suffer great harms because the opportunity to incapacitate him was missed when the exoneree took the offender's place in prison. Existing review processes provide no space for the recognition of these very real harms. A disturbing portion of the wrongful conviction list is comprised of innocent people who pleaded guilty: their detailed accounts of their experiences could be invaluable to our understanding of the system influences that convinced them to abandon their fight.

Besides, existing punitive vehicles deprive the persons harmed by a wrongful conviction of healing that might be experienced if they were allowed to participate in the work of preventing their harrowing experiences being visited on future victims of system error. Medicine's experience with "disclosure and apology" approaches to medical error events indicates that patients (or their survivors) value the opportunity to turn their experience to some use in preventing harm to others.[33] The tireless participation of exonerated men and women in Innocence efforts indicates how strongly the same impulse is felt in criminal justice.[34]

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[31] See Ferguson, *supra*, note 19.

[32] Lara Bazelon, *Rectify:The Power of Restorative Justice After Wrongful Conviction* (Boston, Beacon Press, 2018); Healing Justice, online: https://healingjusticeproject.org.

[33] See Jennifer K Robbennolt, *Apologies and Medical Error* (Philadelphia, Clinical Orthopedics & Related Research, February, 2008) online: https://www.ncbi.nlm.nih.gov/PMC2628492/.

[34] See for example, Witness to Innocence, online: https://www.witnesstoinnocence.org. Healing Justice, online: https://healingjusticeproject.org.

A learning-oriented event review also provides a venue for direct community participation that a disciplinary process does not offer. In most known wrongful conviction cases, after all, a jury, the proxy for the community, played an indispensable role in the tragedy.[35] By lending non-professional citizen participants to a learning review the community can both keep the professional players honest and enforce a measure of transparency. Just as importantly, the community can express its sense of its own accountability for the outcome, rather than seeming to off-load responsibility onto the handiest professional scapegoat. As Sidney Dekker points out, to terminate proceedings with the punishment of a practitioner and nothing more sends a strange message:

> Paying off the first victim and sending off the second [the final practitioner] denies the reality and the humanity of the relationship between the two . . . Where first victims are given the impression that their lives had been entrusted to a disposable cog in the organizational machine, what does that say about the organization's own duty ethic in relation to its patients, passengers, clients? [36]

In a complementary learning review an exonerated citizen can witness his or her community accepting its responsibility for seeing that nothing similar happens in the future. The learning reviews can enhance legitimacy by showing that neither community members nor criminal justice professionals will accept "Nothing to see here, move along" as a response.

Currently the advantages of these learning reviews are being explored in the real world. In the United States, demonstration sites[37] have begun to enlist in the U.S. National Institute of Justice / Bureau of Justice Assistance Sentinel Events Initiative (SEI),[38] an examination of the potentials of non-blaming, all-stakeholders, forward-looking, learning reviews of adverse events, "near misses", and "good catches." Preliminary reports from "beta site" reviews—for example, an all-stakeholders analysis[39] of a "near miss" prosecution of innocent men in a Philadelphia multiple homicide—have shown that the safety-oriented approach can pay the predicted dividends. Additional jurisdictions will gather crucial experience[40] by conducting these pioneering reviews. But the question will remain whether these learning reviews, however useful they prove, can be sustained as an ongoing, routine feature of criminal justice culture.

The safety claim for the event reviews is not simply that they will uncover a large number of system weaknesses—although they will do that—but that if adopted as a normal practice they can introduce a cultural change. What is being tested here is whether the practice of sentinel event reviews can be "[A] key driver of the development and perpetuation of the safety cultures built by

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[35] Submerged misdemeanor wrongful convictions which do not necessarily implicate juries are very likely to be quite numerous. Issa Kohler-Haussman, "Managerial Justice and Mass Misdemeanors" (2014) 66 Stan L Rev 611 at 663-664.

[36] Dekker, *supra,* note 26 at 98.

[37] Online: https://www.bja.gov/sentinel-events-initiative/demonstration-project.html.

[38] Online: https://nij.ojp.gov/topics/articles/sentinel-events-initiative.

[39] John Hollway & Ben Grunwald, "Applying Sentinel Event Reviews to Policing" (2019) 18 Criminol & Pub Pol'y 705 (sentinel event review of "near miss" mistaken homicide investigation).

[40] Katherine Darke Schmidt, et al., *Paving the Way: Lessons Learned in Sentinel Event Reviews* (Washington, DC, National Institute of Justice, 2014); Douglas Starr, "A New Way to Reform the Judicial System" *The New Yorker* (21 March 2015).

the aviation and medical industries." [41] Can we make "[T]he errors themselves the mechanism for learning and change"?[42] Can we help criminal justice practitioners see—and fulfill—their own individual responsibilities for a just collective outcome by making learning reviews an embedded, routine element of criminal justice practice?

These ideas have potential for application across the whole range[43] of criminal justice errors, but their value is particularly striking where the error exposed is a wrongful conviction. No one in criminal justice wants to play a role in another wrongful conviction.

III A Place to Learn: Creating the Space for Stories

But where would all of this happen? It may make sense to begin working on that problem now, as the experience generated by the N.I.J. Sentinel Event demonstration sites accumulates. There have been numerous thoughtful approaches to the challenge of learning from exonerations.[44] Mobilizing the safety-driven notions of system complexity may advance those efforts a little further.

One reflexive response to the "where" question is "We need a National Transportation Safety Board for exonerations." But criminal justice is an intensely local enterprise. Laws, procedures, budgets, demographics, and history vary significantly from place to place. Any event review should harness national reservoirs of expertise, but it must also be attentive to idiosyncratic local features. Although we would ultimately hope to construct a capacity for "forward-looking accountability" with national—even international—scope it seems likely that we had better build it from the ground up rather than from the top down. Besides, we should hesitate before sacrificing the restorative justice and culture shifting advantages that sustained local community and practitioner involvement produce by handing matters over to a distant group of elevated technocrats. A flexible structure resembling the Innocence Network's—a constellation of locally expert and embedded facilities linked to exploit synergies and disseminate lessons—might best exploit the possibilities and provide continuity.

Assembling collaborative learning groups and designing their processes on a "one-off" basis will present a daunting challenge for most jurisdictions, and that will inhibit the mobilization of productive learning reviews. At best, reviews will be executed only on the crisis-oriented basis

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[41] David Klinger, "Organizational Accidents and Deadly Officer Involved Shootings" (2020) Annals of Am Acad Pol & Soc Sci 687, online: https://www.cambridge.org/core/journals/law-and-social-inquiry/article/learning-model-of-useofforce-reviews/B7E9FF03862C5D22F4C72FCEBABB300B.
at 41 [*Klinger*].

[42] Barbara Armacost, 'Police Shootings: Is Accountability the Enemy of Prevention" (2019) Ohio St L J 907 at 938 [*Armacost*].

[43] There is, for example, a growing interest in applying this approach to fatal officer-involved shootings. See Klinger, *supra*, note 41; Armacost, *supra*, note 42.

[44] Barry Scheck and Peter Neufeld immediately proposed a learning from error facility when the first round of DNA exonerations was revealed: Doyle, *supra*, note 8.

of the Warren Commission or the Kaufmann Report[45] into the Guy Paul Morin case, when public outcry following a cataclysmic disaster requires action. That approach threatens to confuse learning and disciplinary review goals and to overlook the opportunities presented by "high frequency, low impact" events that aviation and other fields have found tremendously informative.

There are strong arguments for building stable local and regional platforms where the practice of continuous learning from events can take place, but it isn't clear that any existing model will suffice. An established infrastructure that can be called on when an array of stakeholders recognizes learning potential—rather than one that must be laboriously assembled when some spectacular scandal provides the spur—can better promote a culture of safety in criminal justice. The infrastructure, if designed with supporting a statewide capability in mind, could relieve stakeholders of the burden of "re-inventing the wheel" every time that document management, specialist interviews, and the systems-oriented approaches to the group analysis of an event are implicated. It can provide a coherent platform for integrating the data-driven insights of the researchers with the street level narratives of the practitioners and community members. It can perform the bibliographical function of mustering lessons learned elsewhere. It can promote consistency in de-identifying materials designated for distribution, and then organize sharing the results.

A state or provincial Criminal Justice Safety Learning Center can ameliorate the fact that many stakeholder actors involved in criminal justice events are rooted in overlapping but not co-extensive areas of responsibility. A given event, for example, might involve a neighborhood addiction support program, a City police force, a County prosecutor, a statewide Court system and Public Defender agency, and a regionally or demographically determined forensic science catchment area. These entities might be variously immune from civil suits, or self-insured, or covered within regional risk pools, and may all be attempting to manage their shared risks from individual, atomized positions of vulnerability.

Moreover, a Criminal Justice Safety Learning Center that is available to lend its capacities can address the reality that it is simply impossible for many smaller places[46] to support the standing ability to convene a learning group. It can provide the criminal justice system's leaders with a reliable way to communicate to their communities that whatever the outcome of parallel disciplinary proceedings targeting individuals, the system's leaders are determined that the event at issue will never recur.

A neutral platform supporting a collaboration among equals is more promising than an effort "owned" by one of the collaborators. Contemporary reform efforts often germinate and then focus their efforts within silos. For example, there are progressive District Attorneys who understand the advantages of learning from error analyses. [47] Organizations such as The Institute

[45] *Report of the Kaufman Commission on Proceedings Involving Guy Paul Morin* (Toronto, Attorney General of Ontario, 1998), online: External link to full text of Kaufman Report on Guy Paul Morin.

[46] Lawrence W Sherman, "Reducing Fatal Police Shootings as Systems Crashes: Research, Theory, and Practice" (2018) 1 Ann Rev Criminol 421.

[47] See e.g., George Gascon, "Using Sentinel Events to Promote System Accountability" and John Chisholm, "Moving Beyond a Culture of Defensiveness and Isolation" in *Nat'l Institute of Justice, Mending Justice: Sentinel Event Review* (Washington, DC, National Institute of Justice, 2014).

for Innovation in Prosecution[48] and Fair and Just Prosecution,[49] recognizing the power wielded by local prosecutors, have begun to promote reform programs that mobilize elected prosecutors' unique influence. But this advocacy inevitably summons an image of Heroic Prosecutors, doing justice in their lonely way. An event review conducted by the prosecutor, on the prosecutor's turf, is likely to generate skepticism among the other necessary stakeholders as they are considering enlisting in "the DA's thing." Police and defenders are likely to regard invitations to the District Attorney's office to take part in the District Attorney's initiative without enthusiasm.

Community stakeholders, whose insights into the iatrogenic harms inflicted by the professionals' efforts (and proposed reforms) are indispensable, are likely to be very wary of lending their credibility to what will seem to be a particular agency's campaign of self-rehabilitation. Similar "Do I trust my host?" issues will handicap even police departments (such as Tucson's[50]) that are open to conducting "critical incident reviews" and confronting events (again, a "suicide-by-cop" would be another example) that implicate numerous other agencies and domains.

While the police and prosecutors can lead in these situations, and the Innocence community can have an important catalytic role to play in assembling these elements, this leadership must take the unusual form of leadership that foreswears control—leadership *into collaboration*.

IV Marshaling, Interrogating, Improving, and Disseminating the Data

The ecology of contemporary criminal justice reform is shaped by a commitment to correcting the data-starved state of knowledge about criminal justice work as it is performed. Terms such as "evidence-based" and "data-driven" acquire talismanic significance in reform discourse. The productive role of intensely local data analysis has been illuminated by the dedicated and inventive approaches of Amy Bach and Measures for Justice.[51] This long overdue pull in the direction of improving the system's capacity for introspection through data may make a local event review approach seem irrelevant to some—may make it seem to promise only a pointless accumulation of anecdotes at the expense of rigorous statistical analyses.

This is a short-sighted view. A state or provincial Center with the capacity to develop, solicit and collect data across the agencies implicated in a wrongful conviction will pay important dividends.

Neither event narratives nor data compilations are independently sufficient. Each informs (and challenges) the other. Having the narratives without discerning the patterns into which they fall does not help much. At the same time, "What is measurable is not the same as what is

[48] Online: https://www.prosecution.org/our-mission.

[49] Online: https://fairandjustprosecution.org.

[50] Online: https://www.tucsonaz.gov/police/critical-incident-review-board-cirb-0.

[51] Online: https://measuresforjustice.org. See Amy Bach, *Ordinary Injustice: How America Holds Court*. (New York, Picador Publishing, 2010).

valuable."[52] Any state level Learning Center will facilitate the collection of data, but a state level Learning Center that combines event reviews and data-driven efforts, will also help to ensure that the data we have is the data we need.[53] (For example, data on the cascading racial inequalities[54] embedded in actual law enforcement practices could be collected and analyzed.) It will point to new areas of interest where salient data should be sought, and it will protect against the danger that measures of outputs might unintentionally obscure issues of process. Where the statistical compilations can depict how things are (or were) the narrative event reviews can alert us to where they are going as the environment changes, interactions and overlaps proliferate, caseload and budget pressures grow, and the inevitable processes of practical drift, workarounds, and triage take hold. Whether or not this combination of perspectives generates quick answers it will certainly generate good questions: areas for empirical inquiry about capacities, interactions, and vulnerabilities. The Center can provide a platform where the narratives and the data can be held in productive tension.

V A Model to Amend (Or Reject)

It may prove helpful as results from demonstration sites arrive if observers, critics, and potential adopters have available for contemporaneous review some rough sketch of legislation designed to help allow jurisdictions to provide for continuous learning on a sustained basis. The "draft" below is provided as a starting point. It closely follows (to the point of paraphrase) the enabling legislation[55] for the Betsy Lehman Patient Safety Center, a small Massachusetts state agency that accomplishes in the healthcare sphere much of what a Criminal Justice Safety Learning Center might hope to achieve in criminal justice.

The SEI Demonstration Site efforts will likely take many forms, but the Betsy Lehman Patient Safety Center offers an analogy for criminal justice safety activities that suggests one straightforward and distinctly "doable" approach from the array of possibilities.[56] It indicates that a place to do safety work that offers risk reduction and a measure of restorative justice on a sustained basis may be within reach for a quite modest investment.[57]

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[52] Tricia Wang, "Why Big Data Needs Thick Data" *Ethnography Matters* (13 May 13), online: https://medium.com/ethnography-matters/why-big-data-needs-thick-data-b4b3e75e3d7.

[53] *Ibid*. See generally, Barry Friedman & Elizabeth Jànszky, "Policing's Information Problem, Working Paper" (2019) Pub Law & Leg Theory Res Paper Series 19. On the question of narrative complementing data, see Robert L Wears & Ben-Tzion Karsh, "Thick v. Thin: Description Versus Classification in Learning from Case Reviews" (2008) 51 Annals Emerg Med 262.

[54] James M Doyle, "Discounting the Error Costs: Cross Racial False Alarms in the Culture of Contemporary Criminal Justice" (2001) 7 Psychol Pub Pol'y & L 253.

[55] See *Mass Gen Laws*, 2018, c 12C, §15(e) [*Mass Gen Laws*].

[56] See "Betsey Lehman Center for Patient Safety" online: https://www.betsylehmancenterma.gov.

[57] See *Nat'l Institute of Just., The Sentinel Events Roundtable Summary Proceedings from an Expert Roundtable* (Washington, DC, National Institute of Justice, 2013), online: http://nij.gov/topics/justice-system/sentinel-events/roundtable.htm.

The Betsy Lehman Center is a statewide agency with a small budget and a small professional staff.[58] With a comparable staff available, a state center for Criminal Justice Safety (maintained, for example, at a public university's criminal justice school, or law school, or under the auspices of a state or provincial Attorney General or Supreme Court) could provide local jurisdictions with a neutral moderator, process expertise, and substantive subject matter experts from event-relevant fields. It could provide services to victims and other persons harmed that ensures that they would not be re-traumatized by participation in event reviews. It could manage documents, develop taxonomies of error, and provide de-identifying protocols that would allow for disseminating the event analyses generated by local participants, relieving smaller jurisdictions within a state of the need to maintain a standing review capacity locally.

What could emerge—echoing the structure of the Innocence Network—is a web of Centers, each deeply versed in local law and conditions and experienced in event analysis, networked to achieve coordination, information-sharing, and other synergies.

A version of the Betsy Lehman Center's ability to afford confidentiality[59] to participants could also be an important element of the development of the criminal justice system's safety perspective, although perhaps not in the expected way. It is easy to overstate the seriousness of the threat of increased civil liability for criminal justice harms as a substantive matter. Many important learning events chosen for review (e.g., "near misses", "good catches") trigger no financial liability. In others, (events that in medical cases would be classified as "closed claims") the financial costs have already been realized, and logically can be treated as investments that ought to pay off in lessons to be learned.[60] Beyond the choice of specific events for review, a variety of case-specific devices, such as judicial protective orders and confidentiality agreements can be mobilized to provide sufficient event-specific protection in particular instances. These predictions are open to argument, of course, and the NIJ/BJA "demonstration projects" should shed further light on their accuracy, but there are indications that the liability concerns in terms of actual increased vulnerabilities will be marginal—something to be worked through, not a disqualification.

Besides, as the heroic scholarship of Joanna Schwartz on police indemnification has shown, the public entities paying for the event under current review are in a position to benefit exponentially from enhancements to future safety.[61] The best way to avoid liability is to avoid the harm, and in a context such as policing in which 99.98 percent[62] of money received by plaintiffs

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[58] The Massachusetts Governor's budget request for fiscal year 2017 was $1.53 million: "Center for Health Information and Analysis – Budget Summary" Mass Gov, online: http://budget.digital.mass.gov/bb/h1/fy17h1/brec_17/dpt_17/hlhcf.htm.
The Center is also authorized to seek supplementary foundation and federal support.

[59] See Mass Gen Laws, *supra*, note 55 ("Information collected . . . or reported . . .shall not be a public record . . .shall be considered confidential and shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding. . .").

[60] See Joanna C Schwartz, "Introspection Through Litigation" (2015) 90 Notre Dame L Rev 1055 at 1083.

[61] Joanna C Schwartz, "How Governments Pay: Lawsuits, Budgets, and Police Reform" (2016) 63 UCLA L Rev 1144 at 1181; Joanna C Schwartz, "Police Indemnification" (2014) 89 NYL Sch L Rev 885 at 955.

[62] Joanna C Schwartz, "Police Indemnification" (2014) 89 NYL Sch L Rev 885 at 995. See also, John Rappaport, "How Private Insurers Regulate Public Police" (2017) 130 Harv L Rev 1539 at 1547.

is paid from public funds, not the funds of the practitioners, the reduction in public risk from repeated harms could more than overbalance in policy terms any discomfort that the conduct of learning reviews instills.

Although it may naturally seem to mid-level lawyers in local government agencies that their primary mission is to avoid lawsuits, the mission of the criminal justice system as a public entity is *not* to avoid lawsuits, but to do—and, at least as importantly, to be seen to be doing—justice. If people are harmed by criminal justice error the public (yes, the tax-paying public) wants to see them fairly compensated.[63] The fact is, the fear of liability exposure is actually generated by the recognition that the public—in its civil jury incarnation—will *demand* the payment of damages from public funds if offered that option. Even so, although liability concerns may in fact be outweighed by the benefits that safety perspective learning reviews offer, even mistaken concerns about liability remain significant in practical terms when they frighten stakeholders away from learning-oriented processes.

Progress toward a safety perspective in criminal justice will have to be encouraged by leadership, but it cannot be imposed, from the top downwards. There is not, and there probably never can be, a criminal justice an exact equivalent to the Joint Commission on Accreditation (that imposes accreditation standards on all hospitals), or the National Transportation Safety Board (that compels transportation industry cooperation with investigation of every accident). At least in the United States, experience with generations of reform efforts shows that the highly localized and hyper-fragmented state of the criminal justice institutional environment that Malcolm Feeley identifies as a structural element of the American system simply does not allow for the imposition of this sort of grand scheme from above.[64]

If a safety-oriented approach to criminal justice advances at all it will be by following the classic pattern of diffusion of innovation that Everett M. Rogers described. It will have to attract willing collaborators: first followers, early adopters, an early majority, a late majority, and (eventually) laggards. [65] Because the learning reviews require *all* stakeholders' perspectives to be fully effective, progress will require gathering groups of diverse collaborators in a context in which every potential group membership holds a veto. Fears of liability augmentation, whether they are sincere or are used simply to cloak inertia and inchoate discomfort with novelty, can be a destructive inhibiting force.[66] The anxieties of a few nervous lawyers can easily turn a promising restorative justice moment into a grudging, protracted, process of semi-disclosure that aggravates public distrust in the justice system. Dealing with those inhibitions sooner rather than later, as in the Betsy Lehman Center authorizing legislation's "safe harbor" language, is likely to be a productive strategy. It is at least a strategy to be kept in mind and tested against experience as Demonstration Sites mobilize and proceed.

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[63] Kimberley A Clow, et al., 'Public Perception of Wrongful Conviction: Support for Compensation and Apologies" (2012) Alb L Rev 1415.

[64] Malcolm M Feeley, "How to Think About Criminal Court Reform" (2018) 98 BUL Rev 673.

[65] Everett M Rogers, *Diffusion of Innovations*, 5th ed (New York, Simon & Shuster, 2003).

[66] James M Doyle, "Keeping the Wrong Secrets: The "Cone of Silence" Around Exonerations" *The Crime Report.Org* (New York, The Center on Media, Crime and Justice at John Jay College, 28 May 2019), online: https://thecrimereport.org/2019/05/28/keeping-the-wrong-secrets-the-cone-of-silence-around-exonerations/.

A sketch of a draft statute instituting such a Center follows. Its utility lies less in its substance than in its potential for providing the widely dispersed demonstration site participants and those who observe their progress with a common target to criticize, amend—for that matter, reject.

In this incarnation, the Center is named for John Adams, the second president of the United States and a leader of the movement for American independence from Great Britain. A plaque stands inside the door of the Center, with a quotation from the closing argument Adams delivered when he defended the British soldiers charged in the Boston Massacre:

> It's of more importance to community that innocence should be protected, than it is that guilt should be punished; for guilt and crimes are so frequent in the world, that all of them cannot be punished; and many times they happen in such a manner that it is not of much consequence to the public, whether they are punished or not.
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> But when innocence itself, is brought to the bar and condemned, especially to die, the subject will exclaim, it is immaterial to me whether I behave well or ill; for virtue itself is no security. And if such a sentiment as this should take place in the mind of the subject, there would be an end to all security whatsoever.[67]

Draft statute:

John Adams Center for Public Safety and Criminal Justice Learning; Board; Education and Research program

Section 15.

(a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Adverse event", injury to a person resulting from a criminal justice intervention or failure to intervene and not to the underlying condition of the person.

"Board", the public safety and criminal justice errors reduction board.

"Adams center", the John Adams center for public safety and criminal justice learning.

"Incident", an incident which, if left undetected or uncorrected, might have resulted in an adverse event.

"Criminal justice error", the failure of criminal justice system management to institute or complete as intended a safe action, or the use of a wrong plan to achieve an outcome.

[67] *Rex v Wemms*, in L Wroth & Hiller Zobel, eds, *Legal Papers of John Adams, Vol 3* (Cambridge, Harvard U Press, 1965) at 240.

"Public safety", freedom from accidental or avoidable injury from crime or from the criminal process.

(b) There shall be established the John Adams center for public safety and criminal justice learning. The purpose of the Adams center shall be to serve as a platform and clearinghouse for the development, evaluation and dissemination of learning in criminal justice, including, but not limited to, the sponsorship of training and education programs, the development of best practices for public safety and criminal justice learning, and the conduct of collaborative learning reviews of events. The Adams center shall: (1) coordinate the efforts of state and local agencies engaged in the regulation, contracting or delivery of criminal justice and those individuals or institutions licensed by the commonwealth to provide criminal justice to meet their responsibilities for public safety and criminal justice learning; (2) assist all such entities to work as part of a total system of public safety including public health and mental health services; (3) develop appropriate mechanisms for all stakeholders to be included in a statewide program for improving public safety; and, (4) provide a platform for all-stakeholders, forward-looking, learning reviews of events and incidents in criminal justice (5) provide a platform for identifying, soliciting, interrogating, maintaining, and evaluating data related to criminal justice goals and operation. The Adams center shall coordinate state participation in any appropriate state or federal reports or data collection efforts relative to public safety and criminal justice learning. The Adams center shall conduct learning reviews, support learning reviews at the request of jurisdictions within the state, and analyze available data, research and reports for information that would improve education and training programs that promote public safety.

(c) Within the Adams center, there shall be established a public safety and criminal justice errors reduction board. The board shall consist of the Director of the Executive Office of Public Safety, the Attorney General, the Chief Counsel of the Committee for Public Counsel Services, the executive director of the center, the Director of Public Health, The Director of Mental Health and the Commissioners of Corrections, the Chief Justice of the Supreme Judicial Court and/or their Designees and two Community Representatives to be nominated by the Governor. The board shall appoint, in consultation with the advisory committee, the director of the Adams center by a unanimous vote and the director shall, under the general supervision of the board, have general oversight of the operation of the Adams center. The director may appoint or retain and remove expert, clerical or other assistants as the work of the Adams center may require. The coalition for the prevention of public safety and criminal justice errors shall serve as the advisory committee to the board. The advisory committee shall, at the request of the director, provide advice and counsel as it considers appropriate activities including, but not limited to, serving as a resource for studies and projects undertaken or sponsored by the Adams center. The advisory committee may also review and comment on regulations and standards proposed or promulgated by the Adams center, but the review and comment shall be advisory in nature and shall not be considered binding on the Adams center.

(d) The Adams center shall develop and administer a public safety and criminal justice learning education and research program to assist criminal justice professionals, criminal justice facilities and agencies and the general public regarding issues related to the causes and consequences of criminal justice error and practices and procedures to promote the highest standard for public safety in the commonwealth. The Adams center shall annually report to the governor and the

legislature relative to the feasibility of developing standards for public safety and criminal justice learning programs for any state department, agency, commission or board to reduce criminal justice errors, and the statutory responsibilities of the commonwealth, for the protection of persons together with recommendations to improve coordination and effectiveness of the programs and activities.

(e) The Adams center shall (1) identify and disseminate information about evidence-based best practices to reduce criminal justice errors and enhance public safety; (2) conduct learning reviews in the aftermath of adverse events or incidents that maximize participation by community and practitioner community members, (3) develop a process for determining which evidence-based best practices should be considered for adoption; (4) serve as a central clearinghouse for the collection and analysis of existing information on the causes of criminal justice errors and strategies for error prevention; (5) increase awareness of error prevention strategies through public and professional education; and (6) develop appropriate vehicles for the compensation of persons harmed by criminal justice system errors.

(f)The information collected by the Adams center or reported to the Adams center shall not be a public record as defined in section 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding, except as otherwise specifically provided by law.

(g) The Adams center shall report annually to the Legislature regarding the progress made in improving public safety and criminal justice learning. The Adams center shall seek federal and foundation support to supplement state resources to carry out the Adams center's public safety and criminal justice learning goals.