Preventing Citizen Harms and Improving Accountability Through Event Reviews

Testimony for the Joint Hearings of the Pennsylvania Senate Law and Justice Committee and Judiciary Committee on Ensuring Accountability and Equality in Law Enforcement and the Criminal Justice System

by

Paul Heaton, Academic Director, Quattrone Center for the Fair Administration of Justice, University of Pennsylvania Carey Law School

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Thank you for the opportunity to provide testimony today. My name is Paul Heaton, and I codirect the Quattrone Center for the Fair Administration of Justice at the University of Pennsylvania. The Quattrone Center works with a diverse set of stakeholders, including community organizations and law enforcement, to prevent errors in the criminal justice system.

My comments will build upon testimony you heard yesterday from Kevin Steele, and to do that, I want to start with some data. Figure 1 shows the number of civilians who have died during interactions with police in Pennsylvania in recent years. What sticks out here is that we really haven't improved much in preventing civilian deaths here in Pennsylvania. Despite the additional training, changes to use of force policies, and other measures, we're basically where we were 15 years ago. What these data show, and what you have heard repeatedly yesterday and today, is that we need new approaches to address this problem. Today, I'll describe one such new approach—the *event review*—and discuss how the Senate could make this tool more widely available.

The event review is preventative tool successfully used in aviation, rail transport, medicine, and other complex industries. Like policing today, some decades ago these industries faced calls for reform amid unacceptably high rates of fatal incidents. In the ensuing years, railroad and surgical death rates fell by more than half, and the airline fatality rate fell by over 80%. Contrast the figure I just showed you with this figure (Figure 2), which shows railroad collisions over time in the U.S. During the same period when we've made very limited progress in preventing police-involved civilian deaths here in Pennsylvania, we've reduced railroad collisions by over 50%.

How have we achieved these gains? One important tool has been the event review. Event reviews go by various names, but whether called <u>root cause analyses</u> or <u>sentinel event reviews</u>, their philosophy is the same: when a system generates undesirable events, all stakeholders should come together to investigate those events in a nonpunitive manner, understand *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 <u>National Transportation Safety Board</u> or hospital morbidity and mortality reviews, have fostered significant innovations such as child

safety seats and surgical checklists that have saved thousands of lives. It's time to bring this successful tool from other industries into criminal justice.

Event reviews do not substitute for existing accountability mechanisms such as disciplinary hearings or civil litigation. However, those proceedings ask whether the officer's actions were legally justifiable or permissible under law enforcement policy. That retrospective approach does not reach the question of whether the incident could have been avoided, and how to prevent future incidents. It seems very unlikely that Garrett Rolfe woke up Friday morning and said, today what I'd like to do is shoot and kill someone I am sworn to serve and protect, lose my job, and face possible criminal prosecution. Yet for some reason he nonetheless ended up killing Rayshard Brooks in Atlanta. Firing or criminally prosecuting officers like Garrett Rolfe won't tell us how to prevent the next incident. An event review can.

What would an event review of a police-involved civilian death look like? 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. The team would conduct interviews and review documentary evidence to identify contributing factors and root causes of the event and develop policy recommendations aimed to prevent future, similar incidents. Much as a quarterback might look at game film after throwing an interception to figure out what went wrong and how to re-design the failed play, the event review would seek to understand precisely what was driving the moment-by-moment decisions of participants so as to improve future performance. For example, an event review of a shooting of a mentally ill individual might result in recommendations to develop specific police protocols for dealing with people believed to be mentally ill, or to create response systems that involve mental health professionals in place of police.

The Senate should consider several specific types of legislation related to event reviews. First, we could require law enforcement agencies to conduct an event review after a serious use of force, death in custody, or wrongful conviction and publish the results. My Center has already successfully conducted such reviews in partnership with the Montgomery County District Attorney's office and the multi-agency Philadelphia Event Review Team, so we know they can work. Requiring event reviews would help to institutionalize a process of continual learning and improvement, and create public accountability for implementing specific measures to prevent future harms.

Second, for event reviews to be successful, people need to be able to speak candidly. Participants are sometimes reluctant to contribute to an event review out of fear that their statements may be used against them in future litigation. Healthcare and transportation have addressed this problem with "safe harbor" legislation that protects information generated through the event review process from other legal inquiries. The committees should consider a "safe harbor" law that would shield statements made by law enforcement and other personnel during criminal justice event reviews from litigation, so long as conclusions from the event review are published. Pennsylvania has already recognized the value of these concepts in existing laws like the Pennsylvania Peer Review Protection Act (63 P.S. 425.1) and Parolee Homicide Review Team (61 P.S. 6161).

Third, the committees should consider creating a statewide center for criminal justice event reviews that would provide technical assistance and aggregate data across reviews to identify trends and provide broader recommendations for change. The Betsy Lehman Center for Patient Safety in Massachusetts provides an example of such a center in the health care space; I believe it is time for Pennsylvania to have a similar entity focused on the criminal justice system.

Many of you remember the terrible 2015 Amtrak derailment outside of Philadelphia that killed 8 people and injured 200. Government experts held an event review following that incident, and ultimately Amtrak installed a technology called positive train control and made several other reforms in response to the review. If a similar situation arose today, there would be no derailment, and lives would be saved.

Antwon Rose was an unarmed Black teenager who was shot and killed by an officer during a traffic stop near Pittsburgh in 2018. If a similar traffic stop occurred again today, can we be sure that it would not result in another needless killing? Our communities and law enforcement professionals are calling on you to help prevent these tragedies. Event reviews can do that. Thank you.

Figure 1:



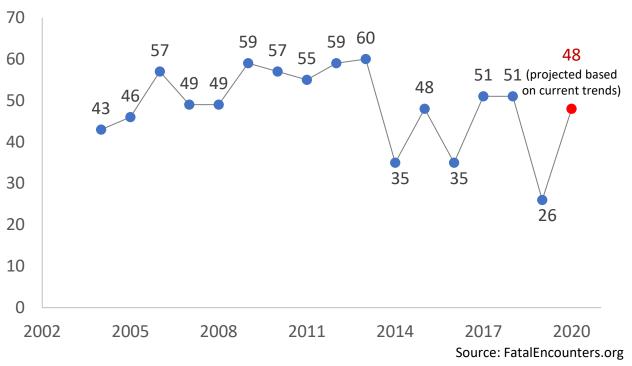


Figure 2



