Justice with a Purpose:
Collaborative Just Culture™
for Law Enforcement and Corrections

2014 IACP Conference
October 27, 2014

Presented by Chief Charles A. "Chuck" Gruber
and
Scott Griffith

IACP 2014
OCTOBER 25-28
ORLANDO, FL
ORANGE COUNTY CONVENTION CENTER

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Presentation Learning Objectives

Participants should be able to:

- Recognize and guard against the Outcome Bias
- Describe a balanced accountability in terms of both systems and human behaviors within the socio-technical pyramid of risk
- Understand the fundamental attributes and advantages of a Collaborative Just Culture™
- Articulate the key concepts of collaboration necessary to produce better outcomes in law enforcement and corrections

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Our Challenges and Opportunities

An Introduction by
Police Chief Charles A.
“Chuck” Gruber

"All too often…we enjoy the comfort of opinion without the discomfort of thought."

John F. Kennedy

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Collaborative Just Culture™

K. Scott Griffith

Why Collaborative Just Culture?

"When I first heard of Just Culture, I didn't know what it was, but I knew immediately that we needed it. Only later did I come to realize its simplicity, power, and effectiveness. I now believe that for any high-consequence endeavor, Just Culture must be the foundation for the organizational effort to succeed."

The Honorable Robert Sumwalt, III
Vice Chairman, National Transportation Safety Board

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Serving High Consequence Industries Worldwide

- Healthcare Organizations
- Airlines
- NASA
- Railroads
- Manufacturers
- Emergency Medical Services
- USDA Forest Service
- Nuclear Power Companies
- Air Traffic Contral
- Information Management
- Law Enforcement
- Fire Services

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Serving Regulators and Associations

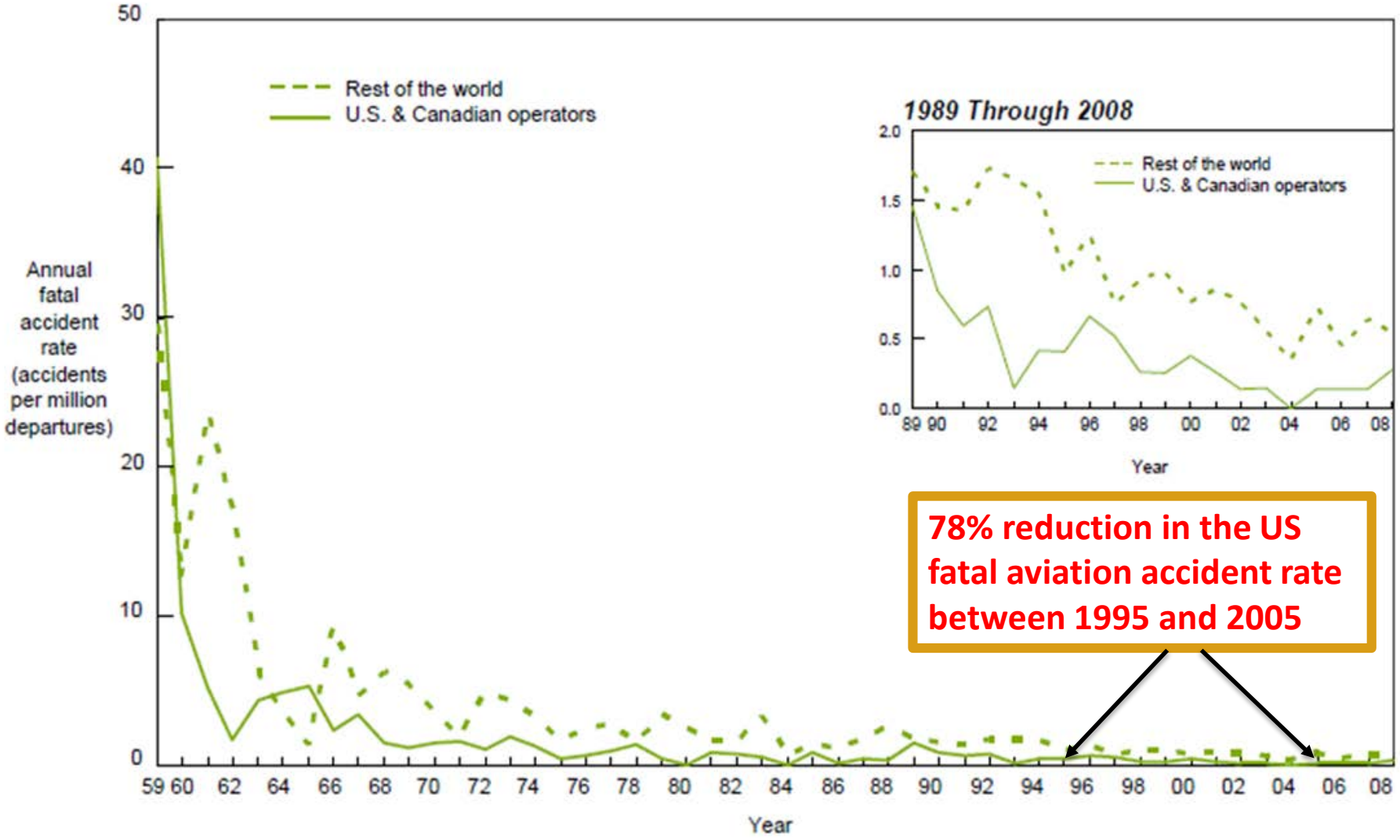
- Federal Aviation Administration
- National Transportation Safety Board
- US Departments of Health
- The Joint Commission
- US Boards of Nursing, Pharmacy, and Medicine
- Labor Associations
- Law Enforcement Organizations
- International Association of Chiefs of Police
- Fire and Emergency Services Organizations
- National Highway Traffic Safety Administration
- Air Services Australia

It’s in Our DNA…

An Important Lesson

U.S. and Canadian Operators Accident Rates by Year

Fatal Accidents – Worldwide Commercial Jet Fleet – 1959 Through 2008



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So How Do We Improve?

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A Police Example

On a windy, raining evening, shortly after evening shift hit the streets, a 911 call was placed by a home owner stating he believed someone was in the downstairs portion of his home. Although coming from a considerable distance, Officer Smith was one of but a handful of officers on duty, as shift change had just occurred. Although alone and coming from a considerable distance, he immediately responded in his 2011 Ford Crown Victoria, activating his emergency lights only and proceeded to the call. .

A Police Example

Taking the most direct route to the call, Officer Smith proceeded through a predominantly business part of town which required him to pass through controlled intersections. As his dash cam and vehicle chip would confirm, Officer Friendly approached each intersection, four (4) in total, traveling at approximately 50 mph over the posted speed limit of 35 mph, disregarding many red traffic control devices, in violation of department policies. As Officer Smith approached the intersections, he periodically activated his siren as he proceeded through.

A Police Example

At the 4th intersection, Officer Smith's vehicle slowed to approximately 40 mph as he activated his siren and entered the intersection on a red signal causing another vehicle, a 2010 Toyota Camry, driven by a 74 year old man, to broadside the driver's side of the police vehicle. The impact of the collision caused the police vehicle to veer into the path of another vehicle entering the intersection in the opposite direction. Officer Smith sustained major injuries requiring hospitalization. The driver of the Camry suffered a heart attack and died at the scene. Both vehicles were totaled.

Questions for the Chief

- What would we do in response to the behavior if no collision had occurred and the officer made it to the scene of the suspected crime-in-progress?
- Would we likely even know about the event?
- Does the outcome of the event influence our decision of how to hold the officer accountable?

Where We've Been in Our Society

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes"

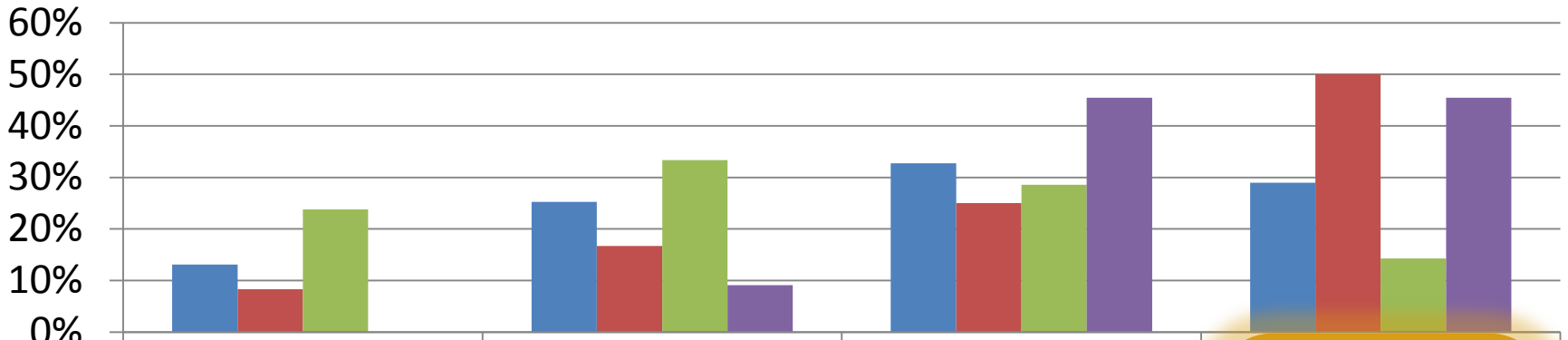
Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement

A Healthcare Example

An experienced surgeon sees a new piece of equipment at a conference. Back at the hospital, a sales representative persuades him to use the equipment for a procedure. He has never used the equipment before and accidentally punctures the patient's bowel. The surgeon repairs the bowel and the patient recovers fully. The OR has a policy that says new equipment will be officially approved and training will be conducted prior to its use. None of the OR staff spoke up when they saw that the physician was about to use equipment that had not been approved.

The Outcome Bias

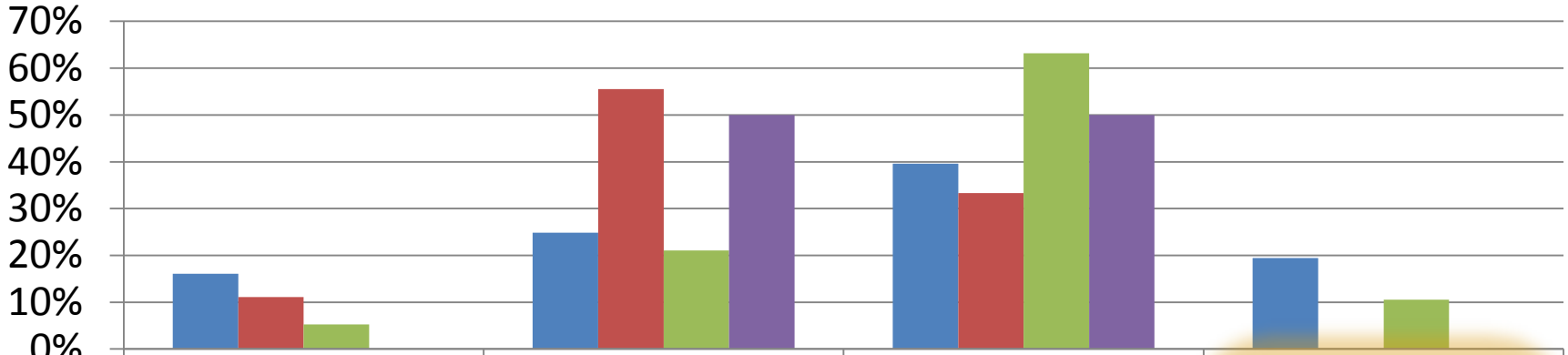
Surgeon Use of Unapproved Equipment – Harmful Outcome



	Take No Action	Warn Not to Make Mistake	Encourage Different Behavior	Discipline or Punish
Staff	13%	25%	33%	29%
Manager	8%	17%	25%	50%
Executive	24%	33%	29%	14%
Physician	0%	9%	45%	45%

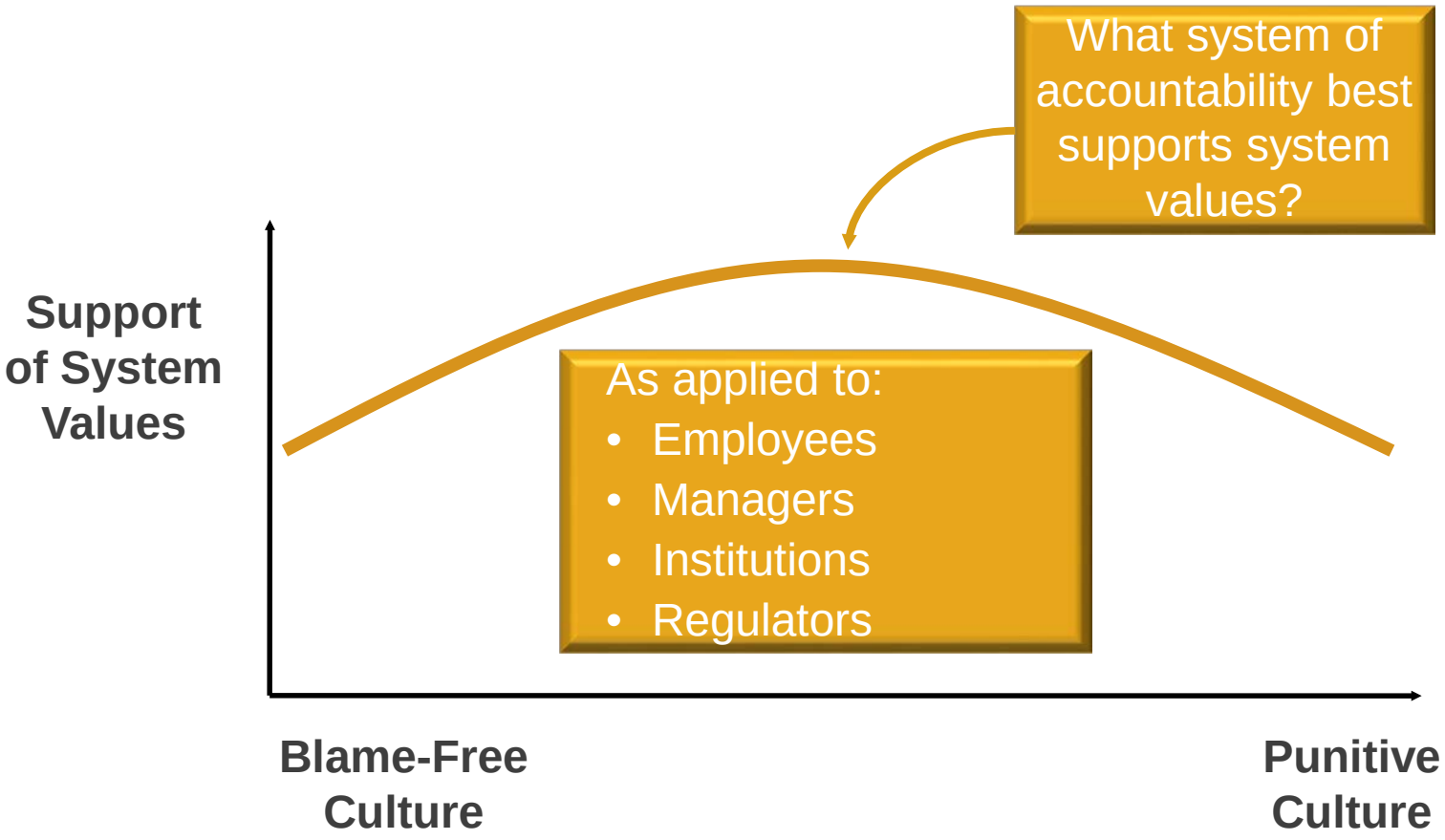
The Outcome Bias

Surgeon Use of Unapproved Equipment – No Harmful Outcome



	Take No Action	Warn Not to Make Mistake	Encourage Different Behavior	Discipline or Punish
Staff	16%	25%	40%	19%
Manager	11%	56%	33%	0%
Executive	5%	21%	63%	11%
Physician	0%	50%	50%	0%

A Balanced Approach



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A Values-Based Approach

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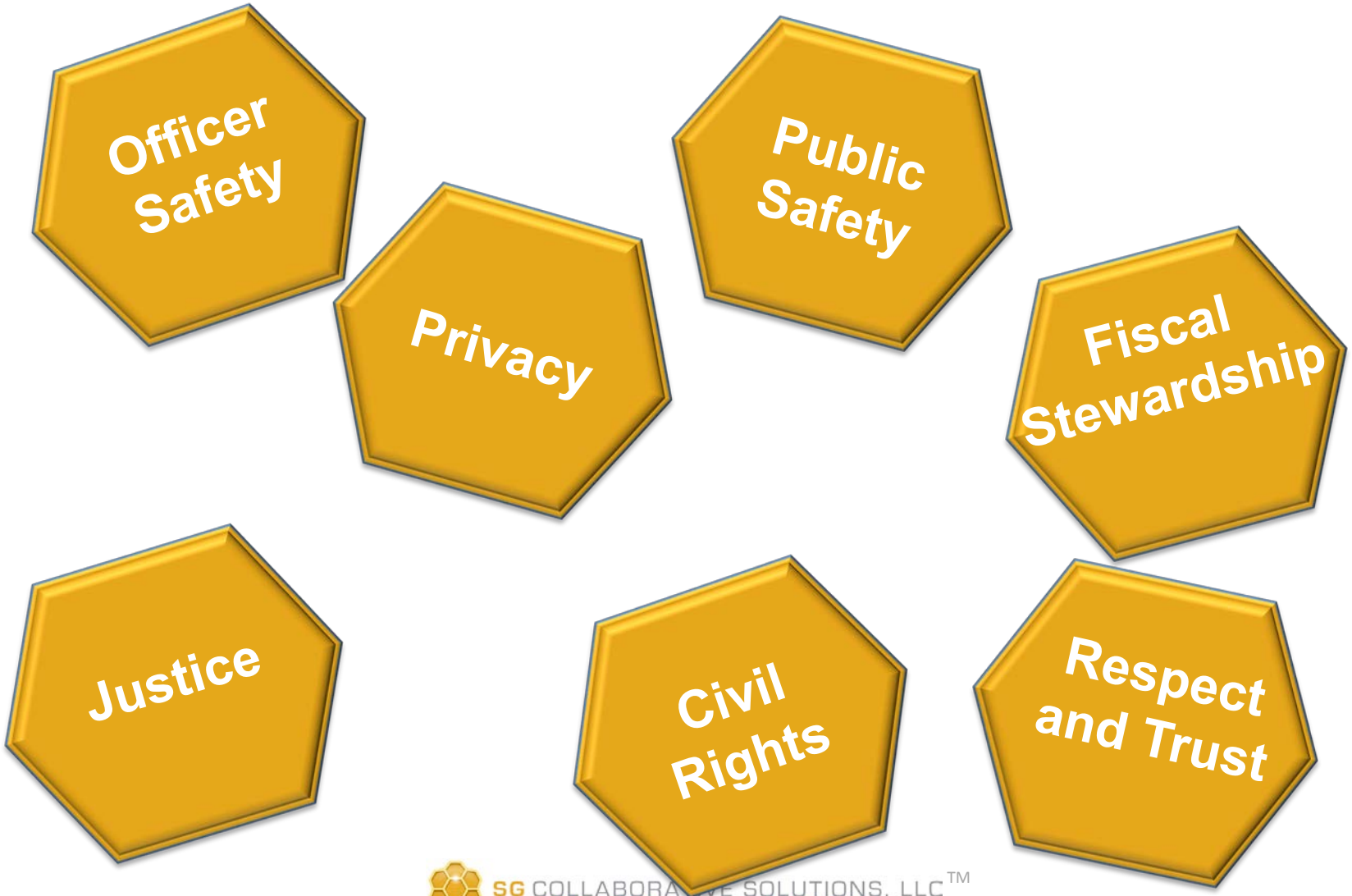
Multiple Departmental Values



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Aligned Departmental Values

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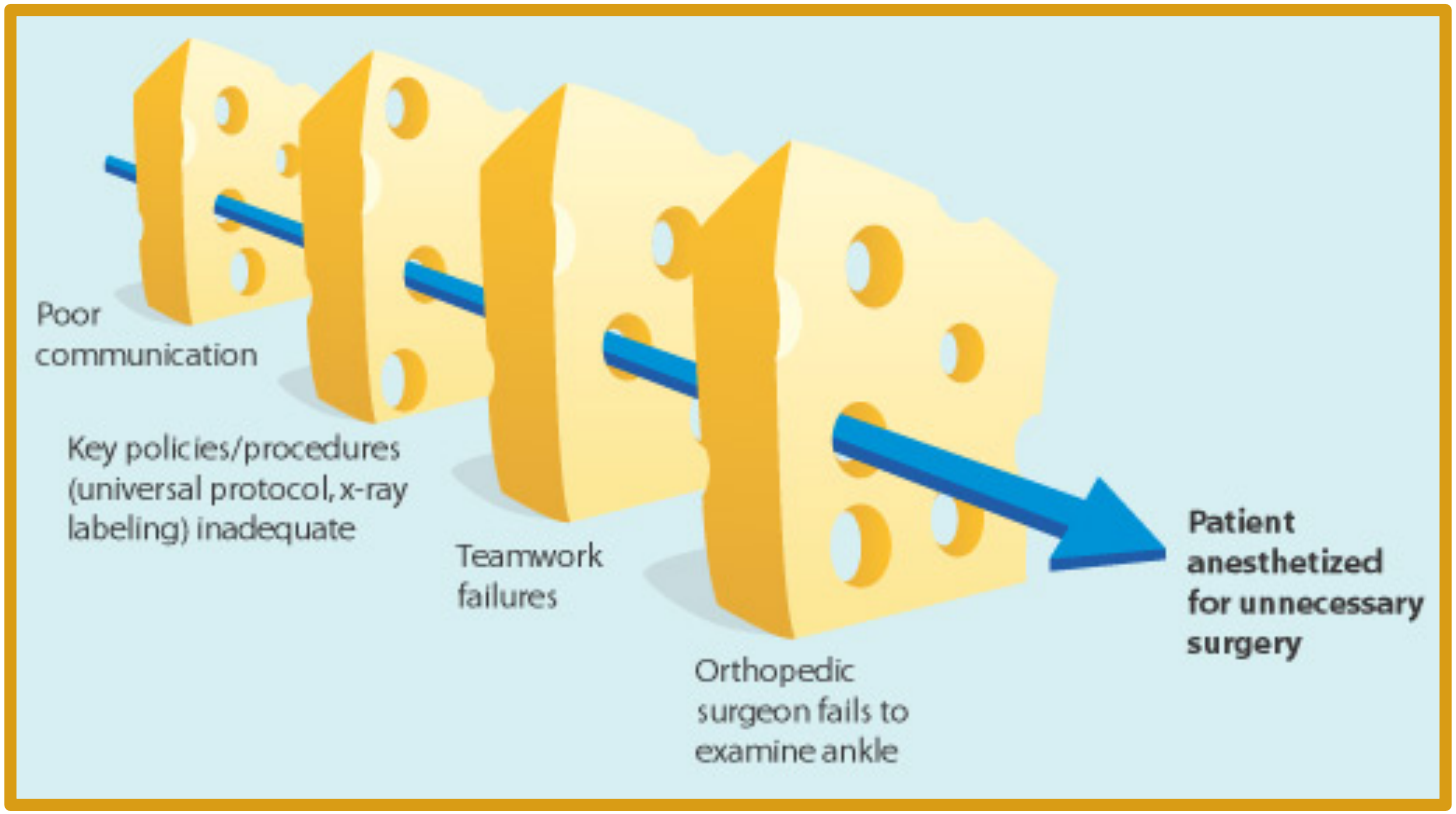
A Brief Introduction to the Science of **Predictive** Risk Management

Simple Models Are Seductive…



…and Sometimes Wrong

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Risk Identification and Ranking

First, a Risk Register

- A ranking of the causes of harm by type of event
- Classified by likelihood, severity, and time criticality

Risk register

Date of risk review.....

Compiled by..... Date .....

Function/activity..... Reviewed by..... Date .....

Ref	The risk: what can happen and how it can happen	The consequences of an event happening		Adequacy of existing controls	Consequence rating	Likelihood rating	Level of risk	Risk priority
		Consequences	Likelihood					

Risk Register Update Cycle

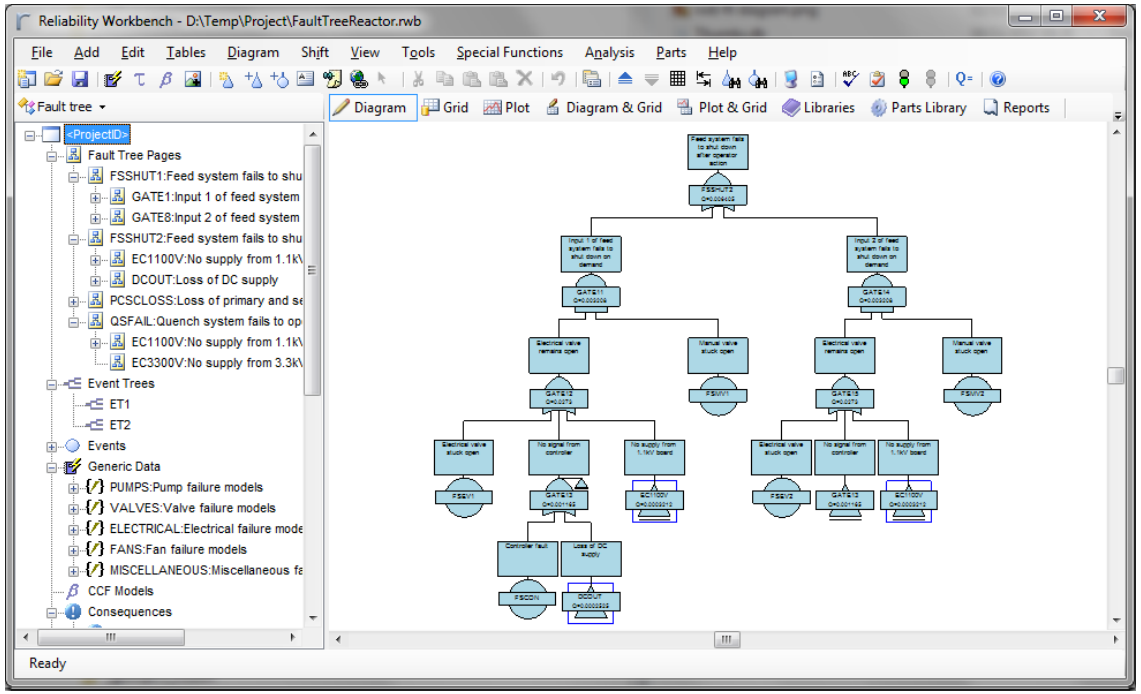
Identify Risks	Qualitative Risk Analysis	Quantitative Risk Analysis	Plan Risk Responses	Monitor & Control Risks
•List of Identified Risks including root causes, consequences etc •List of Potential Responses	•Ranking or Priority list of risks •Risks grouped by categories •Causes of risks •List of risks requiring a near-term response •List of risks for additional analysis and response •Watchlist of low priority risks •Trends in qualitative risk analysis	•Probabilistic Analysis of the Project •Probability of Achieving cost & time objectives •Prioritized list of quantified risks •Trends in quantitative risk analysis	•Agreed upon response strategies •Risk Owner & Assigned Responsibilities •Specific actions to implement the chosen response strategy •Symptoms & warning signs of risk occurrence •Budget and schedule activities required to implement the chosen response •Contingency reserves of time & cost designed to provide for stakeholder risk tolerances •Contingency plans and triggers that call for their execution •Fallback plans •Residual risks expected to remain •Secondary risks •Contingency reserves that are calculated based on quantitative analysis	•Outcomes of risk assessment, risk audits and periodic risk reviews •Closing risks that are no longer applicable •Actual outcomes of Project risks & responses

Causal Mapping and Intervention

Socio-Technical Probabilistic Assessments by Category of Adverse Events

Then, an Explanation

- A description of how the events can occur
- Quantitative set of possible paths
- Linkages between errors, behaviors, equipment failures

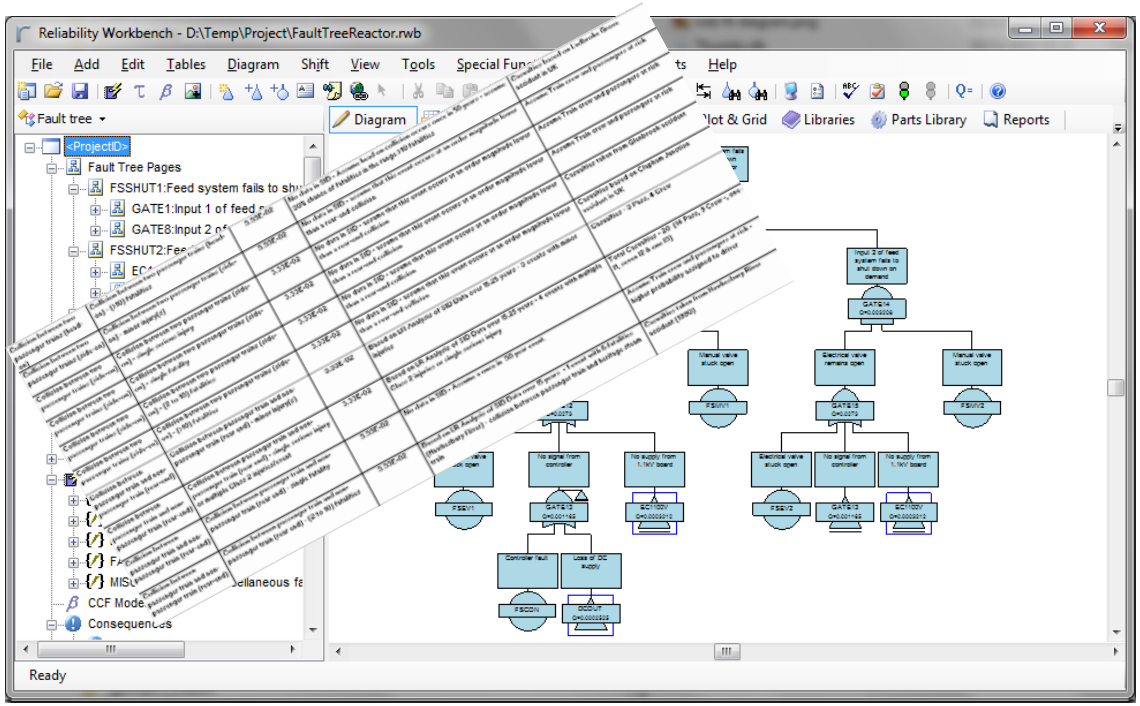


Comparison with Known Events

Third, Event Data

- Events as opportunities to inform the risk model
- Events to let us know how the model is working

Develop Your Strategy and a Dashboard of Predictive Management of Risk



Predictive Science

"Analysis of the circumstances that led to the felonious deaths of 72 law enforcement officers in 2011 will serve as the beginning of a much larger task for the National Center. As the initiative matures, we will draw upon the experiences of officers feloniously assaulted and not killed. Careful analysis of these incidents should yield useful information that can be turned into policy to improve officer safety. As the project continues to mature, it is our intent to look closely at the thousands of officers feloniously assaulted and not killed. "

Law Enforcement Officers Killed by Felonious Assault in 2011 - IACP

Socio-Technical Risk

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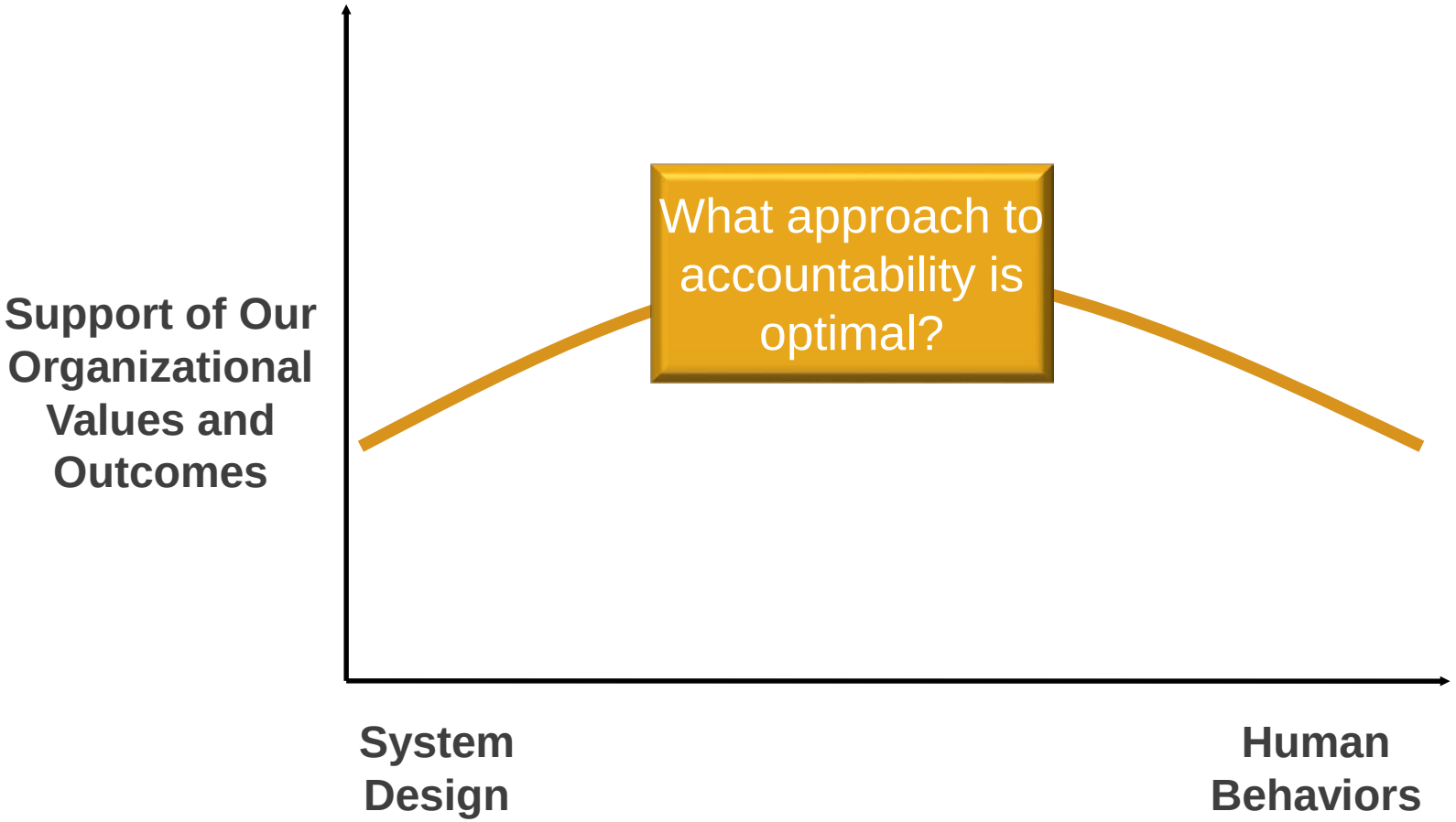
A Balanced Approach



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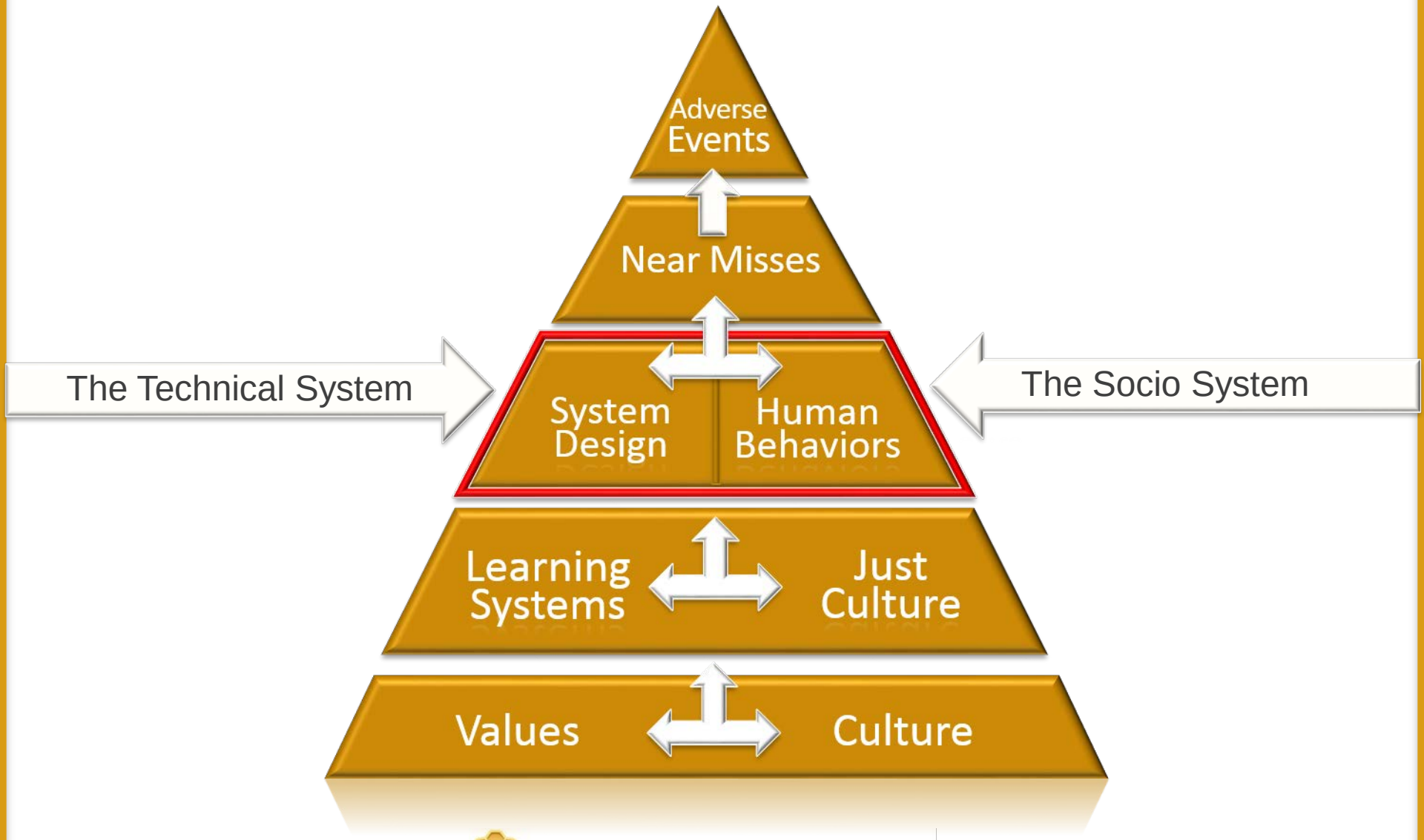
Managing Socio-Technical Risk

The Socio-Technical Pyramid of Risk



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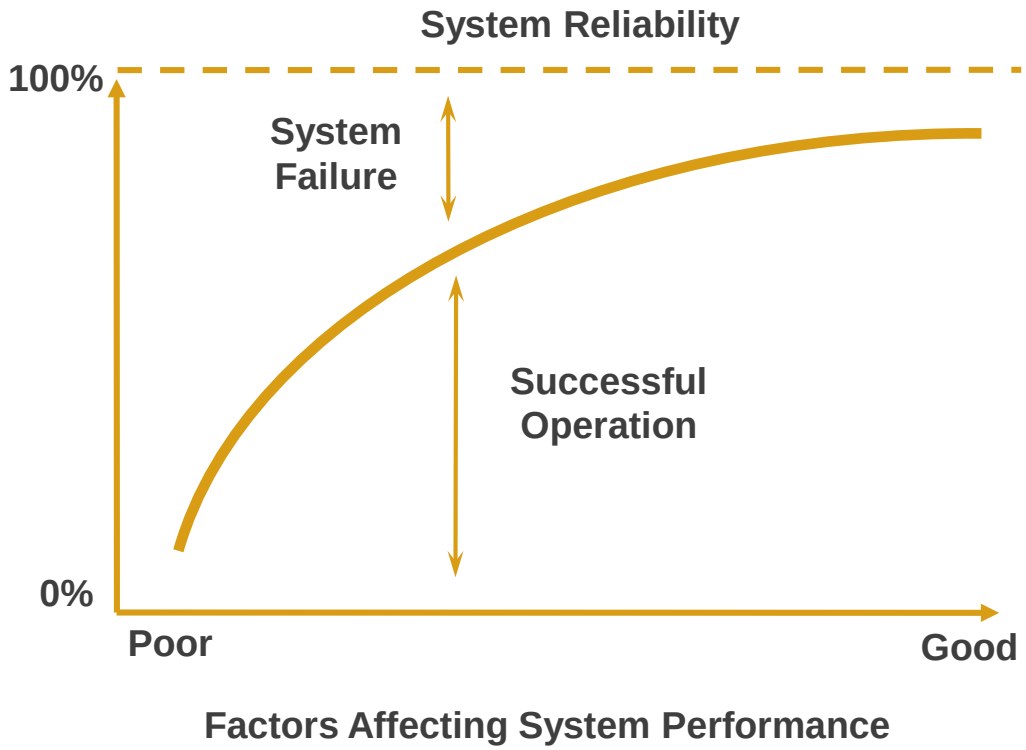
System Reliability

Design for system reliability…

- Human factors design to reduce the rate of error
- Barriers to prevent failure
- Recovery to capture failures before they become critical
- Redundancy to limit the effects of failure



… knowing that systems will never be perfect

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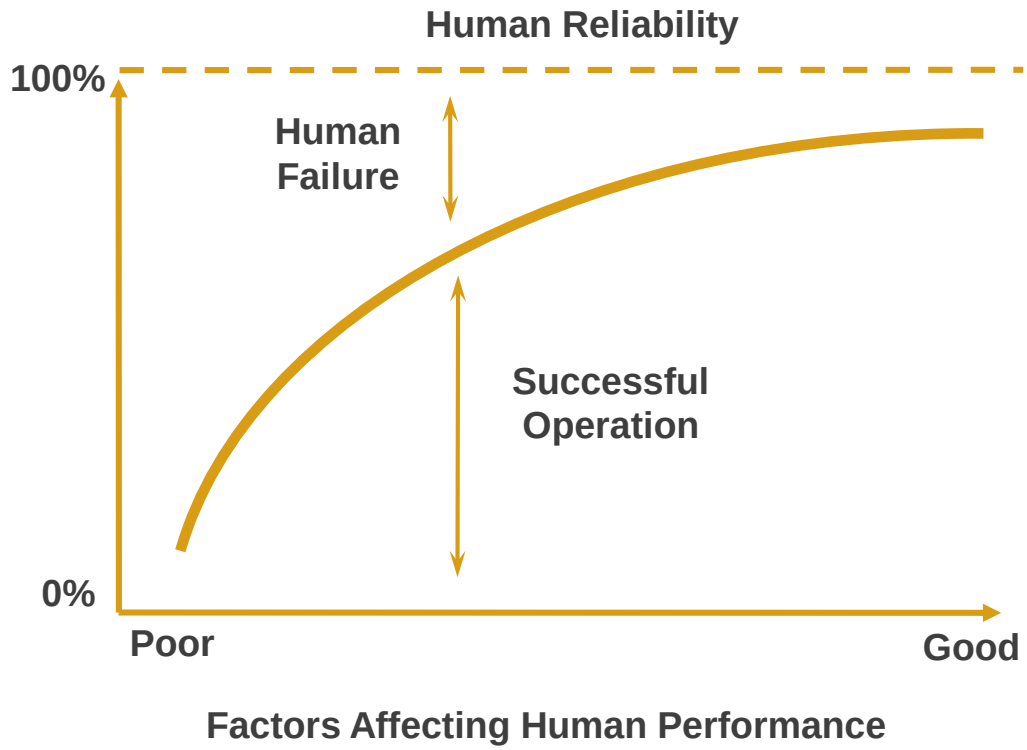
Human Reliability

Design for Human Reliability…

- Information
- Equipment/tools
- Design/configuration
- Job/task
- Qualifications/skills
- Perception of risk
- Individual factors
- Environment/facilities
- Organizational environment
- Supervision
- Communication



… knowing that humans will never be perfect

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System and Behaviors Design Strategies

Human Components

- Expectation of Perfection (A flawed strategy)
- Knowledge and Skill
- Performance Shaping Factors
- Perception of High Risk

System components

- Performance Shaping Factors
- Barriers and Other Forcing Functions
- Redundancies
- Recoveries

Human Behaviors

Three Categories of Behavior

Human Error

The inadvertent action; inadvertently doing other than what should have been done (i.e., a cognitive or physical slip, lapse, or mistake)

At-Risk Behavior

Behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified (action chosen without intention to cause unjustifiable harm)

Reckless Behavior

Behavioral choice to consciously disregard a substantial and unjustifiable risk (action chosen without intention to cause unjustifiable harm)

Two More Categories of Behavior

Impossibility

The risk mitigation strategy (i.e., the policy, procedure, or process was outdated, wrong, or impossible under the circumstances)

Justifiable

Having sufficient grounds for the behavior (i.e., the value chosen superseded the required action)

Two More Higher Culpable Behaviors

Knowingly Causing Unjustifiable Harm

A choice where unjustifiable harm is practically certain to occur

Purpose to Cause Unjustifiable Harm

A choice where the purpose of the behavior is to cause unjustifiable harm

To Err Is Human

Managing Human Error

Response to Employee

- Support and encourage the employee
- Assess and respond to any personal performance shaping factors that contributed to the risk
- Assess and respond to any contributory choices preceding the error

Response to System

- Assess and respond to any system contributors preceding the behavior to manage future risks associated with this human error

To Drift Is Human

At-Risk Behavior

At-Risk Behavior

- A behavioral choice that increases risk without perceiving the risk (i.e., unintentional risk taking), or is mistakenly believed to be justified
- We are driven by our perception of the consequences
  - Immediate and certain consequences are strong
  - Delayed and uncertain consequences are weak
  - Rules are generally weak

Managing Behaviors

Laws aren't stopping drivers' cellphone use

It seems like an epidemic: drivers talking and texting. Now federal regulators have put a number to the dangerous habit.

At any given time about 660,000 drivers are texting, tweeting, talking or otherwise preoccupied with their cellphones while speeding along the freeways or crawling through downtowns and suburban neighborhoods.

That's more people than live in Baltimore.

"There is no way to text and drive safely," said U.S. Transportation Secretary Ray LaHood, whose agency released the survey results Friday. "Powering down your cellphone when you're behind the wheel can save lives, maybe even your own."

Perhaps the most disturbing aspect about the poll, which surveyed 6,000 people ages 16 and older, was that laws meant to curb cellphone use don't seem to be working. Thirty-nine states have tried to prohibit the practice, but there is little evidence that distracted driving has decreased since 2010, according to a National Highway Traffic Safety Administration survey from that year.

That indicates that getting drivers' attention about the dangers of distraction may be more difficult than, for instance, getting them to wear seatbelts, said Jeff Larson, president of Safe Roads Alliance in Boston.

"Police are finding the laws on distracted driving difficult to enforce," he said.

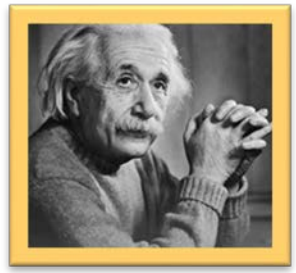
— Los Angeles Times

Managing At Risk Behavior

A behavioral choice:

- Managed by adding forcing functions (barriers to prevent non-compliance)
- Managed by changing perceptions of risk **(Coaching)**
- Managed by changing the consequences
- Examine the system for improvement opportunities

“The definition of insanity is doing something over and over again and expecting a different result.”



Albert Einstein?

But isn’t this our essential challenge in managing at-risk behavior?

Performance Shaping Factors on the Employee

(The strong influences on Human Behavior)

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Managing At Risk Behavior

Response to Employee

- Support and coach the employee and focus attention on any competing values and incentives
- Assess and respond to any personal performance shaping factors
- Mentor the work group around this area of risk and clearly establish expectations

Response to System

- Assess and respond to any system contributors preceding the behavior to manage future risks associated with this at-risk behavior

Managing Reckless Behavior

Managing Reckless Behavior

"The best car safety device is a rear-view mirror with a cop in it."

From the movie *Arthur,* with Dudley Moore

Managing Reckless Behavior

Reckless Behavior

- **Conscious Disregard** of **Substantial**
- and **Unjustifiable** Risk

Manage through:

- Disciplinary action
- Punishment as a deterrent
- How will you achieve the best outcome?

Note: Remediation is always available

Identify the Behaviors (Group Activity)

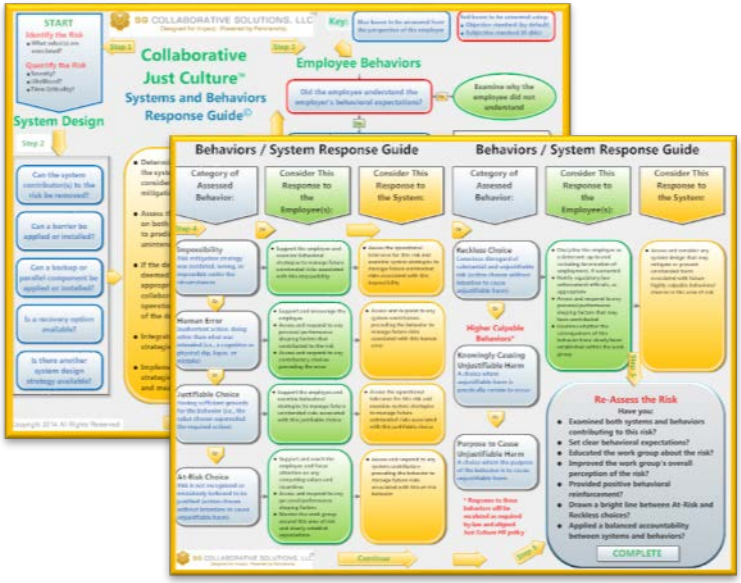
A Pattern for Cultural Success

Establishing and Maintaining Expectations around Behaviors to Support Our Values

- Examine your system(s)
- Begin education
- Change perceptions of risk
- Provide positive reinforcement
- Clearly set expectations
- Provide consistent consequences

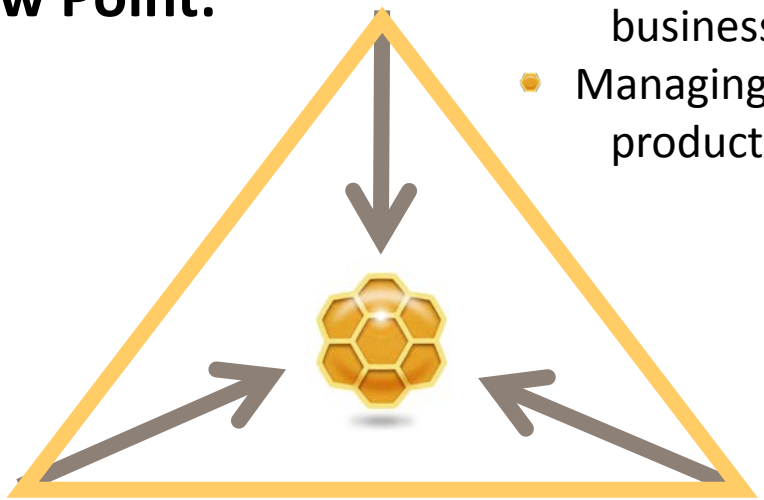
The Collaborative Just Culture™

Systems and Behaviors Response Guide©


Collaborative
Just Culture™
Systems and Behaviors
Response Guide©
Employee Behaviors
System Design
Behaviors / System Response Guide
Behaviors / System Response Guide
Category of Assessed Behavior:
Consider This Response to the Employee(s):
Consider This Response to the System:
Re-Assess the Risk
COMPLETE

Your Primary Collaborators

Collaboration and Optimized Review Point:



Operations

- Driving the business of the business
- Managing relationships & productivity

Human Resources /Labor Associations

- Ensuring Comprehensive Justice
- Monitoring Culture

Risk/Quality/Safety

- Ensuring Reliability
- Culture of Safety
- System Optimization

The Path Ahead: Collaborative Just Culture™ in Law Enforcement and Corrections

Demonstration Projects

- We are looking for opportunities to demonstrate the power of Collaborative Just Culture™ in law enforcement departments worldwide
- Demonstrations projects are being developed to test the model in multiple cities – the projects contain specific timelines, objectives, and measurements that will be shared with IACP and the funding organizations
- Government oversight agencies, municipal governments, and citizen groups will be included in the development, measurement, and reporting process

Topics for Discussion

- How can PD Command Officers and Mid-Managers get police officers to come forward to discuss potential risky behaviors and decision-making by line officers?
- Even model police officers can cut corners, leading to risky behaviors and decision-making
- Police officers can adhere to a “code of silence” in talking about the risky behaviors and decision-making of fellow officers
- Police officers may do their jobs differently when not directly being observed by supervisors and PD Administration

Topics for Discussion

- How do we manage varying risks on a daily basis?
- How do we predict risky behaviors and critical incidents, and revise policies and procedures to avoid or mitigate?
- Can better behaviors produce better outcomes?
- Are Police Chief's and Command Staff's contact and interactions with line officers critical to achieving better outcomes?
- How, where, and when does transparency play a role in achieving better outcomes?

Thank You!

To learn more and download more materials please visit us at:

www.sg-collaborative.com

Or Call Chief Gruber at: 847.878.5012