Comprehensive Internal Review and Root-Cause Analysis of Critical Incidents

"Critical incidents such as officer-involved shootings provide an opportunity for learning and improvement well beyond the determination of whether the use of deadly force was within policy."
OIR Report - 2017

Incidents involving serious use-of-force, especially those resulting in injury or death, are always undesirable. They are, however, rarely but occasionally unavoidable. Police cannot be blamed in every such instance, since sometimes officers are truly required by circumstances to resort to force, even deadly force. Nonetheless, such incidents are always unwanted events that should be minimized as much as possible while permitting police to perform their important public safety duties.

Currently, the institutional mechanisms for reviewing such incidents include internal and external investigations to determine if the officers involved complied with the law and MPD policies. These reviews are undertaken to determine if someone should be held accountable for wrongdoing, either by way of discipline or criminal prosecution. These reviews are of course essential, and must continue, as will be addressed in other recommendations the Ad Hoc Committee will be including in its final report.

But to truly improve policing and work toward minimizing such undesirable incidents, more is needed. Analysis of critical incidents must be robust and holistic, and systems must exist for fostering institutional learning from such incidents. OIR has recommended that MPD conduct comprehensive internal reviews of critical incidents and we endorse this recommendation. Holistic critical incident review meetings can begin convening relatively soon after an incident, utilizing roundtables of command staff and departmental subject matter experts to examine issues including tactical decision-making, communications, supervision, equipment, training concerns, department policies, and individual accountability.

In addition, a key component of comprehensive reviews should be non-blaming inquiries into root causes of problematic incidents. Only through such a non-blaming, learning-focused process can the MPD fully explore ways to minimize use-of-force incidents as much as possible. People function within systems designed by organizations, and redesigning systems can reduce the risk of adverse events. The purpose of root-cause analysis is not to assign blame but to enable complex organizations to identify opportunities for improvement. The Common Council's President's Work Group embraced this approach to learning about systemic error, and directed the Ad Hoc Committee to devise a plan for implementing a root-cause-analysis (President's Work Group Report action item 12).

Models for such learning-focused, non-blaming, root-cause analyses exist widely in medicine, industry, and other areas of government. Perhaps most notably, the National Traffic Safety Board (NTSB) offers an example of the potential for improving public safety in a highly complex system. Additionally, many hospitals have adopted such processes following unexpected or

catastrophic patient outcomes, as part of what has become known as the creation of a "just culture" in medicine. A "just culture" can be defined as "a culture that recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, 'routine rule violations'), but has zero tolerance for reckless behavior." [Agency for Healthcare Research & Quality Glossary]

Creating such root cause analysis processes can be complicated, but fortunately, Madison has the opportunity to take part as a model site for technical assistance from the Quattrone Center for the Fair Administration of Justice at the University of Pennsylvania Law School, under a grant from the U.S. Department of Justice. The Quattrone Center for the Fair Administration of Justice at the University of Pennsylvania Law School is a nonpartisan, national research and policy hub producing and disseminating research designed to prevent errors in the criminal justice system. In 2017, the Quattrone Center was awarded a federal Bureau of Justice Assistance grant to provide technical assistance to 20-25 demonstration sites around the country on sentinel events reviews. As explained in the federal grant RFP, this "is an effort led by the National Institute of Justice—the U.S. Department of Justice's research, development, and evaluation agency—to explore whether an all-stakeholder, forward-looking, non-blaming review of unanticipated events that signal an underlying system weakness in criminal justice can be used to understand areas of system risk and weaknesses, reduce the occurrence of these outcomes, increase safety, and augment the criminal justice system's ability to fulfill its mission." This includes office er-involved shootings.

The federal grant solicitation explains the role of the Quattrone Center as a technical assistance provider in this way:

> The TA Provider will assist in the establishment and facilitation of these multi-stakeholder review panels, and provide ad hoc support for such processes as interviews of relevant parties and negotiation of information-sharing agreements. In addition, the provider will complete a process evaluation to identify promising practices and common challenges to implementation. The TA Provider will be instrumental in establishing and facilitating the reviews at the local level, building on this work to identify promising practices and shared challenges across sites. This effort will build on several years of program development and inquiry at NIJ, including the completion of three pilot efforts in 2014.

Pursuant to that Technical Assistance grant, the Quattrone Center is now considering which jurisdictions to work with to develop these demonstration sites.

The Quattrone Center staff have explained the theoretical basis for their technical assistance in "just culture reviews" in this way:

> Event reviews go by various names, but whether called root cause analyses or sentinel event reviews, their philosophy is the same: When a system generates undesirable events, all stakeholders should come together to review those events in a nonpunitive manner, understand the true underlying causes of *why* events unfolded as they did, and determine how they could have been avoided.
>
> Such insights become the basis for recommendations for system change to prevent the next error. These investigations, epitomized in other industries through structures like the National Transportation Safety Board or hospital morbidity and mortality reviews, have fostered significant innovations such as child safety seats and surgical checklists that have saved thousands of lives.
> …
>
> The question asked in disciplinary hearings or litigation is whether the officer's actions were legally justifiable or permissible under law enforcement policy. This retrospective approach does not reach the question of whether the incident could have been avoided, and how to prevent future incidents. Nor does it address the reality that most shootings, even when legally justified, decrease police legitimacy and fracture the relationship between officers and the communities they are supposed to serve.

The Quattrone Center further notes:

> A "just culture" balances blame-free event reviews with the need for professionals to be personally accountable for adherence to reasonable standards of professional conduct. Typically, this involves the creation of a separate disciplinary process in the event that the root cause analysis uncovers evidence of intentional or reckless wrongdoing by any individual…. In order to preserve the integrity of the root cause analysis as a blame-free event review, it is important that any disciplinary process be additional to, and separate from, the root cause analysis. The individual in charge of making determinations about disciplinary action should be informed by, but not report to or be directly involved with the root cause analysis itself.

Finally, the Quattrone Center explains its role as technical assistance provider in this way:

> An independent facilitator would assemble a review team with subject matter experts, such as former detectives, psychologists or ballistics experts, and include community and police department representatives not directly involved in the incident. They would conduct interviews and review documentary evidence, working together to identify contributing factors and root causes of the event and developing policy recommendations aimed to prevent future, similar incidents. For example, an event review of a shooting of a mentally ill individual might result in recommendations to develop specific police protocols

> for interaction with people believed to be mentally ill, or create law enforcement response systems that include communication or collaboration with mental health professionals. Importantly, the event review would be firewalled from the disciplinary or legal process, to allow those who participate to do so candidly.
>
> In analyzing police shootings, reviews can focus on the use of force and immediately preceding events. But they can also look at the incident response, and how later actions may have compounded the reaction to the initial event. …

John Hollway, Executive Director of the Quattrone Center, attended an Ad Hoc Committee meeting in Madison and expressed interest in working with the MPD and the City of Madison, as soon as possible, if several key stake-holders, including the MPD, City government, and perhaps community groups or other stake-holders, will commit to the process. We note that the MPD does not oppose this recommendation, and indeed, in its response to the OIR Report, wrote:

> The department has had some preliminary discussions with the Quattrone Center on this subject. The Quattrone Center, affiliated with the University of Pennsylvania Law School, focuses on preventing errors in the criminal justice system. One aspect of their work involves root cause analysis (or “just culture” review) with agencies. In 2019, the department will further explore the parameters of how a post-critical incident review process might look and whether it is feasible to work with The Quattrone Center moving forward.

Litigation concerns should not be a bar to implementation. As OIR notes:

> There are legal protections available when a law enforcement agency rigorously self-examines and uses that process to improve. And even if there were some public access and litigation concerns, those should of course take a back seat to any initiative that reduces the likelihood of further deadly force incidents and increases officer safety through critical self-scrutiny.

The Committee strongly recommends taking advantage of this opportunity by committing itself and the MPD, as soon as possible, to work with the Quattrone Center to establish Madison as a demonstration site for technical assistance under the federal Bureau of Justice Assistance grant for creating a root-cause analysis and “just culture” process for learning from critical incidents. For the purpose of increasing the safety of both the public and officers, the Committee recommends that the Common Council direct City personnel to submit a request promptly for assistance from the Quattrone Center.

Recommendation #20:

> MPD should develop a robust review process after a critical incident such as an officer-involved shooting that examines the incident through the lenses of performance,

training, supervision, equipment and accountability. The review process should consider pre-incident decision making and tactics, the use of force, and post-incident response, including the provision of medical care and communication with family members. The review process should include the development of a corrective remedial plan designed to identify and address any issues identified. [OIR Report #75]

Furthermore, MPD and the City should work with the Quattrone Center to develop a root cause analysis procedure. [see President's Work Group Report #12]