



New York State Justice Task Force

Recommendations Regarding Root Cause Analysis

INTRODUCTION

The New York State Justice Task Force was convened on May 1, 2009 by Chief Judge of the State of New York and Chief Judge of the Court of Appeals Jonathan Lippman. Its mission is to eradicate the systemic and individual harms caused by wrongful convictions and to promote public safety by examining the causes of wrongful convictions and recommending reforms to safeguard against any such convictions in the future. Because it is a permanent task force, it is charged not only with the task of implementing reforms but monitoring their effectiveness as well. The Justice Task Force is chaired by Janet DiFiore, Westchester County District Attorney, and The Honorable Carmen Beauchamp Ciparick, former Senior Associate Judge, New York Court of Appeals. Task Force members include prosecutors, defense attorneys, judges, police chiefs, legal scholars, legislative representatives, executive branch officials, forensic experts, and victims' advocates. The differing institutional perspectives of Task Force members allow for thorough consideration of the complex challenges presented by the occurrence of wrongful convictions and the evaluation of recommendations to prevent them in the future, while also remaining mindful of the need to maintain public safety.

Since its inception, the Task Force has focused its efforts on identifying and eliminating the principal causes of wrongful convictions. Its recommendations have included expansion of the New York State DNA databank, expansion of post-conviction access to DNA testing and databank information, the electronic recording of custodial interrogations, the implementation of best practices for the administration of identification procedures, greater access to forensic case file materials, and criminal discovery reform. Individual Task Force members have also been proactive in their respective roles in the criminal justice system in implementing new measures to guard against wrongful convictions. Today the Task Force seeks to answer the logical next question: How can the critical stakeholders in New York State's criminal justice system use the occurrence of a wrongful conviction or near miss (that is, a situation where a wrongful conviction is narrowly avoided) to help prevent such occurrences in the future? To answer this question, the Task Force has turned to the experience and knowledge gathered in other disciplines that use root cause analysis to prevent the recurrence of unwanted outcomes. The Task Force views root cause analysis as an important means of preventing wrongful convictions and promoting public safety.

ROOT CAUSE ANALYSIS AS A WAY TO PREVENT WRONGFUL CONVICTIONS

An "adverse event" (sometimes referred to as a "sentinel event" in the literature relating to root cause analysis) is an unfavorable or undesirable occurrence that might signal underlying weaknesses in a system. In the criminal justice context, examples of adverse events include the conviction of an innocent person, the failure to punish the actual perpetrator of a crime, or the

failure to dismiss a case where dismissal clearly is warranted. Adverse events have dire consequences and may result in a widespread loss of faith in the system.

In many industries, such as engineering, aviation and medicine, adverse events, as well as “near misses” (i.e., situations where an adverse event is narrowly avoided), are examined using a process called “root cause analysis.” Root cause analysis is a process that identifies, in an objective, blame-free environment, why an adverse event or near miss occurred. Conducted in a methodical and repeatable way, root cause analysis seeks to reach conclusions based on an objective, non-judgmental process rather than the subjective opinions of the person or persons conducting the analysis. Root cause analysis begins by identifying the scope of an issue (including whether it warrants further review) and, if so, seeks to uncover the core causative factors and recommend potential improvements intended to prevent recurrence. Root cause analysis focuses on “how” and “why” something happened, rather than seeking to assign blame. In the criminal justice context, various stakeholders in jurisdictions throughout the country—including Montgomery County, Pennsylvania, as well as Milwaukee, Baltimore, and Philadelphia—recently have used root cause analysis as a means of identifying and attempting to solve systemic issues and improve their processes.

The Task Force formed a Root Cause Analysis Subcommittee in December 2014 to consider recommendations regarding the potential use of root cause analysis in the criminal justice context in New York State. The Task Force Subcommittee met once on its own and then convened jointly with the Task Force for four meetings over a four month period. Meeting attendees discussed the nature of root cause analysis, its potential role in preventing wrongful convictions, and examples of relevant legislation designed to preserve the integrity of the process. The group also heard from several speakers, including experts in root cause analysis as well as district attorneys and judges with experience applying the principles of root cause analysis in the criminal justice context.

ISSUES CONSIDERED AND DISCUSSED BY THE TASK FORCE AND SUBCOMMITTEE

At the first joint meeting of the Task Force and the Root Cause Analysis Subcommittee, the group heard from John Hollway, the Executive Director of the Quattrone Center for the Fair Administration of Justice (the “Quattrone Center”), which is affiliated with the University of Pennsylvania Law School.¹ Mr. Hollway provided an overview of how the Quattrone Center has used root cause analysis in the criminal justice context in Montgomery County, Pennsylvania; Philadelphia, and elsewhere. The Honorable Benjamin Lerner, a judge serving in the Philadelphia County Court of Common Pleas, accompanied Mr. Hollway and spoke about his own experience participating in a root cause analysis overseen by the Quattrone Center.

District Attorney Kenneth Thompson (Kings County, New York), accompanied by Assistant District Attorney Mark Hale, who co-leads the Kings County Conviction Review Unit, gave a presentation to the Task Force on the structure, scope, and results of that unit. Other New York District Attorneys, including Task Force members Cyrus Vance (New York County) and Janet DiFiore (Westchester County, New York), also discussed the use of conviction review units in their respective offices.

¹ The Quattrone Center “is a national research and policy hub created to catalyze long term structural improvements to the US criminal justice system.” Quattrone Center for the Fair Administration of Justice, <https://www.law.upenn.edu/institutes/quattronecenter/> (last visited Apr. 20, 2015).

Counsel to the Task Force also examined various legal questions that Task Force members raised concerning the protection of information obtained during root cause analysis from public disclosure or use in litigation. These questions were of particular importance to several Task Force members as a means of protecting the integrity of the process. Counsel's analysis considered measures that might mitigate these concerns, focusing on existing legislation that protects the root cause analysis process in areas such as transportation, medicine, and domestic violence reviews. Counsel reviewed the existing legislation, and analyzed issues relating to the federal Freedom of Information Act, New York's Freedom of Information Law, and civil discovery.

FRAMEWORK FOR RECOMMENDATIONS

The Task Force recognizes that implementation of root cause analysis will take many different forms given the different stakeholders involved in New York State's criminal justice system. Use of root cause analysis is encouraged both at the individual stakeholder level and as part of a broader, multi-stakeholder effort that aims to collectively identify opportunities for systemic improvement. For a smaller office or one without significant resources, root cause analysis may focus primarily on identifying and reviewing an adverse event or near miss. In other contexts, a multi-stakeholder analysis may be feasible, while in others, it may be a hybrid of these two approaches. The Task Force believes that, with the proper support, almost every entity in New York State's criminal justice system can strive to improve its systems and processes with respect to assessing the "why" or—more often—the "whys" of an adverse event or near miss.

By embracing the root cause analysis framework, prosecutors, defense providers, law enforcement officials, laboratories, and courts can begin to identify and learn from adverse events using an objective, non-judgmental, process-driven approach, identifying systemic problems and developing solutions that will prevent recurrence. The steps in a root cause analysis may include, but are not limited to, the following:

- Establishing a group (if one does not already exist) committed to conducting the analysis;
- Identifying a group leader;
- Defining the adverse event that the group seeks to prevent in the future;
- Addressing confidentiality concerns early in the process;
- Gathering and reviewing documents and physical evidence and conducting interviews;
- Creating a timeline of the events that led to the final one;
- Asking "why" repeatedly in order to identify the factors that resulted in an event along the timeline;
- Analyzing the information obtained, presenting it to the group and perhaps others in the organization with relevant expertise, and drawing conclusions;
- Making and implementing recommendations; and
- Determining the effectiveness of the implemented recommendations.

Root cause analysis and review units should be a source of integrity for the criminal justice system, helping to create a culture of shared responsibility where the identification of adverse events and near misses is encouraged and used as an opportunity for improvement.

After careful consideration, the Task Force recommends the use of root cause analysis as a means of improving the State's criminal justice system. The Task Force carefully considered the benefits and practical implications of these proposals. The Task Force members' diverse

backgrounds and relevant experiences provided valuable perspectives that have factored into these recommendations.

RECOMMENDATIONS

A. Internal Root Cause Analysis

The Task Force recommends that all stakeholders (including police departments, District Attorneys' offices, laboratories, defense providers, and the courts) develop internal processes for objectively and systematically identifying and examining adverse events and near misses for the purpose of improving internal systems and processes. Larger agencies may establish conviction review units to analyze adverse events and near misses, or they may otherwise implement procedures to conduct such analyses. Where stakeholders lack the personnel or resources to conduct internal analyses on their own, the Task Force recommends that they seek outside support from entities that have expressed a willingness to provide assistance, such as the District Attorneys' Association of the State of New York and the Office of the Attorney General, or from other groups or individuals, including those willing to provide pro bono assistance. The Task Force commends these and other organizations and individuals that commit to providing such assistance.

B. Multi-Stakeholder Root Cause Analysis

The Task Force recommends that, where feasible, and with statutory protections in place (*see* Section D), multi- or all-stakeholder root cause analysis of adverse events and near misses be undertaken. Such reviews would require the involvement of all relevant parties in the identification and examination of adverse events or near misses, with assistance from non-involved experts or facilitators. The goal would be to identify ways to prevent recurrence of adverse events—as well as (in the case of near misses) to identify the factors that prevented adverse events—in an objective and blame-free environment. Where appropriate, the courts should take it upon themselves to recommend that a multi-stakeholder root cause analysis be undertaken. Ultimately, such reviews will foster a culture of shared responsibility and prevent future wrongful convictions.

C. Training and Culture

The Task Force recommends that all stakeholders be encouraged to use root cause analysis as a training tool for both new and experienced criminal justice professionals. Individuals charged with conducting root cause analysis should be sufficiently trained and be provided with sufficient resources to effectively engage in such analysis. Stakeholders should encourage individuals who may participate in root cause analysis to attend training seminars in root cause analysis where feasible. Participation in such seminars will enable participants to learn from different offices' and entities' experiences.

Additionally, the Task Force recommends that both the reporting of near misses and adverse events and participation in root cause analysis within organizations be strongly encouraged. Ultimately, the Task Force hopes that participation in root cause analysis both within and among stakeholders will receive the same level of encouragement in the profession as pro bono service.

D. Statutory Protections

In an effort to promote and enhance the use of root cause analysis in the criminal justice context, the Task Force recommends that New York State legislators propose legislation similar to that which already exists in other fields to protect the integrity of the process. In particular, the Task Force recommends that the State Legislature take steps to ensure that the work product of root cause analysis is protected from requests made pursuant to the Freedom of Information Act or New York's Freedom of Information Law, as well as from discovery and admissibility in civil litigation. The Task Force recommends that the State Legislature take steps to protect participants in a root cause analysis from being required to testify about the process and/or about the resulting determinations, and to assure that the confidentiality of a root cause analysis process and determinations is preserved. The Task Force further recommends that these same protections be enacted with respect to federal cases, whether through Local Civil Rule or by Congress. The Task Force deems the above protections necessary in order to avoid a chilling effect on participation in the process.

The Task Force has appended to this Report relevant excerpts of existing legislation that may provide models for legislative proposals. (*See Appendix: Three Examples of New York Statutes that Protect Participants in Root Cause Analysis from Disclosure and/or Liability.*)

APPENDIX

Three Examples of New York Statutes that Protect Participants in Root Cause Analysis from Disclosure and/or Liability

Medicine

N.Y. Educ. Law § 6527(3) (Consol. 2014)

No individual who serves as a member of

- (a) a committee established to administer a utilization review plan of a hospital, including a hospital as defined in article twenty-eight of the public health law or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, or
- (b) a committee having the responsibility of the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law or the evaluation and improvement of the quality of care rendered in a hospital as defined in article twenty-eight of the public health law or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, or
- (c) any medical review committee or subcommittee thereof of a local, county or state medical, dental, podiatry or optometrical society, any such society itself, a professional standards review organization or an individual when such committee, subcommittee, society, organization or individual is performing any medical or quality assurance review function including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, either described in clauses (a) and (b) of this subdivision, required by law, or involving any controversy or dispute between (i) a physician, dentist, podiatrist or optometrist or hospital administrator and a patient concerning the diagnosis, treatment or care of such patient or the fees or charges therefor or (ii) a physician, dentist, podiatrist or optometrist or hospital administrator and a provider of medical, dental, podiatric or optometrical services concerning any medical or health charges or fees of such physician, dentist, podiatrist or optometrist, or
- (d) a committee appointed pursuant to section twenty-eight hundred five-j of the public health law to participate in the medical and dental malpractice prevention program, or
- (e) any individual who participated in the preparation of incident reports required by the department of health pursuant to section twenty-eight hundred five-1 of the public health law, or
- (f) a committee established to administer a utilization review plan, or a committee having the responsibility of evaluation and improvement of the quality of care rendered, in a health maintenance organization organized under article forty-four of the public health law or article forty-three of the insurance law, including a committee of an individual practice association or medical group acting pursuant to a contract with such a health maintenance organization

shall be liable in damages to any person for any action taken or recommendations made, by him within the scope of his function in such capacity provided that (a) such individual has taken action or made recommendations within the scope of his function and without malice, and (b) in

the reasonable belief after reasonable investigation that the act or recommendation was warranted, based upon the facts disclosed.

Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health pursuant to section twenty-eight hundred five-1 of the public health law described herein, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting when a medical or a quality assurance review or a medical and dental malpractice prevention program or an incident reporting function described herein was performed, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.

N.Y. Pub. Health Law § 2805-m (McKinney 2014)

1. The information required to be collected and maintained pursuant to sections twenty-eight hundred five-j and twenty-eight hundred five-k of this article, reports required to be submitted pursuant to section twenty-eight hundred five-l of this article and any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be kept confidential and shall not be released except to the department or pursuant to subdivision four of section twenty-eight hundred five-k of this article.
2. Notwithstanding any other provisions of law, none of the records, documentation or committee actions or records required pursuant to sections twenty-eight hundred five-j and twenty-eight hundred five-k of this article, the reports required pursuant to section twenty-eight hundred five-l of this article nor any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.
3. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person, partnership, corporation, firm, society, or other entity on account of the communication of information in the possession of such person or entity, or on account of any recommendation or evaluation, regarding the qualifications, fitness, or professional conduct or practices of a physician, to any governmental agency, medical or specialists society, or hospital as required by sections twenty-eight hundred five-j, twenty-eight hundred five-k and twenty-eight hundred five-l of this article or any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter. The foregoing shall not apply to information which is untrue and communicated with malicious intent.

Domestic Violence

N.Y. Exec. Law § 575(10) (McKinney 2014)

10. Fatality review team.

(a) There shall be established within the office a fatality review team for the purpose of analyzing, in conjunction with local representation, the domestic violence-related death or near death of individuals, with the goal of:

(i) examining the trends and patterns of domestic violence-related fatalities in New York state;

(ii) educating the public, service providers, and policymakers about domestic violence fatalities and strategies for intervention and prevention; and

(iii) recommending policies, practices, procedures, and services to reduce fatalities due to domestic violence.

(b) A domestic violence-related death or near death shall mean any death or near death caused by a family or household member as defined in section eight hundred twelve of the family court act or section 530.11 of the criminal procedure law, except that there shall be no review of the death or near death of a child for those cases in which the office of children and family services is required to issue a fatality report in accordance with subdivision five of section twenty of the social services law.

(c) The team shall review deaths or near deaths in cases that have been adjudicated and have received a final judgment and that are not under investigation.

(d) Members of a domestic violence fatality review team shall be appointed by the executive director, in consultation with the advisory council, and shall include, but not be limited to, one representative from the office of children and family services, the office of temporary and disability assistance, the division of criminal justice services, the state police, the department of health, the office of court administration, the office of probation and correctional alternatives, the department of corrections and community supervision, at least one representative from local law enforcement, a county prosecutor's office, a local social services district, a member of the judiciary, and a domestic violence services program approved by the office of children and family services. A domestic violence fatality review team may also include representatives from sexual assault services programs, public health, mental health and substance abuse agencies, hospitals, clergy, local school districts, local divisions of probation, local offices of the department of corrections and community supervision, the office of the medical examiner or coroner, any local domestic violence task force, coordinating council or other interagency entity that meets regularly to support a coordinated community response to domestic violence, any other program that provides services to domestic violence victims, or any other person necessary to the work of the team, including survivors of domestic violence.

(e) The team shall identify potential cases and shall select which deaths or near deaths will be reviewed each year. Localities may request that the team conduct a review of a particular death or near death.

(f) The team shall work with officials and organizations within the community where the death or near death occurred to conduct each review.

(g) Team members shall serve without compensation but are entitled to be reimbursed for travel expenses to the localities where a fatality review will be conducted and members who are full-time salaried officers or employees of the state or of any political subdivision of the state are entitled to their regular compensation.

(h) To the extent consistent with federal law, upon request the team shall be provided client-identifiable information and records necessary for the investigation of a domestic violence-related death or near death incident, including, but not limited to:

(i) records maintained by a local social services district;

(ii) law enforcement records, except where the provision of such records would interfere with an ongoing law enforcement investigation or identify a confidential source or endanger the safety or welfare of an individual;

(iii) court records;

(iv) probation and parole records;

(v) records from domestic violence residential or non-residential programs;

(vi) records from any relevant service provider, program or organization; and

(vii) all other relevant records in the possession of state and local officials or agencies provided, however, no official or agency shall be required to provide information or records concerning a person charged, investigated or convicted in such death or near death in violation of such person's attorney-client privilege.

(i) Any information or records otherwise confidential and privileged in accordance with state law which are provided to the team shall remain confidential as otherwise provided by law. All records received, meetings conducted, reports and records made and maintained and all books and papers obtained by the team shall be confidential and shall not be open or made available, except by court order or as set forth in paragraphs (k) and (l) of this subdivision.

(j) Any person who releases or permits the release of any information protected under paragraph (i) of this subdivision to persons or agencies not authorized to receive such information shall be guilty of a class A misdemeanor.

(k) Team members and persons who present information to the team shall not be questioned in any civil or criminal proceeding regarding any opinions formed as a result of a meeting of the team. Nothing in this section shall be construed to prevent a person from testifying as to information which is obtained independently of the team or information which is public.

(l) Team members are not liable for damages or other relief in any action brought by reason of the reasonable and good faith performance of a duty, function, or activity of the team.

(m) Consistent with all federal and state confidentiality protections, the team may provide recommendations to any individual or entity for appropriate actions to improve a community's response to domestic violence.

(n) The team shall periodically submit a cumulative report to the governor and the legislature incorporating the aggregate data and a summary of the general findings and recommendations resulting from the domestic violence fatality reviews completed pursuant to this subdivision. The cumulative report shall thereafter be made available to the public, consistent with federal and state confidentiality protections.