Chapter 2
Theoretical Framework

2.1 Brief Overview

This case is described in terms of James Reason's *organizational accident* framework.[1] An organizational accident is a confluence of human, situational and other contextual circumstances that combine and breach established organizational defenses that have been erected to guard against certain hazards; when breached, those hazards produce harmful outcomes (Fig. 2.1). Failure in an organization generally occurs "…when some operation, employee, policy or process produces results that deviate from expectations in substantial and disruptive ways. Failure encompasses accident, non-performance, corrupt performance and deviant behavior."[2] When an organizational accident occurs, it typically takes on four dimensions—organizational factors, unsafe supervision, preconditions for unsafe acts and unsafe acts—that consist of both active failures and latent conditions, which under context-specific situations align to allow a given hazard to breach each level of established defense.

An active failure arises when an employee performs an act of commission or an act of omission that is outside the scope of accepted policy or practice, and the result is likely to have immediate and harmful consequences. Active failures arise in two forms, from errors that are unintentional and from violations that are intentional breaches of accepted policy or practice. Although individual employees are the source of active failures and it is their initial conduct and subsequent failure to correct conditions that combine to cause harm, an active failure is often preceded by latent conditions that lay dormant and go unnoticed or are ignored, yet which play a facilitating role in initiating and accelerating the active failure.

Latent conditions are features of the system (e.g., deficient policies, inadequate supervision, under staffing, inadequate training and technical proficiency) that are substandard and have been left undetected or unresolved until the active failure reveals them. While active failures are committed by operators (i.e., police officers) at the sharp end of the system, latent conditions result from decision and indecision by senior- and mid-level police managers and front-line supervisors

[1] Reason 1997 [1, 2].
[2] Ref. [3]

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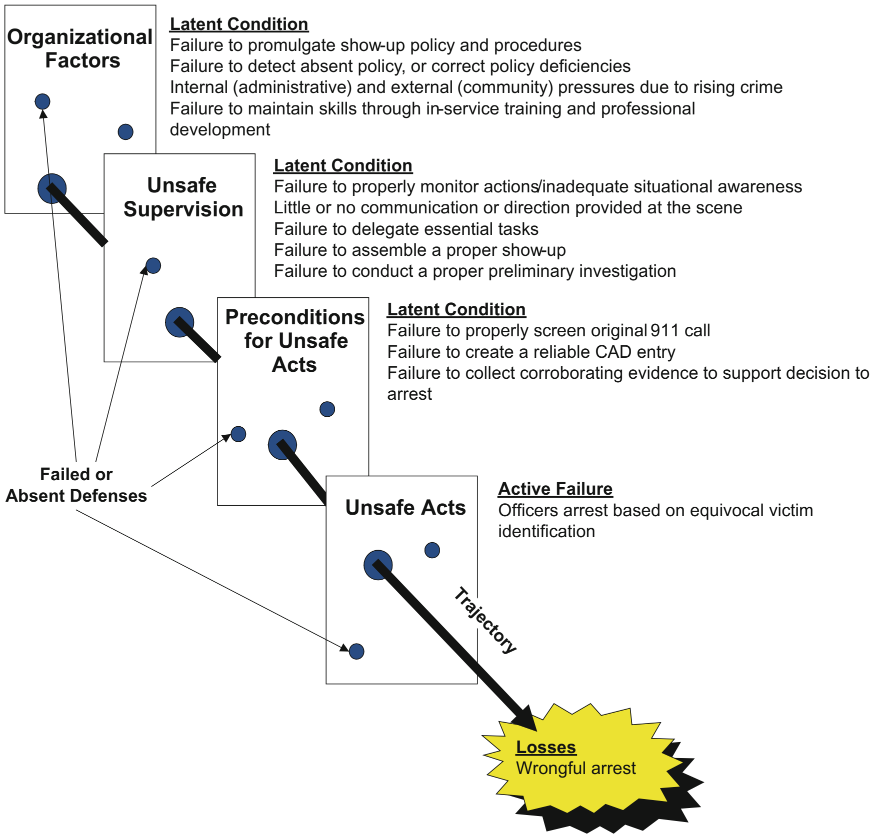

Fig. 2.1 Example of a wrongful arrest following a police show-up framed by the organizational accidental model (modified from [14])

inside the organization and by regulators outside the organization. Latent conditions often lay undetected partly from failure of imagination and complacency because harmful errors are rare events, but also because reviewing and challenging established policies and processes that seem to be working well may be regarded as pointless by managers and subsequently dismissed.[3]

Active failures are guarded against by purposely designing the organization with deep defenses in mind to ensure unsafe acts are stopped before they

[3] Reason 1997 [1], at 6, *The Dangers of the "Unrocked Boat,"* (describing the gradual erosion of safety and the slide into complacency); Ref. [4] (assumption-based planning is intended to counter this complacency); *see also* Reason 1998 [3] (moving toward the ideal informed safety culture includes "not forgetting to be afraid" simply because an accident is a rare event, or has not occurred); Ref. [4, 5]; THE 9/11 COMMISSION REPORT, at 339, 344–348 (citing the "failure of imagination" as a contributing factor of the U.S. Government's failure to act).

materialize, or at least corrected before they cause someone harm. The defenses police departments implement are "soft" in that they are a combination of people and paper: "legislation, regulatory surveillance [scheduled and unscheduled audits, integrity tests and inspections], rules and procedures, training, drills and briefings, administrative controls, licensing, certification and supervisory oversight."[4] When successive gaps or weaknesses align under specific circumstances, the hazard that is sought to be guarded against now comes into damaging contact with people or property and harmful consequences ensue.

2.2 Organizational Factors

Organizational factors reside at the top of the hierarchy and are controlled by executives and managers. The organization takes its design from rational planning exercises undertaken by the top management, which are reflected in Luther Gulick's acronym POSDCORB,[5] where administrators and managers set the climate, decide how to structure the organization and allocate resources to achieve the desired mission. How resources are apportioned impacts the principles embedded in the agency's operating policies. For example, systematically underfunding the agency leads to inadequate staffing; inadequate staffing creates personnel shortages; personnel shortages create gaps at the operating level, where shortcuts and other risky practices become normalized to satisfy competing demands caused by internal and external pressure for productivity. When this occurs, safety is likely compromised.

Similarly, creating and maintaining policy is a matter of directing the organization. When policy is deficient, or entirely absent and left undetected, individual police officers and supervisors are not left with sufficient guidelines on how to operate in a given circumstance. Although an insufficient policy or the failure to promulgate a written policy does not absolve the individual officer from personal responsibility, it does serve as a precursor (i.e., latent condition) that facilitates an unsafe act, which ultimately leads to harmful consequences. Policies are the organization's first line of defense to unsafe acts; they are the bedrock upon which democratic policing is built in rule-of-law societies and must comport with the legal and ethical constraints imposed by the substantive law, procedural law and accepted industry standards. Policies act as safeguards to counterbalance the competing constructs of production and safety in an organization. As the police bureaucracy grows more diversified with specialized units, production increases as

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[4] Reason 1997 [1] at 8 (contrast with "hard" defenses, which are defined as physical devices such as locks, alarms and warning lights).

[5] LUTHER GULICK, NOTES ON THE THEORY OF ORGANIZATION (L. Gulick and L. Urwick Eds., Papers on the Science of Administration 1936 at 3–35, Institute of Public Administration) (POSDCORB: planning, organizing, staffing, directing, coordinating, reporting and budgeting).

does the likelihood for exposure to hazards.[6] Ideally, as production increases, there should be a corresponding increase in safety (i.e., sound operating policies, supervision and span of control[7]), yet they rarely receive parity; production typically wins.

In short, organizational factors inevitably become a "…quality, reliability or safety problem for someone somewhere in the system at some later point."[8]

2.3 Unsafe Supervision

Police supervision is organized at graduated (hierarchical) levels to ensure the procedural, legal and ethical mandates embedded in policies are upheld. Supervisors do this by making decisions and monitoring line staff by lending their knowledge and expertise to specific situations. Supervision at each level provides another layer of defense against unsafe acts, and supervisors are entrusted to oversee operations and make corrections—both proactively and reactively—when warranted. By virtue of their status, supervisors have the authority and responsibility to direct the front-line officers' actions to ensure appropriate action is taken, to provide subordinate personnel with advice and technical assistance, as well as review their work to ensure proper procedures are followed and reasonable standards of workmanship are maintained. Although supervisors may delegate assignments to subordinate personnel with the authority to complete the assignment, the supervisor does not delegate responsibility; the supervisor remains accountable for his or her actions and those of the subordinate personnel, which is a public expectation rooted in accountability.[9]

If a police supervisor is not well versed in policies and practices due to inadequate training, personal preparation or inexperience, then they are likely to make decisions based on outdated information, or rely on outmoded practices or standards that leave a gap sufficient for an unsafe act to breach. When this occurs throughout the supervisory chain, the intended organizational defense (i.e., supervision) is compromised and can do little to stop the accident's trajectory. When higher supervisory elements of the organization are aware of an individual supervisor's

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[6] Production hazards in policing are engaging in arrests, traffic stops, field interviews, custodial interrogations, identification procedures, search and seizure activities particularly search warrant service, vehicular pursuits, using force, employing confidential informants and other similar enforcement actions; *see also* Ref. [4–6] (describing the competing interests of production and safety).

[7] Span of control is defined as the maximum number of subordinate personnel a single supervisor can effectively manage *see* Refs. [7, 8].

[8] Reason, 1997 [1] at 12.

[9] Accountability means to subordinate to a process, where the subject bears an obligation or willingness to accept responsibility and to proffer a statement or explanation of the reasons, causes or motives for their actions; *See* Iannone [7, 8] at 25–28 and Schroeder, Lombardo & Strollo [7, 8] at 26–29, [7, 8].

incompetence and promote the supervisor, or allow the supervisor to continue in their role without remedial training or removing the supervisor from that role, then the organization may assume vicarious liability for negligent supervision and training; in the case of willful disregard of the law or policy, a supervisor may be held liable for malfeasance, misfeasance or civil rights violations.[10]

2.4 Preconditions for Unsafe Acts

Preconditions for unsafe acts involve environmental and personnel factors that account for poor tactics, competing interests and inadequate personal preparedness, which facilitates a breach in the organization's defenses. In the policing context, the environmental factors include the physical surroundings, political climate and the technical interface. The physical environment can present unanticipated hazards that can reduce visual cues or become distracting, which leads to perceptual errors at a time when crucial decisions must be made. The political climate influences the style of policing adopted by the agency, which affects the organizational culture and ultimately how personnel behave.[11] Police chiefs take their cue for organizational structure and institutional behavior from community sentiment that is expressed through elected officials (most often the mayor and council members). Three styles of policing emerged from early research in this area—watchman, legalistic and service.[12] The watchman style is typically found in working-class communities and emphasizes order maintenance, where the preferred method to resolve conditions is discretion, resorting to arrest is the last option. The legalistic style is typically found in communities with high crime and emphasizes formal action and less officer discretion by invoking the law and effecting arrests. The service style is typically found in affluent communities and is oriented toward discretion and addressing community needs. Although each policing style accepts arrests and enforcement actions differently as a measure of policing style, overall crime rate is usually a strong predictor of arrest[13] and there is likely to be some degree of overlap among styles instead of mutual exclusivity.

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[10] *See* 42 USC §1983—Action for Deprivation of Rights; *see also* Monroe v. Pape, 365 U.S. 167, 81 S. Ct. 473 (1961) and Monell v. Department of Social Services. 436 U.S. 658 (1978) (establishing that local governing bodies and local officials can be sued directly under §1983 for damages, where their edicts or acts may fairly be said to represent *de facto* policy. Monell cases are informally referred to as "pattern or practice" suits even though the custom or pattern at issue has not received formal approval through the government's official decision-making channels); *see also* Williams v. Anderson 599 F. 2d 923 (1979), Ford v. Byrd 544 F.2d 194 (1976) (holding management, the police agency and the jurisdiction responsible for acts committed by subordinate personnel); Ref. [9].

[11] Ref. [10]; for an extended discussion of police culture and cultural deviation see O'Hara [3] at 137–179.

[12] Wilson [10].

[13] Ref. [11]

The personnel factors encompass mental and physiological states and technical job knowledge required to carry out the police function in a given situation. Adverse mental conditions include mental fatigue, overconfidence, complacency and physiological states such as physical fatigue, pharmacological and medical conditions that impair performance. The technical environment rests heavily on knowledge of the substantive and procedural law for direction, which is typically embedded in agency rules, regulations and policies.

As a matter of course, the environmental factors shape the operational tempo; when hazardous conditions are present, the operational tempo increases, which requires swifter decisions that may be based on incomplete information or memory lapses eventually compromising safety. As hazardous conditions subside and the scene becomes "secure," the operational tempo slows giving way to decisions based on more complete information and rational thought.[14] In each instance, the demand for technical knowledge is present but is more pressing in the former than the latter. As the police establish control over a situation and slow the pace of the events, they gain an advantage in their decision making and they are better able to apply their technical knowledge as the event unfolds.

The public demands that police officers demonstrate a minimum level of competence before they are permitted to make decisions on their behalf. Once they are admitted to practice, they must undergo periodic professional development to maintain or strengthen their business acumen so their technical competencies do not evanesce. Periodic training ensures police officers are knowledgeable about changes in the laws, policies and procedures that govern their work product, but most importantly that each officer is forearmed with knowledge that allows them to scrupulously monitor the competing interests of crime control and due process.

2.5 Unsafe Acts

Unsafe acts are typically the proximate cause of an organizational accident and include errors and violations, where errors are unintentional and violations are intentional. Errors take many forms, whereas violations are subdivided into two forms, the routine and the exceptional.[15]

Skill-based errors result from divided attention or memory lapses, where the error is inadvertent (e.g., not paying attention to the task). Decision errors represent intentional behavior that proceeds as planned, although the plan itself is poorly designed or inappropriate for the situation. These unsafe acts represent the acts or omissions of individual officers who are "well intentioned," but either lack important technical knowledge or simply make poor choices; in either case, harm results.

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[14] Refs. [12, 13]

[15] Refs. [14–16]

Decision errors typically take two forms, procedural errors and poor choice errors. Procedural decision errors involve sequencing, where structured tasks contain successive steps that must be executed to ensure safety.[16] These errors arise when operators fail to observe accepted industry standards for a given activity. Poor choice errors occur when the decision-maker is confronted with a situation and has options for proceeding, but selects an option that is influenced by external pressure, time, inexperience or insufficient knowledge. In an effort to expedite the matter, or "go along to get along," the individual chooses a path that ultimately proves harmful.

Perceptual errors occur when interpretation differs from reality. Police officers interpret events within their ken, which is informed by personal and vicarious experience and training. They will often rely on perceptual shorthand to sift through rapidly evolving facts that may be mixed with lies, unusual circumstances or other ambiguities that distort reality. When this occurs, the officer is left to make a decision based on incomplete information, which inevitably increases the risk of committing a harmful error. Importantly, the distorted reality confronting the officer is not the perceptual error; rather, the officer's reaction to the distortion is what triggers or accelerates the error.

Hardware errors relate to the quality and availability of equipment necessary to execute the police function. An operational hardware error may occur when equipment is misused based on training or manufacturer's recommendation; however, a latent hardware error occurs when necessary equipment is aging, or is not available (e.g., loss, theft, damage or has never been purchased). Communications errors occur when pertinent information is not collected and transmitted to support the operation, or when instructions are not conveyed or not received and understood by operators from someone who has relevant knowledge or situational awareness. Goal conflict errors arise from competing interests held at different levels of the organization: (1) at the individual level, operators may be preoccupied with or distracted by personal matters; (2) at the work-group level, informal norms and practices may conflict with formal policies; and (3) at the organizational level, there may be disparity between production and safety. Goal conflict may arise formally through written documents or tacitly through pressure from managers and supervisors.

Design errors occur when there is a failure to provide direction through published policy or procedure (the knowledge gap). Maintenance management errors occur when there is a failure to maintain or upgrade individual skills through relevant and timely training, or to maintain equipment at specified intervals dictated by law, policy or manufacturer's recommendation. Lastly, training errors occur when personnel fail to comprehend the material, or when training is downgraded in quantity or quality leaving a gap between innovation and practice.

While errors are unintentional and occur within the confines of the law and established policy, violations are intentional and occur as a matter of routine and

[16] Ref. [17]

exception. Routine violations occur as a matter of accepted past practice and may be tolerated by the organization.[17] Institutionally accepted past practice typical exists when at least three elements are present: (1) clarity and consistency; (2) longevity and repetition; and (3) acceptability. Clarity and consistency define how a given course of conduct is viewed by the organization. When particular conduct is vague or is contradicted as often as it is followed, then it does not qualify as a practice. However, where employees respond in a predictable manner to a given condition, then their conduct will likely develop into a practice. Consistent conduct must be accompanied by a period of time sufficient to establish a pattern of repetitive behavior. Isolated incidents do not establish a practice; however, defining how frequently and over what period of time the conduct must occur before it qualifies as a practice is a value judgment and does not lend itself to a precise formula. Lastly, employees and supervisors alike must know the conduct exists *and* must regard it as a legitimate and customary means of handling a situation. Whether passed along in oral history or deed, conduct becomes acceptable when employees and supervisors acquiesce to it and do not complain about its existence. It is this conduct that partly explains how *Monell* cases (i.e., pattern or practice lawsuits) arise and how *de facto* policy is established. Accepted past practice implicates the supervisory chain insofar as the practice is typically widely known and often condoned by, if not practiced by management, which is tantamount to "bending the rules" and while it "takes two to Tango," management bears the responsibility for stopping it.

Exceptional violations occur, not as a matter of routine, but as a departure from established authority that amounts to an isolated incident, which neither indicates routine practice or management-sanctioned behavior.[18] Exceptional in this context does not refer to the egregiousness of the violation; rather, the violation is exceptional because it is neither characteristic of the individual, nor sanctioned by management. Although uncovering and correcting routine violations should be a matter of practice during periodic audits and inspections, exceptional violations are virtually impossible to predict since they are anomalous and do not reveal themselves through established patterns.

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[17] Reason 1997 [3].

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