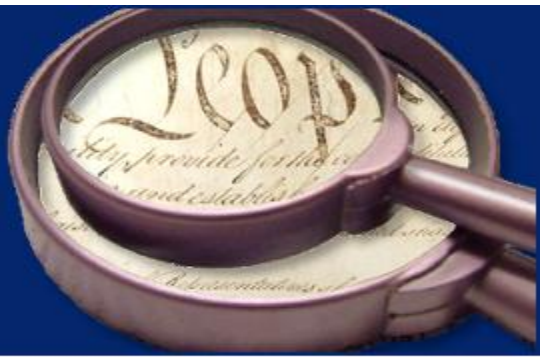
AMERICAN CONSTITUTION SOCIETY FOR LAW AND POLICY

Issue Brief



From Error Toward Quality:
A Federal Role in Support of Criminal Process

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July 2010

American Constitution Society | 1333 H Street, NW, 11th Floor | Washington, DC 20005

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I. Introduction

Contemporary medicine is experiencing a vibrant quality reform movement born in the aftermath of horrific reports of fatal medical errors.[1] This quiet revolution has involved all of medicine's stakeholders – doctors, hospital administrators, insurance carriers, risk managers, and even ICU janitors – in a team-oriented initiative based on the recognition that human errors are inevitable and that only dedication to continuous quality improvement in routine practices can prevent those inevitable errors from ripening into tragedies. Its achievements include a campaign to save 100,000 patients' lives in 18 months that actually surpassed its goal and saved 120,000.[2] The history of that movement's development points the way to a new and productive federal contribution to the local justice systems where most American criminal practice takes place. It is a matter of turning this idea loose in the criminal justice world.

With medicine's experience as a guide, federal support can catalyze the willingness of criminal justice practitioners and stakeholders to learn from their own mistakes – a willingness that they have demonstrated repeatedly in response to DNA exposure of wrongful convictions – and lay the groundwork for a continuous quality improvement initiative in America's criminal justice systems.[3] A modest federal investment can provide infrastructure and technical support for a coherent national effort to improve the reliability of criminal justice.

The effort can begin simply, by marshaling a team of practitioners and experts to design the common template for a non-adversarial process of learning from known errors: from wrongful convictions, mistaken releases, intimidated witnesses, and "near miss" events. It can develop a clearinghouse for collecting and sharing dispassionate analyses of errors – a space where local stakeholders can share nationally the product of their professionalism and generate a permanent ongoing conversation about how to use errors to prevent errors. It can reveal the destructive impacts of decisions – such as epidemic legislative under-funding of indigent defense services – that take place far from the detective, lawyer, or judge at the sharp end of the system.

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[1] CHARLES KENNEY, THE BEST PRACTICE: HOW THE NEW QUALITY MOVEMENT IS TRANSFORMING MEDICINE 30 (2008) [hereinafter, KENNEY, BEST PRACTICE]; TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson, eds., 2000) [hereinafter, TO ERR IS HUMAN].

[2] KENNEY, BEST PRACTICE, *supra* note 1, at 120-25.

[3] *See* James M. Doyle, *Learning From Error In American Criminal Justice*, 100 J. CRIM. L. & CRIMINOLOGY 109 (2010), *available at* http://www.law.northwestern.edu/jclc/backissues/v100/n1/1001_109.Doyle.pdf.

It can set in motion a cultural shift that improves criminal justice, not by imposing top-down federal micro-management, but by exploiting the talents and insights of local systems' frontline practitioners.

In the next section of this Issue Brief, I discuss the resonance between the medical and criminal justice system reform environments. I then describe how the lessons of the medical experience can be mobilized and applied in routine criminal practice. I conclude the Issue Brief by recommending immediate concrete steps that the federal government can take to create and support the productive use of learning from error in state and local criminal justice systems.

II. Learning From Error: The Wrong Patient and the Wrong Defendant

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 28 wrongful convictions exposed by DNA. Efforts by Justice Scalia, among others,[4] to dismiss CONVICTED BY JURIES, EXONERATED BY SCIENCE: CASE STUDIES IN THE USE OF DNA EVIDENCE TO ESTABLISH INNOCENCE AFTER TRIAL[5] (known to practitioners as the "Green Book") as a catalogue of freakish mishaps gained very little traction, in part because every time they were put forward, the Innocence Project exposed yet another horrifying wrongful conviction.

More importantly, though, the criminal justice system's frontline practitioners – the people who actually do the work on the streets and in the courts – showed little interest in the comfort that the system's apologists tried to offer them. The exonerations discussed in the Green Book were the sort of bread-and-butter cases everyone had handled and would handle again, not arcane borderland specimens. The criminal practitioners were all drowning in heavy caseloads, and so they were in a position to remember that even very low *rates* of error would still result in a very high absolute number of tragedies. More importantly, the frontline troops felt that the rarefied utilitarian calculations of error rate that absorbed Justice Scalia were beside the point. The practitioners saw avoiding errors as a matter of professionalism, workmanship, and ultimately self-respect, not as a matter of social policy. The frontline troops 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.

Janet Reno, who, as Attorney General, had insisted on the publication of the Green Book, and decided that its format would include commentary from across the spectrum of criminal justice system players, provided an influential template by convening under the auspices of the National Institute of Justice (NIJ) mixed "Technical Working Groups," which brought every kind of stakeholder to the table to hammer out and then publicize new "best practices" regarding

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[4] Kansas v. March, 548 U.S. 163, 193-98 (Scalia, J., concurring). *See generally* Joshua Marquis, *The Myth of Innocence*, 95 J. CRIM. L. & CRIMINOLOGY 501 (2005).

[5] EDWARD CONNORS ET AL., NAT'L INST. JUST., CONVICTED BY JURIES, EXONERATED BY SCIENCE: CASE STUDIES IN THE USE OF DNA EVIDENCE TO ESTABLISH INNOCENCE AFTER TRIAL (1996). The "Green Book" is certainly only a starting place. A genuinely heroic body of scholarship has marshaled and categorized the exoneration cases. *See* Samuel R. Gross et al., *Exonerations in the United States 1989 Through 2003*, 95 J. CRIM. L. & CRIMINOLOGY 523 (2005); Brandon L. Garrett, *Judging Innocence*, 108 COLUM. L. REV. 55 (2008).

crime scene investigations,[6] death investigations,[7] eyewitness evidence,[8] and an expanding list of topics. Peter Neufeld and Barry Scheck, the co-founders of the Innocence Project, who had been among Reno's Green Book commentators, immediately spoke out for a learning-from-error initiative.[9] In North Carolina, the first impetus came from the conservative Republican chief justice of the North Carolina Supreme Court.[10] In Boston, it came from the elected district attorney;[11] in Illinois, from Northwestern University's Center on Wrongful Convictions and the Governor's Commission on Capital Punishment;[12] and in New Jersey from a Republican attorney general.[13] Every time judges, or police officers, or prosecutors, or Innocence Network lawyers took steps forward, they quickly found allies from all corners of the criminal justice system, often among the adversaries who had been trying to beat their brains out in courtrooms for decades.

Cautious, tentative cooperation on projects aimed at finding ways to develop more and better evidence, and to evaluate that evidence more effectively, began to mark the post-exoneration landscape. To call this development a "movement"[14] captures some of its momentum, but the term obscures the fact that these initiatives arose organically from largely uncoordinated local efforts, spurred by local law enforcement, from within the local bar, or by the local judiciary, often in response to local journalists' coverage of exonerations.

Pulling one strand from the tangle of reforms that have followed the Green Book illuminates the deeper untapped potential for modernization that targeted federal support can activate.

Innocent men who were convicted by the testimony of sincere but mistaken eyewitnesses dominated the Green Book's exoneration list.[15] Reforms to the eyewitness process have moved forward in a diverse range of jurisdictions. In general, these reforms incorporate into local practice new investigative procedures for lineups and photo-arrays advocated by psychological authorities, principally the "double-blind/sequential" procedure. That protocol requires that the lineup or array be administered by an investigator who: (1) does not know which member is the suspect; (2) instructs the eyewitness that the perpetrator may or may not be in the lineup; and (3) displays the lineup members (suspect and fillers) individually ("sequentially") rather than in a

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[6] NAT'L INST. OF JUST., CRIME SCENE INVESTIGATION: A GUIDE FOR LAW ENFORCEMENT (2000).
[7] NAT'L INST. OF JUST., DEATH INVESTIGATIONS: A GUIDE FOR LAW ENFORCEMENT (1999).
[8] NAT'L INST. OF JUST., EYEWITNESS EVIDENCE: A GUIDE FOR LAW ENFORCEMENT (1999).
[9] Barry C. Scheck & Peter J. Neufeld, *Toward the Formation of "Innocence Commissions" in America*, 86 JUDICATURE 98, 99 (2002).
[10] Christine Mumma, *The North Carolina Actual Innocence Commission: Uncommon Perspectives Joined by a Common Cause*, 52 DRAKE L. REV. 647 (2004); Matthew Eiseley, *Better ID Sought In Criminal Inquiries*, NEWS & OBSERVER (Charlotte, NC) Sept. 13, 2003, at B1.
[11] Daniel F. Conley, *Our Duty to Free The Wrongly Convicted*, BOSTON GLOBE, Mar. 19, 2004, at A14. *See generally* Garrett, *supra* note 5.
[12] STATE OF ILL., REPORT OF THE GOVERNOR'S COMMISSION ON CAPITAL PUNISHMENT (2002), *available at* http://www.idoc.state.il.us/ccp/ccp/reports/commissionreport/index.html.
[13] Memorandum from John J. Farmer, N.J. Attorney General on Attorney General Guidelines for Preparing and Conducting Photo and Live Lineup Identification Procedures to All County Prosecutors et al. (Apr. 18, 2001) *available at* http://www.state.nj.us/lps/dcj/agguide/photoid.pdf [hereinafter Attorney General Guidelines].
[14] Garrett, *supra* note 5, at 57-58.
[15] They still do, even now, when the list is up to over 200 wrongful convictions. *Id.* at 78-80.

group ("simultaneously"), as in traditional practice.[16] The advocates of this method argue that it prevents the unconscious steering of witnesses toward suspects and mutes the "looks-most-like" properties of the traditional lineup because it converts a multiple choice *comparison* test into a true/false *recognition* test. Laboratory tests of the procedure 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 in the lineup.[17] Two key characteristics of the eyewitness exoneration cases and the reforms they generated stand out.

To begin with, the eyewitness wrongful convictions were generally "no villains" tragedies. The eyewitnesses were mistaken, but they were sincere, and the police had gone "by the book" as the book then stood. More importantly, though, the remedy the eyewitness cases provoked, because it was aimed at the *prevention* of eyewitness identification errors before they happened (by using modernized lineup techniques) marked a dramatic departure from the dominant strategy of attempting to augment the retrospective *inspection* of eyewitness cases at trial by including eyewitness expert psychological testimony.

These two features of the history of eyewitness procedural reform resonate with the inception of medicine's successful reform movement, but there are also fundamental distinctions.

The "no villains" nature of the collected eyewitness exonerations was a matter of happenstance; in medicine, the understanding that tragedies did not require villains was a hard-won fundamental insight. The endemic assumption in medicine, as in the criminal justice system, had always been "good man, good result."[18] 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?"[19]

Transplant Leape's description of medical culture into criminal justice, and "homicide detective" or "prosecutor" or "defender" or "judge" substitutes effortlessly for "physician." In this familiar conception, any error is an *operator* error: some surgeon, or police officer, or nurse, or forensic scientist, or lawyer, at the site was lazy, or ill-trained, or venal, or careless. Inspection should catch these "bad apples."

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[16] *See, e.g.*, Attorney General Guidelines, *supra* note 13. For a historical discussion of the eyewitness reform battle over its first century, *see generally* JAMES M. DOYLE, TRUE WITNESS: COPS, COURTS, SCIENCE AND THE BATTLE AGAINST MISIDENTIFICATION 169-87.

[17] *See* Doyle, *supra* note 3, at 139-44. Of the elements of the reformers' program, the superiority of the "sequential" technique is the most contested. Roy S. Malpass, *A Policy Evaluation of Simultaneous and Sequential Lineups*, 12 PSYCH. PUB. POL'Y & L. 394 (2006). *But see* Nancy Steblay et al. *Eyewitness Accuracy Rates in Sequential and Simultaneous Lineup Presentations: A Meta-Analytic Comparison*, 25 LAW. & HUM. BEHAV. 459 (2001).

[18] Donald Berwick, *Continuous Improvement as an Ideal in Healthcare*, 320 NEW ENGL. J. MED. 53 (1989).

[19] Lucian Leape, *Error in Medicine*, 272 JAMA 1851, 1852 (1994).

A crucial step for medical reformers was to recognize the dangerousness of depending on end-of-process inspection for "bad apples" as a quality control measure. They realized that any program of measurement was entangled in the minds of the personnel with a system of surveillance and retrospective inspection that had blaming as its sole purpose, and public ignominy as its only possible product. One reason that the measurement of performance in medicine was so inconsistent was that no one saw any advantage to being measured; having your performance measured could only land you in a world of pain. The result was a "cycle of fear" in which medical professionals ignored or suppressed accounts of errors, thereby undermining efforts to prevent such errors in the future. Presumably practitioners directly involved with a harmful error were scarred by the experience and took its lessons with them, but the lessons were not shared. Everyone agreed in the early days of the medical reform campaign that errors were dramatically under-reported.[20] The reformers declared that rather than providing fuel for discipline and disgrace, every error should be treated as a treasure: as a powerful tool for preventing future errors. Their arguments on this point found a willing audience. It turned out that although hospital administrators and risk managers saw error through the lens of protecting large institutions, while physicians saw it through the lens of the individual doctor-patient encounter, *everyone* hated medical errors, and wanted to eliminate them. A cooperative process could be developed.

But a shift in medicine's basic understanding of the nature of error was even more important than medicine's de-emphasis of disciplinary inspection. Medicine came to see errors as the product of capable, dedicated, but fallible people working in systems that did not take account of human fallibility. It is a shift that will pay important dividends if it can be incorporated into criminal justice thinking.

The typical account of a wrongful conviction in an eyewitness case is a laconic narrative along the lines of "the witness made a mistake; we believed her; and the jury believed her too." The early lists of wrongful convictions were quickly distilled to single-cause narratives as a preliminary to ranking "most frequent causes" and targeting those for quasi-legislative action.

But contrast that approach with an article in *Annals of Internal Medicine* reviewing a "wrong patient" operation in which at least two "bad apples" were certainly available: a nurse had mistakenly brought the wrong patient, and an attending physician had failed to introduce himself to the patient at the beginning of the procedure.[21] In analyzing the situation, the authors explicitly invoked the rich literature of "human error" research. In essence, they applied the approach of the interdisciplinary National Transportation Safety Board "Go Teams"[22] that respond to air disasters:

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[20] R. Lawton & D. Parker, *Barriers To Incident Reporting In A Healthcare System*, 11 QUALITY & SAFETY HEALTH CARE 15 (2002); *see also* TO ERR IS HUMAN, *supra* note 1.

[21] Mark R. Chassin & Elise C. Becher, *The Wrong Patient*, 136 ANNALS INTERNAL MED. 826 (2002).

[22] The National Transportation Safety Board dispatches a "Go Team" under the command of an Investigator In Charge to the scene of all accidents. In aviation the team will include specialists in operations, structures, power plants, systems, air traffic control, weather, and human performance. For examples of the reports compiled and issued by these teams, *see* Nat'l Transp. Safety Bd., Major Investigations, http://www.ntsb.gov/ntsb/major.asp (last visited Mar. 27, 2009).

> [T]his event shares many characteristics with other well-known and exhaustively researched calamities, such as the Challenger disaster, the Chernobyl nuclear reactor explosion, and the Bhopal chemical factory catastrophe. These events have been termed "organizational accidents" by psychologist and accident expert James Reason because they happen to complex, modern organizations, not to individuals. No single individual error is sufficiently grave 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.[23]

The authors reviewed the "wrong patient" episode from this perspective and discovered, reported, and analyzed at least 17 distinct errors. The patient's face was draped so that the attending physicians could not see it; a resident left the lab assuming the attending had ordered the invasive procedure without telling him; conflicting charts were overlooked; and contradictory patient stickers were ignored. But the crucial point was that *no single one of the 17 errors they catalogued could have caused the adverse event by itself*.[24]

Like a "wrong patient" surgery, a "wrong man" conviction is an organizational accident, constructed out of a constellation of individual errors and latent conditions. Most wrongful convictions are caused, as Diane Vaughan said of the Challenger tragedy, by "a mistake embedded in the banalities of organizational life."[25] Yes, the eyewitness made a mistake, but many other things had to go wrong before the conviction was finalized. The double-blind/sequential procedure may be a good thing, but a wrong man conviction required much more than the use of sub-optimal identification procedures that failed to employ the double blind/sequential format. Improving isolated *components* of a system is not a guarantee of system reliability.[26] How did this tragedy happen? Was there exculpatory physical evidence on the crime scene that was not collected? Was that a training, supervision, or resource issue? Was it all three? Did the first responders adequately communicate full descriptions of the suspect to the detectives? Were the eyewitnesses' memories protected from contamination at the scenes and in their interviews? Was any of this documented for later use? Were contaminations caused by training gaps, or simple facility shortages? Were the witnesses aware of each other's accounts? Is there a protocol for handling multiple eyewitnesses? How were the discrepancies in descriptions over-looked? Was "tunnel vision" (the premature and exclusive commitment to, and failure to test critically a factual theory) an issue?[27] Was "production pressure" (caseload levels and "clearance rate" evaluations) a contributor?[28] Is there training in place to prevent tunnel vision? Did the prosecutors adequately challenge the police on alternative suspects? What allowed the actual perpetrator to escape? Did the defense investigation serve its purpose?

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[23] Chassin & Becher, *supra* note 21.
[24] *Id.*
[25] DIANE VAUGHAN, THE CHALLENGER LAUNCH DECISION: RISKY TECHNOLOGY, CULTURE AND DEVIANCE AT NASA 9 (1996).
[26] ATUL GAWANDE, THE CHECKLIST MANIFESTO: HOW TO GET THINGS RIGHT 184 (2009).
[27] Keith A. Findley & Michael S. Scott, *The Multiple Dimensions of Tunnel Vision in Criminal Cases*, 2006 WIS. L. REV. 291 (2006).
[28] *See generally* VAUGHN, *supra* note 25.

Why not? Was it a performance issue? A training issue? A funding issue? A discovery issue? Did the defense lawyer miss (or sit on) an alibi? Did the trial process provide a clear picture of events? Were the jurors adequately instructed on the nature of memory evidence? Did small failures interact in unexpected and disastrous ways?[29]

The most likely answer to the question "Who was responsible for this wrongful conviction?" is almost always "Everyone involved, to one degree or another." It is not unreasonable for a frontline detective to bridle when asked to "take the fall" for a wrongful conviction; frontline practitioners are painfully vulnerable to officious second-guessing. As Charles Perrow points out:

> [V]irtually every system we will examine places "operator error" high on its list of causal factors – generally about 60 to 80 percent of accidents are attributed to this factor. But if, as we shall see time and again, the operator is confronted by unexpected and usually mysterious interactions between failures, saying that he should have zigged instead of zagged is possible only after the fact. Before the accident no one could know what was going on and what should have been done.[30]

The way out of that trap is not a wistful shrug; it is an assessment of the role played by conditions latent in the system and the mechanisms by which they take effect.[31]

The recognition that wrongful convictions – among other criminal justice errors – are complex organizational accidents focuses attention on the barriers that hampered the frontline troops who are usually singled out for "bad apple" treatment. After all, as medical researchers have noted, recognizing the distinction between active and latent failures faces the fact that it is not only those people at the sharp end of the system – pilots, operators, doctors, police officers, lawyers, and jurors – who make errors, but that mistakes made by people far from the scene – such as managers, designers, accountants, policy-makers, legislators, and appellate courts – have a significant role in accident causation.[32]

The "organizational accident" conception of wrongful convictions (and wrongful releases, and "near misses," and "cold cases" that stayed cold too long) unlocks access to abiding problems that linger beneath the surface of the idiosyncratic facts of individual cases, and reveals how small errors interact. No individual indigent defender can be the sole "cause" of any wrongful conviction; after all, the defender did not make the arrest or bring the charge. But an inadequately funded indigent defense *system*, employing untrained and overwhelmed young lawyers, is a latent condition implicated in *every* wrongful conviction. How much time and money might have been saved if adequately trained and funded defenders had entered the case earlier, and found (and shared) the cell phone records proving an alibi?

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[29] CHARLES PERROW, NORMAL ACCIDENTS (1984).
[30] *Id* at 9.
[31] On the increasing "systemization" of criminal processes, *see* Brandon L. Garrett, *Aggregation in Criminal Law*, 95 CAL. L. REV. 383 (2007).
[32] *See generally* Douglas McCarthy & David Blumenthal, *Stories from the Sharp End: Case Studies in Safety Improvement*, 84 MILBANK Q. 165 (2006).

III. A Federal Role: Toward the Criminal Justice Virtual Teaching Hospital

The pattern in criminal justice has been to wait for the catastrophic miscarriage of justice. Everyone then looks for an individual or an agency to blame. The targeted agency tries frantically to "keep this in house," or to shift the entire blame to someone else's "house." Only when things go especially well, or the catastrophe is especially public, do we convene a heroic, blue-ribbon law reform group. But this is a pattern that the medical reformers argue dooms the criminal system to staying always one catastrophe behind. Since no individual agency is completely responsible for the error, fixing one agency cannot fix the problem; these are *system* errors. The "organizational accident" approach enhances local criminal justice system practice, not just by helping the hunt for the systems' bad guys (corrupt cops, over-zealous prosecutors, bungling labs, incompetent defenders), but by giving the systems' *good* guys something important to do *before* the next catastrophe takes place. The organizational accident approach is not only a more accurate way to describe what happened in a wrongful conviction; it opens a more productive avenue to remedial action. As Lucien Leape wrote in the medical context:

> Efficient, routine identification of errors needs to be part of hospital practice, as does routine investigation of all errors that cause injuries. *The emphasis is on "routine."* Only when errors are accepted as an inevitable, although manageable part of everyday practice will it be possible for hospital personnel to shift from a punitive to a creative frame of mind that seeks out and identifies the underlying system failures.[33]

Contemporary medicine treats errors as "sentinel events": important opportunities to illuminate hidden flaws. The practice of criminal justice also produces sentinel events on a daily basis, but the legal system's habitual dichotomy of "harmless" and "harmful" errors (the traditional points of contention in, for example, habeas litigation) has obscured the potential of "helpful errors."

In fact the existing system of federal certiorari and habeas review *submerges* those errors that did not independently distort verdicts. Here again, the scandal in indigent defense services provides an example. An ineffective assistance of counsel claim raised in federal habeas – no matter how egregious the lawyer's performance – is only analyzed when it affects the verdict or the sentence. That review does not provide a venue for assessing the likely contribution of endemic indigent defense function weaknesses in the next case, or the next *hundred* cases. But the comatose defense lawyer at the counsel table was there for a reason. Who put him there, trained him, monitored him, and compensated him? He (or someone like him) will be there again. Why was it that no one else wanted the job?

To mobilize the lessons of error we need a workable facility for collecting and disseminating detailed, factual, organizational accident accounts of helpful errors. Aviation has found a regular vehicle for dissecting and communicating the facts of its disasters – and of its near-misses – in NTSB investigations, websites, and *Flying* magazine. Medicine has done the same through *Lancet* and *Annals of Internal Medicine*. Criminal justice, through NIJ, academic

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[33] Leape, *supra* note 19, at 1853 (emphasis added).

law reviews, and professional journals, could easily construct an analogous clearinghouse for the voluntary reporting of errors and the sharing of lessons distilled from those errors.

Obviously, there is work to be done in designing this facility, and it will not be a simple task. But the federal government can play a crucial role in designing it, and in supporting it in operation.

NIJ's post-Green Book Technical Working Groups provide a skeleton that suggests that a national model for error review can be developed. NIJ, perhaps in partnership with private foundations, could convene a new Technical Working Group to design the core process model to be made available to the states and localities. In that model, "everyone-to-the-table" local teams of police, prosecutors, defenders, and judges, supplemented where appropriate by probation or corrections personnel, victims' advocates, and academic subject matter experts, would be formed, and each member empowered to nominate an error or "near miss" for team analysis and report.

A wrongful conviction is one obvious example of the sort of error that might be nominated, but there are many others: a "wrongful acquittal" because of lost evidence, a "cold case" that stayed cold for too long, an intimidated or injured victim or witness, and a prisoner held past his release date are all important sentinel events. The price of participation in the process would be an agreement to see the process to the end: to follow the facts of the individual incident wherever they led, while retaining autonomy concerning any general recommendations or reforms that might be suggested. This requires a change from traditional "every-agency-for-itself" approaches within the criminal justice to one of working groups functioning as virtual teaching hospitals: bridging the gaps within criminal practice, and between criminal practice and scientific and other outside communities of subject matter experts. Despite traditional frictions among police, prosecutors, and defenders, in every jurisdiction, cohorts of criminal justice practitioners grow up together, handling the same cases, with the same defendants, in front of the same courts. As the practitioners move from rookie, to veteran, to leadership status in their roles, they *all* hate error. If these gatekeepers agree that an error is worth examining, and that a sober professional review is an alternative to the media's "gotcha" pillory, then an application for federal support in conducting that examination according to the consistent national process template and distributing a report in a consistent national format are appropriate next steps.[34]

A common national approach to error review enacted locally, and informed and challenged by diverse local experiences, can mitigate the radical fragmentation of American criminal justice. It offers rewards both within scattered local systems and *across* those systems. Reading the analysis of a distant jurisdiction's experience of a completed criminal justice disaster can alert isolated practitioners to the operation of dangerous latent features that are present in their own local systems. Reading reports of remote "near misses" can reveal both those dangerous latent features and potential fail-safe devices that are *not* present locally. Regular analysis and reporting of error can counteract the tendency of today's "best practices," (although they are intended to provide minimum floors for performance) to calcify into ceilings that block innovation.

[34] The familiar Byrne Grant system might be one source of support.

There is evidence that with leadership from law enforcement, prosecutors, the judiciary, or the bar, these teams can be sustained.[35] The experience of the medical quality movement indicates that treating the teams as standing resources (although their individual members may shift from event to event, and be supplemented by different technical and scientific experts as the context demands) that are available to be routinely catalyzed by each new local error, can support a system-wide commitment to an ideal of continuous improvement serving a "culture of safety." As two leading medical commentators noted: "A paradoxical insight is that the adoption of specific improvements both furthers – and is furthered by – organization-wide cultural change."[36]

This effort will not require the level of participation by Olympian dignitaries that Actual Innocence Commissions oriented toward post-catastrophe law reform have employed; it can be carried out at the level of captain and colonel as well as at the level of major general. In medicine, the breakthrough in solving the mystery of an outbreak of central line infections in a Pittsburgh intensive care unit was produced by the janitor member of the quality improvement team.[37] This feature of the process confers important additional benefits. First, by beginning to disentangle fact-finding and law reform, it minimizes the temptation to "game" the fact-finding to avoid anticipated law "reforms" that one participant or another might find unwelcome. More importantly, it creates an increased system-consciousness among the practitioners who staff the criminal justice system's components. The police lieutenants who participate in an error review today will make better police captains next year because of their participation in the practice of rigorous examination of a mistake: an examination that will expose the perspectives, the strengths, and the weaknesses of the elements of the system with which the police interact. And, while the participants themselves gain from their experiences, the systems they operate will gain from their insights. If the reports of errors are disseminated through a national clearinghouse, justice systems – and communities – remote from the site of the original error can learn something from the painful lessons of experience and gain too. A link can be forged between the statistical aggregations of social scientists and the operational realities of individual cases.

Efforts to apply federal resources to improve local practice in America's criminal justice system often evoke Lincoln's complaint that sending troops to the Army of the Potomac was like "shoveling flies across a barnyard." The problems are huge, the costs dizzying, the sites scattered, and coordination and measurable effect are difficult or even impossible to obtain.

But the federal government is not without crucial weapons when it comes to bending approaches in a more productive direction. Among these tools is the Byrne Justice Assistance Grant mechanism for funding state and local criminal justice improvements. The pattern to this point has been to provide "stove-piped" block grants to individual agencies. This creates results that are, at best, incoherent, and at worst, grotesquely unbalanced. The indigent defense function, despite its acknowledged status as a festering crisis, has received significantly less

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[35] Susan Gaertner & John Harrington, *Successful Eyewitness Identification Reform: Ramsey County's Blind Sequential Lineup Protocol*, POLICE CHIEF, Apr., 2009, at 26 (describing the prosecutor's and police chief's report on experience).
[36] McCarthy & Blumenthal, *supra* note 32, at 196.
[37] KENNEY, *supra* note 1, at 121-25.

federal grant money than law enforcement agencies or prosecutors' offices.[38] Why not require local criminal justice systems to apply *as systems* for grants targeted to enable them to mobilize "all-stakeholders" teams to assess sentinel events and uncover their lessons?

DOJ also possesses its own laboratory: the criminal justice system of the District of Columbia, where DOJ, through the United States Attorney, prosecutes the complete range of street crimes, and faces typical state criminal justice challenges.

DOJ can lead here by piloting the all-stakeholders preparation of an "organizational accident" model report of, for example, the wrongful murder conviction of Donald Gates, who was exonerated in December 2009 after serving nearly three decades for the murder of a young woman in Rock Creek Park.[39]

Journalistic accounts of the Gates travesty focus on the false lab reports of FBI hair analyst Michael Malone, a "bad apple" if ever there was one.[40] But the conviction took more than Malone. What in the structure of the FBI lab suggested to Malone that this pattern of conduct was a good (or, at least, safe) one to pursue? False testimony was elicited from a paid informant. Who decided to pay the informant? According to what procedures? What incentives motivated *that* decision? Why wasn't Malone's perjury caught? What structures governed review of his findings by prosecutors and discovery of his findings by defense counsel? What cultural or professional factors within the prosecutor's office influenced those findings? Could the defense have uncovered Malone's fraud on its own even after the prosecutor failed? What role did the race of the victim and the race of Gates play in the decision-making process?

Answering these questions will identify "latent conditions" that continue to lurk in the criminal justice system of the District, waiting to interact with the next individual mistake that will inevitably come along. Those answers cannot be provided by DOJ's Inspector General acting alone; contributions from all of the system's stakeholders are required if these latent causes are to be comprehensively discussed. The value of this effort is the light that it will shine on previously obscured issues.

Consider, for example, the plight of indigent defense. Of course, Gates's defense lawyer did not create Gates's wrongful conviction, although we pretend that the system is designed so that he could have prevented it. A dispassionate inquiry into the Gates fiasco would test that assumption. It would address the degree of training and resources in forensic science available to appointed defenders. How do they get experts? Who funds them? And at what level?

An "organizational accident" report on the Gates experience would also provide a vehicle for assessing the interaction of "latent conditions" generally thought of as independent of each other. It could consider, for example, the impact of prevailing prosecution discovery practices on the performance of the indigent defense role. Do straitened interpretations of the *Brady* rule requiring disclosure of exculpatory evidence within a prosecutor's office both create and

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[38] NAT'L RIGHT TO COUNSEL COMM., THE CONSTITUTION PROJECT, JUSTICE DENIED: AMERICA'S CONTINUING NEGLECT OF OUR CONSTITUTIONAL RIGHT TO COUNSEL 200-02 (2009).
[39] Keith L. Alexander, *DNA Sets Free DC Man Imprisoned in 1981 Student Slaying*, WASH. POST, Dec. 16, 2009, at B1.
[40] *Id.*

multiply the effects of tunnel vision?[41] Did rigorous adherence to Jencks Act restrictions on the discovery of pretrial witness statements encourage the use of an unreliable informant? What is the impact of scant discovery compliance on a weak defender, or poorly-funded defender, who did not uncover the material on his own? What was the impact of that scant compliance on the *cost* of a *good* defender who would have to engage in extensive investigation and motion practice to inspect Malone's results? DOJ could convene this inquiry tomorrow, and its report could fuel important steps toward a safer, more reliable criminal process for years to come.

IV. Conclusion

The phrase "criminal justice system" is everywhere, but in practice the world of criminal justice operates only as a vague eco-system: a swamp or a pond, where something (funding, for example) dumped in on one side has mysterious and unanticipated effects on the far shore. An effort to adopt modern medicine's experience to contemporary criminal practice will enter this problematic environment from a different angle. It is at once both more modest and more ambitious: modest in the investment and the degree of federal interference required; ambitious in that it seeks to change a culture to one that routinely, every day, concentrates on improving the reliability of the criminal process for the victims, the accused, and the public.

It is worth a try.

[41] The Gates trial prosecutor, reflecting on the exoneration and his own role in the conviction noted that "There's a certain amount of institutional pressure. The more you win difficult cases, the more you move up the totem pole." Keith L. Alexander, *Prosecutor Reflects on Wrongful Conviction in DC Killing*, WASH. POST, Mar. 6, 2010, at B1.