Best Practices for Review and Prevention of Deadly Incidents in High-Hazard Professions: Lessons for Police

Summary of Conference Proceedings
May 9 -May 11, 2017

Executive Summary

In the first half of 2017, 65 law enforcement officers lost their lives in the line of duty and 492 civilians died during police-citizen interactions.[1] That tragic loss of life and its predictable recurrence was the subject of a May 2017 conference hosted jointly by the Johnson Foundation at Wingspread and the University of Wisconsin Law School. The conference brought together national experts in critical incident review, along with Wisconsin leaders in government and policing, to discuss ways in which Wisconsin might lead the nation in developing innovative approaches to learning from critical incidents involving police-citizen interactions in order to prevent future harm to citizens and officers alike. The meeting had three primary goals:

1) To review best analytical and learning practices of other high-hazard professions that may be adapted to law enforcement organizational learning mechanisms;
2) To explore the interrelationship of learning systems and accountability systems; and
3) To explore the feasibility of developing an external-learning system for review and prevention of use of deadly force by law enforcement officers in Wisconsin.

Over the course of three days, participants reached agreement on several important points. First, there was unanimous consensus that when critical incidents occur, it is appropriate—wholly apart from any investigation into possible wrongdoing—to gather and analyze data for the purpose of preventing similar future harms. There was also widespread agreement that such a review should be conducted by an independent commission or agency. Additionally, participants emphasized the need to pay equal attention to incidents in which civilians and officers are harmed in order to promote safety for all. The inquiry would include not only the incident itself, but also precursor conditions, including contextual information gathered from the larger community. It would not be limited to determining the proximate cause of the deadly incident alone, but would search for any and all critical contributing causes and factors, particularly those amenable to prevention. Many participants believed that current

[1] Nat'l Law Enforcement Officers Memorial Fund, Officer Fatalities, http://www.nleomf.org/facts/officer-fatalities-data/ (last visited July 3, 2017); Washington Post, Database of Police Shootings 2017, https://www.washingtonpost.com/graphics/national/police-shootings-2017/ (last visited July 3, 2017).

investigations done for the purpose of determining criminal liability collect a great deal of this relevant information already and that a commission could begin its work by reviewing files from recent past investigations.

There was broad consensus on the principles that should animate an external review system. It must be transparent in its procedures and outputs (while also maintaining the ability to collect sensitive information confidentially), non-punitive, and as timely as possible. Its investigators should be qualified experts representing a diversity of backgrounds, including but not limited to those with law enforcement backgrounds. Finally, findings should be shared broadly with the public as well as affected stakeholders.

Participants agreed that over time an external learning system might evolve to include not only post-incident review, but also review of "near misses" and other situations in which harm was averted. Such incidents might yield information not only about what to avoid, but about what best practices should be.

All participants agreed that to move forward, legislative leadership is needed to define the form, mission, legal authority, and funding for a public safety review commission. Next steps include establishing a working group of legislators and representative stakeholders to refine the proposal for such a system and the legislation required to establish it.

Detailed Summary of Conference Panels and Discussions

External Learning Models in Other Fields

Many high-risk fields utilize external learning systems to draw lessons from serious accidents and near misses to prevent their recurrence. At the outset of proceedings, participants heard from four experts representing the fields of aeronautics, medicine, and transportation. Each offered an overview of tested external learning models in their respective fields.

Critical Incident Review in Aeronautics

Linda Connell, Program Director for NASA's Aviation Safety Reporting System (ASRS), described the 41-year old history and current function of the ASRS. Developed following a fatal (and avoidable) TWA crash in 1974, the system provides a mechanism for pilots to report, and for NASA to share, safety information of relevance to other pilots. During the time the system has been operating, aviation accidents have fallen steadily and significantly.

The ASRS encourages self-reporting by pilots and other crew members not only of accidents, but also of near misses, or "incidents"—errors that could have resulted in injury to humans or damage to aircraft, but did not. This system does not replace, but rather complements, other investigative bodies (such as the FAA and NTSB), which are responsible for investigating aviation accidents in which injury or death occurs. There are four key principles of the ASRS learning model:

- Participation is voluntary.
- Confidentiality is legally protected.
- Responses are non-punitive.
- The agency to which reports are made is independent from airlines and the FAA.

The purpose of the ASRS is to gather information in order to assist NASA in generating hypotheses about, and ultimately detecting, safety problems, ideally before tragedies occur. The system serves as a form of quality assurance that is focused on learning for the future. NASA reports its findings to the FAA, which provides funding for the ASRS, as well as to the larger aviation community. Important findings gleaned from ASRS reports are disseminated in several ways. Urgent information is shared through alerts that are immediately disseminated to all affected stakeholders. Less critical findings are sent through periodic circulars and reports. Recommendations include not only changes in the practices of flight personnel, but also changes in manufacturing practices and recommendations for further industry research. Recent deficiencies identified by the system include emerging challenges in the use of unmanned aerial vehicles and problems of altitude deviation attributable to the effect of sun glare on pilots' vision.

The success of the ASRS has led to the adoption of similar systems across multiple professional fields. Examples include the railroad industry's Confidential Close Call Reporting System, the National Fire Fighter Near-Miss Reporting System, and the Bureau of Veteran's Affairs Patient Safety Reporting System.

Critical Incident Review in Medicine

External learning systems can take many different forms. Jamie Robertson, Assistant Director of Simulation-Based Learning at Brigham and Women's Hospital's STRATUS (Simulation, Training, Research and Technology Utilization System) Center for Medical Simulation, described the work of her program in helping doctors reduce medical errors, which account for tens of thousands of deaths and billions of dollars of loss, annually.[2] The STRATUS Center's simulation lab is a partnership of Brigham and Women's Hospital and Harvard Medical School. In the laboratory, doctors are given simulated "disaster" scenarios that allow them to make mistakes and learn from them without exposing live patients to risk. Hands-on training, like that provided by the STRATUS Center, complements formal reporting systems in medicine, which vary from state to state and hospital to hospital.[3]

[2] INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (2000), available at https://www.nap.edu/download/9728 (estimating 44,000-98,000 deaths and losses of $17-29 billion dollars annually as a result of medical error).

[3] In 2000, the National Academy of Sciences issued a report recommending the adoption of both mandatory and voluntary medical error reporting systems across the country. INSTITUTE OF MEDICINE, TO ERR IS HUMAN, at 86-108 Examples of mandatory reporting systems include Minnesota's Adverse Health Events Reporting Law, see Minn. Stat. § 144.7067, and the State of Indiana's Medical Error Reporting System, see 410 Ind. Admin. Code § 15-1.4-2.2. Voluntary reporting systems include the Institute for Safe Medication Practices National Medication Errors Reporting Program, see https://www.ismp.org/errorReporting/reporterrortoISMP.aspx (last visited July 4, 2017). For more information on voluntary reporting systems, see Catherine E. Milch et al., *Voluntary Electronic Reporting of*

Dr. Robertson emphasized the features that research has shown contribute to robust reporting and successful prevention of future harm. Disclosure is facilitated by transparent systems with clear guidelines for reporting; a non-accusatory response that offers protection to those who report error; and a culture that models learning from error. Conversely, barriers to effective reporting include fear of blame and legal and administrative sanctions, inadequate feedback, and confusion about the structure or operation of the reporting system itself. Importantly, she explained, learning requires moving from a "blame culture" to what the medical field calls a "just culture," in which the objective is not to blame individuals, but to discover and correct the systemic flaws that induce or fail to prevent errors. While a "just culture," in this sense, requires a non-accusatory environment and hence is not a "blame culture," it is also not a "no blame culture," because developing and implementing systems for holding individuals accountable for future actions can ultimately be part of the system designed to prevent errors.

Critical Incident Review in Transportation

Perhaps the oldest example of an external learning system is the National Transportation Safety Board (NTSB), which was created by Congress in 1967 as an independent agency, first within the U.S. Department of Transportation and later apart from it, for the purpose of improving safety in the transportation system. The NTSB investigates "accidents in the aviation, highway, marine, pipeline, and railroad modes, as well as accidents related to the transportation of hazardous material."[4] The agency comprises five Board Members, nominated by the President and confirmed by the Senate, who report directly to Congress. Along with their staff, the Board is charged with determining the probable cause or causes of transportation accidents; making recommendations to prevent reoccurrence of such accidents; conducting special studies and investigations; and coordinating resources to assist victims and their families after an accident.

Deputy Managing Director Sharon Bryson and Office of Highway Safety Chief Investigator Peter Kotowki described in detail the unique role the Board plays in the wake of major transportation accidents. When major accidents occur, the NTSB sends a full investigative team to the crash site. NTSB staff work alongside state and local authorities, coordinating parallel investigations and federal assistance, interfacing with and supporting families of disaster victims and briefing the media, and serving as a liaison between carriers and families. When an investigation requires special expertise, the Board contracts with outside parties to verify factual reports and consult on technical issues.

Although there are similarities between the work of law enforcement investigators and the NTSB staff, the focus of the NTSB is on safety, not accountability. The investigative team uses a "nine-point investigative matrix" to structure its factual inquiry, focusing on three factors (people, the environment, and the vehicle(s) involved in the crash) at three different moments in time (pre-crash, crash, and post-crash). The Board has independent subpoena power and is therefore able to obtain documents both on the scene and from party members that may be relevant to the safety investigation. Some records obtained by the Board (such as medical records) are not shared with other parties to the investigation.

Medical Errors and Adverse Events: An Analysis of 92,547 Reports from 26 Acute Care Hospitals, 21 J. GEN. INTERNAL MED. 165 (2005).

[4] Nat'l Transportation Safety Bd., History of the National Transportation Safety Board, https://www.ntsb.gov/about/history/Pages/default.aspx (last visited July 4, 2017).

The process by which the NTSB conducts its review and makes its recommendations promotes transparency. Throughout the investigation, the on-site team shares preliminary facts with party representatives and the public. Public briefings provide data without analysis to promote accuracy and public confidence in the investigation. Following an on-scene investigation, staff draft a preliminary report summarizing factual information. Public hearings are held on the preliminary report, at which time additional testimony may be taken. Following the hearing, the full Board meets to make findings of fact and a determination of the probable cause or causes of an accident. In addition, the Board generates safety recommendations derived from the facts and designed to prevent similar future recurrences. The Board's findings and recommendations are disseminated to the public in a final report.[5]

Work Group Discussions

After hearing about the variety of external learning models already in use, participants engaged in small-group discussions to address three topics: first, the principles that should animate any external learning system designed to address critical incidents in policing; second, the structure such a system might take in Wisconsin; and finally, the next steps for making such a system a reality.

Core Principles and Major Challenges of Preventive Review in Policing

Across working groups, participants were largely uniform in identifying the principles that should guide a learning system. Participants agreed that the review process should focus on "fact finding, as opposed to finger pointing." Although "creating a non-punitive response in the context of officer-involved shootings is politically challenging," participants also agreed that any such process needs to be "focused on prevention and public safety," and "root causes" of incidents: not on punishment.

With regard to the form and structure of the external review system, multiple groups emphasized the need for a clear mission statement for any entity charged with conducting the review. There was widespread agreement that any external learning system should be independent of criminal and internal investigations, and that the relationship between the learning system and these pre-existing investigations would need to be clearly established. To be credible, the external review process should be conducted by "quality people" with "independent expertise" in multiple disciplines. One group emphasized the need for "diversity of thought among members" of the team.

With respect to the content and methods of the review itself, participants wanted to address the need for investigation that is "adequately broad and deep," while remaining sensitive to concerns over timeliness and cost. Among the details such a system must confront are how to protect the mental health of those involved in critical incidents, and to safeguard the voluntariness of witnesses' participation in the review process. (Many groups observed that the availability of reports generated by other investigating entities might inform the review process, minimizing the need for additional interviews of key actors involved in any critical incident.)

[5] For examples of final Board reports, see https://www.ntsb.gov/investigations/AccidentReports/Pages/AccidentReports.aspx (last visited July 4, 2017).

Confidentiality of reporting was also a key principle discussed by several groups. Participants also emphasized the importance of transparency at every stage of review. Several groups discussed the importance of including the community throughout the process in both information gathering and data sharing.

Ultimately, the goal of any external learning system is to "advance public safety and wellness" by preventing future harm to officers and community members. How to do this was a matter of much discussion. Participants emphasized the need for the dissemination of findings and recommendations from any review. While it was clear that findings would be shared among stakeholders, including the community, some groups also noted the potential for important safety findings to be shared with a larger, perhaps national audience. To maximize the utility of any recommendations that flow from external review, it would be necessary to develop a "central repository and information delivery system." Participants also recognized a need for the review process itself to allow for "feedback and review," remaining "open to revision" in ways that allow for constant process improvement.

Finally, several groups noted that the process for reviewing fatal incidents might differ significantly from the process for reviewing voluntary reports of "near-misses" in the field. Most discussion focused on post-incident review, although participants acknowledged that a near-miss reporting system might also yield helpful findings, including potential best practices for avoiding injuries and other negative outcomes.

Legal, Legislative, & Administrative Structures

Having set forth the broad principles that should govern an external learning system for reviewing critical incidents in policing, participants turned to the complex question of what laws and legal structures would need to be created or modified in order to make such a system a reality in Wisconsin today. The goal of this conversation was not to solve every identified problem, but rather to flag the areas in need of more careful attention. Discussion broke down into two primary catgeories: the structure such a system should take and the legal authority it would require.

The ideal structure of the learning system was a matter of debate among participants. Some favored creating an entity within or attached to the University of Wisconsin (one proposal was to utilize the expertise of the Population Health Institute, for example), since a university-affiliated center or institute would have well-developed research experience and potential capacity. Others favored creating one or more independent commissions (statewide or regional within the state) that would be given legal authority to subpoena records or reports generated by other agencies, and perhaps to perform independent investigations related to precursor factors not examined in any criminal investigation or internal review.[6] Wherever such a commission is based, participants agreed that it should include members with policing experience and members with diverse relevant backgrounds. All agreed that the commission's work would require funding, and would likely require staff support in order to be capable of providing meaningful review and recommendations.

The legal authority given to the commission would depend in large part on the scope of its mission. Although there were differences of opinion with respect to the timing of a learning

[6] One group suggested that the Milwaukee Homicide Review Commission might provide a close model.

review, most participants seemed to favor a model that would provide for review only after the completion of any criminal investigation by the Wisconsin Department of Justice or other independent law-enforcement agency, and following any criminal prosecution. Under such a model, the commission would need to gain access to reports and records generated by the primary investigating agency in its investigation, and also to relevant records held by local law enforcement agencies. In addition, depending on the state of the investigative record, the commission might require additional subpoena power or the power to compel responses in specific circumstances to gather information "related to training, fatigue, threat, environment, experience, etc." The commission would need to be able to offer confidentiality in a meaningful way to individuals or entities that provide information to the commission related to safety concerns. Finally, once again, the scope of legal authority needed by the commission would enlarge if it were to address self-reported "near misses" in addition to already-public critical incidents.

Next Steps

By the conclusion of the conference, it was evident that participants shared a core belief that critical incidents in policing—much like transportation and medical disasters—hold lessons for improving the safety of officers and the communities they police. An external review system for policing would provide a new approach to the seemingly intractable problem of dangerous police-citizen interactions. If structured thoughtfully, with attention to the practical challenges of implementing such a system, a public safety review commission could provide a model for Wisconsin and other states, and significantly improve the quality and safety of policing.

Given the importance of the task, participants agreed that the next steps forward involve deeper consideration of the principles and challenges raised at the conference, along with refinement of the group's proposal to explore the feasibility of an independent commission comprising experts in policing, along with other relevant stakeholders, for the purpose of reviewing critical incidents and devising recommendations for reducing the risk of future harm. Participants agreed to proceed in two primary ways: first, by creating this report, which summarizes conference proceedings; and second, by developing a small working group of legislators and other stakeholders to draft a more precise proposal for the structure and legal authority of a public safety review commission.[7]

In early July, at the behest of Michael Bell and Senator Van Wanggaard, several conference invitees met with Representative Peter Barca and members of Senator Wanggaard's staff to share information about the conference. At that time, Representative Barca suggested exploring the possibility of creating a Legislative Study Committee staffed by the Legislative Council to work out the details of any legislation needed to establish a commission to review critical incidents in policing. To aid in that process, a final copy of this summary of proceedings will be forwarded to Representative Barca and Representative Chris Taylor, and to Senator Wanggaard for further action.

[7] A third task discussed at the conference was to consider whether this project might qualify for grant funding from the U.S. Department of Justice's Sentinel Event Program. Unfortunately, the formal solicitation from the National Institute of Justice, released June 20, 2017, does not provide funding through the Sentinel Events Initiative for a project of this nature.

Finally, in order to continue the conversation begun at Wingspread and to draw on the expertise of a larger body of Wisconsin residents with experience in the area of police and citizen safety, the Law School has created a listserv that will provide a forum for conference participants and other interested citizens to continue discussing ideas and best practices for critical incident review. All conference participants will be subscribed automatically. Others who might contribute meaningfully to the conversation are welcome to subscribe also, and may do so by sending an email with a blank subject line and body to join-critical_events_review@lists.wisc.edu. Any future updates regarding progress on the concepts discussed in this document will be posted to the listserv.

CMK
July 20, 2017

Conference Participant List:

Mayor John Antaramian	City of Kenosha
Michael Bell	United States Air Force, retired
Garey Bies	Wisconsin State Assembly, retired
Prof. Mark Bowman	Methodist University
Sharon Bryson	National Transportation Safety Board
James Bueermann	Police Foundation
Chief John Carli	City of Vacaville Police Department
John Chisholm	Milwaukee County District Attorney's Office
Linda Connell	National Aeronautics and Space Administration (NASA)
Sheriff Bruce Daniels	Taylor County
Col. Darryl DeSousa	IACP Fellow/Baltimore Police
Chief Christopher Domagalski	Wisconsin Chiefs of Police Association
James Doyle	U.S. Department of Justice
Prof. Keith Findley	University of Wisconsin Law School
Chief Charles Foulke	Middleton Police Department
Gordon Graham	Independent Police Consultant
Ken Horner	Cities and Villages Mutual Insurance
Chief Art Howell	City of Racine Police Department
Lt. Gov. Rebecca Kleefisch	Office of the Lt. Governor
Prof. Cecelia Klingele	University of Wisconsin Law School
Pete Kotowski	National Transportation Safety Board
Shawn Lauda	Milwaukee Police Association
Lt. Timothy Leitzke	Milwaukee Police Department
Kent Lovern	Office of the Milwaukee County District Attorney
Ismael Ozanne	Dane County District Attorney’s Office
Dr. Jamie Robertson	Harvard Medical School
Andrew Schauer	Wisconsin Professional Police Association
Prof. Michael Scott	Arizona State University
Rep. Chris Taylor	Wisconsin State Assembly
Tina Virgil	Wisconsin Department of Justice
Chuck Wexler	Police Executive Research Forum
Asst. Chief Carianne Yerkes	Milwaukee Police Department