

4-3-2019

# ESSAY: A “SAFETY MODEL” PERSPECTIVE CAN AID DIAGNOSIS, PREVENTION, AND RESTORATION AFTER CRIMINAL JUSTICE HARMS

James M. Doyle

Follow this and additional works at: <https://digitalcommons.law.scu.edu/lawreview>



Part of the [Law Commons](#)

## Recommended Citation

James M. Doyle, *ESSAY: A “SAFETY MODEL” PERSPECTIVE CAN AID DIAGNOSIS, PREVENTION, AND RESTORATION AFTER CRIMINAL JUSTICE HARMS*, 59 SANTA CLARA L. REV. 107 (2019).

Available at: <https://digitalcommons.law.scu.edu/lawreview/vol59/iss1/3>

This Article is brought to you for free and open access by the Journals at Santa Clara Law Digital Commons. It has been accepted for inclusion in Santa Clara Law Review by an authorized editor of Santa Clara Law Digital Commons. For more information, please contact [sculawlibrarian@gmail.com](mailto:sculawlibrarian@gmail.com), [pamjadi@scu.edu](mailto:pamjadi@scu.edu).

**ESSAY: A “SAFETY MODEL” PERSPECTIVE CAN AID  
DIAGNOSIS, PREVENTION, AND RESTORATION  
AFTER CRIMINAL JUSTICE HARMS**

**James M. Doyle\***

TABLE OF CONTENTS

Introduction .....	107
1. The Safety Perspective on Public Safety .....	108
2. The Safety Perspective and Diagnosing Unsafe Outcomes.....	114
3. The Prevention Potential In Forward-Looking Accountability .....	117
4. Participation, Collaboration, Restoration .....	125
5. A Safety Place .....	131

INTRODUCTION

The chemotherapy dose required by the 1994 experimental breast cancer protocol was already high. Then, the Dana-Faber Cancer Institute administered four times that dosage to Betsy Lehman, the health columnist for the *Boston Globe*. Lehman died within days. For two months the hospital did not realize that the overdose had caused her death.<sup>1</sup>

The media coverage was relentless, and its effect was electric. People felt that if this horrific botch was possible at Dana-Farber, it was possible anywhere. As one leader in the struggle against medical error put it, Betsy Lehman’s death was “Patient Safety’s Chernobyl.”<sup>2</sup>

The Lehman tragedy accelerated the recognition that most medical errors are (like the Chernobyl meltdown) system errors, not the result of a solitary practitioner’s mistake.

---

\* Of counsel, Bassil & Budreau, Boston, Massachusetts.

1. Mark Crane, *Who Caused this Tragic Medication Mistake?*, MED. ECON. (Oct. 8, 2001), <http://medicaleconomics.modernmedicine.com/medical-economics/content/who-caused-tragic-medication-mistake>.

2. *Id.*

That re-orientation led to action. Massachusetts moved toward building its health system's capacity for learning—for looking beyond blame for tragedies and focusing on preventing recurrence. The Massachusetts Legislature created a state agency,<sup>3</sup> the Betsy Lehman Patient Safety Center, with the mission of understanding the hidden system-based sources of error. The Lehman Center's enabling statute provides a "safe harbor" where information gathered about patient safety events can be protected: statements, documents, and other materials provided during participation in the Center's investigations are not available from the Center for use in related civil or administrative proceedings.<sup>4</sup> The Center provides a platform for "forward-looking accountability" aimed at cutting future risk, not at apportioning blame.<sup>5</sup>

Now, Massachusetts has seen 30,000 criminal convictions overturned after the exposure of faked drug test results supplied by two state chemists, Annie Dookhan and Sonja Farak.<sup>6</sup> Alone, every faked test created the possibility of an extended pretrial detention, a wrongful conviction, a prison term, a criminal record, a dismembered family—a wrecked life. Aggregated, the faked tests created a certainty of tens of thousands of "wrongful dismissals" and failed prosecutions. (Counterfeit drug "false positives" among the 30,000 must have been far outnumbered by genuine drug cases that the lab frauds required terminating.)

### 1. THE SAFETY PERSPECTIVE ON PUBLIC SAFETY

Criminal justice in the United States is primarily a state and local enterprise and most (if not all) states and localities have experienced some disturbing outcomes. Harris County, Texas, for example, has experienced its own lab scandals.<sup>7</sup> Elsewhere, the innocent are wrongly

---

3. MASS. GEN. LAWS ch. 12C, § 15 (2018).

4. MASS. GEN. LAWS ch. 12C, § 15(e) (2018). "The information collected by the Lehman center or reported to the Lehman 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." This provision does not affect the availability of information from traditional sources even when it is also submitted to the Center.

5. Virginia A. Sharpe, *Promoting Patient Safety: An Ethical Basis for Policy Deliberation*, HASTINGS CTR. REP. S8, S10 (2003), [http://www.thehastingscenter.org/wp-content/uploads/patient\\_safety.pdf](http://www.thehastingscenter.org/wp-content/uploads/patient_safety.pdf).

6. Paul Solotaroff, *And Justice for None: Inside Biggest Law Enforcement Scandal in Massachusetts History*, ROLLING STONE (Jan. 3, 2018), <https://www.rollingstone.com/culture/news/did-falsified-drug-tests-lead-to-wrongful-convictions-w514801>.

7. See Brian Rogers, *Scores of Cases Affected After HPD Crime Lab Analyst Ousted*, HOUS. CHRON. (June 18, 2014), <https://www.houstonchronicle.com/news/houston-texas/houston/article/Scores-of-cases-affected-after-HPD-Crime-Lab-5562835.php>.

convicted while the real perpetrators go free; dangerous prisoners are mistakenly released and then kill again; avoidable “suicide-by-cop” fatalities traumatize families and frontline police. Beneath these front-page spectacles a submerged universe of coerced misdemeanor<sup>8</sup> plea bargains, protracted pretrial detentions, failed re-entry plans, fruitless street stops, “near-misses,” declining “closure rates” and “high frequency, low impact” events of all kinds erode public security and trust in the law.

Could these disasters serve as local “Public Safety Chernobyls” and lead toward the same forward-looking reforms that followed Betsy Lehman’s death? Can we develop “Criminal Justice Safety Centers” that follow the Lehman Center example, and build the capacity—one that is now strikingly lacking—to analyze criminal justice disasters collaboratively and learn their lessons, insulated from litigation’s unpredictable cross-currents of liability, immunity, indemnification, and reciprocal blaming?<sup>9</sup>

Discussions of contemporary American criminal justice do not suffer from any shortage of Models. Herbert Packer set the ball rolling by describing his opposing Crime Control and Due Process Models.<sup>10</sup> John Griffiths deployed a Family Model to show that Packer’s two polar ideologies are really variant versions of a single, unified Battle Model.<sup>11</sup> In the aftermath of the DNA exoneration cases Innocence Movement scholars such as Keith Findley and Marvin Zalman have attempted to point out to partisans for one or the other of Packer’s Models that some version of a Reliability Model<sup>12</sup> or Integrated Justice Model,<sup>13</sup> focusing on factual accuracy, could present a win/win option that simultaneously protects the innocent and targets the actually guilty, whom wrongful convictions leave free to find further victims.

---

8. See generally Jenny Roberts, *Informed Misdemeanor Sentencing*, 46 HOFSTRA L. REV. 171 (2017).

9. This not to say that there is not a great deal to be learned from litigation if we pay attention. See Joanna C. Schwartz, *Introspection Through Litigation*, 90 NOTRE DAME L. REV. 1055 (2015) [hereinafter Schwartz, *Introspection Through Litigation*].

10. HERBERT L. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 150-63 (1968).

11. John Griffiths, *Ideology in Criminal Procedure or a Third “Model” of the Criminal Process*, 79 YALE L.J. 359, 360 (1970). Like Griffiths, I think that “perspective” more accurately expresses what Packer actually delivers than “Model,” but (also like Griffiths) I will use “Model” as a way of preserving a measure of continuity in the conversation.

12. Keith A. Findley, *Toward a New Paradigm of Criminal Justice: How the Innocence Movement Merges Crime Control and Due Process*, 41 TEX. TECH. L. REV. 133, 147 (2008).

13. Marvin Zalman, *An Integrated Justice Model of Wrongful Convictions*, 74 ALB. L. REV. 1465 (2010). See generally Robert J. Norris and Catherine L. Bonventre, *Advancing Wrongful Conviction Scholarship: Toward New Conceptual Frameworks*, 32 JUST. Q. 929 (2015) (advocating a variety in approaches).

Still, there is an embryonic Model that will repay our attention in the context of “wrongful acquittals,” wrongful convictions, and other less spectacular miscarriages of justice. It will not function as a blueprint for organizing ideological life in the Packer manner, but it can provide a reminder that there is another—and potentially paradigm-shifting—way of looking at things.

The last decade has seen a growing interest<sup>14</sup> in a criminal justice orientation derived from a deep reservoir of literature and experience<sup>15</sup> that high-risk fields such as aviation and medicine<sup>16</sup> have tapped to develop “cultures of safety.”<sup>17</sup> The fact that safety concepts are so easily borrowed from other fields probably explains why there have been few efforts to denominate an explicit “Safety Model” in criminal justice.<sup>18</sup> But by now it is easy to list books, articles, and compilations that introduce the basic safety concepts to criminal justice practice

14. See generally Douglas Starr, *A New Way to Reform the Judicial System*, NEW YORKER (Mar. 31, 2015), <https://www.newyorker.com/news/news-desk/the-root-of-the-problem> [hereinafter Starr, *A New Way to Reform the Judicial System*].

15. See generally SIDNEY DEKKER, *SAFETY DIFFERENTLY* (2015); CHARLES PERROW, *NORMAL ACCIDENTS: LIVING WITH HIGH RISK TECHNOLOGIES* (1984); JAMES REASON, *HUMAN ERROR* (1990) [hereinafter REASON, *HUMAN ERROR*]; SCOTT SAGAN, *THE LIMITS OF SAFETY: ORGANIZATIONS, ACCIDENTS, AND NUCLEAR WEAPONS* (1993).

16. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (2000); Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1854 (1994).

17. See, e.g., BOAZ SANGERO, *SAFETY FROM FALSE CONVICTIONS* (2016); JON SHANE, *LEARNING FROM ERROR IN POLICING: A CASE STUDY IN ORGANIZATIONAL ACCIDENT THEORY* (2013); NAT’L INST. OF JUST., U.S. DEP’T OF JUSTICE, *MENDING JUSTICE: SENTINEL EVENT REVIEWS* (2014), <https://www.ncjrs.gov/pdffiles1/nij/247141.pdf>; James M. Doyle, *Learning from Error in American Criminal Justice*, 100 J. CRIM. L. & CRIMINOLOGY 109 (2010) [hereinafter Doyle, *Learning from Error in American Criminal Justice*]; Boaz Sangero & Mordechai Halpert, *A Safety Doctrine for the Criminal Justice System*, 2011 MICH. ST. L. REV. 1293 (2011). A number of criminologists have encouraged further explorations in the safety-minded direction. See, e.g., Richard A. Leo, *The Criminology of Wrongful Conviction: A Decade Later*, 33 J. CONTEMP. CRIM. JUST. 82, 100 (2016). See generally NAT’L INST. OF JUST., *NIJ STRATEGIC RESEARCH AND IMPLEMENTATION PLAN: SENTINEL EVENTS INITIATIVE* (2017), <https://www.ncjrs.gov/pdffiles1/nij/250472.pdf>.

As an element of that effort, Scott Hertzberg, a librarian at the National Criminal Justice Reference Service, has compiled a bibliography illuminating the extent of an interdisciplinary literature that implicates the safety-oriented model. See *Sentinel Events Initiative: A Compiled Bibliography*, NAT’L INST. OF JUST., <https://www.nij.gov/topics/justice-system/Pages/sentinel-events-bibliography.aspx>.

In collaboration with the Bureau of Justice Assistance, NIJ is currently funding technical assistance for an array of state and local collaborations that are organizing and evaluating all-stakeholder “Sentinel Event Learning Reviews.” This effort to shift focus from blame for past miscarriages to cutting the risk of future repetitions is discussed *infra* notes 106-110 and accompanying text.

18. But see Boaz Sangero, *Safety from Plea-Bargains’ Hazards*, 38 PACE L. REV. 301 (2018) (calling for application of a particular “System-Theoretic Accident Model and Processes” to plea bargain dangers).

communities.<sup>19</sup> The National Institute of Justice (NIJ), has given this interest practical form through its “Sentinel Events Initiative” by conducting a sustained investigation of the potential for mobilizing

---

19. Writers on a variety of criminal justice issues have employed the safety concepts. For example, forensic science reformers have adopted system-oriented safety thinking. *See, e.g.*, PAUL BIEBER, ANATOMY OF A WRONGFUL ARSON CONVICTION: SENTINEL EVENT ANALYSIS IN FIRE INVESTIGATION (2017); Itiel Dror & Carolyn Rado, *The Bias Snowball and the Bias Cascade Effects: Two Distinct Biases that May Impact Forensic Decision-Making*, 62 J. FORENSIC SCI. 832 (2017); Mordechai Halpert & Boaz Sangero, *From a Plane Crash to the Conviction of an Innocent Man: Why Forensic Science Evidence Should be Inadmissible Unless It Has Been Developed as a Safety-Critical System*, 32 HAMLIN L. REV. 65 (2009); Jennifer E. Laurin, *Remapping the Path Forward: Toward a Systemic View of Forensic Science Reform and Oversight*, 91 TEX. L. REV. 1051 (2013); D. Michael Risinger, *Whose Fault? Daubert, the NAS Report, and the Notion of Error in Forensic Science*, 38 FORDHAM URB. L.J. 519 (2010).

Commentators on policing issues have also utilized the safety lens. SHANE, *supra* note 17; OFF. OF COMMUNITY ORIENTED POLICING, FINAL REPORT OF THE PRESIDENT’S TASK FORCE ON 21ST CENTURY POLICING 22, Recommendation 2.3 (2015); John Hollway, Calvin Lee & Sean Smoot, *Root Cause Analysis: A Tool to Promote Officer Safety and Reduce Officer Involved Shootings Over Time*, 62 VILL. L. REV. 883 (2017); Joanna C. Schwartz, *Systems Failures in Policing*, 51 SUFFOLK L. REV. (forthcoming 2018) [hereinafter Schwartz, *Systems Failures in Policing*]; Lawrence W. Sherman, *Reducing Fatal Police Shootings as System Crashes: Research, Theory*, 1 ANN. REV. CRIMINOLOGY 421 (2018); Douglas Starr, *What Hospitals Can Teach the Police*, N.Y. TIMES (Apr. 21, 2018), <https://www.nytimes.com/2018/04/21/opinion/sunday/hospitals-police-violence.html>.

Prosecution operations have also been analyzed. *See* Josh Cutino, *Continuous Quality Improvement: Increasing Criminal Prosecution Reliability Through Statewide Systematic Improvement Procedures*, 20 LEWIS & CLARK L. REV. 1065 (2016); James M. Doyle, *Orwell’s Elephant and the Etiology of Wrongful Convictions*, 79 ALB. L. REV. 895 (2015); John Hollway, *Using Root Cause Analysis to Study Prosecutorial Error: A Collaboration between the Montgomery County (Pennsylvania) District Attorney’s Office and the Quattrone Center for the Fair Administration of Justice*, 62 VILL. L. REV. 13 (2016); Mike Nerheim and Meg Reiss, *The Criminal Justice System Needs to Start Learning From Its Mistakes*, THE HILL (Nov. 18, 2017), <http://thehill.com/opinion/criminal-justice/360969-the-criminal-justice-system-needs-to-start-learning-from-its>; Boaz Sangero, *Safety from Plea-Bargains’ Hazards*, 38 PACE L. REV. 301 (2018).

Defense performance has also been evaluated on a system safety basis. *See* James M. Anderson & Paul Heaton, *How Much Difference Does the Lawyer Make?*, 122 YALE L.J. 154, 209 (2012); Eva Brensike Primus, *Culture as a Structural Problem in Indigent Defense*, 100 MINN. L. REV. 1769, 1803-04 (2016).

The Vera Institute has pursued a safety-oriented approach to jail and prison self-harm events. LEAH POPE & AYESHA DELANEY-BRUMSEY, CREATING A CULTURE OF SAFETY: SENTINEL EVENT REVIEW OF SUICIDE AND SELF-HARM IN CORRECTIONAL FACILITIES (2016).

Others have weighed the safety approach in community corrections. *See, e.g.*, Janet Sheil, James Doyle & Christopher T. Lowenkamp, *Imagining Sentinel Event Reviews in the U.S. Probation and Pretrial Services System*, 80 FED. PROB. 33 (Sept. 2016).

At the intersection of criminal justice and its community environment, safety concepts have also been mobilized. *See* Nicole D. Porter, *Expanding Public Safety in the Era of Black Lives Matter*, 70 U. MIAMI L. REV. 533 (2016).

The safety-derived category of “near miss” has been used as a tool for comparing wrongful convictions to just outcomes. Jon B. Gould, Julia Carrano, Richard A. Leo & Katie Hail-Jares, *Predicting Erroneous Convictions*, 99 IOWA L. REV. 471 (2014).

safety thinking in non-blaming, all-stakeholders, “forward-looking” learning reviews after unexpected justice events.<sup>20</sup>

The safety at issue here is everyone’s safety: the safety of crime victims, defendants, and communities—even the safety of law enforcement personnel<sup>21</sup> and legal system practitioners.<sup>22</sup> This wider safety perspective escapes the zero-sum ideology of the Crime Control versus Due Process dialectic in which anything protecting an individual’s rights automatically threatens potential crime victims to an equal extent. It recognizes the impact of iatrogenic<sup>23</sup> (“from the treatment”) injury inflicted by hyper-aggressive “stop, question, and frisk” programs, re-traumatizing victim interviews, mass incarceration,<sup>24</sup> and other interventions, and requires that those harms be weighed in the balance before making criminal justice choices, not deferred to be deplored at some later date.<sup>25</sup> It throws a new light on familiar challenges; examining events in that light reveals opportunities. Familiarity with an emerging Safety Model can improve practice, and may fuel transformation.

At the core of this potential Model is a distinctive etiology—manner of causation—of errors such as mistaken releases and wrongful convictions.<sup>26</sup> It discounts single-cause explanations that focus on a lone

---

20. See *NIJ’s Sentinel Events Initiative*, NAT’L INST. OF JUST., <https://www.nij.gov/topics/justice-system/Pages/sentinel-events.aspx>. I have been a consultant to this effort, however, the views expressed in this Essay are my own.

21. German Lopez, *Police Have Known for 45 Years They Shouldn’t Shoot At Moving Cars. But They Still Do It.*, VOX (May 8, 2018) (reporting that the Las Vegas policy, stating that the pursuing officer in chase should not be the arresting officer, produced a twenty-three percent reduction in the use of force and eleven percent reduction in officer injury, while reducing racial disparity).

22. Several groups have marshaled the existing safety literature and mobilized it for criminal justice purposes. The National Commission on Forensic Science, which included representatives of all implicated communities of practice, adopted a recommendation that safety-derived root cause analyses be applied to crime laboratory failures. See *Recommendation to the Attorney General Root Cause Analysis (RCA) in Forensic Science*, NAT’L COMMISSION ON FORENSIC SCI. (Nov. 17, 2014), <https://www.justice.gov/archives/nfcs/file/786581/download>; OFFICE OF COMMUNITY ORIENTED POLICING SERVICES, PRESIDENT’S TASK FORCE ON 21ST CENTURY POLICING: FINAL REPORT OF THE PRESIDENT’S TASK FORCE ON 21ST CENTURY POLICING (2015); The Quattrone Center for the For the Fair Administration of Justice 2014 Spring Symposium: A Systems Approach to Conviction Integrity (Nov. 17, 2014), [https://issuu.com/pennlawits/docs/qc\\_thank\\_you\\_book\\_2014\\_017496e480b7c9](https://issuu.com/pennlawits/docs/qc_thank_you_book_2014_017496e480b7c9).

23. Jonathan Baert Wiener, *Managing the Iatrogenic Risks of Risk Management*, 9 RISK 39 (Winter 1998).

24. Bruce Western & Becky Pettit, *Incarceration and Social Inequality*, DAEDALUS 8 at 9 (Summer 2010).

25. See generally JAMES FOREMAN, JR., *LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA* (2017).

26. See generally James M. Doyle, *An Etiology of Wrongful Convictions: Error, Safety, and Forward-Looking Accountability in Criminal Justice*, in MARVIN ZALMAN & JULIA

practitioner (e.g., a lab technician, or trial prosecutor, or ineffective defender) or a defective component (e.g., a non-blind lineup or faulty forensic technique).

Safety commentators in aviation, medicine, and other high-risk fields would argue that like the space shuttle *Challenger* launch decision,<sup>27</sup> a “wrong patient” surgery,<sup>28</sup> or the Chernobyl meltdown,<sup>29</sup> wrongful convictions and mistaken releases are system errors: “organizational accidents.” In this conception, miscarriages of justice result from small mistakes and decisions—none of which are independently sufficient to cause the event—that combine with each other and with latent system weaknesses, which only then cause harm. This approach applies to a whole range of errors, including the unspectacular: “cold cases” that stay cold too long, fruitless stops and frisks, avoidable shootings of or by police, distended sentences for trivial violations, and “near miss” and “good catch” events where disaster was averted at the last moment by special skill or good luck.<sup>30</sup>

The safety paradigm, as Richard Leo notes, can:

Move us beyond individual or single-cause explanations of wrongful convictions to more systemic and etiological ones that emphasize routine mistakes, feedback loops, reciprocal impacts, interaction effects, latent conditions, and cumulative error, among other factors to more accurately understand the causes and cures of wrongful convictions.<sup>31</sup>

To the question “who is accountable?,” safety commentators would answer, “everyone involved, to one degree or another, if not by acting themselves, then by failing to anticipate or intercept another’s action.” “Everyone” in this context includes individuals far from the scene of the event who did the hiring and training, set the caseloads, shaped the jurisprudence, imposed the budgets, and created the environment for the sharp-end actors. Dr. Lucien Leape, one of the pioneers in the patient

---

CARRANO, WRONGFUL CONVICTION AND CRIMINAL JUSTICE REFORM: MAKING JUSTICE 56 (2014).

27. DIANE VAUGHAN, *THE CHALLENGER LAUNCH DECISION: RISKY TECHNOLOGY, CULTURE, AND DEVIANCE AT NASA* (1st ed. 1996).

28. Mark R. Chassin & Elise C. Becher, *The Wrong Patient*, 136 ANNALS OF INTERNAL MED. 826, 829 (2002).

29. See CHARLES PERROW, *NORMAL ACCIDENTS: LIVING WITH HIGH-RISK TECHNOLOGIES* 354 (rev. ed. 1999).

30. See Starr, *A New Way to Reform the Judicial System*, *supra* note 14 (describing Philadelphia “sentinel events” review of homicide in which it was discovered that wrong men had been held for six months pretrial). For a discussion of “near miss” and “good catch” approaches in medicine, see Kurt B. Hurzer, et al., *Patient Safety Reporting Systems: Sustained Quality Improvement Using Multidisciplinary Team and “Good Catch” Awards*, 38 JOINT COMM’N J. QUALITY & PATIENT SAFETY 339 (2012).

31. Leo, *supra* note 17, at 97.



safety movement, summarized this perspective: “While an operator error may be the proximate “cause” of the accident, the root causes were often present within the system for a long time. The operator has, in a real sense, been “set up” to fail by poor design, faulty maintenance, or erroneous management decisions.”<sup>32</sup>

Would we think differently about things if we kept the safety perspective in mind?

## 2. THE SAFETY PERSPECTIVE AND DIAGNOSING UNSAFE OUTCOMES

Correcting individual errors (for example, by closing a “cold case” or exonerating a prisoner) and addressing prospectively the systemic weaknesses leading to those errors are two different tasks.<sup>33</sup> The wider lens provided by safety thinking advances both of those efforts, although in different ways. The potential impact on identifying past errors is less direct and more modest than the impact on preventing future harms, and it is felt only one case at a time. Even so, it is real, and should not be ignored.

The legal system’s treatment of miscarriages of justice—known or alleged, completed or looming—traditionally employs a streamlined approach to cause and effect. It isolates a single defective component of the system, sometimes human (for example, a prosecutor who hides exculpatory evidence, or a technician who “dry labs” an evidence sample) and sometimes technical (for example, an unscientific forensic technique, or a faulty communications link) and treats it as the cause.<sup>34</sup> That cause determines a definite effect, just as a defective spring or gear in the clockwork would dictate failure in a wristwatch.

---

32. Leape, *supra* note 16.

33. See generally Keith Findley, *Learning From Our Mistakes: A Criminal Justice Commission to Study Wrongful Convictions*, 38 CAL. W. L. REV. 333 (2002); Kent Roach, *The Role of Innocence Commissions: Error Discovery, Systemic Reform or Both?*, 85 CHI. KENT L. REV. 89 (2010).

34. On general concepts of causation in conventional legal thinking, see, H.L.A. HART & TONY HONORE, *CAUSATION IN THE LAW* (1985). For cause-effect reasoning in error review, see, Brandon L. Garrett, *Innocence, Harmless Error, and Federal Wrongful Conviction Law*, 2005 WISC. L. REV. 35. Safety expert Sidney Dekker draws this contrast between legal and modern safety concepts of causation. SIDNEY DEKKER, *DRIFT INTO FAILURE: FROM HUNTING BROKEN COMPONENTS TO UNDERSTANDING COMPLEX SYSTEMS* 79 (2011) (“The way in which legal reasoning in the wake of accidents separates out one or a few actions (or inactions) on the part of individual people follows such reductive logic. For example, the Swedish Supreme Court ruled that if one nurse had more carefully double-checked a particular medication order before preparing it (mistakenly at ten times the intended dose) a three-month-old baby would not have died. Such condensed, highly focused accounts that converge on one (in)action by one person (the “eureka part”) give componential models of failure a societal legitimacy that keeps reproducing and instantiating Newtonian physics.”).

Media accounts of criminal justice malfunctions reinforce this view because they are obsessed with identifying villains (the racist, trigger-happy cop who shoots the civilian) or fools (the naïve judge who releases the murderous juvenile).<sup>35</sup> So does the rhetoric of appellate opinions that isolate a culpable cause, then gauge its prejudicial effect. Occasionally, when the failures of more than one component (the lab technician and then the prosecutor and then the defender) are noticed, the causal language in the appellate opinion or news story moves from “simple” to “complicated.” Even in those cases, however, the relationship between the “causes” is described as linear and sequential, and the relationship between the proximate cause and the harm is seen as determinative: *x* happened, and so therefore, *y* followed, and *z* followed from that.<sup>36</sup> This “complicated” version can be fully captured by devices such as a timeline, a “Fishbone Diagram,”<sup>37</sup> or a “Swiss Cheese Diagram.”<sup>38</sup>

Contemporary safety writers<sup>39</sup> argue that human interaction with even a simple system very quickly introduces uncertainty, adaptation, and complexity. Once the humans are involved, cause and effect relationships are no longer linear (as in a machine); for every act there can be an unlimited number of effects.<sup>40</sup> A jet airliner is an immensely *complicated* machine, but jet air liners in operation “[B]ecome *complex* because they are opened up to influences that lie way beyond engineering specifications and reliability predictions.”<sup>41</sup>

The production of these effects is not determinate, as throwing a switch would be; it is probabilistic. For example, the decision to use a “simultaneous” lineup technique in which the suspect and fillers are displayed together may generate more “false hit” identifications of an innocent suspect than a “sequential” (one photo at a time) technique, but it does not produce a false hit; it raises the odds in favor of one.<sup>42</sup> That

35. See, e.g., Shawn Cohen & Bruce Golding, *Gun-Grabbing Nut Wasn't the Only Suspect Judge Released Without Bail*, N.Y. POST (July 15, 2017), <https://nypost.com/2017/07/15/judge-released-alleged-gun-grabber-who-could-have-killed-everybody/>.

36. For an example of legal insistence on “but for” causation, see *Burrage v. United States*, 541 U.S. 204 (2014) (drug overdose causation not sufficiently shown).

37. *How to Use the Fishbone Diagram*, CTRS. FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fishbonerevised.pdf>.

38. REASON, HUMAN ERROR, *supra* note 15.

39. See, e.g., Ivan Pupilidy & Crista Vesel, *The Learning Review: Adding to the Accident Investigation Toolbox*, EUR. COMMISSION JOINT RESEARCH CENTRE (Nov. 2017).

40. Sidney Dekker, Paul Cilliers & Jan-Hendrik Hofmeyr, *The Complexity of Failure: Implications of Complexity Theory for Safety Investigations*, 49 SAFETY SCI. 939 (2011).

41. *Id.* at 941-42 (emphasis added).

42. Nancy K. Steblay, Jennifer E. Dysart & Gary L. Wells, *Seventy-Two Tests of the Sequential Lineup Superiority Effect: A Meta-Analysis and Policy Discussion*, 17 PSYCHOL. PUB. POL'Y & L. 99 (2011).

false hit may, in turn, increase the probability that “tunnel vision” cognitive bias in investigators will be triggered.<sup>43</sup> Huge caseloads or intense media pressure may increase the likelihood that the tunnel vision cognitive bias is augmented and alternative suspects or contradictory narratives are disregarded rather than appropriately sought and evaluated.

But these factors will not *require* those outcomes. They are “influences” rather than “causes” in the routine legal sense.<sup>44</sup> They do not act in sequence; they are acting together, and on each other, simultaneously. A decision by a cop, or a prosecutor, or a defender, or a judge may often seem to be a cause, but it is certainly *always* an effect: every decision is the outcome of the practitioners’ struggles to make sense of the swirling influences that are acting on them. The practitioner’s situation during patrol, or investigation, or litigation is dynamic and adaptive, not static and schematic. The presence of any particular influence does not guarantee failure in every case, nor does its absence guarantee safety. This recognition can help to repair a blind spot in the re-evaluations of investigations, prosecutions, convictions, and other processes.

The tight focus on Newtonian scenarios of cause-and-effect channels inquiry and investigation, and it can obscure the fact that a mistake has been made whenever no single, glaring, independently sufficient cause presents itself. The identification of some “smoking gun” cause becomes a triage criterion for the hard-pressed practitioners who must investigate and prepare claims: it is treated as a prerequisite not only to a finding of error, but to the commitment of time and resources required in looking for one.<sup>45</sup> Unless someone can point to a distinct violation with an inevitable product, the harm is not likely to be recognized in any practical sense. Adherence to the everyday causation model leads quickly to a dead end in investigations of possible miscarriages of justice.

But the safety perspective opens a supplemental window on legally significant narratives by explaining how—even without the independently sufficient “smoking gun”—slips and errors occur,

---

43. See Keith A. Findley & Michael S. Scott, *The Multiple Dimensions of Tunnel Vision in Criminal Cases*, 2 WISC. L. REV. 291, (2006).

44. Pupulidy & Vesel, *supra* note 39 and accompanying text at 1.

45. The history of the Innocence Movement, for example, reflects an abiding concern with the triage function imposed on innocence lawyers by the scarcity of resources. See generally ROBERT J. NORRIS, EXONERATED: A HISTORY OF THE INNOCENCE MOVEMENT, 188-89 (2017); Daniel S. Medwed, *Actual Innocents: Considerations in Selecting Cases for a New Innocence Project*, 81 NEB. L. REV. 1097 (2002).

cascade, and cumulate until an unforeseen result takes its toll.<sup>46</sup> Starting from the hypothesis that the result is mistaken with this complex etiology in mind can help to imagine a path of “locally rational” but mistaken decisions and reveal the likelihood that an error has occurred either in convicting or eliminating a suspect. A “within-policy” wrongful conviction or solvable yet still unsolved “cold case” in which everyone followed the rules as the rules then stood and took only those risks that were regarded as “acceptable” is perfectly possible given the potential for human error built into the investigative process and the unreliability of the legal system’s diagnostic capabilities.<sup>47</sup> Even so, retrospectively uncovering individual mistakes is only the beginning of the Safety Model’s potential contribution.

### 3. THE PREVENTION POTENTIAL IN FORWARD-LOOKING ACCOUNTABILITY

No system can survive without disciplining its conscious rule-breakers, and enthusiasts for the “non-blaming” approach to safety reviews have to keep that fact in mind.<sup>48</sup> Certainly, the Massachusetts drug lab scandals, for example, make it very clear that there really are “bad apples” in the criminal justice system, and that there is nothing wrong with dismissing and prosecuting them.<sup>49</sup> In fact, public trust in the system can depend to an important degree on the punishment of insider misconduct. But those debacles also make it clear that the punishment of culpable individuals is a bad place to stop.

One of the Safety Model’s maxims is that it is insufficient to go “down and in” to understand an event; you must also go “up and out” to appreciate the environment that motivated the proximate human agent.<sup>50</sup>

---

46. Cf. Ruth A. Moyer, *To Err is Human; To Cumulate, Judicious: The Need for U.S. Supreme Court Guidance on Whether Federal Habeas Courts Reviewing State Convictions May Cumulatively Assess Strickland Errors*, 61 *DRAKE L. REV.* 447 (2012); D. Michael Risinger, *Unsafe Verdicts: The Need for Reformed Standards for the Trial and Review of Factual Innocence Claims*, 41 *HOUS. L. REV.* 1281 (2004).

47. DAN SIMON, *IN DOUBT: THE PSYCHOLOGY OF THE CRIMINAL JUSTICE PROCESS* (2012).

48. Robert M. Wachter & Peter J. Pronovost, *Balancing “No Blame” with Accountability in Patient Safety*, 361 *NEW ENG. J. MED.* 1401 (2009).

49. An extensive body of commentary addresses how (and by whom) the line between disciplinary and educational reviews should be drawn as organizations strive to institute a “Just Culture” that allows for workers’ participation in addressing safety challenges. See, e.g., SIDNEY DEKKER, *JUST CULTURE: BALANCING SAFETY AND ACCOUNTABILITY* (2007); David D. Woods, *Conflicts Between Learning and Accountability in Patient Safety*, 54 *DEPAUL L. REV.* 482 (2005).

50. See SIDNEY DEKKER, *DRIFT INTO FAILURE: FROM HUNTING BROKEN COMPONENTS TO UNDERSTANDING COMPLEX SYSTEMS* 130-33 (2011).

Standing to the left of Annie Dookhan and Sonja Farak were the people who hired them, trained them, supervised them, and devised the laboratory evidence handling protocols they blithely skated around.<sup>51</sup> Standing to their right was a legion of lab directors and legal system practitioners—prosecutors, defenders, and judges—who failed (throughout the disposition of 30,000 cases) to notice that anything was amiss.<sup>52</sup>

It is easy to see how Dookhan and Farak crippled the work of Massachusetts prosecutors and defenders downstream, but it is important to remember that their awareness of the ramshackle state of the downstream inspection apparatus influenced the *upstream* choices of the two “bad apples.”<sup>53</sup> Besides, simultaneously battering all of these players was an encompassing environment of acute caseload pressures and dire resource shortages that generated the culture of “work-arounds,” triage, and “covert work rules” that made it both attractive and possible for Dookhan and Farak to zig when they should have zagged.<sup>54</sup>

Safety experts would say that the criminal justice scandals that excite media attention are actually proof that Murphy’s Law is mistaken: that everything that could go wrong usually goes *right*, and that we then draw the mistaken conclusion that the absence of visible disaster is proof of safety.<sup>55</sup>

That insight echoes an observation of Dr. Donald Berwick, one of the pioneers of the patient safety movement: “Every defect a treasure.”<sup>56</sup> Berwick’s contention would be that whether or not there is someone to hang after a known miscarriage of justice, there is a great deal that can be learned about preventing recurrence: that there are always many important features revealed that would have stayed hidden if the event had not exploded.<sup>57</sup>

The masked state of these dangers is in the nature of things. As safety expert Sidney Dekker noted:

...[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

---

51. Solotaroff, *supra* note 6.

52. In at least two cases involving Assistant Attorneys General who were notified of the lab errors, the lawyers allegedly worked to cover up the extent of the problem. *Id.*

53. See Laurin, *supra* note 19, at 1056-58.

54. PERROW, *supra* note 15, at 9.

55. WILLIAM LANGEWIESCHE, *INSIDE THE SKY: A MEDITATION ON FLIGHT*, 196 (1998) (referencing Charles Perrow).

56. Donald Berwick, *Continuous Improvement as an Ideal in Healthcare*, 320 *NEW ENG. J. MED.* 53, 54 (1989).

57. See Leape, *supra* note 16, at 1855-57 (arguing for medical adaptation of aviation causation concepts).

progression of small, incremental steps that unwittingly take an operation 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 from which 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 what 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.<sup>58</sup>

An exclusively disciplinary concentration will drive reports of variations further underground. No one wants to become enmeshed in an unpredictable punitive process with potentially disastrous and disproportionate impacts on themselves or co-workers. The Safety Model reminds us that frontline operators are rarely driven by ideological fealty to Crime Control or Due Process models; they are just trying to get through their days, in jobs constructed for them by others. The safety that preoccupies them during those days is their own safety.<sup>59</sup>

Paradoxically, the events that at first seem most responsive to “Bad Apple” analyses provide the clearest illustration of the distinctive efficacy of the safety approach. Take, for example, a trial prosecutor concealing evidence of innocence in a wrongful conviction case.<sup>60</sup> After an exoneration such as that of John Thompson,<sup>61</sup> who spent decades on death row after a prosecutor hid exculpatory lab tests and withheld information about an incentivized witness (who may have been the actual killer), our tendency is to react with rage: to call for prosecution, disbarment, or civil damages—exorcise the culprit, and leave it at that. Safety Model practice would encourage us to go further. It distinguishes a “performance review” of an individual from an “event review”<sup>62</sup> that provides a fuller learning platform.

Why was Thompson chosen in the first place? The Safety Model would prompt us to ask about the multiple failures both in the investigation that preceded the Thompson prosecutor’s decision and in the adversarial inspection stage that followed it. The examination will

---

58. SIDNEY W.A. DEKKER, LUND UNIV. SCH. OF AVIATION, WHY WE NEED NEW ACCIDENT MODELS 6 (2005).

59. David D. Woods, *Conflicts Between Learning and Accountability in Patient Safety*, 54 DEPAUL L. REV. 482 (2005).

60. See generally James M. Doyle, *Orwell’s Elephant and the Etiology of Wrongful Convictions*, 79 ALB. L. REV. 895 (2016).

61. See *Connick v. Thompson*, 563 U.S. 51 (2011); JOHN HOLLWAY & RONALD M. GAUTHIER, *KILLING TIME: AN 18-YEAR ODYSSEY FROM DEATH ROW TO FREEDOM* (2010).

62. SIDNEY DEKKER, *THE SECOND VICTIM: ERROR, GUILT, TRAUMA, AND RESILIENCE* 42 (1st ed. 2013) (quoting Ivan Pupulidy) [hereinafter DEKKER, *THE SECOND VICTIM*].

reveal valuable new questions in each of these phases. Did the investigation fail in evidence collection, analysis, or evaluation?<sup>63</sup> All three? How? Why? Was there confirmation bias, tunnel vision, external media, or political pressure involved? Were there training or supervision weaknesses? Crime scene technical incompetence? Did the defenders fail to intercept the mistake and find out about the lab results because of funding shortages, caseloads, training issues, grudging discovery rules, see-no-evil trial judges, or individual lethargy?

For a modern safety analyst, the prosecutor's personal character would not provide a satisfying answer to the question of how to prevent another Thompson case. Research indicates that ethical conduct is not stable either within or across individuals; it is malleable and dynamic, affected by circumstances.<sup>64</sup> Stating ethical principles in a manual is not sufficient. Having ethical principles and applying those ethical principles are two different things, and there is an entire field of Behavioral Ethics<sup>65</sup> available to help us probe what environmental features affected this prosecutor and might affect the next young prosecutor who weighs discovery obligations.

What levers in the prosecutor's environment influenced his behavior? The relative unlikelihood of discipline was probably one, but was it the only one? An absence of training? A straitened focus on conviction rates as the only measure of performance? Pressure from superiors or the media to deliver those "outputs"? What were the impacts of the need to persuade jurors to convict (or defendants to plead) on the cognitive frame the prosecutor employed?<sup>66</sup> Did the prosecutors' office culture generate informal "counterfactuals" ("He *could* have been guilty") that lessened the ethical price in the eyes of the prosecutor's peers?<sup>67</sup> Had withholding more and more exculpatory evidence in weaker and weaker cases become, by small increments, more and more normal?

---

63. See generally KIM ROSSMO, CRIMINAL INVESTIGATIVE FAILURES (2009).

64. Max H. Bazerman & Francesca Gino, *Behavioral Ethics: Toward a Deeper Understanding of Moral Judgment and Dishonesty*, 8 ANN. REV. L. SOC. SCI. 85 (2012) ("[T]he study of systematic and predictable ways in which individuals make ethical decisions and judge the ethical decisions of others . . ."). I am grateful to Professor Robert Norris and Professor Catherine Bonventre for alerting me to the relevance of this field.

65. *Id.*

66. See generally Barbara O'Brien, *A Recipe for Bias: An Empirical Look at the Interplay Between Institutional Incentives and Bounded Rationality in Prosecutorial Decision Making*, 74 MO. L. REV. 999 (2009).

67. Daniel A. Effron, *It Could Have Been True: How Counterfactual Thoughts Reduce Condemnation of Falsehoods and Increase Political Polarization*, 44 PERSONALITY & SOC. PSYCHOL. BULL. 729 (2018). See generally Susan Bandes, *Loyalty to One's Convictions: The Prosecutor and Tunnel Vision*, 49 HOW. L.J. 475, 481-83 (2010) (discussing the role of loyalty in prosecutors' offices).

When a Presidential Commission examined the tragic space shuttle *Challenger* launch decision it concluded that NASA managers and engineers had deviated from safety rules in order to meet a launch schedule dictated by political and budgetary pressures—in other words, the Commission placed the blame on individuals’ moral and ethical laxity.<sup>68</sup> But when Diane Vaughan looked more closely at the tragedy from a safety perspective she demonstrated that “[i]t was conformity, not deviation, that caused the disaster”,<sup>69</sup> that the *Challenger* story was one of “incremental descent into poor judgment.”<sup>70</sup> Everyone did pretty much what they thought they were expected to do: they accepted the organizational “acceptable risks.”<sup>71</sup> The launch decision was “[A] mistake embedded in the banality of organizational life.”<sup>72</sup>

A Safety Model assessment of the Thompson exoneration would not evade the fact that there was individual misconduct, but it would also ask whether John Thompson was the victim not only of a rogue prosecutor but of a criminal justice system that had replicated, in its own way, the culture of “structural secrecy” that Vaughan argued characterized NASA—a culture that kept secrets *from itself*, and produced a tragedy that no one wanted.<sup>73</sup> Is this a system that can be expected to do the same thing again?

The capacity of the Safety lens to reveal additional weaknesses at both the component level and system level can also be applied across the whole spectrum of iatrogenic harms flowing from police-citizen encounters that are usually understood (when they are examined at all) through a tightly focused assessment of the performance of the officer at the sharp end. There are police shootings in which the racial bias, explicit or implicit, of the officer who pulls the trigger is a glaring factor.<sup>74</sup> There are other events where an officer, actively menaced by an armed and mentally ill citizen who was bent on “suicide-by-cop,” had

---

68. PRESIDENTIAL COMMISSION ON THE SPACE SHUTTLE CHALLENGER ACCIDENT, REPORT TO THE PRESIDENT 105 (1986), [https://spaceflight.nasa.gov/outreach/SignificantIncidents/assets/rogers\\_commission\\_report.pdf](https://spaceflight.nasa.gov/outreach/SignificantIncidents/assets/rogers_commission_report.pdf).

69. Diane Vaughan, *Theorizing Disaster: Analogy, Historical Ethnography, and the Challenger Disaster*, 5 ETHNOGRAPHY 315, 337 (2004).

70. *Id.* at 328.

71. VAUGHAN, *supra* note 27, at 81-82.

72. *Id.* at xiv.

73. *Id.* at 238-77.

74. *Complaints Against Police Officer Jason Van Dyke*, N.Y. TIMES (Nov. 18, 2015), <https://www.nytimes.com/interactive/2015/11/18/us/chicago-police-complaints.html> (collecting documents in complaint history of officer in fatal Chicago police shooting).



no choice except to shoot.<sup>75</sup> There are “high frequency, low impact” events such as fruitless stops and frisks that humiliate law-abiding citizens.<sup>76</sup> When examined from a safety perspective with the goal of preventing recurrence, these familiar scenarios are not simple.

Even when a shooting is perpetrated by a racist cop there are safety questions remaining about the system’s hiring, training, and supervision components.<sup>77</sup> Could he have been screened out? Were red flags missed during his career or in his off-duty life? Even assuming the cop was a racist, why did he shoot *this* time, but not the hundreds of other times when his racism would have been operating? Safety practice would distinguish the performance review of the individual from the *event* review that accounts for the confluent and cascading system influences that led to the death, and that might lead to another in the future.

Did the encounter have to occur in the first place? Studies show that traffic stops for equipment violations are heavily biased along racial lines.<sup>78</sup> They are dangerous to civilians (and, disproportionately to minority civilians) and they are dangerous to officers too.<sup>79</sup> So why do we insist at the department level on a practice of equipment violation stops when notice-to-owner programs could achieve similar results? Could everyone’s safety be enhanced if the number of these events is reduced?

In safety terms, understanding a fatal police shooting of an acutely mentally ill citizen does not begin and end with the officer’s final decision to fire, but pursues the etiological question of why these two individuals, in these mental states, and with this training, treatment, and

---

75. Maria Cramer, ‘If I Hadn’t Called [911], He Would Be Here,’ BOSTON GLOBE (Apr. 4, 2018), <http://www.bostonglobe.com/metro/2018/04/04/mother-man-fatally-shot-police-sues-city/bvFMFKU2zii5uhnMthIwAN/story.html?event=event12>.

76. Amanda Geller et al., *Aggressive Policing and the Mental Health of Young Urban Men*, 104 AM. J. PUB. HEALTH 2321 (2014).

77. See, e.g., Cramer, *supra* note 75.

78. See BUREAU OF JUST. STAT., POLICE BEHAVIOR DURING TRAFFIC AND STREET STOPS, 2011 (revised Oct. 27, 2016), <https://www.bjs.gov/content/pub/pdf/pbtss11.pdf>; Emma Pierson et al., *A Large Scale Analysis of Racial Disparities in Police Stops Across the United States* (Stanford Open Policing Project, Working Paper 2017), <https://5harad.com/papers/traffic-stops.pdf>. See also FRANK R. BAUMGARTNER, DEREK A. EPP & KELSEY SHOUB, SUSPECT CITIZENS: WHAT 20 MILLION TRAFFIC STOPS TELL US ABOUT POLICING AND RACE (2018); Wesley Lowery, *A Disproportionate Number of Black Victims in Fatal Traffic Stops*, WASHINGTON POST (Dec. 24, 2015), [https://www.washingtonpost.com/national/a-disproportionate-number-of-black-victims-in-fatal-traffic-stops/2015/12/24/c29717e2-a344-11e5-9c4e-be37f66848bb\\_story.html](https://www.washingtonpost.com/national/a-disproportionate-number-of-black-victims-in-fatal-traffic-stops/2015/12/24/c29717e2-a344-11e5-9c4e-be37f66848bb_story.html) (reporting one in three victims of fatal traffic stop shootings was African-American).

79. Schwartz, *Systems Failures in Policing*, *supra* note 19. This states a question; it is not an answer. The point is that the safety trade-offs (e.g., lost seizures of contraband) implicated by a decrease (or increase) in equipment violation stops, or traffic stops in general, should be carefully studied, not simply assumed, and should be weighed against the iatrogenic safety implications.

equipment influencing them, met on this occasion.<sup>80</sup> What was the history of the deceased? How was the continuity of his treatment managed? What was the training of the officer? Of the dispatcher who sent him? Was the officer equipped with and trained in de-escalation and non-lethal options? Did the Department have a Crisis Intervention capability? Did fatigue, augmented by Departmental shift-work arrangements, affect the officer’s decision-making?<sup>81</sup> Would any of these things, done differently, have produced a different result?

Further along the spectrum, a street stop-and-frisk of a blameless citizen on his or her way to work is a harm that could be analyzed if safety is what we have in mind. Assessing that coercive interaction purely on the basis of the decision of the cop who makes the stop is in safety terms radically incomplete. What factors combined to create this “high frequency low impact” harm? What influenced the decision? What departmental policy or practice shaped the street cop’s prediction that he would find something if he stopped the citizen? Or convinced him that it didn’t really matter very much whether he found something on *this* citizen or not: that any harm would be trivial?<sup>82</sup> Was the officer impacted by a CompStat quota that misused (or failed entirely to use) geo-spatial predictive resources?

The Safety Model also encourages us to see that the most obvious victims of miscarriages of justice are not the only victims. Certainly, John Thompson was a victim of a wrongful conviction, but his wrongful conviction harmed others too. The real murderer may have found further victims while Thompson served his time. Thompson’s family was victimized; his conviction cheated the murder victim’s family of whatever solace a just outcome would have provided, and the revelation of the miscarriage re-traumatized the family. Thompson’s overmatched appointed defenders should certainly—like the NICU nurse who is the last person in the chain of delivery of the fatal overdose to an infant—be regarded as “second victims,”<sup>83</sup> wounded by learning that they had failed to protect an innocent man from a death sentence.

A police officer who lives to walk away from the fatal shooting of a mentally ill citizen doesn’t walk away unharmed, no matter how

---

80. See generally International Association of Chiefs of Police, *One Mind Campaign: Improving Police Response to Persons With Mental Illness*, <http://www.theiacp.org/onemindcampaign/>; Jim Palmer & James Doyle, “Suicide by Cop”: *The Questions that Don’t Get Asked*, CRIME REPORT (Feb. 13, 2017), <https://thecrimereport.org/2017/02/13/suicide-by-cop-the-questions-that-never-get-asked/>.

81. See KAREN AMENDOLA ET AL., POLICE FOUNDATION, *THE SHIFT LENGTH EXPERIMENT: WHAT WE KNOW ABOUT 8-, 10-, AND 12-HOUR SHIFTS IN POLICING 1* (2011).

82. Cf. James M. Doyle, *Discounting the Error Costs: Cross-Racial False Alarms in the Culture of Contemporary Criminal Justice*, 7 PSYCHOL. PUB. POL’Y & LAW 253 (2001).

83. DEKKER, *THE SECOND VICTIM*, *supra* note 62.

“within policy” the shooting might have been. The existential terror of the encounter, the trauma of the shooting, the legal jeopardy the shooting created, will all leave enduring wounds.<sup>84</sup>

The Safety Model captures intergenerational and community harms generated by criminal justice choices that are ordinarily not accounted for in the analysis of events.<sup>85</sup> The safety perspective comprehends that criminal justice is, as Angela Harris put it, “environmental justice,”<sup>86</sup> and takes account of the radiating collateral damage the system produces.<sup>87</sup>

The Safety Model imports from industrial and medical practice a number of tested techniques (e.g., Root Cause Analysis, “Fishbone” diagrams, “Five Why” inquiries) that will improve the quantity of faulty components exposed and will also offer a new degree of precision in describing them.<sup>88</sup> It is virtually certain that by applying these tools the Safety Model approach will uncover multiple defects and that those defects will be present across many jurisdictions. We can have a more comprehensive catalog of component weaknesses and sites of harm—a longer “to-do” list of useful repairs. The Safety Model can improve practice incrementally in this way. A “Library,”<sup>89</sup> or “Clearinghouse,”<sup>90</sup> or “Database”<sup>91</sup> sharing reports of learning events can be an extremely useful resource.

But it would be a mistake to allow the multiplied insights these tools produce to be treated as the end product. The Safety Model warns that a preemptive focus on optimizing individual components provides a poor route to overall system safety.<sup>92</sup> A Root Cause Analysis “[T]oo often results in a simple linear narrative that displaces more complex, and potentially fruitful, accounts of multiple and interacting

---

84. See generally DAVID KLINGER, INTO THE KILL ZONE: A COP’S EYE VIEW OF DEADLY FORCE (2006).

85. Nicole D. Porter, *Essay: Expanding Public Safety in the Era of Black Lives Matter*, 70 U. MIAMI L. REV. 533 (2016).

86. Angela P. Harris, *Criminal Justice as Environmental Justice*, 1 J. GENDER RACE & JUST. 1, 4 (1997).

87. On the mental health impacts of police shootings of unarmed African-American on distant, unrelated African-Americans, see Jacob Bor et al., *Police Killings and Their Spillover Effects on the Mental Health of Black Americans: A Population-Based, Quasi-Experimental Study*, THE LANCET (June 21, 2018), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31130-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31130-9/fulltext).

88. For commentary discussing these techniques at work, see John Hollway, Calvin Lee & Sean Smoot, *Root Cause Analysis: A Tool to Promote Officer Safety and Reduce Officer Involved Shootings Over Time*, 62 VILL. L. REV. 883 (2017).

89. SCOTT A. SNOOK, FRIENDLY FIRE: THE ACCIDENTAL SHOOTDOWN OF U.S. BLACKHAWKS OVER NORTHERN IRAQ 232-36 (2000).

90. Doyle, *Learning from Error in American Criminal Justice*, *supra* note 17, at 130-37.

91. The Joint Commission, the accrediting body for hospitals, maintains a database of its mandated reports, available at [https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx).

92. Berwick, *supra* note 56, at 54.

contributions to how events really unfold.”<sup>93</sup> Any “fix” we generate this way will be subject to attack from its environment. Caseloads will rise, budgets will fall. Our “fix” will impact distant elements of the system in unanticipated ways, and adjustments made at those sites will then affect our site in turn. Inevitably, triage, “workarounds,” and “covert work rules” will multiply on the frontlines. Safety specialists recognize that we will need a new “fix” tomorrow, and then another fix on the day after that.<sup>94</sup>

Criminal justice is an environment where nothing can really be “fixed” within an organizational silo, no matter how precise in technocratic terms its internal Root Cause Analysis or Fishbone Diagram may be. When (as in Camden, New Jersey) sixty-seven percent of the people who are arrested and involved in the criminal justice system also cycle through hospital emergency departments, it is not really possible to say which system is “upstream” and which is “downstream;” each is both upstream *and* downstream of the other.<sup>95</sup> Both are buffeted by external forces derived from budgets, drug epidemics, housing shortages, and economic disasters.<sup>96</sup>

Ultimately, safety (and its opposite) can no more be seen in a single component than “wetness” can be seen in a single molecule of H<sub>2</sub>O. Safety is an emergent quality that must be sought on the system level, and safety is not finally generated by discrete “fixes” to components in themselves, but by the cultivation and maintenance of a culture of continuous improvement.<sup>97</sup> Resiliency, not the permanent “fix,” is the Safety Model’s goal.

#### 4. PARTICIPATION, COLLABORATION, RESTORATION

In the final paragraph of his magisterial *The Collapse of American Criminal Justice*, William Stuntz argued that:

The criminals we incarcerate are not some alien enemy. Nor, for that matter, are the police officers and prosecutors who seek to fight crime in those criminals’ neighborhoods. Neither side of this divide

---

93. Mohammad Farhad Peerally, Susan Carr, Justin Waring & Mary Dixon-Woods, *The Problem with Root Cause Analysis*, 26 BRIT. MED. J. QUALITY & SAFETY 417 (2016).

94. See generally SIDNEY DEKKER, DRIFT INTO FAILURE: FROM HUNTING BROKEN COMPONENTS TO UNDERSTANDING COMPLEX SYSTEMS (1st ed. 2011).

95. Anne Milgram, Jeffrey Brenner, Dawn Wiest, Virginia Bersch & Aaron Truchil, *Integrated Health Care and Criminal Justice Data—Viewing the Intersection of Public Safety, Public Health, and Public Policy Through a New Lens: Lessons from Camden, New Jersey*, HARV. KENNEDY SCH. PROGRAM IN CRIM. JUST. POL’Y & MGMT 5-6 (Apr. 2018), [https://www.hks.harvard.edu/sites/default/files/centers/wiener/programs/pcj/files/integrated\\_healthcare\\_criminaljustice\\_data.pdf](https://www.hks.harvard.edu/sites/default/files/centers/wiener/programs/pcj/files/integrated_healthcare_criminaljustice_data.pdf).

96. *Id.*

97. Berwick, *supra* note 56.

is “them.” Both sides are us. Democracy and justice alike depend on getting that most basic principle of human relations right.<sup>98</sup>

For fifty years academic debate about the relative merits of Herbert Packer’s Crime Control and Due Process Models<sup>99</sup> has rested comfortably atop a criminal justice discourse that takes for granted the divided society Stuntz decries. Crime Control Model partisans argue for more expansive state control over citizens; Due Process Model advocates call for greater control over state power.<sup>100</sup> The conversation is carried on along lines—the argument over Blackstone’s ratio of nine guilty going free being better than one innocent convicted<sup>101</sup> is one good example—that would be familiar to John Stuart Mill and the early English Utilitarians who were (not coincidentally) occupied during their official careers with administering the government of a subordinate people in distant colonial India.<sup>102</sup> Contemporary popular news and entertainment media are saturated by a vision of inner cities as exotic places: as a There seemingly as distant from Here as Bombay from London—Hearts of Darkness, inhabited by an intrinsically different population of fulltime predators and their fulltime prey.<sup>103</sup> Policies institutionalizing the biased division of housing<sup>104</sup> and wealth creation<sup>105</sup> by race have given concrete form to this vision. Ordinary white Americans never visit the inner cities, but they are perfectly certain of what they would find if they *did* visit.<sup>106</sup>

These factors have mutually nourished each other, and their synergetic effects have both instigated and been augmented by criminal justice system practices leading to the profligate distribution of criminal histories, pretrial detentions, and mass incarceration.<sup>107</sup> A “[r]igidly

---

98. WILLIAM STUNTZ, *THE COLLAPSE OF AMERICAN CRIMINAL JUSTICE* 312 (2011).

99. HERBERT PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 158-68 (1968).

100. *Id.*

101. See Marvin Zalman, *The Anti-Blackstonians*, 48 SETON HALL L. REV. 1319 (2018).

102. See generally ERIC STOKES, *THE ENGLISH UTILITARIANS AND INDIA* (1990). See also Malcolm Feeley & Jonathan Simon, *The New Penology: Notes on the Emerging Strategy of Corrections and Its Implications*, 30 CRIMINOLOGY 449 (1992).

103. See generally James M. Doyle: *Into the Eight Ball: The Colonialists’ Landscape In American Criminal Justice*, 12 B.C. THIRD WORLD L.J. 65, 66-67 (1992) [hereinafter Doyle, *Into the Eight Ball*]; James M. Doyle, “It’s the Third World Down There!.” *The Colonialist’s Vocation in American Criminal Justice*, 27 HARV. C.R.C.L. L. REV. 71 (1992). On colonial governance traditions transported into current urban criminal justice, see Malcolm M. Feeley, *How to Think About Criminal Court Reform*, 98 B.U. L. REV. 673, 722 (2018).

104. See RICHARD ROTHSTEIN, *THE COLOR OF LAW* (2017).

105. *Id.*

106. See generally ALBERT MURRAY, *THE OMNI-AMERICANS* (1970); Doyle, *Into the Eight Ball*, *supra* note 103, at 74-75.

107. See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010); see generally PAUL BUTLER, *CHOKEHOLD: POLICING BLACK MEN* (2017); see generally ELIZABETH HINTON, *FROM THE WAR ON*

binomial opposition of ‘ours’ and ‘theirs’”<sup>108</sup> dominates this thinking, and a ratcheting effect takes hold, driving the authorities and the communities further apart. The conversation sinks to a level at which the question is defined as whether Black Lives Matter *or* whether Blue Lives Matter, as if the two were mutually exclusive.<sup>109</sup> Remembering the Safety Model perspective could offer us a way out of this trap.

To begin with, the safety perspective suggests that the fascination with control that animates the Crime Control and Due Process antagonists entangled in Packer’s Battle Model is a detour.<sup>110</sup> Control may be a means to an end, but it is not an end in itself, and control (like safety itself) is at best evanescent, always fragile, and at times completely illusory.<sup>111</sup> In a racially and economically divided society, the blind pursuit of control for its own sake or as if it were the indispensable precondition to progress in any direction comes at a price, and it has proven destructive.

John Griffiths argued that Herbert Packer’s Crime Control and Due Process Models were not really the polar opposites that Packer claimed, but were variant versions of a single “Battle Model,” both predicated on a zero-sum contest carried out between an irreconcilable state and individual: an inevitable war in which one side wins, and one side loses.<sup>112</sup> To make his point Griffiths conjured up a contrasting “Family Model” derived from another institution in society that regularly hands out discipline and punishment but is built on a foundation of love and an assumption that the offending child and the disciplinarian parent will ultimately reconcile.<sup>113</sup>

Griffiths also recounted the failed effort of the early juvenile justice reform movement to treat delinquency prosecutions as exercises in pursuing the best interests of the child: “the closest thing to a Family

POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA (2016); *see generally* JOHN PFAFF, LOCKED IN: THE TRUE CAUSES OF MASS INCARCERATION AND HOW TO ACHIEVE REAL REFORM (2017); *see generally* BRUCE WESTERN, HOMEWARD: LIFE IN THE YEAR AFTER PRISON (2018); *see generally* BRUCE WESTERN, PUNISHMENT AND INEQUALITY IN AMERICA (2006).

108. EDWARD W. SAID, ORIENTALISM 227 (1979).

109. Periodic Videos, *What America Thinks: Black Lives vs. Blue Lives*, RASMUSSEN REP. (June 7, 2016), [http://www.rasmussenreports.com/public\\_content/videos/2016\\_06/what\\_america\\_thinks\\_black\\_lives\\_vs\\_blue\\_lives](http://www.rasmussenreports.com/public_content/videos/2016_06/what_america_thinks_black_lives_vs_blue_lives).

110. *See, e.g.*, SIDNEY DEKKER, THE SAFETY ANARCHIST: RELYING ON HUMAN EXPERTISE AND INNOVATION, REDUCING BUREAUCRACY AND COMPLIANCE (2017) [hereinafter DEKKER, THE SAFETY ANARCHIST].

111. “Control” when it is employed in safety usage is generally treated as a capability to be mobilized, not as a fixed condition, and in that usage its fragility is taken into account. *Cf.* Boaz Sangero, *Safety from Plea-Bargains’ Hazards*, 38 PACE L. REV. 301 (2018).

112. Griffiths, *supra* note 11, at 367.

113. *Id.* at 371-73.

Model idea we have ever had in this country.”<sup>114</sup> The juvenile court reform movement of the early twentieth century collapsed, Griffiths concluded, because “it was an idea imposed artificially upon an unchanged Battle Model substratum . . . A rhetorical abstraction of love was superimposed upon a reality of indifference, hostility, and ostracism.”<sup>115</sup> The movement’s result was a juvenile process that was simply the criminal process minus protections for the accused.<sup>116</sup>

It might seem that a similar doom awaits any attempt at realizing a Safety Model in criminal justice. But although the Safety Model and the Family Model confront the same Battle Model culture, they encounter it from radically different angles. To begin with, the Safety Model’s own central logic makes it clear that the Safety Model could never be imposed on frontline culture from on high (in the manner in which Griffiths’ “Family Model” of juvenile justice was imposed) in the first place.<sup>117</sup> The “culture of safety” that the Safety Model sketched in this Essay requires is by its nature collaborative and diverse: involving all-stakeholders (at all ranks) and their array of perspectives. It is informed of current knowledge in the implicated fields, promotes the reporting of errors and “near misses,” creates an atmosphere of trust for frontline workers, remains flexible in adapting to changing demands, and is willing and able to learn about the functioning of its own safety system.<sup>118</sup>

The Safety Model constitutes a wager on the frontline troops—it sees them as a resource, not as a menace.<sup>119</sup> It recognizes that the local motivations for practitioners’ “workarounds” and “practical drift”—influences that would be repudiated as “excuses” in any retrospective disciplinary process—are an indispensable element of any forward-looking inquiry aimed at preventing future harms. Safety must be “co-produced” by the officials and the communities working together to identify harms or it won’t be produced at all, and it requires an understanding of the perspectives of all ranks, in all stakeholder roles. Just as the patient safety version of analyzing events includes the

---

114. *Id.* at 399.

115. *Id.* at 400.

116. *Id.*

117. I am referring here to the Safety Model’s own intrinsic properties, but it is also true that those properties, by mobilizing concepts of goals and workmanship generally shared (or at least professed) by the wide array of criminal justice actors may alleviate the problems created by the “hyper-fragmented” state of the American governmental system where it intersects with criminal justice. *See* Feeley, *supra* note 103, at 675-76.

118. *See generally* JAMES REASON, *MANAGING THE RISKS OF ORGANIZATIONAL ACCIDENTS* (1997) [hereinafter REASON, *MANAGING THE RISKS*].

119. *See* DEKKER, *THE SAFETY ANARCHIST*, *supra* note 110 (criticizing the proliferation of safety rules and bureaucracies).

patient's family and the operating room nurse as well as the Chief of Surgery, the public safety incarnation must value the community and patrol officer perspectives as well as those of the Assistant Commissioner and the Chief Judge.

Besides, the Safety Model's interaction with the Battle Model staff is not about their violation of rules, or the generation of more rules. Its focus is not legality, but *workmanship*.<sup>120</sup> It accepts the reality that work, as designed and reflected in rules, is often not the same as the work as it must be performed, and it mobilizes operators' pride in their work to help bolster their individual senses of accountability for a just collective outcome. We expect our novices to simply follow the rules, but we expect our experts to deal with the unexpected, to innovate and improvise, even to ignore the rules when the situation demands it.<sup>121</sup> As Egon Bittner has written, "at its core workmanship consists of the ability to call upon resources of knowledge, skill, and judgement to meet and master the unexpected within one's sphere of competence."<sup>122</sup> The fact that there is no one to hang (or even that some individual has already *been* hung) for violating a pre-existing rule during a harmful event does not mean there is nothing to learn about improving workmanship. Discipline, prosecution, and civil damages will have to follow from specific particular violations in order to provide fair compensation and preserve public trust, but we do not have to stop there.

There is a range of criminal justice errors including wrongful convictions, mistaken street stops, and avoidable uses of force for which the "Battle Model substratum" Griffiths identified will not want to see its participants punished, as long as their acts are "legal," or perhaps unless they are flagrantly *illegal*.<sup>123</sup> The Crime Control perspective generally accepts these errors as a cost of doing business.<sup>124</sup> Still, the fact that there are law professors who can live contentedly with this utilitarian balancing of error costs does not prove that the people who actually work in criminal justice every day see these errors as desirable, nor want to repeat these outcomes if repetition can be avoided.<sup>125</sup> No one wants to play a role in convicting an innocent man and allowing the

---

120. See Egon Bittner, *Legality and Workmanship: Introduction to Control in the Police Organization*, 13 ETHNOGRAPHIC STUD. 247 (2013).

121. Pupulidy & Vesel, *supra* note 40, at 2. Cf. WILLIAM LANGEWIESCHE, *FLYING BY WIRE* (2012) (airline pilot "Sully" Sullenberger successfully lands in Hudson by innovating and ignoring checklist).

122. Bittner, *supra* note 120, at 248.

123. See generally George C. Thomas III & Barry S. Pollack, *Balancing the Fourth Amendment Scales: The Bad-Faith Exception to Exclusionary Rule Limitations*, 45 HASTINGS L.J. 21 (1993).

124. HERBERT PACKER, *THE LIMITS OF THE CRIMINAL SANCTION*, 158-62 (1968).

125. See Zalman, *supra* note 102, at 1338-43.



real perpetrator to go free. Likewise, no one wants to shoot a mentally ill civilian unnecessarily.

Avoiding these outcomes whenever you can is a source of pride on the frontlines, and working daily to prevent them becomes a matter of self-respect. Most criminal justice practitioners agree with James Reason's statement of safety thinking, which accepts error as a part of the human condition: "You cannot change the human condition, but you can change the conditions under which people work."<sup>126</sup> Changes to some work conditions will produce negligible results; changes to others are beyond the power of leadership.<sup>127</sup> But there are some changes to working conditions that will have meaningful impact on operations that can be felt quickly: these will improve the working lives of the people at the frontlines as well as the lives of their communities.<sup>128</sup>

By participating in collaborative learning reviews of unexpected outcomes, criminal justice practitioners can communicate that they accept that they "are accountable to the community for meeting even those standards of adequate workmanship that cannot be formulated in advance, and explicitly."<sup>129</sup> They can enhance public trust in the law and system legitimacy by showing that they care about getting things right. There are differences between medicine and criminal justice, of course, but there is reason to hope that the healing that patients and their families experience when medicine includes them in its "disclosure and apology"<sup>130</sup> approach after a medical error can begin to be replicated for persons and communities harmed by criminal justice outcomes. Persons harmed value their inclusion in efforts to see that no one else experiences their suffering in the future.<sup>131</sup>

As things stand, the people most impacted by the justice system are least able to influence it.<sup>132</sup> The safety approach could construct a participatory platform where the value we as a society give to safe workmanship—in a version of workmanship that gives due weight to the

---

126. James Reason, *Human Error: Models and Management*, 320 BRIT. MED. J. 768, 769 (2000).

127. On the barriers to effective change faced by leaders in the "hyper-fragmented" American criminal justice system generally, see Feeley, *supra* note 103, at 681-82.

128. Pupilidy & Vesel, *supra* note 40, at 7-8.

129. Bittner, *supra* note 120, at 249.

130. See Jennifer K. Robbennolt, *Apologies and Medical Error*, CLINICAL ORTHOPEDICS & RELATED RES. (Feb. 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628492/>.

131. Evidence of the value victims of harm place on their participation in restorative justice efforts can be found in organizations such as Witness to Innocence, an exoneree organization (<https://www.witnesstoinnocence.org>) or Healing Justice, a multi-stakeholder, persons-harmed restorative justice (<http://www.healingjusticeproject.org>).

132. Jesse Jannetta, Jeremy Travis & Evelyn McCoy, *Participatory Justice*, US PARTNERSHIP ON MOBILITY FROM POVERTY (2018) (advocating for a participatory justice model).

benefits of systemization and standardization—can be expressed by taking account of its opposite, and of the right of community members to be free of unnecessary intrusions and curtailments.

Orderly adjudications of disciplinary proceedings cannot be conducted as all-stakeholders colloquies. In our existing processes, focused entirely on discipline and punishment, respect for the due process rights of the accused practitioner explains excluding, for example, civilian community representatives. Learning-oriented reviews, on the other hand, provide a complementary avenue for the continuous community participation in criminal justice that can establish safety as a guiding principle, nourish interactions, build connections, cultivate young leaders, and create an environment where diversity and innovation can increase.<sup>133</sup> These reviews will generate, mobilize, and apply data. They will provide the “thick data” insights that complement the “big data” picture by accepting the complexity of events and revealing the social context of connections between data points.<sup>134</sup> These reviews will sometimes (although not always) generate answers to problems. Perhaps most importantly, they will always generate new questions—questions from one stakeholder to another, and from the group of stakeholders to the relevant fields of inquiry—that can be subjected to empirical inquiry and detailed analysis.

## 5. A SAFETY PLACE

If this safety work is worth doing, where and how can it be done?

The National Institute of Justice has been pursuing a methodical exploration of those questions since 2011.<sup>135</sup> Focused on a core concept of non-blaming, all-stakeholders, all-ranks, forward-looking reviews of incidents and events, the NIJ Sentinel Events Initiative has conducted a diverse Roundtable of stakeholders,<sup>136</sup> solicited and reported on three

---

133. For example, learning reviews would be suitable enterprises for law school clinical program participation directed toward supporting community “co-production” of justice. Cf. Edgar S. Cahn & Christine Gray, *Clinical Education: Where Next? Clients as Co-Producers of System Change*, 24 CLINICAL L. REV. 171, 196 (2018).

134. Tricia Wang, *Why Big Data Needs Thick Data*, ETHNOGRAPHY MATTERS (May 13, 2013), <http://ethnographymatters.net/blog/2013/05/13/big-data-needs-thick-data/>.

135. See Nancy Ritter, *Testing A Concept and Beyond: Can the Criminal Justice System Adopt a Nonblaming Practice?*, NIJ J. (2015), <https://www.nij.gov/journals/276/Pages/sentinel-events.aspx>.

136. NAT’L INST. OF JUST., *The SENTINEL EVENTS ROUNDTABLE SUMMARY: PROCEEDINGS FROM AN EXPERT ROUNDTABLE* (2013), <http://nij.gov/topics/justice-system/sentinel-events/roundtable.htm> [hereinafter NIJ ROUNDTABLE SUMMARY].

“beta” site learning review efforts,<sup>137</sup> convened community and “persons-harmed” sessions, and organized and disseminated the colloquies generated by an “all-stakeholders” gathering.<sup>138</sup> It is now poised, in collaboration with the Bureau of Justice Assistance, to provide technical assistance (through the Quattrone Center for the Fair Administration of Justice) to state and local coalitions who will develop individualized versions of the learning review processes.<sup>139</sup> The expectation is that a range of individualized adaptations will be developed, pursued, and evaluated.

These efforts will likely take many forms, but the Betsy Lehman Patient Safety Center offers an analogy for criminal justice safety activities and suggests one straightforward and distinctly “doable” approach from the array of possibilities.<sup>140</sup> It indicates that a place to do safety work is within reach for a quite modest investment.<sup>141</sup>

The Betsy Lehman Center is a statewide agency with a small budget and a small professional staff.<sup>142</sup> With an equivalent staff available, a state center for criminal justice safety (maintained, for example, at a state university) could, on request, provide jurisdictions with a neutral moderator, process expertise and substantive experts from event-relevant fields. It could manage documents and develop protocols 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.

A version of the Betsy Lehman Center’s ability to afford confidentiality<sup>143</sup> 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.

---

137. KATHARINE BROWNING ET AL., NAT’L INST. OF JUST., *PAVING THE WAY: LESSONS LEARNED IN SENTINEL EVENT REVIEWS* (2015). See also Starr, *A New Way to Reform the Judicial System*, *supra*, note 14.

138. *National Institute of Justice Sentinel Events Initiative All-Stakeholder Forum*, NAT’L INST. OF JUST. (2017), <https://www.nij.gov/topics/justice-system/Pages/sentinel-events-stakeholder-forum.aspx>.

139. *Empowering Local Communities to Advance Justice: NIJ and BJA Launch Sentinel Events Initiative National Demonstration Collaborations*, NAT’L INST. OF JUST. (Sept. 29, 2017), <https://www.nij.gov/topics/justice-system/Pages/sentinel-events-technical-assistance-provider.aspx>.

140. See BETSEY LEHMAN CENTER FOR PATIENT SAFETY, <https://www.betsylehmancenterma.gov>.

141. See NIJ ROUNDTABLE SUMMARY, *supra* note 136.

142. The Massachusetts Governor’s budget request for FY 2017 was \$1.53 million. *Center for Health Information and Analysis – Budget Summary*, MASS.GOV, [http://budget.digital.mass.gov/bb/h1/fy17h1/brec\\_17/dpt\\_17/hlhcf.htm](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.

143. See MASS. GEN. LAWS ch. 12C, § 15(e) (2018) and text accompanying note 4.

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.<sup>144</sup> 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 around, not a disqualification.

Besides, as the heroic scholarship of Joanna Schwartz on police indemnification has shown, the public entities paying for the current event under review are in a position to benefit exponentially from enhancements to future safety.<sup>145</sup> The best way to avoid liability is to avoid the harm, and in a context such as policing in which 99.98 percent<sup>146</sup> of money received by plaintiffs is paid from public funds, not the funds of the practitioners, the reduction in public risk from repeated harms should more than overbalance in policy terms any discomfort that the conduct of learning reviews instills.

Even so, although liability concerns may in fact be outweighed by the benefits that safety perspective learning reviews promise, 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 cannot be imposed from the top-down. There is not, and there never can be, a criminal justice equivalent to the Joint Commission that imposes accreditation standards on hospitals, or the National Transportation Safety Board that compels transportation industry cooperation. 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

---

144. See Schwartz, *Introspection Through Litigation*, *supra* note 9, at 1083.

145. Joanna C. Schwartz, *How Governments Pay: Lawsuits, Budgets, and Police Reform*, 63 UCLA L. REV. 1144, 1181 (2016); Joanna C. Schwartz, *Police Indemnification*, 89 N.Y.U. L. REV. 885, 955 (2014).

146. Schwartz, *Police Indemnification*, *supra* note 145, at 955; *see also* John Rappaport, *How Private Insurers Regulate Public Police*, 130 HARV. L. REV. 1539, 1547 (2017).

the design of the American system simply does not allow for the imposition of this sort of grand scheme.<sup>147</sup>

If the Safety Model advances at all it will have to be by following the classic pattern of diffusion of innovations 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.<sup>148</sup> Because the learning reviews require *all* stakeholders' perspectives to be fully effective, progress will require gathering groups of diverse collaborators in which every potential group member holds a veto. Fears of liability augmentation, whether actual or used simply to cloak inertia and inchoate discomfort with novelty, can be a destructive inhibiting force. Dealing with those inhibitions sooner rather than later, as in the Betsy Lehman Center authorizing legislation, is likely to be a productive strategy.

In the end, barriers and inhibitions notwithstanding, safety is something everyone wants: for their communities, for their families, and for themselves. It is valued by both the community and the criminal justice professionals across all of the criminal justice "silos." Safety-oriented reviews will support an ongoing collaborative *practice* of questioning, explaining, and exploring. If they are conducted by diverse professional and community stakeholders as equals, all working to make things safe, over time we can expect important learning, but we can also hope for healing.

---

147. See generally Feeley, *supra* note 103.

148. EVERETT M. ROGERS, *DIFFUSION OF INNOVATIONS* (5th ed. 2003).