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Learning About Learning From Error

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There has been a lot of learning from error going on in American criminal justice since the publication in 1996 of the U.S. Department of Justice's compilation of the first twenty-eight wrongful convictions exposed by DNA. Does it indicate that criminal justice practitioners can adopt some version of the quality reform initiatives that have reshaped other high-risk fields such as aviation and medicine? Can the criminal justice system embrace "a theory of work, which conceptualize[s] the continual improvement of quality as intrinsic to the work itself" (Kenney 2008, 30)? Is it possible that the current era, characterized by episodic patches motivated by high-profile tragedies, can be replaced by a new period dedicated to the sustained, routine practice of learning from error? Criminal justice practitioners may be ready to give it a try. There are strong arguments that the policing community can and should

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lead the way toward a systems-oriented approach to known errors and near misses that begins to move beyond a culture of blame and builds partnerships across all stakeholders in the criminal justice system.

The goal here is to outline a path for future exploration, not to sell a fixed set of prescriptions. The possibilities I have in mind are complex and difficult ones. Still, we do have a place to start.

The Exonerations and Their Aftermath

Attempts by U.S. Supreme Court Justice Antonin Scalia, among others, to dismiss the exonerations listed in the National Institute of Justice's (NIJ) *Convicted by Juries, Exonerated by Science: Case Studies in the Use of DNA Evidence to Establish Innocence After Trial* (Connors, Lundregan, Miller, and McEwen 1996) (known to practitioners as the Green Book) as a catalogue of freakish mishaps have gained very little traction (*Kansas v. Marsh* 2006). In part, this is because whenever these arguments are put forward the Innocence Project exposes yet another horrifying wrongful conviction. But a more fundamental reason that the influence of the DNA exoneration cases continues to grow is that the criminal justice system's frontline practitioners—the people who actually do the work on the streets and in the courts—show very little interest in the comfort that Scalia and the system's other apologists have tried to offer them. The DNA exonerations involve the sort of bread-and-butter cases everyone had handled and would handle again, not arcane borderland specimens. All veteran criminal practitioners had seen mistakes in similar cases, and many veterans had themselves been involved with one—or at least with an uncomfortably close near miss. It came as no surprise to veteran detectives that eyewitnesses make mistakes; veteran detectives have been to a lot of lineups and watched witnesses identify lots of known innocent "fillers."

For the frontline troops, the rarefied utilitarian calculations of error rate that fascinated Justice Scalia missed the point. Because practitioners in all roles were drowning in heavy caseloads, they could readily see that even very low rates of error still result in a very high absolute number of tragedies. Police practitioners confronting the early exonerations were uniquely sensitive to a key fact: whenever the wrong guy was convicted, the right guy got away and claimed further victims. Of course, many people managed to shrug this off as just the unavoidable cost of doing business. But other practitioners—again, particularly police practitioners—saw avoiding errors as a matter of professionalism, workmanship, and, ultimately, self-respect, not as an issue of social policy (Bittner 1990). This early group accepted the Green Book as a call to action. For them, one error was too many. Dozens of jurisdictions, independently of each other, mobilized efforts to address the problems identified in the Green Book.

The initial leadership came from different players in different places. Former attorney general Janet Reno, who decided that the Green Book would include commentary from the full spectrum of criminal justice system actors, provided an influential template. She convened technical working groups under the auspices of NIJ, which brought together diverse stakeholders to hammer out and publicize new criminal justice best practices. These groups addressed crime scene investigations, death investigations, and eyewitness evidence, among other topics. Peter Neufeld and Barry Scheck, cofounders of the Innocence Project, who had been among Reno's Green Book commentators, called for a learning-from-error initiative.

In North Carolina, the first impetus came from the conservative Republican chief justice of the North Carolina Supreme Court. In Boston and Minneapolis, it came from elected district attorneys; in Illinois, from Northwestern University's Center on Wrongful Convictions and the Governor's Commission on Capital Punishment; and in New Jersey, from a Republican attorney general (Doyle 2005). More recently, the International

Association of Chiefs of Police has decided to convene a wrongful convictions summit.

Because exonerations take place at (or many years past) the end of the normal criminal justice process, many of the pioneering learning-from-error initiatives that responded to the DNA exonerations were dominated by the lawyers who operate the system's terminal phases. A group of lawyers in these circumstances tends to luxuriate in examining the question, "How did the police screw *this* one up?" and then to share their answers generously with the media.

Some in the policing community have resisted the temptation to duck these gatherings. This was not true of everyone, of course; plenty of people just hoped the whole thing would blow over. In many places, nothing has changed. This is not yet a mass movement. But in all instances where anything positive has grown out of the lessons of exonerations it has been because the police have at least acquiesced in the process, and usually because they have actively participated in or led it. Practitioners who do not share much else share this much: they all hate wrongful convictions. Every time judges, cops, prosecutors, or Innocence Network lawyers took steps forward, they found allies from all points of the criminal justice system, often from among their courtroom adversaries (Saloom 2010).

If we can learn, as medicine has learned, to treat errors as sentinel events to be studied rather than embarrassments to be buried, we can all do a much better job.

Others have catalogued these efforts and considered their merits. I want to look at them as precursors and ask where these first steps could lead. There is potential here for a new approach to mistakes and near misses that promises more than the penitential baring of police throats to media abuse and lawyers' criticisms. Tragic mistakes inspired medicine and aviation to blaze trails towards cultures of safety in ways that illuminate what we might develop within the criminal justice system. If we can learn, as medicine has learned, to treat errors as sentinel events to be studied rather than embarrassments to be buried, we can all do a much better job. A conscious effort to see errors as an opportunity to find abiding root causes can drastically reduce future risks.

Do the police have the most to lose from the frank evaluation of errors? It may be that the police have the most to gain. In the age of DNA, there is no point in pretending that mistakes do not happen; illusions of infallibility have been placed irretrievably out of reach. As things stand, the police take the largest share of public blame for wrongful convictions anyway. In this environment, a public commitment to the frank confrontation of known errors and near misses can provide an important bulwark for police legitimacy. Besides, there are errors other than exonerations—wrongful releases, cold cases that stayed cold too long, hot spots that were not identified or eliminated, avoidable street stops and frisks of harmless citizens—that can yield valuable lessons.

The approaches learned by medicine, aviation, and other high-risk endeavors can knit policing and policing research

back into the development of criminal justice system policy and practice. Pursuing those approaches can identify a common ground on which to mobilize and share the insights of the past decade of evidence based and problem solving policing expertise and to recapture a role that has been muted since the Warren Court's original interventions in criminal investigative practice in the 1960s.

The Wrong Man, The Wrong Patient, The System's Errors

To see the potential in this new orientation, it helps to take a brief detour through one of the best-known and most productive efforts to salvage something from tragic mistakes: the recent wave of reforms that integrate into investigative operations psychological findings concerning eyewitness memory.

Innocent men who were convicted by the testimony of sincere but mistaken eyewitnesses dominate the DNA exonerations list. Reforms to the eyewitness investigative process have moved forward in a diverse range of jurisdictions. These reforms incorporate into local practice new science-based procedures for lineups and photo arrays—principally the double-blind sequential procedure—advocated by psychological researchers. This protocol requires that the lineup or photo array be administered by an investigator who: (1) does not know which member of the group is the suspect; (2) instructs the witness that the real perpetrator may or may not be present; (3) displays lineup suspects and the fillers individually (sequentially) rather than in a group (simultaneously), as in traditional practice; and (4) solicits a confidence statement from the witness at the time of any choice. Advocates of this method argue that it prevents the inadvertent steering of a witness toward a suspect and an unconscious bolstering of the witness's confidence, while it also mutes the dangerous "looks-most-like" properties of the traditional lineup because it converts a multiple-choice comparison test into a true/false recognition test. Laboratory studies of the model indicate that it produces a lower rate of "false-positive" identifications of innocent lineup members at the cost of a slightly higher rate of "false misses"—failures to identify the perpetrator when he is present in the lineup (Wells, Steblay, and Dysart 2011). In effect, the double-blind sequential method provides a new, more conservative screening test for guilt.

Two characteristics of the eyewitness exoneration experience and the reforms it generated stand out. To begin with, the eyewitness wrongful conviction cases were generally no-villain tragedies. The eyewitnesses were mistaken but they were sincere, and the police had usually gone by-the-book as their book then stood. There were no obvious miscreants to hunt for and punish. The eyewitness reforms, largely by accident, were generated in a non-blaming context. Just as importantly, because of the nature of the underlying psychological findings, the remedial program the eyewitness cases provoked marked a dramatic departure from the criminal justice reformers' usual strategy: it did not try to augment the retrospective *inspection* of eyewitness cases at the adversary trial by inserting psychological testimony by defense experts. The new reforms are forward-looking, aimed at the *prevention* of eyewitness errors before they happen, not at catching them later. They fell into police territory, not into the lawyers' courtroom realm.

These features resonate with contemporary medicine's quiet revolution in patient safety (Kenney 2008). Just as the criminal justice system is haunted by the fact that it sometimes convicts the wrong man, medicine is haunted by the fact that it sometimes operates on the wrong patient. But when modern medical researchers began to look carefully into wrong-patient events, they uncovered surprising insights. For example, one intensive examination of a wrong-patient surgery discovered not just one but at least seventeen errors (Chassin and Becher

2002). The patient's face was draped so that the physicians could not see it; a resident left the lab assuming the attending physician had ordered the invasive surgery without telling him; conflicting charts were overlooked; and contradictory patient stickers were ignored. But the crucial point for the researchers was that no single one of the seventeen errors they catalogued could have caused the wrong-patient surgery by itself.

Analysis showed not only mistakes by individual doctors and nurses, but also latent systemic problems. Communication between staff was terrible; computer systems did not share information. When teams failed to function, no one was surprised or bothered because of a culture of low expectations that "led [staff] to conclude that these red flags signified not unusual, worrisome harbingers but rather mundane repetitions of the poor communication to which they had become inured" (Chassin and Becker 2002). Deviations from good practice had become normal, and a tragedy resulted.

What this meant to medical reformers was that the lessons of closely studied events such as the Chernobyl meltdown and the Challenger launch tragedy could be applied to health care. Like those tragedies, the wrong-patient surgery was an organizational accident. No single error is sufficient to cause an organizational accident; the errors of many individuals (active errors) converge and interact with system weaknesses (latent conditions), increasing the likelihood that individual errors will do harm. The practitioners and organizations involved in these tragedies did not choose to make errors; they *drifted* into them (Dekker 2011). These events involved normal people, doing normal work, in normal organizations (Dekker 2007). They suffered, in Charles Perrow's (1984) memorable phrase, "normal accidents." Like the Challenger launch decision, they were "mistake[s] embedded in the banality of organizational life" (Vaughan 1996, xiv).

These insights apply to a wrong-man conviction. Our traditional wrongful conviction narrative (the witness picked the wrong guy; the cops and the district attorney believed her; so did the jury) is not adequate. Nor is it adequate to isolate the imperfections of one operator or one investigative technique employed in the case—for example, the traditional non-blind, simultaneous lineup—as either a sole cause or a silver bullet vehicle to a stable solution.

Lots of things have to go wrong before the wrong man is convicted. Yes, the witness has to choose the wrong man from an array, but the police have to put him into the array in the first place and design the format of the array. Forensic evidence on the crime scene could have been overlooked or, although properly collected and tested in the lab, distorted in the courtroom presentation. Cell phone, Metrocard, or other alibi information could have been ignored or considered insignificant. Tunnel vision, augmented by clearance rate and caseload pressures from above, may have overwhelmed the investigators and the prosecutors. Poorly funded or untrained defense counsel may have failed to investigate alternative explanations or to execute effective cross-examination. The witness erred; the cops erred; the technicians erred; the prosecutors erred; the defense erred; the judge and the jury erred; the appellate court erred, too. No single one of these errors would have been enough without the others. The errors combined and cascaded; then there was a tragedy.

The right answer to the question, "Who is responsible for this wrongful conviction?" is usually "Everyone involved, to one degree or another," if not by making a mistake, then by failing to catch one. And "everyone" includes not only cops and lawyers at the sharp end of the system, but also legislators, policy makers, funders, and appellate judges far from the scene of the event, who dictated the conditions under which the sharp-end operators work. Look twice at the DNA-exposed wrongful convictions and you see that, as Charles Perrow (1984, 9) noted, "[T]ime and again, the operator

is confronted by unexpected and usually mysterious interactions among failures, [so that] saying that he should have zigged instead of zagged is possible only after the fact." This is as true of a whole spectrum of criminal justice errors—mistaken releases, prisoners lost in prisons, and cold cases that stayed cold too long—as of wrongful convictions.

The habit of treating horrific wrongful convictions as single-cause events, and then totaling up, ranking, and prioritizing these causes has produced useful reforms, but it does not really engage the nature of the problem. The solutions it has generated stop short of fundamentally improving future system reliability. Although a new set of best practices or checklists can be a helpful thing, they have to be operationalized and executed. And they have to be maintained, monitored, evaluated, and perhaps junked and replaced when environments change or science advances. No new set of best practices or checklists can cover every circumstance, so an irreducible zone of discretion always survives, and operators are forced to manage life within that zone. Every new checklist is under immediate and constant assault from caseload pressure and other environmental factors from the moment it is written. *Drift* toward failure remains a threat to our new best practices just as it was to their discredited predecessors (Dekker 2011). No one had more checklists than NASA; NASA launched Challenger anyway.

The Hunt for Bad Apples

The single-cause approach is especially flawed when everyone assumes, as we tend to do, that the single cause must be a bad apple. If someone can be blamed, then discipline him: charge him, sue him, fire him, at the very least shame him and exhort him to do better. The bad-apple explanation is not only wrong as a descriptive matter but it has a crippling impact on any remedial potential.

In medicine, the endemic assumption had always been "good man, good result." As Dr. Lucian Leape wrote in his seminal 1994 essay, *Error in Medicine*:

> Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians, not unlike test pilots, come to view error as a failure of character—you weren't careful enough, you didn't try hard enough. This kind of thinking lies behind a common reaction by physicians: How can there be an error without negligence?

Transplant Leape's description of medical culture into criminal justice, and homicide detective, prosecutor, defender, forensic scientist, or judge substitutes smoothly for physician. In this familiar conception, any error is an *operator* error: some surgeon, police officer, nurse, forensic scientist, or lawyer at the site was lazy, ill-trained, venal, or careless. The task of conscientious professionals in this vision is to act as the custodians of a presumptively safe system and to protect it from incompetent and destructive humans (Dekker 2007).

Practitioners do not want to be blamed or to be part of the unpredictable machinery of blaming colleagues; thus, nothing gets reported.

Health care reformers quickly noticed that the first effect of the focus on blaming culprit-operators is that it drives valuable reports of errors and near misses underground (Berwick 1989). Practitioners do not want to be blamed or to be part of the unpredictable machinery of blaming colleagues; thus, nothing gets reported. This tendency affects agencies as well as individuals. In a blame-oriented environment, when sentinel events cannot be buried completely, the pressure intensifies to keep them in-house or to try to shift the blame to someone else's "house." But since no individual "house" can fully explain an organizational accident, weaknesses that might be studied and understood are glossed over and remain latent in the system, waiting for the next patient or the next case to come along. A search for *the* cause blocks understanding of how complex systems fail through the confluent, cascading errors, active and passive, of multiple contributors from many "houses" (Woods 2005).

There is a sense in which everyone knows this, because we watch it play out all the time. Now and then, a tragic wrongful conviction or similar error generates a public clamor for the punishment of the responsible bad apple. The most common understanding of accountability holds that a tragic event requires that tragic punitive consequences fall on somebody. The system's leaders oblige and undertake the hunt for the bad apple. But when internal affairs, the grand jury, or the civil rights division actually investigates the event closely, it almost invariably turns out to have been a complex organizational accident with many contributing causes and no villain suitable for shouldering the exclusive blame. Unless things are so bad that a scapegoat is absolutely required, a report is issued, expressing regret and explaining that no individual will be punished.

That may be fair enough in regard to the individual targets, but it is a bad place to stop. No one learns anything useful from these exercises and, to make matters worse, when fruitless hunts for bad apples result in little or no action, they actually tend to *decrease* police legitimacy. When an airline official on an air crash scene says, "Let's wait for the National Transportation Safety Board report," the public and the media are generally content to wait. When police officials say after an exoneration, "We're doing a report," the public response is more likely to be, "Let's wait for the whitewash."

Accounting for Our Errors

Our decisions take place in the context of an expectation that we may be called on to give accounts of those decisions to various parties. The way we are held accountable influences how we make decisions and the quality of our decisions. How, and to whom, we expect to be called on to account for our performance can affect our performance in explicit and implicit ways (Woods 2005.) Expectations for what will be seen as an adequate account (and the consequences if the account is seen as inadequate) are critical parts of a *cycle* of giving accounts and being called to account that shapes our conduct (Woods 2005, 3). This is as true in the criminal justice system as it is anywhere else.

The history of the exoneration cases illuminates a missing element in the architecture of the criminal justice system: the capacity for a "forward-looking accountability" that balances demands for individual responsibility with the need for learning and improvement (Sharpe 2003). We lack a vehicle for accounting for tragic outcomes that allows for working on continuous quality improvement—a means for anticipating and preventing the next catastrophe before it happens.

Detectives speak of making cases; lawyers speak of trying them. In this respect, the work of criminal justice system actors mimics work in other enterprises. The police operate a production stage in which they make the case, and the lawyers and judges run an inspection stage, during which

the legal system evaluates the investigators' product.

Inspection during an adversary trial before a lay jury is a permanent feature of our system. It expresses fundamental American convictions about the relationship between the accused individual and the state. Besides, the lay jury's one-time concentration on a specific narrative provides a bracing challenge to the professional practitioner's endemic tendency to believe that we know the odds in our fields and therefore simply play those odds.

But the goal of the trial process is to protect *this* innocent citizen from the state. The DNA exonerations have augmented doubts about the adversary trial's efficacy even in that limited role (Simon 2011), but no one claims that the trial's role is to analyze the investigative and charging processes and make them more reliable in the future. A jury that believes it has caught a faulty investigation says "not guilty" and nothing more. Appellate courts review the legal procedures; they do not reconsider the facts, and their review is entirely backward-looking. Both are necessarily uninformative.

Medicine, aviation, and other modern industries that achieve high reliability in the face of potential catastrophic failures regard as insane exclusive reliance on end-of-process inspection to improve reliability and quality control. It is axiomatic in these other industries that *all* end-of-process inspection schemes, although they are necessary components of their system, are poor routes to overall system quality (Berwick 1989). Practitioners who are subject to inspection are resourceful when it comes to avoiding the inspection altogether or to gaming the inspection when they cannot. Those being inspected usually end up owning the process, and their primary goal is usually their own safety (Berwick 1989). Criminal justice system operators are not immune to these tendencies.

Of course, only a tiny portion of criminal cases actually receive jury scrutiny. This certainly has something to do with the costs of trials in terms of time and money. But it also reflects all professional practitioners' shared disinclination to submit to inspection by unpredictable lay jurors, especially when that inspection takes place in an exposed zero-sum courtroom contest where one side wins, and one side loses, all. The disturbing segment of the exoneration list that recounts prosecutors' failures to turn over exculpatory material does not show the prosecutors' desire to frame the known innocent, but rather reveals their impulse to shape the adversary trial inspection stage so that it comes out (from the prosecutors' perspective) the right way. Exculpatory material is hidden by prosecutors in order to convict the people the prosecutors believe are guilty without interference from red herrings that defense lawyers might have manufactured out of dissonant facts.

The downstream consequences of hiding exculpatory material are obvious when a wrongful conviction case is seen in hindsight: the trial stage inspectors were foiled and prevented from catching the mistake before DNA technology intervened decades later. Less obvious, but just as important if prevention is our goal, are the *upstream* consequences of a looming inspection architecture.

The prosecutors in the wrongful conviction cases, like workers in many production processes, evidently adopted a "covert work system" (Woods 2005). They decided to evade well-known formal disclosure requirements and buried alternative narratives because they believed sharing the exculpatory facts would interfere with achieving the real goal assigned to them by officials to whom they were accountable. The police investigators may have been encouraged by the prosecutors (or, mistakenly believing they had been encouraged by the prosecutors, decided on their own) to avoid

exploring and documenting discordant leads that might have falsified the original theory of the case. Both of these practices augment the universal human tendency toward tunnel vision by rewarding surrender to tunnel vision with a "cleaner" trial inspection for the hypothesis that the practitioners prematurely decided is accurate. Tunnel vision makes a causal contribution to the wrongful conviction, but aggravated tunnel vision is also an *effect* of the sharp-end operators' discomfort with the demands of the end-stage inspection machinery.

All of this is on display in the recent U.S. Supreme Court case of *Connick v. Thompson* (2011). John Thompson was convicted of murder in New Orleans in 1985. After a trial where he opted not to testify, Thompson was sentenced to death and spent the next eighteen years in prison, fourteen of them on death row. A few weeks before Thompson's scheduled execution in 1999, a defense investigator learned that a cancer-stricken member of the prosecution team had confessed on his deathbed to having withheld crime lab results from the defense, as well as removing a blood sample from the evidence room. In addition, Thompson's defense learned that the New Orleans district attorney's office had failed to disclose that Thompson had been implicated in the murder by a person who received a reward from the victim's family, and that an eyewitness identification did not match Thompson. Thompson's conviction was overturned on appeal. On retrial, a jury exonerated Thompson in only thirty-five minutes. The public's most lasting impression was undoubtedly "the cops got the wrong guy; the prosecutors covered up for the cops."

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The only available response for addressing this travesty was a civil lawsuit, which by its nature meant hunting for someone to blame. The line prosecutors were dead, judgment proof, or immune; the office of the district attorney denied responsibility for its staffers' actions. In other words, both the operators and their bosses successfully ran for cover, and the U.S. Supreme Court held that the government could not be held liable under the 1964 Civil Rights Act since the *Thompson* wrongful conviction was (as far as the judges knew) a single incident. Thompson, the victim of this misconduct, was not compensated; no concrete consequences fell on the prosecutors.

This case has provoked a heated campaign for more criminal charges and more aggressive discipline of unethical prosecutors, including more severe punishment designed to hold prosecutors accountable (Gertner and Scheck 2012). We can never dispense altogether with disciplinary actions aimed at consciously unethical behavior. Characters like rogue forensic scientist Fred Zain, who falsified lab work in dozens of cases, will crop up from time to time. But there is an additional failure in accountability embedded in the *Thompson* aftermath—a failure in forward-looking accountability. No one learned anything about the real, abiding issues in the *Thompson* narrative, and those issues were left to surface again in future cases.

Unless sociopathic *Thompson* prosecutors consciously set out with the goal of convicting a known innocent, the question that *Thompson* raises is not

whether the choices of either the district attorney's office as an agency or the individual frontline prosecutors who hid the evidence were wrong. Of course those choices were wrong. The real question is *why did the mistaken choices seem to be good choices at the time* (Dekker 2011). Or, at least, why did the mistaken choices seem like the only, or least bad, ones. Exculpatory evidence has to be turned over. Why didn't the prosecutors know this? Why, knowing it, did they decide their best choice was not to act on it? While it might be perfectly fitting to blame prosecutors who knowingly disregard legal requirements or best practices, what about the other participants? There is a difference between malfeasance and error and, further up and down the stream from the prosecutors, it looks very much as if error, not conspiratorial malfeasance, is what we are confronting.

Why couldn't the defenders themselves find the exculpatory evidence? Why didn't the detectives know this and follow up on the court's failure to make use of the exculpatory evidence they had generated during their investigation? Why did they decide to stand by silently and watch the trial unfold? After all, the police were going to take the blame for any error in the end. Were the detectives caught in the classic administrative double blind, held accountable for an outcome they did not feel they had the authority to control or influence?

Congratulating ourselves on simply seeing that mistaken choices were made will not get us anywhere if we do not account for the root causes of the mistakes. That is why a sentinel-event approach is crucial. A process that *would* get us somewhere would involve calling to the table representatives of all stakeholder roles to analyze known errors or near misses, not distilling each to a single cause or a single villain but appreciating and describing its complexity. As Lucien Leape (1994) noted in the medical context, "Efficient, routine, error identification needs to be part of hospital practice as does routine investigation of all errors that cause injury." The all-stakeholders approach is necessary if we decide to see a wrongful conviction or other error as an organizational accident that required cascading, confluent contributions from everyone's "house." And, among the stakeholders, practitioners not too far divorced from sharp-end practice have to be included. Medical reformers are fond of pointing to a mysterious outbreak of central line infections in a Pittsburgh intensive care unit that was solved by the janitor member of the error-review team (Kenney 2008.)

The missing weapon in our approach to error is not a once-in-a-decade, blue-ribbon panel of august dignitaries at the chief justice and superintendent level, convened to redesign the architecture of the criminal justice system. We have examples of that approach now, and it cannot be denied that, when the goal is changing structural elements by legislation or rulemaking,

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the political heft of those high-ranking players is useful, even essential (Saloom 2010).

What is missing is a commitment to regular, routine review of known errors and near misses, conducted by experienced practitioners and stakeholders (for example, victims' rights professionals) supplemented where appropriate by subject-matter experts and (at least in the beginning) by specialists in analyzing the sources of system error and in the error-review process itself. As Leape (1994) argued, "The emphasis is on *routine*. Only when error is accepted as an inevitable, although manageable, part of everyday practice will it be possible to shift from a punitive to a creative frame of mind that seeks out and identifies the underlying system failures."

What If? Continually Improving Reliability

What if, when the next wrongful conviction is announced, the police—usually described as famously inbred, suspicious, paranoid, and wrapped in a pathological blue code of silence—amaze the world by calling for an all-stakeholders examination of the error? Or, what if DNA results back from the lab six months after an arrest show that they arrested the wrong guy, and police suggest that a team examination of this near miss might pay dividends?

Just as all aviation industry participants and the public expect the National Transportation Safety Board to convene a mixed team of specialists to give an account of what happened when a plane goes down, criminal practitioners and the public could learn to expect that we will marshal a team, including an investigator or patrol supervisor, a prosecutor, a forensic scientist, a defender, a judge, a victims' representative, and the jurisdiction's risk management officers, joined by additional specialists as needed, in a non-blaming process of dissecting the facts of what happened and sharing the account they have developed. The goal would be to understand the gritty facts, to do the sort of clinical fact-finding that inevitably suffers when everyone in a turf-conscious, blue-ribbon group is anxiously looking over his or her shoulder at potentially sweeping and unwelcome legal reforms.

Continually working on improving system reliability means changing the system's culture, not its architecture. Overhauling institutional arrangements, identifying best practices, and devising checklists, as difficult as these might be, are the easy parts. Working on changing the culture means concentrating on giving a primary place to workmanship and professionalism instead of blame and discipline.

It would take a more messianic temperament than my own to believe that everyone, everywhere will start doing this immediately and all of the time. There are some jurisdictions where the police leadership knows that the chief public defender is a self-aggrandizing loudmouth, or the district attorney is a vainglorious idiot, or the unions are permanently and obstructively antagonistic. Even in jurisdictions where none of this is true, there are some sentinel events that will be simply too hot to handle. But a lot will be achieved if some people in some places start doing this some of the time and share the product of their work.

The best way forward allows practitioners themselves to nominate their sentinel events, their collaborators, and their formats. Since nothing will work unless everyone consents, why not allow practitioners to choose? In this scheme, the police can go first. The police are best positioned to identify the common ground—in this particular example, a hatred of wrongful convictions and a forward-looking approach to avoiding them—onto which all stakeholders are willing to enter, and (even more importantly) to set the terms on which they and all other stakeholders would be willing to defend that common ground (Woods 2005). Stakeholders will have to agree to forego some short-term pleasures (e.g., paying off in the media an ancient grudge against a counterpart agency) in order to pursue the longer-term and more fundamental goal of fully

understanding the root causes of the organizational accident under scrutiny.

It is not as if learning from error in the aftermath of catastrophe has never succeeded from a police perspective. The Los Angeles Police Department's frank morning-after analysis of the MacArthur Park disorder and the role of its own staff had disciplinary consequences, but the report's thrust was not disciplinary. Much was learned from it, and public confidence in the LAPD and its leadership rose measurably when the report was released (McGreevey and Winton 2007). Milwaukee police regularly participate in the Milwaukee Homicide Review Commission's interdisciplinary investigations of homicides (O'Brien, Woods, and Cisler 2007).

A near miss can work just as well or better as a sentinel event. The Will County, Illinois, Sheriff's Department commissioned an investigation by the experienced staff of Andrews International Group (including former chiefs John Timoney and Patrick Hartnett) to analyze investigative missteps in the mistaken prosecution of an Illinois father who was exonerated pretrial by DNA in the rape and murder of his daughter. The report shed light on the origins of the father's false confession and on the efficacy of new DNA techniques, while generating cogent recommendations for the future and avoiding personal humiliation of any of the actors (Andrews International Group 2010).

In all of these examples, concerns about incident liability were successfully balanced against the need to manage future risks by identifying root causes that will trigger repetitions. Participants recognized that the new, marginal exposure caused by a careful evaluation was minimal. The worst that could happen had already happened; if you were going to be sued, you were going to be sued. The goal of not getting sued again was kept in mind.

The "keep this in-house" impulse is understandable, and even has its more attractive side—an ethic of responsibility, of cleaning up our own mess. Still, this admirable impulse feeds a go-it-alone approach that suffers from built-in limitations. Read any police-only scrutiny of a mistaken conviction and you are left to ask, "Where were the prosecutors?" or "What was it about the trial environment that made this seem like a good idea?" or "Who funded this crime lab?" or even "Where was the defense?" Comparable efforts by prosecutors' offices to handle conviction integrity entirely in-house suffer from comparable handicaps (see Scheck 2010). Of course, an in-house investigation might ask those questions but it cannot answer them.

An all-stakeholders review, by contrast, would involve everyone in the discussion. It would uncover—and not in the context of excuse-making—the operational constraints imposed on the police by actors far from the immediate scene of the police investigation. It would expose everyone's role in the outcome. It would illuminate many police choices that are dictated (or at least heavily influenced) by the policy and practices of prosecutors, judges, or other actors. It would supplement the in-house impulse to go "down and in" to find a broken component with the modern safety expert's recognition that, because no organization acts in isolation, we also need to go "up and out" to assess the environment's impact on existing procedures and practices (Dekker 2011).

A coherent program of non-blaming, learning from error that includes the evaluation of near misses offers rewards both within local systems as well as across scattered systems. A common, national template for error review, enacted locally and informed and challenged by diverse local experiences, can substantially mitigate the fragmentation of American criminal justice.

These advantages can be multiplied if a simple mechanism—a clearinghouse or a wiki-style community of practitioners, researchers, and policy makers—could be developed for distributing and commenting on the reports of errors (Doyle 2010). This process

could provide a platform where participants would not be forced to choose between the valuable contributions of evidence-based policing (Weisburd and Neyroud 2011) and problem-solving policing (Sparrow 2011), but could mobilize both and perhaps alert both schools to factors that neither had yet considered. Reading of a distant system's experience of completed accidents can alert currently isolated practitioners to the operation of dangerous latent features in their own local systems. Reading studies of remote near misses can reveal both those dangerous latent features as well as potential fail-safe devices or procedures not present locally, which provided resilience and kept the near miss from becoming a tragic hit. It can counteract the tendency of today's best practice to calcify into a ceiling that blocks future improvements.

Conclusion

There is truth in the warnings of David Kennedy (Wessels 2006), among others, that conditioning any decision to act on establishing our firm confidence in "fixing the criminal justice system" is a recipe for paralysis. There is no arrangement of gears and switches in criminal justice, no system in that sense that we can reach for and fix with a wrench or a hammer. But, like it or not, the world of criminal justice is a complex functioning ecosystem like a pond or a swamp where well-meaning actions on this coast can have disastrous, unanticipated impacts on the far shore. Ignoring this fact will fulfill the axiom that the cause of problems is solutions. Improve your property crime clearance rate by swabbing everything in sight and you will raise the rape-kit backlog at the lab.

But there is opportunity as well as danger in this interdependency of criminal justice's operators. Working steadily on organizational error analysis creates an increased system consciousness among the practitioners who staff the components of the criminal process. The forward-looking accountability that this practice creates can be an important—and arguably indispensable—element of a new professionalism (Stone and Travis 2011). Today's police lieutenants will make better police captains next year thanks to their participation in the rigorous organizational accident analysis of a known error or near miss. Bratton's "collaborate or perish" is a good warning to keep in mind, and the power of collaboration to improve forward-looking accountability is one more reason for collaboration (Bratton and Tumin 2012). A disciplined commitment to team analysis of error can lay the foundation in criminal justice for realizing the new ideal of continuous quality improvement that is transforming the culture of contemporary medicine.

Today's police lieutenants will make better police captains next year thanks to their participation in the rigorous organizational accident analysis of a known error or near miss.

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